

**Medical Policy: Durable Medical Equipment (DME)**

Effective Date: 05/22/07

Revised/Reviewed: 08/11/11, 4/16/12, 10/5/15, 8/10/23

Reviewed/No Updates: 1/28/13, 2/13/14, 2/12/15, 2/11/16,  
2/9/17, 2/8/18, 2/14/19, 2/13/20, 2/11/21, 2/17/22, 2/2/23,  
2/8/24, 2/20/25

## DURABLE MEDICAL EQUIPMENT (DME)

### DEFINITIONS:

**Durable Medical Equipment:** DME refers to non-expendable articles of equipment, recognized as such by Medicare Part B, that meet all the following criteria:

- It is usually designed for and can stand repeated use
- It is primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience (e.g. to allow patient to go shopping)
- It is usually not useful to a person in the absence of sickness or injury
- It is appropriate for home or institutional (e.g. nursing home) use
- It must be related to the patient's physical disorder

Examples include wheelchairs, hospital beds, traction equipment, walkers, ventilators, oxygen, monitors, pressure mattresses, lifts, nebulizers, bilirubin blankets and bilirubin lights

### NOTE:

- a) DME items that can be purchased Over-the Counter (OTC), with or without a prescription, are not covered benefits (Exceptions may be found under 'Home Health Care Services' and 'Hospice Care'). There are situations when coverage of an over-the-counter DME and supplies may need to be covered as medically necessary. This will require proper documentation and medical necessity review and approval by the Plan's Medical Director.
- b) Casts, splints, trusses, non-dental braces, and prosthetic devices are not considered DME. (see "Prosthetics and Orthotics")
- c) There is a separate policy for Hospital Beds and Accessories
- d) Refer to **Appendix A** (Chart of DME Coverage) at the end of this document.

### DME Policy

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**Benefit Coverage - VCHCP will:**

- Provide coverage for DME when it is determined to be medically necessary because the criteria and guidelines for its use are met.
  - Provide coverage for Repairs, Maintenance and Replacement of eligible DME on an individual consideration basis when it is necessary to make the equipment usable.
  - Review the option to rent or purchase eligible DME on an individual consideration basis.
- e) Replacement supplies for DME such as tubing or masks for a Continuous Positive Airway Pressure (CPAP) or Intermittent Positive Airway Pressure (BIPAP) are covered under normal wear and tear or every six (6) months or as medically necessary.

**Maintenance, Repairs, and Replacement of PURCHASED DME (See policy specific to DME Replacement):**

- Repairs or maintenance to equipment that is purchased may be covered on an individual consideration basis when necessary to make the equipment usable. Maintenance, repair, or replacement and supplies are eligible for separate reimbursement under a contracted maintenance fee with a DME supplier acceptable by the Plan.
- If the expense for repairs exceeds the estimated expense of purchasing or renting another item of equipment for the remaining period of medical need, no payment can be made for the amount in excess
- The repair charge may include the use of "loaner" equipment when necessary.
- When equipment is purchased, coverage for a maintenance or service agreement may be considered on an individual consideration basis. Further benefits will be subject to the terms of the provider's contracted maintenance agreement.
- Replacement of a purchased item may occur when the item is irreparably damaged, or if replacement is required during repair and/or maintenance of a specific item. The cost will be negotiated on a rental versus purchase agreement. Replacement may be based on the maintenance contract as stated above.
- Replacement or repair of an item that has been misused or abused by the member or member's caregiver will be the responsibility of the member.

**Maintenance, Repairs, and Replacement of RENTAL DME:**

- DME rental fees will cover the cost of maintenance, repairs, replacements, adjustments, supplies, and accessories. Please note that rental fees also include equipment delivery services and set-up, education and training for patient and family, and nursing visits; and these services are not eligible for separate

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reimbursement. Payment of eligible fees will begin on the day the device is delivered to our member.

- Replacement of the rental equipment may occur when the rented item is irreparably damaged, or if replacement is required during repair and/or maintenance of a specific item. Monthly rental fees allow for the replacement costs and are not eligible for separate reimbursement.
- Replacement or repair of an item that has been misused or abused by the member or member's caregiver will be the responsibility of the member.

**Coverage for DME ADD-ONS OR UPGRADES:**

Add-ons or Upgraded DME equipment will be reviewed on an individual consideration basis for medical necessity.

