Provider Ordered

DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLY FORMULARY

UTILIZATION MANAGEMENT

Revised on April 20, 2023

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLY FORMULARY CATEGORIES

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DERMATOLOGY

BURN GARMENT

INDICATIONS-ALL MUST BE MET

1. Provide support and protection from contamination due to a burn injury
2. The patient is at risk for a post-burn contracture in the affected area where the garment will be applied
3. The patient is receiving physical or occupational therapy to prevent contractures or the need for skin grafting

Burn Garment	**DESCRIPTION**	**BRAND**
  	▪ Compression burn garment, bodysuit (head to foot) ▪ Compression burn garment, chin strap, ▪ Compression burn garment, glove to wrist ▪ Compression burn garment, glove to elbow ▪ Compression burn garment, glove to axilla ▪ Compression burn garment, foot to knee length ▪ Compression burn garment, foot to thigh length ▪ Compression burn garment, upper trunk to waist including arm openings (vest) ▪ Compression burn garment, trunk, including arms down to leg openings (leotard) ▪ Compression burn garment, not otherwise classified ▪ Compression burn mask, face, and/or neck, plastic or equal	Varies

CUSHION

❖ WHEELCHAIR SEAT

INDICATIONS

1. Prevention or treatment of pressure injuries
2. Use of cushion can also include:
    a. Education about weight shifting and frequent off-loading
    b. Review and reduction of impact of other controllable factors, including shear, moisture, friction, temperature, nutrition, and hydration
    c. Consideration of cushion types such as inflatable seat cushion, foam seat cushion, gel seat cushion, solid seat cushion

Cushion Seat Inflatable 	**DESCRIPTION** Seat Cushion ROHO® Quadtro Select® Low Profile® 16” (W) x 16” (D) x 2” (H) Neoprene Rubber. Cushion comes with 2-way stretch cover, hand inflation pump and repair kit. Postural adjustments are made while the user is seated. Cushion is designed to conform to an individual's seated shape. Helps in minimizing side to side or front to back motion. Effective for individuals that require accommodation of pelvic asymmetry up to approximately 1" (mediolateral or anterior/posterior).	**BRAND** ROHO Quadtro Select Low Profile Cushion Fits Chair 16” (W) x 16” (D) Mfr: Quadtro Mfr Part#: QS910LPC
Cushion Seat Inflatable High Profile 	**DESCRIPTION** High profile seating and positioning wheelchair seat cushion 18" W x 20" L x 4" H. Four-compartment cushion adjusted through a single valve.	**BRAND** Brand: Roho, Mfr Permobil US ASIN B002LCIJYY Roho Quadtro Select High Profile Seating and Positioning Wheelchair Cushion
Cushion Seat Wheelchair Foam 	**DESCRIPTION** Seat Cushion McKesson 16” (W) x 18” (L) x 3” (H) Convoluted Polyurethane Foam. Non-inflatable, 2" overlay.	**BRAND** McKesson Convoluted Foam Wheelchair Seat Cushion 16” (W) x 18” (L) x 3” (H) Item#: 136-58132. Sold each or 18/pack.
Gel Foam 	**DESCRIPTION** Titanium Skin Protection and Positioning Gel/Foam Wheelchair Cushion, 20" (W) x 16" (D) x 3.5" (H). Top layer of foam combined with a dual-chamber gel bladder. Low-shear, fluid-resistant stretch nylon cover, middle layer of high-resilient, high-density foam, non-skid bottom. Pommel acts as a built-in leg abductor.	**BRAND** Drive Medical Titanium Skin Protection and Positioning Gel/ Foam Wheelchair Cushion, 20" (W) x 16" (D) x 3.5" (H) Mfr Part#: FPT-3

❖ DAY CHAIR/GERIATRIC CHAIR

INDICATIONS
Risk for sacral wound; requires pressure relieving support surface

Ring Invalid Foam Non-Latex 	**DESCRIPTION** Foam Invalid Rings, 14” 2/box. Cushion is made of soft high density therapeutic non-latex foam.	**BRAND** Medline Foam Invalid Ring, 14" with cover, 2/box. Material#: MSC192102
Cushion Foam Molded Ring 	**DESCRIPTION** DMI Contoured Foam Ring Cushion, white, 18" x 15" x 3". High-density foam with removable, machine washable polyester/cotton cover.	**BRAND** DMI Contoured Foam Ring Cushion, white, 18" x 15" x 3" Brand: Duro Med Mfr: Briggs Healthcare Mfr Part#: 513-8018-1900

HEEL/FOOT PROTECTOR

INDICATIONS
Per Pressure Injury Prevention protocol

Heel/Foot Protector 	**DESCRIPTION** Heel protector, convoluted foam, one size fits most. Heel insert covered with low friction fabric for reduction of sweating and friction burns. Two cloth hook and loop strap fasteners. Includes auxiliary foam pad for extending the length or height. Multiple ventilation holes.	**BRAND** Skil-Care Mfr#: 503450 McKesson#: 844173

NEGATIVE PRESSURE WOUND THERAPY/VACUUM ASSISTED CLOSURE

INDICATIONS
Patient has non-healing wound(s) and ONE of the following conditions exists:

1. There are complications of a surgically created wound (e.g., dehiscence, post sternotomy disunion with exposed sternal bone, post sternotomy mediastinitis, or postoperative disunion of the abdominal wall).
2. There is a traumatic wound (e.g., preoperative flap or graft, exposed bones, tendons, or vessels) and a need for accelerated formation of granulation tissue not achievable by other topical wound treatments (e.g., the individual has comorbidities that will not allow for healing times usually achievable with other available topical wound treatments).

(if present), maintenance of an adequate nutritional status, and weekly evaluations with documentation of wound measurements (i.e., length, width, and depth) in ONE of the following clinical situations:

a. Chronic Stage III or Stage IV pressure ulcer
    i. The patient has been on an appropriate turning and repositioning regimen
    ii. The patient has used an appropriate pressure relief device (e.g., low air loss bed, alternating pressure mattress) for pressure ulcers on the posterior trunk or pelvis
    iii. The patient's moisture and incontinence have been appropriately addressed
b. Chronic diabetic neuropathic ulcer
    i. The patient has been on a comprehensive diabetic management program
    ii. The patient has had appropriate foot care
    iii. The patient has been non-weight-bearing, if appropriate
c. Chronic venous ulcer
    i. Compression garments/dressings have been consistently applied
    ii. Leg elevation and ambulation have been encouraged

The use of NPWT beyond four months may be allowed only when medical necessity continues to be met as previously outlined and there is evidence of clear benefit from the NPWT treatment already received.

PRESSURE REDUCING SUPPORT SURFACE

❖ MATTRESS

INDICATIONS

1. Increased risk for development of pressure injuries as indicated by 1 or more of the following:
    a. Braden scale score of 14 or less (refer to care guide for Wound Care)
    b. Braden scale score of 18 or less with risk factors as indicated by 1 or more of the following:
        i. Age older than 75 years
        ii. Diastolic pressure below 60 mm Hg
        iii. Fever
        iv. Poor dietary intake of protein
2. National Pressure Injury Advisory Panel Stage 1 Pressure Injury (Non-blanchable erythema of intact skin) (refer to care guide for Wound Care) or greater pressure injury as indicated by 1 or more of the following:
    a. Single pressure injury in location other than heel
    b. Two or more pressure injuries in locations that allow patient to be repositioned and offload pressure injuries.

Mattress Overlay, Foam Gel 	**DESCRIPTION** 34" x 76" x 3" Weight capacity 300 lbs. Horizontal chambers encapsulate gel with foam beads to conform to body. Standard foam top layer. Nylon top cover with skid-resistant vinyl bottom layer. Elastic straps secure corners of overlay to a mattress.	**BRAND** Medline Remedy Brand Standard Gel Foam Overlay. Mfr: Medline Mfr Part #: MSCGELOV

WOUND CARE DRESSING*

INDICATIONS

1. When a wound cover with an adhesive border is being used, no other dressing is needed on top of it and additional tape is usually not required. Reasons for use of additional tape must be well documented. An adhesive border is usually more binding than that obtained with separate taping and is therefore indicated for use with wounds requiring less frequent dressing changes.
2. Use of more than one type of wound filler or more than one type of wound cover in a single wound is rarely medically necessary and the reasons must be well documented. An exception is an alginate or other fiber gelling dressing wound cover or a saline, water, or hydrogel impregnated gauze dressing which might need an additional wound cover.
3. It may not be appropriate to use some combinations of a hydrating dressing on the same wound at the same time as an absorptive dressing (e.g., hydrogel and alginate).
4. Because composite dressings, foam and hydrocolloid wound covers, and transparent film, when used as secondary dressings, are meant to be changed at frequencies less than daily, appropriate clinical judgment should be used to avoid their use with primary dressings which require more frequent dressing changes. While a highly exudative wound might require such a combination initially, with continued proper management the wound usually progresses to a point where the appropriate selection of these products results in the less frequent dressing changes which they are designed to allow. An example of an inappropriate combination is the use of a specialty absorptive dressing on top of non-impregnated gauze being used as a primary dressing.
5. Dressing size must be based on and appropriate to the size of the wound. For wound covers, the pad size is usually about 2 inches greater than the dimensions of the wound. For example, a 5 cm x 5 cm (2 in. x 2 in.) wound requires a 4 in. x 4 in. pad size.
6. Dressing needs may change frequently (e.g., weekly) in the early phases of wound treatment and/or with heavily draining wounds.

Dressing change frequency:

- Alginate wound cover - dressing change once daily
- Alginate wound filler- dressing change once daily, up to (2) 6” strips per dressing change
- Composite dressing - 3 times per week, 1 dressing per dressing change
- Contact layer - once per week
- Foam dressing - up to 3 times per week
- Foam wound filler - once daily
- Gauze - 3 times per day, no more than 2 pads on a wound (non-impregnated)
- Gauze - once daily (impregnated - other than water or saline)
- Gauze - Non-covered, reduced to regular non-impregnated gauze level (impregnated with water or saline)
- Hydrocolloid cover and filler - 3 times per week
- Hydrogel wound cover - once daily (or 3 times per week if using adhesive border)
- Hydrogel wound filler - once daily, no more than 3 ounces per wound in a 30-day period
- Specialty absorptive dressing - once per day (or every other day if using adhesive border)
- Transparent film - up to 3 times per week
- Wound filler not classified - once per day
- Wound pouch - up to 3 times per week
- Tape - determined by frequency of dressing change
- Elastic bandage - 1 per week
- Gauze, elastic - determined by the frequency of dressing change of the primary dressing
- Gauze, non-elastic - determined by the frequency of dressing change of the primary dressing

ENDOCRINOLOGY

DIABETIC SUPPLIES/MONITOR*

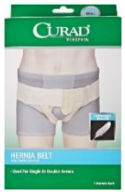
INDICATIONS

1. Long-term use in a type 1 diabetic age 25 years or older
2. Long-term use in a type 1 diabetic age 24 years or younger with recurrent, severe hypoglycemic events (i.e., blood glucose < 50 mg/dL) despite appropriate modifications in insulin therapy and compliance with frequent self-monitoring of blood glucose (i.e., at least four times daily)
3. Long-term use in a type 2 diabetic with recurrent, severe hypoglycemic events (i.e., blood glucose < 50mg/dL) despite appropriate modifications in insulin therapy, and compliance with frequent self-monitoring of blood glucose (i.e., at least four times daily) and EITHER of the following:
    a. Fasting C-peptide level ≤ 110% of the lower limit of normal of the laboratory's measurement method AND a concurrently obtained fasting glucose ≤ 225 mg/dL
    b. Renal insufficiency with a creatinine clearance (actual or calculated from age, gender, weight and serum creatinine) ≤ 50 ml/minute AND a fasting C-peptide level ≤ 200% of the lower limit of normal of the laboratory's measurement method

GASTROENTEROLOGY

BELT – HERNIA

INDICATIONS
Support for single and double inguinal hernias.

