MEDICAL POLICY

POLICY TITLE	DURABLE MEDICAL EQUIPMENT AND SUPPLIES
POLICY NUMBER	MP 6.026

CLINICAL BENEFIT	☐ MINIMIZE SAFETY RISK OR CONCERN. ☐ MINIMIZE HARMFUL OR INEFFECTIVE INTERVENTIONS. ☐ ASSURE APPROPRIATE LEVEL OF CARE. ☐ ASSURE APPROPRIATE DURATION OF SERVICE FOR INTERVENTIONS. ☒ ASSURE THAT RECOMMENDED MEDICAL PREREQUISITES HAVE BEEN MET. ☐ ASSURE APPROPRIATE SITE OF TREATMENT OR SERVICE.
Effective Date:	**10/1/2025**

POLICY

Durable Medical Equipment (DME) may be considered **medically necessary** when it can be expected to make a meaningful contribution to the treatment of a specific patient's illness or injury or to improve the function of a malformed body part. The continuing need for DME must be verified at least every 12 months.

Below is an item listing used in determining the coverage status of certain pieces of DME. The first column lists the generic or brand name of the DME item and the second column identifies the coverage status of that item. Please refer to the list below or related medical policy if one is referenced.

When DME is considered **medically necessary**, coverage may include:

- The repair, adjustment, or replacement of parts and accessories necessary for the normal and effective functioning of the equipment. Repair and maintenance of rental equipment is the responsibility of the vendor/supplier; or
- The rental charges (not to exceed the contracted price except for certain life sustaining items due to the frequency of maintenance), or the purchase of the item; or
- Replacement of an item when there is a change in the patient's condition; or
- Supplies and accessories necessary for the effective functioning of the DME.
    - Based on actual member usage
    - May be less than the potential maximum allowed
    - Should be documented each billing cycle

The provider requesting/ordering the DME should be a provider the member has an established relationship and is involved in the ongoing care of the member and the condition for which the DME/orthotic is prescribed.

Policy Guidelines

Durable Medical Equipment (DME) consists of items that meet these criteria:

- Primarily and customarily used to serve a medical purpose
- Not useful to a person in the absence of illness or injury
- Ordered by a professional provider within the scope of their license
- Appropriate for use in the home
- Reusable

Except in circumstances of risk of disability or death, there are generally no benefits for replacement DME when repairs are due to equipment misuse and/or abuse or for replacement of lost or stolen items. Replacement due to a change in employment, school or home settings are not eligible unless medically necessary due to change in health condition.

Medical supplies are medical goods that support the provision of therapeutic and diagnostic services but cannot withstand repeated and are disposable or expendable in nature. Benefits for medical supplies include items such as hoses, tubes and mouthpieces that are medically necessary for proper functioning of covered DME.

Not considered DME and therefore will not be covered under this policy. This includes, but is not limited to:

Comfort and convenience items

- Beds-Lounge (power or manual), carafes, elevators, emesis basins, enuresis monitors, hot packs, ice packs, massage pillow, thermocyclopad, overbed tables, rolling chairs, spare tanks of oxygen, and standing table

Equipment used for environmental control

- Air cleaners, air conditioning, dehumidifiers, central heating or cooling systems, humidifiers (room or central heating system types), and portable room heaters

Equipment inappropriate for home use

- Diathermy machines (standard and pulse wave), esophageal dilator, mobile monomatic sanitation system, paraffin bath units (standard), tractomatic electrical intermittent traction unit, hospital grade breast pump

Consumable medical supplies

- Disposable sheets, fabric supports (includes suit therapy device), surgical face masks, surgical stockings

Equipment that is not primarily medical in nature

- Continence supplies, irrigating kit, overtoilet commode, bed lifter, bed boards, exercise equipment, positioning pillow, seat tilt, sauna baths, strollers

Modifications to vehicles, dwellings, and other structures.

- Wheelchair ramps

Duplicate equipment for use when traveling or for an additional residence, whether or not prescribed by a professional provider

Considered DME and may be covered when all the above requirements are met.