**DME Add-ons or Upgrades- When Durable Medical Equipment and Services ARE NOT COVERED:**

- When the DME add-ons or upgrades are intended primarily for convenience or upgrades beyond what is necessary to meet the member's legitimate medical needs. Examples include decorative items, unique materials (e.g. special wheelchair wheels, lights, extra batteries, etc.)
- When it does not provide a therapeutic benefit to a patient in need because of certain medical conditions or illnesses
- When the DME has not been prescribed by a physician within the scope of his license
- When the DME serves primarily as a comfort or convenience item (e.g. trays, back packs, wheelchair racing equipment)
- When the equipment is used in a facility that is expected to provide such items to the patient ( e.g. a skilled nursing facility). Such equipment should be provided as part of the facility services.
- When the devices and equipment are used to enhance the environmental setting (e.g. air conditioners, humidifiers, air filters, portable Jacuzzi pumps, or chair lifts used to go up and down the stairs). These are not primarily medical in nature and will not be eligible for coverage.
- Equipment delivery services and set-up, education and training for patient and family, and nursing visits, are not eligible for separate reimbursement regardless of agreement to rent or purchase
- Routine periodic servicing, such as testing, cleaning, regulating and checking which the manufacturer does not require be performed by an authorized technician.

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- Rental or purchase of an allowed item, other than life-support equipment, solely to be used as a back-up to currently owned or rented equipment
- Vehicle lifts that are non-detachable and/or manufactured for a specific vehicle that cannot be removed from one vehicle and used in another vehicle are viewed as customizations to the vehicle and not an accessory to the wheelchair and are not covered
- Household chairs
- Recliner chairs
- Exercise equipment, spas, whirlpools, hot tubs, swimming pools
- DME add-ons or upgrades that are intended primarily for member/caregiver convenience, or that do not significantly enhance DME functionality are not covered.

The cost to structurally change a home to accommodate DME is excluded.

Any item deemed by the medical reviewer not to be of medical necessity

#### Home DME that is subject to medical necessity review.

- Items that do not meet the definition of DME may be covered under certain conditions. These items may be covered as DME when it is clearly established that the items serve a therapeutic purpose in an individual case.
- DME that requires a prescription to rent or purchase *before* it is eligible for coverage.
- Payment of eligible fees that will begin on the day the device is delivered, set-up, and ready for use by our member at the location needed.
- DME rental rates and maintenance fees calculated for payment on a prorated basis, based on provider contracted rates, when a full 30 days are not utilized by the member.

#### Guidelines for purchasing DME- Rental Versus Purchase:

DME rental versus purchase coverage is based on the item prescribed, the patient's prognosis, the timeframe required for use, and the total cost (rental vs. purchase) for the equipment. When DME is purchased, the total benefits available cannot exceed the contracted fee schedule.

#### DME may be *purchased* if:

- 1) The total amount paid for monthly rentals would exceed the fee schedule purchase amount. Examples may include but are not limited to low pressure and positioning equalization pads, home blood glucose monitors, braces for legs, arms, cast boots, cervical brace, and Jobst stockings.
- 2) Long term use is expected based on the patient's prognosis

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3) a rental trial period (applied toward purchase price) has documented patient compliance, patient tolerance, and clinical benefits.

**Guidelines for *renting* DME:**

DME rental vs. purchase coverage is based on the item prescribed, the patient's prognosis, the time frame required for use, and the total cost (rental vs. purchase) for the equipment. When DME is rented, the benefits cannot exceed the total of the cost to purchase the DME or the contracted fee schedule.

**DME may be rented when:**

- DME is not classified as "Routinely Purchased DME", is inexpensive and anticipated medical need is for a limited timeframe, or equipment requires high maintenance (requires specialized skills to service the item).

Examples include but are not limited to the following: apnea monitors, hospital beds, bili lights and bili blankets, traction, infusion pumps, IPPB, nebulizers, CPAP, BiPAP, DPAP, lymphedema pumps, oxygen equipment (portable and stationary), ventilators, and TENS units.

- DME rental fees will cover the cost of maintenance, repairs, replacements, supplies and accessories. Equipment delivery services and set-up, education and training for patient and family, and nursing visits, are not eligible for separate reimbursement.
- Equipment that is purchased without prior rental will be owned by the patient.