Belt Hernia Elastic 	**DESCRIPTION** CURAD Hernia Belts, elastic, retail packaging, Small. 30"-35 circumference, 4/CS. Hook and loop closure. Removable foam compression pads.	**BRAND** CURAD Hernia Belt with Compression Pads, Small Size, Beige. Brand: CURAD Mfr: Medline Item Model#: ORT22400SDHH
Belt Hernia Peristomal 	**DESCRIPTION** Peristomal Hernia Belt Nu-Form™ 2X-Large 4” (W). Opening size, 2-3/4” centered. Hip size 47"-52". Adjustable hook and loop closure. For support of hernias around and adjacent to the stoma. Helps manage prolapsed stomas, protect abdominal hernia repairs, and prevent recurrence.	**BRAND** Peristomal Hernia Belt, 2X-Large, 4” wide Brand: Nu-Form Mfr: Nu-Hope Laboratories Mfr#: 6314

BINDER – ABDOMINAL

INDICATIONS
Compression and support for post-natal or post-abdominal surgery, abdominal strains and weakness. Temporary use of an abdominal binder can be useful in patients with large-necked hernias, during the pre-operative period or in situations where there is a high risk of surgery on a long-term basis. Non-surgical management of abdominal wall hernias with an abdominal binder is not considered effective but may be the only option in a patient who is not a reasonable candidate for surgery. However, binders can place pressure on skin and bowel, induce related injury and mask signs of incarceration and strangulation.

Binder Abdominal 	**DESCRIPTION** Abdominal Binder DJO Procare® 12” 4-Panel 3X-Large Contact Closure 82 - 100” waist measurement, 12” (W), Unisex 9” 3-Panel Elastic Binder, 30"-45" waist measurement, 9" (W) 12” 4-Panel 2X-Large Contact Closure 72 - 84”12” Unisex	**BRAND** ***12” 4-Panel XXXL*** DJO ProCare Abdominal Binder 12” 4-Panel 3X-Large Contact Closure 82 - 100” waist measurement, 12” (W), Unisex 9” 3-Panel Elastic Binder, 30"-45" waist measurement, 9" (W) 12” 4-Panel 2X-Large Contact Closure 72 - 84”12” Unisex Mfr: DJO Mfr# 79-89280

OSTOMY SUPPLIES

INDICATIONS

1. When liquid barrier is necessary, either a liquid or spray or individual wipes is appropriate. Use of both is not medically necessary.
2. Patients with continent stomas may use the following to manage/prevent drainage: *stoma cap, *stoma plug, or *gauze pads. No more than one type of supply would be medically necessary on a given day.
3. Patients with urinary ostomies may use a bag or bottle for drainage at night. It is not medically necessary to have both.

PERSONAL HYGIENE WIPE (BOTTOM BUDDY)

INDICATIONS

For elderly, disabled, injured, pregnant or others having difficulty wiping after using the toilet.

Personal Hygiene Wipe (Bottom Buddy) 	**DESCRIPTION** Essential Medical Supply Personal Hygiene Wipe. Plastic. Extends user's reach more than 12". Features easy release button and works with toilet paper or pre-moistened wipes.	**BRAND** Essential Medical Supply. Product # L3060

SITZ BATH*

INDICATIONS

The patient has a perineal injury or infection and sitz bath is part of a medically necessary prescribed treatment regimen.

Sitz Bath 	**DESCRIPTION** High–impact plastic bowl with 2000 ml capacity solution bag with shut-off clamp on the tubing control flow. Packaged 10 per case, individually bagged	**BRAND** McKesson Mfr: McKesson Brand Mfr#: 56-80102

TRUSS HERNIA SUPPORT

INDICATIONS

Used for the purpose of supporting a weak or deformed body part or restricting or eliminating motion.

Hernia Aid Belt 	**DESCRIPTION** Adjustable form-fitting hernia belt. Two fully adjustable contoured foam supporting pads can be worn together or as a single support on either side. Pads retain hernia without putting pressure on the lower abdomen. Hip size 46”-52”	**BRAND** Mfr: Alimed Mfr#: 63561

HEARING ASSISTED DEVICES

HEARING AID

INDICATIONS
See InterQual/Durable Medical Equipment/General/Hearing Aid

HEARING IMPAIRED DISABILITY VEST

INDICATIONS
Hearing Impaired:

1. Individual is deaf or severely hearing impaired and requires written notes, sign language, or lip-reading accommodation to achieve effective communication.
2. Individual has a hearing impairment and uses an assistive hearing device to achieve effective communication.
3. Patients with permanent hearing disability and MUST have an 1845 with DPH or DNH code; temporary issue for DNH with 7410 when hearing aids are not available.

Vest Hearing Impair YLW Reg 	**DESCRIPTION** ADA Fluorescent yellow mesh vest. Constructed with breathable 3.0 oz 100% polyester mesh.	**BRAND** TBD

NEUROLOGY

HELMET - SEIZURE

INDICATIONS

1. Frequent, violent and/or uncontrollable seizures
2. Balance disorders or other conditions increasing risk of head trauma
3. Following cranial surgery. Annual replacement of any removable inner liner is considered medically necessary

Helmet Seizure	**DESCRIPTION**	**BRAND**
 	Lightweight Soft-Shell Helmet made of shock-absorbent foam that is fully ventilated. Coated in vinyl. There is no hardware included so the user's face will not connect with anything hard or sharp. Supplied with snap closure chin strap. Sizing pads available for size adjustments.	Danmar Products Lightweight Soft-Shell Helmet, Casa Tan Item#: 9820, XXL is not a stock item

OBSTETRICS/GYNECOLOGY

BREAST PUMP

INDICATIONS

1. If direct nursing at the breast is established during the neonatal period (the period immediately following birth and continuing through the first 28 days of life) and nursing is interrupted, a manual breast pump is indicated for any the following medical conditions:
    a. The mother has a medical condition that requires treatment of her breast milk before infant feeding
    b. The mother is receiving chemotherapy or other therapy with pharmaceutical agents that render her breast milk unsuitable for infant feeding
    c. The infant developed a medical condition or requires hospitalization that precludes direct nursing at the breast on a regular basis
2. If direct nursing at the breast is not established during the neonatal period, a manual breast pump is indicated for any the following medical conditions:
    a. Any maternal medical condition that precludes direct nursing at the breast
    b. The infant has a congenital or acquired neuromotor or oral dysfunction that precludes effective direct nursing at the breast
    c. The infant has a congenital or acquired condition that precludes effective direct nursing at the breast
    d. The infant continues to be hospitalized and the mother is no longer an inpatient

Breast Pump	**DESCRIPTION**	**BRAND**
	Manual breast pump kit. Portable manual breast pump with silicone massage inserts and built-in back flow protection device to ensure safe and hygienic expressing.	Spectra. Mfr: Mother's Milk Inc. Mfr#: MM0109

VAGINAL DILATOR

INDICATIONS

Vaginal dilators are to be used after vaginoplasty to maintain, lengthen, and stretch the neovagina. Dilation is necessary to prevent the neovagina from losing depth and width. Vaginal dilation usually begins shortly after surgery and continues for a lifetime.

Vaginal Dilator	**DESCRIPTION**	**BRAND**
	Rigid polyurethane dilators with tapered rounded tip. Vary in diameter and length from 7/8" x 9" to 1 3/8" x 9". Available individually and sets of 4.	Mfr: Soul Source GRS Vaginal Dilators

OPHTHALMOLOGY AND OPTOMETRY

CANE

❖ **FOLDING WHITE CANE, TAPPING CANE**

INDICATIONS

Impaired vision assistive device. Patients with permanent visual disability and MUST have an 1845 with DPV or DNV code; required to have Certified Orientation and Mobility Specialist (COMS) Training prior to provision.
Color variations:

a. All white cane: user is completely blind and has no usable vision
b. White cane with red bottom: user has low, but some usable, vision
c. White and red striped cane: user is total blind and/or deaf
d. Different tips are used in different environments. Please order per COMS instructor recommendations e.g.: pencil, roller, marshmallow, metal glide

Folding White Cane, Tapping Cane 	**DESCRIPTION** Folding Cane for Blind Aluminum 46" Red / White	**BRAND** Walking cane for the blind Part#: 713324

CONTACT LENSES (MUST UTILIZE RFS PROCESS)

INDICATIONS

Rigid contact lenses are medically necessary for:

1. Anisometropia of > 4 diopters provided amblyopia (lazy eye), or strabismus is not present.
2. High ametropia (hyperopia, myopia) of greater than or equal to 10 diopters only if refractive correction with eyeglasses is insufficient.
3. Keratoconus when best correction with eyeglasses is worse than 20/80.
4. Aphakia (lack of the lens due to surgical removal or congenital absence)
    a. Unilateral aphakia with the aphakic eye having best corrected visual acuity of 20/100 or better
    b. Contact lenses are not required if the eye is amblyopic or has extensive macular damage.

Soft contact lenses are medically necessary for:

1. Not for correction of refractive errors
2. Therapeutic soft (hydrophilic) contact lenses and gas permeable fluid ventilated scleral lenses are medically necessary when used as corneal bandages for the following:
    a. Corneal stem cell deficiency (e.g., Stevens-Johnson syndrome/toxic epidermal necrolysis [TEN], chemical and thermal eye injuries including surgical procedures, aniridia, idiopathic corneal stem cell deficiency and ocular pemphigoid)
    b. Neurotrophic (anesthetic) cornea that may result from
        i. Acquired conditions such as acoustic neuroma surgery, trigeminal ganglionectomy, trigeminal rhizotomy, herpes simplex/zoster of the cornea, diabetes
        ii. Congenital etiologies such as corneal anesthesia (familial dysautonomia) or Seckel's syndrome
    c. Severe dry eyes (keratoconjunctivitis sicca) from Sjogren's syndrome, chronic graft vs host disease, radiation, surgery or Meibomian gland deficiency when other standard treatments have failed.
    d. Corneal disorders associated with systemic autoimmune disease (rheumatoid arthritis, atopic

epidermolysis bullosa, epidermal dysplasia)
   e. Epidermal ocular disorders (atopy, ectodermal dysplasia, epidermolysis bullosa)
   f. Corneal exposure (anatomic or paralytic)
3. Scleral shell contact lenses are medically necessary for the following indications:
   a. For the treatment of keratoconjunctivitis sicca or “dry eye"
   b. When prescribed to support orbital tissue (such as where an eye has been rendered sightless and shrunken by inflammatory disease)
   c. Replacement lenses are considered medically necessary because of a change in the patient's physical condition (not including refractive changes)

Contact Lenses	**DESCRIPTION**	**BRAND**
	▪ Rigid Gas Permeable ▪ Soft Lens (Hydrophilic) ▪ Scleral Shell	Varies

EYEGLASSES

❖ **APHAKIA**

INDICATIONS

The following lenses or combinations of lenses are medically necessary following cataract surgery to essentially restore the vision provided by the crystalline lens of the eye. These include:

1. Bifocal spectacles
2. Spectacles for far vision or for near vision

❖ **PRESCRIPTION HANDHELD**

INDICATIONS

Vision impairment; must be accompanied with a prescription.

Eyeglasses Prescriptions	**DESCRIPTION**	**BRAND**
	Eyeglasses, patient specific. Prescription order only	Varies

MAGNIFIER

INDICATIONS

Magnification for the patient with reduced best corrected visual acuity. Required level of magnification is typically task specific, may vary for different activities, and is determined by a low vision rehabilitation specialist.

❖ HANDHELD

Magnifier - Handheld	**DESCRIPTION**	**BRAND**
	Large handheld LED magnifier, 4" magnifying glass. Large 4" 2.4x, 3 LED-lit handheld magnifier with a 4x bifocal lens and 10x 1" secondary lens in the handle. Extra wide field of view. Uses 3 AAA batteries.	Varies

❖ HEADBAND

Magnifier - Headband	**DESCRIPTION**	**BRAND**
	Adjustable Headband Magnifying Glass with LED Light- 8x, 15x 23x, 2 LED lights, magnifier goggles binocular glasses, handsfree magnifier for magnifying glasses for reading, jewelry loupe, watch and electronic repair. Made of high-quality plastic, imported acrylic optical lens, ***not*** glass. Requires 3 AAA batteries (Batteries are not included).	Varies

OCULAR CONFORMER

INDICATIONS

Used as post-operative enucleation stent to provide a smooth surface for the lids to blink over while protecting the surgical closure beneath it.

