DURABLE MEDICAL EQUIPMENT (DME) GUIDELINES

Effective: November 15, 2024

VERSION 2.0.2024

EviCore
By EVERNORTH

EviCore healthcare Clinical Decision Support Tool Diagnostic Strategies: This tool addresses common symptoms and symptom complexes. Imaging requests for individuals with atypical symptoms or clinical presentations that are not specifically addressed will require physician review. Consultation with the referring physician, specialist and/or individual's Primary Care Physician (PCP) may provide additional insight.

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Administrative Guidelines

Guideline Page

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Durable Medical Equipment (DME) General Criteria

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HCPCS Codes

All

DME, Prosthetics, Orthotics, and Supplies - General Criteria

Clinical Information to Establish Medical Necessity

Current clinical information is necessary for determining the medical necessity of durable medical equipment, prosthetics, orthotics and supplies including **all** of the following:

- Information provided has clinical relevance to the request
- A pertinent clinical evaluation, or meaningful technological contact (telehealth visit, telephone call, electronic mail or messaging) is required including **both**:
  - A relevant history and physical (symptoms, laboratory results, imaging reports)
  - Medical treatments relevant to the request (medication records, therapy records)

Medical necessity cannot be supported if the provided information makes no reference to the indication for the request.

Requests for equipment when same or similar equipment has already been placed is not supported without clear documentation that fulfills guideline criteria.

Base DME Items and Accessories: When medical necessity for a base item of durable medical equipment has not been met, any accessories that are requested to use with the base item are also not considered medically necessary.

Same or Similar DME, Prosthetics, and Orthotics

Overutilization of durable medical equipment, prosthetics and orthotics occurs when HCPCS codes for same or similar devices are requested in one case or within a short time frame. This can result in unnecessary duplication. As an example, two oxygen concentrators that have the same purpose have been requested at the same time when only one is medically necessary.

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Same or Similar Durable Medical Equipment

Duplication of same or similar durable medical equipment, prosthetics and orthotics within the same case is not medically necessary.

Same or similar durable medical equipment, prosthetics and orthotics may only be indicated when **one** of the following applies:

- The individual has a change in medical condition resulting in the need for a new device
- The individual has a new medical diagnosis resulting in the need for an additional device
- Medical necessity criteria for replacement have been met

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Replacement and Continued use of DME

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Replacement and Continued use of DME - Criteria

- Continued durable medical equipment (DME) rental after initial rental period can be approved when **ALL** of the following apply:
  - Individual has been re-evaluated by treating practitioner
  - Documentation of continued use and medical need
- Replacement of DME can be approved when **all** of the following apply:
  - Individual has been evaluated by treating practitioner
  - There is documentation of continued medical need
  - There is documentation of **one** of the following:
    - Device has been lost or stolen
    - Device is no longer effective due to significant change in patient condition
    - Device is not operating **both**:
      - DME supplier has physically evaluated the device and determined that it is unable to be repaired
      - Device to be replaced is no longer covered under a warranty

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General Clinical Use and Supplies

Guideline Page

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Custom Fabricated Devices

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Custom Fabricated Device Criteria

Custom-fabricated equipment, prosthetics and orthotics may be indicated when basic coverage criteria have been met and there is documentation of any **one** of the following:

- Deformity precludes use of prefabricated device
- Body type precludes use of prefabricated device
- Need for stabilization that cannot be met with a prefabricated device
- Failed trial of prefabricated device

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Custom Fit DME

DME.CU.102.A
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Custom Fit DME Criteria

Custom-fit equipment, prosthetics and orthotics may be indicated when basic coverage criteria have been met and there is documentation of **one** of the following:

- Deformity precludes use of standard fitting
- Body type precludes use of standard fitting
- Need for stabilization that cannot be met with a standard fitting
- Failed trial of device with standard fitting

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Standing Frames

DME.CU.104.A
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HCPCS Codes

E0638, E0641, E0642

Standing Frames - Criteria

A standing frame is indicated when there is documentation of **all** of the following:

- Inability to stand without support as a result of muscle tone abnormalities or decreased motor control
- Inability to ambulate
- Individual is under the care of a physician trained to evaluate function, rehabilitation and the neuromuscular system
- Device is prescribed by physician for daily home use
- Device will be used for at least 12 months
- Individual has had a trial of the device and can tolerate being upright
- Individual and/or caregiver can operate the device

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Cranial Hair Prosthesis (wig)

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A cranial hair prosthesis is a prosthetic appliance for hair loss that is used to conceal baldness.

