Non-Preferred Durable Medical Equipment
Medical Necessity Guideline

Medical Necessity Guideline (MNG) Title: Non-Preferred Durable Medical Equipment		
MNG #: 013	☒ **SCO** ☒ **One Care** ☒ **MA Medicare Premier** ☒ **MA Medicare Value** ☒ **RI Medicare Preferred** ☒ **RI Medicare Value** ☒ **RI Medicare Maximus**	**Prior Authorization Needed?** ☐ **Yes (always required)** ☒ **Yes (only in certain situations. See this MNG for details)** ☐ **No**
Clinical: ☒	**Operational:** ☐	**Informational:** ☐
Benefit Type: ☒ **Medicare** ☒ **Medicaid**	**Approval Date:** 5/02/2019;	**Effective Date:** 09/15/2019; 2/8/2024
Last Revised Date: 2/27/2020; 9/25/2021; 6/10/2022; 9/1/2022; 2/8/2024	**Next Annual Review Date:** 05/02/2020; 2/27/2021; 9/25/2022; 6/10/2023; 9/1/2023; 2/8/2025	**Retire Date:**

OVERVIEW:

Commonwealth Care Alliance (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 may authorize requests for non-preferred medical equipment when ONE of the following criteria are met:

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 include the following:
    a. The member has tried the preferred item, equipment or supply; and
    b. Describe why the preferred item did not meet the member's needs, AND
    c. 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). A letter of medical necessity (LMN) is required from the PCP or requesting

provider who is treating the problem for which the item, equipment, or supply is requested. The LMN should include must include the following:

a. Why the preferred item will not meet the member's needs; and
b. Why the requested item will meet the member's needs.

List of current DME items with preferred vendors/brands:

Diabetic Supplies to Monitor Blood Glucose, including:

- Blood glucose monitor
- Blood glucose test strips
- Lancet devices and lancets
- Glucose-control solutions for checking the accuracy of test strips and monitors

Diabetic products include:

Abbott Diabetes Care products:	**LifeScan products:**
• FreeStyle Precision Neo® Meter • FreeStyle Precision Neo® Test Strips • FreeStyle Lite® Meter • FreeStyle Freedom Lite® Meter • FreeStyle Lite ® Test Strips • FreeStyle® Lancets • Freestyle® Test Strips • Freestyle InsuLinx ® Test Strips • Precision Xtra ® Meter • Precision Xtra® Test Strips • Precision Xtra Beta Ketone® Test Strips	• OneTouch Ultra 2® Meter • OneTouch Ultra Mini® Meter • OneTouch Ultra ® Test Strips • OneTouch Verio® Meter • OneTouch Verio® Reflect Meter • OneTouch Verio® Flex Meter • OneTouch Verio® Test Strips • OneTouch Delica® Lancets • OneTouch Delica® Plus Lancets • OneTouch Delica® Ultrasoft Lancets

AUTHORIZATION:

- Prior authorization is not required for diabetic testing supplies when a preferred brand is requested.
- Preferred diabetic testing supplies can be obtained with a new prescription, and supplies can be filled at a local pharmacy or by contacting a preferred DME supplier.
- Prior authorization is required for any DME items and/or supplies from non-preferred suppliers or manufacturers.

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Disclaimer

Commonwealth Care Alliance (CCA) follows applicable Medicare and Medicaid regulations and uses evidence based InterQual© criteria, when available, to review prior authorization requests for medical necessity. This Medical Necessity Guideline (MNG) applies to all CCA Products unless a more expansive and applicable CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), or state-specific medical necessity guideline exists. Medical Necessity Guidelines are published to provide a better understanding of the basis upon which coverage decisions are made. CCA makes coverage decisions on a case-by-case basis by considering the individual member's health care needs. If at any time an applicable CMS LCD or NCD or state-specific MNG is more expansive than the criteria set forth herein, the NCD, LCD, or state-specific MNG criteria shall supersede these criteria.

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. This Medical Necessity Guideline is subject to all applicable Plan Policies and Guidelines, including requirements for prior authorization and other requirements in Provider's agreement with the Plan (including complying with Plan's Provider Manual specifications).

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.

RELATED REFERENCES:

N/A

REVISION LOG:

REVISION DATE	DESCRIPTION
6/10/2022	Template changed to include PA requirements and benefit type. Regulatory notes updated.
05/02/2019	Reviewed and approved by CCA's Medical Policy Committee
8/22/2022	Revision made to reflect changes in preferred diabetic products beginning in 2023.
12/31/23	Approved by Utilization Management Committee
02/08/2024	Revision made to show updated preferred diabetic products, Abbott and LifeScan for 2024

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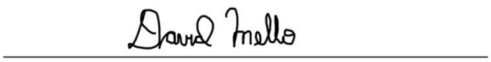
APPROVALS:

David Mello	Senior Medical Director, Utilization Review and Medical Policy
CCA Senior Clinical Lead [Print]	**Title [Print]**
	2/8/2024
Signature	**Date**
CCA Senior Operational Lead [Print]	**Title [Print]**
Signature	**Date**
Nazlim Hagmann	Chief Medical Officer
CCA CMO or Designee [Print]	**Title [Print]**
	2/8/2024
Signature	**Date**