Ocular Conformer	**DESCRIPTION**	**BRAND**
	Ocular Conformer for post-operative enucleation stents	Varies

VISION IMPAIRED DISABILITY VEST

INDICATIONS

Patients with permanent visual disability and MUST have an 1845 with DPV or DNV code; temporary issue for DNV with 7410 when eyeglasses or contact lenses are not available.

Vest Vision Impair YLW Reg 	**DESCRIPTION** ADA Fluorescent yellow mesh vest. Constructed with breathable 3.0 oz 100% polyester mesh.	**BRAND** TBD

ORTHOPEDICS

ANKLE FOOT ORTHOSES/KNEE ANKLE FOOT ORTHOSES (AFO/KAFO)

INDICATIONS

For non-ambulatory patients:

1. Ankle contracture splints - medically necessary if ALL the following criteria are met:
    a. The ankle contracture splint is used as a component of a therapy program that includes active stretching of the involved muscles and/or tendons
    b. The contracture is interfering or expected to interfere significantly with the patient's functional abilities
    c. There is a reasonable expectation of the ability to correct the contracture
    d. The patient has a plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least 10 degrees (i.e., a non-fixed contracture)
    e. If an ankle contracture splint is used for the treatment of a plantar flexion contracture, the pre-treatment passive range of motion must be measured with a goniometer and documented in the health record. There must be documentation of an appropriate stretching program carried out by professional staff.

For ambulatory patients:

1. Ankle Foot Orthoses - medically necessary for ambulatory patients with weakness or deformity of the foot and ankle which require stabilization for medical reasons and have the potential to benefit functionally. This would include patients with multiple sclerosis, cerebral palsy, cerebrovascular accident, spina bifida, traumatic brain injury, peripheral neuropathy or spinal cord injury who have orthopedic or neurologic conditions with noted weakness of the ankle stabilizer muscles such as foot drop.
2. Knee-ankle-foot orthoses (KAFO) - medically necessary for ambulatory patients for whom an ankle-foot orthosis is clinically indicated and for whom additional knee stability is required.
3. Molded-to-patient model AFO's and KAFO's - Custom-made AFOs and KAFOs that are "molded-to-patient-model" are considered medically necessary for ambulatory patients when the basic medical necessity criteria are met and one of the following criteria is met:
    a. The condition necessitating the orthosis is expected to be permanent or of longstanding duration (more than 6 months)
    b. There is a need to control the knee, ankle or foot in more than one plane.
    c. The patient could not be fit with a prefabricated (off-the-shelf) AFO
    d. The patient has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury
    e. The patient has a healing fracture that lacks normal anatomical integrity or anthropometric proportions

AFO Male Right/Left One Size	**DESCRIPTION**	**BRAND**
	Medline Ankle/Foot Orthosis. One size fit most. Maximum Strength with Medio-Lateral Stability Drop Foot Control. Easy to Customize if Required. Hook & Loop Closure. Natural Polypropylene.	Medline Ankle/Foot Orthosis. Mfr: Bolt Systems, Inc. Men's left Material#: ORT27900ML Men's right Material#: ORT27900MR

Knee Ankle Foot Orthosis	**DESCRIPTION**	**BRAND**
	Prefabricated carbon fiber Knee Ankle Foot Orthosis Leg Brace. Open heel design helps prevent sores. Less skin contact at ankle-foot area. Stronger and lighter than traditional plastic knee ankle foot orthosis.	Ottobock (Medline.com). Componenets sold separately. Mfr#: Prefabricated carbon fiber thigh component ALI667015ML Mfr#: Prefabricated carbon fiber polycentric knee joint ALI66703A6

❖ ANKLE - SUPPORT

INDICATIONS

Use after an acute ankle sprain or with chronic ankle instability. Semi-rigid braces with a stirrup design restrict inversion under passive and rapidly induced conditions. A stirrup brace in the treatment of lateral ankle sprains improves ankle joint function at 10 days and 1 month after injury compared with standard elastic support. It is also suitable for severe ankle sprains.

Support Ankle Universal	**DESCRIPTION**	**BRAND**
	Ankle Support Surround® with Gel Large Hook and Loop Closure Left or Right Foot, 10” (H), white. Rigid thermoplastic shells with adjustable heel strap. Air and gel bladder may be used for cold therapy.	DJO Surround® with Gel Ankle Support, Large Hook and Loop Closure, Left or Right Foot. Brand: Surround with Gel Mfr: DJO Mfr Part#: 888912041744

❖ BOOT WALKER

INDICATIONS

Severe ankle sprain, stable fracture of the foot/ankle/lower leg, and post-operative immobilization.

Boot Ankle Walker Standard Unisex LG 	**DESCRIPTION** Standard walking boot with semi-rigid shell that supports the limb while providing protection. Two adjustable distal air cells housed within the shell provide compression and support the malleoli. Rocker sole encourages a natural gait.	**BRAND** Aircast AirSelect Walker Boot, Standard, Large Hook and Loop Closure; Male 10 to 13/Female 11 to 15, Left or Right Foot. Brand: Aircast Mfr: DJO GLOBAL Sku: 01EF-L
Boot Ankle Walker Short Unisex LG 	**DESCRIPTION** Standard walking boot with semi-rigid shell that supports the limb while providing protection. Two adjustable distal air cells housed within the shell provide compression and support the malleoli. Rocker sole encourages a natural gait.	**BRAND** Aircast AirSelect Walker Boot, Short, Large Hook and Loop Closure; Male 10 to 13/Female 11 to 15, Left or Right Foot. Brand: Aircast Mfr: DJO GLOBAL Sku: 01ES-L

ARM SLING

INDICATIONS

Usually temporary issue; upper extremity splint or cast; undiagnosed upper extremity injury. Shoulder sling indicated after acute dislocation and status post Bankhart repair (surgery to repair instability and restore function of a dislocated shoulder) or rotator cuff repair.

Arm Sling LG 	**DESCRIPTION** McKesson Buckle Closure Arm Sling, Large (also available in One Size Fits Most), 7-1/2" x 18-1/2" Left or Right Arm, Cotton/Polyester, 6 Count. Cast support or support for injured arm, shoulder, wrist or hand. Web shoulder strap with clip buckle fastener for one-handed adjustment.	**BRAND** McKesson Buckle Closure Arm Sling Large. Also available in One Size Fits Most. Mfr Part#: 155-79-84027

Arm Sling LG, Hook and Loop 	**DESCRIPTION** Arm Sling One Size, 7 x 18" left or right arm. Immobilizes injured arm, shoulder or wrist and provides cast support. Equipped with 42" adjustable de-rotation strap and contact closure that feed through double O-rings to prevent internal rotation. Sling has inner contact closures to adjust length of the sleeve. Shoulder strap has a clip buckle closure.	**BRAND** McKesson Hook and Loop Closure Arm Sling One Size 7 x 18" Left or Right Arm, Cotton/Polyester

BRACE

❖ BACK

INDICATION

1. Hard Shell Back Braces (Thoracolumbar Spinal Orthosis-TLSO/Lumbosacral Orthosis-LSO) are indicated for compression or stable fractures, excluding spondylolisthesis
2. Post-operatively in the acute healing phase for spinal surgeries such as laminectomy or fusion
3. May be effective at supporting weak spinal/core muscles in patients with neuromuscular conditions (e.g., spinal cord injury, amyotrophic lateral sclerosis)

Back Braces - TLSO 	**DESCRIPTION** Thoracic lumbar sacral orthosis brace, high back, short. Taylor-type brace made from heat-moldable Kydex frame. Lightweight, low profile and made of breathable foam. Maintains lower spine in neutral position and stabilizes thoracic spine.	**BRAND** Restorative Care of America Item#: 46TLS-S
Back Braces – LSO 	**DESCRIPTION** Trulife Fast-Wrap Thoracolumbar Support provides compression and stabilization to thoracic, lumbar, sacral and abdominal regions. Padded adjustable shoulder straps offer comfort and compliance. Elastic lower cinch straps control the level of support and separated elastic side sections improve fit. Two 17" contoured steel stays offer firm posterior support. Four posterior slots allow optional steel stays. Hook and loop closure allows easy donning and doffing. Front measures 7" in (H) and back measures 21" in (H). Available in 44" to 48" hip circumference and 54" to 56" hip circumference.	**BRAND** Trulife Fast Wrap. Mfr: Allmed Mfr#: 2686/NA/XXL McKesson#: 1183565

❖ KNEE

INDICATIONS

1. Functional knee braces – designed to provide stability for the anterior-cruciate ligament (ACL) or other ligament deficiency of the knee and provide protection for the ACL or other ligaments after repairs or reconstructions.
2. Rehabilitative knee braces – designed to allow protected and controlled motion of knees that have been injured and/or treated operatively. Commonly used for 6 to 12 weeks after injury.
3. Unloader/off-loader knee braces – specifically designed to reduce the pain and disability associated with osteoarthritis of the medial compartment of the knee by bracing the knee in the valgus position to unload the compressive forces on the medial compartment.

Support Knee Hinged Sizes: Small to X-Large 	**DESCRIPTION** Knee Support AliMed® X-Large Slip-On 16-1/2 to 18" Circumference Left or Right Knee. Plastic polycentric hinges that adjust to knee movement; medial/lateral stability with a hyperextension stop. Adjustable 180-degree U-shaped patella buttress. Superior and inferior 2" stabilizing straps.	**BRAND** AliMed Small to X-Large Hinged/U-Shaped Patella Buttress Mfr # 66298/NA/NA/XL McKesson# 726988
Splint Knee 3 Panel 24in 	**DESCRIPTION** Knee Immobilizer PROCARE® One Size Fits Most Hook and Loop Closure 24" Length Left or Right Knee. 31" thigh maximum circumference measured 4 inches above patella. Trimmable foam laminate body with 6" wide encircling straps. Movable medial/lateral stay casing for proper positioning.	**BRAND** Brand: Procare Mfr DJO Mfr#: 79-80180 7980090 16" 7980110 16" 7980170 20" 7980020 20" McKesson# 380221
Immobilizer Knee Closure Straps 16in 	**DESCRIPTION** Knee Immobilizer Select® 16" Length, up to 29" thigh circumference, left or right knee. Closed patella/medial and lateral stays	**BRAND** Brand and Mfr: McKesson Knee Immobilizer Mfr#: 155-79-96016
Knee Brace Full Universal X-Act ROM 	**DESCRIPTION** Knee Brace X-Act ROM™ One Size Fits Most Hook and Loop Closure Adjustable Length Left or Right Knee, Hinged. Aluminum hinges provide extension settings from -1 to 90 degrees and flexion settings at -10 to 120 degrees	**BRAND** Knee Brace Brand: X-Act ROMTM Mfr: DJO for McKesson Mfr#: 11-2151-9 McKesson#: 800415

INDICATIONS

Osteoarthritis, pre-operative internal derangements. Evidence suggests this brace may help prevent falls and increase walking distance in those with knee osteoarthritis. There is no evidence that this brace reduces pain or improves function in those with patellofemoral pain

Brace Knee XXL 	**DESCRIPTION** Knee Brace Reddie® Brace 2X-Large, Black, Wraparound / Hook and Loop Straps 25-1/2 to 28" Circumference, Left or Right Knee, Black Neoprene. Posterior strap adjustment for proper positioning of hinges. Removable dual axis polycentric hinges provide medial/lateral support	**BRAND** Reddie Brace Knee Brace 2X-Large Wraparound/Hook and Loop Straps. 25-1/2 to 28" Circumference, Left or Right Knee. Brand: Reddie Brace Mfr: DJO Mfr Part#: 79-82399
Support Slip-on LG 	**DESCRIPTION** Knee Brace X-Act ROM™ One Size Fits Most Hook and Loop Closure Adjustable Length Left or Right Knee, Hinged. Aluminum hinges provide extension settings from -1 to 90 degrees and flexion settings at -10 to 120 degrees	**BRAND** Knee Brace Brand: X-Act ROMTM Mfr: DJO for McKesson Mfr#: 11-2151-9 McKesson#: 800415

INDICATIONS

Metal hinged knee braces (functional brace) are indicated for use in cases of knee instability as determined by physical exam and/or imaging. Can enhance functionality with ligamentous instability pre-operatively. May be used post-operatively to enhance knee stability through increased skin contact, resulting in improved neuromuscular control.

