Durable Medical Equipment

Policy ID:	HWC-PA-RP-025
Approved By:	Highmark Wholecare – Market Leadership
Provider Notice Date:	07/27/2026
Original Effective Date:	10/01/2026
Annual Approval Date:	10/01/2026
Last Revision Date:	06/2026
Products:	Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1 of 42

Disclaimer

Highmark Wholecare medical policy is intended to serve only as a general reference resource regarding coverage for the services described. This policy does not constitute medical advice and is not intended to govern or otherwise influence medical decisions.

POLICY STATEMENT

This policy provides information regarding the coverage of medical benefits, as determined by applicable federal and/or state legislation.

This policy is designed to address medical necessity guidelines that are appropriate for the majority of individuals with a particular disease, illness or condition. Each person's unique clinical circumstances warrant individual consideration, based upon review of applicable medical records.

The qualifications of the policy will meet the standards of the National Committee for Quality Assurance (NCQA) and the Pennsylvania Department of Health (DHS) and all applicable state and federal regulations.

DEFINITIONS

Durable Medical Equipment- Medical item or device that can be used in a member's home or in any setting where normal life activities occur and is generally not used unless a person has an illness or injury.

Durable Medical Equipment Supplies (DMES)- Supplies that are disposable and usually used once or short term

Highmark Wholecare – Managed care organization serving vulnerable populations that have complex needs and qualify for Medicaid. Highmark Wholecare members include individuals and families with low income, expecting mothers, children, and people with disabilities. Members pay nothing to very little for their health coverage. Highmark Wholecare currently services Pennsylvania Medicaid: PA HealthChoices.

Prior Authorization
Prior authorization may be required. Please refer to Prior Authorization Code Lookup .

Please note that an authorization by Utilization Management is always required for any Durable Medical Equipment that is not covered by MA, services provided by a non-participating DME vendor or when a miscellaneous code is requested.

PROCEDURES

Ordering DME

When ordering DME, the following information is needed when ordering DME services/supplies:

Patient name, Highmark Wholecare ID number, prior authorization number (if applicable).
- DME vendor/provider NPI number.
- Ordering practitioner/provider, including NPI number.
- Diagnosis ICD Code or precise terminology.
- Name of requested equipment or HIPAA compliant HCPC code MA fee schedule code, cost.
- Indicate purchase or a rental request.
- Amount of items requested—over what period of time (if requesting rental).
- Clinical information to support the request

Maintenance and Repairs of DME

Home modifications, such as home repairs, or changes to the home, are not a covered benefit.

Repairs and replacements should be addressed and paid through the manufacturer's warranty before submitting any claims.

Braces and Supports

Braces and supports are prosthetic or orthotic devices which steady, align, protect, or strengthen weakened, injured, or deformed body parts.

Custom fitted orthotics are prefabricated, may require some assembly, and are substantially modified for individual fitting at the time of delivery by a certified orthotist, or an individual with equivalent specialized training.

Substantial modifications are changes by a certified orthotist or an individual with equivalent specialized training in compliance with licensure and regulatory requirements to achieve an individualized fit using CAD/CAM technology.

Minimal self-adjustment can be performed by the individual and does not require expertise of a certified orthotist. Off-the-shelf (OTS) orthotics are prefabricated, may require some assembly and/or minimal self-adjustment, but not requiring expertise of a certified orthotist.

Pennsylvania Mandate
Effective February 12, 1999 as defined by Pennsylvania Act 98 - 1998 Diabetes Supplies and Education Mandate diabetic services and education orthotics equipment and supplies are eligible for patients with insulin or noninsulin dependent diabetes insulin or noninsulin using diabetes or gestational diabetes. These services and supplies must be prescribed by a health care professional legally authorized to prescribe such items. Therefore requests for these services and supplies must include a physician prescription including necessary information for the service or supply being requested.
Coverage for the services as defined by Pennsylvania Act 98 - 1998 for diabetic services and supplies are subject to annual deductibles and coinsurances and all other terms and conditions set forth in the patient's contract
Braces and supports addressed in this medical policy may be considered medically necessary when **ALL** of the following general criteria are met, **AND** any category specific criteria:

General Criteria

- Appropriate for the individual's condition; **and**
- Is a rigid or semi-rigid device that:
  - Supports weak or deformed body part; **or**
  - Restricts or eliminates motion in diseased or injured body part; **and**
- Provides support and counterforce; **and**
- Is prefabricated or custom-fabricated; **and**
- Able to withstand long term use.

Devices not meeting the above criteria are considered not medically necessary.
Purchase of more than two (2) of the same type of device on the same day is considered not medically necessary.
Dispensing a device for post-operative use prior to the procedure is considered not medically necessary.

Casts-Braces-Splints
Comfort, non-therapeutic cast-braces (Cam Walker) may be considered medically necessary when **ALL** of the following criteria are met:

- General criteria; **and**
- After a fracture or surgery.

Comfort, non-therapeutic cast-braces are considered not medically necessary for all other indications.

Air casts/air splints may be considered medically necessary for treatment of fractures or other injuries (i.e., sprains, torn ligaments) when general criteria are met.

Air casts/air splints are considered not medically necessary for all other indications.

Rehabilitation braces may be considered medically necessary when **ALL** of the following criteria are met:

- General criteria; **and**
- Applied within six (6) weeks of surgery or injury.

Rehabilitation braces are considered not medically necessary for all other indications.

Braces for congenital defects or advanced neuromuscular conditions may be considered medically necessary when general criteria are met.
Replacement braces may be considered medically necessary when:

- The individual has outgrown the previous brace; or
- The condition has changed making the previous brace unusable.

Braces for congenital defects or advanced neuromuscular conditions are considered not medically necessary for all other indications not listed above.

Cervical (neck) braces may be considered medically necessary when **ALL** of the following criteria are met:

- General criteria; **and**
- Neck injury is documented.

Cervical (neck) braces are considered not medically necessary for all other indications.

Supportive back braces may be considered medically necessary when any ONE of the following are met:

- General criteria are met; and
- To facilitate healing following an injury to the spine or related soft tissues; or
- To facilitate healing following a surgical procedure on the spine or related soft tissue; or
- To reduce pain by restricting mobility of the trunk; or
- To support weak spinal muscles and/or a deformed spine.

Supportive back braces are considered not medically necessary for all other indications.

Custom-fitted and custom-fabricated back braces may be considered medically necessary when criteria for supportive back braces and ONE of the following are met:

- A prefabricated back brace modified to fit a specific individual is required due to failure, contraindication, or intolerance to an unmodified, prefabricated back brace; or
- As the initial brace after surgical stabilization of the spine following traumatic injury; or
- A custom-fabricated back brace (individually constructed to fit a specific individual from component materials) is required due to a failure, contraindication, or intolerance to a custom-fitted back brace.

Custom-fitted or custom-fabricated back braces are considered not medically necessary for all other indications.

Postoperative back braces may be considered medically necessary when ALL of the following are met:

- General criteria are met; and
- It is considered part of the surgical protocol; and
- It will facilitate healing; and
- Is applied within six (6) weeks following a surgical procedure on the spine or related soft tissue.

Postoperative back braces are considered not medically necessary for all other indications.

Cervical-thoracic-lumbar-sacral or thoracic-lumbar-sacral orthoses may be considered medically necessary for the treatment of scoliosis in juvenile and adolescent individuals at high-risk of progression when ALL of the following criteria are met:

- General criteria; and
- Idiopathic spinal curve angle between 25 and 60 degrees; and
- Spinal growth has not been completed (Risser grade 0-3; no more than one (1) year post-menarche in females); or
- Idiopathic spinal curve angle greater than 20 degrees; and
- There is documented increase in the curve angle; and
- At least two (2) years growth remains (Risser grade 0 or 1; pre-menarche in females).

Cervical-thoracic-lumbar-sacral or thoracic-lumbar-sacral orthoses are considered not medically necessary for all other indications.

Quantity Level Limits (QLL) for all back braces
One (1) back brace per every five (5) years may be considered medically necessary as the reasonable lifetime of a back brace is no less than five (5) years.
Quantity level limits or quantity of supplies that exceed the frequency guidelines listed above will be denied as not medically necessary.

Hernia supports (corset or truss style) may be considered medically necessary when ALL of the following criteria are met:

- General criteria; and
- Hernia is reducible.

Hernia supports (corset or truss style) are considered not medically necessary for all other indications.

Postoperative Hip Braces may be considered medically necessary after any ONE of the following procedures:

- Partial hip hemiarthroplasty; or
- Total hip arthroplasty; or
- Conversion of previous hip surgery to total hip arthroplasty; or
- Revision of total hip arthroplasty; or
- Osteotomy and transfer of greater trochanter of femur; or
- Arthroscopy with removal of loose body or foreign body, debridement or with synovectomy; or
- Arthroscopy with femoroplasty; or
- Arthroscopy with acetabuloplasty; or
- Arthroscopy with labral repair.

Postoperative hip braces are considered not medically necessary for all other indications.

Childhood hip braces (Pavlik harness, Frejka pillow splint, Friedman strap) may be considered medically necessary for children with hip disorders when ALL of the following criteria are met:

- General criteria; and
- To stabilize the hip; or
- To correct and maintain hip abduction.

Childhood hip braces are considered not medically necessary for all other indications.

Functional cast-braces (patella tendon bearing (PTB) cast brace, PTB fracture brace, molded ankle-foot orthosis (MAFO), fracture brace with pelvic band, achilles tendon hinged brace) may be considered medically necessary when ALL of the following criteria are met:

- General criteria; and
- After a fracture or surgery.

Functional cast-braces are considered not medically necessary for all other indications.

Wheaton braces may be considered medically necessary to treat metatarsus adductus in infants, replacing the need for serial casting when general criteria are met.

Wheaton braces are considered not medically necessary for all other indications.

Splints and Immobilizers
The following devices may be considered medically necessary when general criteria are met:

- Acromio-clavicular splint (Zimmer splint)
- Wrist extension control cock-up splint
- Clavicle splint (Figure-8 splint)
- Denis Browne splint (for children with clubfoot or metatarsus valgus to maintain and correct abduction)
- Finger splints
- Shoulder immobilizer

Splints and immobilizers are considered not medically necessary for all other indications.

Casting of a sprain or casting following a surgical procedure may be considered medically necessary.

Casting for all other indications is considered not medically necessary.
The following braces and supports do not meet the definition of covered durable medical equipment because they are not made to withstand long term use; and are therefore considered non-covered:

- Completely elastic supports (e.g., athletic supporter, joint supports, non-rigid trusses, etc.)
- Inflatable lumbar supports;
- Protective body socks;
- Cervical foam neck collars.

