Medicare Advantage Medical Policy

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Durable Medical Equipment – Medicare Advantage

Medicare Advantage Plan
☒ Medicare Plus Blue℠
☒ BCN Advantage℠

UM Committee Approval Date:1/28/2026
Effective Date: 2/28/2026

Description

Durable medical equipment (DME) is defined as equipment that provides therapeutic benefits to a patient who has specific needs due to a medical condition or illness. To be considered durable medical equipment, the item must meet the following conditions:

- Can withstand repeated use.
- Is reusable.
- Is primarily used to serve a medical purpose.
- Is generally not useful to a person in the absence of illness, injury or disease.
- Is appropriate for use in the member's home. A member's home may be defined as the member's own dwelling, relative's home, apartment, home for the aged or other type of institution **AND**

Requires a prescription for purchase and is prescribed by a qualified health care provider.

Related Medical Coverage Policies

- Orthotic Devices

Policy Guidelines

Blue Cross Blue Shield of Michigan (BCBSM) and Blue Care Network of Michigan (BCN) adhere to guidance from the Centers for Medicare and Medicaid Services (CMS), including when performing organization determinations for Medicare Advantage plan members. CMS Medicare statutes, regulations, manuals, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and other sub-regulatory guidance provide the clinical guidelines for coverage determinations, payment integrity functions, and all other uses by CMS regulations. When CMS Medicare guidance is silent, incomplete, or insufficient, CMS permits BCBSM/BCN to utilize "internal coverage criteria", such as independent criteria, health plan policy research, LCD/LCAs outside the services area or research from independent medical research repositories (i.e., Hayes) for coverage policies 42 CFR § 422.101.

BCBSM/BCN internal medical coverage policies are developed and based on current evidence in widely accepted treatment guidelines or clinical literature; in addition, they address how clinical benefits may or may not outweigh member harm.

Clinical review follows guidance provided in the BCBSM Medicare Advantage Coverage Determination Hierarchy policy, which may be found at https://www.bcbsm.com/providers/mpradmin/ by entering the policy name.

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

Apart from durable medical equipment (DME), Medicare Administrative Contractor (MAC) jurisdiction for the purpose of clinical determination is based upon place of service. The place of service for laboratory testing is defined as the geographic location of the reference laboratory. Non-jurisdictional LCD/LCAs may not be utilized for a determination unless they have been specifically identified as internal coverage criteria by the policy. Alternatively, jurisdiction for DME MAC is determined by the member place of residence. Please see CMS Medicare Administrative Contractors (MAC) table for state MAC assignments below.

CMS Guidance	Additional Guidance
National Regulatory Guidance Medicare Benefit Policy Manual, Chapter 15 §110-§130 Medicare Benefit Policy Manual, chapter 15 §110 Durable Medical Equipment Medicare Benefit Policy Manual Chapter 15 §110.2 Repairs, Replacement and Maintenance and Delivery Medicare Benefit Policy Manual Chapter 15 §110.3 Coverage of Supplies and Accessories Medicare Benefit Policy Manual Chapter 15 §120 Prosthetic Devices Medicare Claims Processing Manual Chapter 20 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) **National Coverage Determinations** **NCD: 280.1 Durable Medical Equipment Reference List** NCD 40.3 Closed-Loop Blood Glucose Control Device (CBGCD) NCD 240.4 Continuous Positive Airway Pressure (CPAP) Therapy for Obstructive Sleep Apnea (OSA) NCD 160.7 Electrical Nerve Stimulators NCD 270.1 Electrical Stimulation (ES) and Electromagnetic Therapy for the treatment of wounds NCD 50.2 Electronic Speech Aids	BCBSM/BCN will follow CMS guidance as the primary source for coverage determinations. However, in instances where CMS guidance is silent, incomplete, or insufficient for a particular code, BCBSM/BCN internal coverage criteria will be applied to ensure consistent and informed decision-making. In such cases, please refer to the relevant BCBSM/BCN policy for guidance: *Durable Medical Equipment* To access this policy, please visit the BCBS Michigan Medical Policy Router Search page at https://www.bcbsm.com/providers/mpradmin/ and enter the policy name in the search field.