Support Knee Hinged Buttress Univ 2XL 	**DESCRIPTION** Hinged Knee Support PROCARE® 2X-Large Hook and Loop Closure Left or Right Knee. Universal buttress adjustable for medial, lateral, inferior or superior patellar stabilization. Removable dual axis stainless steel hinges and encircling contact closure provide mild support to medial/lateral ligaments. Compressive neoprene knee support with open patella available with and without buttress. 1/8" with reinforced pad.	**BRAND** Procare Hinged Knee Support, 2X-Large. Brand: Procare Mfr: DJO Mfr#: 98213000

❖ WRIST

INDICATIONS

1. Carpal Tunnel Syndrome. Symptom duration less than 3 months and absence of sensory impairment at presentation are predictive of a lasting response to conservative management.
2. Rheumatoid arthritis, though there is not strong evidence to demonstrate that wrist braces reduce pain, decrease swelling or improve grip strength.

*NO benefit to patients with tendinitis or De Quervain's tenosynovitis.

Wrist Brace Plastic RT/LT Hand XS 	**DESCRIPTION** Wrist Brace Ossur® Exoform® Palmar Stay Aluminum / Plastic Right Hand Black Extra Small. Wrist Circumference: 5.25"-6.25"	**BRAND** Ossur Wrist Brace Exoform Palmar Stay Aluminum, Extra Small Brand: Exoform Mfr: Ossur Right Hand Mfr#: 507072 Left hand Mfr#: 507082

BELT

❖ HERNIA

INDICATIONS

Support for single and double inguinal hernias.

Belt - Hernia Elastic 	**DESCRIPTION** CURAD Hernia Belts, elastic, retail packaging, Small. 30"-35 circumference, 4/CS. Hook and loop closure. Removable foam compression pads.	**BRAND** CURAD Hernia Belt with Compression Pads, Small Size, Beige Brand: CURAD Mfr: Medline. Item Model#: ORT22400SDHH
Belt - Hernia Peristomal 	**DESCRIPTION** Peristomal Hernia Belt Nu-Form™ 2X-Large 4” (W). Opening size, 2-3/4” centered. Hip size 47"-52". Adjustable hook and loop closure. For support of hernias around and adjacent to the stoma. Helps manage prolapsed stomas, protect abdominal hernia repairs and prevent recurrence.	**BRAND** Peristomal Hernia Belt, 2X-Large, 4” wide. Brand: Nu-Form Mfr: Nu-Hope Laboratories Mfr#: 6314

❖ **RIB**

INDICATIONS
Compression and extra support after an injury or medical condition.

Belt – Rib	**DESCRIPTION**	**BRAND**
	Rib Belt PROCARE® One Size Fits Most Hook and Loop Closure, foam/pile. 24” to 50” Waist Circumference X 6” (W) Male. Gray/white.	Procare Universal Rib Belt, Male. Hook and loop closure, Waist measurement 24" to 50", 6” (W). Brand: ProCare Mfr: DJO Mfr Part#: 79-89060

BINDER ABDOMINAL

INDICATIONS
Compression and support for post-natal or post-abdominal surgery, abdominal strains and weakness. Temporary use of an abdominal binder can be useful in patients with large-necked hernias, during the pre-operative period or in situations where there is a high risk of surgery on a long-term basis. Non-surgical management of abdominal wall hernias with an abdominal binder is not considered effective but may be the only option in a patient who is not a reasonable candidate for surgery. However, binders can place pressure on skin and bowel, induce related injury and mask signs of incarceration and strangulation.

Binder Abdominal	**DESCRIPTION**	**BRAND**
	Abdominal Binder DJO Procare® 12” 4-Panel 3X-Large Contact Closure 82 – 100” waist measurement, 12” (W) Unisex 9” 3-Panel Elastic Binder, 30 - 45" waist measurement, 9" (W) 12” 4-Panel 2X-Large Contact Closure 72 - 84” waist measurement, 12” (W) Unisex	***12” 4-Panel XXXL*** DJO ProCare Abdominal Binder 12” 4-Panel 3X-Large Contact Closure 82 - 100” waist measurement, 12” (W), Unisex 9” 3-Panel Elastic Binder, 30"-45" waist measurement, 9" (W) 12” 4-Panel 2X-Large Contact Closure 72 - 84” waist measurement, 12” (W) Unisex Mfr: DJO Mfr#: 79-89280

CANE

❖ ALUMINUM

INDICATIONS

For individuals with minimal to moderate balance deficits or those who have an antalgic gait. Canes can offload the opposite lower extremity by 40-60%.

Cane Aluminum 30" – 39"	**DESCRIPTION**	**BRAND**
	McKesson Cane, Offset Handle-Aluminum, 300 lbs. Capacity, 30-39" (H)	McKesson Cane, Offset Handle-Aluminum, 300 lbs. Capacity, 30-39" (H) SKU 1065214CS Mfr Part#: 146-RTL10306

COMMODE CHAIR

INDICATIONS

- **Standard stationary commode chair** – due to a medical or surgical condition, the patient is confined to a room lacking a toilet or unable to use standard bathroom facilities.

- **Extra-wide, heavy-duty stationary commode chair** – the patient meets medical necessity criteria for a standard commode chair and weighs ≥ 300 pounds.

- **Stationary commode chair with detachable arms –** the patient meets medical necessity criteria for a standard commode chair but requires either extra width or detachable arms to facilitate transfers.

Commode Chair	**DESCRIPTION**	**BRAND**
	Folding steel frame commode with fixed arms, back bar and 8-quart bucket. Three-in-one design for use as a bedside commode, raised toilet seat or toilet safety frame. Weight capacity range: 251-500 lbs. Seat height: 15 ½" or 21 ¾". Seat width: 13 ¼".	McKesson. Mfr: McKesson Brand Mfr#: 46-11148N-4

COLLAR CERVICAL UNIVERSAL

INDICATIONS

Semi-hard cervical collar and rest for 3-6 weeks is comparable to physiotherapy or physiotherapy accompanied by home exercises for 6 weeks in substantially reducing neck and arm pain compared with a wait-and-see policy in the early phase of cervical radiculopathy. For neck pain and associated disorders (NAD) Grade III (No signs or symptoms of major structural pathology, but presence of neurologic signs such as decreased deep tendon reflexes, weakness, or sensory deficits), there is no evidence of effectiveness, and a cervical collar should not be used for NAD Grade III greater than 3 months duration. Treatment with a soft collar was found to have no obvious benefit in terms of functional recovery after neck injury and was associated with a prolonged time period off work.

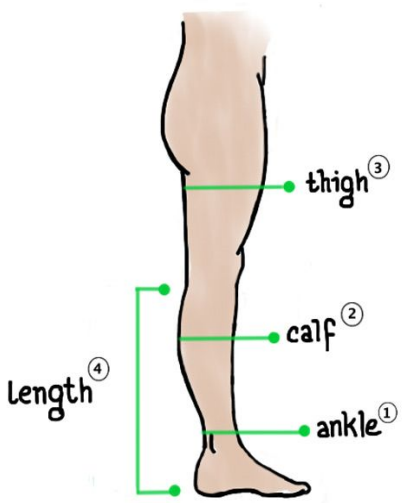
Collar Cervical Universal	**DESCRIPTION**	**BRAND**
	ProCare Cervical Collar Universal Contoured/Medium Density Adult, One Size Fits Most. One-Piece, 3" (H), 24" (L), 10-1/2 to 24" Neck Circumference. Hook and Loop Closure. Cotton stockinette cover. Includes additional cotton stockinette cover.	ProCare Cervical Collar Universal Contoured/Medium Density Adult, One Size Fits Most. One-Piece, 3" (H), 24" (L), 10-1/2 to 24" Neck Circumference. Brand: ProCare Universal Mfr: DJO Mfr Part#: 79-83500

COMPRESSION STOCKING

INDICATIONS

1. Venous or lymphatic condition, as indicated by 1 or more of the following:
    a. Chronic venous disease (e.g., venous insufficiency due to valvular dysfunction, venous stasis ulcer, stasis dermatitis, superficial thrombophlebitis)
    b. Deep venous thrombosis of lower extremity and need for prevention or treatment
    c. Following invasive saphenous vein procedure (e.g., vein stripping, laser ablation, radiofrequency ablation)
    d. Lymphedema of lower extremity following node dissection
    e. Lymphedema of upper extremity either with or without auxiliary node dissection
    f. Postural hypotension, lipodermatosclerosis, negative pressure wound therapy, post sclerotherapy, post-phlebitic syndrome, post-thrombotic syndrome.
2. No severe peripheral arterial disease (i.e., ankle-brachial index not less than 0.5).
3. No untreated cellulitis.

HOW TO MEASURE

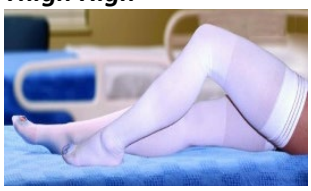


How to Measure

1. **Ankle:** Measure the circumference of your ankle, right above the ankle bone.
2. **Calf:** Measure the circumference of the widest part of your calf.
3. **Thigh:** Measure the circumference of your upper thigh, about 3 inches below the buttocks.
4. **Length:** Measure the length of your leg, from the floor to the back crease of your knee.

Compression Stocking – Knee High 	**DESCRIPTION** Compression Stocking JOBST® Knee High Medium Beige Closed Toe, LF, Compression Rating 30-40 mmHG, Ankle 8-3/8 to 9-7/8" Calf 11-7/8 to 16-1/2" Circumference	**BRAND** Jobst Relief Knee Highs Closed Toe Unisex 30-40 mm Hg Item#: 114631 Ankle and calf circumference dependent on size ordered (Compressionsale.com) Amazon ASIN B087NFRQF7
Compression Stocking – Knee High 	**DESCRIPTION** Juzo Basic Knee High. Unisex, two-way stretch elasticity, seamless. Open or closed toe available. Standard or short length. Compression 15-20, 20-30 and 30-49 mmHg. Size based on Ankle and calf circumference.	**BRAND** Juzo SKU (compressionhealth.com) 4411ADFF10

Compression Stocking – Knee High 	**DESCRIPTION** Sigvaris High Tech Knee High for women and men. Nylon-polyester-spandex fibers for thermal control. Anatomically contoured shape with cushioned footbed, Achilles tendon and sole. Firm compression (20-30 mmHg). Size based on circumference of ankle and calf plus shoe size.	**BRAND** Sigvaris Series: High Tech (formerly Traverse) SKU# (Foryourlegs.com) 412CSS00
Stocking Antiembolism – Knee High 	**DESCRIPTION** ***LRG-LNG*** T.E.D.™ Knee High Large, Long White Inspection Toe Anti-Embolism Stockings, calf circumference 15”-17.5”. Length: more than 18” ***SM-LNG*** T.E.D.™ Knee High Small, Long White Inspection Toe Anti-Embolism Stockings. Calf circumference (measure at greatest portion) less than 12”, length (measure in standing position, if possible, from bend of knee to the bottom of heel), more than 16”.	**BRAND** ***LRG-LNG*** T.E.D. Knee High Large, Long White Inspection Toe Anti-Embolism Stockings, calf circumference 15”-17.5” Length: more than 18” Brand: T.E.D. Mfr: Kendal Covidien Mfr Part#: 7203 McKesson SKU MCK-59400300 ***SM-LNG*** Mfr: Kendal Covidien Brand Name: Kendall Model # 7339
Stocking Antiembolism Knee High MED-REG 	**DESCRIPTION** Anti-embolism Stockings McKesson Knee High Medium, Regular White Inspection Toe	**BRAND** McKesson Anti-embolism Medi-Pak Knee-high Medium, Regular, White Inspection Toe. Compression rating 20-30 mm Hg. McKesson Mfr Part#: 84-02
Compression Stocking – Thigh High 	**DESCRIPTION** Sigvaris Dynaven 970 Series Thigh High with Grip Top, open toe. Unisex. Two-way stretch knit. Compression 20-30 mmHg. Size based on ankle and thigh circumference, length of leg and shoe size.	**BRAND** Sigvaris SKU (compressionhealth.com) 972N (S/M/L/X) LO99

