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| **Department:** | Medical Management | **Original Approval:** | 12/03/2008 |
| **Policy #:** | MM136 | **Last Approval:** | 02/28/2019 |
| **Title:** | Durable Medical Equipment | | |
| **Approved By:** | UM Medical Subcommittee | | |

## REQUIRED CLINICAL DOCUMENTATION FOR REVIEW

History and physical
Recent (within the past 3 months) chart notes from medical provider and from therapist, as applicable, documenting the need for the DME
List of other DME tried and why it was not appropriate

## BACKGROUND

Community Health Plan of Washington (CHPW) considers durable medical equipment, orthotics and prosthetics medically necessary when the applicable criteria are met.
DME items have the following characteristics and should meet all the following requirements:

- Is prescribed by a physician; and
- The order contains the physician's signature, not a stamp,(except as below); and
- Can withstand repeated use; and
- Is primarily and customarily used to serve a medical purpose; and
- Is appropriate for use in the client's place or residence; and
- Meets the definition of DME

Exceptions: DME order can be signed by provider other than a physician in certain circumstances:

- Medication administration or monitoring (such as, blood glucose testing, continuous glucose monitoring, or insulin pumps), or home infusions
- Respiratory supplies (such as, CPAP mask or tubing)
- Breast pumps
- DME requests while member is in a facility (SNF, Inpatient Rehab, Long Term Acute Care or hospital. Signature will be required for members in custodial care, adult family home, or long-term care.

## DEFINITIONS

*Durable*
Medical equipment considered durable is equipment that can withstand repeated use, such as, the type of item that can be rented. Medical supplies of an expendable nature, such as incontinence pads, lamb's wool pads, catheters, ace bandages, elastic stockings, surgical facemasks, sheets, and bags are not considered "durable" within the meaning of the definition. There are other items that although durable

in nature, may fall into other coverage categories such as supplies and orthotics and prosthetics. Orthotics and Prosthetics items include, but are not limited to, braces, artificial limbs and eyes.

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

## INDICATIONS/CRITERIA

For **Medicare Advantage** members, if national or local coverage determinations (NCDs, LCDs), as outlined by the Centers for Medicare and Medicaid Services (CMMS), are available, then these will be used to determine coverage and criteria to determine medical necessity. If none are available, CHPW uses CHPW Clinical Coverage Criteria and then MCG as noted below.

For **WA Health Care Authority (HCA) Apple Health members**: In all cases when available, HCA Health Technology Assessment program determinations are used. For DME not addressed by the HCA HTA Program, CHPW uses CHPW Coverage Criteria next. For DME not addressed by either, CHPW uses MCG.

For both **Medicare and Apple Health Members**, any requests for DME must also meet all the following criteria:

- A current (within 3 months) face-to-face evaluation by the treating physician and therapist, as applicable, showing medical need for the device by the member
- A physical or occupational therapy assessment, including home assessment, if appropriate, to determine the type of device that meets the member's medical needs, is efficacious and safe for the member's use, including during transfers and fits properly in the physical space of the member's home
- Successfully trial by the member of the device or a close simulation of the device
- Results of trials of less expensive devices, if apparently available, and explanation of why these less expensive devices are not appropriate for the member's condition and situation

## SPECIAL CONSIDERATIONS

**Rental of DME**

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

**Repair of DME**

- Repair of any DME must meet relevant criteria for medical necessity, including prior authorization if required for similar new equipment.
- Repair is considered only for client-owned equipment after expiration of warranty period.
- It is the expectation of CHPW that the provider will have checked for warranty coverage before submitting a request for a DME repair. Warranty coverage will be reviewed, along with repair cost, at the time of assessment for prior authorization.
- Repairs do not require a face to face evaluation with the physician but do require a physician signature on the order.