DME ITEM	Coverage Status	Associated Coding

Accessories	Reimbursement may be made for the replacement of essential accessories such as hoses, tubes, mouthpieces, etc. for medically necessary DME, only if the individual owns the equipment.	No specific coding
Abdominal binders	Covered when for medical purposes, such as, but not limited to, abdominal surgery or abdominal hernia. Not covered when used for convenience, appearance, or cosmetic purposes.	A4461, A4463
Antiembolism and Gradient Compression Stockings (i.e., Surgical Leggings, Aero-Pulse Surgical Leggings, Jobst, TEDS)	GRADIENT COMPRESSION SURGICAL DRESSING WRAPS/STOCKINGS Gradient compression surgical dressing nonelastic wraps with a pressure between 30- and 50-mm Hg are considered medically necessary and, therefore, covered when prescribed for open venous stasis ulcers and/or surgically created wounds. Gradient compression surgical dressing stockings with a pressure between 30- and 50-mm Hg are considered medically necessary and, therefore, covered when prescribed for open venous stasis ulcers and/or surgically created wounds. ANTIEMBOLISM STOCKINGS Antiembolism (surgical or thrombo-embolic deterrent [TED]) stockings are considered medically necessary and, therefore, covered when they are used to prevent and/or treat conditions such as, but not limited to, deep vein thrombosis. Compression garments that exceed the established frequency limits are not covered.	A6544, A6534, A6535, A6539-A6541, A6530, A6533, A6536, A6537, A6537, A6538, A6531, A6532, A6552, A6553, A6555, A6558, A6559, A6560, A6561, A6562, A6563, A6564, A6554, A6556, A6557, A6610, A4495, A4510, A4490, A4500

Bed Pans (autoclavable hospital type)	Covered if an individual is bed confined.	No specific coding
Canes	Covered if individual's condition impairs ambulation.	E0100, E0105
Commodes (including commode chair on wheels)	Covered if the individual is confined to bed or room (see additional information below). **Note**: The term "room confined" means that the individual's condition is such that leaving the room is medically contraindicated. The accessibility of bathroom facilities generally would not be a factor in this determination. However, confinement of an individual to their home in a case where there is no toilet facilities in the home may be equated to room confinement. Moreover, payment may also be made if an individual's medical condition confines them to a floor of their home and there is no bathroom located on that floor.	E0165, E0163, E0171, E0167, E0168
Commode Chair with Seat Lift Mechanism	**Covered** when **all** of the following are met: • The individual is confined to bed or room (see commodes); **and** The item is prescribed by a provider for an individual with severe arthritis of the hip or knee and for individuals with muscular dystrophy or other neuromuscular diseases when it has been determined that the individual can benefit therapeutically from use of the device.	E0170, E0172
Crutch, underarm, articulating, spring assisted	Covered for individuals with Spinal Bifida, Cerebral Palsy, or spinal cord injury.	E0117

Crutch Substitute, lower leg platform, with or without wheels (e.g. RollerAid)	Covered when ordered by a provider as **medically necessary** and only after bunionectomy, or foot / ankle surgery when the individual must maintain total non-weight bearing of the affected foot for 4 to 6 weeks.	E0118
Crutches	Covered if individual's condition impairs ambulation.	E0110-E0114, E0116
Face Masks (oxygen)	Covered.	A4620
Flow meter	Covered.	A4614
Gait Trainer (Type of walker with upper body support frame)	Basic models (Crocodile type or equivalent for those under 100 lbs. And/or Rifton type or equivalent for all other weights) are covered when ordered by a provider for individuals greater than or equal to two years old that require moderate to maximum support for walking **AND** individual has reciprocal leg motion capability and strength and leg and foot alignment to support upright weight for long periods and therefore can walk with the device.	E8000-E8002
Heating Pads or Heat Lamps	Covered- A heating pad or lamp may be considered **medically necessary** if the provider determines the individual's medical condition is one for which the application of heat in the form of a heating pad or lamp is therapeutically effective.	**Heating Pad:** E0221, E0210, E0215, E0217 **Heat Lamps:** E0205, E0200
Helmet with face guard and soft interface material, prefabricated	Covered when ordered by a provider as **medically necessary** for individuals with seizure or behavior disorders that are at risk for injury to the head and face. For cranial orthosis refer to MP 6.056 Adjustable Cranial Orthoses for Positional Plagiocephaly and Craniosynostoses.	A8000