Covered Codes for Braces and Supports

Code	Description
L0120	Cervical, Flexible, Non-adjustable, prefabricated, off the shelf (foam collar)
L0130	Cervical, Flexible Thermoplastic molded to patient
L0140	Cervical, semi-rigid, adjustable (plastic collar)
L0150	Cervical, semi-rigid, adjustable molded chin cup (plastic collar with mandibular/occipital piece)
L0160	Cervical, semi-rigid, wire frame occipital/mandibular support, prefabricated, off the shelf
L0170	Cervical, collar, molded to patient model
L0172	Cervical, Collar, semi-rigid thermoplastic foam, two piece, prefabricated, off the shelf
L0174	Cervical, Collar, semi-rigid thermoplastic foam, two piece with thoracic extension, prefabricated, off the shelf
L0180	Cervical, multiple post collar occipital/mandibular supports, adjustable
L0190	Cervical, multiple post collar occipital/mandibular supports, adjustable cervical bars (somi, Guilford, Taylor Types)
L0200	Cervical, multiple post collar occipital/mandibular supports, adjustable cervical bars and thoracic extension
L0220	Thoracic, rib belt, custom fabricated

L0720	Cervical thoracic lumbar sacral orthosis with anterior posterior lateral control
L0970	Tlso, Corset Front
L0972	Lso, corset front
L0974	Tlso, Full Corset
L0976	Lso, Full Corset
L0978	Axillary crutch extension
L1000	Cervical-thoracic lumbar sacral (cltso) (Milwaukee), inclusive of furnishing initial orthosis including model
L1001	Cervical-thoracic lumbar sacral orthosis, immobilizer, infant size, prefabricated, includes fitting and adjustment
L1005	Tension based scoliosis orthosis and accessory pads, includes fitting and adjustment
L1010	Addition to Ctlso or scoliosis orthosis, axilla sling
L1020	Addition to Ctlso or scoliosis orthosis, Kyphosis Pad
L1025	Addition to Ctlso or scoliosis orthosis, Kyphosis Pad, floating
L1030	Addition to Ctlso or scoliosis orthosis, Lumbar
L1040	Addition to Ctlso or scoliosis orthosis, Lumbar or Lumbar Rib Pad
L1050	Addition to Ctlso or scoliosis orthosis, Sternal Pad
L1060	Addition to Ctlso or scoliosis orthosis, Thoracic Pad
L1070	Addition to Ctlso or scoliosis orthosis, Trapeze Sling
L1080	Addition to Ctlso or scoliosis orthosis, Outrigger
L1085	Addition to Ctlso or scoliosis orthosis, Outrigger Bilateral with vertical extensions
L1090	Addition to Ctlso or scoliosis orthosis, Lumbar Sling
L1100	Addition to Ctlso or scoliosis orthosis, Ring Flange, Plastic or leather
L1110	Addition to Ctlso or scoliosis orthosis, Ring Flange, Plastic or leather, Molded to patient model
L1120	Addition to Ctlso or scoliosis orthosis, Cover for upright, each
L1210	Addition to Tlso, (low profile thoracic extension)
L1220	Addition to Tlso, (low profile) anterior thoracic extension
L1230	Additions to Tlso, (low profile) Milwaukee Type Superstructure
L1240	Additions to Tlso, (low profile), Lumbar Derotation Pad
L1250	Additions to Tlso, (low profile), Anterior Asis Pad
L1260	Additions to Tlso, (low profile), Anterior Thoracic Derotation Pad
L1270	Additions to Tlso, (low profile), Abdominal Pad
L1280	Additions to Tlso, (low profile), Rib Gusset (elastic), each

L1290	Additions to Tlso, (low profile), Lateral Trochanteric Pad
L1600	Hip Orthosis, Abduction Control of hip joints Frejka Type with cover, prefabricated item that has been trimmed, bent, molded, assembled or otherwise customized to fit a specific patient by an individual with expertise
L1610	Hip Orthosis, Abduction Control of hip joints, flexible, (Frejka cover only) prefabricated item that has been trimmed, bent, molded, assembled or otherwise customized to fit a specific patient by an individual with expertise
L1620	Hip Orthosis, Abduction Control of hip joints, flexible, (pavlik Harness), prefabricated item that has been trimmed, bent, molded, assembled or otherwise customized to fit a specific patient by an individual with expert
L1630	Hip Orthosis, Abduction Control of hip joints, Semi flexible (von Rosen Type), Custom-fabricated
L1640	Hip Orthosis, Abduction Control of hip joints, Static, Pelvic Band or spreader bar, thigh cuffs, custom fabricated
L1650	Hip Orthosis, Abduction Control of hip joints, Static, Adjustable, (ifled type), prefabricated, included fitting and adjustment
L1652	Hip Orthosis, Bilateral thigh cuffs with adjustable abductor spreader bar, adult size includes fitting and adjustment, any type
L1653	Bilateral hip orthosis with thigh cuffs and an adjustable abductor spreader bar
L1660	Hip orthosis, abduction control of hip joints, static, plastic prefabricated, included fitting and adjustment
L1680	Hip orthosis, abduction control of hip joints, dynamic, pelvic control, adjustable hip motion control, thigh cuffs (rancho hip action type), custom fabricated
L1685	Hip orthosis, abduction control of hip joint, post operative hip abduction type, custom fabricated
L1686	Hip orthosis, abduction control of hip joint, post operative hip abduction type, prefabricated, included fitting and adjustment
L1690	Combination, bilateral, lumbo-sacral, hip, femur orthosis providing adduction and internal rotation control, prefabricated, included fitting and adjustment
L3980	Upper extremity fracture orthosis, humeral, prefabricated, includes fitting and adjustment
L3981	Upper extremity fracture orthosis, humeral, prefabricated, includes shoulder cap design, with or without joints, forearm section, may include soft interface straps, includes fitting and adjustments
L3982	Upper extremity fracture orthosis, Radius/ulnar, Prefabricated, includes fitting and adjustment
L3984	Upper extremity fracture orthosis, wrist, Prefabricated, includes fitting and adjustment
L8300	Truss, single with standard pad
L8310	Truss, Double with standard pads
L8320	Truss, addition to standard pads, water pad
L8330	Truss, addition to standard pads, scrotal pad

Diabetic Supplies

Diabetes outpatient self-management and training service is a program which educates individuals in self-monitoring of blood glucose, diet, exercise, and insulin management.

Continuous Glucose Monitoring (CGM) Systems (also known as Real-Time or interstitial) monitor, measure, and record glucose levels in interstitial fluid and produce data that show trends in glucose measurements. CGM systems consist of a sensor, transmitter and receiver. Currently, CGM system sensors can be used 3-90 days before replacement. Personal CGM system can exist as a stand-alone system or integrated with an insulin pump. Glucose results are used by the individual to closely monitor their glucose levels to help them to better self-manage their diabetes.

Orthotics protect, restore and/or improve the function of moveable parts of the body with orthopedic appliances or apparatus. Orthotic appliances or apparatus support, align, prevent and/or correct deformities.

Pennsylvania Mandate

Effective February 12, 1999 as defined by Pennsylvania Act 98 - 1998 Diabetes Supplies and Education Mandate diabetic services and education orthotics equipment and supplies are eligible for patients with insulin or noninsulin dependent diabetes insulin or noninsulin using diabetes or gestational diabetes. These services and supplies must be prescribed by a health care professional legally authorized to prescribe such items. Therefore requests for these services and supplies must include a physician prescription including necessary information for the service or supply being requested,

Coverage for the services as defined by Pennsylvania Act 98 - 1998 for diabetic services and supplies are subject to annual deductibles and coinsurances and all other terms and conditions set forth in the patient's contract.

Diabetic Equipment and Supplies

The following diabetic equipment and supplies designed for individual use are eligible for coverage when prescribed by a physician:

- Insulin; **or**
- Injection aids; **or**
- Injection aids, including insulin; **or**
- Syringes and needles; **or**
- Insulin infusion devices and related supplies; **or**
- Pharmacological agents for controlling blood sugar; **or**
- Blood glucose monitors; **or**
- Monitor supplies; **or**
- Skin prep supplies; **or**
- Supplies.

Diabetic equipment and supplies are covered when the glucose monitor is covered.

External Insulin Infusion Pumps for Adults

A United States Food and Drug Administration (U.S. FDA) approved external insulin pump for the management of diabetes mellitus may be considered medically necessary for individuals that meet **ALL** of the following criteria**:**

- Has completed a comprehensive diabetes education program; **and**
- The individual has been on a program of multiple daily injections (i.e., at least three (3) injections per day), with frequent self-adjustments of insulin dose for at least six (6) months to initiation of the insulin pump; **and**
- The individual has documented frequency of glucose self-testing an average of at least four (4) times per day during the two months prior to initiation of the insulin pump or utilizing a continuous glucose monitor; **and**
- The individual meets at least one of the following criteria while on multiple daily injections (more than three (3) injections per day) of insulin:
    - Glycosylated hemoglobin level (HbAlc) greater than 7.0%; **or**
    - History of recurring hypoglycemia; **or**
    - Wide fluctuations in blood glucose before mealtime; **or**
    - Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dl; **or**
    - History of severe glycemic excursions; **or**
    - The individual has been on a pump prior to enrollment in the health plan, and has documented frequency of glucose self-testing an average of at least four (4) times per day during the month prior to health plan enrollment.

Continued coverage of an external insulin pump and supplies, when the insulin pump has been approved initially, includes the following:

- The individual must be evaluated by the treating provider at least every six (6) months; **and**
- Follow-up care must be rendered by a provider who manages multiple individuals on continuous subcutaneous insulin infusion therapy, and who works closely with a diabetes care team including nurses, diabetic educators, and dieticians who are knowledgeable and trained in the use of continuous subcutaneous insulin infusion.

Replacement insulin pump may be considered medically necessary for the following indications:

- Insulin infusion pumps that are out of warranty, are malfunctioning and cannot be repaired; **or**
- Replacement of an external insulin pump may be medically necessary for individuals who require the closed loop insulin pump system if the individual meets the criteria as indicated in this policy.

Replacement insulin pump would be considered not medically necessary for a functioning insulin pump with an insulin pump with wireless communication to a glucose monitor.

Individuals not meeting the as indicated in this policy criteria for external insulin pumps is considered not medically necessary

Replacement insulin pump is considered medically necessary for children 18 and younger for the following indications:

- Insulin infusion pumps that are out of warranty, are malfunctioning and cannot be repaired; **or**
- For children who require a larger insulin reservoir; **or**
- For children who require the closed loop insulin pump system if the individual meets the above criteria.

Short Term Interstitial CGM

Use of an U.S. FDA approved short term interstitial CGM, minimum of 72 hours may be considered medically necessary for type I or type II diabetics when **ANY ONE** of the following criteria are met:

- History of poorly controlled diabetes (i.e., unexplained hypoglycemic episodes, hypoglycemic unawareness, suspected postprandial hyperglycemia, and recurrent diabetic ketoacidosis); **or**
- Pregnant female that requires insulin therapy; **or**
- Pregnant female who develops gestational diabetes; **or**
- An individual who requires determination of basal insulin level measurements prior to insulin pump initiation; **or**
- An individual who has documentation of **ALL** of the following:
    - Inability to recognize or communicate their symptoms of hypoglycemia; **and**
    - Pediatric individuals (age 2 (two) to 18 years of age) must be managed by endocrinologist; **and**
    - The parent or caregiver must have the ability to understand the technology and be willing to use the monitor, read and interpret the glucose data; **and**
    - Received diabetes self-management education and instruction from a health care professional with expertise in the management of diabetes; **and**
    - Is on an intensive insulin regimen, requiring three (3) or more insulin administrations per day, or utilizes an insulin pump; **and**
    - Has **ONE** or **MORE** of the following while on an intensive insulin regimen:
        - Unexplained large fluctuations in daily glucose values before meals; **or**
        - Unexplained frequent hypoglycemic attacks (e.g., greater than one (1) per week or three (3) per month); **or**
        - Episodes of ketoacidosis or hospitalizations for significantly elevated glucose levels.

For short-term diagnostic use, no more than four (4) CGM periods may be considered medically necessary within a 12-month period.