**Documentation Requirements:**

The supplier is responsible for obtaining a signed, dated, written agreement from the member for the additional charges prior to delivery of the non-covered items.

**Individual Consideration**

Medical policies are written for most of our members based on available medical research. To request review of an individual patient's unique medical circumstances, physicians may contact VCHCP's Medical Director.

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VCHCP has developed the following chart of what is generally considered to be “durable medical equipment” (DME). The DME in the following chart (Appendix A) is classified according to the following categories:

Ambulatory Aids	Lights
Bathtub Equipment and Supplies	Nerve Stimulators
Beds/Bed Equipment	Pacemakers
Breast Related Supplies	Respiratory Aids and Supplies
Communication Systems	Self Help Equipment
Cushions, Pads and Mattresses	Speech Device
Diabetic Equipment	Supports
Environmental Control Items	Toilet Equipment
Exercise Equipment	Wheelchairs
Eyewear	Whirlpools
Lifts	Miscellaneous

**Appendix A**

Category / Equipment	Coverage Comments	Related or Specific Policy
<b>AMBULATORY AIDS</b>		
Canes	No	
Crutches	No	
Crutch substitute (knee walker), crutch walker	No	
Walkers	Yes, if condition impairs ambulation	
<b>BATHTUB EQUIPMENT &amp; SUPPLIES</b>		
Bathtub lift	No	
Bathtub Rails	No	
Bathtub Seat	No	
Bed Bath	No	
Century Bed Bath	No	
Eaton E-Z Bath	No	

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<b>Category / Equipment</b>	<b>Coverage Comments</b>	<b>Related or Specific Policy</b>
Nolan Bath Chair	No	
Sauna Bath	No	
Sitz Bath	No	
Tub Chair or Stool or Bench	Yes, for safety reasons due to balance/ instability issues and debilitation	
<b>BEDS/BED EQUIPMENT</b>		
Adjust-A-Bed	No	
Air Fluidized Bed, Powered Air Flotation Bed, Bead Bed (Clinitron)	No	
Bed Board	No	
Bed Side Rail	Yes, if bed confined & has chronic seizures, chronic vertigo, chronic disorientation or neurological disorders	See policy: Hospital Beds & Accessories
Bed – Lounge (i.e., Ease-o-matic, Electro-Rest)	No	
Hospital Bed – Electric	Yes, when: 1) bed confined and 2) frequent position change required, delay in change can't be tolerated, and 3) patient can operate bed (except brain/spinal cord injury patients).	See policy: Hospital Beds & Accessories Policy
Hospital Bed – Manual	Yes, when: 1) bed confined & 2) condition requires position changes ordinary bed can't accommodate, or 3) condition requires frequent position changes.	See policy: Hospital Beds & Accessories Policy
Trapeze Bar	Yes	See policy: Hospital Beds & Accessories Policy

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<b>Category / Equipment</b>	<b>Coverage Comments</b>	<b>Related or Specific Policy</b>
Lounge Bed	No	
Ortho-Prone Bed	No	
Oscillating Bed	No	
Springbase Bed	No	
Overbed Table	No	
Vasculating Bed	No	
<b>BREAST RELATED SUPPLIES</b>		
Bra, post-mastectomy	Yes, if specifically made to accommodate a prosthesis. Provide one bra at a time as needed.	
Breast Prosthesis	See policy	See policy: Breast Reconstructive Surgery after Mastectomy for Breast Cancer
Breast Pump	Yes.	See Breast pump policy
Lymphedema Sleeve (operative side only)	Yes, for post-mastectomy arm when medical necessity is met.	
<b>COMMUNICATION SYSTEMS</b>		
Communic Aid	No	
Communicator	No	
Electric/Computer Communication Devices	No	
Touch Talker	No	
Vocaid	No	
<b>CUSHIONS, PADS AND MATTRESSES</b>		
Abduction Pillow	Yes, for child with hip disorder	
Air Mattress or Alternating Air Pressure Pad & Mattress	Yes, if has, or is, highly susceptible to decubitus ulcers	See policy: Hospital Beds & Accessories
Aquamatic K Pad	No	