HCPCS Codes

A9282

Cranial Hair Prosthesis (wig) - Criteria

A cranial hair prosthesis is indicated when an individual has hair loss due to **any** of the following conditions:

- Burns causing permanent alopecia
- Chemotherapy
- Congenital baldness
- Medication-induced hair loss unresponsive to other treatment
- Infections causing hair loss unresponsive to other treatment
- Lupus
- Radiation therapy
- Traumatic injury
- Other documented medical conditions that result in hair loss

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Home Care

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Hospital Beds

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HCPCS Codes

E0250, E0261, E0290, E0291, E0328, E0255, E0256, E0292, E0293, E0260, E0261, E0294, E0295, E0329, E0265, E0266, E0296, E0297, E0301, E0303, E0302, E0304

Hospital Beds - Criteria

Fixed Height Hospital Bed

HCPCS (E0250, E0261, E0290, E0291, E0328)

- A fixed height hospital bed is indicated when **one** the following applies:
  - The individual requires body positioning that is not feasible with a standard bed
  - The individual has a medical condition that requires the head of the bed to be elevated 30 degrees or more
  - The individual requires specialized equipment that can only be attached to a hospital bed

Variable Height Hospital Bed

HCPCS (E0255, E0256, E0292, E0293)

- A variable height hospital bed is indicated when there is documentation of **both** of the following:
  - The individual requires a different bed height for transfers to chair, wheelchair or standing position
  - **One** or more of the following applies:
    - The individual requires body positioning that is not feasible with a standard bed
    - The individual has a medical condition that requires the head of the bed to be elevated 30 degrees or more
    - The individual requires specialized equipment that can only be attached to a hospital bed

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Semi-electric Hospital Bed

HCPCS Codes (E0260, E0261, E0294, E0295, E0329)

- A semi-electric hospital bed is indicated when there is documentation of **both** of the following:
  - The individual requires frequent changes in body position or has an urgent need for a change in body position
  - **One** the following applies:
    - The individual requires body positioning that is not feasible with a standard bed
    - The individual has a medical condition that requires the head of the bed to be elevated 30 degrees or more
    - The individual requires specialized equipment that can only be attached to a hospital bed

Total Electric Hospital Bed

HCPCS Codes (E0265, E0266, E0296, E0297)

A total electric hospital bed is indicated when there is documentation of **all** of the following:

- The individual requires frequent changes in body position and/or has an urgent need for a change in body position
- The electric adjustable bed height is needed for independent transfers
- **One** or more of the following applies:
  - The individual requires body positioning that is not feasible with a standard bed
  - The individual has a medical condition that requires the head of the bed to be elevated 30 degrees or more
  - The individual requires specialized equipment that can only be attached to a hospital bed

Heavy Duty Extra Wide Hospital Bed

HCPCS Codes (E0301, E0303)

A heavy duty extra wide hospital bed is indicated when there is documentation of **both** of the following:

- The individual weighs more than 350 pounds but does not exceed 600 pounds
- **One** or more of the following applies:
  - The individual requires body positioning that is not feasible with a standard bed
  - The individual has a medical condition that requires the head of the bed to be elevated 30 degrees or more

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- The individual requires specialized equipment that can only be attached to a hospital bed

Extra Heavy Duty Hospital Bed

HCPCS Codes (E0302, E0304)

An extra heavy duty hospital bed is indicated when there is documentation of **both** of the following:

- The individual weighs more than 600 pounds
- **One** or more of the following applies:
  - The individual requires body positioning that is not feasible with a standard bed
  - The individual has a medical condition that requires the head of the bed to be elevated 30 degrees or more
  - The individual requires specialized equipment that can only be attached to a hospital bed

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Mobility

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Manual Wheelchairs and Accessories

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Definitions

Mobility	The ability to move about in one's environment
Activities of daily living (ADLs)	Activities required for personal care including toileting, feeding, dressing, grooming and bathing

