



CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

PROVIDER ORDERED DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLY FORMULARY

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DERMATOLOGY

BURN GARMENT

Indication(s): 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.

<p>Burn Garment</p> 	<p>DESCRIPTION</p> <ul style="list-style-type: none"> ▪ 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 	<p>BRAND Varies</p>
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CUSHION

Indication(s): Risk for sacral wound; requires pressure relieving support surface.

INVALID FOAM RING CONTOURED CUSHION

	<p>DESCRIPTION Invalid foam rings, 16", 1/box. Cushion is made of puncture-resistant foam. Removable polyester/cotton cover is washable.</p>	<p>BRAND Medline Invalid Foam Ring Contoured Cushion, 16" with cover, 1/box. Medline #: DUR8016W</p>
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DONUT SEAT CUSHION


	<p>DESCRIPTION 18 ¾" W x 14 ¾" D x 2 ¾" H molded high compression polyurethane foam. Removable machine washable polyester/cotton cover. Available dimensions: 16" W x 12 ½" D x 2 ¾" to 18 ¾" W x 14 ¾" D x 2 ¾" H. Weight capacity: 250 lbs.</p>	<p>BRAND Donut Seat Cushion, Foam Mfr: Nova Ortho Med Mfr #: 2674-R McKesson #: 1172861</p>
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WHEELCHAIR SEAT


Indication(s):

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

	<p>DESCRIPTION Seat Cushion RODO Quadro 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. Available dimensions: 13"W x 16"D X 2 ¼"H to 24"W X 18"D X 2 ¼" H</p>	<p>BRAND ROHO Quadro Select® Low Profile® Cushion Fits Chair 16" (W) x 16" (D) Mfr: Crown Therapeutics Mfr #: QS99LPC McKesson #: 577301</p>
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CUSHION SEAT INFLABLE HIGH PROFILE

	<p>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. Low dexterity ISOFLO Memory Control regulates airflow between the four quadrants to set the cushion up for use in different functional activities without changing the air volume in the cushion. Cushion comes with two-way stretch cover, hand inflation pump and repair kit. Available dimensions: 15" W x 15" D x 4 1/4" H to 22" W x 20" D x 4 1/4" H</p>	<p>BRAND Roho® Quadro Select Profile® Seating Cushion Mfr: Crown Therapeutics Mfr #: QS1010C McKesson #: 630953</p>
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CUSHION SEAT WHEELCHAIR FOAM


	<p>DESCRIPTION Seat Cushion McKesson 16" (W) x 18" (L) x 3" (H) Convoluted Polyurethane Foam. Non-inflatable, 2" overlay.</p>	<p>BRAND McKesson Convoluted Foam Wheelchair Seat Mfr: McKesson Brand Mfr #: 136-58132 18/pack McKesson #: 929210</p>
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GEL FOAM

	<p>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. Available dimensions: 16" x 16" x 3" to 22" x 18" x 3". Weight capacity: up to 20"- 275 lbs.; 22" and up-500 lbs.</p>	<p>BRAND Drive Medical Titanium Skin Protection and Positioning Gel/ Foam Wheelchair Cushion, 20" (W) x 18" (D) x 3.5" (H) Mfr #: FPT-2018 McKesson #: 1154033</p>
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HEEL/FOOT PROTECTOR

Indication(s): Per Pressure Injury Prevention protocol.


<p><i>Heel/Foot Protector</i></p> 	<p>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.</p>	<p>BRAND Heel Protection Boot Skil-Care Mfr #: 503450 McKesson #: 844173</p>
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NEGATIVE PRESSURE REDUCING SUPPORT MATTRESS

Indication(s):

1. Increased risk for development of pressure injuries as indicated by one or more of the following:
 - a. Braden scale score of 14 or less (Refer to the [Chronic Wound Management Care Guide](#)).
 - b. Braden scale score of 18 or less with risk factors as indicated by 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 the [Chronic Wound Management Care Guide](#)) or greater pressure injury as indicated by one 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.

<p>Mattress Overlay, Foam Gel</p> 	<p>DESCRIPTION 34" W x 76" L x 3" D. Weight capacity 300 lbs. Core with horizontal chambers. Filled with gel and foam beads to conform to body. Standard foam top layer, Fluid-resistant nylon top cover; skid-resistant vinyl bottom cover. Elastic straps secure corners of overlay to a mattress.</p>	<p>BRAND Medline Standard Gel/Foam Mattress Overlay Mfr: Medline Mfr #: MSCGELOV</p>
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NEGATIVE PRESSURE WOUND THERAPY/VACUUM ASSISTED CLOSURE

Indication(s): 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).
3. 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 Negative Pressure Wound Therapy (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.

WOUND CARE DRESSING

Indication(s):

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 two inches greater than the dimensions of the wound. For example, a 5 cm x 5 cm (2" x 2") wound requires a 4" x 4" 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 two 6" strips per dressing change
- Composite dressing – Three times per week, one dressing per dressing change
- Contact layer – Once per week
- Foam dressing – Up to three times per week
- Foam wound filler – Once daily
- Gauze – Three times per day, no more than two 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 – Three times per week
- Hydrogel wound cover – Once daily (or three times per week if using adhesive border)
- Hydrogel wound filler – Once daily, no more than three ounces per wound in a thirty-day period
- Specialty absorptive dressing – Once per day (or every other day if using adhesive border)
- Transparent film – Up to three times per week
- Wound filler not classified – Once per day
- Wound pouch – Up to three times per week
- Tape - Determined by frequency of dressing change
- Elastic bandage – Once 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

DIABETIC SUPPLIES/MONITOR

Indication(s):



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 \leq 110% of the lower limit of normal of the laboratory's measurement method AND a concurrently obtained fasting glucose \leq 225 mg/dL.
 - b. Renal insufficiency with a creatinine clearance (actual or calculated from age, gender, weight and serum creatinine) \leq 50 ml/minute AND a fasting C-peptide level \leq 200% of the lower limit of normal of the laboratory's measurement method.

GASTROENTEROLOGY

HERNIA SUPPORT


BELT (HERNIA)

Indication(s): Support for single and double inguinal hernias.

<p><i>Belt Hernia Elastic</i></p> 	<p>DESCRIPTION Hernia Belt. Removable and adjustable pads. Double belt. Waist sizes 35"-41". Small, medium, large sizes available.</p>	<p>BRAND Hernia Belt Sport-Aid Mfr: Scott Specialties Mfr #: SA1500 WHI MD (Medium) McKesson #: 697366 (Medium)</p>
<p><i>Belt Hernia Peristomal</i></p> 	<p>DESCRIPTION Peristomal Hernia Belt Nu-Form™. Opening size, 2 1/8", 1 1/2" from bottom, right side. Large belt hip size 36"-41", 7"- width. Sizes available: hip size 28"-31" to 47"-52", width 3" to 9". Adjustable hook and loop closure. For support of hernias around and adjacent to the stoma. Helps manage prolapsed stomas, support nonreducible hernias and protect abdominal hernia repairs.</p>	<p>BRAND Peristomal Hernia Belt, Large Brand: Nu-Form Mfr: Nu Hope Laboratories Mfr #: 6447-L McKesson #: 802193</p>


BINDER (ADOMINAL)

Indication(s): 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.