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<b>Category / Equipment</b>	<b>Coverage Comments</b>	<b>Related or Specific Policy</b>
Egg Crate Mattress	No	
Elbow Protector	No	
Gel Flotation Pad & Mattress	Yes, if has, or is, highly susceptible to decubitus ulcers	
Heat & Massage Foam Cushion Pad	No	
Heating Pad	No	
Heel Protector	No	
Jobst Hydro Float	Yes	
Lamb's Wool Pad	No	
Mattress – Regular	Yes, when hospital bed is covered	
RoHo Positioning Pillow	Yes, if medically necessary	
Steam Pack	No	
Stryker Flotation Pad & Mattress	Yes, if has, or is, highly susceptible to decubitus ulcers	
Water and Pressure Pads & Mattress	Yes, if has, or is, highly susceptible to decubitus ulcers	
<b>DIABETIC EQUIPMENT</b>		
Blood Glucose Monitoring Devices	Per Pharmacy Benefit Coverage	See: Preferred Drug List
Insulin Infusion Pump	See Medical Policy	See policy: Insulin Infusion Pumps for Diabetes
Pen Pump syringe, i.e., Novajet, Mediject, Precijet	Per Pharmacy Benefit Coverage	See: Preferred Drug List
<b>ENVIRONMENTAL CONTROL ITEMS</b>		
Air Cleaner	No	
Air Conditioner	No	
Dehumidifier	No	
Electric Air Cleaner	No	
Electrostatic Machine	No	
Environmental Control Equipment	No	

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<b>Category / Equipment</b>	<b>Coverage Comments</b>	<b>Related or Specific Policy</b>
Heater, Portable	No	
Humidifier (Central or Room)	No	
Micronaire Environmental	No	
Pollen Extractor	No	
Portable Room Heaters	No	
<b>EXERCISE EQUIPMENT</b>		
Continuous Passive Motion Device (CPM)	No	
Exercise Equipment	No	
Exercycle (including cardiac use)	No	
Functional Electrical Stimulation	No	
Gravity Guidance Inversion Boots	No	
Gravitronic Traction Device	No	
Moore Wheel	No	
Parallel Bars	No	
Pulse Tachometer	No	
Restorators	No	
Tilt Table	No	
Training Balls	No	
Treadmill Exercisor	No	
Weighted Quad Boot	No	
<b>EYEWEAR</b>		
Eyeglasses/Contact Lenses	No, except for the first pair needed due to the following: 1) Post cataract surgery; or 2) Accident which occurs while covered under the group plan, if glasses were not needed prior to the accident.	See policy: Intraocular Lens
<b>LIFTS</b>		
Bathtub Lift	No	

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<b>Category / Equipment</b>	<b>Coverage Comments</b>	<b>Related or Specific Policy</b>
Bed Lift	No	
Burke Bed Elevator	No	
Cheney Safety Bath Lift	No	
Electric Powered Recliner and Elevating Seat	No	
Elevator	No	
Hoyer Lift	Yes, when M.D. certifies that periodic movement from bed will significantly improve, arrest, or retard deterioration and without the lift, the patient would be confined to bed.	
Hydraulic Patient Lift	Yes, when M.D. certifies that periodic movement from bed will significantly improve, arrest, or retard deterioration and without the lift, the patient would be confined to bed.	
Patient Lifts Requiring Home Modification (i.e., ceiling tracks)	No	
Seat Lift Chair	No	
Seat Lift Mechanism for patient-owned furniture	No	
Stairglide	No	
Van Lift	No	
Wheel-O-Vator	No	
<b>LIGHTS</b>		
Bilirubin Blanket	Yes, in home up to 5 days rental for hyperbilirubinemia (jaundice) when the bilirubin is elevated	
Lamp, Heating	No	
Lamp, Ultraviolet	No	

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<b>Category / Equipment</b>	<b>Coverage Comments</b>	<b>Related or Specific Policy</b>
Phototherapy Light (Bilirubin Light)	Yes, in home up to 5 days rental for hyperbilirubinemia (jaundice) when the bilirubin is elevated)	
Ultraviolet Cabinet	See Medical Policy	See policy: Phototherapy and Photochemotherapy (PUVA) for skin conditions
<b>NERVE STIMULATORS</b>		
Dorsal Column Stimulator	See Medical policy	See policy: Spinal Cord Stimulators
Functional Electrical Stimulation (FES)	No	
Neuro Muscular Stimulator	See Medical policy	See policy: TENS Unit
Pelvic Floor Stimulator	No	
Transcutaneous Electrical Stimulator (TENS)	See Medical policy	See policy: TENS Unit
<b>PACEMAKERS</b>		
Audible/Visual Signal Pacemaker Monitor	Yes, for cardiac pacemaker patients	
Breathing Pacemaker	Yes, when neurological control of breathing is lost	
Digital Electronic Pacemaker Monitor	Yes, for cardiac pacemaker patients	
<b>RESPIRATORY AIDS &amp; SUPPLIES</b>		
<i>Due to heavy maintenance requirements and serious ramifications of malfunction, oxygen equipment and respirators should be rented rather than purchased for plans that provide this benefit.</i>		
Aerochamber Nebulizer Mask	Yes	
Air compressor	Yes	

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<b>Category / Equipment</b>	<b>Coverage Comments</b>	<b>Related or Specific Policy</b>
Bennett IPPB Machine	Yes, for severe respiratory impairment	
Bird Respirator	Yes, for severe respiratory impairment	
Breathing Assistor	Yes, when home IPPB is necessary. No, when oxygen therapy is given.	
CPAP/BiPAP/VPAP/DPAP	See Medical policy	See policy: Airway Pressure Management in Sleep Apnea
External Respirator	Yes, for respiratory paralysis	
Face Mask for Oxygen	Yes	
Hand-D-Vent Inhalator	Yes, for severe respiratory impairment	
Humidifier	Yes, when prescribed for use with oxygen equipment	
IPPB Machine	Yes, for severe respiratory impairment	
Iron Lung	Yes, for respiratory paralysis	
IPV (Intrapulmonary Percussive Ventilator) “Cough-o-lator”	No	
LC-3 Oxygen System	No	
Liberator Stroller System	Yes	
Life-O-Gen Tank	Yes	
Linde Oxygen Walker System	Yes	
Marxs Oxygen Concentrator	Yes	
Mouthpiece	Yes	
Nebulizer	Yes, for respiratory impairment	See policy: Nebulizers
Oxygen, Standard and Portable Systems	Yes	See policy: Oxygen for Home Use
Oxygen Mask	Yes	

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<b>Category / Equipment</b>	<b>Coverage Comments</b>	<b>Related or Specific Policy</b>
Oxygen Concentrator	Yes	
Oxygen Tank (including spare)	Yes, as part of cost of oxygen	
Oxygen Tent	Yes	
Oxylite	Yes	
Peak Flowmeter	Yes	See policy: Peak Flow Meters
Postural Drainage board	Yes, for chronic and severe pulmonary disease	
Preset Oxygen system (flow rate not adjustable)	No, emergency, first-aid or precautionary equipment, essentially not therapeutic in nature	
Respiratory support System	Yes	
Spirometer	No	
Suction Machine	Yes	
Vaporizer	No	
<b>SELF-HELP EQUIPMENT</b>		
Automobile Control	No	
Automobile Lift	No	
Safety Grab Bars	No	
Stand Aid	No	
Standing Table	No	
Transfer Board	Yes	
<b>SPEECH DEVICE</b>		
Phone Mirror Handivoice	No	
Servox	Yes	
Speech Teaching Machine	No	
Voice Prosthesis	Yes, post laryngectomy	
<b>SUPPORTS</b>		
Cervical Collar	Yes, post-surgery	
Cervical Pillow	No	

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<b>Category / Equipment</b>	<b>Coverage Comments</b>	<b>Related or Specific Policy</b>
Compression Hose or Stockings	See policy	See policy: Compression Stockings & Garments
Floor Sitter	Yes, for children with cerebral palsy or other severe neuromuscular conditions. No, for any other condition	
Floor Stander	No	
Foam Neck Collar	Yes, post-surgery	
Lumbar-Sacral Support	Yes, post-surgery	
Orthotrac Pneumatic Vest	No	
Prone Board	Yes, for children with spastic quadriplegia	
Rib Belt	No	
Rib Brace	No	
<b>TOILET EQUIPMENT</b>		
Bed Pan	Yes, if bed confined	
Commode	Yes, if bed confined	
Raised Toilet Seat	Yes, for safety reasons due to balance/ instability issues and prevention of reinjury after spinal or hip surgery	
Toilet Trainer	No	
Urinal	Yes, if bed confined	
<b>WHEELCHAIRS</b>		
Amigo Motorized Wheelchair	No	
Broda Chair	No	
Care Chair, Pogon Buggy, Sleek Seat, Travel Chair	Yes, for non-ambulatory children who either require more support than regular wheelchair provides or are too small for a child's wheelchair	