HCPCS Codes

Paragraph

Manual Wheelchairs

Standard Wheelchair (HCPCS K0001)

A standard wheelchair may be indicated when **all** of the following apply:
- The individual has limited mobility that affects mobility-related activities of daily living (MRADLs)
- The individual's mobility needs cannot be met with a cane, walker or crutches
- The individual or caregiver can propel the wheelchair
- The individual's home has access and space for the wheelchair
- The wheelchair will be used in the home

Hemi Wheelchair (HCPCS K0002)

A hemi wheelchair may be indicated when **all** of the following apply:
- The individual has limited mobility that affects mobility-related activities of daily living (MRADLs)
- The individual's mobility needs cannot be met with a cane, walker or crutches
- The individual or caregiver can propel the wheelchair
- The individual needs a low seat height due to (**any**):
  - Short stature
  - To enable patient's feet to touch the ground for self-propulsion
- The patient's home has access and space for the wheelchair
- The wheelchair will be used in the home

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Lightweight Wheelchair (HCPCS K0003)

A lightweight wheelchair may be indicated when **all** of the following apply:

- The individual has limited mobility that affects mobility-related activities of daily living (MRADLs)
- The individual's mobility needs cannot be met with a cane, walker or crutches
- The individual cannot propel a standard wheelchair
- The individual can propel a lightweight wheelchair
- The individual's home has access and space for the wheelchair
- The wheelchair will be used in the home

High Strength Lightweight Wheelchair (HCPCS K0004)

A high strength lightweight wheelchair may be indicated when **all** of the following apply:

- The individual has limited mobility that affects mobility-related activities of daily living (MRADLs)
- The individual's mobility needs cannot be met with a cane, walker or crutches
- The individual will spend at least 2 hours per day in the wheelchair
- The individual can propel the high strength lightweight wheelchair
- The individual can propel the wheelchair while engaging in activities at home that cannot be accommodated by a standard, lightweight or hemi wheelchair OR the individual requires a seat depth, height or width that cannot be accommodated by a standard, lightweight or hemi wheelchair
- The individual's home has access and space for the wheelchair
- The wheelchair will be used in the home

Ultra Lightweight Wheelchair (HCPCS K0005)

An ultra lightweight wheelchair may be indicated when **all** of the following apply:

- The individual has limited mobility that affects mobility-related activities of daily living (MRADLs)
- The individual's mobility needs cannot be met with a cane, walker or crutches
- The individual or a caregiver can propel the wheelchair
- The individual must use the wheelchair full-time
- The individual must require unique fitting and adjustments that cannot be provided by another wheelchair type
- The individual must have a wheelchair specialty evaluation performed by a medical professional with specific training and expertise in wheelchair assessments
- The individual's home has access and space for the wheelchair
- The wheelchair will be used in the home

Heavy Duty Wheelchair (HCPCS K0006)

A heavy duty wheelchair may be indicated when **all** of the following apply:
- The individual has limited mobility that affects mobility-related activities of daily living (MRADLs)
- The individual's mobility needs cannot be met with a cane, walker or crutches
- The individual or caregiver can propel the wheelchair
- The individual's home has access and space for the wheelchair
- The wheelchair will be used in the home
- The individual weighs more than 250 pounds or has severe spasticity

Extra Heavy Duty Wheelchair (HCPCS K0007)

An extra heavy duty wheelchair may be indicated when **all** of the following apply:
- The individual has limited mobility that affects mobility-related activities of daily living (MRADLs)
- The individual's mobility needs cannot be met with a cane, walker or crutches
- The individual or caregiver can propel the wheelchair
- The individual's home has access and space for the wheelchair
- The wheelchair will be used in the home
- The individual weighs more than 300 pounds

Manual Wheelchair with Tilt in Space (HCPCS E1161)

A manual wheelchair with tilt in space may be indicated when **all** of the following apply:
- The individual has limited mobility that affects mobility-related activities of daily living (MRADLs)
- The individual's mobility needs cannot be met with a cane, walker or crutches
- The individual or caregiver can propel the wheelchair
- The individual's home has access and space for the wheelchair
- The wheelchair will be used in the home
- The individual must have a wheelchair specialty evaluation performed by a medical professional with specific training and expertise in wheelchair assessments
- The individual has documented medical or functional impairments that would preclude the use of a wheelchair without the tilt feature