Short-term interstitial CGM not meeting the criteria as indicated in this policy is considered experimental/investigational and therefore non-covered because the safety and/or effectiveness of this service cannot be established by the available published peer-reviewed literature.

Long Term Interstitial CGM Systems

Use of an U.S. FDA approved long term interstitial CGM system as an adjunct and non-adjunct (i.e., greater than 72 hours) may be considered medically necessary for type I or type II diabetics when **ANY ONE** of the following criteria are met:

- Pregnant female with poorly controlled diabetes (i.e., unexplained hypoglycemic episodes, hypoglycemic unawareness, suspected postprandial hyperglycemia, and recurrent diabetic ketoacidosis); **or**
- Recurrent, unexplained, severe (generally blood glucose levels less than 50 mg/dL) hypoglycemia that puts the individual or others at risk; **or**
- History of poorly controlled diabetes (i.e., unexplained hypoglycemic episodes, hypoglycemic unawareness, suspected postprandial hyperglycemia, and recurrent diabetic ketoacidosis); **and**
- Documentation of **ALL** of the following:
    - The CGM is prescribed by a professional provider; **and**

- Is on an intensive insulin regimen, requiring three (3) or more insulin administrations per day, or utilizes an insulin pump; **and**
- The individual (parent or caregiver if individual is a child) has been instructed by a health care professional in the management of diabetes including care of the CGM, alarm use and problem solving and use of real time CGM application in diabetic care; **and**
- Pediatric individuals (age 2 (two) -12 years old: The CGM is recommended and managed by a pediatric endocrinologist:
  - **Note:** CGM may be approved for those under two (2) years of age with exceptional circumstances requiring individual consideration; **and**
- The individual (parent or caregiver if the individual is a child) must have the ability to understand the technology and be willing to use the monitor (I.e., hear alarms, read and interpret glucose data and can take action based on the data interpretation; **and**
- The responsible individual demonstrates mastery of the fundamentals of diabetes self-management, which includes **BOTH** of the following:
  - Routine, regular testing of blood glucose levels; **and**
  - Maintaining accurate records of blood glucose testing.

Long-term interstitial CGM system not meeting the criteria as indicated in this policy is considered experimental/investigational and therefore non-covered because the safety and/or effectiveness of this service cannot be established by the available published peer-reviewed literature.
Receiver/Reader kits are limited to one (1) per Benefit Period. Sensor kits are limited to one (1) unit every thirty (30) days, unless otherwise required due to manufacturer packaging restrictions. Transmitter kits are limited to (1) unit every ninety (90) days unless otherwise required due to manufacturer packaging restrictions.

Supplies related to continuous subcutaneous insulin infusion via external insulin infusion pump and the infusion sets and dressings are limited to manufacturer recommendations.

Replacement supplies related to continuous subcutaneous insulin infusion via external insulin infusion pump and the infusion sets and dressings may be considered medically necessary and are limited to manufacturer recommendations.

Supplies exceeding the manufacturer's recommendation will be denied as not medically necessary.

Quantity Level Limits (QLL) for test strips, lancets, and lens shield cartridge
The quantity of test strips, lancets and replacement lens shield cartridges that are covered depends on the medical needs of the diabetic individual according to the following guidelines:
Pediatric
Less than or equal to 12 years old and under:

- Test strips*- 300 per one (1) month and 900 every 90 days; **and**
- Lancets**- 300 per one (1) month and 900 every 90 days; **or**
- Lens shield cartridge- one (1) every one (1) month.

Adolescent/Adult
Greater than or equal to 13 years old:

- Test strips*- 300 up to 30 days and 612 every 35-90 days; **and**
- Lancets**- 300 up to 30 days and 612 every 35-90 days; **or**
- Lens shield cartridge- one (1) every one (1) month.

When **ALL** of the following criteria are met:

- The equipment and supplies are prescribed by a physician; **and**
- The glucose monitor is covered; **and**
- The supplier of the test strips and lancets or lens shield cartridge maintains in its records the order from the treating physician; **and**
- The individual has nearly exhausted the supply of test strips and lancets or useful life of one lens shield cartridge previously dispensed.

*Glucose test strips - one (1) unit of service = one (1) box (50-51 strips).
**Lancets- one (1) unit of service = one (1) box (100 lancets).
Quantity of supplies that exceeds the frequency guidelines listed on the policy are considered not medically necessary.

All Diabetic Individuals

- Spring powered device-one (1) every six (6) months.

More than one (1) spring powered device every six (6) months is considered not medically necessary.

QLLs Exceeded for test strips, lancets, or lens shield cartridge

QLLs that exceed the allowed amount of strips, lancet, and lens shield cartridges may be considered medically necessary when **ALL** of the following are met.

- The equipment and supplies are prescribed by a physician; **and**
- The glucose monitor is covered; **and**
- The supplier of the test strips and lancets, or lens shield cartridge maintains in its records the order from the treating physician; **and**
- The individual has nearly exhausted the supply of test strips and lancets, or useful life of one (1) lens shield cartridge previously dispensed; **and**
- The treating physician has ordered a frequency of testing that exceeds the frequency guidelines in this policy and has documented in the individual's medical record the specific reason for the additional materials for that particular individual; **and**
- The treating physician has seen the individual and has evaluated their diabetes control within six (6) months prior to ordering quantities of strips and lancets, or lens shield cartridges that exceed the frequency guidelines in this policy; **and**
- If refills of quantities of supplies that exceed the frequency guidelines in this policy are dispensed, there must be documentation in the physician's records (e.g., a specific narrative statement that adequately documents the frequency at which the individual is actually testing or a copy of the individual's log) or in the supplier's records (e.g., a copy of the individual's log) that the individual is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed. If the individual is regularly using quantities of supplies that exceed the frequency guidelines in this policy, new documentation must be present at least every six (6) months.

QLLs of test strips, lancets, or lens shield cartridges not meeting the criteria as indicated in this policy and exceeding the frequency guidelines in this policy are considered not medically necessary.

Diabetes Outpatient Self-Management and Training Services

Diabetes outpatient self-management and training services may be considered medically necessary for the diabetic individual, in **ANY** of the following circumstances:

- Initial diagnosis of diabetes; **or**

- Significant change in the individual's symptoms or condition, such as fluctuation in blood glucose values, risk for hypoglycemic events**; or**
- Uncontrolled diabetes despite optimization of medical therapy; **or**
- The introduction of new medication or new therapeutic process in the treatment/management of the individual's symptoms/condition.

Self-management and training services not meeting the criteria as indicated in this policy are considered not medically necessary

Orthotics

Diabetic shoes and the Lang Medical Shoe foot pressure off-loading/supportive devices inserts and/or modifications to those shoes are eligible when **BOTH** of the following criteria are met:

- The individual has diabetes mellitus; **and**
- The individual has one (1) or more of the following conditions:
    - Previous amputation of the other foot or part of either foot; **or**
    - History of previous foot ulceration of either foot; **or**
    - History of pre-ulcerative calluses of either foot; **or**
    - Peripheral neuropathy with evidence of callus formation of either foot; **or**
    - Foot deformity of either foot; **or**
    - Poor circulation in either foot.

Orthotics not meeting the criteria as indicated in this policy are considered not medically necessary.

QLLs for Diabetic Shoes and Inserts

Individuals meeting the above orthotic coverage are limited to **ONE** (1) of the following within one (1) calendar year:

- One (1) pair of custom-molded shoes and two (2) pairs of inserts; **or**
- One (1) pair of depth shoes and three (3) pairs of inserts (not including the non-customized removable inserts provided with such shoes).

A modification of a custom-molded or depth shoe may be considered medically necessary as a substitute for an insert. Custom-molded and depth shoe modification payments may not exceed the limit set for inserts. The following list of common shoe modifications is not an exhaustive list:

- Wedges; **or**
- Roller bottoms; **or**
- Offset heels; **or**
- Metatarsal bars; **or**
- Rigid rocker bottoms.

Diabetic shoes, modifications, and inserts not meeting the criteria as indicated in this policy are considered not medically necessary.

Non covered services for Diabetes

Non-invasive CGM
Non-invasive CGM and related supplies are considered experimental/investigational, and therefore, non-covered because the safety and/or effectiveness of this service cannot be established by the available published peer-reviewed literature.

Remote CGM
A remote interstitial CGM (e.g., mySentry™) is considered investigational/experimental and therefore, non-covered because the safety and/or effectiveness of this service cannot be established by the available published peer-reviewed literature.

I-Port Injection Port (Patton Medical Devices)
I-Port Injection Port (Patton Medical Devices) is considered experimental/investigational and, therefore, non-covered. There is a lack of scientific-based evidence of long-term studies demonstrating the safety and efficacy of this device.

V-Go Disposable Insulin Delivery Device
V-Go disposable nonprogrammable insulin delivery device for the management of Type 1 or Type 2 diabetes mellitus is considered experimental/investigative and therefore, non-covered because the safety and/or effectiveness of this service cannot be established by the available published peer-reviewed literature.

Deluxe Shoe Feature is non-covered because it does not contribute to the therapeutic function of the shoe. Features may include but are not limited to style color or type of leather.

Covered Codes for Diabetic Services

Code	Description
95249	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; patient-provided equipment sensor placement hook up calibration of monitor patient training, and printout of recording
95250	Laryngeal function studies (ie, aerodynamic testing and acoustic testing)
95251	Evaluation of speech fluency (eg, stuttering, cluttering)
A4206	Syringe with needle, sterile, 1 Cc or Less,each
A4207	Syringe with needle, sterile, 2 Cc each
A4208	Syringe with needle, sterile, 3 Cc each
A4209	Syringe with needle, sterile,5cc or greater each

A4210	Needle-free injection device, each
A4212	Non-coring needle or stylet with or without catheter
A4213	Syringe ,sterile, 20 Cc or greater each
A4215	Needle, sterile, any size, each
A4230	Infusion set for external insulin pump, non needle cannula type
A4231	Infusion set for external insulin pump, Needle type
A4271	Integrated lancing and blood sample testing cartridges for home blood glucose monitor, per 50 tests
E2104	Home blood glucose monitor for use with integrated lancing/blood sample testing cartridge
G0108	Diabetes outpatient self management training services, individual, per 30 minutes
G0109	Diabetes outpatient self management training services, Group session (2 or more) , per 30 minutes
S5001	Prescription Drug, Brand name
S8490	Equestrian/hippotherapy, per session

Covered Diagnosis Codes for Procedure Codes A4230 and A4231

E08.00	E08.01	E08.10	E08.11	E08.21	E08.22	E08.29
E08.311	E08.319	E08.3211	E08.3212	E08.3213	E08.3219	E08.3291
E08.3292	E08.3293	E08.3299	E08.3311	E08.3312	E08.3313	E08.3319
E08.3391	E08.3392	E08.3393	E08.3399	E08.3411	E08.3412	E08.3413
E08.3419	E08.3491	E08.3492	E08.3493	E08.3499	E08.3511	E08.3512
E08.3513	E08.3519	E08.3521	E08.3522	E08.3523	E08.3529	E08.3531
E08.3532	E08.3533	E08.3539	E08.3541	E08.3542	E08.3543	E08.3549
E08.3551	E08.3552	E08.3553	E08.3559	E08.3591	E08.3592	E08.3593
E08.3599	E08.36	E08.37X1	E08.37X2	E08.37X3	E08.37X9	E08.39
E08.40	E08.41	E08.42	E08.43	E08.44	E08.49	E08.51
E08.52	E08.59	E08.610	E08.618	E08.620	E08.621	E08.622
E08.628	E08.630	E08.638	E08.641	E08.649	E08.65	E08.69
E08.8	E08.9	E09.00	E09.01	E09.10	E09.11	E09.21
E09.22	E09.29	E09.311	E09.319	E09.3211	E09.3212	E09.3213
E09.3219	E09.3291	E09.3292	E09.3293	E09.3299	E09.3311	E09.3312
E09.3313	E09.3319	E09.3391	E09.3392	E09.3393	E09.3399	E09.3411