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<b>Category / Equipment</b>	<b>Coverage Comments</b>	<b>Related or Specific Policy</b>
Rollabout Chair with casters over 5” in diameter	No	
Scooters	Yes	
Standing Wheelchair	No	
Wheelchair – Adult (manual)	Yes	
Wheelchair – Adult (electric)	Yes	
Wheelchair – Child’s	Yes, for non-ambulatory children who either require more support than regular wheelchair provides or are too small for an adult wheelchair	
Wheelchair – Standing	No	
Wheelchair Inserts	Yes	
Wheelchair Pads	Yes, when ordered by an M.D. to treat and prevent pressure areas on wheelchair-confined patients.	
<b>WHIRLPOOLS</b>		
Action Bath Hydro Massage	No	
Aero Massage	No	
Aqua Whirl	No	
Aquasage Pump	No	
Hand-D-Jet	No	
Hydro Jet	No	
Jacuzzi	No	
Turbojet	No	
Whirlpool Bath Equipment	No	
Whirlpool Pump	No	
<b>MISCELLANEOUS</b>		
Bath Chairs/Seats (for special needs children)	No	
Batteries	No if OTC product	See Evidence of Coverage (EOC)



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2/8/24, 2/20/25

<b>Category / Equipment</b>	<b>Coverage Comments</b>	<b>Related or Specific Policy</b>
Car Seats (for special needs children)	No	
Chairs, Elite by Broda (full or semi recliner, or tilt)	No	
Cold Therapy Devices (See Cold Therapy)	No	
Cranial Remodeling Bands (cranial molding helmets)	Yes, See medical policy	See policy: Cranial Remodeling Band
Ear Plugs	No	
Flash Switches (for toys)	No	
Helmet, Safety	Yes, only custom-made helmets for children with seizure disorders or who are recovering from cranial surgery	
Home Prothrombin Time Monitoring	Yes, See medical policy	See policy: Home Prothrombin Time Monitoring
Lymphedema Pump	Yes, for intractable edema of extremity	
Obdurators	Yes	
Paraffin Bath	No	
Personal Adaptive Equipment (tongs, grabbers, lifters)	No	
Personal Care Utensils (toothbrush, spoon, fork, hairbrush)	No	
Pulse Oximetry	No	
Stethoscope	No	
Sphygmomanometer (Blood Pressure Cuff)	No	
Telephone Alert System	No	
Telephone Arm	No	
Traction Equipment home, bed, or over the door only	Yes	

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Category / Equipment	Coverage Comments	Related or Specific Policy
Wigs	No	

**Additional Information on Specific Items & Issues**

**Blood Pressure Monitors and Stethoscopes:**

VCHCP does not cover blood pressure monitors (sphygmomanometers, blood pressure cuffs) or stethoscopes for home use, except for home hemodialysis or home peritoneal dialysis patients with end stage renal disease. Home blood pressure monitors and stethoscopes do not meet our definition of covered durable medical equipment in that they may be of use in the absence of illness and injury.

**Exercise Equipment:**

VCHCP does not cover exercise equipment. These devices are not considered to be durable medical equipment under CMS’s guidelines. In addition, VCHCP excludes from coverage items that are not primarily medical in nature, and/or those that are normally of use to persons who do not have a disease or injury.

Examples of exercise equipment that are excluded from coverage: Abdominal exercisers (AB-BLASTER), Ankle exercisers (e.g., Ankl-Izer), Balance beams, Computerized home exercise equipment (e.g., ERGYS Home Rehabilitation System, REGYS Clinical Rehabilitation System), Dumbbells, Exercise bikes (e.g., Limb-O-Cycle, Ergometer Cycle, Bicycle Exerciser), Foot inversion treads, Hand exercisers (e.g., Fitness Power Grip), Home exercise equipment (e.g., Upper Body Power Trainer, Basic Power Trainer), Incline mats, Inversion bars, Parallel bars, Rowing machines, Stairs, Stimulation boards, Thigh exercisers (e.g., ThighMaster, Kegelmaster), Wrist exercisers (e.g., Thera-Plast), Training balls, Treadmill exerciser (e.g., Jogger Treadmill, Jogacisor), Weight belt, Weighted quad boots

**Pacemaker Monitors:**

VCHCP covers self-contained pacemaker monitors for patients with cardiac pacemakers. These include the following types:

1. Digital electronic pacemaker monitors -- these devices provide the patient with an instantaneous digital readout of his/her pacemaker pulse rate.
2. Audible/visible signal pacemaker monitors -- these devices produce an audible and visible signal that indicates the pacemaker rate.

