Department:	Medical Management	**Original Approval:**	12/03/2008
Policy No:	MM136	**Last Approval:**	05/15/2026
Policy Title:	Medical Equipment and Supplies Clinical Coverage Criteria		
Approved By:	UM Criteria Subcommittee		
Applicable Line(s) of Business:	☒ **Washington Apple Health (Medicaid)** ☐ **Behavioral Health Services Only** ☒ **Apple Health Expansion** ☐ **State Medicaid Agency Contract (SMAC)** ☐ **Health Homes** ☐ **Medicare Advantage/Special Needs Plan** ☒ **Cascade Select**		

Required Clinical Documentation for Review

History and physical exam

Recent (within the past 6 months) chart notes from medical provider and from therapist, as applicable, documenting the need for the requested Medical Equipment (also called Durable Medical Equipment or DME)

List of other Medical Equipment tried and why it was not appropriate

Details of any specific needs related to risk, trauma, or cultural concerns, specifically to address health equity concerns.

Background

Medical Equipment items have the following characteristics and must meet all the following criteria in the Medical Equipment Definition:

1. Is prescribed by a provider: Physician (MD, DO, or DPM), Advanced Registered Nurse Practitioner, Physician Assistant, or Certified Nurse Midwife. Licensed Midwives can also prescribe DME within their field of specialty as per WAC 246-834-250; and
2. The order contains the prescriber's signature or electronic signature, from within the past year (not a stamp); and
3. Is primarily and customarily (traditionally) used to serve a medical purpose; and
4. Generally, is not useful for a person in the absence of illness or injury; and
5. Can withstand repeated use; and

6. Can be reusable or removable; and
7. Is suitable for use in any setting where normal life activities take place

For Wheelchairs, see the CHPW Wheelchair Clinical Coverage Criteria MM195.

Definitions

Durable

Medical equipment considered durable is equipment that can withstand repeated use, such as, the type of item that can be rented. Medical supplies of an expendable nature, such as incontinence pads, lamb's wool pads, catheters, ace bandages, elastic stockings, surgical facemasks, sheets, and bags are not considered "durable" within the meaning of the definition. There are other items that although durable in nature, may fall into other coverage categories such as supplies and orthotics and prosthetics. Orthotics and Prosthetics items include, but are not limited to, braces, artificial limbs, and eyes.

Medical Equipment

Medical equipment is defined as equipment primarily and customarily used for medical purposes and is not generally useful in the absence of illness or injury. In most instances, no documentation will be needed to support whether a specific item of equipment is medical in nature. However, some cases will require documentation to determine whether the item constitutes medical equipment. This documentation would include the advice of local medical organizations and facilities and specialists in the field of physical medicine and rehabilitation. If the equipment is new on the market, it may be necessary, prior to seeking professional advice, to obtain information from the supplier or manufacturer explaining the design, purpose, effectiveness, and method of using the equipment in the home as well as the results of any tests or clinical studies that have been conducted.

Indications/Criteria

For **Individual & Family (Cascade Select) and AH members**: In all cases when available, HCA Health Technology Assessment program determinations are used. For Medical Equipment not addressed by the HCA HTA Program, CHPW uses the CHPW Coverage Criteria next. For Medical Equipment not addressed by either, CHPW uses MCG.

Limitations on Medical Supplies for AH members are found in WAC 182-543-5500.

For **Individual & Family (Cascade Select), and AH Members**, any requests for Medical Equipment must also meet all the following criteria:

1. A current (within 6 months) face-to-face evaluation by the treating physician and therapist, (who are prohibited of being employees of the provider of the item by WAC 182-543-2200), as applicable, showing medical need for the device by the member.
2. A physical or occupational therapy assessment, to determine the type of device that meets the member's medical needs, is efficacious and safe for the member's use, including during transfers.
3. Home assessment, if indicated, (which can be performed by DME supplier) showing that the equipment fits properly in the physical space of the member's home. (Licensed facilities, including Adult Family Home (AFH), Assisted Living Facilities, and DDA Supportive Living, are able to accommodate hospital beds, bath, toilet DME, and wheelchairs and do not need a home assessment.)
4. Successful trial by the member of the device or a close simulation of the device
5. Results of trials of less expensive devices, if apparently available, and explanation of why these less expensive devices are not appropriate for the member's condition and situation
6. CHPW considers one piece of mobility/positioning equipment medically necessary if criteria are met for the equipment. Second items are considered a convenience.
7. Medical Equipment that duplicates equipment that the member already has is not medically necessary per WAC 182-543-7100. This includes:
    a. Purchase, rental, or repair of Medical Equipment that duplicates equipment that the client already owns, rents, or that CHPW has authorized for the client. If the provider believes the purchase, rental, or repair of medical equipment is not duplicative, the provider must request prior authorization and submit medical records showing the following:
        i. Why the existing equipment no longer meets the member's medical needs; or
        ii. Why the existing equipment could not be repaired or modified to meet the member's medical needs.
        iii. How the member's condition meets the criteria for Medical Necessity for the Medical Equipment.

Special Considerations

Rental of Medical Equipment

1. CHPW follows HCA guidelines by applying Medical Equipment rental fees towards the eventual purchase of a device. (Some Medical Equipment are for purchase only. Rules regarding rental versus purchase should be checked.)