Compression Stocking – Thigh High 	**DESCRIPTION** Juzo 4400 Series Basic Thigh High Compression Sock with Silicone Band. Unisex. Two-way stretch elasticity, seamless. Open or closed toe available. Compression 15-20, 20-30 and 30-40 mmHg. Size based on ankle and thigh circumference and length of leg.	**BRAND** Juzo SKU (compressionhealth.com) 4411AGFFSB14
Stocking Antiembolism Thigh High 	**DESCRIPTION** T.E.D.TM Knee High Small, Long White Inspection Toe Anti-Embolism Stockings. Calf circumference (measure at greatest portion) less than 12", length (measure in standing position, if possible, from bend of knee to the bottom of heel), more than 16". OR Anti-embolism Stockings McKesson Thigh High Large, Long White Inspection Toe, 20-30 mm Hg	**BRAND** Mfr: Brand Name: Kendall Model#: 7339 OR McKesson Anti-Embolism Medi-Pak™ Thigh-High Inspection Toe Stockings, Large, Long. Calf circumference: greater than 15". Upper thigh circumference: less than 25". Length (gluteal furrow to bottom of heel: greater than 33"). McKesson Mfr Part#: 84-01

CRUTCHES

INDICATIONS

For individuals with minimal balance deficits after an injury or surgery. Aluminum crutches are easier to adjust but wooden crutches are more durable. Use of crutches with osteoarthritis may help reduce pain, facilitate exercise and maintain function by assisting ambulation and reducing load on the affected joint. Crutches can assist with walking with some weight-bearing on the injured leg or can be used to completely avoid putting weight on the injured leg. Crutches should have:

1. A soft pad over the arm rest and a non-skid pad at the tip
2. Be adjusted to the correct height: top of the crutches should be about 2 fingers' width below the axilla when standing.
3. When holding the grips, the elbows should be partially bent and the wrists straight.

Crutch Underarm Aluminum Regular 	**DESCRIPTION** ***Regular*** Underarm Crutch Aluminum Frame Adult 350 lbs. weight capacity, user height 5'2" to 5'10" ***Tall*** Underarm Crutch Aluminum Adult Tall 350 lbs. weight capacity, user height 5'10" to 6'6"	**BRAND** ***Regular*** McKesson Underarm Crutches Aluminum Frame Adult 350 lbs. weight capacity, push button/wing nut adjustment Mfr#: 146-10400-8 (8 PAIRS) ***Tall*** Underarm crutches McKesson Aluminum Frame Tall Adult 350 lb. weight capacity, push button/wing nut adjustment. Mfr#: 1065231 (8 PAIRS)
Crutch – Accessory Crutch Underarm Aluminum Reg Euro Clip 	**DESCRIPTION** Crutch accessory-included with crutches.	**BRAND** Varies
Crutch – Accessory Grip Hand Crutch Closed 	**DESCRIPTION** McKesson Crutch Replacement Pillows -foam. Accessory kit includes 2 underarm covers, and 2 hand grip covers, machine washable. Universal to fit most standard walking crutches.	**BRAND** McKesson Crutch Replacement Pillows-Foam, Fits All Standard Crutches. SKU 1095262PA

Custom Foot Orthoses

Indications

Medically necessary when there is failure, contraindication, or intolerance to prefabricated foot orthosis for ANY of the following conditions:

1. The foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace
2. The foot orthosis is used to compensate for a missing portion of the foot (e.g., amputation) and is necessary for the alleviation or correction of illness, injury, or congenital defect
3. Neurologic or neuromuscular condition (e.g., cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment or pathological positioning of the foot where there is reasonable expectation of improvement.

Fall Prevention Slipper Socks

Indications

Fall Prevention slipper socks for patients with high fall risk.

Slipper Double Tread Red 1SZ Fit Most 	**Description** Medline Double-Tread Fall Prevention Patient Slippers with double-sided, nonslip treads. Available in yellow. Inside slipper material: terry. Also available in M, L, XL, 2XL, Bariatric.	**Brand** Double-Tread Fall Prevention Patient Slippers, Item#: MDT211218RH (1 pair) or MDT211250R (48/pack)

Mobility Impaired Disability Vest

Indications

Patients with permanent mobility impairment who are physically unable to sit on the ground and MUST have an 1845 with DPO, DPM or DNM code. Patients with a 7410 with DPO, DPM or DNM code may need a vest temporarily after an injury or medical procedure based on medical provider evaluation. Inability to sit does not include patients who only require additional time to attain a seated position during an emergency.

Vest Mobility Impair YLW Reg 	**Description** ADA Fluorescent yellow mesh vest. Constructed with breathable 3.0 oz 100% polyester mesh.	**Brand** TBD

POST–OPERATIVE CARE

❖ SHOE: POST–OPERATIVE

INDICATIONS

Management of broken toes, metatarsal fractures, foot, and ankle sprains, and in the treatment of diabetic ulcers.

Shoe Post-Op Open Toe Velcro MED 	**DESCRIPTION** ***Medium*** Post-Op Shoe ProCare® Medium Male Blue Size 9-11. Low-profile foam/nylon mesh upper with protective tongue. Rigid E.V.A rocker sole and contoured heel. Hook and loop closure. Open toe/closed heel. ***Small Male Blue*** Post-Op Shoe ProCare® Small Male Blue	**BRAND** ***Medium*** Brand: ProCare Mfr: DJO Mfr#: 79-90185

❖ SUPPORT – ATHLETIC

INDICATIONS

Post-operative care

Support – Athletic SM 	**DESCRIPTION** Athletic Supporter Small 26”-32” Medium 32”-38”, Large 38”-44”	**BRAND** Sportaid Athletic Supporter of Size: 26”-32”, small, white Order #Sa1503Sm (UPC763189530576), 32”-38”, Medium #SA1503MD (UPC 763189530583), 38”-44” Large UPC 763189530590

PROSTHETIC LIMBS

❖ LOWER EXTREMITY

INDICATIONS

Prosthesis is prescribed by physician and patient will maintain a defined functional state within a reasonable period of time; Patient needs prosthetic for ambulation.

❖ UPPER EXTREMITY

INDICATIONS

When the patient has an amputation or missing limb at the wrist or above and patient has demonstrated sufficient neurological and cognitive function to operate prosthesis effectively and meets functional evaluation indicating that the use of the prosthesis will meet the functional needs of the individual when performing activities of daily living.

SHOULDER IMMOBILIZER

INDICATIONS

Support and protection of the shoulder after injury or surgery.

Shoulder Immobilizer 	**DESCRIPTION** Designed to exert upward pressure and immobilize the arm and shoulder. Waist and shoulder straps with contact closure. Made to fit right or left arm. Available in extra small to extra-large sizes.	**BRAND** McKesson Hook and Loop Closure Arm Sling One Size 7 x 18" Left or Right Arm, Cotton/Polyester

SPLINT

❖ ARM

INDICATIONS

To immobilize a body part after surgery or injury, to stabilize an affected area to decrease pain, bleeding, prevent further soft tissue, vascular or neurologic compromise and permit healing.

Splint Arm Folder 18" 	**DESCRIPTION** SAM Medical Products Flat Fold Splint, 18". Item dimensions: 8.7" x 4.3" x 0.8". Washable, reusable, waterproof, lightweight. Can be rolled or folded	**BRAND** SAM Medical Products Flat Fold Splint, 18" Brand and Mfr: SAM Medical Part#: 3018

❖ FINGER

INDICATIONS

Immobilize a body part after surgery or injury in order to stabilize an affected area to decrease pain, bleeding, prevent further soft tissue, vascular or neurologic compromise and permit healing.

Splint Plastic Finger 4 Prong LG 	**DESCRIPTION** Finger Guard Grafco® Prokot Plastic Finger Guard Kit, Variety Pack of 12, 4 Each of Small, Medium and Large Sizes (not available in large only)	**BRAND** Grafco Prokot Plastic Finger Guard Kit, Variety Pack of 12, 4 each of Small, Medium, Large Brand: Graham-Field Part Number: 1968-1
Sprint Finger Stackies 	**DESCRIPTION** Molded polypropylene splints to protect and help stabilize the distal fingertip. 30-piece kit contains an assortment of 30 splints (plastic storage container included). Available in eight sizes. Open nail design with ventilation holes.	**BRAND** Mfr, Item Name, Product ID: Medline Stackies Finger Splint Kit and Replacement Mfr: Medline Mfr part#: ORT32700

❖ SHOULDER

INDICATIONS

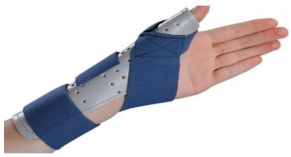
Support and protection of the shoulder after injury or surgery.

Shoulder Immobilizer with Foam Straps 	**DESCRIPTION** Designed to exert upward pressure and immobilize the arm and shoulder. Waist and shoulder straps with contact closure. Made to fit right or left arm. Available in extra small to extra-large sizes.	**BRAND** Mfr, item name, product ID: Procare Shoulder Immobilizer with Foam Straps. Brand: DJ Orthopedics. Item # 79-84162 (XS), DJ79-84163 (SM), DJ79-84165 (MED), DJ79-84167 (LG), 79-84168 (XL)

❖ THUMB

INDICATIONS

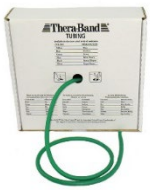
Immobilize a body part after surgery or injury in order to stabilize an affected area to decrease pain, bleeding, prevent further soft tissue, vascular or neurologic compromise and permit healing.

Splint Thumb Spica Left/Right Size Small to X-Large 	**DESCRIPTION** Thumb Splint ThumbSPICA™ Thumb Spica Foam / Cotton-Terry Left Hand Blue / Gray Large / X-Large, 9" length. Perforated outer foam shell, terry cloth liner, position splint with elastic circumferential closure straps.	**BRAND** ThumbSPICA Thumb Splint Spica Foam/Cotton-Terry, Size Large/X-Large, Length 9" Left Item#: 79-87118

THERABAND

INDICATIONS

Used in physical therapy to exercise and strengthen muscles in the upper and lower body to build strength, increase motion and improve conditioning.