Transport Wheelchair (HCPCS E1037, E1038, or E1039)

A transport wheelchair may be indicated when **all** of the following apply:
- The individual has limited mobility that affects mobility-related activities of daily living (MRADLs)
- The individual's mobility needs cannot be met with a cane, walker or crutches

- The individual's caregiver can propel the wheelchair
- The individual's home has access and space for the wheelchair
- The wheelchair will be used in the home
- There is documentation why a standard wheelchair would not be appropriate for the individual

Wheelchair Accessories

Adjustable Height Arm Rests (HCPCS E0973, K0017, K0018, K0020)

Adjustable height wheelchair arm rests may be indicated when **both** of the following apply:

- Medical necessity criteria for a manual wheelchair have been met
- The patient has a medical or functional reason for the standard wheelchair arm height and spends 2 hours or more in the wheelchair each day

Elevating Leg Rests (HCPCS E0990, K0046, K0047, K0053, K0195)

Elevating wheelchair leg rests may be indicated when **both** of the following apply:

- Medical necessity criteria for a manual wheelchair have been met
- The individual has **one** of the following:
  - Lower extremity edema
  - A condition that prevents 90 degree flexion at the knee
  - A reclining wheelchair back

Nonstandard Seat Frame (HCPCS E2201, E2202, E2203, E2204)

A nonstandard wheelchair seat frame may be indicated when **both** of the following apply:

- Medical necessity criteria for a manual wheelchair have been met
- The patient has physical dimensions that preclude the use of a standard frame

Manual Fully Reclining Back (HCPCS E1226)

A manual fully reclining wheelchair back may be indicated when **both** of the following apply:

- Medical necessity criteria for a manual wheelchair have been met
- The individual has **one** of the following:
  - not perform a functional weight shift
  - Individual uses intermittent catheterization for bladder management and cannot independently transfer from wheelchair to bed

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Power Operated Vehicles Guideline

DME.WC.109.A
v2.0.2024

HCPCS Codes

K0800, K0801, K0802, K0806, K0807, K0808, K0812

Power Operated Vehicles Guidelines

Definitions

Mobility	The ability to move about in one's environment
Activities of daily living (ADL's)	Activities required for personal care including toileting, feeding, dressing, grooming and bathing
Power operated vehicle	A 3- or 4-wheeled motorized mobility device with tiller steering and limited seat modification capabilities that is used for people with mobility limitations

Standard Group 1 POV (K0800)

- A standard group 1 power operated vehicle may be indicated when **all** of the following apply:
  - The patient has limited mobility that affects mobility-related activities of daily living (MRADLs)
  - The patient's mobility needs cannot be met with a cane, walker or crutches
  - The patient cannot propel a manual wheelchair
  - The patient can safely and independently control the power operated vehicle
  - The patient can safely transfer into and out of the power operated vehicle
  - The patient's home has access and space to maneuver the power operated vehicle

Heavy Duty Group 1 POV (K0801)

A heavy duty group 1 power operated vehicle may be indicated when **all** of the following apply:

- The patient has limited mobility that affects mobility-related activities of daily living (MRADLs)
- The patient's mobility needs cannot be met with a cane, walker or crutches

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- The patient cannot propel a manual wheelchair
- The patient can safely and independently control the power operated vehicle
- The patient can safely transfer into and out of the power operated vehicle
- The patient's home has access and space to maneuver the power operated vehicle
- The patient weighs 301 to 450 pounds

Very Heavy Duty Group 1 POV (K0802)

A very heavy duty group 1 power operated vehicle may be indicated when **all** of the following apply:

- The patient has limited mobility that affects mobility-related activities of daily living (MRADLs)
- The patient's mobility needs cannot be met with a cane, walker or crutches
- The patient cannot propel a manual wheelchair
- The patient can safely and independently control the power operated vehicle
- The patient can safely transfer into and out of the power operated vehicle
- The patient's home has access and space to maneuver the power operated vehicle
- The patient weighs 451 to 600 pounds