**Replacement of DME**

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

**ADDITIONAL DME CRITERIA:**
**PLEASE SEE ALSO MM162 "MEDICAL APPROPRIATENESS FOR SERVICE" POLICY, WHICH APPLIES TO ALL DME.**

| EQUIPMENT | CRITERIA |
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| AFO/KAFO/ORTHOTICS | See CHPW policy MM158 |
| BONE GROWTH STIMULATORS | For Medicare members: CMS Coverage Criteria in Noridian LCD L33796<br><br>For HCA WA Apple Health: WA HTA 20090828B: Bone Growth Stimulation, 10/30/2009 https://www.hca.wa.gov/assets/program/findings_decision_bgs_103009[1].pdf<br><br>CMS NCD criteria referenced by the HTA 20090828B:<br>National Coverage Determination (NCD) for Osteogenic Stimulators (150.2) |
| CHEST COMPRESSION DEVICES | For Medicare Members:<br>Noridian LCD L33785: High Frequency Chest Wall Oscillation Devices |

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| | For Apple Health members:<br>Chest Compression device is medically necessary in addition to chest physiotherapy where there is documented failure of standard treatments to adequately mobilize retained secretions with at least 1 of the following conditions:<br><br>A. Bronchiectasis, confirmed by CT scan, characterized by daily productive cough for at least 6 continuous months or by frequent (i.e., more than 2 times/year) exacerbations requiring antibiotic therapy; *or*<br>B. Cystic fibrosis or immotile cilia syndrome; *or*<br>C. The member has one of the following neuromuscular disease diagnoses:<br>a. Acid maltase deficiency<br>b. Anterior horn cell diseases, including amyotrophic lateral sclerosis<br>c. Hereditary muscular dystrophy<br>d. Multiple sclerosis<br>e. Myotonic disorders<br>f. Other myopathies<br>g. Paralysis of the diaphragm<br>h. Post-polio<br>i. Quadriplegia regardless of underlying etiology |
| COMMUNICATION DEVICES (E.G. SPEECH GENERATORS) | See CHPW policy MM167 Speech Generating Devices (Augmentative Communication Devices ) |
| CONTINUOUS PASSIVE MOTION SYSTEM (CPM) | Medicare: National Coverage Determination (NCD) for Durable Medical Equipment Reference List (280.1)<br>Coverage criteria require all of the following:<br>1) Only covered after a total knee replacement<br>2) Use of the device must commence within 2 days following surgery<br>3)Coverage is limited to that portion of the 3-week period following surgery during which the device is used in the patient's home<br>There is insufficient evidence to justify coverage of these devices for longer periods of time or for other applications.<br><br>For WA Apple Health: Up to 10 days rental during any 12-month period, upon hospital discharge, when the client is diagnosed with one of the following:<br>1) Frozen joints<br>2) Intra-articular tibia plateau fracture<br>3) Anterior cruciate ligament injury<br>4) Total knee replacement |
| COUGH STIMULATING DEVICES | For Medicare Members:<br>Noridian LCD L33795: Mechanical In-exsufflation Devices |

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| | For WA Apple Health:<br>MCG Guidelines |
| CPAP/BIPAP | See CHPW Clinical Coverage Criteria MM135 |
| GAIT TRAINERS | MCG Guidelines |
| HEARING AIDS | **see MM168: Hearing Assist Devices** |
| INSULIN PUMPS and CONTINUOUS GLUCOSE MONITORING | For Medicare members:<br>Noridian LCD 11570: External Infusion Pumps<br><br>For WA Apple Health:<br>HTA 20180119B - Continuous glucose monitoring 03/16/2018<br>https://www.hca.wa.gov/assets/program/cgm-final-findings-decision-20180318.pdf |
| HOSPITAL BEDS AND SUPPLIES | For Medicare Members:<br>Noridian LCD 11572: Hospital Beds And Accessories<br><br>For HCA WA Apple Health members<br><br>Hospital beds: **WAC 182-543-3000**<br>The Medicaid agency covers one hospital bed in a ten-year period, per client, with the following limitations:<br>(Manual Hospital beds are not routinely carried by DME suppliers)<br><br>A semi-electric hospital bed only when:<br>• Has a medical condition that necessitates upper body positioning at no less than a thirty-degree angle the majority of time the client is in the bed, or needs to be in t Trendelenburg position, or client's medical condition requires immediate position changes.<br>• The client's medical need requires the client to be positioned in a way that is not possible in a regular bed and the position cannot be attained through less costly alternatives (e.g., the use of bedside rails, a trapeze, pillows, bolsters, rolled up towels or blankets);<br>• The client is able to operate the controls independently.<br><br>**Additional criteria for special beds:**<br><br>Indications for a semi-electric hospital bed must be met.<br><br>• **Fully electric bed:** brain injury, spinal cord injuries, and/or neurological damage that prevents the member from getting in and out of bed.<br><br>• **Heavy-duty, extra-wide/bariatric bed**: member's weight is more than 350 pounds but less than 600 pounds. |

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| | • **Extra-heavy-duty bed:** member's weight is 600 pounds or more.<br><br>Rental of bed:<br>• The above criteria for the particular bed are satisfied<br>• The patient has less than 12 months length of need<br>• Has a chronic or terminal condition such as chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), lung cancer or cancer that has metastasized to the lungs, or other pulmonary conditions that cause the need for immediate upper body elevation<br><br>Purchase of bed:<br>• The above criteria for the particular bed are satisfied<br>• The patient has 12 months or more length of need<br>• The patient has diagnosis of one of the following: quadriplegia;<br>• tetraplegia;<br>• Duchenne muscular dystrophy;<br>• amyotrophic lateral sclerosis (ALS),<br>• ventilator-dependent; or<br>• COPD or CHF with aspiration risk or shortness of breath that causes the need for a immediate change of upper body positioning of more than thirty degrees. |
| Mandibular Advancement Devices (MAD) | Medicare Members: Noridian Local Coverage Article:<br>Oral Appliances for Obstructive Sleep Apnea - Policy Article (A52512)<br><br>Apple Health Members:<br>One custom made (no prefabricated) MAD per client (aged 21 years and older), every five years would be covered with prior authorization under code EO486 when the following criteria are met:<br>A. A face to face evaluation with a sleep medicine physician prior to sleep testing is completed in agency-designated center of excellence (COE)<br>B. Sleep testing criteria for CPAP is met<br>1. AHI or RDI ≥ 15 per hour with minimum of 30 events **OR**<br>2. The AHI or RDI ≥ 5 and ≤ 14 events per hour with minimum of 10 events and documentation of:<br>a. Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or,<br>b. Hypertension, ischemic heart disease, or history of stroke; or,<br>3. If the AHI> 30 or the RDI> 30 and meets either of the following(a or b):<br>a. The member is not able to tolerate a positive airway pressure (PAP) device; or,<br>b. The treating physician determines that the use of a CPAP device is contraindicated. |

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| | C. The client has tried and failed the use of CPAP. Documentation of at least a 6 month trial period, describing why CPAP failed, or reason explaining why CPAP is not the appropriate treatment<br>D. Device is ordered by treating provider post review of sleep study<br>E. The device is provided and billed for by a licensed dentist (DDS or DMD).<br>F. The device must be titrated in a sleep center by a qualified provider who has experience in titrating the MAD<br>G. The client must have their own teeth (no dentures or partials<br>**Exclusions**<br>Prefabricated (E0485) appliances are not considered reasonable and necessary due to insufficient evidence and are not a covered benefit. Not medically necessary are:<br>· Oral occlusal appliances for (TMJ)<br>· Tongue retaining devices used to treat OSA and/or snoring<br>· All oral appliances used only to treat snoring without a diagnosis of OSA<br>· Oral appliances used to treat other dental conditions<br>· Oral appliances that require repeated fitting and/or adjustments, beyond the first 90-days, in order to maintain fit and/or effectiveness |
| OXYGEN | See CHPW Clinical Coverage Criteria MM144 |
| PATIENT LIFTS | For Medicare members:<br>Noridian LCD 11577: Patient Lifts<br><br>For WA Apple Health members: MCG Guidelines |
| PROSTHETICS | For Medicare members:<br>Noridian LCDs Consult specific LCD on Noridian index at<br>https://med.noridianmedicare.com/web/jddme/policies/lcd/active<br><br>For WA Apple Health members: MCG Guidelines<br>For Ankle Foot Orthotics and Ankle Knee Orthotics, see CHPW Clinical Coverage Criteria MM158 Ankle Foot Orthotics and Ankle Knee Orthotics |
| Positioning Car Seat<br>For EPSDT children <21 years with special orthopedic or neurologic needs (HCPCS T5001) | For WA Apple Health Members:<br>Both of the following criteria are required for approval of a positioning car seat:<br><br>1. **The patient has a significant physical or neurologic or orthopedic condition including one or more of the following:**<br>– Significant hypotonicity, hypertonicity, athetosis, ataxia, spasticity, seizure disorder, or muscle spasming which results in uncontrollable movement and position change<br>– Orthopedic disease processes resulting in significant bony fragility<br>– Inability to maintain an unsupported sitting position independently<br>2**. A rear-facing Child Safety Seat (CSS) cannot be used because of one or more of the following:** |

