This booklet is designed to serve as an overview of Medicare guidelines and is not a complete listing of required elements for billing to the Medicare program. For an inclusive list of Medicare requirements please visit www.cignagovernmentservices.com and look for the Medicare local coverage determination section.
Thank you for choosing All Saints Home Medical. This booklet is designed as a guide for healthcare providers to use when ordering home medical equipment and supplies. Please note the insurance guidelines listed throughout this booklet are based on Medicare standards. While most insurance companies follow these standards when providing coverage, not all do. All Saints Home Medical accepts Medicare, Medicaid, Community Care, Blue Cross Blue Shield, Aetna, United Health Care and most other major insurances. Should you have any questions about coverage or our services, please feel free to call us at 918-624-4400, or for home infusion questions call 918-488-6660.

Sincerely,

Your All Saints Home Medical team

**Insurance Standard: Feeding Pump**

- Feeding pump is supplied for patients with one of these two afflictions:
  1. Permanent non-function or disease of the structures that normally permit food to reach the small bowel.
  2. Disease of the small bowel which impairs digestion and absorption of an oral diet.

- Patients must also pass these three requirements:
  1. Adequate nutrition must not be possible by dietary adjustment and/or oral supplements.
  2. Pump must be justified by patient not tolerating gravity feed such as reflux, aspiration, diarrhea, dumping syndrome, circulatory overload, etc.
  3. The patient must require tube feedings to maintain weight and strength.

**Bedside Commodes**

*Common Diagnoses:* Renal failure (586), CHF (428.0), paralysis and various neuromuscular disorders.

**Insurance Standard:**

- A commode is covered by Medicare when the patient is physically incapable of utilizing regular toilet facilities. The patient must meet one of the follow criteria:
  1. The patient is confined to a single room; or
  2. The patient is confined to one level of the home and there is no toilet on that level; or
  3. The patient is confined to the home and there are no toilet facilities in the home.

**Bath Aids – Tub Transfer Bench, Shower Chair, Grab Bars, Hand Held Shower Heads**

- Not covered by Medicare, however, may be covered by some commercial plans.
2. The patient has had a recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days).
   - The patient has to have been on a Group 2 support surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 days).
3. The patient has large or multiple stage III or IV pressure ulcers on the trunk or pelvis.

**Other Considerations:**
- Group 1 Includes Alternating Pump and Pad, Gel Overlay, and Therapeutic Foam
- Group 2 Includes Low Air Loss Mattresses, alternating pressure reduction with low air loss
- All support surfaces require a detailed written order prior to delivery.

**Enteral – Nutrition and Feeding Pump**

**Common Diagnoses:** Dysphasia (787.2) and any other diagnoses that includes impaired lower bowel absorption or inability to swallow.

**Insurance Standard:** Nutrition
- Nutrition is covered if a patient experiences one of the following two occurrences:
  1. A permanent non-function or disease of the structures that normally permit food to reach the small bowel.
  2. Disease of the small bowel which impairs digestion and absorption of an oral diet.
- Both of these occurrences require tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the patient’s overall health status.
- If the patient can swallow, they may not qualify.

**Respiratory**

**Oxygen – Concentrators, Portable Tanks, Home Fill Units, Liquid Oxygen**

**Common Diagnosis:** COPD (496), CHF (428.0), and Pneumonia/three months (486).

**Insurance Standard:**
- A patient qualifies for 12 months if the following criteria are met:
  1. Their pO\(_2\) is less than or equal to 55 mmHg or their spO\(_2\) is less than or equal to 88 percent.
  2. Their qualifying data (saturation at rest and required liter flow) is reported within 30 days of an outpatient office visit or within 48 hours of hospital discharge.
  3. Their saturation levels are performed at a doctor’s office, hospital, or qualified lab.

**Nebulizer – Desktop and Portable Units**

**Common Adult Diagnoses:** COPD (496), Asthma (493.90), and Chronic Bronchitis (491.0).

**Common Pediatric Diagnosis:** RSV (079.6) Asthma (493.90) and Acute Bronchiolitis (466.1).

**Insurance Standard:**
- Patient qualifies for coverage if the nebulizer is deemed medically necessary and the appropriate medication solution is ordered.