CMS Guidance	Additional Guidance
NCD 40.2 Home Blood Glucose Monitors NCD 240.2 Home Use of Oxygen NCD 280.7 Hospital Beds NCD 80.1 Hydrophilic Contact Lens for Corneal Bandage NCD 80.4 Hydrophilic Contact Lenses NCD 230.10 Incontinence Control Devices NCD 280.14 Infusion Pumps NCD 40.4 Insulin Syringe NCD 240.5 Intrapulmonary Percussive Ventilator (IPV) NCD 280.3 Mobility Assistive Equipment (MAE) NCD 160.12 Neuromuscular Electrical Stimulation (NMES) NCD 230.8 Non-implantable Pelvic Floor Stimulator NCD 150.2 Osteogenic Stimulator NCD 160.19 Phrenic Nerve Stimulator NCD 280.6 Pneumatic Compression Device NCD 280.10 Prosthetic Shoe NCD 280.16 Seat Elevation Equipment (Power Operated) on Power Wheelchairs NCD 280.4 Seat Lift NCD 20.8.2 Self-Contained Pacemaker Monitors NCD 50.1 Speech Generating Device NCD 50.4 Tracheostomy Speaking Valve NCD 10.2 Transcutaneous Electrical Nerve Stimulation (TENS) for Acute Post-Operative Pain NCD 160.2 Treatment of Motor Function Disorders with Electric Nerve Stimulation NCD 160.27 Transcutaneous Electrical Nerve Stimulation (TENS) for Chronic Low Back Pain (CLBP) NCD 230.17 Urinary Drainage Bags NCD 230.7 Water Purification and Softening Systems Used in Conjunction with Home Dialysis NCD280.2 White Cane for Use of Blind Person **DME MACs: CGS (JB, JC) and Noridian (JA, JD)** L33690, A52458: Automatic External Defibrillators L36267, A54516: Bowel Management Devices L33733, A52459: Canes and Crutches L33823, A52476: Cervical Traction Devices L33735, A52460: Cold Therapy L33736, A52461: Commodes	

CMS Guidance	Additional Guidance
L38955: Enteral Nutrition L33317: External Breast Prostheses L33794, A52507: External Infusion Pumps L39591, A59680: External Upper Limb Tremor Stimulator Therapy L33737: Eye Prostheses L33738: Facial Prostheses L33822, A52464: Glucose Monitors L33784, A52502: Heating Pads and Heat Lamps L33785, A52494: High Frequency Chest Wall Oscillation Devices L33820, A52508: Hospital Beds and Accessories L33824: Immunosuppressive Drugs L33786, A52477: Infrared Heating Pad Systems L33786, A52495: Intrapulmonary Percussive Ventilation System L33610: Intravenous Immune Globulin L33318, A52465: Knee Orthoses L33787: Lower Limb Prostheses L33788, A52497: Manual wheelchair bases L33795, A52510: Mechanical In-exsufflation Devices L33370, A52466: Nebulizers L33821, A52511: Negative Pressure Wound Therapy Pumps L33826: Oral Anticancer Drugs L33827: Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics) L33611, A52512: Oral Appliances for Obstructive Sleep Apnea L33641: Orthopedic Footwear L33796, A52513: Osteogenesis Stimulators L33828: Ostomy Supplies L33797, A52514: Oxygen and Oxygen Equipment L38953: Parenteral Nutrition L33799, A52516: Patient Lifts L33718, A52467: Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea A52498: Power Mobility Devices L33830, A52489: Pressure Reducing Support Surfaces Group 1 L33642, A52490: Pressure Reducing Support Surfaces Group 2	

CMS Guidance	Additional Guidance
L33692, A52468: Pressure Reducing Support Surfaces Group 3 L33793: Refractive Lenses L3380, A52517: Respiratory Assist Devices L33801, A52518: Seat Lift Mechanisms L33739, A52469: Speech Generating Devices (SGD) L33790: Spinal Orthoses: TLSO and LSO A55429: Standard Documentation Requirements for all Claims Submitted to DME MACs L33612, A52519: Suction Pumps L33831: Surgical Dressings L33369: Therapeutic Shoes for Persons with Diabetes L33832, A52492: Tracheostomy Care Supplies L34821, A52713: Transcutaneous Electrical Joint Stimulation Devices (TEJSD) L33802, A52520: Transcutaneous Electrical Nerve Stimulation (TENS) L34823, A52711: Tumor Treatment Field Therapy (TTFT) L33803: Urological Supplies L34824: Vacuum Erection Devices (VED) L33791, A52503: Walkers L33792, A52504: Wheelchair Options/Accessories L33312: Wheelchair	

Code	Description
A7003-A7016	Nebulizer and Supplies code range
E0100-E8002	DME code range
K0001-K0886	Wheelchair and Power Operated Vehicles; Groups 1-4
K0890-K0891	Pediatric Power Wheelchairs
K0898	Power Wheelchair, Not otherwise classified
K0899	Power Mobility Device, not coded by SADMERC or does not meet criteria

The above information is current as of the review date for this policy. However, the coverage issues and policies maintained by CMS are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document.