Home prothrombin Time INR Monitoring Device (CoaguCheck, Protime)	Covered.	G0249
Humidifiers (oxygen)	Covered.	E0560, E0550, E0555
Injectors (hypodermic jet devices for injection of insulin and supplies for self-administered injections)	Covered for diabetic individuals who are unable to use a syringe.	A4210
Intermittent Positive Pressure Breathing (IPPB) Machines	Covered for individuals with asthma, chronic obstructive pulmonary disease (COPD) and other respiratory diseases. individual	E0500
Medical Oxygen Regulators	Covered.	E1352, E1353
Nebulizer	A small volume, non-filtered nebulizer with compressor may be considered medically necessary for the administration for inhaled medications, as per The U.S. Food and Drug Administration (FDA) indications for **ANY** of the following conditions listed below. Pulmonary disease, including, but not limited to: • Chronic bronchitis • Chronic Obstructive Pulmonary Disease (COPD) • Emphysema • Asthma • COVID-19 (Coronavirus Disease 2019), • Bronchiectasis • Persistent thick or tenacious secretions • Croup	E0570, E0575, E0585, E0574, E0580
Non-elastic Binders for Extremities (Circ-aid, Med Assist, Reid Sleeve, Tribute)	Covered for Lymphedema.	A4465

Oxygen	Covered.	E0441-E0444
Oxygen Humidifiers	Covered.	E0560, E0550
Oxygen Regulators (Medical)	Covered.	E1353
Oxygen Tents	Covered.	E0455
Paraffin Bath Units (Portable)	Covered when the individual has undergone a successful trial period of paraffin therapy ordered by a provider and the individual's condition is expected to be relieved by long-term use of this modality. NOTE: Includes coverage of Paraffin when the unit is considered **medically necessary.**	E0235
Patient Lifts Patient lift mechanisms are hydraulic or motorized (electric) lifts that enable the individual to transfer from the bed to a chair or other sitting device, or vice versa.	Covered if the provider determines that the individual's condition is such that periodic movement is necessary to effect improvement or to arrest or retard deterioration in condition. Not covered if it requires home modification.	E0625, E0630, E0621, E0635, E0640, E0627, E0629, E0636, E0639, E0637, E0638, E0641, E0642
Peak Flow Meters	Covered for the diagnosis of Asthma.	S8096, S8110
Pneumatic Cervical Traction Unit	May be considered **medically necessary** when all of the following are met: • Prescribed by a provider or other eligible provider within the scope of their license; **and** • The diagnosis is one or a combination of symptoms below: o Tension headache; **or** o Cervical root lesions; **or** o Cervical spondylosis without myelopathy; **or** o Displacement cervical disc; **or** o Cervical disc degeneration; **or**	E0860

	o Degeneration intervertebral disc, site unspecified; **or** o Cervicalgia; **or** o Cervical radiculopathy; **or** o Cervicocranial syndrome; **or** o Cervicobrachial syndrome; **or** o Osteoarthritis, of the cervical spine localized, primary; **or** o In addition, **one** of the following diagnoses will be considered **medically necessary** with a documented trial of physical therapy: ▪ Osteoarthritis, involving more than one site, but not specified as generalized; **or** ▪ Spinal stenosis unspecified region; **or** ▪ Muscle spasm; **or** ▪ Myofasciitis; **or** ▪ Neuralgia, radiculopathy; **or** ▪ Fasciitis unspecified; **or** ▪ Headache; **or** ▪ Cervical sprain/strain; **or** Spinal stenosis in cervical region.	
Portable Oxygen Systems: ▪ Regulated (adjustable flow rate) Preset (flow rate not adjustable)	Regulated: (adjustable flow rate) - Covered. Preset (flow rate not adjustable): Deny- emergency, or first-aid, equipment; essentially not therapeutic in nature.	E0433, E0431