<p><i>Binder Abdominal</i></p> 	<p>DESCRIPTION Abdominal Binder provides compression and support for post-abdominal surgery or abdominal strains. Constructed with multi-panel elastic and flannel lined with contact closure. One size fits most. Has three panels, 9"- height, 45"-62" waist circumference.</p>	<p>BRAND ProCare® Premium One Size Fits Most Hook and Loop Closure. Mfr: DJO Mfr #: 79-99431 McKesson #: 412880</p>
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TRUSS HERNIA SUPPORT

Indication(s): Used for the purpose of supporting a weak or deformed body part or restricting or eliminating motion.

<p><i>Hernia Aid Belt</i></p> 	<p>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" (X-Large)</p>	<p>BRAND Hernia Aid Belt (X-large) Mfr: Alimed Mfr #: 2970005595 McKesson #: 711300</p>
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OSTOMY SUPPLIES

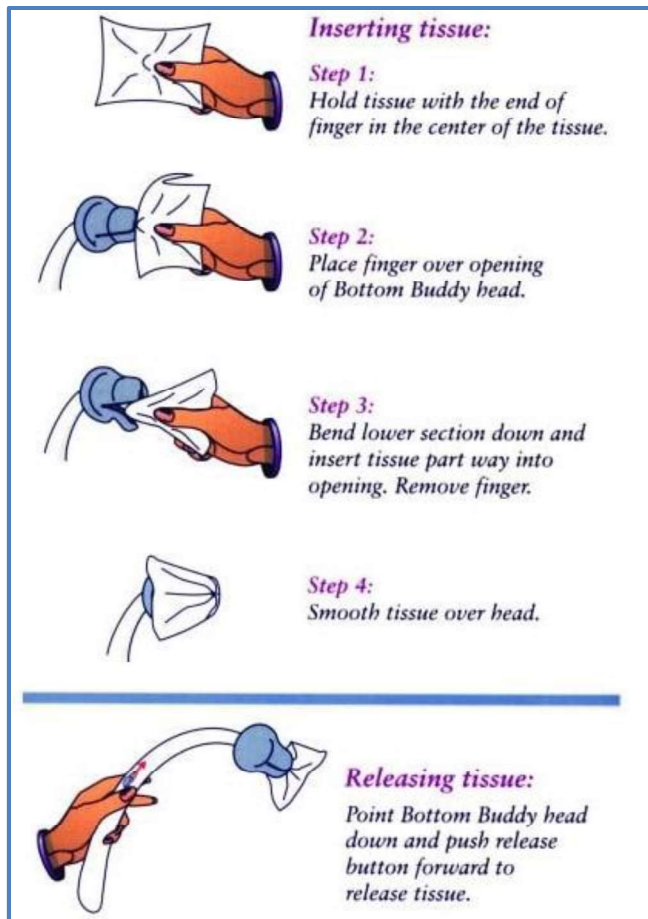
Indication(s):

1. When liquid barrier is necessary, either a liquid or spray or individual wipes is appropriate. Use of more than one barrier 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)


Indication(s): For elderly, disabled, injured, pregnant or others having difficulty wiping after using the toilet.

<p><i>Personal Hygiene Wipe (Bottom Buddy Toilet Aid)</i></p> 	<p>DESCRIPTION Designed for self-cleansing. Soft flexible head grips tissue. Features easy release button and works with toilet paper or pre-moistened wipes. 10 ½" long.</p>	<p>BRAND Bottom Buddy™ Toileting Aid Mfr: Performance Health Mfr #: 555400 McKesson #: 577276</p>
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SITZ BATH

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

<p>Sitz Bath</p> 	<p>DESCRIPTION High-impact plastic bowl with 2000 ml capacity solution bag with shut-off clamp on the tubing to control flow. Packaged 10 per case, individually bagged.</p>	<p>BRAND Sitz Bath Round Graphite Plastic Mfr: McKesson Brand Mfr #: 56-80102 McKesson #: 1028137</p>
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HEARING ASSISTIVE DEVICES

HEARING AID


Indication(s): See InterQual/Durable Medical Equipment/General/Hearing Aid.

HEARING IMPAIRED DISABILITY VEST

Indication(s):

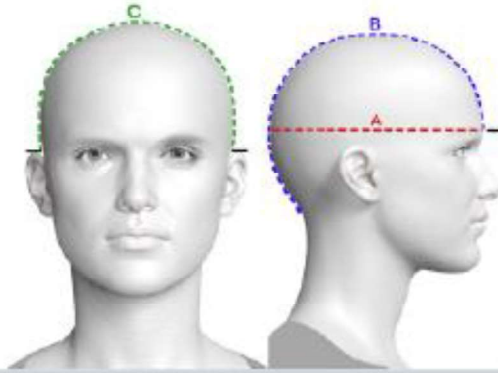
Hearing Impaired

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 a hearing aid(s) to achieve effective communication.
3. Patients with permanent hearing disability **MUST** have an CDCR 1845 with DPH or DNH code. Temporarily issue DNH with CDCR 7410 when hearing aids are not available.

<p><i>Vest Hearing Impair YLW Reg</i></p> 	<p>DESCRIPTION ADA Fluorescent yellow mesh vest. Constructed with breathable 3.0 oz, 100% polyester mesh. Available in sizes small to 8X Large.</p>	<p>BRAND CalPIA Item #: 492500</p>
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HELMET SIZING AND SELECTION INFORMATION

HELMET SIZING AND SELECTION INFORMATION



Since proper fit is important for the effectiveness of the helmet as well as comfort of the person wearing headgear, measurements should be determined by professional personnel.

Measure the head circumference (all the way around) (A) at the eyebrow level. The Occipital measurement (B) is taken from the eyebrow level to the back of the head at the point that the helmet is to end. For (C) measure from the top of one ear over the head to the top of the other ear. If for some reason the measurements do not fall within the above guidelines, or if there are other considerations to be taken into account, please refer to the next page for information on Custom Helmets, or feel free to call us for help with sizing at (800) 783-1998.