Please refer to the Medicare Coverage Database website at https://www.cms.gov/medicare-coverage-database/search.aspx for the most current applicable NCD, LCD, LCA, and CMS Online Manual System Transmittals.

CMS Medicare Administrative Contractors (MAC) Jurisdictions Guidance

Part A and Part B MAC Jurisdictions	
Wisconsin Physicians Service Insurance Corporation (WPS)	IA, IN, KS, MI, MO, NE
CGS Administrators, LLC	KY, OH
First Coast Service Options, Inc	FL, PR, US VI
National Government Services, Inc (NGS)	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI,
Noridian Healthcare Solutions, LLC, Jurisdiction JE	CA, HI, NV, American Samoa, Guam, Northern Mariana Islands
Noridian Healthcare Solutions, LLC, Jurisdiction JF	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
Novitas Solutions, Inc	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX,
Palmetto GBA	AL, GA, TN NC, SC, VA, WV
DME MAC Jurisdictions	
CGS Administrators, LLC, Jurisdictions JB and JC	AL, AR, CO, FL, GA, IL, IN, KY, LA, MI, MN, MS, NM, NC, OH, OK, Puerto Rico, SC, TN, TX, VA, Virgin Island, WI, WV
Noridian Healthcare Solutions, LLC, Jurisdictions JA and JD	AK, American Soamoa, AZ, CA, CT, DE, DC, Guam, HI, ID, IA, KS, MA, MD, ME, MO, MT, ND, NE, NH, NJ, NV, NY, Northern Mariana Islands, OR, PA, RI, SD, UT, VT, WA, WY

Important Reminder

BCBSM and BCN follow CMS Medicare coverage guidance to limit coverage to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. Medicare Advantage Medical Policies list the criteria BCBSM and BCN use to decide which medical services are considered "reasonable and necessary" when Medicare coverage rules are not fully developed, or as otherwise may permitted by CMS Medicare regulations. Individual member benefit plan documents, such as the Evidence of Coverage and Annual Notice of Change, as well as applicable laws govern benefit coverage, including any inclusion, exclusion, and/or other restrictions.

Medicare Advantage Medical policies are created when permitted by CMS Medicare regulations, reviewed regularly, and may be revised periodically. BCBSM/BCN Medical Policies are proprietary and should not be copied or disseminated without the express, prior written approval of BCBSM. All providers are required to review applicable BCBSM reimbursement policies prior to claim submission and bill for covered services in accordance with those policies. Additionally, providers contracted with BCBSM or BCN's Medicare Advantage network(s) should review the provider manual for any additional claim submission requirements. Providers not contracted with BCBSM or BCN's Medicare Advantage network may be required to submit documentation to BCBSM, BCN, or its delegated entity supporting billed claims, including but not limited to applicable medical records.

Note: U.S. Food and Drug Administration (FDA) approval for a specific indication or the issuance of a CPT code is not sufficient for a procedure to be considered medically reasonable and necessary. Similarly, the presence of a procedure/device code or payment amount for the service in the Medicare fee schedule does not necessarily indicate coverage. If a service is deemed not reasonable and necessary, to treat illness or injury for any reason (including lack of safety and efficacy because it is an experimental procedure, etc.), the procedure is considered not covered.

Disclaimer: This medical policy is not an authorization, certification, explanation of benefits, or a contract for the services, devices, or drugs that is referenced in the medical policy. Medical policies do not constitute medical advice and do not guarantee any results or outcomes or guarantee payment. The medical policy is not intended to replace independent medical judgment for the treatment of individuals. Treating physicians and health care providers are solely responsible for determining what care to provide to their patients. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test, or procedure over another.

Pursuant to Section 1557 and Section 504, Blue Cross does not discriminate on the basis of race, color, national origin, age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes). This includes our rules, benefit designs and medical policies.

BCBSM/BCN Medicare Advantage Policy History

Policy Effective Date	UM Committee Approval Date	Comments
08/17/2024	07/17/2024	Medicare Advantage policy established
02/22/2025	01/22/2025	MA policy foundational language updated. Adoption of JUMP policy updates.
02/28/2026	01/28/2026	Adoption of JUMP policy updates.