Positioning Support System (Vitrectomy chair)	Covered for several weeks (up to six weeks) to assist in maintaining a suggested postoperative position following surgery, such as vitrectomy and repair of a retinal tear via intraocular gas.	No specific coding
Postural Drainage Boards	Covered if an individual has a chronic pulmonary condition.	E0606
Pulse Oximeters & replacement probes	Covered when a clear plan is in place for provider endorsed individual-initiated therapy changes based on pulse-ox levels. This includes initial oxygen weaning for newborns after hospital discharge.	E0445, A4606
Rib Belts	Covered when not used for convenience, appearance, or cosmetic purposes.	L0220
Seat Lift (mechanism only)	Covered when prescribed by a provider for **any** of the following indications: • The individual must have severe arthritis of the hip, knee, or severe neuromuscular disease; **or** • The seat lift mechanism must be prescribed to effect improvement, arrest, or retard deterioration in the individual's condition; **or** • The individual must be completely incapable of standing up from a regular armchair or any chair in their home. (*The fact that a individual has difficulty or is incapable of getting up from a chair, particularly a low chair, is not sufficient justification for a seat lift mechanism*); **or** • Once standing, the individual must have the ability to	E0627, E0629, E0621, E0635, E0630

	ambulate. A seat lift mechanism which operates by spring release mechanism with a sudden, catapult-like motion and jolts the individual from a seated to a standing position is considered **investigational.**	
Self-Contained Pacemaker	Covered when prescribed by a provider for an individual with a cardiac pacemaker.	E0615, E0610
Sitz Bath	Covered if the individual has an infection or injury of the perineal area and the item has been prescribed by the individual's provider as a part of their planned regimen of treatment in the individual's home.	E0160-E0162
Spacers	Covered when used to assist the individual in administration of inhaled breathing medications.	S8100, S8101
Standers (Standing Frames)	Non-powered standers or standing frames are considered **medically necessary** if all of the following criteria are met: • The individual has a neuromuscular disease (e.g., cerebral palsy, spasticity, multiple sclerosis, paraparesis, etc.) which results in the inability to stand independently or ambulate, despite use of other assistive devices, and having undergone physical therapy or occupational therapy; **AND** The individual has the necessary lower body residual strength to stand with the assistance of the standing system.	E0642, E0641, E0638, E0637
Strollers, specialized	Customized pediatric strollers are covered for a child who is non-ambulatory when either of the	No specific code

	following conditions applies: • The child requires more support than is available in a standard pediatric wheelchair, **or** • The child is too small to safely use a standard pediatric wheelchair.	
Suction Machine	Covered if the provider determines that the machine specified is medically required and appropriate for home use without technical or professional supervision.	K0743
Traction Equipment	Covered if an individual has orthopedic impairment requiring traction equipment which prevents ambulation during the period of use.	E0860, E0855, E0849, E0840, E0880, E0850, E0900, E0890, E0856, E0870, E0830
Ultrasonic Nebulizer	Covered only where individual is unable to clear bronchopulmonary secretions using a standard nebulizer or when used by an individual with cystic fibrosis.	E0575
Urinals (autoclavable hospital type)	Covered if an individual is bed confined.	E0325, E0326
Vaporizers	Covered if an individual has a respiratory illness.	E0605
Ventilators	Covered for treatment of neuromuscular diseases, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease. Includes both positive and negative pressure types. When the above criteria are met a second ventilator may be **medically necessary** when it is required to	A4611-A4613

	serve a different purpose as determined by the individual's medical needs. Examples (not all-inclusive) of situations in which multiple ventilators may be considered **medically necessary** are: • An individual requires one type of ventilator (e.g., a negative pressure ventilator with a chest shell) for part of the day and needs a different type of ventilator (e.g., positive pressure ventilator with a nasal mask) during the rest of the day. • An individual who is confined to a wheelchair requires a ventilator mounted on the wheelchair for use during the day and needs another ventilator of the same type for use while in bed. Without both pieces of equipment, the individual may be prone to certain medical complications, may not be able to achieve certain appropriate medical outcomes, or may not be able to use the medical equipment effectively. Multifunctional ventilators, which perform any or all of the additional functions of oxygen concentration, drug nebulization, aspiration, and cough stimulation will not be covered the same rental month as other single function devices which are a component of the multifunction device.	
Walkers	Covered if individual's condition impairs ambulation.	E0135, E0143, E0141, E0130, E0150, E0152,

		E0149, E0144, E0147, E0140, E0148

When there is a medical policy addressing a specific item or service, refer to the specific policy for applicable medical necessity criteria.

DME ITEM	Medical Policy
Air-Fluidized Bed	Refer to MP 6.001 Hospital and Specialized Beds.
Alternating Pressure Pads including Water and Pressure Pads and Mattresses	Refer to MP 6.001 Hospital and Specialized Beds.
Augmentative Communication Device	Refer to MP 6.032 Speech Generating Devices.
Automatic External Defibrillator (AED) (e.g. LifeVest)	Refer to MP 1.081 Cardioverter-Defibrillators (Implantable and External.)
Beds-Oscillating	Refer to MP 6.001 Hospital and Specialized Beds.
Cold Pad-Water circulating with pump	Refer to MP 6.040 Cooling Devices Used in the Outpatient Setting.
Communicator	Refer to MP 6.032 Speech Generating Devices.
Continuous Positive Airway Pressure (CPAP)	Refer to MP 2.045 Diagnosis and Medical Management of Obstructive Sleep Apnea.
Electric Hospital Beds	Refer to MP 6.001 Hospital and Specialized Beds.
Electrical Nerve Stimulation	Refer to the following: • MP 6.020 Transcutaneous Electrical Nerve Stimulation • MP 6.046 Threshold Electrical Stimulation as a Treatment of Motor Disorders • MP 6.047 Interferential Stimulation for Treatment of Pain • MP 6.050 Percutaneous Electrical Nerve Stimulation (PENS) and Percutaneous Neuromodulation Therapy (PNT)

	• MP 1.069 Spinal Cord Stimulation • MP 1.042 Deep Brain Stimulation • MP 1.034 Implantable Electrical Nerve Stimulators. • MP 2.092 Cranial Electrotherapy Stimulation (CES) and Auricular Electrostimulation. • MP 1.134 Percutaneous and Implantable Tibial Nerve Stimulation • MP 2.372 Occipital Nerve Stimulation
Gel Flotation Pads and Mattresses	Refer to MP 6.001 Hospital and Specialized Beds.
Hospital Beds	Refer to MP 6.001 Hospital and Specialized Beds.
Hospital/ Specialty Beds and bed accessories	Refer to MP 6.001 Hospital and Specialized Beds.
Infusion Pumps	Refer to MP 1.058 Implantable Infusion Pumps for Pain and Spasticity or MP 6.007 External Infusion Pumps for Insulin Delivery and Artificial Pancreas Device.
Jaw Motion Rehabilitation System	Refer to MP 2.062 Temporomandibular Joint Dysfunction (TMJ)
Lamb Wool Pads	Refer to MP 6.001 Hospital and Specialized Beds.
Lymphedema Pumps	Refer to MP 6.013 Pneumatic Compression Devices for Treatment of Lymphedema and Chronic Venous Insufficiency.
Mattress	Refer to MP 6.001 Hospital and Specialized Beds.
Motorized Wheelchairs	Refer to MP 6.037 Power Wheelchairs, Power Operated Vehicles (POV), and related Options and Accessories.
Muscle Stimulators	Refer to the following: • MP 6.046 Threshold Electrical Stimulation as a Treatment of Motor Disorders. • MP 6.047 Interferential Current Stimulation.