(A) CIRCUMFERENCE RANGE

	Soft Shell	Hard Shell
Infant	16 ½ - 17	Not available in infant
XX-Small	17 ½ - 18 ¼	18½ - 19 ¼
X-Small	19 - 19 ¾	19 ¾ - 20
Small	20 ¼ - 21 ½	20 ½ - 21 ¾
Medium	21 ½ - 22 ¼	21 ½ - 22 ¼
Large	23 - 23 ¼	22 ½ - 23 ½
X-Large	24 - 24 ¾	24 ½ - 25 ¼
XX-Large	25 ½ - 26 ¼	26" - 26 ¼

(B) OCCIPITAL

	Soft Shell	Hard Shell
Infant	11 ½	Not available in infant
XX-Small	12 ¼	12 ¼
X-Small	13 ¼	13 ¼
Small	14 ½	15
Medium	15 ¼	16 ½
Large	16 ½	16 ¼
X-Large	17 ½	17 ½
XX-Large	18 ½	18 ¼

(C) EAR TO EAR

	Soft Shell	Hard Shell
Infant	8 ¼	Not available in infant
XX-Small	9 ½	9 ¼
X-Small	9 ½"	10
Small	10 ½	11 ¼
Medium	11	12 ½
Large	12	12 ¼
X-Large	13	13 ¼
XX-Large	15 ¼	15

Measurements are in inches

HEADGEAR SELECTION


Some suggested considerations to use in helping to determine that type of helmet would be suitable for your client are:

- Degree of physical activity.
- Potential for striking surfaces (floor, walls, furniture, etc.).
- Nature of self-abusiveness.
- Severity and frequency of seizures or spasticity.
- Length of time worn.

HELMET (SEIZURE)

Indication(s):


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.

<p>Helmet Seizure</p> 	<p>Description</p> <p>Lightweight Soft-Shell Helmet made of ½” thick shock-absorbent foam that is fully ventilated and weighs less than eight ounces. 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. Sizes small, medium, large.</p>	<p>BRAND</p> <p>Soft shell helmet Mfr: Alimed Mfr #: 2970000666 McKesson #: 866301</p>
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BREAST PUMP

Indication(s):

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 of 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.

<p>Breast Pump</p> 	<p>DESCRIPTION Manual breast pump kit. Portable manual breast pump with silicone massage insert and built-in back flow protection device.</p>	<p>BRAND Spectra Manual Breast Pump. Mfr: Mother's Milk Inc. Mfr #: MM010964 McKesson #: 1039356</p>
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OPHTHALMOLOGY AND OPTOMETRY

CANE, FOLDING WHITE/TAPPING CANE

Indication(s): Impaired vision assistive device. Patients with permanent visual disability and have a CDCR 1845 with DPV or DNV code are required to have Certified Orientation and Mobility Specialist (COMS) Training prior to provision.

TYPES OF WHITE CANE

1. All white cane: user is totally blind and has no usable vision.
2. White cane with red bottom: user has low, but some usable, vision.
3. White and red striped cane: user is totally blind and/or deaf.
4. Different tips are used in different environments. Please order per COMS instructor recommendations (e.g., pencil, roller, marshmallow, and metal glide).

<p>Folding White Cane, Tapping Cane</p> 	<p>DESCRIPTION Aluminum with double elastic assembly. Top of the cane has a standard flat-sided rubber grip similar to that found on a golf club. Strip of red reflective tape near the tip of the cane. Available in lengths 36"-72". Variety of tips available.</p>	<p>BRAND Premium Aluminum Mobility Cane Brand: AmbuTech</p>
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CONTACT LENSES (MUST UTILIZE RFS PROCESS)

Indication(s):


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 indication(s):
- a. 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
	<ul style="list-style-type: none"> ▪ Rigid Gas Permeable ▪ Soft Lens (Hydrophilic) ▪ Scleral Shell 	Varies

EYEGASSES

APHAKIA


Indication(s): 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

Indication(s): Vision impairment; must be accompanied with a prescription.

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

OCULAR CONFORMER

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

<p>Ocular Conformer</p> 	<p>DESCRIPTION Ocular Conformer for post-operative enucleation stents</p>	<p>BRAND Varies per ocularist recommendation.</p>
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READING GLASSES


Refer to Appendix: Non-Durable Medical Equipment and Over-the-Counter (OTC) Items

SUNGLASSES

Refer to Appendix: Non-Durable Medical Equipment and Over-the-Counter (OTC) Items

VISION IMPAIRED DISABILITY VEST


Indication(s): Patients with permanent visual disability and MUST have a CDCR 1845 with DPV or DNV code; temporary issue for DNV with CDCR 7410 when eyeglasses or contact lenses are not available.

<p>Vest Vision Impair YLW Reg</p> 	<p>DESCRIPTION ADA Fluorescent yellow mesh vest. Constructed with breathable 3.0 oz, 100% polyester mesh. Available in sizes small to 8x Large.</p>	<p>BRAND CalPIA Item #: 492500</p>
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ORTHOPEDICS

ABDOMINAL BINDER

Indication(s): 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.

<p><i>Binder Abdominal</i></p> 	<p>DESCRIPTION</p> <p>Abdominal Binder provides compression and support for post-abdominal surgery or abdominal strains. Constructed with multi-panel elastic and flannel lined with contact closure. One size fits most. Has 3 panels, 9" height, 45"-62" waist circumference.</p>	<p>BRAND</p> <p>ProCare® Premium One Size Fits Most Hook and Loop Closure. Mfr: DJO Mfr #: 79-99431 McKesson #: 412880</p>
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ANKLE FOOT ORTHOSES/KNEE ANKLE FOOT ORTHOSES (AFO/KAFO)

Indication(s):

For non-ambulatory patients:



1. Ankle Contracture Splints – Medically necessary if ALL of 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 (AFO) – 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 six 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.

<p>AFO Male Right/Left One Size</p> 	<p>DESCRIPTION Ankle/foot orthosis. Hook and loop closure. Provides static dorsiflexion and lateral stability area. Thicker polyethylene on the vertical aspect for rigidity; thinner footplate may be trimmed to fit with scissors. Available in female shoe size up to 9 1/2, male shoe size 12, right or left foot.</p>	<p>BRAND Freedom® Swedish Ankle Foot Orthosis (AFO) Mfr: Alimed Mfr #: 2970004476 McKesson #: 567554</p>
<p>Knee Ankle Foot Orthosis</p> 	<p>DESCRIPTION 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. Made up of three components: thigh component, ankle foot orthosis (AFO) component, and choice of either drop-lock or polycentric knee joint component. All sold separately.</p>	<p>BRAND Ottobock (Medline.com). Components sold separately. Mfr #: Prefabricated carbon fiber thigh component, size L ALI66700LG Mfr #: Prefabricated carbon fiber polycentric knee joint size A6 ALI66703A6</p>



ANKLE SUPPORT

Indication(s): 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 one month after injury compared with standard elastic support. It is also suitable for severe ankle sprains.

<p>Support Ankle Universal</p> 	<p>DESCRIPTION Ankle Support Surround® with Gel, Large. Hook and Loop Closure, Left or Right Foot, 8 ½" or 9" length, white. Rigid thermoplastic shells with adjustable heel strap. Air and gel bladder may be used for cold therapy.</p>	<p>BRAND DJO Surround® with Gel Ankle Support, Large Hook and Loop Closure, Left or Right Foot. Mfr: DJO Mfr #: 79-97863 McKesson #: 362644</p>
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ARM SLING

Indication(s): Usually temporary issue for upper extremity splint or cast or 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.