Theraband Exercise Resistance Tubing 	**DESCRIPTION** Round cord rather than flat exercise band. Use with optional handles or door anchor. Can cut off the length needed. Available in a 100-foot coil box in varying resistance: medium to special heavy.	**BRAND** Thera-Band 100 Foot Coil Box Item#: 1216-04-heavy green

THERAPEUTIC SHOES

INDICATIONS

Medically necessary under the following conditions:

1. A shoe that is an integral part of a leg brace, and its expense is included as part of the cost of the brace
2. Therapeutic shoes furnished to selected diabetic patients
3. The diabetic patient must have one or more of the following conditions affecting one or both feet:
    a. History of partial or complete foot amputation
    b. History of previous foot ulceration
    c. History of pre-ulcerative callus
    d. Foot deformity and peripheral neuropathy with evidence of callus formation
    e. Diminished blood supply to the foot
4. Therapeutic shoes for certain peripheral vascular and neuropathic conditions.
    a. History of previous ulceration
    b. Diabetes
    c. Buerger's disease (thromboangiitis obliterans)
    d. Chronic thrombophlebitis
    e. Peripheral neuropathies involving the feet
5. Rehabilitative foot orthotics as part of postsurgical or post-traumatic casting care
6. Prosthetic shoes - used when all or a substantial portion of the front part of the foot is missing. A prosthetic shoe can be used as a terminal device (i.e., a structural supplement replacing a totally or substantially absent foot)

Indications for Orthotics, Foot (All)

1. Standard shoes not suitable for condition/requiring custom-made orthosis
2. Medical record documentation supports medical necessity of orthosis
3. Stability and support necessary for: (choose one)
    a. Deformity of foot
    b. Chronic weakness of lower extremity
    c. Chronic ankle instability
    d. Limb length discrepancy of ≥ 1.5 inches

Therapeutic Shoes – White	**DESCRIPTION**	**BRAND**
	Life walker strap - leather upper w/ brushed nylon lining and dual strap closure, firm heel counter with removeable footbed, cushioned EVA midsole with herring-bone tread rubber outsole - WHITE	Propet Life Walker Strap-Men's Orthopedic Walking Shoes SKU number based on width, size, color

TOILET SEAT LIFT (ERECTOR)

INDICATIONS

1. Medically necessary only when patient is unable to rise from toilet seat without assistance.
2. Seat lift mechanism incorporated into a commode chair may be medically necessary when patient meets criteria for commode chair and unable to rise from toilet seat without assistance.

WALKER

INDICATIONS

1. Ambulation is impaired and 1 or more of the following:
    a. Mobility-related activities of daily living (ADLs) unable to be completed
    b. Mobility-related ADLs unable to be completed in a reasonable amount of time
    c. Mobility-related ADLs unable to be completed safely.
2. Other ambulatory assistive device (e.g., cane, crutches) does not sufficiently resolve mobility deficit.
3. Patient able to ambulate with and safely use walker.
4. Prescription is for 1 or more of the following:
    a. Standard walker
    b. Hemi-walker
    c. Platform walker
    d. Front-wheeled walker
5. Provider with appropriate expertise in patient's condition has evaluated patient and recommended walker.

Walker Folding 32-39 IN w/Wheels 	**DESCRIPTION** Folding Walker Adult McKesson Aluminum 350 lb. capacity. 32" to 39" x 24" base width, hand grips 17" apart, push-button dual release mechanism for easy folding.	**BRAND** McKesson Aluminum Folding Walker with Wheels 350 lb. weight capacity. SKU 146-10210-1-EA1
Walker Accessory – Walker Rollator 	**DESCRIPTION** Rolling walker with under seat pouch, padded seat, back rest and locking hand brakes. 12.25" x 25.4" x 35" to 40" folded dimension. Seat width 13 ½". Seat height 12 ½". 6" x 7.25" x 16" basket/bag. Non-marring caster, soft-grip tires. User height 5'2" to 5'8". 300 lb. weight capacity.	**BRAND** Zoom 20 Mfr: McKesson and Nova Ortho Med Mfr#: 4220

WHEELCHAIR

INDICATIONS

1. The functional mobility deficit cannot be sufficiently resolved by the prescription of a cane or walker
2. A wheelchair can reasonably be expected to significantly improve the patient's ability to perform or obtain assistance to participate in mobility-related activities of daily living (MRADLs)
3. The patient demonstrates the capability and willingness to consistently operate the wheelchair safely, independently or with the help of an inmate/helper
4. The patient has sufficient strength and postural stability to propel a manual wheelchair to participate in MRADLs during a typical day

HOW TO MEASURE

Seat width – In a seated position, measure the widest distance from hip to hip. *Add on 1 ½ - 2 inches* to this measurement to allow a space between the arm rest and each side of the hip.

1. *Considerations*:
    a. The 1 ½ - 2 inches added to the measurement allows room for clothing such as coats and prevents skin irritation between the thighs and the armrests.
    b. If the wheelchair is too wide, it will be more difficult to propel, fit through doorways, and will not provide adequate postural support.

Wheelchair 	**DESCRIPTION** Wheelchair, Adult, Lightweight, 20" Seat, Dual Axle	**BRAND** Invacare Tracer SX5 Wheelchair, Flip-Back Full-Length Arms, 20"x16". Color: Silver. Lightweight frame: 34 lbs. Dual axle. 300 lb. capacity. Product ID: TRSX50FBFP
Wheelchair *Bariatric 24" Full Length* 	**DESCRIPTION** Bariatric Wheelchair Sentra EC Heavy Duty. Detachable padded arm rests, black vinyl upholstery. 24" 450 lbs.	**BRAND** Drive Medical Bariatric Sentra EC HD 20"-24" wheelchair, weight capacity 450 lbs. width open with 24" seat: 32" (20", 22" 24" seat available). height: 36" Item#: STD20ECDDAHD-ELR UPC# 82238323932
Wheelchair *Bariatric and Heavy Duty* 	**DESCRIPTION** Wheelchair, ADA, Extra wide, 22 X 18, 450LB weight capacity. Reinforced, heavy-duty frame. Heavy duty seat liner. 15-gauge cross-braces.	**BRAND** Invacare Tracer IV Wheelchair. Seat width 18-24". Wt. capacity 350-450 lbs. Product ID T4

Wheelchair *Tamper Proof* 	**DESCRIPTION** Wheelchair, adult 18” w/seat, tamper proof, folding seat and armrests Color: Yellow	**BRAND** Merlexi Craft Tamper Proof Inmate Wheelchair. Reinforced polypropylene body, 17"-18" seat length, fixed arm rest standard, folds to 13.5" wide with wheels. Weight limit 300 lb. Available in yellow, red, blue, black.

❖ **ACCESSORIES: IV/OXYGEN HOLDER**

Wheelchair – Accessory *IV/Oxygen Holder* 	**DESCRIPTION** IV/Oxygen holder wheelchair assembly (for use with Invacare wheelchairs – MFR# T4X22RDAP)	**BRAND** Invacare 1496 IV/Oxygen Holder Assembly for Wheelchairs. Compatible with Invacare std. wheelchairs such as Tracer SX5. Brand name: Invacare Part#: 1496

❖ **ACCESSORIES: GLOVES**

Wheelchair – Accessory *Gloves* 	**DESCRIPTION** Gloves, Wheelchair, All-Purpose, Padded Leather. Black, fingerless, leather palm with gel padding, foam. Permeable backing.	**BRAND** Prime Sports All-Purpose Padded Leather Wheelchair Gloves Order#: W-1019

PODIATRY

ANKLE FOOT ORTHOSES/KNEE ANKLE FOOT ORTHOSES (AFO/KAFO)

INDICATIONS

For non-ambulatory patients:

1. Ankle contracture splints - medically necessary if ALL the following criteria are met:
   The ankle contracture splint is used as a component of a therapy program that includes active stretching of the involved muscles and/or tendons
   a. The contracture is interfering or expected to interfere significantly with the patient's functional abilities
   b. There is a reasonable expectation of the ability to correct the contracture
   c. The patient has a plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least 10 degrees (i.e., a non-fixed contracture)
   d. If an ankle contracture splint is used for the treatment of a plantar flexion contracture, the pre-treatment passive range of motion must be measured with a goniometer and documented in the health record. There must be documentation of an appropriate stretching program carried out by professional staff.

For ambulatory patients:

1. Ankle Foot Orthoses - medically necessary for ambulatory patients with weakness or deformity of the foot and ankle which requires stabilization for medical reasons and have the potential to benefit functionally. This would include patients with multiple sclerosis, cerebral palsy, cerebrovascular accident, spina bifida, traumatic brain injury, peripheral neuropathy or spinal cord injury who have orthopedic or neurologic conditions with noted weakness of the ankle stabilizer muscles such as foot drop.
2. Knee-ankle-foot orthoses (KAFO) - medically necessary for ambulatory patients for whom an ankle-foot orthosis is clinically indicated and for whom additional knee stability is required.
3. Molded-to-patient model AFO's and KAFO's - Custom-made AFOs and KAFOs that are "molded-to-patient-model" are considered medically necessary for ambulatory patients when the basic medical necessity criteria are met and one of the following criteria is met:
   a. The condition necessitating the orthosis is expected to be permanent or of longstanding duration (more than 6 months)
   b. There is a need to control the knee, ankle, or foot in more than one plane
   c. The patient could not be fit with a prefabricated (off-the-shelf) AFO
   d. The patient has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury
   e. The patient has a healing fracture that lacks normal anatomical integrity or anthropometric proportions

AFO Male Right/Left One Size	**DESCRIPTION** Medline Ankle/Foot Orthosis. One size fit most. Maximum Strength with Medio-Lateral Stability Drop Foot Control. Easy to Customize if Required. Hook & Loop Closure. Natural Polypropylene.	**BRAND** Medline Ankle/Foot Orthosis. Mfr: Bolt Systems, Inc. Men's left Material#: ORT27900ML Men's right Material#: ORT27900MR

Knee Ankle Foot Orthosis	**DESCRIPTION**	**BRAND**
	Prefabricated carbon fiber Knee Ankle Foot Orthosis Leg Brace. Open heel design helps prevent sores. Less skin contact at ankle-foot area. Stronger and lighter than traditional plastic knee ankle foot orthosis.	Ottobock (Medline.com). Componenets sold separately Mfr#: Prefabricated carbon fiber thigh component ALI667015ML Mfr#: Prefabricated carbon fiber polycentric knee joint ALI66703A6

❖ ***ANKLE - SUPPORT***

INDICATIONS

Use after an acute ankle sprain or with chronic ankle instability. Semi-rigid braces with a stirrup design restrict inversion under passive and rapidly induced conditions. A stirrup brace in the treatment of lateral ankle sprains improves ankle joint function at 10 days and 1 month after injury compared with standard elastic support. It is also suitable for severe ankle sprains.

Support Ankle Universal	**DESCRIPTION**	**BRAND**
	Ankle Support Surround® with Gel Large Hook and Loop Closure Left or Right Foot, 10” (H), white. Rigid thermoplastic shells with adjustable heel strap. Air and gel bladder may be used for cold therapy.	DJO Surround® with Gel Ankle Support, Large Hook and Loop Closure, Left or Right Foot. Brand: Surround with Gel Mfr: DJO Mfr Part#: 888912041744

❖ ***BOOT WALKER***

INDICATIONS

Severe ankle sprain, stable fracture of the foot/ankle/lower leg, and post-operative immobilization.

Boot Ankle Walker Standard Unisex LG 	**DESCRIPTION** Standard walking boot with semi-rigid shell that supports the limb while providing protection. Two adjustable distal air cells housed within the shell provide compression and support the malleoli. Rocker sole encourages a natural gait.	**BRAND** Aircast AirSelect Walker Boot, Standard, Large Hook and Loop Closure; Male 10 to 13/Female 11 to 15, Left or Right Foot. Brand: Aircast Mfr: DJO GLOBAL Sku: 01EF-L
Boot Ankle Walker Short Unisex LG 	**DESCRIPTION** Standard walking boot with semi-rigid shell that supports the limb while providing protection. Two adjustable distal air cells housed within the shell provide compression and support the malleoli. Rocker sole encourages a natural gait.	**BRAND** Aircast AirSelect Walker Boot, Short, Large Hook and Loop Closure; Male 10 to 13/Female 11 to 15, Left or Right Foot Brand: Aircast Mfr: DJO GLOBAL Sku: 01ES-L

CUSTOM FOOT ORTHOSES

INDICATIONS

Medically necessary when there is failure, contraindication, or intolerance to prefabricated foot orthosis for ANY of the following conditions:

1. The foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace
2. The foot orthosis is used to compensate for a missing portion of the foot (e.g., amputation) and is necessary for the alleviation or correction of illness, injury, or congenital defect.
3. Neurologic or neuromuscular condition (e.g., cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot where there is reasonable expectation of improvement

FALL PREVENTION SLIPPER SOCKS

INDICATIONS

Fall Prevention slipper socks for patients with high fall risk.