E09.3412	E09.3413	E09.3419	E09.3491	E09.3492	E09.3493	E09.3499
E09.3511	E09.3512	E09.3513	E09.3519	E09.3521	E09.3522	E09.3523
E09.3529	E09.3531	E09.3532	E09.3533	E09.3539	E09.3541	E09.3542
E09.3543	E09.3549	E09.3551	E09.3552	E09.3553	E09.3559	E09.3591
E09.3592	E09.3593	E09.3599	E09.36	E09.37X1	E09.37X2	E09.37X3
E09.37X9	E09.39	E09.40	E09.41	E09.42	E09.43	E09.44
E09.49	E09.51	E09.52	E09.59	E09.610	E09.618	E09.620
E09.621	E09.622	E09.628	E09.630	E09.638	E09.641	E09.649
E09.65	E09.69	E09.8	E09.9	E10.10	E10.11	E10.21
E10.22	E10.29	E10.311	E10.319	E10.3211	E10.3212	E10.3213
E10.3219	E10.3291	E10.3292	E10.3293	E10.3299	E10.3311	E10.3312
E10.3313	E10.3319	E10.3391	E10.3392	E10.3393	E10.3399	E10.3411
E10.3412	E10.3413	E10.3419	E10.3491	E10.3492	E10.3493	E10.3499
E10.3511	E10.3512	E10.3513	E10.3519	E10.3521	E10.3522	E10.3523
E10.3529	E10.3531	E10.3532	E10.3533	E10.3539	E10.3541	E10.3542
E10.3543	E10.3549	E10.3551	E10.3552	E10.3553	E10.3559	E10.3591
E10.3592	E10.3593	E10.3599	E10.36	E10.37X1	E10.37X2	E10.37X3
E10.37X9	E10.39	E10.40	E10.41	E10.42	E10.43	E10.44
E10.49	E10.51	E10.52	E10.59	E10.610	E10.618	E10.620
E10.621	E10.622	E10.628	E10.630	E10.638	E10.641	E10.649
E10.65	E10.69	E10.8	E10.9	E11.00	E11.01	E11.10
E11.11	E11.21	E11.22	E11.29	E11.311	E11.319	E11.3211
E11.3212	E11.3213	E11.3219	E11.3291	E11.3292	E11.3293	E11.3299
E11.3311	E11.3312	E11.3313	E11.3319	E11.3391	E11.3392	E11.3393
E11.3399	E11.3411	E11.3412	E11.3413	E11.3419	E11.3491	E11.3492
E11.3493	E11.3499	E11.3511	E11.3512	E11.3513	E11.3519	E11.3521
E11.3522	E11.3523	E11.3529	E11.3531	E11.3532	E11.3533	E11.3539
E11.3541	E11.3542	E11.3543	E11.3549	E11.3551	E11.3552	E11.3553
E11.3559	E11.3591	E11.3592	E11.3593	E11.3599	E11.36	E11.37X1
E11.37X2	E11.37X3	E11.37X9	E11.39	E11.40	E11.41	E11.42
E11.43	E11.44	E11.49	E11.51	E11.52	E11.59	E11.610
E11.618	E11.620	E11.621	E11.622	E11.628	E11.630	E11.638
E11.641	E11.649	E11.65	E11.69	E11.8	E11.9	E13.00
E13.01	E13.10	E13.11	E13.21	E13.22	E13.29	E13.311
E13.319	E13.3211	E13.3212	E13.3213	E13.3219	E13.3291	E13.3292
E13.3293	E13.3299	E13.3311	E13.3312	E13.3313	E13.3319	E13.3391
E13.3392	E13.3393	E13.3399	E13.3411	E13.3412	E13.3413	E13.3419
E13.3491	E13.3492	E13.3493	E13.3499	E13.3511	E13.3512	E13.3513
E13.3519	E13.3521	E13.3522	E13.3523	E13.3529	E13.3531	E13.3532
E13.3533	E13.3539	E13.3541	E13.3542	E13.3543	E13.3549	E13.3551
E13.3552	E13.3553	E13.3559	E13.3591	E13.3592	E13.3593	E13.3599
E13.37X1	E13.37X2	E13.37X3	E13.37X9	E13.39	E13.40	E13.41
E13.42	E13.43	E13.44	E13.49	E13.51	E13.52	E13.59
E13.610	E13.618	E13.620	E13.621	E13.622	E13.628	E13.630
E13.638	E13.641	E13.649	E13.65	E13.69	E13.8	E13.9
O24.011	O24.012	O24.013	O24.019	O24.02	O24.03	O24.111
O24.112	O24.113	O24.119	O24.12	O24.13	O24.311	O24.312

O24.313	O24.319	O24.32	O24.33	O24.410	O24.414	O24.419
O24.420	O24.424	O24.429	O24.430	O24.434	O24.439	O24.811
O24.812	O24.813	O24.819	O24.82	O24.83	O24.911	O24.912
O24.913	O24.919	O24.92	O24.93	O99.810	O99.814	O99.815

Covered Diagnosis codes for Procedure Codes: A4271, E2104, 95249, 95250, and 95251 (Short and Long Term Interstitial)

E10.10	E10.11	E10.21	E10.22	E10.29	E10.311	E10.319
E10.3211	E10.3212	E10.3213	E10.3291	E10.3292	E10.3293	E10.3311
E10.3312	E10.3313	E10.3391	E10.3392	E10.3393	E10.3411	E10.3412
E10.3413	E10.3491	E10.3492	E10.3493	E10.3511	E10.3512	E10.3513
E10.3521	E10.3522	E10.3523	E10.3529	E10.3531	E10.3532	E10.3533
E10.3541	E10.3542	E10.3543	E10.3551	E10.3552	E10.3553	E10.3591
E10.3592	E10.3593	E10.36	E10.37X1	E10.37X2	E10.37X3	E10.39
E10.40	E10.41	E10.42	E10.43	E10.44	E10.49	E10.51
E10.52	E10.59	E10.610	E10.618	E10.620	E10.621	E10.622
E10.628	E10.630	E10.638	E10.641	E10.649	E10.65	E10.69
E10.8	E10.9	E11.00	E11.01	E11.10	E11.11	E11.21
E11.22	E11.29	E11.311	E11.319	E11.3211	E11.3212	E11.3213
E11.3291	E11.3292	E11.3293	E11.3311	E11.3312	E11.3313	E11.3391
E11.3392	E11.3393	E11.3411	E11.3412	E11.3413	E11.3491	E11.3492
E11.3493	E11.3511	E11.3512	E11.3513	E11.3521	E11.3522	E11.3523
E11.3531	E11.3532	E11.3533	E11.3541	E11.3542	E11.3543	E11.3551
E11.3552	E11.3553	E11.3591	E11.3592	E11.3593	E11.36	E11.37X1
E11.37X2	E11.37X3	E11.39	E11.40	E11.41	E11.42	E11.43
E11.44	E11.49	E11.51	E11.52	E11.59	E11.610	E11.618
E11.620	E11.621	E11.622	E11.628	E11.630	E11.638	E11.641
E11.649	E11.65	E11.69	E11.8	E11.9	O24.011	O24.012
O24.013	O24.019	O24.02	O24.03	O24.111	O24.112	O24.113
O24.119	O24.12	O24.13	O24.414	O24.419	O24.424	O24.429
O24.434	O24.439	Z79.4				

Eye Pads/Patches

Eye pads and patches are covered for conditions such as strabismus

Code	Description
A4610	EYE PAD, STERILE, EACH
A4611	EYE PAD, NON-STERILE, EACH
A4612	EYE PATCH, OCCLUSIVE, EACH

Fluidic Breathing Assistor
Covered Where there is need for intermittent positive pressure breathing (IPPB) device but oxygen is not required.

Code	Description
E0500	IPPB MACHINE, ALL TYPES, WITH BUILT-IN NEBULIZATION; MANUAL OR AUTOMATIC VALVES; INTERNAL OR EXTERNAL POWER SOURCE

Hearing Aids/Hearing Devices

Hearing Aids are limited to one pair a year for recipients 21 under, and have been prescribed through the EPSDT program, and for repairs to hearing aids owned by the recipient when the invoice is accompanied by an itemized statement. If hearing aid is lost, they are able to have another pair. Batteries are also covered.

Any hearing aid that is not U.S. FDA approved will be denied as non-covered.

Please note that Assistive listening devices are used to improve speech intelligibility by reducing the degrading effects of distance and background noise. These devices are functionally similar to a personal sound amplifier system. These devices do not replace the function of the middle ear, cochlea or auditory nerve. Therefore, they are not considered as prosthetic devices and are non-covered

Covered Codes under Hearing Aids

Code	Description
L8618	Transmitter cable for use with cochlear implant device or auditory osseointegrated device, replacement
L8624	Lithium ion battery for use with cochlear implant or auditory osseointegrated device speech processor, ear level, replacement, each
L8625	External recharging system for battery for use with cochlear implant or auditory osseointegrated device, replacement only, each
L8691	Auditory Osseointegrated device, external sound processor, excludes transducer/actuator, replacement only,each
L8694	Auditory Osseointegrated device transducer/actuator, replacement only, each
V5230	Hearing Aid, contralateral routing system, binaural, glasses
V5242	Hearing Aid, analog, monaural, Cic (completely in the ear canal)
V5243	Hearing Aid, analog monaural, Itc (in the canal)
V5248	Hearing Aid, analog, binaural, cic
V5249	Hearing Aid, analog, binaural, Itc

Helmet with Face Guard and Soft Interface Material, Prefabricated

- When ordered by a physician as medically necessary for individuals with seizure or behavior disorders who are at risk for injury to the head and face.

Code	Description
A8000	HELMET, PROTECTIVE, SOFT, PREFABRICATED, INCLUDES ALL COMPONENTS AND ACCESSORIES
A8001	HELMET, PROTECTIVE, HARD, PREFABRICATED, INCLUDES ALL COMPONENTS AND ACCESSORIES
A8002	HELMET, PROTECTIVE, SOFT, CUSTOM FABRICATED, INCLUDES ALL COMPONENTS AND ACCESSORIES
A8003	HELMET, PROTECTIVE, HARD, CUSTOM FABRICATED, INCLUDES ALL COMPONENTS AND ACCESSORIES

Home Dialysis Equipment and Supplies

Home dialysis equipment is all equipment, supplies and support services, and certain drugs and biologicals that are required to effectively perform dialysis in the home. This includes instruments and non-medical supplies [e.g., scales, blood pressure cuffs, stop watches, stethoscope, heating pad for peritoneal dialysis, etc.] and disposable supplies [e.g., alcohol wipes, sterile drapes, etc.]

Home use of dialysis equipment, supplies, and selected medications may be considered medically necessary when the individual has a diagnosis of end-stage renal disease (ESRD).
All other uses of home dialysis equipment, supplies and selected medications not meeting the criteria as indicated in this policy are considered not medically necessary.

An exception to the general coverage of all dialysis supplies is the “Patient Aid,” a device used to train dialysis patients in correcting alarm conditions. These devices are considered not medically necessary.
The instruments and non-medical supplies must either be purchased or provided as part of the actual dialysis equipment and included in the overall charge for such equipment. (Coverage does not extend to the rental of these items separately. Claims submitted for rental of the instruments/non-medical equipment (as separate units) will not be separately reimbursed. Disposable supplies are covered as separate items.)

Total payments for a rental item may not exceed its allowable purchase price, except for those items identified as life sustaining DME.

Shipping charges for home dialysis supplies are covered.

Code	Description
A4660	Sphygmomanometer/blood pressure apparatus with cuff and stethoscope

A4663	Blood pressure cuff only
A4670	Automatic Blood pressure monitor
A4927	Gloves, non-sterile, per 100
A4928	Surgical mask, per 20
A4930	Gloves, sterile, per pair
E1510	Kidney, dialysate delivery system kidney machine, pump recirculating, air removal system, flowrate meter, power off, heater and temp control with alarm I.v.poles, pressure gauge, concentrate container
E1590	Hemodialysis machine
E1592	Automatic intermittent peritoneal dialysis system
E1594	Cycler dialysis machine for peritoneal dialysis
E1600	Delivery and/or installation charges for hemodialysis equipment
E1610	Reverse osmosis water purification system for hemodialysis
E1615	Deioizer water purification system, for hemodialysis
E1625	Water softening system, for hemodialysis

Incontinence Items

All incontinence products must be obtained through a contracted DME vendor as opposed to a participating pharmacy.
Incontinence Items will be covered by Highmark Wholecare without requesting an EOB from any other plan.

Injectors and Injection Aid Device

- Individuals who are unable to use a syringe.

Code	Description
A4210	NEEDLE-FREE INJECTION DEVICE, EACH

Intermittent Positive Pressure Breathing (IPPB) machine

- Covered if individual's ability to breathe is severely impaired.

Code	Description
E0500	IPPB MACHINE, ALL TYPES, WITH BUILT-IN NEBULIZATION; MANUAL OR AUTOMATIC VALVES; INTERNAL OR EXTERNAL POWER SOURCE

Non-Custom/Custom-Made Gradient Compression Garments/Stockings/Sleeves

Gradient compression garments are stretch knit fabrics that are worn over an area of the body. They can be used to treat lymphedema and various venous stasis ulcers; to prevent clots; and/or to provide general comfort. Custom-made gradient compression stockings are tailored to the specific individual's measurements.

Custom-made Gradient Compression Garments/Stockings/Sleeves
Custom-made gradient compression stockings/sleeves may be considered medically necessary when prescribed and documented by a health care provider (i.e., physician, physician assistant, or certified registered nurse practitioner) when **ANY ONE** of the following are met:

- Failure for a prefabricated garment to fit properly; **or**
- Failure to provide the therapeutic support (i.e., lost elasticity, tears, etc.); **or**
- Reinforced areas (e.g., heels) or zippers alone are not unique and do not constitute a custom garment; **or**
- Documentation for diagnosis of obesity (BMI measurement not applicable); **or**
- Documentation for diagnosis of venous insufficiency.
- When **ALL** of the following criteria are met:
    - A written, signed, and dated order must be received by the supplier before dispensing custom-made gradient compression stockings/sleeve; **and**
    - A qualified health care professional must document the clinical characteristic of the individual's affected area that is requiring a compression stockings/sleeve (i.e., physician, physician assistant, certified registered nurse practitioner, or nurse); **and**
    - Complete documentation of medical assessment and covered diagnosis.

AND
ANY ONE of the following:

- Lymphedema; **or**
- Burns (addressed separately below); **or**
- Varicose veins (except spider veins); **or**
- Chronic venous insufficiency; **or**
- Venous stasis disease; **or**
- Venous valvular insufficiency; **or**
- Venous insufficiency; **or**
- Post thrombotic syndrome; **or**
- Venous ulcer (stasis ulcer), including **ANY ONE** of the following:
    - Edema; **or**
    - Venous; **or**
    - Lymph; **or**
    - Post traumatic; **or**
    - Post-surgical; **or**
    - Lipedema; **or**
    - Angiodysplasia; **or**
    - Prevention of thrombosis post-operatively; **or**
    - Post sclerotherapy; **or**
    - Documented thrombosis risk; **or**
    - Venous eczema; **or**
    - Lipodermatosclerosis.

- Custom-made gradient garments will only be dispensed in the amount prescribed by the physician, physician assistant, or nurse practitioner.

Replacement Custom-Made Gradient Compression Garments/Stockings/Sleeves
Custom-made gradient compression garments/stocking/sleeve replacements, when replaced prior to six (6) months, are considered medically necessary when **ANY ONE o**f the following are met:

- Compression garment cannot be repaired (i.e., lost elasticity, tears, etc.); **or**
- Changes in physical condition (e.g., change in size, unusual drainage, wear that weakened the support); **and**
- A yearly written, signed, and dated order must be received by the supplier before dispensing replacement custom-made gradient compression stockings/sleeve.

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Quality Level Limits
ONLY six (6) individual (or three (3) pairs per individual for a total of three (3) pairs) of pressure gradient support garments/stockings/sleeves (in any combination i.e. knee-high, thigh-high etc.) will be dispensed at initial disbursement and every six (6) months thereafter. A pair is two (2) of the same items.

Any custom-made gradient compression garment/stocking/sleeve not meeting the criteria as indicated in this policy is considered not medically necessary.

Custom- Made Burn Compression Gradient Support Garments/Stockings/Sleeves
The following information is **ONLY** for those individuals with burn injuries and need custom-made compression gradient support garments/stockings/sleeves for management of edema, hypertrophic scarring, and joint contractures.
Custom-made burn compression gradient support garments/stockings/sleeves may be considered medically necessary when **ALL** of the following criteria are met:

- When prescribed and documented by a health care provider (i.e., physician, physician assistant, or certified registered nurse practitioner); **and**
- A written, signed, and dated order must be received by the supplier before dispensing custom-made gradient compression stockings/sleeve; **and**
- A qualified health care professional must document the clinical characteristic of the individual's affected area that is requiring a compression stockings/sleeve (i.e., physician, physician assistant, certified registered nurse practitioner, or nurse); **and**
- Burns must be classified as **ANY ONE** of the following:
  - Second (2nd) degree burns; **or**
  - Third (3rd) degree burns.

Quality Level Limits

ONLY eight (8) individual (or four (4) pairs) of custom-made burn compression gradient support garment/stockings/sleeves will be dispensed at initial disbursement and every three (3) months thereafter.
A custom-made burn compression gradient garment/stocking/sleeve is considered medically necessary when prescribed for the treatment and of burns in the management of the resulting edema, hypertrophic scarring and joint contractures following a burn injury.
Replacement of Custom-Made Burn Compression Gradient Support Garments/Stockings/Sleeves
Replacement of custom-made burn gradient compression support garments/stockings/sleeves, when dispensed prior to three (3) months, may be considered medically necessary when **ALL** of the following are met:

- Pre-measuring for changes must be performed before a new prescription is issued; **and**
- Documentation must support medical necessity; **and**

- Medical record must support documented changes in physical condition (e.g., change in size, drainage amount increased, etc.); **and**
- A written, signed, and dated order must be received by the supplier before dispensing replacements.

***Special Consideration for Replacements for Children – Burn Injuries Only**

Due to continuous growth changes in infants and children, special consideration to replacement frequency will be given to those burn injury individuals, ages zero (0) to four (4) years of age, regarding significant increased replacement frequencies that require less than three (3) months for any custom-made burn compression gradient support garment replacement. A yearly evaluation of an individual's condition is required to continue medical necessity for a custom fit garment.
Any custom-made burn gradient compression garment/stocking/sleeve not meeting the criteria as indicated in this policy is considered not medically necessary.

Non-Custom-Made Gradient Compression Garments/Stockings/Sleeves
Non-custom-made gradient compression garments/stockings/sleeves may be considered medically necessary when **ALL** of the following are met:

- The garments(s) must be specifically ordered and documented by a health care provider (i.e., physician, physician assistant, or certified registered nurse practitioner) caring for an individual; **and**
- Documentation must support medical necessity; **and**
- A written, signed, and dated order must be received by the supplier before dispensing non-custom-made gradient compression garment or stocking; **and**
- A qualified health care professional must document the clinical characteristic of the individual's affected area that is requiring a compression stockings/sleeve (i.e., physician, physician assistant, certified registered nurse practitioner, or nurse).

AND
ANY ONE of the following:

- Lymphedema; **or**
- Varicose veins (except spider veins); **or**
- Chronic venous insufficiency; **or**
- Venous stasis disease; **or**
- Venous valvular insufficiency; **or**
- Venous insufficiency; **or**
- Post thrombotic syndrome; **or**
- Venous ulcer (stasis ulcer), including **ANY ONE** of the following:
    - Edema; **or**
    - Venous; **or**
    - Lymph; **or**
    - Post traumatic; **or**
    - Post-surgical; **or**
    - Lipedema.
- Angiodysplasia; **or**
- Prevention of thrombosis post-operatively; **or**
- Post sclerotherapy; **or**
- Documented thrombosis risk; **or**
- Venous eczema; **or**
- Lipodermatosclerosis.

Replacement of Non-Custom-Made Gradient Compression Garments/Stockings/Sleeves
Replacement of non-custom-made gradient compression garments/stockings/sleeves, when dispensed prior to six (6) months may be considered medically necessary when **ALL** of the following are met:

- Pre-measuring for changes must be performed before a new prescription is issued; **and**
- Documentation must support medical necessity; **and**
- A written, signed, and dated order must be received by the supplier before dispensing replacement of non-custom-made gradient compression garment/stocking.

AND
ANY ONE of the following:

- The compression garment cannot be repaired (i.e., lost elasticity, tears, etc.); **or**
- Changes in physical condition (e.g., change in size, unusual drainage, wear that weakened the support).

Quality Level Limits
ONLY six (6) individual (or three (3) pairs per individual for a total of three (3) pairs) of gradient compression garments/stockings/sleeves (in any combination i.e. knee-high, thigh high etc.) per six (6) months can be dispensed. A pair is two (2) of the same items.

Any non-custom-made compression garments not meeting the criteria as indicated in this policy is considered not medically necessary.

Non-pneumatic active compression devices for upper or lower extremities, are considered medically necessary when the individual has **ONE** or more of the following conditions:

- Lymphedema; **or**
- Phlebolymphedema; **or**
- Venous insufficiency; **or**
- Lipedema.