A specialized telephone attachment for trans-telephonic transmission of pacemaker monitoring results is also covered. The Pace Trac is an example of a pacemaker monitor currently on the market.

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A pacemaker controls cardiac arrhythmias by repeated electrical stimulation of the heart. Pacemaker monitoring equipment is needed to detect impending battery failure and to monitor the performance of the pacemaker. The design of the self-contained pacemaker monitor makes it possible for the patient to monitor his or her pacemaker periodically and minimizes the need for regular visits to the outpatient department of the provider.

**Pillows:**

VCHCP does not cover most therapeutic pillows and cushions because they do not meet the durability requirement for covered durable medical equipment and because they are not primarily medical in nature and not mainly used in the treatment of disease or injury. Cushions may be covered if they are an integral part of, or a medically necessary accessory to, covered durable medical equipment. See, e.g., CPB on Wheelchairs (wheelchair seat cushions are covered to prevent or treat severe burns or decubiti).

**Pulse Tachometers:**

VCHCP does not cover pulse tachometers (pulse rate monitors, heart rate monitors), as they are not medically necessary for monitoring the pulse of homebound patients with or without a cardiac pacemaker. In addition, they do not meet our definition of covered durable medical equipment in that they are not primarily medical in nature and are normally of use in the absence of illness or injury. Examples of brand names of pulse tachometers include the Exersentry, the Insta-Pulse, and the MacLevy Omni Pulse.

**PROCEDURE:**

A treatment authorization request (TAR) must be submitted by the provider to VCHCP's UR department for approval.

**Attachment: None**

**History:**

Author/Reviewer: Cynthian Wilhelmy, MD & Sheldon Haas, MD; Date: April/ May 2007

Committee Review: UM on 05/17/07 & QA on 05/22/07

Review/Revised: Albert Reeves, MD; Date: 08/11/11

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Committee Review: UM: February 20, 2025; QAC: February 25, 2025

**References:**

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<b>Revision Date</b>	<b>Content Revised (Yes/No)</b>	<b>Contributors</b>	<b>Review/Revision Notes</b>
2/9/17	No	Catherine Sanders, MD; Robert Sterling, MD	Annual Review
2/8/18	No	Catherine Sanders, MD; Robert Sterling, MD	Annual Review
2/14/19	No	Catherine Sanders, MD; Robert Sterling, MD	Annual Review
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2/2/23	No	Howard Taekman, MD; Robert Sterling, MD	Annual Review
8/10/23	Yes	Howard Taekman, MD; Robert Sterling, MD	Made the following updates:  <ul style="list-style-type: none"> <li>• Added this after the first paragraph: “Note: Many DME items can be purchased over-the-counter</li> </ul>

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			<p>(OTC), with or without a prescription. Be sure to check for OTC availability when reviewing any DME requests”.</p> <ul style="list-style-type: none"> <li>• Titled the Coverage list near the end of the document <b>‘Appendix A’</b> and added the following at the beginning of the document: “NOTE: Refer to Appendix A (Chart of DME Coverage) at the end of this document.</li> <li>• Added this near the top of the document: “NOTE: There is a separate policy for Hospital Beds and Accessories</li> </ul>
2/8/24	No	Howard Taekman, MD; Robert Sterling, MD	Annual Review
2/20/25	Yes	Howard Taekman, MD; Robert Sterling, MD; Faustine Dela Cruz, RN; Gia Zabala RN	Added “Examples include wheelchairs, hospital beds, traction equipment, walkers ventilators, oxygen, monitors, pressure mattresses, lifts, nebulizers, bilirubin blankets and bilirubin lights. Removed duplicates of



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			sentences and reimbursement language not applicable. Added conditional considerations for tub stool or bench, raised toilet seats
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