Medical Necessity Guideline

Medical Necessity Guideline (MNG) Title: Non-Preferred DME		
MNG #: 013	**☒SCO ☒One Care** **☒ MAPD-MA Medicare Preferred** **☒ MAPD-MA Medicare Value** **☒ MAPD-RI Medicare Preferred** **☒ MAPD-RI Medicare Value** **☒ DSNP-RI Medicare Maximus**	**Prior Authorization Needed?** **☒Yes ☐No**
Clinical: ☒	**Operational: ☐**	**Informational: ☐**
Medicare Benefit: **☒Yes ☐No**	**Approval Date:** 5/02/2019;	**Effective Date:** 09/15/2019;
Last Revised Date: 2/27/2020; 9/25/2021;	**Next Annual Review Date:** 05/02/2020; 2/27/2021; 9/25/2022;	**Retire Date:**

OVERVIEW:

CCA will, from time to time, choose a specific preferred brand of durable medical equipment (hereafter "DME" or "equipment") for all of its members who require such equipment. In general, it is our expectation that the brand or vendor we select can provide the maximal benefit to our members at a reasonable cost, and that the type of equipment available will meet the needs of the vast majority of our members.

DECISION GUIDELINES:

Clinical Coverage Criteria:

Occasionally, a member will not achieve an acceptable result with the preferred item or equipment. CCA can authorize coverage of non-preferred medical equipment after review by a medical director in the following circumstances:

1) The member has tried to use the preferred item but has been unable to obtain an appropriate therapeutic result (EXAMPLE: The member receives incorrect glucose readings from the preferred blood glucose meter). Documentation is required, usually in the form of a letter of medical necessity from your PCP or the physician, NP or PA (hereafter "provider") who is treating the problem for which the item, supply, or equipment is needed. The documentation must clearly (1) state that the member has tried the preferred item, equipment or supply, (2) describe why the preferred item did not meet the member's needs, AND (3) indicate that the requested item has been tried and shown to meet the member's needs.
2) There is a clear reason to believe the member will not be able to use the preferred item, equipment or supply, because the member requires a feature not available on the preferred device for medical reasons (EXAMPLE: The member is blind and requires a device that can provider verbal prompts or information, such as a glucometer with voice output). Documentation is required, in the form of a letter of medical necessity from your PCP or the provider who is treating the problem for which the item, equipment, or supply is requested. The letter should clearly indicate (1) why the preferred item will not meet the member's needs AND (2) why the requested item will meet the member's needs.

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KEY CARE PLANNING CONSIDERATIONS:

List of current DME items with preferred vendors/brands:

Abbott Diabetes Care

For supplies to monitor your blood glucose, including the following:

- A blood glucose monitor (Freestyle, Precision Xtra glucometers)
- Blood glucose test strips
- Lancet devices and lancets
- Glucose-control solutions for checking the accuracy of test strips and monitors

AUTHORIZATION:

Prior authorization is not required for these items when a preferred brand is requested. Prior authorization is required for any DME items and/or supplies received from other manufacturers.

Disclaimer:

This Medical Necessity Guideline is not a rigid rule. As with all of CCA's criteria, the fact that a member does not meet these criteria does not, in and of itself, indicate that no coverage can be issued for these services. Providers are advised, however, that if they request services for any member who they know does not meet our criteria, the request should be accompanied by clear and convincing documentation of medical necessity. The preferred type of documentation is the letter of medical necessity, indicating that a request should be covered either because there is supporting science indicating medical necessity (supporting literature (full text preferred) should be attached to the request), or describing the member's unique clinical circumstances, and describing why this service or supply will be more effective and/or less costly than another service which would otherwise be covered. Note that both supporting scientific evidence and a description of the member's unique clinical circumstances will generally be required.

REGULATORY NOTES:

N/A

RELATED REFERENCES:

N/A

ATTACHMENTS:

EXHIBIT A:	
EXHIBIT B:	

REVISION LOG:

REVISION DATE	DESCRIPTION

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05/02/2019	Reviewed and approved by CCA's Medical Policy Committee

APPROVALS:

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	2/27/2020
Signature	**Date**
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