Repair of Medical Equipment

1. Repair of any Medical Equipment must meet relevant criteria for medical necessity, including prior authorization if required for similar new equipment.
2. Repair is considered only for client-owned equipment after expiration of warranty period.
3. It is the expectation of CHPW that the provider will have checked for warranty coverage before submitting a request for a Medical Equipment repair. Warranty coverage will be reviewed, along with repair cost, at the time of assessment for prior authorization.
4. Repairs do not require a face-to-face evaluation with the physician but do require a physician signature on the order.
5. CHPW does not pay for the repair of equipment, devices, or supplies which have been broken, destroyed, or stolen as a result of the client's carelessness, negligence, recklessness, deliberate intent, or misuse unless:
    a. Extenuating circumstances exist that result in a damage or destruction of equipment, devices, or supplies, through no fault of the client that occurred while the client was exercising reasonable care under the circumstances; or
    b. Otherwise allowed under specific HCA program rules.

Replacement of Medical Equipment

1. Replacement of any Medical Equipment must meet relevant criteria for medical necessity, including prior authorization if required for similar new equipment.
2. Any requests for Medical Equipment replacement must include documentation of a current (within 6 months) face-to-face evaluation by the treating physician and therapist, as applicable, showing medical need for the device by the member.
3. The Medical Equipment is not under warrantee
4. CHPW does not pay for replacement of equipment that is functioning appropriately or that can reasonably be repaired.
5. CHPW does not pay for the replacement of equipment, devices, or supplies which have been sold, gifted, lost, broken, destroyed, or stolen as a result of the client's carelessness, negligence, recklessness, deliberate intent, or misuse unless:
    a. Extenuating circumstances exist that result in a loss or destruction of equipment, devices, or supplies, through no fault of the client that occurred while the client was exercising reasonable care under the circumstances; or
    b. Otherwise allowed under specific HCA or CMS program rules.

Loaner Medical Equipment

For Individual & Family (Cascade Select) and AH: CHPW does not rent equipment during the time that a request for similar purchased equipment is being assessed, when authorized

equipment is on order, or while the client-owned equipment is being repaired and/or modified. The vendor of service is expected to supply the client with an equivalent loaner.

Additional Medical Equipment Criteria:

Please See Also MM162 "Medical Appropriateness for Service or Medication" Policy, Which Applies to All Medical Equipment: for a service to be medically appropriate, the following criteria must be met:

1. Consistent with standards of good medical practice and supported by evidence-based medicine;
2. Medically necessary is defined as "a term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the enrollee that endanger life, or cause suffering of pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative, or substantially less costly course of treatment available or suitable for the enrollee requesting the service. For the purpose of this section, 'course of treatment' may include mere observation or, where appropriate, no medical treatment at all." (WAC 182-500-0070);
3. Consistent with the symptoms, diagnosis, treatment, and plan of care of the enrollee's condition;
4. Not solely for the convenience of the enrollee, the enrollee's family, or the provider of service; and,
5. Delivered in the least intensive and most appropriate delivery setting.
6. For use of an unlisted code: if the request is for a DME item, include the name of the item, description, the manufacturer, product number, a copy of the invoice (include pricing), and documented evidence that there is no comparable standard code available.

Limitation Extension Criteria for Medical Supplies:

See limitations in the current HCA Provider Billing Guide for Medical Equipment and Supplies.

Many medical supplies have limitations on quantity and frequency designed to avoid the need for prior authorization on items normally considered medically necessary for quantities sufficient for a 30-day supply for a member. Limitation extension requires prior authorization per **WAC 182-501-0169.**

Criteria for limitation extension of medical supplies require:

1. Meeting criteria from MM162 Medical Appropriateness for Service or Medication summarized above on page 5 of this policy.

Equipment	Criteria
ACTIVITY CHAIR	For Cascade Select and AH members: An activity chair is medically necessary for a member if both the following criteria are met: 1. The member has a significant neurologic impairment that causes inability to control trunk position; and 2. Does not already have a mobility or positioning device (such as wheelchair, or other prescribed supportive seating) 3. The device is needed to enable participation in activities of daily living that cannot be performed safely or effectively without the device
AFO/KAFO/ORTHOTICS	See CHPW policy MM158
Airway Clearance Devices (Such as, Mechanical Insufflation-Exsufflation, High Frequency Chest Compression, Cough Stimulating, Percussion Vest Devices)	For Cascade Select and AH members: See MCG
BONE GROWTH STIMULATORS	For Cascade Select and AH members medical necessity criteria for bone growth stimulators are found in: WA HTA 20090828B: Bone Growth Stimulation, 10/30/2009 which references CMS NCD criteria from National Coverage Determination (NCD) for Osteogenic Stimulators (150.2) summarized as follows: 1. Non-invasive electrical bone growth (non-spinal applications E0747, spinal applications E0748) stimulator is medically necessary only when the one of the following criteria are met: (1) For nonunion of long bone fractures, both the following criteria are required:

	a. A minimum of 2 sets of radiographs separated by a minimum of 90 days has been obtained prior to starting treatment with the osteogenic stimulator. If the fracture was treated surgically, the 2 sets of radiographs must both be after the surgery. b. Each radiograph set must include multiple views of the fracture site accompanied with a written interpretation by a physician stating that fracture healing has ceased for 3 or more months. (Callous formation alone is not clinically significant evidence of fracture healing). c. As an adjunct to spinal fusion surgery for patients at high risk of pseudarthrosis, both the following criteria are required: 1. Due to previously failed spinal fusion at the same site or for those undergoing multiple level fusion. 2. Multiple level fusion involves 3 or more vertebrae (e.g., L3-L5, L4-S1, etc.). d. Failed fusion of a joint (spine or other) where a minimum of 9 months has elapsed since the last surgery e. Congenital pseudarthroses 1. Invasive (surgically implanted) Electrical Stimulator (E0749) is medically necessary only when one of the following criteria are met: a. For nonunion of long bone fractures, both the following criteria are required: I. A minimum of 2 sets of radiographs separated by a minimum of 90 days is obtained prior to starting treatment with the osteogenic stimulator. If the fracture was treated surgically, the 2 sets of radiographs must both be after the surgery. II. Each radiograph set must include multiple views of the fracture site accompanied with a written interpretation by a physician stating that fracture healing has ceased for 3 or more months. (Callous formation alone is not clinically significant evidence of fracture healing).

	b. As an adjunct to spinal fusion surgery for patients at high risk of pseudarthrosis, one of the following criteria are required: I. A previous spinal fusion failed at the same site II. The patient is undergoing multiple level fusion involving 3 or more vertebrae (e.g., L3-L5, L4-S1, etc.). 2. Ultrasonic Bone Growth Stimulator is only when the following criteria are met: a. For nonunion of fractures both the following criteria are required: I. A minimum of 2 sets of radiographs is obtained prior to starting treatment with the osteogenic stimulator, separated by a minimum of 90 days. If the fracture was treated surgically, the 2 sets of radiographs must both be after the surgery. II. Each radiograph set must include multiple views of the fracture site accompanied with a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the 2 sets of radiographs. (Callous formation alone is not clinically significant evidence of fracture healing). 3. Ultrasonic bone growth stimulators are not medically necessary in the following situations: a. Nonunion fractures of the skull, vertebrae and those that are tumor-related b. Ultrasonic osteogenic stimulators used concurrently with other non-invasive osteogenic devices. **c.** Ultrasonic osteogenic stimulators for fresh fractures and delayed unions
COMMUNICATION DEVICES (E.G. SPEECH GENERATORS)	See CHPW policy MM167 Speech Generating Devices (Augmentative Communication Devices)
CONTINUOUS PASSIVE MOTION SYSTEM (CPM)	For Cascade Select and AH members: Up to 21 days rental during any 12-month period, upon hospital discharge, when the client is diagnosed with one of the following:

	1) Frozen joints 2) Intra-articular tibia plateau fracture 3) Anterior cruciate ligament injury 4) Total knee replacement
CPAP/BIPAP	See CHPW Clinical Coverage Criteria MM135
GAIT TRAINERS	Gait trainer is a physical therapy device, not a mobility device See MCG Guidelines
HEARING AIDS	**see MM168: Hearing Assist Devices**
CONTINUOUS GLUCOSE MONITORING	For Cascade Select and AH members: a. Initial request: medical necessity criteria are specified in HTA 20180119B Continuous glucose monitoring 03/16/2018 (in effect until the newer version, with final adoption on June 13, 2025 HTA 20250321B – Continuous glucose monitoring, is implemented by the HCA) For AH, and Cascade Select: Continuation of CGM and continuation of supplies for these devices, for is medically necessary when there is documented evidence of adherence to the therapeutic plan for use of the CGM (including reporting), and adherence to the medical management plan for diabetes (including intensive insulin therapy), and one of the following criteria is met: a. The records demonstrate that the patient is benefiting from the use of the CGM, *or* b. There is documented improvement of hypoglycemia, *or* c. The device is malfunctioning and out of warranty Ongoing requests are not medically necessary if: a. The use of an external insulin pump or CGM is for any indication other than those listed above, *or* b. Member was previously pregnant, and this was the only reason CGM was initially approved, however, member is no longer pregnant but still is requesting CGM.

	c. The member is not consistently using the CGM and/or pump or is not adherent to the therapeutic plan for diabetes.
Enclosed Bed Systems	These are custom beds that are marketed as safety equipment primarily to individuals who may be prone to wandering or unsafely exiting from the bed. The FDA has published concerns about the safety of these products (Hospital Beds | FDA), which are classified as "patient bed with canopy/restraints," with a regulation description of "protective restraint" and defined as "enclosed bed canopy system used as passive restraint." These concerns are based on reports of serious safety risks including entrapment and product misuse, as well as FDA Level 1 recalls. The evidence is insufficient to support clinical efficacy, safety, or improved health outcomes over other alternative treatment interventions. According to the Center for Evidence Based Policy Medicaid Coverage of Enclosed Beds, "No studies on enclosed bed use in home settings or for children or youth were found. Due to this lack of evidence, clinical guidelines do not include enclosed beds in recommendations for managing sleep issues, wandering, or fall risks in people with neurodevelopmental disorders. Instead, guidelines recommend behavioral therapy and melatonin for improving sleep and using locks on doors or windows to prevent wandering. Several systematic reviews emphasize the lack of evidence for most sleep interventions in these populations, with melatonin and behavioral approaches being the most studied." Criteria require all the following: • The treatment must be supported by evidence-based medicine and aligned with standards of care (see above). • The member must have a medical condition that prevents the safe use of a standard, non-medical crib or bed, or mattress on the floor, necessitating the use of a hospital bed or an enclosed pediatric hospital bed, (See below for hospital bed medical necessity criteria); and • The member is at serious risk of unsafe exiting from the bed due to medical conditions such as neurological, neuromuscular and seizure disorders that cause uncontrolled movements; and • Equipment and supplies that are mainly for the comfort of the member or caregiver, for convenience, solely for safety, or for controlling the environment do not meet the definition of medical equipment as outlined in WAC 182-543-1000. • There is no equally effective, more conservative, less costly option for treatment
HOSPITAL BEDS	For Cascade Select and AH members:

	Hospital beds: WAC 182-543-3000 The Medicaid agency covers one hospital bed in a ten-year period, per client, with the following limitations: (Manual Hospital beds are not routinely carried by Medical Equipment suppliers) A semi-electric hospital bed only when: 1. Has a medical condition that necessitates upper body positioning at no less tha a thirty-degree angle the majority of time the client is in the bed, or needs to b in the Trendelenburg position, or client's medical condition requires immediate position changes, or body positioning that cannot be achieved with a regular be (such as with neuromuscular disease, stroke, and spinal cord disorders), or the condition requires special equipment that necessitates a hospital bed for use 2. The client's medical need requires the client to be positioned in a way that is not possible in a regular bed and the position cannot be attained through less costly alternatives (e.g., the use of bedside rails, a trapeze, pillows, bolsters, rolled up towels or blankets); 3. The client is able to operate the controls independently. **Additional criteria for special beds:** Indications for a semi-electric hospital bed must be met. a. **Fully electric bed:** brain injury, spinal cord injuries, and/or neurological damage that prevents the member from getting in and out of bed. b. **Heavy-duty, extra-wide/bariatric bed (**E0301, E0303): member's weight is more than 350 pounds but less than 600 pounds. c. **Extra-heavy-duty bed (**E0302, E0304): member's weight is 600 pounds or more. d. **Variable height hospital bed:** Member needs transfer to chair, wheelchair or standing (such as with hip fracture, neurologic impairment). Rental of bed: a. The above criteria for the particular bed are satisfied b. The patient has less than 12 months length of need

	c. Has a chronic or terminal condition such as chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), lung cancer or cancer that has metastasized to the lungs, or other pulmonary conditions that cause the need for immediate upper body elevation d. For Apple Health Members hospital bed rental is limited to 11 months in a 12-month, period as long as all other criteria are met. Purchase of bed: a. The above criteria for the particular bed are satisfied b. The patient has 12 months or more length of need c. The patient has diagnosis of one of the following: quadriplegia; d. tetraplegia; e. Duchenne muscular dystrophy; f. amyotrophic lateral sclerosis (ALS), g. ventilator-dependent; or h. COPD or CHF with aspiration risk or shortness of breath that causes the need for an immediate change of upper body positioning of more than thirty degrees.
Hospital bed supplies	For bed accessories such as bed cradle, side rails, trapeze equipment use: 1. AH and Cascade Select: MCG current edition **Mattress overlays and mattresses**: Group 1 (E0181, E0182, E0184, E0185, E0186, E0187, E0188, E0189, E0196, E0197, E0198, E0199 and A4640): 1. AH and Cascade Select: MCG current edition Pressure-Relieving Support Surface, Simple (A-0347) Group 2 (E0193, E0277, E0371, E0372, E0372, E0373): 1. AH and Cascade Select: MCG current edition Pressure-Relieving Support Surface, Advanced (A-0348) Group 3 (E0194): 1. AH and Cascade Select: MCG current edition Pressure-Relieving Support Surface, Advanced (A-0348)
Insulin Pumps (Omnipod and Omnipod Dash)	For Cascade Select and AH members criteria include the following: 1. Member has type 1 diabetes and 2. Uses up to 15 pods per 30 days

	For other indications and for ETR requests, see MCG current edition, Insulin Infusion Pump (A-0339) Continuation of Insulin Pump and supplies for these devices is medically necessary when the following criteria are met: 1. Criteria were met for initiation of the insulin pump and 2. There is documented evidence of adherence to the therapeutic plan for use of the insulin pump (including reporting), and 3. Adherence to the medical management plan for diabetes, and 4. One of the following criteria is met: a. The records demonstrate that the patient is benefiting from the use of the insulin pump, or b. The device is malfunctioning and out of warranty
Mandibular Advancement Devices (MAD)	Cascade Select and AH members: One custom made (no prefabricated) MAD per client (aged 21 years and older), every five years would be covered with prior authorization under code EO486 when the following criteria are met: 1. A face-to-face evaluation with a sleep medicine physician prior to sleep testing is completed in agency-designated center of excellence (COE) 2. Sleep testing criteria for CPAP are met a. AHI or RDI > 15 per hour with minimum of 30 events OR b. The AHI or RDI > 5 and < 14 events per hour with minimum of 10 events and documentation of either: i. Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or ii. Hypertension, ischemic heart disease, or history of stroke; 3. AHI >30 or RDI >30 and one of the following criteria are met: a. The member is unable to tolerate a positive airway pressure device, or b. The treating physician determines that the use of a CPAP device is contraindicated 4. The member has tried and failed the use of CPAP. Documentation of at least a 6-month trial period, describing why CPAP failed, or reason explaining why CPAP is not the appropriate treatment 5. Device is ordered by treating provider post review of sleep study

	6. The device is provided and billed for by a licensed dentist (DDS or DMD). 7. The device must be titrated in a sleep center by a qualified provider who has experience in titrating the MAD 8. The client must have their own teeth (no dentures or partials) **Exclusions** Prefabricated (E0485) appliances are not considered reasonable and necessary due to insufficient evidence and are not a covered benefit. Not medically necessary are: 1. Oral occlusal appliances for (TMJ) 2. Tongue retaining devices used to treat OSA and/or snoring 3. All oral appliances used only to treat snoring without a diagnosis of OSA 4. Oral appliances used to treat other dental conditions 5. Oral appliances that require repeated fitting and/or adjustments, beyond the first 90-days, in order to maintain fit and/or effectiveness
OXYGEN	See CHPW Clinical Coverage Criteria MM144
PATIENT LIFTS	For Cascade Select and AH members: current edition of MCG Guidelines
PROSTHETICS	See MM158 Prosthetics, Orthotics and Therapeutic Diabetic Shoes
Positioning Car Seat For EPSDT children <21 years with special orthopedic or neurologic needs (HCPCS T5001)	For Cascade Select, positioning car seat is not a covered benefit. For AH members: The following criteria are required for approval of a positioning car seat: 1. Requires specialized positioning to be safely transported in a vehicle, and 2. The member has one or more of the following medical conditions: a. Significant head and trunk instability and/or weakness, or b. Significant hypotonicity, hypertonicity, athetosis (writhing movements), ataxia (loss of muscle control/coordination), spasticity, or muscle spasming which results in uncontrollable movement and position change, or c. Absence or latency of protective reactions, or d. Inability to maintain an unsupported sitting position independently, or e. Other significant positional needs that cannot be met in the conventional commercial car seat, or

	f. Cannot be safely restrained in a car without a positioning car seat, and 3. A commercially available Child Safety Seat (CSS) cannot be used because of one or more of the following: a. Member's weight is greater than 65 lbs b. Significant casting (such as spica cast for hip dislocation) c. Tracheostomy d. Severe hydrocephalus e. Requirement of prone or supine positioning after surgery (such as for myelomeningocele) f. Significant contractures that would result in an inability to perform postural corrections due to vehicle motion g. Severe scoliosis, which interferes with proper positioning Many currently available convertible Child Safety Seats (CSSs) can be used rear facing to 45-50 lbs and forward facing to 65 lbs. According to Child Passenger Safety: American Academy of Pediatrics: All children should be restrained in a rear facing CSS for as long as possible. "Children with certain temporary or permanent physical and behavioral conditions such as altered muscle tone, decreased neurologic control, skeletal abnormalities, or airway compromise that may preclude the use of regular CSSs may require specialized restraint systems."
STANDING FRAME and SIT TO STAND FRAME (HCPCS codes E0637, E0638, E0641, E0642)	For Cascade Select: Not covered AH: criteria require one or more of the following: 1. Member has lower extremity contractures that impact the member's ADLs and that failed physical therapy and home stretching program, and the device will be used to treat the contractures 2. Device is being used as part of an ongoing PT plan with the goal of the member being able to stand or walk 3. See MCG current edition: Standing Frame
Specialized Strollers for EPSDT members	For Cascade Select members: strollers are not a covered benefit For AH members: The member meets the applicable criteria from MCG current edition, Wheelchairs, Manual (A-0354)

	The member does not have a wheelchair or plans for a wheelchair A commercially available (non- Medical Equipment) stroller will not meet the member's mobility needs
TENS UNITS	For Cascade Select and AH members: Electrical Neural Stimulation is not medically necessary outside of medically supervised facility settings and is not medically necessary for home use. This is because according to HTA 20091030A – Electrical Neural Stimulation, ENS showed insufficient evidence to conclude it was effective in reducing pain, increasing patient satisfaction and reducing analgesic consumption
TUMOR-TREATING FIELDS (ALSO CALLED: NOVOCURE, OPTUNE, ALTERNATING ELECTRIC FIELD THERAPY) FOR GLIOBLASTOMA	For Cascade Select and AH members: According to the HTCC 20181116A - Tumor treating fields, (TTF) – re-review, which is based on current evidence, this technology is not medically necessary for the treatment of newly diagnosed or recurrent glioblastoma multiforme or for the treatment of other cancers due to unproven efficacy and less cost-effective than comparators.
VENTILATOR, Invasive or Non-invasive	See MM135 Positive Airway Pressure Devices
VENTILATOR, BACK-UP	See MM135 Positive Airway Pressure Devices
WEARABLE CARDIOVERTER DEFIBRILLATOR	For Cascade Select and AH members: Current edition MCG Guidelines A-0566 Must be reevaluated after 3 months.
MANUAL WHEELCHAIRS (AND ACCESSORIES)	See CHPW Wheelchair Clinical Coverage Criteria policy

POWER MOBILITY DEVICES	See CHPW Wheelchair Clinical Coverage Criteria policy.
WOUND VAC SYSTEMS:	https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=33821&ver=25&bc=0For Cascade Select and AH members, medical necessity criteria are specified in: WA HTA 20161118A: Negative pressure wound therapy for home use (NPWT) 01/20/2017 Additional criteria showing medical necessity for all lines of business: If the wound vac was applied in the hospital, the initial 1 month can be approved

Limitations/Exclusions

Please see link to member coverage documents below:

Line of Business	Link to Member Coverage Documents
Medicare Advantage Plans	
Apple Health	https://www.chpw.org/for-members/benefits-and-coverage-imc/
Individual & Family (Cascade Select)	https://chnwhealthinsurance.chpw.org/member-center/plan-benefits/

List of Appendices

None.

Citations & References

CFR		
WAC	284-43-2050, 182-552-1000, 182-501-0050; 182-543-1000; 182-543-7100; 182-543-2200; 284-43-5642; 284-43-5642; 182-543-5500.	
RCW		
LOB & Contract Citation	☒ **WAHIMC** ☐ **BHSO** ☐ **Wraparound** ☐ **SMAC** ☐ **HH**	IMC Section 1.102: Durable Medical Equipment (DME); IMC Section 1.197; Medical Equipment definition; IMC Section 1.200: Medically Necessary; IMC Section 11.1: Utilization Management General Requirements; IMC Section 11.3: Medical Necessity Determination; IMC Section 7.11.2: The Contractor shall develop

		practice guidelines based on recognized sources such as the United States Preventive Services Task Force (USPSTF) and the current Advisory Committee on Immunization Practices (ACIP) recommended immunization schedule published by the Centers for Disease Control (CDC) as primary guideline sources; IMC Section 17.1.23: Medical Equipment and Supplies; IMC Section 17.1.31: EPSDT benefit
	☒ **AHE**	AHE Section 1.151: Medically Necessary Services; AHE Section 11.1: Utilization Management General Requirements; AHE Section 11.3: Medical Necessity Determination
	☐ **MA/DSNP**	
	☒ **CS**	P&P supports all LOB requirements
Other Requirements	Medicare Claims Processing Manual Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Wheelchair Options/Accessories - Policy Article- A52504 Local Coverage Determination (LCD) Power Mobility Devices L33789 CHPW Clinical Practice Guidelines: Child Passenger Safety: American Academy of Pediatrics	
NCQA Elements	UM2, UM5	
References	MCG Guidelines Standing Frames: Effectiveness and Safety Rapid Review, November 2019 (Review by OHSU commissioned by the HCA) Noridian Group 2 and Group 3 Single and Multiple Power Wheelchair Checklist Noridian Group 1, 2, 3 No Power Option Power Wheelchair Checklist Wheelchair Options/Accessories L33792) NCA - Seat Elevation Systems as an Accessory to Power Wheelchairs (Group 3) (CAG-00461N) - Decision Memo (cms.gov) Local Coverage Article: Standard Documentation Requirements for All Claims Submitted to DME MACs A55426 (for replacement of DME). Hospital Beds | FDA	

	Center for Evidence-Based Policy: med-workgroup-tool-coverage-of-enclosed-beds.pdf.

Revision History

Revision Date	Revision Description	Revision Made By
12/03/2008	Approval	MMLT
12/08/2010	Approval	MMLT
02/11/2011	Added sentence on current evaluation for replacement	Lucy Sutphen, MD, FACP
12/14/2011	Approval	MMLT
11/21/2012	Updated DME prior authorization requirements	Lucy Sutphen, MD, FACP
11/28/2012	Approval	MMLT
03/31/2014	References updated with active links	Kate Brostoff MD
06/20/2014	Updated DME prior authorization requirements	Kate Brostoff MD
06/23/2014	Approval	MMLT
06/15/2015	References updated with active links	Kate Brostoff MD
06/23/2015	Approval	MMLT
08/08/2016	References updated with active links	Cyndi Stilson, RN
08/08/2016	Updated links and MCG reference	Jane Daughenbaugh, RN
08/09/2016	Reviewed – no changes	Victor Collymore, MD
08/09/2016	Approval	MMLT
09/19/2016	Added criteria for high-risk fractures per HCA request	Cyndi Stilson, RN
09/27/2016	Approved	MMLT
05/31/2017	Changed 'VENTILATORS' criteria to MCG. Links checked and updated	Cyndi Stilson, RN
06/01/2017	Approved	MMLT
03/26/2018	Changed from UM006	Cindy Bush
04/05/2018	Transferred to new template	Cindy Bush
05/02/2018	Updated and corrected links. Corrected links to HTA for insulin pumps and CGM and for negative pressure wound vac. Corrected bone growth stimulation to reference WA HTA. Corrected speech generating device and cough stimulating devices guidelines for	LuAnn Chen, MD

	Medicare members. Removed summary for bone growth stimulation because the linked guidelines are clear. Removed erroneous information about rental caps.	
5/30/2018	Approved	UM Medical Subcommittee
06/18/2018	Added characteristics for DME per AHMC contract 1.55 DME; Added definition; Removed box under indications/criteria "Medicaid Members" and "Medicare Members" – no information	Yves Houghton, RN
06/22/2018	Approval	UM Committee
07/19/2018	Added CMS information about respiratory assist devices. Added WAC requirements for ventilators, (home, pressure, back-up). Added limitations on replacement due to client's recklessness etc as per WAC 182-501-0050.	LuAnn Chen, MD
08/02/2018	Additional information added for communication devices. Added details regarding semi electric hospital beds	LuAnn Chen, MD
08/14/2018	Approval	UM Medical Subcommittee
09/06/2018	Added criteria for positional car seats and clinical practice guidelines related to child passenger safety. Added criteria for Continuous Passive Motion System. Need to remove SGD and hearing aids since new policies are being created.	LuAnn Chen, MD
09/20/2018	Added criteria for electric bed, heavy-duty, extra-wide/bariatric bed and extra-heavy-duty bed	Yves Houghton RN
09/20/2018	Approval	UM Medical Subcommittee
09/26/2018	Approval	UM Committee
10/12/2018	Clarified that prosthetics criteria: MCG AFO/KAFO/orthotics: MM158. Need to remove speech devices when the new policy is posted. Bathroom DME will be separate policy.	LuAnn Chen, MD
10/18/2018	Removed criteria for speech devices and posted the reference to CHPW policy MM167 Speech Generating Devices (Augmentative Communication Devices).	LuAnn Chen, MD

10/19/2018	Approval	UM Medical Subcommittee
11/14/2018	Added indications for Chest compression devices for EPSDT children	LuAnn Chen, MD
11/15/2018	Approved	UM Medical Subcommittee
12/07/2018	Removed reference to non-covered DME items (TENS) for Apple Health, due to CMS requirement.	LuAnn Chen, MD
12/07/2018	Approved	UM Medical Subcommittee
12/18/2018	Added Mandibular Advancement Devices	LuAnn Chen, MD
12/20/2018	Approved	UM Medical Subcommittee
01/04/2019	Added requirement for physician signature	LuAnn Chen, MD
01/04/2019	Approved	UM Medical Subcommittee
01/11/2019	Expanded Chest compression criteria for AH members to include adults	LuAnn Chen, MD
01/15/2019	Approval	UM Committee
1/29/2019	Updated Patient Lifts to use MCG guidelines and removed criteria for hearing aids	Yves Houghton
02/01/2019	Approval	UM Committee
02/27/2019	Requirement for submitting results of trials with similar devices, and home assessment. Removed requirement for physician visit prior to DME repair. Physician signature not needed for certain DME or DME ordered for SNF members (can be signed for by ARNP or PA)	LuAnn Chen, MD
02/28/2019	Approved	UM Medical Subcommittee
03/18/2019	Added criteria for standing frames and sit to stand frames. Change face to face requirement to be 6 months instead of 3 months	LuAnn Chen, MD
04/05/2019	Approval	UM Medical Subcommittee
09/19/2019	Added criteria for Tumor-Treating Fields	LuAnn Chen, MD
10/11/2019	Approval	UM Medical Subcommittee

11/08/2019	Corrected links for Insulin pumps and CGM for Medicare members. Corrected Tumor-Treating Fields criteria to align with the HTA. Corrected link to LCD for Patient Lifts. Corrected lower limb prosthesis LCD link.	LuAnn Chen, MD
11/15/2019	Approval	UM Medical Subcommittee
01/03/2020	Clarified definition of DME and requirement for all DME to have physician signature.	LuAnn Chen, MD
1/10/2020	Added criteria for continued use of CGM	Yves Houghton, RN
01/14/2020	Added criteria for hospital bed for AH members who need body positioning that cannot be achieved with a regular bed and criteria for variable height bed. Combined Ventilator Home, with Ventilator Invasive and Non-invasive, update criteria to use MCG for both LOBs. Updated Ventilator Back up criteria to use MCG for both LOBs.	LuAnn Chen, MD and Yves Houghton, RN
01/21/2020	Approval	UM Medical Subcommittee
02/12/2020	WAH-IMC and MA Contract Citations updated	LuAnn Chen, MD
02/19/2020	Added definition of physician to include MD, DO, DPM. Medicare Claims Processing Manual Chapter 20 referenced.	LuAnn Chen, MD
02/20/2020	Approval	UM Medical Subcommittee
03/04/2020	Clarified definition of DME. Criteria added for activity chair. Added Loaner DME criteria. Added criteria on medical appropriateness. Clarified that CHPW considers one piece of mobility/positioning equipment medically necessary, if criteria are met for the equipment. Second items are considered a convenience. And that DME that duplicates equipment that the member already has is not medically necessary. Added citation of WAC 182-543-7100 and WAC 182-543-2200.	LuAnn Chen, MD; Yves, Houghton, RN
03/12/2020	Approval	UM Medical Subcommittee