<p>Arm Sling Buckle Closure</p> 	<p>DESCRIPTION McKesson Buckle Closure Arm Sling, Large (also available in One Size Fits Most, S/M/XL), 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.</p>	<p>BRAND McKesson Buckle Closure Arm Sling Large. Also available in One Size Fits Most, S/M/XL. Mfr: McKesson Brand McKesson #: 1159080</p>
<p>Arm Sling Hook and Loop</p> 	<p>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 strap with double O-rings and contact closure. Sling has inner contact closures to adjust length of the sleeve.</p>	<p>BRAND McKesson Hook and Loop Closure Arm Sling One Size 7 x 18" Left or Right Arm, Cotton/Polyester. One each per box. Mfr: McKesson Brand McKesson #: 1159082</p>

BOOT WALKER

Indication(s): Severe ankle sprain, stable fracture of the foot/ankle/lower leg, and post-operative immobilization.



<p>Boot Ankle Walker Standard Unisex Large</p> 	<p>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.</p>	<p>BRAND Aircast AirSelect Walker Boot, Standard, Large. Hook and Loop Closure; Male 10 to 13/Female 11 to 15, Left or Right Foot. Mfr: DJO Mfr #: 01EF-L McKesson #: 835871</p>
<p>Boot Ankle Walker Short Unisex Large</p> 	<p>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.</p>	<p>BRAND Aircast AirSelect Walker Boot, Short, Large. Hook and Loop Closure; Male 10 to 13/Female 11 to 15, Left or Right Foot. Mfr: DJO Mfr #: 01ES-L McKesson #: 835885</p>

BRACE

BACK

Indication(s):


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).




<p>Back Braces - TLSO</p> 	<p>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.</p>	<p>BRAND Medline Restorative Care Thoracic Lumbar Sacral Orthosis Brace, High Back, Average Mfr: Restorative Care of America Item #: LRD46TLSA</p>
<p>Back Braces – LSO</p> 	<p>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. Hook and loop strap closure. Front measures 7" (H) and back measures 21" (H). Available in 44" to 48" hip circumference and 54" to 56" hip circumference.</p>	<p>BRAND Back Support Trulife Fast Wrap Large Hook and Loop Strap Closure Mfr: Allmed Mfr #: 2970002974 McKesson #: 1085585</p>

KNEE

REHABILITATIVE KNEE BRACE


Indication(s): Designed to allow protected and controlled motion of knees that have been injured and/or treated operatively. Commonly used for six to 12 weeks after injury.

<p>Support Knee Hinged Sizes: Small to X-Large</p> 	<p>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. Plastic/neoprene. Sizes Small to X-Large.</p>	<p>BRAND AliMed® Small to X-Large Hinged/U-Shaped Patella Buttress Mfr #: 66298/NA/NA/XL McKesson #: 726988</p>
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<p>Splint Knee 3 Panel 24in</p> 	<p>DESCRIPTION Knee Immobilizer One Size Fits Most, Hook and Loop Closure, 24" Length, Left or Right Knee. 31" thigh maximum circumference measured 4" above patella. Three-piece design for adjustment and correct fit. Foam body may be trimmed for customized fit. Also available in 16" and 20" lengths.</p>	<p>BRAND Knee Immobilizer ProCare® One Size Fits Most 24" Length Left or Right Knee Mfr: DJO Mfr #: 79-80180 7980090 16" 7980110 16" 7980170 20" 7980020 20" McKesson #: 410247</p>
<p>Immobilizer Knee Closure Straps 16in</p> 	<p>DESCRIPTION Knee Immobilizer 16" Length, up to 29" thigh circumference, left or right knee. Adjustable medial/lateral stays and rigid posterior stay. Foam laminate construction with wide 3" elastic contact closure straps.</p>	<p>BRAND Knee Immobilizer McKesson One Size Fits most. Up to 29" Thigh Circumference, 16" Length Left or Right Knee Mfr: McKesson Brand Mfr #: 155-79-96016 McKesson #: 1159093</p>
<p>Knee Brace Full Universal X-Act ROM™</p> 	<p>DESCRIPTION Adjustable length knee Brace, one Size Fits Most. Left or Right Knee, Hinged. Aluminum hinges provide extension settings from -1 to 90 degrees and flexion settings at -10 to 120 degrees. Foam lining provides viscous contact points between leg and the brace. All four sliders telescope independently to allow strap placement away from surgical site.</p>	<p>BRAND Knee Brace X-Act ROM™ One Size Fits Most, Adjustable Length, Left or Right Knee Mfr: DJO Mfr #: 11-2151-9 McKesson #: 800415</p>


UNLOADER/OFFLOADER KNEE BRACE

Indication(s): 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.

<p>Brace Knee XXL</p> 	<p>DESCRIPTION McKesson Hinged Knee Brace 2X-Large, Black, Wraparound / Hook and Loop Straps, 25-1/2" to 28" Circumference, Left or Right Knee, Neoprene/Elastic. Removable dual axis polycentric hinges provide medial/lateral support. Posterior strap adjustment for positioning of hinges. Removable dual axis polycentric hinges provide medial/lateral support.</p>	<p>BRAND McKesson Knee Brace 2X-Large Mfr: McKesson Brand Mfr #: 155-81-82399 McKesson#: 1159104</p>
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FUNCTIONAL KNEE BRACE


Indication(s): 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.

<p>Support Knee Hinged Buttress Univ 2XL</p> 	<p>DESCRIPTION Hinged Knee Support PROCARE® 2X-Large D Ring/Hook and Loop Closure Left or Right Knee. 3/8" universal buttress adjustable for medial, lateral, inferior or superior patellar stabilization. Removable dual axis hinges and superior/inferior contact closure straps provide support to medial/lateral ligaments. Compressive neoprene knee support with open patella.</p>	<p>BRAND Knee Brace ProCare® Hinged Knee Support Mfr: DJO Mfr #: 79-82739 McKesson #: 351587</p>
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WRIST

Indication(s):


1. Carpal Tunnel Syndrome. Symptom duration less than three 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.

<p>Wrist Brace Plastic RT/LT Hand One Size Fits Most</p> 	<p>DESCRIPTION Wrist Brace with Abducted Thumb, McKesson. Aluminum/Foam/Spandex/Plastic, Left or Right Hand, Black. Dual aluminum stays support palmar surface of wrist and extensor surface of thumb. Contact closure straps. Wrist circumference: 5 1/2" to 8 1/2"; Length: 7 1/2", 8" and 8 1/2". Size: XS to XL.</p>	<p>BRAND Wrist Brace with Abducted Thumb McKesson Aluminum/Foam/Spandex/Plastic Left or Right Hand, Black Mfr: McKesson Brand Mfr #: 155-81-87315 McKesson #: 1159141</p>
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CANE

Indication(s): 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%.