**Other Considerations:**
- Pneumonia and wheezing are not covered diagnoses.
Overnight Pulse Oximetry Testing

**Common Diagnoses:** COPD (496), Asthma (493.90), and Chronic Bronchitis (491.0).

**Insurance Standard:**
1. Patient qualifies for coverage if there is suspicion of nocturnal desaturation.
2. Test can be completed every thirty days.
3. Test is not covered by Medicare.

Positive Airway Pressure (PAP) Devices – BiPAP/CPAP

**Common Diagnoses:** Obstructive Sleep Apnea (327.23), OSA (327.23)

**Insurance Standard:**
1. BiPAP/CPAP machines and accessories are covered if the patient has:
   1. A face-to-face clinical evaluation by the treating physician prior to the sleep test to assess the patient for obstructive sleep apnea.
   2. A Medicare-covered sleep test that meets either of the following criteria:
      - The Apnea-Hypopnea Index (AHI) or Respiratory Disturbance Index (RDI) is greater than or equal to 15 events per hour with a minimum of 30 events.
      - The AHI or RDI is greater than or equal to five and less than or equal to 14 events per hour with a minimum of 10 events. Documentation of excessive daytime sleepiness, impaired cognition, mood disorders, insomnia, hypertension, ischemic heart disease, or history of stroke is also required.

Other considerations:
1. Other diagnoses may be covered such as Central Sleep Apnea, COPD, and neuromuscular diseases. More information on these diagnoses are available upon request.

Pressure Reducing Support Surfaces – Group 1 and Group 2

**Common Diagnoses:** Quadriplegia – unspecified (344.00), Decubes/Hip (707.04), Decubes/Buttocks (707.05), Decubes/trunk (707.02 - 707.03), Alzheimer’s (331.0), CHF (428.0), and a number of spinal cord injuries.

**Insurance Standard:**
1. Patient qualifies for coverage of Group 1 pressure reducing support surfaces if one of these three criteria are met:
   1. The patient is completely immobile (patient cannot make changes in body position without assistance); or
   2. The patient has limited mobility (patient cannot independently make changes in body position significant enough to alleviate pressure) PLUS one of the following:
      - impaired nutritional status
      - fecal or urinary incontinence
      - altered sensory perception
      - compromised circulatory status; or
   3. The patient experiences any stage pressure ulcer on the trunk or pelvis PLUS one of the following:
      - impaired nutritional status
      - fecal or urinary incontinence
      - altered sensory perception
      - compromised circulatory status.

**Insurance Standard: Group 2**
1. Patient qualifies for coverage of Group 2 pressure reducing support surfaces if one of these three criteria are met:
   1. The patient experiences multiple stage II pressure ulcers located on the trunk or pelvis.
      - The patient has to have been on a comprehensive ulcer treatment program for at least the past month which included the use of an appropriate Group 1 support surface.
      - The ulcers have to be worse or the same over the past month.
1. The patient requires positioning of the body in ways not feasible with an ordinary bed for at least 30 days; or
2. The patient requires positioning of the body in ways not practical with an ordinary bed to alleviate pain; or
3. The patient requires the head of the bed to be elevated greater than 30 degrees most of the time due to CHF, COPD, or problems with aspiration. Pillows and wedges must have been considered and ruled out; or
4. The patient requires traction equipment and one of the following:
   - A bed height different than a fixed height bed to accommodate transfers.
   - Frequent changes in body position with an immediate need for change in position.

**Hoyer Lifts**

*Common Diagnoses:* Quadriplegia – unspecified (344.00), Parkinson’s (332.0), Lung Cancer (162.9), CHF (428.0), and various neuromuscular disorders.

*Insurance Standard:*

- Hoyer lifts are covered by Medicare if the transfer between bed and chair, wheelchair, or commode requires the assistance of more than one person and without the lift the patient would be bed confined.