	• MP 6.049 H-Wave Electrical Stimulation. • MP 6.050 Percutaneous Electrical Nerve Stimulation (PENS) and Percutaneous Neuromodulation Therapy (PNT.) • MP 6.051 Neuromuscular and Functional Neuromuscular Electrical Stimulation.
Percussors	Refer to MP 6.015 Airway Clearance Devices.
Speech Generating Devices	See MP 6.032 Speech Generating Devices.
Ultraviolet Cabinet	Refer to MP 2.046 Ultraviolet Light Therapies.
Wheelchairs, Manual	Refer to MP 6.059 Manual Wheelchairs and Accessories.
Wheelchairs (power operated) and wheelchairs with other special features	Refer to MP 6.037 Power Wheelchairs, Power Operated Vehicles (POV), Options and Accessories.

PRODUCT VARIATIONS

This policy is only applicable to certain programs and products administered by Capital Blue Cross and subject to benefit variations. Please see additional information below.

FEP PPO - Refer to FEP Medical Policy Manual. The FEP Medical Policy manual can be found at:

https://www.fepblue.org/benefit-plans/medical-policies-and-utilization-management-guidelines/medical-policies .

Note* - The Federal Employee Program (FEP) Service Benefit Plan does not have a medical policy related to these services.

DESCRIPTION/BACKGROUND

Durable Medical Equipment (DME), also referred to as Home Medical Equipment (HME), is any equipment, which provides therapeutic benefits to a patient with a specific illness, injury, or medical condition. Examples of DME include, but are not limited to, hospital beds, wheelchairs, canes, crutches, traction, walkers, ventilators, oxygen, monitors, lifts, commodes, suction machines, nebulizers, pressure mattresses, bilirubin lights, and hemodialysis equipment.

Back-up or secondary DME refers to an identical or similar piece of equipment to the one already in use, which could be utilized to meet the same medical needs of the patient.

POLICY TITLE	DURABLE MEDICAL EQUIPMENT AND SUPPLIES
POLICY NUMBER	MP 6.026

DEFINITIONS

MEDICAL SUPPLIES are medical goods that support the provision of therapeutic and diagnostic services but cannot withstand repeated use and are disposable or expendable in nature.

DURABLE MEDICAL EQUIPMENT consists of items which are primarily and customarily used to serve a medical purpose; are not useful to a person in the absence of illness or injury; are ordered by a physician; are appropriate for use in the home; are reusable; and can stand repeated use.

MEDICAL PURPOSE – Medical equipment is equipment that is primarily and customarily used for medical purposes and is not generally useful in the absence of illness or injury. Equipment that is primarily and customarily used for a non-medical purpose may not be considered "medical" equipment for which payment can be made under the DME benefit. This applies even though the item has some remote medically related use.

DISCLAIMER

Capital Blue Cross' medical policies are used to determine coverage for specific medical technologies, procedures, equipment, and services. These medical policies do not constitute medical advice and are subject to change as permitted by law or applicable clinical evidence from independent treatment guidelines. Treating providers are solely responsible for medical advice and treatment of members. These policies are not a guarantee of coverage or payment. Payment of claims is subject to a determination regarding the member's benefit program and eligibility on the date of service, and a determination that the services are medically necessary and appropriate. Final processing of a claim is based upon the terms of contract that applies to the members' benefit program, including benefit limitations and exclusions. If a provider or a member has a question concerning this medical policy, please contact Capital Blue Cross' Provider Services or Member Services.

CODING INFORMATION

Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

- ***See tables above***

REFERENCES

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POLICY HISTORY

MP 6.026	**06/22/2020 Consensus Review.** Policy statement unchanged. Product variation, benefit variation, and disclaimer updated. References and tables reviewed.
	08/12/2021 Minor Review. Additional criteria for the DME supplies. References updated.
	12/08/2022 Consensus Review. No changes to policy statement. Updated referenced policy titles in table, FEP, references.
	11/13/2023 Minor Review. Changed standers from 'deny' to MN with criteria. References updated.
	02/15/2024 Minor Review. Removed language regarding blood pressure cuffs. References updated.
	12/16/2024 Consensus Review. No changes to policy statement. Updated cross-references.
	02/25/2025 Major Review. No changes to policy statement. Updated policy guidelines. Codes added to policy table.
	06/30/2025 Administrative Update. Removed Benefit Variations Section and updated Disclaimer.

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	09/09/2025 Administrative Update. Added code E0150. Eff 10/01/2025.

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