OFFSET

<p>Cane Offset 30" – 39"</p> 	<p>DESCRIPTION McKesson Cane, Offset Handle-Aluminum, 300 lbs. capacity, 30"-39" adjustable height. Foam rubber grip and wrist strap. 3/4" rubber tip with metal washer inserts.</p>	<p>BRAND Offset Cane McKesson Aluminum, 30"–39" height. Mfr: McKesson Brand Mfr #: 146-RTL10306 McKesson #: 1065214</p>
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QUAD

<p>Quad Cane</p> 	<p>DESCRIPTION Small Base Quad Cane McKesson Steel 30"–39" height. 7/8" aluminum shaft and steel base. Push button design with locking bolt adjusts height in 1" increments. Offset handle with foam rubber grip.</p>	<p>BRAND Small Quad Cane McKesson Mfr: McKesson Brand Mfr #: 146-10201F-4 McKesson #: 1065219</p>
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COLLAR (CERVICAL)

Indication(s):

1. Semi-hard cervical collar and rest for three to six weeks is comparable to physiotherapy or physiotherapy accompanied by home exercises for six weeks in substantially reducing neck and arm pain compared with a wait-and-see policy in the early phase of cervical radiculopathy.
2. 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 three months duration.
3. 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.


<p>Collar Cervical Universal</p> 	<p>DESCRIPTION Cervical Collar ProCare Universal Contoured/Medium Density Adult, One Size Fits Most. One-Piece, 3" (H), 24" (L), Available in 2 1/2", 3" and 3 1/2" height. 10-1/2" to 24" Neck Circumference. Hook and Loop Closure. Cotton stockinette cover. Includes additional cotton stockinette cover.</p>	<p>BRAND Cervical Collar ProCare Universal Contoured/Medium Density, Adult, One Size Fits Most. One-Piece, 3" (H), 24" (L), 10-1/2" to 24" Neck Circumference. Mfr: DJO Mfr #: 79-83500 McKesson #: 410232</p>
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COMMUNE CHAIR


Indication(s):

1. **Standard stationary commode chair** – Due to a medical or surgical condition, the patient is confined to a room lacking a toilet or is unable to use standard bathroom facilities.
2. **Extra-wide, heavy-duty stationary commode chair** – The patient meets medical necessity criteria for a standard commode chair and weighs ≥ 300 pounds.
3. **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.


COMMUNE CHAIR

	<p>DESCRIPTION Commode Chair McKesson Fixed Arms Steel Frame Back Bar. Three-in-one design for use as a bedside commode, raised toilet seat or toilet safety frame. Weight capacity 650 lbs. Seat height: 15 ½" to 22". Seat width: 13 ¾". Seat depth: 16 ½". 12-quart commode bucket.</p>	<p>BRAND McKesson Commode Chair Mfr: McKesson Brand Mfr #: 146-11117N-1 McKesson #: 1065225</p>
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COMMUNE CHAIR BARIATRIC, EXTRA WIDE

	<p>DESCRIPTION Commode with fixed arms, adjustable height, extra wide bariatric. Comes with 12 quart commode bucket with carry handle, cover and splash shield. Plastic armrests, removable tool-free back. Durable plastic 16 ½" deep snap-on seat with lid. Seat depth 16 ½"; seat height 15"-21"; seat width range 16 ½" to under 20".</p>	<p>BRAND McKesson Commode Chair, Extra Wide Mfr: Fabrication Enterprises Mfr #: 43-2332 McKesson #: 1138413</p>
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COMMUNE CHAIR HEAVY DUTY WITH DROP ARMS


	<p>DESCRIPTION Oversized drop-arm commode with heavy duty steel tubing to support up to 1000 lbs. Snap on seat designed for extra depth and width for bariatric patients. Easy-to-release arm mechanism allows for safe lateral patient transfers to and from commode. Twelve quart commode bucket includes a carry handle and cover. Seat depth 18 ½"; seat height 17 ½" to 22"; seat width 23 ¼" with width range 20" to 25".</p>	<p>BRAND McKesson Commode Chair 1000 lb. Capacity Mfr: McKesson Brand Mfr #: 146-11135-1 McKesson #: 1065226</p>
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CRUTCHES

Indication(s): 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 two fingers' width below the axilla when standing.
3. When holding the grips, the elbows should be partially bent and the wrists straight.

<p>Crutch – Accessory Hand Grip Crutch Closed</p> 	<p>DESCRIPTION McKesson Crutch Replacement Pillows - foam. Includes two underarm covers and two hand grip covers, machine washable. Fits all standard crutches. One pack per box, eight boxes per case.</p>	<p>BRAND McKesson Crutch Pillows Mfr: McKesson Brand Mfr #: 146-RTL-10355 McKesson #: 1095262</p>
<p>Crutch Underarm Aluminum Regular</p> 	<p>DESCRIPTION Regular Underarm Crutch Aluminum Frame Adult 350 lb. weight capacity, user height 5'2" to 5'10". Crutch height: 45"-53". Push button/wing nut height adjustment. Hand grip position adjusts with Euro-style clip.</p> <p>Tall Underarm Crutch Aluminum Adult Tall 350 lb. weight capacity, user height 5'10" to 6'6". Crutch height 53" to 61". Push button/wing nut height adjustment. Euro-style clips and push pin hand grip adjustments.</p>	<p>BRAND Regular McKesson Push Button Aluminum Crutches with Euro-Style Clip. Mfr: McKesson Brand Mfr #: 146-10430-8 (8 PRS/CS) McKesson #: 1065230</p> <p>Tall Underarm crutches Aluminum Frame Tall Mfr: McKesson Brand Mfr #: 146-RTL10433 (8 PRS/CS) McKesson #: 1095263</p>


CUSTOM FOOT ORTHOSES

Indication(s): 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.


MOBILITY IMPAIRED DISABILITY VEST

Indication(s): Patients with permanent mobility impairment who are physically unable to sit on the ground during an emergency alarm. Having an assigned DPO, DPM, DNM or DLT code alone does not qualify for a mobility impaired disability vest. Patients with a CDCR 7410 with a temporary mobility impairment who are unable to sit on the ground during an emergency alarm 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.

<p>Vest Mobility Impair YLW Reg</p> 	<p>DESCRIPTION ADA Fluorescent yellow mesh vest. Constructed with breathable 3.0 oz 100% polyester mesh. Available sizes small to 8X-large.</p>	<p>BRAND Cal PIA #: 492500</p>
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RIB BELT

Indication(s): Compression and extra support after an injury or medical condition.