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| | – Weight 50 lbs or more<br>– Significant casting (such as spica cast for hip dislocation)<br>– Tracheostomy<br>– Severe hydrocephalus<br>– Requirement of prone or supine positioning after surgery (such as for myelomeningocele)<br>– Significant contractures that would result in an inability to perform postural corrections due to vehicle motion<br>– Severe scoliosis, which interferes with proper positioning<br>According to Child Passenger Safety: American Academy of Pediatrics:<br>Most currently available convertible Child Safety Seats (CSSs) can be used rear facing to 40-50 lbs. All children should be restrained in a rear facing CSS for as long as possible. |
| TENS UNITS | For Medicare members:<br>Noridian LCD L33802: Transcutaneous Electrical Nerve Stimulators (TENS)<br><br>For WA Apple Health members: Refer to:<br>WA HTA 20091030A – Electrical Neural Stimulation, 11/20/2009<br>https://www.hca.wa.gov/assets/program/findings_decision_ens_103009%5B1%5D.pdf |
| VENTILATOR, HOME | For Medicare members:<br>Respiratory Assist Devices<br>Medical Necessity Determination: MCG Guidelines A-0893<br><br>For Apple Health Members:<br>Medical Necessity Determination: MCG Guidelines A-0893<br>See the Washington Administrative Code for the rules regarding coverage of home ventilators, and ventilator supplies: WAC 182-552-1000 |
| VENTILATOR, PRESSURE SUPPORT | For Medicare members:<br>Respiratory Assist Devices<br>Medical Necessity Determination: MCG Guidelines A-0893<br><br>WA Apple Health:<br>Medical Necessity Determination: MCG Guidelines A-0893<br><br>See the Washington Administrative Code for the rules regarding coverage of pressure ventilators, and ventilator supplies: WAC 182-552-1000<br>Pressure support ventilators all the following must be met in order to use the Expedited Prior Authorization (EPA) process:<br>a) The client is currently using a pressure support ventilator;<br>b) The client must be able to take spontaneous breaths;<br>c) There must be an authorized prescriber's order for the pressure support setting; and<br>d) The client must be utilizing the ventilator in the pressure support mode. |

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| | (ii) If the client has no clinical potential for weaning, the medicaid agency's EPA is valid for twelve months; or<br>(iii) If the client has the potential to be weaned, then the medicaid agency's EPA is valid for six months;<br>(iv) To continue using EPA after the valid time period has lapsed, a vendor must document in the client's file that the client continues to meet the EPA criteria for a pressure support ventilator. |
| VENTILATOR, BACK-UP | For Medicare members:<br>Respiratory Assist Devices<br>Medical Necessity Determination: MCG Guidelines A-0893<br><br>For Apple Health Members:<br>See the Washington Administrative Code for the rules regarding coverage of home ventilators, and ventilator supplies: WAC 182-552-1000<br>CHPW covers a back-up ventilator when one or more of the following clinical criteria are met:<br>(a) The client cannot maintain spontaneous ventilations for four or more consecutive hours;<br>(b) The client lives in an area where a replacement ventilator cannot be provided within two hours;<br>(c) The client requires mechanical ventilation during mobility as prescribed in their plan of care. |
| WEARABLE CARDIOVERTER DEFIBRILLATOR | For Medicare members: Local Coverage Determination (LCD): Automatic External Defibrillators (L33690)<br>https://med.noridianmedicare.com/documents/2230703/7218263/Automatic+External+Defibrillators<br>Must be reevaluated after 3 months.<br><br>For Apple Health Members: MCG Guidelines A-0566<br>Must be reevaluated after 3 months. |
| WHEELCHAIRS (AND ACCESSORIES) AND SCOOTERS | For Medicare members:<br>Manual Wheelchairs: Noridian LCD L33788<br>https://med.noridianmedicare.com/documents/2230703/7218263/Manual+Wheelchair+Bases+LCD+and+PA<br><br>Power mobility devices: Noridian LCD L33789:<br>https://med.noridianmedicare.com/documents/2230703/7218263/Power+Mobility+Devices<br><br>Wheelchair Options and Accessories:<br>Noridian LCD L33792<br>https://med.noridianmedicare.com/documents/2230703/7218263/Wheelchair+Options+Accessories+LCD |