Slipper Double Tread Red 1SZ Fit Most 	**DESCRIPTION** Medline Double-Tread Fall Prevention Patient Slippers with double-sided, nonslip treads. Available in yellow. Inside slipper material: terry. Also available in M, L, XL, 2XL, Bariatric.	**BRAND** Double-Tread Fall Prevention Patient Slippers, Item#: MDT211218RH (1 pair) or MDT211250R (48/pack)

THERAPEUTIC SHOES

INDICATIONS

Medically necessary under the following conditions:

1. A shoe that is an integral part of a leg brace, and its expense is included as part of the cost of the brace
2. Therapeutic shoes furnished to selected diabetic patients
3. The diabetic patient must have one or more of the following conditions affecting one or both feet:
    a. History of partial or complete foot amputation
    b. History of previous foot ulceration
    c. History of pre-ulcerative callus
    d. Foot deformity and peripheral neuropathy with evidence of callus formation
    e. Diminished blood supply to the foot or is being treated under a comprehensive diabetic care plan
4. Therapeutic shoes for certain peripheral vascular and neuropathic conditions.
    a. History of previous ulceration
    b. Diabetes
    c. Buerger's disease (thromboangiitis obliterans)
    d. Chronic thrombophlebitis
    e. Peripheral neuropathies involving the feet
5. Rehabilitative foot orthotics as part of postsurgical or post-traumatic casting care
6. Prosthetic shoes - used when all or a substantial portion of the front part of the foot is missing. A prosthetic shoe can be used as a terminal device (i.e., a structural supplement replacing a totally or substantially absent foot)

Indications for Orthotics, Foot (All)

1. Standard shoes not suitable for condition/requiring custom-made orthosis
2. Medical record documentation supports medical necessity of orthosis
3. Stability and support necessary for: (choose one)
    a. Deformity of foot
    b. Chronic weakness of lower extremity
    c. Chronic ankle instability
    d. Limb length discrepancy of ≥ 1.5 inches

Therapeutic Shoes – White 	**DESCRIPTION** Life walker strap - leather upper w/ brushed nylon lining and dual strap closure, firm heel counter with removeable footbed, cushioned EVA midsole with herringbone tread rubber outsole - WHITE	**BRAND** Propet Life Walker Strap-Men's Orthopedic Walking Shoes SKU number based on width, size, color

WASH BASIN

INDICATIONS

Soaking limbs/feet/hands, rinsing, washing. Emesis basin.

Wash Basin 	**DESCRIPTION** Rectangular plastic bedside soaking tub (7 quart)	**BRAND** Brand: Vakly No SKU#. 13.25" L x 10" W x 4.5" H, gray. Graduated markings in quarts. Rolled rim. Available individually, packs of 2, 5, 10, 25, 50 (Amazon.com) McKesson Mfr #: 56-80342. 13"L x 10" W X 5" D. Rolled rim.50/case.

PULMONOLOGY

BUBBLE HUMIDIFIER

INDICATIONS

For patients complaining of dryness of nose and throat after getting continuous oxygen supplementation at 4 liters per minute for more than 24 hours.

Bubble Humidifier	**DESCRIPTION**	**BRAND**
	Black lid bubble humidifier bottle with 6 PSI safety valve provides effective humidification for oxygen therapy. Bubble humidifier bottle has a 6 PSI audible pop-off pressure alarm to warn of any obstructions to oxygen flow and help reduce the likelihood of concentrator damage due to downstream occlusion.3.25" x 7.00"	Salter Black Lid Bubble Humidifier. Mfr: Salter Labs Part#: 7600-0

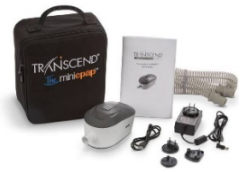
NON-INVASIVE AIRWAY ASSISTIVE DEVICES (CPAP)

INDICATIONS

1. Central sleep apnea due to congestive heart failure as indicated by:
    a. CPAP shown to reduce Apnea-Hypopnea Index (AHI) to below 15/hour
    b. Inadequate response to aggressive medical management
2. Obesity hypoventilation syndrome with:
    a. BMI > 30
    b. Daytime hypercapnia PaCO2 >45 mm Hg without other etiology (e.g., kyphoscoliosis, lung parenchymal disease, myopathy, severe hypothyroidism).
    c. Sleep disordered breathing with AHI >5
    d. Increased PaCO2 during sleep by >10 mm Hg above value while awake
    e. O2 sat <90% not explained by obstructive apneas
    f. TSH does not demonstrate hypothyroidism
3. Obstructive sleep apnea indicated by
    a. Mild OSA defined as AHI between 5-15 determined by polysomnography and 1 or more of the following:
        i. CVD (HTN, HF, stroke)
        ii. Excessive daytime sleepiness
        iii. Fibromyalgia-like symptoms
        iv. Headaches on awakening
        v. Heartburn/reflux
        vi. Impaired cognition
        vii. Mood disorder
        viii. Night sweats
        ix. Observed apnea/choking
        x. Snoring
        xi. Nocturia

b. moderate/severe OSA with AHI> 15

4. Chronic obstructive pulmonary disease
5. Severe hypoventilation syndrome
6. Restrictive thoracic disorders
7. Neuromuscular disorders such as amyotrophic lateral sclerosis
8. Severe thoracic cage abnormalities such as post-thoracoplasty for tuberculosis

CPAP *Auto-Heated Humidifier* 	**DESCRIPTION** Resvent iBreeze™ 20A Pro	**BRAND** iBreeze™ Resvent CPAP Machine SKU#: 20C/20C Pro
CPAP *Auto-Heated Humidifier* 	**DESCRIPTION** IntelliPAP Auto-Adjust and Heated Humidification System CPAP System	**BRAND** IntelliPAP Auto Adjust and Heated Humidification System, Mfr: Drive Medical, Mfr# DV54D-HH
CPAP *Transcend Portable Mini Somnetics* 	**DESCRIPTION** Transcend 3 Auto Travel CPAP. Auto-adjust CPAP therapy, EZEX pressure relief and ramp technology. Pressure range 4-20 cm H2O. Sound pressure 30 dBA. Size of a soda can, weighs 1 lb. Options: battery, DC and solar charging.	**BRAND** Portable Mini CPAP machine. Brand: Transcend. Mfr: Somnetics International, Inc. SKU#: 503104

❖ *ACCESSORIES: CPAP*

INDICATIONS

1. **Humidifier:** Relieve dry mouth, congested or runny nose, chapped lips, nosebleeds and improve compliance with CPAP use. Indicated in patients with the above symptoms or who are taking oral medications which can cause dry mouth.
2. **Nasal Pillow CPAP with Headgear:** CPAP Part. For patients who cannot wear a face mask due to:
    a. Claustrophobia
    b. Facial hair which prevents a good seal
    c. Facial deformity

d. Patients with arthritis or muscle weakness (may be easier to put in place or adjust). May not be tolerated if CPAP is above 12 cm H2O due to discomfort of excessive turbulent airflow directly impacting the nasal mucosa. Heated humidification decreases nasal resistance by approximately 50% by raising the relative humidity of the PAP airflow

CPAP *Humidifier CPAP 500ML* 	**DESCRIPTION** IntelliPAP™ CPAP Humidifier 500 mL Universal. For use with DeVilbiss IntelliPAP and Sleep Cube devices. Reservoir volume: 500 mL. Moisture output: 40 mg H2O/ Liter. *To use with previous models	**BRAND** Drive Medical IntelliPAP CPAP Humidifier 500 mL, Universal. Brand: IntelliPAP, Mfr: Drive Medical. Mfr ID: DVSHH.
CPAP *Nasal Pillow CPAP with headgear all size kit* 	**DESCRIPTION** Nasal Pillow System Aloha™ NASAL PILLOW SYSTEM, CPAP with headgear. Wide-set headgear provides limited points of contact on the face and no interference with the eyes. Nasal pillow accommodates any movement during sleep. Nasal pillows (small, medium, large) come with headgear and frame system.	**BRAND** Drive Medical Aloha Nasal Pillow System for CPAP. Brand: Aloha Mfr: Drive Medical. Product#: ALO100

NON-INVASIVE AIRWAY ASSISTIVE DEVICES (BIPAP)

INDICATIONS

1. Central sleep apnea (idiopathic) and BiPAP with backup rate as indicated by ALL the following:
    a. Primary central sleep apnea as indicated by ALL the following:
        i. Central Apnea Hypoxia index > 5 predominantly in non-REM sleep; events lasting longer than 10 seconds
        ii. Central apneas + central hypopneas are >50% of all apneas/hypopneas
        iii. No Cheyne-Stokes respiration
        iv. No nocturnal hypoventilation (i.e., no hypercapnia) as indicated by no sleep PCO2 > 55 mmHG for > 10 minutes or sleep PCO2 increasing by at least 10 mm Hg vs awake supine PCO2 and > 50 mmHg for > 10 minutes
    b. Symptoms of sleep-disordered breathing (1 or more): daytime sleepiness, frequent nighttime awakenings, gasping during sleep, insomnia, respiratory pauses during sleep, restless sleep, snoring
    c. Titration study with polysomnography demonstrates improvement in apnea-hypopnea index (AHI)
    d. No evidence of medical disorders or medications that explain symptoms
2. Chronic obstructive pulmonary disease (COPD) and BiPAP needed as indicated by 1 or more of the following:
    a. Chronic hypercapnia with PaCO2 of 50-52 mmHg and
        i. Arterial O2 saturation < 88% for 5 consecutive minutes during nocturnal oximetry while on at least 2L oxygen per minute AND/OR

ii. Invasive or non-invasive ventilation for acute exacerbation required during > 2 hospitalizations per year

b. Chronic hypercapnia with PaCO2 of > 52 mm Hg or greater
c. Palliative care in a patient with end-stage disease or advance directive stating no desire for intubation
d. End-stage lung disease with hypercapnic respiratory failure in a patient awaiting lung transplant and BiPAP needed e.g., COPD, cystic fibrosis, idiopathic pulmonary fibrosis, sarcoidosis.

3. Obesity hypoventilation syndrome and BiPAP needed as indicated by ALL the following:
   a. BMI> 30.
   b. Daytime hypercapnia with PaCO2 > 45 mm Hg without other etiology (e.g., kyphoscoliosis, lung parenchymal disease, myopathy, severe hypothyroidism).
   c. Sleep-disordered breathing or hypoventilation on polysomnography as indicated by 1 or more of the following:
      i. AHI > 5
      ii. Increase in PaCO2 during sleep by > 10 mm Hg above value while awake
      iii. TSH level does not demonstrate hypothyroidism
      iv. Significant oxygen desaturation (i.e., < 90%) not explained by obstructive apneas or hypopneas.
4. Obstructive sleep apnea (OSA) and BiPAP needed as indicated by 1 or more of the following:
   a. Mild OSA defined as AHI between 5-15 determined by polysomnography and 1 or more of the following:
      i. Documented cardiovascular disease
      ii. Excessive daytime sleepiness
      iii. Fibromyalgia-like symptoms
      iv. Headaches upon awakening
      v. Heartburn and reflux
      vi. Impaired cognition
      vii. Mood disorder
      viii. Night sweats
      ix. Nocturia or nocturnal enuresis
      x. Observed apnea or choking episodes
      xi. Patient is a commercial vehicle driver
      xii. Snoring
   b. Moderate-severe OSA with AHI > 15
   c. CPAP unsuccessful or not appropriate as indicated by 1 or more of the following:
      i. Comorbid sleep-related hypoventilation (arterial, end-tidal or transcutaneous PCO2 > 55 mm Hg for > 10 minutes or increase in arterial, end-tdal or transcutaneous PCO2 of > 10 mm Hg above awake supine value resulting in PCO2 > 50 mm Hg for >10 minutes in a patient with OSA
      ii. Intolerance of CPAP pressures (difficulty exhaling against fixed airway pressure)
      iii. Titration study demonstrates OSA despite CPAP 15 cm H2O that is responsive to BiPAP

BiPAP *Auto-Heated with Humidifier*	**DESCRIPTION** DeVilbiss IntelliPAP Bilevel S. 6.4" x 6.5" x 8.4". 4.45 lbs. Pressure range 3-25 cm H2O. Noise level 26 dB. Can be operated in CPAP or BiPAP mode.	**BRAND** DeVilbiss IntelliPAP Bilevel BiPAP Machine. Brand: IntelliPAP Mfr: DeVilbiss SKU#: DV55D

		
BiPAP *With Humidifier* 	**DESCRIPTION** DreamStation Auto BiPAP System with Humidifier 3.3” x 7.6” x 11.7”. Pressure range 4-30 cm H2O. Ramp time 0-45 min (5 min increments).	**BRAND** Philips DreamStation BiPAP autoSV Brand: DreamStation Mfr: Philips Mfr Part#: DSX700H11

OXYGEN CONCENTRATOR*

INDICATIONS

1. Cancer with episodic or persistent breathlessness OR continuous O2 therapy needed with O2 sat <88%.
2. Central sleep apnea.
3. Chronic obstructive pulmonary disease
4. Cluster headache in a patient receiving preventive therapy (e.g., verapamil).
5. Cystic fibrosis and interstitial lung disease with O2 sat < 88%.
6. Neuromuscular or skeletal disorder (severe kyphoscoliosis, thoracic dystrophy, ALS) with O2 sat < 88%
7. Obesity hypoventilation syndrome with daytime O2 sat persistently < 88% and failure to improve despite BiPAP while asleep.
8. Pulmonary hypertension with O2 sat < 90%.