<p>Belt – Rib</p> 	<p>DESCRIPTION Rib Belt PROCARE® One Size Fits Most, Hook and Loop Closure. 6" two-panel elastic belt with flannel lining. 24" to 50" waist circumference x 6" height. Male. Gray/white.</p>	<p>BRAND Rib belt ProCare Universal Deluxe One Size Fits Most Hook and Loop Closure 28" to 50" Rib Cage Circumference, 6" height, Adult Mfr: DJO Mfr #: 79-89150 McKesson #: 368046</p>
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SHOULDER IMMOBILIZER


Indication(s): Support and protection of the shoulder after injury or surgery.

<p>Shoulder Immobilizer</p> 	<p>DESCRIPTION Shoulder immobilizer, one size fits most. Fiber laminate waist-hook and loop closure/shoulder strap with buckle/arm band and hand band-hook and loop closure, adjustable left or right arm. Designed to exert upward pressure and immobilize the arm and shoulder. Multiple adjustment features to fit most users with waist measurement up to 52". Unisex. Nylon, cotton, polyester.</p>	<p>BRAND McKesson Hook and Loop Closure Arm Sling One Size fits most, Left or Right Arm Mfr: McKesson Brand Mfr #: 155-79-84100C McKesson #: 1159131</p>
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SPLINT



ARM

Indication(s): Immobilize the arm after surgery or injury; to stabilize an affected area to decrease pain, bleeding, prevent further soft tissue, vascular or neurologic compromise and permit healing.

<p>Splint Arm Flat</p> 	<p>DESCRIPTION Arm splint SAM®. Can be rolled or folded for storage in emergency kits. Closed pore impermeable foam surface for cleaning and disinfection. Available in 4.5" x 36" and 5.5" x 36" sizes.</p>	<p>BRAND SAM® Flat Fold Splint Mfr: The Seaburg Company Mfr #: SP506-OB-EN McKesson #: 683775</p>
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FINGER

Indication(s): Immobilize a finger 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.

<p>Splint Plastic Finger 4 Prong LG</p> 	<p>DESCRIPTION Finger guard, plastic. Full length protects entire digit. Available in small/medium/large sizes.</p>	<p>BRAND Finger guard, plastic Mfr: Dukal Mfr #: 4406L (large size) McKesson #: 742854</p>
<p>Finger Splint Kit</p> 	<p>DESCRIPTION Medline Stackies Finger Splint Kit and Replacements. 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.</p>	<p>BRAND Medline Stackies Finger Splint Kit and Replacement Mfr: Medline Mfr #: ORT32700</p>


SHOULDER

Indication(s): Support and protection of the shoulder after injury or surgery.

<p>Shoulder Immobilizer</p> 	<p>DESCRIPTION Shoulder immobilizer, one size fits most. Fiber laminate waist-hook and loop closure/shoulder strap with buckle/arm band and hand band-hook and loop closure, adjustable left or right arm. Designed to exert upward pressure and immobilize the arm and shoulder. Multiple adjustment features to fit most users with waist measurement up to 52". Unisex. Nylon, cotton, polyester.</p>	<p>BRAND McKesson Hook and Loop Closure Arm Sling One Size fits most, Left or Right Arm Mfr: McKesson Brand Mfr #: 155-79-84100C McKesson #: 1159131</p>
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THUMB

Indication(s): Immobilize the thumb 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.

<p>Thumb Splint</p> 	<p>DESCRIPTION Thumb Splint ThumbSPICA™ Perforated outer foam shell, terry cloth liner. Elastic circumferential contact closure straps. 9" length. Available in small/medium and large/X-large sizes for left or right hand. Large/X-Large fits most men and larger women.</p>	<p>BRAND ThumbSPICA™ Thumb Splint Spica Mfr: DJO Mfr #: 79-87118 McKesson #: 331831</p>
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SLIPPER SOCKS, FALL PREVENTION

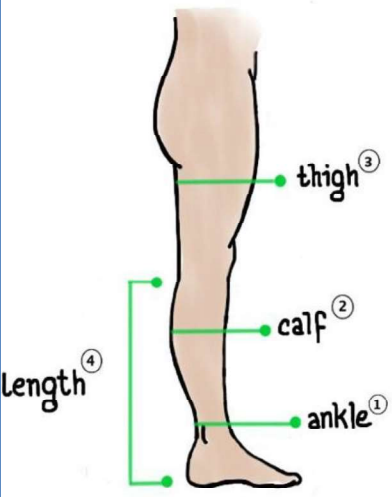
Indication(s): Fall Prevention slipper socks for patients with high fall risk.

<p>Slipper Double Tread Red One Size Fits Most</p> 	<p>DESCRIPTION Medline Risk Alert Fall Prevention Slippers with double-sided, nonslip treads. Available in red or yellow. Inside slipper material: terry. Available in one size fits most, M, L, XL, 2XL, Bariatric.</p>	<p>BRAND Medline Risk Alert Fall Prevention Slippers Item #: MDT211218RH (one pair)</p>
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STOCKING (COMPRESSION)

HOW TO MEASURE

How to Measure



The diagram shows a side view of a human leg with four measurement points indicated by green lines and numbered circles: 1. Ankle (at the ankle bone), 2. Calf (at the widest part of the lower leg), 3. Thigh (on the upper thigh, about 3 inches below the buttocks), and 4. Length (from the floor to the back crease of the knee).

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.

Indication(s):


1. Venous or lymphatic condition, as indicated by one 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-plebetic syndrome, post-thrombotic syndrome.
2. No severe peripheral arterial disease (i.e., ankle-brachial index not less than 0.5).
 3. No untreated cellulitis.

COMPRESSION STOCKING, KNEE HIGH


<p>Compression Stocking – Knee High, 30-40 mm Hg compression</p> 	<p>DESCRIPTION Compression Stocking JOBST® Relief® Knee High X-Large Beige Closed Toe, LF, Compression Rating 30-40 mmHg, Ankle 7" -8 ¼ to 12"-14" circumference: Calf 11"-15" to 18"-24" circumference. Greater than 15" length.</p>	<p>BRAND JOBST® Relief® Knee Highs Closed Toe Unisex 30-40 mm Hg, Ankle and calf circumference dependent on size ordered Mfr: BSN Medical Mfr #: 114633 (XL) McKesson #: 555961 (XL)</p>
<p>Compression Stocking – Knee High, 15-20 mm Hg compression</p> 	<p>DESCRIPTION JOBST® Relief® Basic Knee High. Large, Unisex, Beige Closed Toe. 15" or greater than 15" length. Compression 15-20 mm Hg. Size based on ankle and calf circumference. Ankle: 7"-8 ¼" to 12"-14". Calf: 11"-15" to 18"-24".</p>	<p>BRAND Compression Stocking JOBST® Relief® Knee High, Large, Beige, Closed Toe Mfr: BSN Medical Mfr #: 114808 (Lg) McKesson #: 702834 (Lg)</p>
<p>Compression Stocking – Knee High, 20-30 mm Hg compression</p> 	<p>DESCRIPTION Compression stocking JOBST® Relief® Knee High, Large, Beige, Closed Toe. Unisex, greater than 15" length. Compression 20-30 mm Hg. Size based on ankle and calf circumference. Ankle: 7"-8 ¼"- to 12"-14" Calf: 11"-15" to 18"-24".</p>	<p>BRAND Compression Stocking JOBST® Relief® Knee High, Large, Beige, Closed Toe Mfr: BSN Medical Mfr #: 114622 McKesson #: 423054</p>