Code	Description
A6520	Gradient Compression garment, glove, padded, for nighttime use, each
A6522	Gradient Compression garment, arm, padded, for nighttime use, each
A6524	Gradient Compression garment, lower leg and foot, padded, for nighttime use, each
A6526	Gradient Compression garment, full leg and foot, padded, for nighttime use, each
A6528	Gradient Compression garment, bra, for nighttime use, each
A6552	Gradient Compression stocking, below knee, 30-40 Mmhg, each

A6554	Gradient Compression stocking, below knee, 40 Mmhg or greater, each
A6556	Gradient Compression stocking, Thigh length, 18-30 Mmhg, custom, each
A6558	Gradient Compression stocking, Thigh length, 40 Mmhg or greater, custom, each
A6570	Gradient Compression garment, genital region, each
A6572	Gradient Compression garment, toe caps, each
A6575	Gradient Compression arm sleeve and glove combination, each
A6578	Gradient Compression arm sleeve ,each
A6581	Gradient Compression glove, each
A6582	Gradient Compression gauntlet, each
A6583	Gradient Compression wrap with adjustable straps, below knee, each
A6585	Gradient Compression wrap with adjustable straps, above knee, each
A6586	Gradient Compression wrap with adjustable straps, full leg, each
A6587	Gradient Compression wrap with adjustable straps, foot, each
A6588	Gradient Compression wrap with adjustable straps, arm, each
A6589	Gradient pressure wrap with adjustable straps, bra, each
A6594	Gradient Compression bandaging supply, bandage liner, lower extremity, any size or length, each
A6595	Gradient Compression bandaging supply, bandage liner, upper extremity, any size or length, each
A6596	Gradient Compression bandaging supply, conforming gauze, per linear yard, any width, each
A6597	Gradient Compression bandage roll, elastic long stretch, linear yard, any width, each
A6598	Gradient Compression bandage roll, elastic medium stretch, per linear yard, any width, each
A6599	Gradient Compression bandage roll, inelastic short stretch, per linear yard, any width, each
A6600	Gradient Compression bandaging supply, high density foam sheet, per 250 square centimeters, each
A6601	Gradient Compression bandaging supply, high density foam pad, any size or shape, each
A6602	Gradient Compression bandaging supply, high density foam roll for bandage, per linear yard, any width, each
A6603	Gradient Compression bandaging supply, low density channel foam sheet, per 250 square centimeters, each
A6604	Gradient Compression bandaging supply, low density flat foam sheet, per 250 square centimeters, each

A6605	Gradient Compression bandaging supply, padded foam, per linear yard, any width, each
A6606	Gradient Compression bandaging supply, padded textile, per linear yard, any width, each
A6607	Gradient Compression bandaging supply, tubular protective absorption layer, per linear yard, any width, each
A6608	Gradient Compression bandaging supply, tubular protective absorption padded layer, per linear yard, any width, each
S8424	Gradient Pressure Aid (sleeve), ready made
S8427	Gradient Pressure Aid (glove), ready made
S8428	Gradient Pressure Aid (gauntlet), ready made

Sitz Bath

- When the individual has an infection or injury of the perineal area and prescribed by the individual's physician as a part of a planned regimen of treatment in the patient's home.

Code	Description
E0160	SITZ TYPE BATH OR EQUIPMENT, PORTABLE, USED WITH OR WITHOUT COMMODE
E0161	SITZ TYPE BATH OR EQUIPMENT, PORTABLE, USED WITH OR WITHOUT COMMODE, WITH FAUCET ATTACHMENT/S

Speech Generating Devices

Speech generating devices (SGDs) are speech aids that provide individuals with severe speech impairment the ability to meet their functional speaking needs. SGDs provide digitized speech as well as synthesized speech. However, SGDs do not include external speech processors that are part of a cochlear device/system used to capture and amplify sound.

SGDs may be considered medically necessary when ordered by the treating physician and ALL of the following criteria are met:

- A formal evaluation of the individual's cognitive and communication abilities has been performed by a Speech Language Pathologist (SLP). The findings of this evaluation must be documented as a formal written evaluation and forwarded to the individual's treating physician prior to the device being ordered. The written evaluation must include ALL of the following elements:
    - Current communication impairment, including the type, severity, language skills, cognitive ability, and anticipated course of the impairment; and
    - An assessment of whether the individual's daily communication needs could be met using other natural modes of communication; and
    - A description of the functional communication goals expected to be achieved and treatment options; and

  - Rationale for selection of a specific device and any accessories; and
  - Demonstration that the individual possesses the cognitive and physical abilities to effectively use the selected device and any accessories to communicate; and
  - A treatment plan that includes a training schedule for the selected device; and
  - For a subsequent upgrade to a previously issued SGD, information regarding the functional benefit to the individual of the upgrade compared to the initially provided SGD; and
- The individual's medical condition is one resulting in a severe expressive speech impairment; and
- The individual's speaking needs cannot be met using natural communication methods; and
- Other forms of treatment have been considered and ruled out; and
- The individual's speech impairment will benefit from the device ordered; and
- The device ordered, will meet the individual's current communication needs, and
- The device ordered will meet the individual's anticipated communication needs, or the device can be modified as necessary to meet the individual's anticipated needs

Accessories may be considered medically necessary if the coverage criteria for the base device are met and the medical necessity for each accessory is clearly documented in the formal written evaluation by the SLP. Speech pathology services pertaining to the individual's evaluation and training in use of these devices may also be considered medically necessary.

SGD's not meeting the criteria as indicated in this policy are considered not medically necessary. When the SGD is not covered, accessories are also not covered.

Laptop computers, desktop computers, tablet computers, personal digital assistant s (PDAs) or other devices that are not dedicated SGDs are not covered because they do not meet the definition of durable medical equipment (DME). This is a benefit denial.

Communication aids that are not speech generating devices (e.g., communication boards) do not meet the definition of DME. Therefore, they are benefit denials. In addition, services related to non-speech generating devices are also not covered.

Related Components and Accessories for SGDs

The SGD and its components may not be billed separately.

Speech generating software programs enabling a laptop computer, desktop computer, tablet computers, or PDA to function as an SGD may be considered medically necessary as a SGD within the terms of this policy. Installation of the program or technical support is not separately reimbursable.

Separate billing should not be made for any software, interfaces, cables, adapters, interconnects, or switches necessary for the accessory to interface with the SGD.

Eye gaze or eye glance technology (e.g., DynaVox EyeMax System) may be considered medically necessary when **ALL** of the following criteria are met:

- Individual is unable to control or sustain fine/gross body movements; **and**
- Individual must have direct vision in one or both eyes; **and**
- Individual should have the ability to look up, down, left and right; **and**

- Individual must have adequate vision to view the screen; **and**
- Individual must have the ability to focus on one spot for a brief period of time; **and**
- Provider must submit medical records and/or additional documentation to determine coverage for eye gaze access devices.

Eye gaze or eye glance technology not meeting the criteria as indicated in this policy is considered not medically necessary.

Code	Description
E1902	Communication Board, non-electronic Augmentative or Alternative Communication Device

Surgical Mask

- When medically necessary and used in the home.

Code	Description
A4928	SURGICAL MASK, PER 20

Thermometers

- For chronic renal failure when furnished in conjunction with dialysis services.
- Must be submitted with modifier AX.

Code	Description
A4931	ORAL THERMOMETER, REUSABLE, ANY TYPE, EACH
A4932	RECTAL THERMOMETER, REUSABLE, ANY TYPE, EACH

Traction Equipment

- If individual has orthopedic impairment requiring traction equipment which prevents ambulation during the period of use.
- Ambulatory traction device, all types, are considered non-covered

Code	Description
E0870	TRACTION FRAME, ATTACHED TO FOOTBOARD, EXTREMITY TRACTION, (E.G. BUCK'S)
E0890	TRACTION FRAME, ATTACHED TO FOOTBOARD, PELVIC TRACTION
E0900	TRACTION STAND, FREE STANDING, PELVIC TRACTION, (E.G., BUCK'S)
E0920	FRACTURE FRAME, ATTACHED TO BED, INCLUDES WEIGHTS
E0930	FRACTURE FRAME, FREE STANDING, INCLUDES WEIGHTS
E0942	CERVICAL HEAD HARNESS/HALTER

E0944	PELVIC BELT/HARNESS/BOOT
E0945	EXTREMITY BELT/HARNESS
E0946	FRACTURE, FRAME, DUAL WITH CROSS BARS, ATTACHED TO BED, (E.G. BALKEN, 4 POSTER)
E0947	FRACTURE FRAME, ATTACHMENTS FOR COMPLEX PELVIC TRACTION

Urinals

- If individual is bed confined.

Code	Description
E0325	URINAL; MALE, JUG-TYPE, ANY MATERIAL
E0326	URINAL; FEMALE, JUG-TYPE, ANY MATERIAL

Vaporizers

- If individual has a respiratory illness.

Code	Description
E0605	VAPORIZER, ROOM TYPE

Wheelchairs

Manual Wheelchairs (WCs) (rigid or folding, standard or specialized) are devices used to assist adults and children in the mobility-related activities of daily living (MRADLs),

Power mobility devices (PMDs) - Power wheelchairs (PWCs) and power-operated vehicles (POVs, scooters) are collectively referred to as PMDs. They are used to assist individuals in their MRADLs in the home.

Mobility-assistive equipment (MAE) are necessary devices used to assist adults and children in the MRADLs. MAE includes, but is not limited to: manual WCs, rolling chairs, PWCs, and POVs.

Options/Accessories - Options and accessories for WCs and mobility devices are any adaptive equipment that is necessary if the individual has a WC, PMD or MAE and the option/accessory for the device.

Standard WCs
Standard WCs may be considered medically necessary when ALL of the following criteria are met:

- The individual would otherwise be confined to a bed or chair. The individual is considered confined to a bed or chair if they are unable to ambulate from, for example, bed to bathroom, bedroom to kitchen, or around the home; and
- The individual has a disease process or injury for which weight-bearing and/or ambulation is contraindicated; and

- The individual has a disease process or injury that precludes use of the lower extremities (e.g., a neuromuscular disease).

Standard WCs not meeting the criteria as indicated in this policy are considered not medically necessary.

Specialized manual WCs, strollers and/or WC enhancements
Specialized manual WCs, strollers and/or WC enhancements may be considered medically necessary when the individual meets coverage criteria for a standard WC and the additional accompanying criteria for the specified enhancement are also met:

- A transport chair as an alternative to a standard manual WC; or
- As a standard hemi-WC when the individual requires a lower seat height (17"-18") because of short stature or cannot otherwise place his or her feet on the ground for propulsion; or
- A lightweight WC when the individual cannot self-propel in a standard WC but is able to self-propel in a lightweight WC; or
- An ultra-lightweight WC when the individual cannot self-propel in a standard or lightweight WC but is able to self-propel in an ultra-lightweight WC; or
- A high-strength, lightweight WC when ONE of the following additional criteria is met:
    - The individual can self-propel a high-strength lightweight WC while engaging in frequently performed activities that cannot otherwise be completed in a standard or lightweight WC; or
    - The individual requires a seat width, depth or height that cannot be accommodated in a standard, lightweight or hemi-WC and spends at least two (2) hours per day in the WC:or
    - A high-strength lightweight wheelchair is rarely reasonable and necessary if the expected duration of need is less than three (3) months (e.g., post-operative recovery).
- A heavy-duty WC if the individual weighs greater than 250 pounds or has severe spasticity; or
- An extra-heavy-duty WC if the individual weighs greater than 300 pounds; or
- A manual WC with tilt in space is covered if the beneficiary meets the general coverage criteria for a manual WC above; or
- A custom WC base is covered as medically necessary only if the feature needed is not available as an option to an existing manufactured base; or
- A pediatric size WC if a seat width and/or depth of 14 inches or less is recommended; or
- A customized pediatric stroller for a child who is non-ambulatory when ONE of the following criteria is met:
    - The child requires more support than is available in a standard pediatric WC; or
    - The child is too small to safely use a standard pediatric WC; or
- A semi/fully reclining WC when ANY of the following criteria are met:
    - Quadriplegia; or
    - Fixed hip angle; or
    - Trunk or lower extremity casts/braces that require the reclining back feature for positioning; or
    - Excess extensor tone of the trunk muscles; or
    - The need to rest in the recumbent position two or more times during the day and transfer between WC and bed is difficult.