Standard Group 2 POV (K0806)

- A standard group 2 power operated vehicle may be indicated when **all** of the following apply:
  - The patient has limited mobility that affects mobility-related activities of daily living (MRADLs)
  - The patient's mobility needs cannot be met with a cane, walker or crutches
  - The patient cannot propel a manual wheelchair
  - The patient can safely and independently control the power operated vehicle
  - The patient can safely transfer into and out of the power operated vehicle
  - The patient's home has access and space to maneuver the power operated vehicle
  - There is documentation of a medical reason why a group 1 power operated vehicle cannot be used in the home

Heavy Duty Group 2 POV (K0807)

A heavy duty group 2 power operated vehicle may be indicated when **all** of the following apply:

- The patient has limited mobility that affects mobility-related activities of daily living (MRADLs)
- The patient's mobility needs cannot be met with a cane, walker or crutches
- The patient cannot propel a manual wheelchair
- The patient can safely and independently control the power operated vehicle

- The patient can safely transfer into and out of the power operated vehicle
- The patient's home has access and space to maneuver the power operated vehicle
- The patient weighs 301 to 450 pounds
- There is documentation of a medical reason why a group 1 power operated vehicle cannot be used in the home

Very Heavy Duty Group 2 POV (K0808)

A very heavy duty group 2 power operated vehicle may be indicated when **all** of the following apply:

- The patient has limited mobility that affects mobility-related activities of daily living (MRADLs)
- The patient's mobility needs cannot be met with a cane, walker or crutches
- The patient cannot propel a manual wheelchair
- The patient can safely and independently control the power operated vehicle
- The patient can safely transfer into and out of the power operated vehicle
- The patient's home has access and space to maneuver the power operated vehicle
- The patient weighs 451 to 600 pounds
- There is documentation of a medical reason why a group 1 power operated vehicle cannot be used in the home

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Skin Protection Wheelchair Cushion

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HCPCS Codes

E2603, E2604, E2622, E2523

Skin Protection Wheelchair Cushion

- Skin protection wheelchair cushion is indicated when **both**:
  - The patient has a manual or power wheelchair with a sling/solid seat/back and basic wheelchair coverage criteria have been met
  - The individual has **one** of the following:
    - Current pressure ulcer or history of pressure ulcer in the area of contact with the seating surface
    - Absent or impaired sensation in area of contact with the seating surface or inability to perform a functional weight shift

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Power Wheelchair Repairs and Replacement Accessories

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HCPCS Codes

E2359, E2361, E2363, E2365, E2371, K0733,E2366, E2367, E2397, E2358, E2360, E2362, E2364, E2372, E1002, E1003, E1004, E1005, E1006, E1007, E1008, E1009, E1010, E1012, K0739, K0839, K0840, K0843, K0860, K0861, K0862, K0863, K0864, K0890, K0891, E1399, K0669, A9900, A9999, E0978, E1028, E2351, K0015, K0017, K0018, K0019, K0020, E2209, E0973, E0951, E0952, E0954, E0990, E0995, E1020, K0037, K0038, K0039, K0040, K0041, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052, K0053, E2367, E2366, E2300, E2301, E2310, E2311, E2312, E2313, E2321, E2322, E2323, E2324, E2325, E2326, E2327, E2328, E2329, E2330, E2331, E2373, E2374, E2375, E2376, E2377, E1016, E1019, E2351, E2368, E2369, E2370, E2378, E2381, E2382, E2383, E2384, E2385, E2386, E2387, E2388, E2389, E2390, E2391, E2392, E2394, E2395, E2396, K0098, E0705, E0950, E0978, E0981, E0982, E1029, E1030, E2207, E2208, K0105, K0108

Power Wheelchair Repairs and Replacement Accessories - Criteria

- Power wheelchair repairs and replacement accessories may be indicated when **both** of the following apply:
  - The patient uses a medically necessary power wheelchair
  - There is documentation of a problem with the wheelchair and/or accessories that impact its ability to function

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Musculoskeletal

Guideline Page

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Pediatric Foot Orthotics and Orthopedic Shoes

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This policy applies to patients under the age of 18