<p>Compression Stocking – Knee High, 20-30 mm Hg compression</p> 	<p>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.</p>	<p>BRAND Sigvaris Series: High Tech SKU #: 412CSS00 (Compressionstore.com)</p>
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COMPRESSION STOCKING, THIGH HIGH

<p>Compression Stocking – Thigh High 20-30 mm Hg compression</p> 	<p>DESCRIPTION Sigvaris Dynaven Opaque Thigh High with Grip Top, open toe. Unisex. Two-way stretch knit. Compression 20-30 mmHg. Size based on ankle, calf, thigh and hip circumference, length of calf and thigh, and shoe size.</p>	<p>BRAND Sigvaris Dynaven Opaque Thigh High 20-30 mmHg, open toe compression stockings SKU #: 972NSSO66 (compressionhealth.com)</p>
<p>Compression Stocking – Thigh High</p> 	<p>DESCRIPTION JOBST® Relief® Thigh High, Beige, Closed Toe Compression Sock with Silicone Band. Unisex. Compression 15-20, 20-30 and 30-40mmHg available. Size based on ankle, calf, and thigh circumference. Length greater than 15". Ankle: From 7"-8 ¼" to 11 ½" to 13" Calf: From 11"-15" to 13 3/8" to 19 5/8" Thigh: From 15 ¾"-24 3/8" to 23 5/8"-32"</p>	<p>BRAND Compression Stocking JOBST® Relief® Thigh High, Beige, Closed Toe Mfr: BSN Medical Mfr #: 114824 McKesson #: 676965</p>


ANTI-EMBOLISM STOCKING

<p>Stocking Anti-embolism – Knee High</p> 	<p>DESCRIPTION T.E.D.™ Knee High, Large, White, Inspection Toe Anti-embolism stockings. Designed to reduce venous stasis below the knee when thigh length styles are medically contraindicated. Inspection toe opening provides access for medical examination. Size based on calf circumference: less than 12" to 17 ½"-20".</p>	<p>BRAND Anti-embolism Stocking T.E.D.™ Knee High, Large, Regular, White, Inspection Toe Brand: T.E.D. Mfr: Cardinal Mfr #: 7203 McKesson #: 10196</p>
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<p>Stocking Anti-embolism – Thigh High</p> 	<p>DESCRIPTION Anti-embolism T.E.D.™ Thigh High, Regular, White, Inspection Toe. Size based on calf and thigh circumference. Short, regular, and long lengths. Calf: Less than 12” to 12”-15” Thigh: Less than 25”</p>	<p>BRAND T.E.D. Anti-embolism stocking, thigh-high, regular, white, inspection toe Mfr: Cardinal Mfr #: 3728LF (size large, regular length) McKesson #: 583000</p>
<p>Anti-embolism Stocking McKesson Thigh High</p> 	<p>DESCRIPTION Anti-embolism Stocking, Thigh High, White, Inspection Toe. Unisex. Provides 20-30 mm Hg compression from ankle upward. Size based on calf and thigh circumference. Calf: Less than 12” to 12”-15”. Thigh: Less than 25” to 25”-32”. Lengths: up to 29”, 29”-33”, 33” and up.</p>	<p>BRAND Anti-embolism stocking Thigh High McKesson Mfr: McKesson Brand Mfr #: 84-32M McKesson #: 1229447 (Medium/Regular length)</p>


THERABALL

Indication(s): Used in physical therapy to improve grip strength, dexterity, mobility, and fine & gross motor skills.

<p>Hand Exercise Ball</p> 	<p>DESCRIPTION CanDo® Gel Squeeze Ball hand exerciser 2” diameter. Heat or chill for use in hot or cold therapy. Can withstand temperatures ranging from -76 degrees Fahrenheit to 167 degrees Fahrenheit. Available in 1 ¾” x 2 3/20” diameter or 2” diameter. Also available in 2X-light, X-light, and X-heavy resistance.</p>	<p>BRAND Squeeze Ball CanDo® Green Standard Size Brand: CanDo® Mfr: Fabrication Enterprises Mfr #: 10-1493 (medium resistance), 10-1490 (2X light resistance), 10-1970 (X-light resistance), 10-0777-12 (light resistance), 10-1495 (X-heavy resistance) McKesson #: 766146 (medium), 776887 (2X-light), 766144 (X-light), 766145 (light), 776888 (X-heavy)</p>
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TheraBand

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

<p>Exercise Resistance Band</p> 	<p>DESCRIPTION</p> <p>Exercise Resistance Band 5" x 50 yard. TheraBand Exercise Resistance Band. Full spectrum of colors and resistance levels available. Synthetic rubber. Red: 5" x 50 yards, light resistance; Green: 5" x 50 yards, medium resistance; Blue: 6" x 50 yards, heavy resistance</p>	<p>BRAND</p> <p>McKesson CanDo® Exercise Resistance Band Mfr: McKesson Brand Mfr #: 169-5623 (medium resistance) McKesson #: 1199532</p>
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Therapeutic Shoes


Indication(s):

Medically necessary under the following conditions:

- a. A shoe that is an integral part of a leg brace, and its expense is included as part of the cost of the brace
- b. Therapeutic shoes furnished to selected diabetic patients
- c. 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
- d. 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
- e. Rehabilitative foot orthotics as part of postsurgical or post-traumatic casting care
- f. 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 "

<p>Therapeutic Shoes –White</p> 	<p>DESCRIPTION Life Walker Strap Men’s Orthopedic Leather Sneaker. EVA midsole with herringbone tread rubber outsole. Leather upper with brushed nylon lining and firm heel counter. Diabetic friendly, orthotic friendly. Sizes available: 7-18, Widths: Medium-XX Wide.</p>	<p>BRAND Propet Life Walker Strap- Men's Orthopedic Walking Shoes SKU #: M3705</p>
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TOILET SEAT LIFT (ERECTOR)


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

WALKER


Indication(s):

1. Ambulation is impaired and one 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 one of the following. Provider with appropriate expertise in patient’s condition has evaluated patient and discussed walker options and preference.
 - a. Front-wheeled walker: Lightweight appropriate for balance deficits, lower extremity weakness and to reduce weight on lower extremities.
 - b. Front-wheeled walker with seat: Indicated for those with poor endurance, balance deficits and lower extremity weakness.
 - c. Four-wheel Rollator walker with seat: Heavier and harder to maneuver for some. Appropriate for patients with poor endurance, balance deficits and lower extremity weakness. Patient must be able to use hand brakes safely, particularly on decline walkways. Easier use than a front-wheeled walker that must be lifted with each step.