Specialized manual WCs, strollers and/or WC enhancement not meeting the criteria as indicated in this policy are considered not medically necessary.

Power Mobility Devices (PMD)
The following PMDs may be considered medically necessary when the device-specific criteria are met:

- PWC; or
- POV/scooter (i.e., 3-4 wheeled); or
- Push-rim activated power assist device.

The supporting materials submitted with a request for a PMD must include a formal written evaluation by a physical therapist (PT), occupational therapist (OT), or physician.
The evaluation clearly states why the specific device and enhancements (if any) are being requested and why they are medically necessary for the individual.
The requesting PT, OT, or physician is trained and experienced in rehabilitation PMD evaluations and have no financial relationship with the supplier or manufacturer.
PMD's not meeting the criteria as indicated in this policy are considered not medically necessary.

Power-operated Vehicles (POV)
POV Group 1 may be considered medically necessary when ALL of the following criteria are met:

- The individual meets criteria for a standard manual WC; and
- The individual is unable to operate a standard manual WC due to lack of upper body or arm strength or lack of upper body or arm mobility; and
- The individual has a mobility limitation that significantly impairs his/her ability to participate in one (1) or more MRADLs (e.g., toileting, feeding, dressing, grooming, and bathing) in the home; and
- The individual's mobility limitation cannot be resolved by the use of an appropriately fitted cane or walker; and
- The individual does not have sufficient upper extremity function to self-propel a manual WC in the home to perform MRADLs; and
- The individual is able to transfer to and from a POV, can operate the tiller steering system and can maintain postural stability and position while operating the POV in the home; and
- The individual's mental capabilities (e.g., cognition, judgment) and physical capabilities (e.g., vision) are sufficient for safe mobility using a POV in the home; and
- The individual's home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the POV being requested; and
- The individual's weight does not exceed the weight capacity of the POV being requested; and
- Use of a POV will significantly improve the individual's ability to participate in MRADLs, and the individual will use it in the home; and
- The individual is agreeable to the use of a POV in the home.

The allowance for a POV includes all options and accessories that are provided at the time of initial issue, including but not limited to batteries, battery chargers, seating systems, etc.
If an individual owned POV meets coverage criteria, medically necessary replacement items are covered.
POV Group 1 devices not meeting the criteria as indicated in this policy are considered not medically necessary.

Power Wheelchairs (PWC)
PWCs may be considered medically necessary when ALL of the following criteria are met:

- The individual meets criteria for a standard manual WC; and
- The individual is unable to operate a standard manual WC due to lack of upper body or arm strength or lack of upper body or arm mobility; and

- The individual has a mobility limitation that significantly impairs his/her ability to participate in one (1) or more MRADLs (e.g., toileting, feeding, dressing, grooming, and bathing) in the home; and
- The individual's mobility limitation cannot be resolved by the use of an appropriately fitted cane or walker; and
- The individual does not have sufficient upper extremity function to self-propel a manual WC in the home to perform MRADLs; and
- The individual has the mental and physical capabilities to safely operate the PWC being requested or the individual has a caregiver who is unable to adequately propel an optimally configured manual WC, but is available, willing, and able to safely operate the PWC being requested; and
- The individual's weight does not exceed the weight capacity of the PWC being requested; and
- The individual's home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the PWC being requested; and
- Use of a PWC will significantly improve the individual's ability to participate in MRADLs, and the individual will use it in the home. For individuals with severe cognitive and/or physical impairments, participation in MRADLs may require the assistance of a caregiver; and
- The individual is agreeable to the use a PWC in the home.

Group 1 PWC
Group 1 standard PWC may be considered medically necessary when ALL the above PWC criteria are met and PWC is appropriate for the individual's weight.
Group 1 standard PWC not meeting the criteria as stated in this policy is considered not medically necessary.

Group 2 PWC
Group 2 PWC may be considered medically necessary when ALL the criteria under PWC are met for ANY of the following indications:

- Standard PWC:
  - PWC is appropriate for individual's weight; or
- Single power option PWC:
  - Individual requires a drive control interface other than a hand or chin-operated standard proportional joystick (e.g., head control, sip and puff, switch control); or
  - Individual meets criteria for a power tilt, power recline, or combination power tilt/power recline seating system and the system is to be used on the WC; or
- Multiple power option PWC:
  - Individual meets coverage for a power tilt, power recline, or power tilt, or combination power tilt/power reclilne seating system and the system is to be used on the WC; and/or
  - Individual uses a ventilation which is mounted on the WC.

Group 2 PWC not meeting the criteria as indicated in this policy is considered not medically necessary.

Group 3 PWC
Group 3 PWC may be considered medically necessary when ALL the criteria under PWC are met for ANY of the following indications:

- No power options:
  - When the individual's mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity*; or
- Single power option PWC:

    - When the individual's mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity*; and
    - Group 2 single power option criteria are met; or
- Multiple power option PWC:
    - When the individual's mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity*; and
    - Group 2 multiple power option criteria are met.

Group 3 PWC not meeting the criteria as indicated in this policy is considered not medically necessary.

Group 4 PWC

Group 4 PWCs are considered not medically necessary for use in the home.

Group 5 PWC

Group 5 PWC may be considered medically necessary when ALL the criteria under PWC are met for ANY of the following indications:

- Single power option PWC:
    - Individual is expected to grow in height; and
    - Group 2 single power option criteria are met; or
- Multiple power option PWC:
    - Individual is expected to grow in height; and
    - Group 2 single power option criteria are met.

Group 5 PWC not meeting the criteria as indicated in this policy is considered not medically necessary.

Examples of neurological conditions, myopathies and congenital skeletal deformities include but are not limited to:

- Amyotrophic lateral sclerosis; or
- Bilateral hemiparesis; or
- Cerebral palsy (spastic diplegia); or
- Choreoathetosis- neurological; or
- Dystonia musculorum deformans; or
- Huntington's chorea; or
- Myasthenia gravis; or
- Multiple sclerosis; or
- Parkinson's disease; or
- Polyneuropathy; or
- Post-polio syndrome; or
- Quadriparesis; or
- Quadriplegia; or
- Refractory carpal tunnel syndrome/disease; or
- Spinocerebellar degeneration.

Push-rim Activated Power Assist Device
Push-rim activated power assist device for a manual WC (e.g., INDEPENDENCE™ iGLIDE™) may be considered medically necessary for use in the home when ALL of the following criteria are met:

- The individual has a mobility limitation that significantly impairs his/her ability to participate in one (1) or more MRADLs (e.g., toileting, feeding, dressing, grooming, and bathing) in the home; and
- The individual's mobility limitation cannot be resolved by the use of an appropriately fitted cane or walker; and
- The individual has been self-propelling in a manual WC for at least one (1) year but no longer has sufficient upper extremity function to self-propel a manual WC in the home to perform MRADLs.

One (1) month's rental of a PWC or POV may be considered medically necessary if the individual-owned PWC or PVC is being repaired.
An add-on to convert a manual WC to a joystick-controlled power mobility device or to a tiller-controlled power mobility device will be denied as not medically necessary.
Payment is made for only one (1) WC at a time. Backup chairs are denied as not medically necessary.
Push-rim activated power assist devices not meeting the criteria as indicated in this policy are considered not medically necessary.

WC Options and Accessories
Medically Necessary
Certain WC accessories may be considered medically necessary if the WC is considered medically necessary and the options or accessories are necessary for the individual to function in the home and perform the activities of daily living.
The following WC options and accessories may be considered medically necessary when the individual meets the medical necessity criteria for a WC. This list is not all-inclusive;

- Adjustable arm-height option, when BOTH indications are met:
    - The individual requires an arm height that is different than that available using non-adjustable arms; and
    - The individual spends at least two (2) hours per day in the WC, or
- Amputee adapter; or
- Anti-rollback device and anti-tip device when the individual is able to propel himself/herself and needs the device because of ramps, or
- Articulating foot platforms/ center mount power elevating leg rest/platform for ANY of the following indications:
    - Individual has impaired lower extremity functioning including but not limited to neurological conditions; or
    - Individual needs to independently elevate their lower extremities (e.g. increase circulation); or
    - Individual requires specific positioning of their lower extremities; or
    - Individual needs to navigate small or tight areas their home environment; or
    - Individual needs for independent or minimally assisted standing pivot transfers.or
- Arm trough when the individual has quadriplegia, hemiplegia, or uncontrolled arm movements; or
- Chin or head control when the individual has weak neck muscles and needs a chin or head control for support; or
- Custom fabricated seat cushion when BOTH of the following are met:
    - The individual meets ALL of the coverage criteria for a prefabricated skin protection seat cushion or positioning seat cushion; and

  - There is a comprehensive written evaluation by a licensed/certified medical professional, such as a PT or OT, which clearly explains why a prefabricated seating system is not sufficient to meet the individual's seating and positioning needs; or
- Custom fabricated back cushion when ALL of the following are met:
  - Individual meets ALL of the coverage criteria for a prefabricated positioning back cushion; and
  - There is a comprehensive written evaluation by a licensed/certified medical professional, such as a PT or OT, which clearly explains why a prefabricated seating system is not sufficient to meet the individual's seating and positioning needs; or
- Dynamic seating frame for pediatric size WC when ALL of the following are met:
  - The individual has a WC that meets coverage criteria; and
  - The individual's condition is such that without the use of a WC, he/she would otherwise be bed or chair confined (an individual may qualify for a WC and still be considered bed confined); and
  - The options/accessories are necessary for the individual to perform EITHER of the following activities:
  - Function in the home; or
  - Perform instrumental activities of daily living; or
- Electronic interface to allow a speech generating device SGD) to be operated by the power WC control interface. Electronic interface to control lights or other electrical devices it considered not medically necessary because it is not primarily medical in nature; or
- Elevating leg rests, Articulating (telescoping) elevating leg rests for ANY of the following:
  - The individual has a musculoskeletal condition or the presence of a cast or brace that prevents 90 degree flexion of the knee; or
  - The individual has significant edema of the lower extremities that requires having an elevating leg rest; or
  - The individual meets criteria for a WC and has a reclining back.
- General use seat cushion and general use WC back cushion when the individual has a manual WC or a PWR with a sling/solid seat/back.
  - If the individual does not have a covered WC, then the cushion will be denied as not medically necessary.
  - If the individual has a POV or a PWC with a captain's chair seat, the cushion will be denied as not medically necessary; or
- Handles- push, telescoping, stroller; or
- Headrest if the individual meets the criteria for and has a medically necessary manual tilt-in-space, manual, semi or fully reclining back on a manual WC, or a manual or fully reclining back on a PWC, or power tilt and/or recline seating system; or
- Heel loops; or
- Intravenous (IV) rod; or
- Lap tray WC attachment when used to provide trunk support in WC. Lap traps are considered not medically necessary for ANY of the following:
  - WC trays not used to provide trunk support, or
  - Work trays, or
  - Cutout tables; or
- Manual fully reclining back option for ONE of the following conditions:
  - The individual is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; or