HCPCS Codes

A9283, L3000, L3001, L3002, L3003, L3010, L3020, L3030, L3031, L3040, L3050, L3060, L3070, L3080, L3090, L3100, L3140, L3150, L3160, L3201, L3202, L3203, L3204, L3206, L3207, L3209, L3211, L3212, L3214, L3215, L3216, L3217, L3219, L3221, L3222, L3224, L3225, L3230, L3250, L3251, L3252, L3253, L3254, L3255, L3257, L3260, L3300, L3310, L3320, L3330, L3332, L3334, L3340, L3350, L3360, L3370, L3380, L3390, L3400, L3410, L3420, L3430, L3440, L3450, L3455, L3460, L3465, L3470, L3480, L3485, L3500, L3510, L3520, L3530, L3540, L3550, L3560, L3570, L3580, L3590, L3595, L3600, L3610, L3620, L3630, L3640, L3649

Pediatric Foot Orthotics and Orthopedic Shoes - Criteria

Foot orthotics and/or orthopedic shoes can be approved for pediatric patients when there is documentation of **one** or more of the following conditions:

- A foot or ankle deformity
- Abnormal foot or ankle range of motion
- Foot or ankle weakness
- Cerebral palsy with abnormal gait
- Juvenile arthritis

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Static Upper Extremity Orthoses

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HCPCS Codes

L3650, L3660, L3670, L3671, L3674, L3675, L3676, L3677, L3678, L3702, L3710, L3720, L3730, L3740, L3760, L3761, L3762, L3763, L3764, L3765, L3766, L3806, L3807, L3808, L3809, L3891, L3900, L3901, L3904, L3905, L3906, L3908, L3912, L3913, L3915, L3916, L3917, L3918, L3919, L3921, L3923, L3924, L3925, L3927, L3929, L3930, L3931, L3933, L3935, L3956, L3960, L3961, L3962, L3967, L3971, L3973, L3975, L3976, L3977, L3978, L3980, L3981, L3982, L3984, L3995, L3999

General Information

Orthosis is an external device used to stabilize or immobilize a body part, prevent or correct deformity, protect healing tissues, treat injury and increase function

The following upper extremity orthoses are covered by these criteria
- shoulder
- shoulder-elbow
- shoulder-elbow-wrist-hand
- elbow
- elbow-wrist-hand
- elbow-wrist-hand-finger
- wrist-hand-finger
- wrist-hand
- hand-finger
- finger

Static Upper Extremity Orthosis - Criteria

A static upper extremity orthosis can be approved for an individual with documentation of **both** of the following:
- **One** of the following conditions is present:
  - A recent injury or surgery
  - Arthritis
  - Peripheral nerve compression
  - Epicondylitis
  - A fracture

- Tenosynovitis or tendinitis
- A medical condition resulting in upper extremity paresis, paralysis or muscle weakness
- An upper extremity contracture and **both** of the following:
  - There has been no or minimal progress with occupational or physical therapy
  - The patient's function is affected
- Spasticity and **both** of the following:
  - The patient's function is affected
  - Botulinum toxin injections are being used or have been discussed with the patient and/or caregiver

• Therapy or exercise is included in the plan of care

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Spinal Orthoses (Lumbar Sacral and Thoraco Lumabar Sacral)

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v2.0.2024

HCPCS Codes

L0450, L0452, L0454, L0455, L0456, L0457, L0458, L0460, L0462, L0464, L0466, L0467, L0468, L0469, L0470, L0472, L0480, L0482, L0484, L0486, L0488, L0490, L0491, L0492, L0621, L0622, L0623, L0624, L0625, L0626, L0627, L0628, L0629, L0630, L0631, L0632, L0633, L0634, L0635, L0636, L0637, L0638, L0639, L0640, L0641, L0642, L0643, L0648, L0649, L0650, L0651

Spinal Orthoses (Lumbar Sacral and Thoraco Lumabar Sacral) - Criteria

A spinal orthosis may be indicated when **one** of the following applies:

- Individual has had an injury to the spine or surrounding soft tissue
- Individual has had surgery on the spine or related soft tissue
- Device will be used to decrease pain by restricting spinal movement
- Individual has a spinal deformity and/or weak spinal muscles

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Respiratory

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High Frequency Chest Wall Oscillation Systems

DME.O2.101.A
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HCPCS Codes

E0483, A7025, A7026

High Frequency Chest Wall Oscillation Systems - Criteria

A high frequency chest wall oscillation system is indicated when **both** of the following apply:

- There is documentation of **one** of the following:
  - The individual has neuromuscular disease
  - The individual has cystic fibrosis

    The individual has bronchiectasis on imaging with **either:**
    - Daily productive cough
    - Frequent exacerbations requiring antibiotics
- The individual has had failure of, intolerance to, or contraindication to standard treatments such as chest percussion and/or postural drainage

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Skin and Wound Care

Guideline Page

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Pneumatic Compression Devices

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HCPCS Codes

E0650, E0651, E0652, E0655, E0660, E0665, E0666, E0667, E0668, E0669, E0670, E0671, E0672, E0673, E0675 (only for PAD), E0676 (only for DVT prevention)

Pneumatic Compression Devices - Criteria

Basic Pneumatic Compression Device

HCPCS codes (E0650, E0651)

- A basic pneumatic compression device is indicated when **one** of the following applies:
  - The individual has documented, symptomatic lymphedema and **both**:
    - Has documented skin changes or measurements have been taken over time
    - Has failed 4 or more weeks of conservative treatments (ie compression garment or bandage, exercise and limb elevation, manual lymphatic drainage)
  - The individual has venous insufficiency with venous leg ulcers and **either**:
    - 6 months of compression treatment have failed
    - The individual cannot tolerate compression treatment

Pneumatic Compression Device with Calibrated Gradient Pressure

HCPCS codes (E0652)

A pneumatic compression device with calibrated gradient pressure is indicated when **all** of the following apply:

- The individual has lymphedema extending to the chest, trunk and/or abdomen
- The individual has documented, symptomatic lymphedema and **both** of the following:
  - Has documented skin changes or measurements have been taken over time
  - Has failed 4 or more weeks of conservative treatments (i.e., compression garment or bandage, exercise and limb elevation, manual lymphatic drainage)

Pneumatic Compression Device

HCPCS codes (E0676)

A pneumatic compression device may be indicated when **both** of the following apply:

- The pump will be used to prevent deep venous thrombosis in an immobile individual

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- There is a clinical reason that anticoagulation alone would not be effective

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Group 2 Pressure Reducing Support Surfaces

DME.SW.103.A
v2.0.2024

HCPCS Codes

E0193, E0277, E0371, E0372, E0373

Group 2 Support Surface Criteria

Group 2 Support Surfaces may be indicated when there is documentation of the one of the following:

- Multiple stage 2 pressure ulcers on the trunk or pelvis and **both**:
  - There is documentation of a comprehensive ulcer treatment program. A comprehensive ulcer treatment program includes **all** of the following elements:
    - Regular assessment by a physician, nurse, practitioner, or other licensed healthcare provider
    - Appropriate turning and positioning
    - Appropriate wound care
    - Management of moisture/incontinence
    - Nutritional assessment and treatment
  - There is documentation of **one** of the following:
    - Group 1 support surface tried and failed
    - Group 1 support surface contraindicated
- One or more stage 3 or stage 4 pressure ulcers on the trunk or pelvis
- A myocutaneous flap or a skin graft for a pressure ulcer of the trunk or pelvis within the last 60 days

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Negative Pressure Wound Therapy

DME.SW.105.A
v2.0.2024

HCPCS Codes

A6550, A7000, E2402

Negative Pressure Wound Therapy Continued Rental - Criteria

Continued rental of negative pressure wound therapy is indicated when **all** of the following apply:

- There is documentation that wound healing is progressing
- There is monthly documentation of wound length, width and depth
- There is physician documentation of proper use and continued benefit

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Stimulators

Guideline Page

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Transcutaneous Electrical Nerve Stimulation (TENS) Unit

DME.ST.112.A
v2.0.2024

Transcutaneous Electrical Nerve Stimulation (TENS) Unit - Criteria

A transcutaneous electric nerve stimulation (TENS) unit is a medical device that sends electrical currents to affect pain signals, resulting in pain relief.