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| | For WA Apple Health members use MCG for medical necessity including the below specific requirement. This applies to both Rental/Purchase wheelchairs:<br>MCG current edition: Power Wheelchair, Manual Wheelchair, or Scooter<br><br>A standard lightweight wheelchair if the client's medical condition does not allow the client to use standard weight wheelchair because of one of the following:<br><br>• The client cannot self-propel a standard weight wheelchair.<br>• Custom modifications cannot be provided on a standard weight wheelchair<br><br>A high-strength lightweight wheelchair for a client who meets one of the following:<br><br>• Whose medical condition doesn't allow the client to self-propel a lightweight or standard weight wheelchair<br><br>• Requires custom modifications that cannot be provided on a standard weight or lightweight wheelchair<br><br>A heavy duty wheelchair for a client who requires a specifically manufactured wheelchair designed to meet one of the following:<br><br>• Support a person weighing 300 pounds and over<br><br>• Accommodate a seat width up to 22 inches wide (not to be confused with custom heavy-duty wheelchairs) |
| WOUND VAC SYSTEMS: | For Medicare members:<br>Noridian LCD 11489 Negative Pressure Wound Therapy Pumps<br>https://med.noridianmedicare.com/documents/2230703/7218263/Negative+Pressure+Wound+Therapy+Pumps+LCD+and+PA/21a6cc9a-7d71-4b36-9445-6d7585c4eac9<br><br>For WA Apple Health members:<br>WA HTA 20161118A: Negative pressure wound therapy for home use (NPWT) 01/20/2017<br>https://www.hca.wa.gov/assets/program/npwt-final-findings-decision-20170120.pdf |

## LIMITATIONS/EXCLUSIONS

Please refer to a product line's certificate of coverage for benefit limitations and exclusions for these services:

| PRODUCT LINE | LINK TO CERTIFICATE OF COVERAGE |
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| MEDICARE ADVANTAGE | http://healthfirst.chpw.org/for-members/resource-library/handbooks-and-guides |
| WASHINGTON APPLE HEALTH | http://chpw.org/our-plans/apple-health/ |
| INTEGRATED MANAGED CARE | http://chpw.org/our-plans/apple-health/ |

## Citations & References

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| **CFR** | | |
| **WAC** | As required by WAC 284-43-2050, WAC 182-552-1000, WAC 182-501-0050 | |
| **RCW** | | |
| **Contract Citation** | ☒ WAH | 1.55 Durable Medical Equipment |
| | ☒ IMC | |
| | ☒ MA | |
| **CHPW Clinical Practice Guidelines** | Child Passenger Safety: American Academy of Pediatrics | |
| **Other Requirements** | | |
| **NCQA Elements** | | |
| **References** | MCG Guidelines | |

## Revision History

| Revision Date | Revision Description | Revision Made By |
|---|---|---|
| 12/03/2008 | Approval | MMLT |
| 12/08/2010 | Approval | MMLT |
| 02/11/2011 | Added sentence on current evaluation for replacement | Lucy Sutphen, MD, FACP |
| 12/14/2011 | Approval | MMLT |
| 11/21/2012 | Updated DME prior authorization requirements | Lucy Sutphen, MD, FACP |
| 11/28/2012 | Approval | MMLT |
| 03/31/2014 | References updated with active links | Kate Brostoff MD |
| 06/20/2014 | Updated DME prior authorization requirements | Kate Brostoff MD |
| 06/23/2014 | Approval | MMLT |