    - The individual utilizes intermittent catheterization for bladder management and is unable to independently transfer from the WC to bed; or
- Manual or power standing system if the individual has cerebral palsy, spasticity, multiple sclerosis, or paraparesis. NOTE: For other conditions, individual consideration will be given; or
- Mechanical or power shear reduction features; or
- Mechanically linked leg elevation feature when the individual meets medical necessity criteria for a power recline seating system; or
- Narrowing device; or
- Non-powered seat elevator or standing device when the individual is unable to bend or sit; or
- Non-standard seat width, depth, or height when ALL of the following criteria are met:
    - The ordered item is at least two (2) inches greater than or less than a standard option; and
    - The individual's dimensions justify the need; or
- One-arm drive attachment when ALL of the following are met:
    - The individual propels the chair himself/herself with only one hand; and
    - The need is expected to last at least six (6) months.
- Oxygen carrier; or
- Power add-ons to manual WC; or
- Power leg elevation feature; or
- Power tilt and/or recline seating systems -- tilt only, recline only, or a combination tilt and recline -- with or without power elevating leg rests when ALL of the following are met:
    - The individual meets medical necessity criteria for a PWC; and
    - A specialty evaluation was performed by a licensed/certified medical professional, such as a PT or OT or physician who has specific training and experience in rehabilitation WC evaluations documents the individual's seating and positioning needs; and
    - EITHER of the following criteria are met:
    - Individual is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; or
    - The individual uses intermittent catheterization for bladder management and is unable to independently transfer from the WC to bed; or
- PWC drive control systems, an attendant control allows the caregiver to drive the WC instead of the individual. The attendant control is usually mounted on one of the rear canes of the WC. This is considered medically necessary when ALL of the following are met:
    - The individual is unable to operate a manual or PWC; and
    - A caregiver who is unable to operate a manual WC but is able to operate a PWC; or
- Reinforced back upholstery or reinforced seat upholstery when ALL of the following are met:
    - When used with a PWC base; and
    - Individual weighs more than 200 pounds; or
- Safety belt/pelvic strap when the individual has weak upper body muscles, upper body instability or muscle spasticity, which requires use of this item for proper positioning; or
- Solid seat insert when the individual spends at least two (2) hours per day in the WC; or
- Speech generating device (SGD) table; or
- Step tube; or
- Suspension fork; or
- Swingaway, retractable, or removable hardware when the component needs to move out of the way so that the individual could perform a slide transfer to a chair or bed. It is considered not medically necessary

when the primary indication for its use is to allow the individual to move close to desks or other surfaces; or
- Ventilator tray; or
- WC locks-manual, automatic, hub; or
- Wide stance arm bracket.

Batteries/Chargers
Up to two (2) batteries at one (1) time may be considered medically necessary if required for the PWC.
Non-sealed lead acid batteries are considered not medically necessary.
There is no additional/separate payment when a dual mode battery charger is provided at the time of initial issue of a PWC.
A battery charger is included in the allowance for a power WC base.
The usual maximum frequency of a replacement for a lithium-based battery is one (1) every three (3) years. Only one (1) battery is allowed at any one time.

Specialized Seat, Back Cushions, Power Tilt and/or Recline Seating Systems
A seat or back cushion includes any rigid or semi-rigid base or posterior panel, respectively that is an integral part of the cushion. It also includes any mounting hardware that is directly attached to the cushion.

Specialized Seat and Back Cushions Table

Specialized Seat and Back Cushions	**Medical Necessity Criteria**
Non-adjustable skin protection seat cushion or an adjustable skin protection seat cushion.	**For EITHER of the following indications:** • **Past history or current pressure ulcer on the area of contact with the seating surface; or** • **Absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift due to ONE of the following diagnoses:** o **Spinal cord injury resulting in quadriplegia or paraplegia; or** o **Other spinal cord disease; or** o **Multiple sclerosis; or** o **Other demyelinating disease; or** o **Cerebral palsy; or** o **Anterior horn cell diseases including amyotrophic lateral sclerosis; or** o **Post-polio paralysis; or** o **Traumatic brain injury resulting in quadriplegia; or** o **Spina bifida; or** o **Childhood cerebral degeneration; or** o **Alzheimer's disease; or**

	o **Parkinson's disease.**
Non-adjustable combination skin protection and positioning seat cushion or adjustable combination skin protection and positioning seat cushion.	**When BOTH of the following are met:** • **A skin protection seat cushion; and** • **A positioning seat cushion.**
Positioning seat cushion, positioning back cushion, and positioning accessory	**The individual has any significant postural asymmetries that are due to ANY of the following diagnoses:** • **Spinal cord injury resulting in quadriplegia or paraplegia; or** • **Other spinal cord disease; or** • **Multiple sclerosis; or** • **Other demyelinating disease; or** • **Cerebral palsy; or** • **Anterior horn cell diseases including amyotrophic lateral sclerosis; or** • **Post-polio paralysis; traumatic brain injury resulting in quadriplegia; or** • **Spina bifida; childhood cerebral degeneration; or** • **Alzheimer's disease; or** • **Parkinson's disease; or** • **Monoplegia of the lower limb, or hemiplegia due to stroke, or** • **Traumatic brain injury, or other etiology; or** • **Muscular dystrophy; or** • **Torsion dystonias; or** • **Spinocerebellar disease.**
A PWR seat cushion is a battery-powered, prefabricated cushion in which an air pump provides either sequential inflation or deflation of the air cells or a low interface pressure throughout the cushion. One type of powered seat cushion is an alternating pressure cushion.	**Experimental/investigational because its effectiveness has not been established.**

Replacement

Replacement of WC seat cushion, WC back cushion, or WC positioning accessories may be considered medically necessary when the useful life-time has been exceeded (i.e., greater than or equal to five (5) years) unless ONE of the following conditions is met:

- The item has been accidentally, irreparably damaged (other than usual wear and tear); or
- The item has been lost or stolen; or

- There is a change in the individual's medical condition that requires a different type of seating or positioning item.

Not medically necessary

- WC accessories that do not meet the above criteria are considered not medically necessary.
- A static, prefabricated WC seat or back cushion not meeting the definition of general use, skin protection, or positioning cushion; or
- Roll about chair seat and back cushions: Separate payment is not allowed for a WC seat and back cushion for use with a roll about chair; or
- Transport chair seat and back cushion: A seat or back cushion that is provided for use with a transport chair.

Non-Covered

A WC accessory/attachment or WC upgrade is considered a convenience* item when used to adapt to the outside environment work, perform leisure or recreational activities.

*Convenience items do not meet the definition of DME and therefore are non-covered.

The following WC options and accessories are considered non-covered as they are categorized as personal convenience* items:

- Back support systems; or
- Battery charger; or
- Canopies; or
- Clothing guards to protect clothing from dirt, mud, or water thrown up by the wheels (similar to mud flaps for cars); or
- Crutch or cane holder; or
- Flat-free inserts (zero pressure tubes); or
- Gloves; or
- Home modifications: Modifications to the structure of the home to accommodate WC are not considered treatment of disease. Examples of home modifications and installations that are non-covered include WC ramps, wheelchair accessible showers, elevators, and lowered bath or kitchen counters and sinks; or
- Identification devices (such as labels, license plates, name plates); or
- Lighting systems; or
- Power add-ons to manual WC: A power add-on is used to convert a manual WC to a motorized WC (e.g., an add-on to convert a manual WC to a joystick-controlled power mobility device or to a tiller-controlled power mobility device); or
- Shock absorbers; or
- Snow tires for WC; or
- Speed conversion kits; or
- Tie-down restraints; or
- Warning devices, such as horns and backup signals; or
- WC baskets, bags, or pouches - used to hold personal belongings; or
- WC lifts (e.g., Wheel-O-Vator, trunk loader) - devices to assist in lifting WC up stairways, into motorized vehicle; or
- WC locks for van/vehicle; or
- WC rack for automobile (auto carrier) - car attachment to carry WC; or
- WC ramp - provides access to stairways or van; or
- WC tie downs (i.e., transit option device, locking tin device); or

- Wheels-upgraded and specialty wheels (e.g., Spinergy) (not required for MRADLs); or
- The following features of a power WC:
    - Stair climbing; or
    - Electronic balance; or
    - Ability to elevate the seat by balancing on two (2) wheels; or
    - Remote operation; or
- An electrical connection device where the sole function of the connection is for a power seat elevation or power standing feature; or
- Swingaway, retractable, or removable hardware if the primary indication for its use is to allow the individual to move close to desks or other surfaces; or
- A manual standing system for a manual WC.

Covered codes for Wheelchairs

Code	Description
E1032	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware used with joystick or other drive control interface
E1033	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for headrest, cushioned, any type
E1034	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for lateral trunk or hip support, any type
E1060	FULLY-RECLINING WHEELCHAIR, DETACHABLE ARMS, DESK OR FULL LENGTH, SWING AWAY DETACHABLE ELEVATING LEGRESTS
E1083	HEMI-WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEG REST
E1100	SEMI-RECLINING WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEG RESTS
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 LEGRESTS
E1223	WHEELCHAIR WITH DETACHABLE ARMS, FOOTRESTS
E1224	WHEELCHAIR WITH DETACHABLE ARMS, ELEVATING LEGRESTS
E1227	SPECIAL HEIGHT ARMS FOR WHEELCHAIR
E1228	SPECIAL BACK HEIGHT FOR WHEELCHAIR
E1230	POWER OPERATED VEHICLE (THREE OR FOUR WHEEL NONHIGHWAY) SPECIFY BRAND NAME AND MODEL NUMBER
E1295	HEAVY DUTY WHEELCHAIR, FIXED FULL LENGTH ARMS, ELEVATING LEGREST
E1296	SPECIAL WHEELCHAIR SEAT HEIGHT FROM FLOOR
E1297	SPECIAL WHEELCHAIR SEAT DEPTH, BY UPHOLSTERY

E1298	SPECIAL WHEELCHAIR SEAT DEPTH AND/OR WIDTH, BY CONSTRUCTION
E2340	POWER WHEELCHAIR ACCESSORY, NONSTANDARD SEAT FRAME WIDTH, 20-23 INCHES
E2341	POWER WHEELCHAIR ACCESSORY, NONSTANDARD SEAT FRAME WIDTH, 24-27 INCHES
E2342	POWER WHEELCHAIR ACCESSORY, NONSTANDARD SEAT FRAME DEPTH, 20 OR 21 INCHES
E2343	POWER WHEELCHAIR ACCESSORY, NONSTANDARD SEAT FRAME DEPTH, 22-25 INCHES
E2628	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, RECLINING
E2630	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT, MONOSUSPENSION ARM AND HAND SUPPORT, OVERHEAD ELBOW FOREARM HAND SLING SUPPORT, YOKE TYPE SUSPENSION SUPPORT
E2632	WHEELCHAIR ACCESSORY, ADDITION TO MOBILE ARM SUPPORT, OFFSET OR LATERAL ROCKER ARM WITH ELASTIC BALANCE CONTROL
E2633	WHEELCHAIR ACCESSORY, ADDITION TO MOBILE ARM SUPPORT, SUPINATOR
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
K0014	OTHER MOTORIZED/POWER WHEELCHAIR BASE

Post-payment Audit Statement
The medical record must include documentation that reflects the medical necessity criteria and is subject to audit by Highmark Wholecare at any time pursuant to the terms of your provider agreement.

Place of Service: Outpatient

REIMBURSEMENT

Participating facilities will be reimbursed per their Highmark Wholecare contract.

References

MedicaidManual.pdf

HIghmark Wholecare 2025 Pennsylvania Medicaid Member Handbook

HWC 2026 HealthChoices Agreement w Appendices and Exhibits.pdf