HCPCS Codes

E0720, E0730, A4557, A4595 , K1023

2 Lead TENS Unit

HCPCS Codes (E0720, A4557, A4595)

A 2 lead TENS unit is indicated when **either**:

- The individual has acute post-operative pain and **both** of the following:
  - There have been 30 days or less since surgery
  - The TENS unit will be used in addition to or in place of medication
- The individual has chronic intractable pain other than low back pain and **all** of the following:
  - The pain has lasted at least 3 months
  - Other standard treatments have been tried and failed
  - A 30 day trial period has taken place

4 Lead TENS Unit

HCPCS Codes (E0730, A4557, A4595)

A 4 lead TENS unit is indicated when **either**:

- The individual has acute post-operative pain and **all** of the following:
  - There have been 30 days or less since surgery
  - The TENS unit will be used in addition to or in place of medication
  - There is a medical reason why a 2 lead unit cannot meet the individual's needs
- The individual has chronic intractable pain other than low back pain and **all** of the following:

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- The pain has lasted at least 3 months
- Other standard treatments have been tried and failed
- A 30 day trial period has taken place
- There is a medical reason why a 2 lead unit cannot meet the individual's needs

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Electrical Bone Growth Stimulation (Spine)

DME.ST.109.A
v2.0.2024

HCPCS Codes

E0748

Electrical Bone Growth Stimulation (Spine) - Criteria

Indications

- Noninvasive (beginning at any time from the time of surgery until up to 6 months after surgery with the exception of this timeline for an urgent/emergent condition for spinal fusion surgery excluding primary or metastatic neoplastic disease) electrical bone growth stimulation may be considered medically necessary for spinal fusion surgery in patients at high risk for pseudarthrosis with **one or more** of the following risk factors for fusion failure when associated with an approved spinal fusion surgery:
  - Alcohol Use Disorder (AUD)
  - Body mass index (BMI) > 30
  - Diabetes, renal disease, or other metabolic diseases when bone healing is likely to be compromised
  - Glucocorticoid dependent
  - Meyerding Grade III or worse lumbar/lumbosacral spondylolisthesis
  - Multi-level spinal fusion including three (3) or more vertebrae
  - Nutritional deficiency/malnutrition
  - One or more previously failed spinal fusion(s)
  - Osteoporosis defined as T-score of -2.5 on a recent (within one year) DEXA
  - Severe anemia
  - Smoking history
  - Immunocompromised status
- Noninvasive electrical bone growth stimulation is considered medically necessary as a treatment for patients with failed spinal fusion when **both** of the following are met:
  - A minimum of 6 months has passed since the date of the original surgery
  - Serial plain X-rays or appropriate imaging studies confirm there is no evidence of progression of healing/consolidation of the spinal fusion for 3 months during the later portion of the 6 month post-fusion surgery period

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- Urgent/emergent conditions for spine fusion surgery are exceptions to the above timelines for noninvasive electrical bone growth stimulation excluding primary or metastatic neoplastic disease

Non-Indications

Noninvasive electrical bone growth stimulation is considered experimental, investigational, or unproven (EIU) for **all** of the following:

- Acute or chronic lumbar spondylolysis (pars interarticularis defect) with or without spondylolisthesis
- Failed cervical or lumbar disc arthroplasty
- Spinal malignancy
- As nonsurgical treatment of an established pseudarthrosis

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Non-Spinal Electrical Osteogenesis Stimulator

DME.ST.110.A
v2.0.2024

HCPCS Codes

E0747

Definitions

Electrical osteogenesis stimulator	An electrical osteogenesis stimulator is a medical device that provides electrical stimulation to enhance bone healing
Non-union fracture	Failure of healing after a broken bone
Congenital pseudoarthrosis	Rare condition that can result in non-union, most frequently of the tibia

Non-Spinal Electrical Osteogenesis Stimulator - Criteria

A non-spinal electrical bone stimulator is indicated when **one** of the following applies:

- Individual has a non-spinal nonunion fracture with no progress in bone healing on repeat imaging studies
- Individual has a failed non-spinal surgical joint fusion
- Individual has congenital pseudoarthrosis

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