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| 06/15/2015 | References updated with active links | Kate Brostoff MD |
| 06/23/2015 | Approval | MMLT |
| 08/08/2016 | References updated with active links | Cyndi Stilson, RN |
| 08/08/2016 | Updated links and MCG reference | Jane Daughenbaugh, RN |
| 08/09/2016 | Reviewed – no changes | Victor Collymore, MD |
| 08/09/2016 | Approval | MMLT |
| 09/19/2016 | Added criteria for high risk fractures per HCA request | Cyndi Stilson, RN |
| 09/27/2016 | Approved | MMLT |
| 05/31/2017 | Changed 'VENTILATORS' criteria to MCG. Links checked and updated | Cyndi Stilson, RN |
| 06/01/2017 | Approved | MMLT |
| 03/26/2018 | Changed from UM006 | Cindy Bush |
| 04/05/2018 | Transferred to new template | Cindy Bush |
| 05/02/2018 | Updated and corrected links. Corrected links to HTA for insulin pumps and CGM and for negative pressure wound vac. Corrected bone growth stimulation to reference WA HTA. Corrected speech generating device and cough stimulating devices guidelines for Medicare members. Removed summary for bone growth stimulation because the linked guidelines are clear. Removed erroneous information about rental caps. | LuAnn Chen, MD |
| 5/30/2018 | Approved | UM Medical Subcommittee |
| 06/18/2018 | Added characteristics for DME per AHMC contract 1.55 DME; Added definition; Removed box under indications/criteria "Medicaid Members" and "Medicare Members" – no information | Yves Houghton, RN |
| 06/22/2018 | Approval | UM Committee |
| 07/19/2018 | Added CMS information about respiratory assist devices. Added WAC requirements for ventilators, (home, pressure, back-up). Added limitations on replacement due to client's recklessness etc as per WAC 182-501-0050. | LuAnn Chen, MD |
| 08/02/2018 | Additional information added for communication devices.<br>Added details regarding semi electric hospital beds | LuAnn Chen, MD |
| 08/14/2018 | Approval | UM Medical Subcommittee |
| 09/06/2018 | Added criteria for positional car seats and clinical practice guidelines related to child passenger safety. | LuAnn Chen, MD |

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| | Added criteria for Continuous Passive Motion System. Need to remove SGD and hearing aids since new policies are being created. | |
| 9/20/18 | Added criteria for electric bed, heavy-duty, extra-wide/bariatric bed and extra-heavy-duty bed | Yves Houghton RN |
| 09/20/2018 | Approval | UM Medical Subcommittee |
| 09/26/2018 | Approval | UM Committee |
| 10/12/2018 | Clarified that prosthetics criteria: MCG AFO/KAFO/orthotics: MM158<br>Need to remove speech devices when the new policy is posted. Bathroom DME will be separate policy. | LuAnn Chen, MD |
| 10/18/2018 | Removed criteria for speech devices and posted the reference to CHPW policy MM167 Speech Generating Devices (Augmentative Communication Devices). | LuAnn Chen, MD |
| 10/19/2018 | Approval | UM Medical Subcommittee |
| 11/14/2018 | Added indications for Chest compression devices for EPSDT children | LuAnn Chen, MD |
| 11/15/2018 | Approved | UM Medical Subcommittee |
| 12/07/2018 | Removed reference to non-covered DME items (TENS) for Apple Health, due to CMS requirement. | LuAnn Chen, MD |
| 12/07/2018 | Approved | UM Medical Subcommittee |
| 12/18/2018 | Added Mandibular Advancement Devices | LuAnn Chen, MD |
| 12/20/2018 | Approved | UM Medical Subcommittee |
| 01/04/2019 | Added requirement for physician signature | LuAnn Chen, MD |
| 01/04/2019 | Approved | UM Medical Subcommittee |
| 01/11/2019 | Expanded Chest compression criteria for AH members to include adults | LuAnn Chen, MD |
| 01/15/2019 | Approval | UM Committee |
| 1/29/2019 | Updated Patient Lifts to use MCG guidelines and removed criteria for hearing aids | Yves Houghton |
| 02/01/2019 | Approval | UM Committee |
| 02/27/2019 | Requirement for submitting results of trials with similar devices, and home assessment. Removed requirement for physician visit prior to DME repair. Physician signature not needed for DME ordered for SNF members (can be signed for by ARNP or PA) | LuAnn Chen, MD |

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| 02/28/2019 | Approved | UM Medical Subcommittee |