



Summary of Medicare Coverage for Medical Equipment

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Summary of Medicare Coverage

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Summary of Medicare Coverage

Air-Fluidized Bed – COVERED

Coverage Criteria:

- **The patient has a stage III (full thickness tissue loss) or Stage IV (deep tissue destruction) pressure sore.**
- **The patient is bedridden or chair bound as a result of severely limited mobility.**
- In the absence of an air-fluidized bed, the patient would require hospitalization.
- **The air-fluidized bed is ordered in writing by the patient's attending physician.**
- Treatment has generally included: Education of the patient and caregiver on the prevention and/or management of pressure sores. Assessment by the physician, nurse, or other healthcare practitioner at least weekly. Use of a Group 2 support surface if appropriate. Appropriate turning and positioning. Appropriate wound care. Appropriate management of moisture/incontinence. Nutrition assessment and intervention.
- **The patient must generally have been on the conservative treatment program for at least one month prior to the use of the air fluidized bed with worsening or no improvement of the ulcer. The evaluation generally must be performed within a week prior to initiation of therapy with the air fluidized bed.**
- A trained adult caregiver is available to assist the patient with activities of daily living, fluid balance, dry skin care, repositioning, recognition and management of altered mental status, dietary needs, prescribed treatment and management and support of the air-fluidized bed system and its problems, such as leakage.
- a physician directs the home treatment regimen, and reevaluates and recertifies the nee4ds for the air-fluidized bed on a monthly basis.
- all other alternative equipment has been considered and ruled out.
- Coverage is limited to the air-fluidized bed itself. **A physician's written prescription for the bed must be furnished to the supplier prior to delivery of the bed.** A monthly assessment by the physician must be kept on file by the supplier. The DMERC CMN must be recertified after the first six months of treatment. Caregiver services and electrical or structural improvements to the patient's room are not covered.
- **Not covered under the following circumstances:** the patient has no co-existing pulmonary disease, the patient requires moist wound dressings that are not protected with an impervious covering, like plastic wrap, the patient is unwilling or unable to provide the care required if an air-fluidized bed is used, structural support in the home environment cannot accommodate the weight of an air fluidized bed, the home electrical system cannot handle the anticipated increase in energy usage, or any other known contraindications exist.

Alternating Pressure (power pressure reducing mattress) - COVERED

- Multiple stage II pressure ulcers located on the trunk or pelvis **and** patient has been on a comprehensive ulcer treatment program for at least the past month which has included the use of an appropriate group I support surface **and** the ulcer has worsened or remained the same over the past month, **or**
- Large or multiple Stage III or IV pressure ulcer(s) on the trunk or pelvis, **or**
- Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the last 60 days) **and** the patient has been on a Group II or Group III support surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 days)



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- **A physician's written order must be furnished to the supplier prior to delivery.** Monthly assessments must be conducted for continued coverage. These assessments can be conducted and documented by a home health agency.

Note:

- **A physician's written order must be furnished to the supplier prior to delivery.** Monthly assessments must be conducted for continued coverage. These assessments can be conducted and documented by a home health agency.
- Stage I: Non blanchable erythema or intact skin
- Stage II: Partial thickness skin loss involving the epidermis and/or dermis
- Stage III: Full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia
- Stage IV: Full thickness skin loss with extensive destruction, tissue necrosis, damage to muscle, bone or supportive structures

Alternating Pressure Pad with Pump and Mattress (APP) (includes all flotation devices: air, water, gel, etc.) - COVERED

- Patient is completely immobile (i.e. cannot make changes in body position without assistance), **or** limited mobility, **or** any stage pressure ulcer on the trunk or pelvis **with one of the following conditions:** *impaired nutritional state, fecal or urinary incontinence, altered sensory perception, compromised circulatory status.*
- **A physician's written prescription/order must be furnished to the supplier prior to delivery.**

Apnea Monitor (infant) – DENIED/Not covered

Aqua K Pad - COVERED

Coverage criteria:

- If the patient's condition would benefit from the application of heat in the form of a heating pad.

Bathtub Lift - DENIED/Not covered

Coverage criteria:

- Convenience item; not primarily medical in nature.

Bathtub Seat - DENIED/Not covered

Coverage criteria:

- Convenience item; not primarily medical in nature.

Bed Bath - DENIED/Not covered

Coverage criteria:



Summary of Medicare Coverage

- Hygienic item; not primarily medical in nature

Bedboard - DENIED/Not covered

Coverage criteria:

- Convenience item; not primarily medical in nature.

Bed Cradle – COVERED

Coverage criteria:

- If the patient has gouty arthritis or is suffering from burns.

Bed Lifter - DENIED/Not covered

Coverage criteria:

- Convenience item; not primarily medical in nature.

Bed Pan - COVERED

Coverage criteria:

- If the patient is confined to bed. Only the autoclavable hospital-type bedpan is covered.

Bed Side Rails - COVERED

Coverage criteria:

- If the side rails are provided along with a hospital bed. See. HOSPITAL BED

Bi-Level Positive Pressure Machine – See Respiratory Assist Device

Blood Glucose Monitor - COVERED

Coverage criteria:

- For patients who are diabetic (ICD-9 Code 250.00-250.93) and who can better control their blood glucose levels by checking these levels and appropriately contacting their physician for advice and treatment.

Notes:

- **Normal Utilization**
 - For a patient who is NOT currently being treated with insulin injections, up to 100 test strips and 100 lancets every 3 months.
 - For a patient who is currently being treated with insulin injections, up to 100 test strips and 100 lancets every month.
 - Patient has ICD-9 Code 250.00-250.93 which is being treated by a physician, the monitor and supplies have been ordered by the treating physician, the patient or caregiver has been trained in the use of the monitor and supplies, the patient (or caregiver) is capable of using the test results to assure the patient appropriate glycemic control and the monitor is designed for home use.



Summary of Medicare Coverage

- **High Utilization:**

- For a patient who is NOT currently being treated with insulin injections, more than 100 test strips and 100 lancets every 3 months.
- For a patient who is currently being treated with insulin injections, more to 100 test strips and 100 lancets every month.
- Normal utilization requirements listed above must be met in addition to the following: the beneficiary has nearly exhausted his/her current supply; the treating physician has ordered a frequency of testing that exceeds the utilization and has documentation to support this; and the physician has seen the patient and evaluated their diabetic control within 6 months prior to ordering quantities that exceed normal utilization. A beneficiary or their caregiver must specifically request refills of glucose monitor supplies before they are dispensed. The supplier must not automatically dispense a quantity of supplies on a predetermined regular basis, even if the beneficiary has "authorized" this in advance. No more than a 3-month supply of test strips and/or lancets should be dispensed at a time. A new prescription is required every 6 months. Assignment is accepted on the monitor, lancets, and test strips at time of set-up. When lancets and test strips are ordered again, we will not accept assignment and the patient is required to pay at time of delivery.

Blood Pressure Monitor: COVERED

Coverage criteria:

- If prescribed by a physician as part of a home hemodialysis system, a sphygmomanometer and stethoscope are covered. Coverage for an automatic blood pressure monitor is limited to reasonable charges for a sphygmomanometer with cuff and stethoscope, unless documentation establishes that the patient's condition does not permit to the least expensive automatic blood pressure monitor that is medically effective.

Breast Prosthesis - COVERED

Coverage criteria:

- If the patient has had a mastectomy, limit a form per side every two years.

Cane - COVERED

Coverage criteria:

- If the patient's condition impairs the patient's ability to walk, a cane can be covered in conjunction with a wheelchair, if the cane is required for gait therapy.

Colostomy Equipment and Supplies – COVERED - see *Ostomy Equipment and Supplies*

Commode - COVERED

Coverage criteria:

- If the patient is incapable of utilizing regular toilet facilities. The patient must be confined to a single room or to one level of their home environment.



Summary of Medicare Coverage

Commode with Removable Arms - COVERED

Coverage criteria:

- If the patient has met above criteria and the patient requires transfer or body configuration requires extra width.

Concentrator – see *Oxygen Systems*

Continuous Passive Motion Device (CPM) - COVERED

Coverage criteria:

- If the patient has undergone a total knee replacement. To qualify for reimbursement, the **device must be used within two days of surgery. Coverage in the home is limited to a maximum of 21 days immediately following surgery. (includes days in hospital). Date of surgery is required for claim submission. Need date of therapy initiation, discharge date, and which side is effected.**

Continuous Positive Airway Pressure (CPAP) - COVERED

Coverage criteria:

- If the patient is diagnosed with moderate or severe obstructive sleep apnea, and surgery is a likely alternative. Diagnosis of obstructive sleep apnea (OSA) **must include documentation of at least 30 episodes of apnea, each lasting a minimum of 10 seconds, during the 6-7 hours of recorded sleep.** Initial claims must also certify that documentation supportive the diagnosis of OSA is available. Supplies will be reimbursed separately.

Notes:

- Accessories in excess of these timeframes are rarely considered medically necessary.
- Covered with a medically necessary CPAP or BiPAP. Must be listed on prescription.
 - Mask: 1 per 3 months
 - Nasal pillows (pair): 2 per 1 month
 - Headgear: 1 per 6 month
 - Chin Strap: 1 per 6 months
 - Tubing: 1 per 1 month
 - Disposable filters: 1 per 1 month
 - Non-Disposable filters: 1 per 6 months

Crutches - COVERED

Coverage criteria:

- If the patient's condition impairs the patient's ability to walk.



Summary of Medicare Coverage

Diapers - DENIED/Not covered

Coverage criteria:

- Non reusable disposable supplies

Disposable Sheets and Bags - DENIED/Not covered

Coverage criteria:

- Non reusable disposable supplies.

Elastic Stockings - DENIED/Not covered

Coverage criteria:

- Non reusable supplies; not rental-type items

Electronic Speech Aid - COVERED

Coverage criteria:

- If the patient has had a laryngectomy, or the patient's larynx is permanently inoperative.

Enteral Equipment and Supplies - COVERED

Coverage criteria:

- If the patient has a permanent non function or disease of the structures that normally permit food to reach the small bowl or (b) disease of the small bowel which impairs digestion and absorption of an oral diet, either of which requires tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the patient's overall health status. The patient must have a permanent impairment. Permanence does not require a determination that there is no possibility that the patient's condition may improve sometime in the future. If the judgement of the attending physician, substantiated in the medical record, is that the condition is of long and indefinite duration (ordinarily at least three months), the test of permanence is considered met. Enteral nutrition will be denied as non-covered in situations involving temporary impairments.
- If the coverage requirements are met, all related supplies, equipment and nutrients are also covered, including IV poles and enteral nutrition preparation. No more than one month's supply of enteral nutrients, equipment or supplies are allowed for one month's prospective billing.
- If a pump is ordered, gravity feeding must be ruled out as satisfactory feeding.

Flow Meter – COVERED – See Oxygen System

Foley Catheter - COVERED

Coverage criteria:



Summary of Medicare Coverage

- If prescribed by a physician for permanent urinary incontinence, the Foley is covered under the prosthetic device benefit. One catheter per month is covered for routine catheter maintenance. Non-routine catheter changes are covered when documentation from physician substantiates medical necessity. Permanence is considered when a condition lasts at least three months.
- **HOMESTAR DOES NOT ACCEPT ASSIGNMENTS ON CATHETERS**

Gel Flotation Pad/Mattress: COVERED

Coverage criteria:

- If the patient is **completely immobile, i.e., cannot make changes in body position without assistance, or limited mobility** - i.e., patient cannot independently make changes in body position significantly enough to alleviate pressure or any stage pressure ulcer on the trunk or pelvis -- **with one of the following conditions:**
 - **Impaired nutritional status**
 - **Fecal or urinary incontinence**
 - **Altered sensory perception**
 - **Compromised circulatory status**
- A physician's written prescription must be furnished to the supplier prior to delivery

Glucometer – see *Blood Glucose Monitor*

Grab Bars - DENIED/Not covered

Coverage criteria:

- Self-help device; not primarily medical in nature

Heating Pad - COVERED

Coverage criteria:

- If the application of heat in the form of a heating pad is therapeutically effective for the patient's medical condition.

Heat Lamp - COVERED

Coverage criteria:

- If the application of heat in the form of a heat lamp is therapeutically effective for the patient's medical condition.

Hospital Bed - COVERED

Coverage criteria:

- **If the patient's prescription establishes medical necessity due to one of the following reasons:**
- The patient's condition requires positioning of the body. To alleviate pain, prevent contractures, avoid respiratory infections, in ways not feasible in an ordinary bed.
- The patient's condition requires special attachments that cannot be affixed to or used on an ordinary bed.



Summary of Medicare Coverage

- The patient who requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or wedges must be tried and failed.
- **Hospital beds going to an Assisted Living Facility must go out with half rails.**

Hoyer Lift – see *Patient Lift*

Humidifier - COVERED

Coverage criteria:

- If the humidifier is necessary to the operation of the patient's covered oxygen or continuous positive airway pressure equipment.
- See *Continuous Positive Airway Pressure* or *Oxygen System*

Hydraulic Lift – see *Patient Lift*

Ileostomy Equipment and Supplies – see *Ostomy Equipment and Supplies*

Incontinence Pads - DENIED/Not covered

Coverage criteria:

- Non reusable disposable supplies

Incontinence Supplies (indwelling catheters, drainage bags, urinary catheters, etc.) - **COVERED**

Coverage criteria:

- If prescribed by the physician that the condition resulting in the need for the device is of long and indefinite duration (at least three months), one catheter per month is covered for routine catheter maintenance. Non-routine catheter changes are covered when documentation substantiates medical necessity, i.e., urine leaks around catheters, urinary tract infection, catheter is removed by patient, etc. See *Foley Catheter*
- **Note: HOMESTAR DOES NOT ACCEPT ASSIGNMENT**

IPPB Machine - COVERED

Coverage criteria:

- If the patient's ability to breathe is severely impaired

Iron Lung - COVERED

Coverage criteria:

- If the patients has respiratory paralysis



Summary of Medicare Coverage

Irrigating Kit - **COVERED**

Coverage criteria:

- Only for patients whose ostomy equipment and supplies are covered under the prosthetic device benefit. See *Ostomy Equipment and Supplies and Prosthetic Devices*

Lamb's Wool Pad - **DENIED/Not covered**

Coverage criteria:

- Does not meet the definition of durability; and, therefore, will be denied as non-covered.

Liquid Oxygen System – see *Oxygen System*

Low Air Loss Bed - **COVERED**

Coverage criteria:

- **If the following conditions are met:**
 - Multiple stage II pressure ulcers located on the trunk or pelvis **AND** patient has been on a comprehensive ulcer treatment program for at least the past month which has included the use of an appropriate Group I Support surface **AND** the ulcers have worsened or remained the same over the past month, or
 - Large of multiple stage III or IV pressure ulcer(s) (see below) on the trunk or pelvis, or
 - Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days limited to coverage to 60 days from the date of surgery **AND** the patient has been on a group II or III support surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 days).
- **Notes:**
 - Stage I: Non blanchable erythema or intact skin
 - Stage II: Partial thickness skin loss involving the epidermis and/or dermis
 - Stage III: Full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia
 - Stage IV: Full thickness skin loss with extensive destruction, tissue necrosis, damage to muscle, bone or supportive structures
- Coverage is limited to the low-air loss bed itself. A physician's written prescription for the bed must be furnished to the supplier prior to delivery of the bed.

Lymphedema Pump – see *Pneumatic Compression Device*

Mask (oxygen or CPAP) - **COVERED**

Coverage criteria:

Summary of Medicare Coverage

- If the face mask is necessary to the operation of the patient's covered oxygen or continuous positive airway equipment. See *Continuous Positive Airway Pressure* or *Oxygen System*

Mask (surgical) - DENIED/Not covered

Coverage criteria:

- Non-reusable disposable item.

Mattress - COVERED

Coverage criteria:

- If a hospital bed is medically necessary and coverage requirements for the hospital bed have been met, a mattress for the hospital bed is also covered. See *Hospital Bed*.
- A replacement mattress for the hospital is covered if the patient **OWNS** the hospital bed

Motorized Wheelchair – see Wheelchair

Nasal CPAP – See Continuous Positive Airway Pressure (CPAP)

Nebulizer - COVERED

Coverage criteria:

- Medically necessary to administer betadrenergics, anticholinergics, corticosteroids, and cromolyn for the management of obstructive pulmonary disease (491.0-555), or
- Medically necessary to administer gentamycin, tobramycin, amikacin, or dornase alpha to a patient with cystic fibrosis (277.0), or
- Medically necessary to administer pentamidine to patients with HIV (042), or
- Medically necessary to administer mucolytics (other than dornase alpha) for persistent thick or tenacious pulmonary secretions. (786.4)
- *Note:* Need to know if MDI tried/failed and medications.

Nebulizer Supplies - COVERED

Coverage criteria:

- **Supplies are reimbursed separately**
- Administration set, disposable - two/month
- Small volume, nonfiltered pneumatic nebulizer, disposable - two/month
- Aerosol mask, used with nebulizer -- one/month
- Filter, disposable -- two/month
- Non-disposable pari-neb -- 1 every six months



Summary of Medicare Coverage

Ostomy Equipment and Supplies - **COVERED**

Coverage criteria:

- If the patient is diagnosed with an ostomy (a surgically created opening (stoma) to divert urine, feces, or ileal contents outside the body)
- If coverage is established, all related equipment and supplies are also covered, including colostomy and other bags, irrigation and flushing equipment and other items directly related to colostomy care, whether or not the attachment of a bag is required. The quantity of ostomy supplies needed by a patient is determined by the type of ostomy, its location, its construction, and the condition of the skin surface surrounding the stoma.
- *Note:* HomeStar **does not** accept assignment

Overbed Table - **DENIED/Not covered**

Coverage criteria:

- Convenience item; not primarily medical in nature

Oxygen Systems - **COVERED**

Coverage criteria:

- For patients with significant hypoxemia in the chronic stable state. If the patient is diagnosed with either a severe primary lung disease such as:
 - Chronic obstructive pulmonary disease
 - Cystic fibrosis
 - Bronchiectasis
 - Widespread pulmonary neoplasm, or
 - The patient is diagnosed with hypoxia-related symptoms that may improve with oxygen therapy such as:
 - Pulmonary hypertension - recurrent CHF due to chronic cor pulmonale, or
 - Erythrocytosis
- **Note Pneumonia is not a covered diagnosis for oxygen**
- **Information needed to qualify patient:**
 - Where test was done
 - When test was done (needs to be within 48 hours of discharge from hospital if ordered on discharge from a hospital)
 - SAT or Arterial blood gas level (see below for information on levels)
 - Whether the above test was performed at rest, during sleep, or with exercise
 - Whether the above test was performed on room air or with oxygen (need liter flow)
 - Provided the following conditions are met:
 - The attending physician has determined that the patient has a severe lung disease of hypoxia-related symptoms that might be expected to improve with oxygen therapy
 - The patient's blood gas levels indicate the need for oxygen therapy, and
 - Alternative treatment measures have been tried or considered and deemed clinically ineffective