04/02/2020	Clarified that Medicare does not reimburse for standing frame. Specified MCG as criteria for AH members for standing frame.	LuAnn Chen, MD
04/03/2020	Approval	UM Medical Subcommittee
06/29/2020	Clarified need for records from within the past 6 months. Clarified that CHPW does not pay for repair of damage to DME caused by neglect or intentional destruction. Clarified criteria for ongoing approval of CGM.	LuAnn Chen, MD
6/29/2020	Added criteria for ongoing ventilator use	Yves Houghton, RN BSN
07/21/2020	Approval	UM Medical Subcommittee
08/03/2020	Corrected link to Medicare CGM criteria. Clarified that ENS is not medically necessary for home use based on HTA. The HTAs on negative pressure wound therapy for home use and the HTA on Bone Growth Simulators supplies medical necessity criteria for these devices. Added criteria for CHNW Cascade Select. Added exception to physician signature for the COVID-19 PHE.	LuAnn Chen, MD
09/10/2020	Approval	UM Medical Subcommittee
10/28/2020	Updates regarding adherence to the plan for use of the device and the medical management plan for diabetes	LuAnn Chen, MD
10/30/2020	Approval	UM Medical Subcommittee
12/11/2020	Corrected all LCD numbers and links. Added criteria for very heavy-duty wheelchair.	LuAnn Chen, MD
12/22/2020	Approval	UM Medical Subcommittee
02/01/2021	Criteria for osteogenesis stimulators clarified for Medicare and AH-IMC and Cascade Select.	LuAnn Chen, MD
02/12/2021	Approval	UM Medical Subcommittee
04/06/2021	Expanded criteria from WAC 182-543-7100. Renamed “Durable Medical Equipment” to Medical Equipment as per the HCA contract and WAC 182-543-1000. Corrected definition of Medical	LuAnn Chen, MD

	Equipment to align with HCA contract and WAC 182-543-1000. Updated citations.	
05/03/2021	Approval	UM Medical Subcommittee
11/12/2021	Updates to insulin pump and CGM continuation criteria. Citations updated.	LuAnn Chen, MD
11/22/2021	Approval	UM Medical Subcommittee
03/30/2022	Added CNM and Licensed Nurse Midwives to list of providers who can prescribe DME. Updated citations.	LuAnn Chen, MD
03/30/2022	Approval	UM Medical Subcommittee
06/24/2022	Specified criteria for hospital bed mattresses and overlays. Corrected weights for heavy duty and very heavy-duty wheelchairs and hospital beds.	LuAnn Chen, MD
07/19/2022	Corrected weights for heavy duty and extra heavy-duty wheelchairs and hospital beds.	LuAnn Chen, MD
07/28/2022	Approval	CMO Cabinet
11/23/2022	Changed criteria for insulin pumps to align with pharmacy criteria. Moved non-invasive ventilators to MM135.	LuAnn Chen, MD
02/10/2023	Added rental limitations for hospital beds and wheelchairs for AH members. Added WAC 182-543-5500WAC 182-543-5500 for limitations on medical equipment. Updated citations. Removed references to CHNW. Removed invasive ventilators from MM136 and moved them to MM135. Updated citations.	LuAnn Chen, MD
03/09/2023	Approval	UM Medical Subcommittee
04/10/2023	Clarified that criteria for Power Mobility Devices for all members is included in the LCD. Summarized L33789 in Appendix A below. Licensed facilities do not need a home assessment.	LuAnn Chen, MD
04/13/2023	Clarified that the power elevated seat and power standing seat functions are not medically necessary	LuAnn Chen, MD
04/13/2023	Approval	UM Medical Subcommittee
05/19/2023	Corrections made to Group 3 PWC based on consultation with network ATP specialist. Added new	LuAnn Chen, MD

	CMS criteria for Power Seat Elevation. Simplified Group 2 and 3 criteria based on Noridian checklists.	
06/02/2023	Approval	UM Medical Subcommittee
06/06/2023	Clarified that the RESNA recommendations must align with the PT/OT recommendations. Added prosthesis as an ambulatory device. Clarified criteria for replacement of equipment.	LuAnn Chen, MD
06/08/2023	Approval	UM Medical Subcommittee
06/27/2023	Removed manual wheelchairs and power mobility devices due to creation of new policy for these devices.	LuAnn Chen, MD
07/01/2023	Approval	UM Medical Subcommittee
09/20/2023	Clarified that Home Assessment can be performed by DME supplier.	LuAnn Chen, MD
09/26/2023	Approval	UM Medical Subcommittee
02/01/2024	Added wound vac criteria for devices applied in the hospital. Updated citations.	LuAnn Chen, MD
02/14/2024	Approval	UM Criteria Subcommittee
03/11/2024	Added A55426. For replacement of DME for Medicare members.	LuAnn Chen, MD
03/13/2024	Approval	UM Criteria Subcommittee
11/22/2024	Removed Medicare, added AHE. Moved A55426 to references.	LuAnn Chen, MD
12/11/2024	Approval	UM Criteria Subcommittee
10/11/2025	Changed title to Medical Equipment and Supplies in alignment with HCA Provider Billing Guide. Added limitation extension criteria for supplies. Separated insulin pumps from CGMs. Minor edits to criteria for mandibular advancement devices to align with the HCA provider Billing Guide. Updated citations and links.	LuAnn Chen, MD
10/17/2025	Approval	UM Criteria Subcommittee

10/18/2025	Edited Continuous Passive Motion to align with HCA Medical Equipment and Supplies Provider Billing guide with maximum rental for 21 days.	LuAnn Chen, MD
10/23/2025	Approval	UM Criteria Subcommittee
05/08/2026	Removed Cough Stimulating Devices and Chest Compression Devices. Added Airway Clearance Devices that directs to MCG. Criteria for standing frame for AH members added. Removed gait trainer as supportive seating under activity chair. Updated criteria for positioning car seat.	LuAnn Chen, MD