Oxygen Concentrator *5LPM* 	**DESCRIPTION** CONCENTRATOR, OXYGEN 5 L With Oxygen Sensor. Devilbiss Model 525. Max Output 5 Liter Per Minute. Small Size Home Oxygen Concentrator. 37 Lbs. Sound Level 48 Dba Typical.	**BRAND** DeVilbiss Oxygen Concentrator, 5 Liter with oxygen sensor Brand: DeVilbiss Mfr: Drive Medical Model 525DS.
Oxygen Concentrator *With extended battery* *SimplyGo*	**DESCRIPTION** Portable Oxygen Concentrator SimplyGo Mini with Extended Battery - up to 9 hours of operation	**BRAND** Philips Respironics SimplyGo Mini portable oxygen concentrator, carrying case, one std. rechargeable lithium-ion

		battery, DC, AC power cords, accessory bag Mfr#: 1113601
Oxygen Concentrator *Portable* 	**DESCRIPTION** SEQUAL ECLIPSE 5 - Portable Oxygen Concentrator w/ continuous flow and pulse dose therapy	**BRAND** Caire SeQual Eclipse 5 portable concentrator SKU: 6900BTSEQ

TRACHEOSTOMY CARE SUPPLIES*

INDICATIONS

1. A tracheostomy care kit is medically necessary for a patient following a surgical tracheostomy which has been open or is expected to remain open for at least three months.
2. A tracheostomy care or cleaning starter kit is medically necessary following an open surgical tracheostomy. One tracheostomy care kit per day is considered necessary for routine care of a tracheostomy.

VOICE PROSTHESES/AUGMENTATIVE COMMUNICATION/SPEECH GENERATING DEVICE

INDICATIONS

Communication aids (also known as alternative or augmentative communication [AAC] devices) assist patients who are unable to speak due to a disease, injury, or a congenital condition. They may be appropriate if medical staff determines that the patient suffers from severe speech impairment and the medical condition warrants the use of a device.

Speech generating devices are defined as speech aids that provide a patient who has severe speech impairment with the ability to meet his functional speaking needs. Speech generating devices are characterized by:

1. Being a dedicated speech device used solely by a person who has a severe speech impairment
2. May have digitized speech output using pre-recorded messages less than or equal to 8 minutes recording time
3. May have digitized speech output using pre-recorded messages greater than 8 minutes recording time
4. May have synthesized speech output which requires message formulation by spelling and device access by physical contact with the device-direct selection techniques
5. May have synthesized speech output which permits multiple methods of message formulation and multiple methods of device access

6. May be software that allows a laptop computer, desktop computer, or personal digital assistant (PDA) to function as a speech generating device

A speech generating device (SGD) may be considered medically necessary when ALL the following criteria are met:

1. Prior to delivery of the SGD, the patient has had a formal evaluation of cognitive and communication abilities by a speech-language pathologist. The formal written evaluation must include, at a minimum, the following elements:
    a. Current communication impairment, including the type, severity, language skills, cognitive ability, and anticipated course of the impairment
    b. An assessment of whether the individual's daily communication needs could be met using other natural modes of communication (gestural, speech, and/or written communication)
    c. A description of the functional communication goals expected to be achieved and treatment options
    d. Rationale for selection of a specific device and any accessories
    e. Demonstration that the patient possesses a treatment plan that includes a training schedule for the selected device
    f. Patient has the cognitive and physical abilities to effectively use the selected device and any accessories to communicate
    g. Any request for upgrading from a previously issued SGD must provide information regarding the functional benefit to the patient
2. The patient's medical condition is one resulting in a severe expressive speech impairment
3. The patient's speaking needs cannot be met using gestural, speech, and/or written communication
4. Other forms of treatment have been considered and ruled out
5. The patient will gain intelligible speech with the device despite the patient's severe communication impairment demonstrated by a one-month trial therapy utilizing the device prior to purchase

Tracheoesophageal Voice Prosthesis

Tracheoesophageal (TE) voice prostheses are surgically placed to permit laryngectomized and other non-vocal (e.g., amyotrophic lateral sclerosis) patients TE speech by shunting inhaled air from the lungs into the esophagus resulting in a vibration of the esophageal tissue. TE voice prostheses provide adequate speech following total laryngectomy.

An indwelling tracheoesophageal voice prosthesis or handheld artificial larynx may be medically necessary when recommended by a laryngologist or a speech language pathologist for voice rehabilitation following total laryngectomy, or thelarynx is permanently non-functional for speech following trauma or disease.

The patient must meet ALL the following criteria:

1. Patient must have the manual dexterity to care for the prosthesis several times daily
2. Patient must have adequate pulmonary function to force air from the trachea through the prosthesis into the esophagus
3. Patient must be motivated to use the device and have well-defined treatment goals
4. Patient must be unable to meet daily communication needs without the use of an augmentative communication device
5. Patient has the cognitive, motor, and receptive language skills to use an augmentative communication device to meet daily communication needs and achieve functional communication goals

A trachea tube has been determined to satisfy the definition of a prosthetic device, and the tracheostomy speaking valve is an add-on to the trachea tube which may be considered a medically necessary accessory that enhances the function of the tube. In other words, it makes the system a better prosthesis. As such, a tracheostomy speaking valve is covered as an element of the trachea tube which makes the tube more effective (CMS National Coverage Determination 50.2).

Replacement every 3 to 6 months is consistent with the documented life span of most voice prostheses. It is usually carried out as an outpatient procedure.

Leakage of fluid (saliva, reflux) through or around a voice prosthesis as well as increased airflow resistance are the main indications to remove the prosthesis for inspection and, if necessary, replacement. Replacement of TE voice prosthesis should only be carried out by a physician or a speech-language pathologist and is usually performed in an outpatient setting.

UROLOGY

INCONTINENCE SUPPLIES*

INDICATIONS

Patients with an underlying medical condition that involves loss of bladder or bowel control.

URINAL

INDICATIONS

For patients having difficulty reaching the bathroom to urinate.

Urinal – Female 	**DESCRIPTION** Can be used in several positions by patient. Graduation marks to measure output. Can hold 32 oz. Sturdy grip for easy handling; designed to prevent spills. Lightweight, durable and easy to clean.	**BRAND** Mfr: Drive Medical SKU# RTLPC23201-F (dmesupplyusa.com)
Urinal – Male 	**DESCRIPTION** Can be used in several positions by patient. Graduation marks to measure output. Can hold 32 oz. Sturdy grip for easy handling; designed to prevent spills. Lightweight, durable and easy to clean. Cap helps confine odors.	**BRAND** Mfr: Drive Medical SKU# 1103369 (dmesupply.com)

UROLOGIC SUPPLIES*

INDICATIONS

No more than one indwelling catheter per month is allowed for routine catheter maintenance. Non-routine catheter changes are indicated when documentation substantiates medical necessity, such as for:

1. Catheter is accidentally removed (e.g., pulled out by patient)
2. Malfunction of catheter (e.g., balloon does not stay inflated, hole in catheter)
3. Catheter is obstructed by encrustation, mucous plug, or blood clot
4. History of recurrent obstruction or urinary tract infection for which it has been established that an acute event is prevented by a scheduled change frequency of more than once per month

Leg bags are indicated for patients who are ambulatory or are chair or wheelchair bound. The use of leg bags for bedridden patients is not medically necessary.

Supplies for intermittent irrigation of an indwelling catheter are necessary when they are used on an as needed (non-routine) basis in the presence of acute obstruction of the catheter.

Supplies for continuous irrigation of a catheter are necessary when there is a history of obstruction of the catheter and the patency of the catheter cannot be maintained by intermittent irrigation in conjunction with medically necessary catheter changes. Continuous irrigation as a primary preventative measure (i.e., no history of obstruction) is not medically necessary.

Intermittent catheterization is medically necessary when the patient can perform the procedure. Non-sterile lubricating gel is indicated for use with clean, non-sterile catheterization technique. Eight ounces is included per month. Intermittent catheterization using sterile technique is medically necessary when the patient requires catheterization, and the patient meets one of the following criteria:

1. Patient is immunosuppressed, for example (not all inclusive): on a regimen of immunosuppressive drugs post-transplant, or on cancer chemotherapy or has Acquired Immunodeficiency Syndrome (AIDS), or has a drug-induced state such as chronic oral corticosteroid use
2. Has radiologically documented vesico-ureteral reflux while on a program of intermittent catheterization
3. A spinal cord injured female with neurogenic bladder who is pregnant (duration of pregnancy only)
4. Has had distinct, recurrent urinary tract infections while on a program of clean intermittent catheterization, twice within the 12 months prior to the initiation of sterile intermittent catheterization. For this policy, a urinary tract infection is considered to be present if a urine culture with greater than 10,000 colony forming units of a urinary pathogen AND concurrent presence of 1 or more of the following signs, symptoms or laboratory findings is documented:
    a. Fever (oral temperature greater than 38° C [100.4° F])
    b. Systemic leukocytosis
    c. Change in urinary urgency, frequency, or incontinence
    d. Appearance of new or increase in autonomic dysreflexia (sweating, bradycardia, blood pressure elevation)
    e. Physical signs of prostatitis, epididymitis, orchitis
    f. Increased muscle spasms
    g. Pyuria (greater than 5 white blood cells per high-powered field)

External Catheters/Urinary Collection Devices

1. Male external catheters (condom-type) or female external urinary collection devices are medically necessary for patients who have permanent urinary incontinence when used as an alternative to an indwelling catheter. The utilization of male external catheters generally should not exceed 35 per month. Greater utilization of these devices must be accompanied by documentation of medical necessity.
2. Specialty type male external catheters (e.g., inflate or include a faceplate) are medically necessary only when documentation substantiates the medical necessity for such a catheter. For female external urinary collection devices, more than one metal cup per week, or more than one pouch per day are not medically necessary.

Miscellaneous Urinary Drainage Supplies

1. Appliance cleaner is allowed when used to clean the inside of certain urinary collecting appliances. More than 1 unit of service (16 oz.) per month is rarely medically necessary.
2. One external urethral clamp or compression device is appropriate every 3 months or sooner if the rubber/foam casing deteriorates.

3. Tape used to secure an indwelling catheter to the patient's body is included. More than 10 units (1 unit = 18 sq. in.; 10 units = 180 sq. in. = 5 yds. of 1”tape) per month is not medically necessary unless the request is accompanied by documentation justifying a larger quantity in the individual case.
4. Adhesive catheter anchoring devices (3 per week) and catheter leg straps (1 per month) for indwelling urethral catheters.