Summary of Medicare Coverage

- **A physician's written prescription is required and it must specify:**
 - Diagnosis of the disease requiring oxygen therapy (see above)
 - The oxygen flow rate (e.g. 2 liters per minute)
 - The frequency and duration of oxygen use (e.g. 10 minutes per hour, 12 hours a day)
 - The duration of oxygen need (e.g. 4-12 months or lifetime)
- There are three basic groups of values for ABGs and O2 saturation that will determine coverage:
 - **Group I: Arterial Blood Gas (PO2) is less than or equal to 55 mm Hg or the O2 sat is less than or equal to 88% (awake and at rest)**
 - If the patient has higher levels, but demonstrates desaturation to these levels during sleep or exercise then O2 may be reimbursed.
 - If during sleep, the levels are higher than 55 mm Hg or saturation higher than 88%, but represent a drop of 10 mm Hg (ABGs) or 5% (sat) from awake and at rest levels and are associated with demonstrated cor pulmonale, pulmonary hypertension and erythrocytosis, the patient may qualify.
 - **Group II: If the Arterial Blood Gas (PO2) is 56-59 mm Hg or the O2 sat is at 89% (awake or at rest), covered if:**
 - Dependent edema secondary to congestive heart failure, pulmonary hypertension, Cor pulmonale, Erythrocytosis (the hematocrits for the erythrocytosis would have to be at least 56%)
 - **Group III: If the Arterial Blood Gas (PO2) is 60 mm Hg or greater or the O2 sat is 90% or greater.**
 - Medicare will **NOT** reimburse supplemental oxygen, since according to the results, the patient is not truly hypoxemic and supplemental oxygen is not considered medically necessary.
- **Initial Certification:** Group I and II patients must be tested within 30 days prior to the date of Initial Certification for patients that have already been:
 - Discharged from the hospital, or
 - Within two days prior to discharge from an inpatient facility to home.
- **Recertification:**
 - Group I patients with a prescribed length of need of less than a lifetime are required to be re-tested within 30 days prior to recertification.
 - Group II patients must be tested between the 61st and 90th day after date of the initial certification.
- **Physician Evaluation**
 - **Initial Certification:** Group I and II patients must be seen and evaluated within 30 days prior to the date of initial certification.
 - **Recertification:** Group I and II patients must be seen and re-evaluated within 90 days prior to the recertification date.
- **Notes:**
 - Patient's arterial blood gas test (PO2) or oxygen saturation test (SaO2) must be performed with the patient in a chronic stable state as an outpatient **OR** within TWO days prior to discharge from an inpatient facility to home.
 - If oxygen therapy coverage is approved, the coverage applies regardless of delivery system chosen. If coverage is approved, any equipment and supplies necessary to the patient's use of covered home oxygen therapy, like regulators (flow meters), humidifiers, and facemasks are also covered. Back-up oxygen tanks are not covered.



Summary of Medicare Coverage

Oxygen System Ordered for More than 4 LPM – COVERED

Coverage criteria:

- Same as oxygen system. However, due to the fact that Medicare reimburses at a higher monthly rental amount, oxygen flow rates greater than 4 LPM, **it is necessary to submit blood results obtained while the patient is breathing oxygen at 4 LPM in order to demonstrate the need for the higher flow rate.** Using the same blood gas levels as those listed previously, if the results obtained on 4 LPM do not justify the higher flow rate, then only the basic oxygen rental amount will be allowed. See *Oxygen System*

Oxygen Portable System - COVERED

Coverage criteria:

- If the patient qualifies for reimbursement under the OXYGEN coverage guidelines noted above and the patient is mobile within the home beyond extension tubing
- Preset portable oxygen units, i.e. units in which the flow rate is not adjustable, are not covered.

Paraffin Bath (portable) - COVERED

Coverage criteria:

- If the patient has undergone a successful trial period of paraffin therapy and long-term use will relieve the patient's condition.
- Institutional baths are not covered.

Patient Lift - COVERED

Coverage criteria:

- If the patient requires transfer between bed and a chair, wheelchair or commode, that requires the assistance of more than one person and without the use of a lift, the patient would be bed confined.

Peak Flow Meters - COVERED

Coverage criteria:

- Are covered for the self-monitoring of patients with pure asthma (ICD-9 493.11) when they are used as part of a comprehensive management program.

Percussor - COVERED

Coverage criteria:

- If the patient has mobilizing respiratory tract secretions caused by COPD, chronic bronchitis or emphysema, has been trained by a physician or a therapist to use the percussor and no one is available to administer manual therapy to the patient.

Pneumatic Compression Device (used for lymphedema) - COVERED

Coverage criteria:

- Only for treatment of refractory lymphedema involving one or more limbs

Summary of Medicare Coverage

- A pneumatic compression device is covered only for patients with intractable lymphedema (accumulation of excessive lymph fluid resulting from occlusion of lymphatic vessels) of the extremities. This condition is a relatively infrequent medical problem. Causes of lymphedema include:
 - Spread of malignant tumors with lymphatic obstruction
 - Radical surgical procedures with removal of regional groups of lymph nodes (e.g. after radical mastectomy)
 - Post-radiation fibrosis
 - Post-inflammatory thrombosis and scarring of lymphatic channels
 - Congenital anomalies
 - Essential lymphedema (Milroy's Disease)
- Patients who are prescribed the device for the treatment of chronic venous insufficiency with edema and/or venous ulcers DO NOT qualify for Medicare reimbursement unless the patient is diagnosed with refractory edema from venous insufficiency which is complicated by recurrent cellulitis and all of the following criteria have been met:
 - There is significant ulceration of the lower extremity(ies), and
 - The patient has received repeated, standard treatment from a physician using such methods as:
 - A compression bandage system and its equivalent, and
 - The ulcer(s) have failed to heal after 6 months of continuous treatment.

Portable Oxygen System – see *Oxygen System (portable)*

Positive Pressure Ventilator – see *Ventilator*

Power Operated Vehicle (POV) - COVERED

Coverage criteria:

- For patients with the following conditions:
 - Without the use of a wheelchair, he/she would otherwise be bed or chair confined, and
 - Unable to operate a manual wheelchair, and capable of safely operating controls for the POV, and
 - Can safely transfer in and out of the POV and has adequate stability to be able to safely ride in the POV
- A power operated vehicle is usually covered only if it is ordered by a physician who has one of the following specialties: physical medicine, orthopedic surgery, neurology, or rheumatology. When such a specialist is not reasonably accessible (e.g. more than a one day round trip from the patient's home, or the patient's condition precludes such travel). Medicare will individually consider with appropriate documentation from ordered physician.
- **A physician's prescription/order must be furnished to the supplier prior to deliver. Prior authorization is available.**

Prosthetic Devices - COVERED

Coverage criteria:

Summary of Medicare Coverage

- When furnished on the order of a physician. The prosthetic device must replace all or part of the function of a permanently inoperative or malfunctioning organ. To pass the test for performance, the patient's medical record, including the judgement of the attending physician, must indicate that the impairment will be of a long and indefinite duration.
- Examples of covered prosthetic devices include cardiac pacemakers, prosthetic lenses, breast prosthesis including surgical brassier for post-mastectomy patients, maxillofacial devices and devices which replace all or part of the ear or nose. The foley catheter is covered when ordered for use with a patient's ventilator system. Equipment and supplies are covered as integral parts of the patient's medically necessary organ replacement system. Nonreusable supplies are not integral to the organ replacement system, like chucks, diapers, rubber sheets, etc. are not covered.

Quad Cane - COVERED

Coverage criteria:

- If the patient's condition impairs the patient's ability to walk, a quad cane would be covered in conjunction with a wheelchair, if the quad cane is required for gait therapy only.

Raised Toilet Seat - DENIED/Not covered

Coverage criteria:

- Hygienic convenience item; not primarily medical in nature.

Recliner with Elevating Seat – see *Seat Lift Mechanism*

Regulator (oxygen) – See *Oxygen System*

Repairs - COVERED

Coverage criteria:

- Covered when they are necessary to make the equipment serviceable. Assignment is not accepted or done non-assigned. Payment is made up front.

Respiratory – see *Ventilator*

Respiratory Assist Device - COVERED

Coverage criteria:

- Covered for the following conditions:
 - Restrictive Thoracic Disorder
 - Documentation of a progressive neuromuscular disease.

Summary of Medicare Coverage

- A PaCO₂>52 mm Hg while awake and breathing the patient's usual FIO₂ and a sleep oximetry <88% for at least 5 continuous minutes on patient's usual FIO₂ or progressive neuromuscular disease, with maximal inspiratory pressure <60 cm H₂O or forced vital capacity is less than 50% predicted
 - COPD does not contribute significantly to the patient's pulmonary limitation.
 - Severe COPD
 - A PaCO₂ > 52 mm Hg while awake and breathing the patient's usual FIO₂ and sleep oximetry <88% for at least 5 continuous minutes at 2 LPM or on the patient's usual FIO₂, and
 - Prior to initiation therapy, OSA and treatment with a CPAP have been considered and ruled out.
 - A respiratory assist device with a backup rate will not be covered for the first two months of therapy.
 - A respiratory assist device without a backup rate must have been tried for at least two months (for those patients with severe COPD)
 - If a respiratory assist device with a backup rate is required after the first two months of use of a respiratory assist device without backup rate, the following is required:
 - A repeat PaCO₂ performed no sooner than 61 days, **AND**
 - Repeat sleep oximetry no sooner than 61 days, **AND**
 - The beneficiary and physician statements are required.
 - *Note: The tests listed above must meet the following criteria (A DME SUPPLIER IS NOT CONSIDERED A QUALIFIED PROVIDER OF THESE TESTS)*
 - Central Sleep Apnea
 - The exclusion of obstructive sleep apnea (OSA) as a primary cause of sleep associated hypoventilation, and
 - Ruling out a CPAP as effective therapy if OSA is a component of sleep associated hypoventilation.
 - Oxygen saturation is <88% for at least 5 continuous minutes breathing oxygen at 2 LPM or the patient's usual FIO₂, and
 - Significant improvement of sleep associated hypoventilation on the setting ordered for use in the home while breathing the patient's usual FIO₂.
 - Obstructive Sleep Apnea
 - Only a respiratory assist device without a backup rate is covered for patients with OSA.
 - Must have a trial with CPAP.
 - A respiratory assist device with a back up rate is not covered for this diagnosis.
 - Complete facility-based, attended polysomnogram (*A DME is NOT considered a qualified provider of these tests*) has established the diagnosis of OSA, and
 - A single-level device (CPAP) has been tried and proven ineffective.
- Miscellaneous information:
 - All patients must be re-evaluated within 61-90 days after initiation of treatment to ensure compliance and demonstrate improvement. A statement from the patient and the patient must be obtained during this time frame and filed in the patient's file.
 - Supplies can be billed separately for respiratory assist device, with a backup rate, used with noninvasive interface (e.g. nasal or facial mask) only. These supplies are included in the rental of the respiratory assist device without a backup rate.

Summary of Medicare Coverage

- DME supplies are required to have copies of **ALL** relevant test results and documentation in the patient's file which supports the medical need for the respiratory assist dev.
- A DME supplier is **NOT** considered a qualified provider of the tests in this coverage area.

Rollabout/Rolling Chair - COVERED

Coverage criteria:

- If the physician's prescription establishes the medical necessity for a rolling chair, and it has been prescribed in lieu of a wheelchair. Coverage is limited to those rolling chairs with casters at least 5 inches in diameter, that have been designed specifically for impaired individuals.

Safety Rollers - COVERED

Coverage criteria:

- For patients unable to use a standard wheeled walker due to obesity, a severe neurological disorder or restricted use of one hand. In these cases, reimbursement may exceed reasonable charges for a standard wheeled walker.

Seat Lift Mechanism - COVERED

Coverage criteria:

- Note: *Chair is paid in full up front and then bill will be submitted to Medicare for reimbursement of lift mechanism*
- If prescribed by a physician for patients with severe arthritis of the hip or knee, muscular dystrophy or some other neuromuscular disease and use of the device benefits the patient therapeutically. *Coverage is limited to the seat lift mechanism only.* Coverage is limited to seat lifts that operate smoothly, can be controlled by the patient, and can help the patient stand and sit without other assistance.
- Coverage will not be provided for seat lifts that operate using a spring-release mechanism with a sudden catapult-like motion that jolts the patient from a seated to a standing position. Also, if the seat lift uses a recliner feature, this feature will not be covered.
- To establish the medical necessity, evidence must show that:
 - The patient must have severe arthritis of the hip or knee, or have severe neuromuscular disease.
 - The seat lift mechanism must be a part of the physician's course of treatment and be prescribed to affect improvement or arrest or retard deterioration in the patient's condition.
 - The patient must be completely incapable of standing up from a regular armchair or any chair in their home. (The fact that a patient has difficulty or is even incapable of getting up from a chair, particularly a low chair, is not sufficient justification for a seat lift mechanism).
 - Once standing, the patient must have the ability to ambulate.
 - All appropriate therapeutic modalities to enable the patient to transfer from a chair to a standing position (e.g. medication, physical therapy) must have been tried and failed.
- A physician's prescription must be furnished to the supplier prior to deliver. Prior authorization is available.



Summary of Medicare Coverage

Sitz Bath - COVERED

Coverage criteria:

- If the patient has been diagnosed with an infection or injury of the perineal area and the physician has prescribed the sitz bath as part of a planned regimen of home care treatment.

Speaking Valve - COVERED

Coverage criteria:

- Is covered for tracheostomy patients under the prosthetic guidelines. See *Prosthetic Devices*

Standing Table - DENIED/Not covered

Coverage criteria:

- Convenience item; not primarily medical in nature.

Stethoscope - COVERED

Coverage criteria:

- If prescribed by a physician as part of a home hemodialysis system. Otherwise, not covered

Suction Catheters - COVERED

Coverage criteria:

- Are covered when a suction pump is supplied to the patient. Tracheal suction catheters are considered supplies and are separately payable. Sterile catheters are medically necessary only for deep tracheostomy suctioning. An oropharyngeal suction catheter is a reusable accessory to the suction pump owned by the patient.
- Utilization limits:
 - Three sterile catheters per day are covered.
 - Three oropharyngeal suction catheters per week are covered.
 - 30-day supply will be permitted each month.

Suction Machine - COVERED

Coverage criteria:

- If patient has difficulty raising and clearing secretions secondary to any of the following conditions:
 - Cancer or surgery of the throat or mouth
 - Dysfunction of the swallowing muscles
 - Unconsciousness or obtunded state
 - Tracheostomy



Summary of Medicare Coverage

Surgical Dressing - COVERED

Coverage criteria:

- When they are medically necessary for the treatment by a surgical procedure or when debridement of a wound is medically necessary.
- **HomeStar does not accept assignment. Patient must pay at time of service. HomeStar will submit to insurance.**

Surgical Leggings - DENIED/Not covered

Coverage criteria:

- Non reusable disposable supply

Toilet Seat - DENIED/Not covered

Coverage criteria:

- Not primarily medical in nature.

Tracheostomy Care Kit - COVERED

Coverage criteria:

- Are covered for patient following an open surgical tracheostomy which has been or is expected to be open for at least three months.
- One tracheostomy care kit per day is considered necessary for routine care of a tracheostomy. Claims for additional kits for non-routine tracheostomy care must be accompanied by a substantiating documentation. TRACHEOSTOMY STATUS DIAGNOSIS: V44.0, V55.0, 519.0, 519.4, 519.8, 519.9

Transcutaneous Electrical Nerve Stimulator (TENS) and Supplies - COVERED

Coverage criteria:

- For the treatment of patients with chronic, intractable pain or acute post-operative pain who meet the following:
- The pain must have been present for at least three months, and
- The presumed etiology of pain must be a type which is accepted as responding to TENS therapy. This includes headache, visceral abdominal pain, pelvic pain, TMJ pain, etc.
- Other appropriate treatment modalities must have been tried and failed, and the medical record must document what treatment modalities have been used (including the names and dosages of medications), the length of time that each type of treatment was used, and the results.
- When a TENS unit is used for acute post-operative pain, the medical necessity is limited to 30 days from the day of surgery. Payment will be made only as a rental. A TENS unit will be denied as not medically necessary for acute pain (less than three months duration) other than post-operative pain.
- A one-month trial is limited to the amount which would be payable for the total service, including TENS and evaluation, if provided by the physician or therapist. If the initial TENS therapy trial takes longer than one month, documentation of medical necessity must be provided for all services furnished beyond the first month. The trial period is limited to two months.



Summary of Medicare Coverage

- After the trial period, purchase of the TENS unit can be covered under the prosthetic devices benefit. See *Prosthetic Devices*
- Replacement supplies are covered when they are medically necessary and are used with a TENS unit that has been purchased.
- A physician's written prescription for the TENS unit must be furnished to the supplier prior to the delivery. Prior authorization is available.

Trapeze Bar - COVERED

Coverage criteria:

- If the patient is confined to bed, and needs to sit up because of respiratory conditions, to change position or to get in and out of bed.

Traction Equipment - COVERED

Coverage criteria:

- If orthopedic impairment prevents the patient from walking during the period the traction equipment is in use. Medicare will all consider covering devices used when the patient is ambulatory (like cervical traction collars), under the brace provision.

Tub Chair - DENIED/Not covered

Coverage criteria:

- Comfort or convenience item; not primarily medical in nature.

Urinals - COVERED

Coverage criteria:

- If the patient is bed confined.

Vaproizer - COVERED

Coverage criteria:

- If the patient has a respiratory illness.

Ventilator - COVERED

Coverage criteria:

- For treatment of neuromuscular diseases, restrictive thoracic disease and chronic respiratory failure consequent to chronic obstructive pulmonary disease.
- Coverage includes both positive and negative pressure ventilators
- If ventilator coverage requirements are met, the patient's tracheal catheter is also covered.
- Used to treat chronic respiratory failure when life support is needed (>12 hrs per days and/or patient cannot breathe independently).



Summary of Medicare Coverage

Walker - **COVERED**

Coverage criteria:

- If the patient's condition impairs the patient's ability to walk.
- A walker can be covered in conjunction with a wheelchair if the walker is required for gait therapy only.

Water Pressure Pad and Mattress - **COVERED**

Coverage criteria:

- If the patient is completely immobile, i.e., cannot make changes in body position without assistance or limited mobility with one of the following conditions:
 - Any stage pressure ulcer on trunk or pelvis
 - Impaired nutritional status
 - Fecal or urinary incontinence
 - Altered sensory perception
 - Compromised circulatory status
- A physician's prescription must be furnished to the supplier prior to delivery.

Wheelchair - **COVERED**

Coverage criteria:

- If the patient would be confined to bed or chair without the use of a wheelchair.
- Patient must be confined to wheelchair a minimum of 2 hours per day
- Special sizes (i.e. narrow, extra-wide, lightweight) are covered if the supplier can determine from the information provided on file or other sources, that a special size is necessary to accommodate the physical size of the patient or any size restrictions imposed on the patient's home (i.e. narrow doorways).
- **Hemi-wheelchairs** are covered if the patient is confined to bed or chair and medical documentation establishes that the patient is unable to use a standard wheelchair because the patient:
 - Is an amputee
 - Has had a stroke, with accompanying paralysis or semi-paralysis
 - Propels the wheelchair with his feet
 - Has a weight imbalance
 - Is too short for a standard wheelchair
- **Lightweight wheelchairs** are covered when a patient cannot propel himself in a standard wheelchair and the patient is actually able to propel in a lightweight chair.
- **High strength wheelchairs** are covered when the patient needs the wheelchair while engaging in frequent activities that can be performed in a less expensive wheelchair or the patient requires a seat width, depth or height that cannot be accommodated in a

Summary of Medicare Coverage

standard, lightweight or hemi-wheelchair and spends at least two hours per day in the wheelchair. This type of wheelchair would rarely be medically necessary if the expected duration of need is less than three months.

- **Heavy duty wheelchairs** are covered for patient weighing more than 300 lbs. Or having severe spasticity.
- **Custom manual/power wheelchairs** are covered for patient requiring a uniquely constructed wheelchair. The wheelchair is covered only if the feature needed is not available in an already manufactured wheelchair or component of a wheelchair. This has to be customization to the wheelchair frame to be considered customized.
- **Power wheelchairs** are covered when the following criteria are met:
 - Patient's condition is such that without the use of a wheelchair he/she would otherwise be bed or chair confined, and
 - Patient's condition is such that a wheelchair is medically necessary and the patient is unable to operate the wheelchair manually, and
 - Patient is capable of safely operating the controls for the power wheelchair
- To be covered, the prescription must be furnished by a specialist in physical medicine, orthopedic surgery, neurology or rheumatology. The specialist must evaluate the patient's medical and physical condition and assure that the patient requires the vehicle and is capable of using it.
- A power wheelchair prescription is acceptable from the patient's primary physician only in cases when a specialist is not reasonably accessible, i.e. is located more than one day's round trip from the patient's home or patient travel is medically inadvisable.