**Trapeze Bar**

*Common Diagnoses:* Hip Fracture (820.8), COPD (496), Quadriplegia – unspecified (344.00), Parkinson’s (332.0), Lung Cancer (162.9), Osteoarthrosis (715.00).

*Insurance Standard:*

- Trapeze bars are covered when a patient needs the device to sit up because of respiratory conditions, to change body positions for other medical conditions, or to get in and out of bed.

**Suction Pump:**

*Common Diagnoses:* COPD (496), Tracheostomy (v44.0), ALS (335.20), various neuromuscular disorders.

*Insurance Standard:*

- Patient qualifies for coverage if they experience one of the following events:
  1. A tracheostomy
  2. Difficulty raising and clearing secretions due to cancer or surgery of mouth or throat.
  3. Dysfunction of swallowing muscles.
  4. The patient is unconscious.

**Ventilator – Adult and Pediatric**

*Common Diagnoses:* ALS (335.20), Tracheostomy (V44.0), End Stage COPD (496), and various neuromuscular disorders.

*Insurance Standard:*

- The ventilator is covered if the patient is physically unable to breathe or breathing insufficiently.
  - Because the failure of a mechanical ventilation system may result in death, it is classed as a life-critical system.

*Other considerations:*

- Ventilators require extensive discharge planning to include residence assessment, equipment selection, insurance preauthorization and patient/caregiver training during their inpatient stay. Patient must have been on ventilation a minimum of 48 hours prior to a Monday-Thursday discharge.

**Cough Assist – Adult and Pediatric**

*Common Diagnoses:* Multiple Sclerosis (340), Quadriplegia (344.00-344.09), Muscular Dystrophy (359.0-359.1) and various other neuromuscular disorders.
Insurance Standard:
Patient qualifies for coverage if both of the following criteria are met:
1. A diagnosis of a neuromuscular disease
2. The condition is causing a significant impairment of the chest wall and/or diaphragmatic movement such that it results in an inability to clear secretions.
Order must include pressure settings.

Mobility

Wheelchairs

Common Diagnoses: Various lower body fractures including Leg Fracture (827.0), Femur Fracture: nos – open (821.10), and Tibia Fracture: nos – closed (823.80). Other diagnoses include Osteoarthrosis (715.0), COPD (496), and various neurological diagnoses.

Insurance Standard:
- Wheelchairs are covered if the following criteria are met:
  1. The patient has a mobility limitation that impairs their ability to participate in one or more ability-related activity of daily living.
  2. Their mobility limitation cannot be sufficiently resolved with a walker or cane.
  3. The patient has sufficient upper body strength and mental capacity to self-propel; OR has a caregiver that is able and willing to propel the patient.

Other considerations:
- Heavy duty chairs are available for those patients weighing greater than 250 pounds and extra heavy duty chairs are available for patients weighing greater than 300 pounds.
- Lightweight versions are covered only if patient cannot propel the standard weight chair.
- In most cases if a patient qualifies for a wheelchair, he or she will also qualify for a wheelchair cushion. The cushion requires a detailed written order prior to delivery.

Walk Aids – Crutches, Canes, Walkers, and Rollators

Common Diagnoses: Osteoarthrosis (715.0), Abnormal Gait (781.2), Malaise/Fatigue (780.79), COPD (496), CHF (428.0), and various other lower body injuries.

Insurance Standard:
- Walk aids are covered if the following criteria are met:
  1. The patient must have a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activity of daily living in the home.
  2. The patient is able to use the walk aid safely.
  3. The functional mobility deficient can be sufficiently resolved by the selected walk aid.

Other considerations:
- Typically only one walk aid will be covered in a five-year period unless the patient’s condition positively or negatively changes and requires a different walk aid.

General DME

Hospital Bed – Semi-Electric and Low Beds

Common Diagnoses: Quadriplegia – unspecified (344.00), Parkinson’s (332.0), Lung Cancer (162.9), COPD (496), CHF (428.0), Osteoarthrosis (715.0), and any other diagnosis requiring special body positioning.

Insurance standard:
- Semi-electric beds are covered if one of these four criteria are met: