

DME benefits grid

These services may or may not be covered by your HealthPartners plan. Please see your plan documents for your specific coverage information. If there is a difference between this general information and your plan documents, your plan documents will be used to determine your coverage.

Administrative Process

Prior authorization is not applicable for items listed below

Coverage

This benefit information does not apply to Minnesota Health Care Program products. For MHCP products, please see Related Content box to the right for links to MHCP Provider Manual: Equipment and Supplies and MHCP Medical Supply Coverage Guide.

Items listed below are generally covered subject to the indications listed below and per your plan documents.

Indications that are covered

See grid below

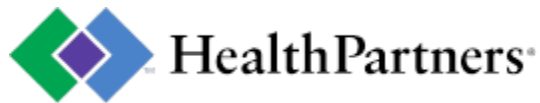
Indications that are not covered

See grid below

Codes

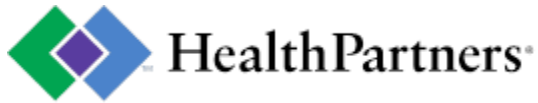
If available, codes are listed for informational purposes only, and do not guarantee member coverage or provider reimbursement. The list may not be all-inclusive.

DME item	Coverage	Criteria/limitations	Codes
Aids for visually impaired diabetics, such as: syringe magnifier (i.e., Magni-Guide), blood collection dropper (i.e., Smart Dot, Sure Shot), and non-visual insulin measurement device (i.e., Count-A-Dose).	Covered		
Air compressor	Covered		E0565
Ambu bag	Covered		S8999
Anti-nausea wristband	Not covered - over the counter items are not a covered benefit		A9999 E1399
Apnea monitor	Covered - rental		E0618, E0619
Aqua K pad and pump	Not covered, items for comfort are not a covered benefit.		E0217, E0249
Artificial larynx, trachea-esophageal voice prosthesis, tracheostomy speaking-valve and voice amplifier	Covered	Post laryngectomy	L8500, L8501, L8507, L8510



Bath bench	Not covered, items for hygiene, comfort, or convenience are not a covered benefit		E0245, E0247, E0248
Batteries	Limited coverage	<p>Covered for scooters, power assist wheels, zinc air battery for use with cochlear implants and replacement batteries for wearable cardioverter defibrillators. All others are not covered including but not limited to: diabetic monitors, TENS units, hearing aids, etc. as over the counter items are not a covered benefit.</p> <p>Batteries and battery chargers for power wheelchairs: please refer to Wheelchairs - mobility assistive equipment (MAE) coverage policy.</p>	A4233, A4234, A4235, A4236, A4601, A4602, A4611, A4638, E1356, E2359, E2361, E2363, E2365, E2366, E2371, E2397, K0601, K0602, K0603, K0604, K0605, K0607, K0733, L7360, L7364, L7367, L8505, L8621, L8622, L8623, L8624, Q0496, Q0503, Q0506, V5266
Bed pan	Covered		E0275, E0276
Bedwetting/ enuresis alarms	Not covered – items for comfort, convenience are not a covered benefit	Bedwetting alarms are not covered because they are considered a household item or for comfort or convenience, which is excluded in your member contract.	S8270
Bilirubin lights	Covered		E0202
Blood glucose test strips and their monitors/meters	<p>Preferred blood glucose test strips and their monitors are covered at pharmacies.</p> <p>Non-preferred blood glucose test strips and their monitors, and all coverage as a medical claim, require prior authorization from Pharmacy.</p>	<p>The preferred Blood Glucose Testing Product List is available.</p> <p>Coverage details are available in the “Glucose Testing Supplies” medical policy.</p>	A4253, A4255, A4271, A9275, E2100, E0607, E2101, E2104
Blood Pressure Monitors	Not covered – items for comfort, convenience are not a covered benefit		A4660, A4663, A4670
Braces, sleeves, or supports made entirely of elastic	Not covered – over the counter items are not a covered benefit		A4467
Breastfeeding Equipment and Supplies	Covered	Hospital grade breast pumps (E0604) - covered as a rental unit only	<p>Breast Pump E0602, E0603, E0604</p> <p>Breastfeeding Supplies</p>

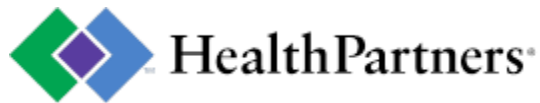
		<p>Breast pumps: (standard manual, standard electric, and heavy-duty hospital grade)</p> <p>Breastfeeding supplies: Replacement tubing for breast pump, replacement adapter for breast pump, replacement breast pump shield, replacement breast pump polycarbonate bottle, replacement breast pump locking ring, disposable collection, and storage bag for breast milk</p>	<p>A4281, A4282, A4283, A4284, A4285, A4286, A4287</p>
Bronchial drainage board. Postural drainage board, bronchial drainage table or tilt table	Covered		E0606
Cane or crutches	Covered		E0100, E0105, E0110, E0111, E0112, E0113, E0114, E0116, E0117
Car Seats	Not covered – items for comfort, convenience, recreation or safety, are not a covered benefit		
Cochlear implants – replacement of external equipment	Covered	Replacement of external communication equipment is covered. External communication equipment includes items such as mini-speech processor, microphone, headset and audio input selector, zinc air batteries, rechargeable batteries, charger.	<p>L8614, L8615, L8616, L8617, L8618, L8619, L8621, L8622, L8623, L8624. L8627, L8628, L8629</p>
Commode	<p>Standard, wide or extra wide commode is covered.</p> <p>All others not covered – including but not limited to: shower commode, or rolling commode, commode with seat lift mechanism. Items for comfort, convenience are not a covered benefit</p>		<p>E0163, E0165, E0168</p> <p>E0170, E0171 (not covered)</p>



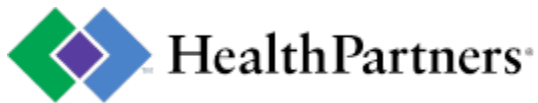
Continuous Glucose Monitoring System (CGMS), transmitter, sensors and receivers	Prior authorization is required from Pharmacy for both medical and pharmacy requests related to CGMS. Certain products must be purchased from a pharmacy. Certain employer groups may allow Continuous Glucose Monitoring System (CGMS) and supplies to be ordered through a DME provider and would not be subject to prior authorization.	Coverage details are available in the "Glucose Testing Supplies" policy. For implantable CGMS (e.g., Eversense) see the Investigational services - list of non-covered services policy	A9276, A9277, A9278, A4238, A4239, E2102, E2103
Continuous positive airway pressure (CPAP) device	Covered	Initial CPAP is a rent to purchase. Replacement CPAPs can be billed as an outright purchase. Please reference the Durable Medical Equipment (DME) and Prosthetics coverage criteria policy for more details about when replacement items are considered covered.	E0601
Cotton balls, alcohol wipes, rubbing alcohol, and Sharps containers	Not covered – over the counter items are not a covered benefit		
Cranial remolding helmet/ band	Covered		S1040
Danny sling	Not covered – items for comfort, convenience are not a covered benefit		No specific code
Diabetic monitoring equipment and supplies for blood glucose and urine ketones, such as: syringes, lancets, lancet devices, control / calibrating solutions (for checking accuracy of testing equipment & test strips), and urine ketone test strips.	Covered		
Diabetes infusion pump supplies such as	Covered		

infusion sets, needles, tubing and connector, syringe reservoir, sterile insertion-site dressing (i.e., Tegaderm) and tape needed to secure.			
DOSER for inhaled medications	Covered		K0730
Electrodes	Covered when required for use of a covered DME item		A4555, A4556, A4595, K0609
Enema or bowel management kit	Enema not covered - over the counter items are not a covered benefit Bowel management kits - covered		Not Covered A4649 (when used to describe enema) Covered A4458 A4459 E0350 E0352
Exercise equipment	Not covered – items for convenience, recreation are not a covered benefit		A9300
Foot orthotics, shoe inserts, and arch supports obtained over the counter	Not covered – over the counter items are not a covered benefit		L3040, L3050, L3060
Haberman Feeders and nipples	Covered		S8265
Humidifier	Humidifier - not covered. Household equipment and items for comfort, convenience are not a covered benefit Humidified air - covered when part of a tracheostomy, oxygen, CPAP, BIPAP or ventilator system	Please see continuous positive airway pressure (CPAP) device	A7046, E0550, E0555, E0560, E0561, E0562
In-exsufflation device (also called CoughAssist™, In-Exsufflator, Cofflator™, cough machine) and supplies	Covered		E0482, A7020
Insulin pump, including a combined or integrated continuous subcutaneous insulin infusion pump and	Covered		E0784, A9274

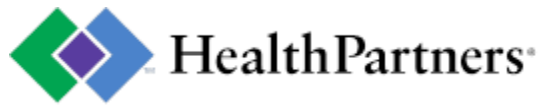
blood glucose monitoring system. Some of these integrated models have been referred to as artificial pancreases.			
Intermittent positive pressure breathing (IPPB) machine	Covered		E0500
Iontophoresis machine	Not covered for home use as items for comfort, convenience or recreation are not a covered benefit		E1399
IV therapy and pump supplies	Covered		A4213, A4220, A4221, A4222, A4223, A4300, A4301, A4305, A4306, E0776, E0781, E0791, K0105, S1015,
K-Y jelly	Not covered - over the counter		A9999 or E1399
Medical alert systems	Not covered		A9280
mySentry remote glucose monitor	Not covered – items for convenience are not a covered benefit		E1399
Nebulizer	Covered		A7003, A7004, A7005, A7006, A7007, A7008, A7017, E0570, E0572, E0574, E0575, E0580, E0585
Needles/syringes	Covered		A4206, A4207, A4208, A4209, A4212, A4213, A4215, A4232, A4322, A4657, C1715, C1830, C2618, K0552, S8490
Oscillatory positive expiratory pressure device, nonelectric, any type, each	Covered		E0484
Ostomy supplies	Covered	Colostomy / Ileostomy / Nephrostomy / Ureterostomy - Covered supplies include items such as belt, pouch, bags, wafer, face plate, insert, barrier, filter, gasket, plug irrigation kit/sleeve, tape, skin prep, adhesives, drain sets, adhesive remover, pouch deodorant, gauze and skin barrier preps.	A4357, A4361, A4364, A4366, A4369, A4371, A4373, A4375, A4378, A4384, A4385, A4387, A4390, A4394, A4396, A4398, A4400, A4402, A4404, A4427, A4435, A4436, A4437, A4450, A4452, A4455, A4456, , A5051, A5052, A5057, A5061, A5063, A5081, A5083, A5093, A5102, A5120, A5122, A5126, A5131, A5200
Overbed table	Not covered – convenience items are not a covered benefit (Unless enrolled in hospice)		E0274
Oximeter	Covered		E0445
Paraffin bath-portable	Not covered – items for comfort,		E0235



	convenience are not a covered benefit		
Patient lifts (Hoyer, etc.)	Coverage varies	E0625, E0630, E0637 (hydraulic or mechanical lift) are covered. E0635, E0636, E0639 (electric lift) are not covered	E0625, E0630, E0637, E0635, E0636, E0639
Peak flow meter	Covered		A4614, S8096, S8097
Percussor, electric or pneumatic, home model	Covered		E0480
Pleural effusion drainage systems	Covered		A7048
Positioning chairs	Not covered – items for comfort, convenience are not a covered benefit		
Protective helmets	Not covered – items for recreation and over the counter items are not a covered benefit		A8000, A8001, A8002, A8003, A8004
Prothrombin time monitors	Covered		G0248, G0249, G0250
Respiratory assist device (includes BiPAP or Bilevel Positive Airway Pressure device)	Covered	Excludes vests (E0483)	E0470, E0471, E0472
Scales	Not covered – household equipment and items for comfort, convenience are not a covered benefit		A9999 or E1399
Seating support cushion (for wheelchair seating support, refer to Wheelchairs – Mobility Assist Equipment (MAE) policy)	Not covered, items for comfort, convenience are not a covered benefit		No specific code
Sitz baths	Not covered, items for hygiene, comfort, or convenience are not a covered benefit		E0160, E0161, E0162
Spacers for use with inhalers	Covered	Types of spacers include Aerochamber™, Breathancer™, Inhal-Aid™, Inspirease™, Spinhaler-Turbo™ and OptiChamber®.	A4627, S8100, S8101
Splints	Covered		
Standing frame/stander	Covered		E0637, E0638, E0641, E0642



Suction machine and catheters	Covered	Coverage is limited to no more than 3 months stock of catheters at a time.	A7002, A4605, A4624, A4628, E0600, E2000, E2001
Therapeutic light box; tabletop or desk top lightboxes	Covered	Floor stands, carrying case, and optional desk stands are not covered as they are comfort, convenience or recreational items	E0203, A9999
Tracheostomy supplies	Covered	Covered items include trach tube, ties (also referred to as twill tape), holders, cannula, tracheostomy care kit, tube brush, pipe cleaners, cotton tip applicators, 4x4 sponge/gauze, saline, sterile water. No more than a 3 month stock is covered at a time. Tracheostomy speaking valve, also called a stint or tracheal esophageal speaking valve, is covered.	A4481, A4605, A4623, A4624, A4625, A4626, A4629, A7501, A7502, A7503, A7504, A7505, A7506, A7507, A7508, A7509, A7520, A7521, A7522, A7523, A7524, A7525, A7526, A7527, L8501, S8189
Traction equipment	Covered except for spinal unloading devices and spinal decompression therapy (see the Investigational services - list of non-covered services policy)		E0830, E0840, E0849, E1399
Transfer belt	Covered		E0705
Transfer board	Covered	A basic transfer board is covered	E0705
Truss	Covered		L8300, L8310, L8320, L8330
Urinal	Covered		E0325, E0326
Urinary supplies	Covered		A4321, A4327, A4328, A4331, A4332, A4333, A4334, A4351, A4352, A4353, A4356, A4357, A4358, A4360, A5105, A5112
Vaginal cones or dilators	Covered		A9999 or E1399
Ventilator and supplies	Covered	A ventilator is a rental item only. Supplies (usually purchase only) required to maintain the ventilator are covered.	A4483, A4611, A4612, E0465, E0466, E0467
Vitrectomy table	Covered	The face support equipment and necessary chair or table support attachments are covered. Rental or purchase from an approved DME vendor.	E1399
Wearable defibrillator and replacement garments and electrodes	Covered		K0606, K0608 and K0609
Wedges, pillows, cushions	Not covered – items for comfort, convenience are not a covered benefit		E0190
Wheelchair accessories:	Not covered – items for comfort,		K0108



<ul style="list-style-type: none">• Cup holders• Cell phone sleeves/ holders• Baskets, backpacks, carry bags, pouches, bag hooks• Lights/ LED light kits• Custom paint• Flags• Horns• USB ports• Bluetooth modules• Sunshades• Crutch holders	convenience or recreation are not a covered benefit		
---	---	--	--

CPT Copyright American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.

Products

This information is for most, but not all, HealthPartners plans. Please read your plan documents to see if your plan has limits or will not cover some items. If there is a difference between this general information and your plan documents, your plan documents will be used to determine your coverage. These coverage criteria do not apply to Medicare Products. For more information regarding Medicare coverage criteria or for a copy of a Medicare coverage policy, contact Member Services at 952-883-7272 or 1-877-778-8384.

Approved Benefits Committee: 1/24/17, 1/8/18, 2/4/19, 4/20/20, 10/1/2020, 6/28/2021, 10/21/2021, 4/29/2024, 7/29/2024, 10/28/2024, 11/25/2024, 4/28/2025.

Revised 5/11/17; 8/10/2017; 9/25/17, 11/06/17, 1/29/18, 3/5/18, 3/21/18, 4/11/18, 6/6/18, 8/6/18, 8/24/18, 9/27/18, 11/28/18, 1/3/19, 2/5/19, 3/8/19, 3/28/19, 5/30/19, 9/25/2019, 3/18/20, 4/20/20, 10/1/2020, 6/28/21, 10/21/21, 4/29/2024, 7/29/2024, 10/28/2024, 11/25/2024, 4/28/2025.

Annual Review: 1/2018, 1/2019, 4/2020, 4/2021, 4/2022, 7/2024.

Vendor

For in-network benefits to apply, item must be received from a contracted vendor or provider.