WALKER, 2-WHEELED

	<p>DESCRIPTION Dual Release Folding Walker with wheels, adjustable height, McKesson. Aluminum frame, 350 lb. weight capacity. 32" to 39" height, 24" base width, hand grips 17" apart, push-button dual release mechanism for easy folding. User height 5'4" to 6'2".</p>	<p>BRAND Walker, 2-Wheeled McKesson Mfr: McKesson Brand Mfr #: 146-10210-1 McKesson #: 1076176</p>
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WALKER, 2-WHEELED WITH SEAT

	<p>DESCRIPTION Dual Release Folding Walker with Wheels and Seat, adjustable height. Aluminum frame. Rear leg tips act as brakes when pressed down. 300 lb. weight capacity. 29"-38" height, 23 ¼" base depth, 22" base width, 20 ½" seat height. 12 pound product weight.</p>	<p>BRAND Walker, 2-Wheeled with Seat Mfr: Drive Medical Mfr #: 1239RD McKesson #: 1027532</p>
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WALKER, 4-WHEELED ROLLATOR

	<p>DESCRIPTION Four Wheel Rollator McKesson walker with zippered storage pouch on the bottom of the seat and vinyl carry pouch below padded seat. Hinged padded back rest and locking hand brakes. Weighs 13 lbs. Folding aluminum frame. 27 ½" base depth, 24 ½" base width. 32" to 37" handle height, 17" inside grip width. Non-marring casters, soft-grip tires. 300 lb. weight capacity.</p>	<p>BRAND McKesson Lightweight Aluminum Rollator, Blue Mfr: McKesson Brand Mfr #: 146-R726BL McKesson #: 1065264</p>
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WALKER, STANDARD, BARIATRIC

	<p>DESCRIPTION Bariatric dual release folding walker, adjustable height, McKesson. Aluminum with steel legs and side braces, 500 lb. capacity. 32 ½" to 39" height, 24 ½" base width, 19 ½" inside grip width. Push-button, dual-release mechanism for easy folding.</p>	<p>BRAND Walker, 2-wheeled, bariatric. McKesson Mfr: McKesson Brand Mfr #: 146-10220-2 McKesson #: 1065262</p>
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WALKER, 2-WHEELED, BARIATRIC

	<p>DESCRIPTION Bariatric dual release folding walker, adjustable height. Aluminum with wider and deeper frame, 600 pound capacity. 32" to 39" height, 27" base width. 5" dual front wheels.</p>	<p>BRAND Walker, bariatric dual release folding walker with wheels. Drive Medical Mfr: Fabrication Enterprises Mfr #: 70-0116 McKesson #: 1235554</p>
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WALKER, 4-WHEELED ROLLATOR, BARIATRIC

	<p>DESCRIPTION</p> <p>Bariatric 4 wheel rollator McKesson walker with steel frame, zippered storage pouch on the bottom of the padded seat, hinged backrest that can be folded up, down or removed and locking hand brakes. Weighs 26 lbs. Folding aluminum frame. 26 ¾" base depth, 30 ½" base width. 35 ¼" to 39 ½" handle height, 23 ½" inside grip width. 18" to 19" seat width. 8" swiveling caster wheels. 500 lb. weight capacity.</p>	<p>BRAND</p> <p>Walker, bariatric 4-wheel rollator, blue. McKesson Mfr: McKesson Brand Mfr #: 146-10215BL-1 McKesson #: 1205411</p>
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WHEELCHAIR

Indication(s):

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 assistance.
4. The patient has sufficient strength and postural stability to propel a manual wheelchair to participate in MRADLs during a typical day.
5. Prescription is for one of the following. Provider with appropriate expertise in patient's condition has evaluated patient and discussed wheelchair options and preference:
 - a. Lightweight and bariatric wheelchairs: for patients who are unable to ambulate because of deconditioning or balance. Must have use of arms to push, although can use feet to go short distances.
 - b. Transportation wheelchair: for transporting patient only. Patient is unable to push self because does not have large wheels.


HOW TO MEASURE

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

1. Considerations
 - a. The 1 ½"–2" 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.

ACCESSORIES


GLOVES

	<p>DESCRIPTION</p> <p>Push gloves, fingerless, black. Half-finger wheelchair gloves. Cotton mesh backing, leather palms with foam padding.</p>	<p>BRAND</p> <p>Hatch Fingerless Push Gloves Mfr: Performance Health Mfr #: 81173657 McKesson #: 1217698</p>
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OXYGEN HOLDER

	<p>DESCRIPTION Oxygen tank holder for wheelchair (For use with Invacare Tracer® IV wheelchair)</p>	<p>BRAND Oxygen Holder for Invacare Tracer IV Wheelchair. Mfr: Invacare Mfr #: 1496 McKesson #: 415768</p>
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IV POLE

	<p>DESCRIPTION Telescoping IV pole for universal wheelchair</p>	<p>BRAND Telescoping IV Pole for Universal Wheelchair Mfr: Drive Medical Mfr #: STDS820 McKesson #: 624270</p>
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WHEELCHAIR, LIGHTWEIGHT


	<p>DESCRIPTION Lightweight wheelchair, dual axle, available with full-length arms with 20" seat width or desk-length arms with 16", 18", or 22" seat width. Weight capacity 250 lbs. (desk-length arms) or 300 lbs. (full-length arms).</p>	<p>BRAND Tracer SX5 Wheelchair. Product weight: 34 lbs. Mfr: Invacare Mfr #: TRSX50FBFP McKesson #: 944494</p>
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WHEELCHAIR, HEMI-LEVEL SEAT


	<p>DESCRIPTION Wheelchair with multi-position castor forks and a dual axle that allows the seat to be moved to a hemi-level position. 16", 18", or 20" seat width. Weight capacity 300 lbs.</p>	<p>BRAND ProBasics K2 Wheelchair Mfr: ProBasics Mfr #: WC22016DS</p>
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WHEELCHAIR, BARIATRIC


	<p>DESCRIPTION Bariatric Wheelchair Sentra EC Heavy Duty, dual axle. Detachable padded desk length arm with 20" seat width and elevating leg rest or full-length arm with 20" seat width and elevating leg rest or 22" or 24" seat width with swing away leg rest. Weight capacity 450 lbs.</p>	<p>BRAND Bariatric wheelchair, heavy duty dual axle Drive™ Sentra EC Mfr: Drive Medical Mfr #: STD24ECDFA-SF McKesson #: 804753</p>
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	<p>DESCRIPTION Bariatric wheelchair, heavy duty frame, dual axle. Fixed desk length padded arm style, 22" and 24" seat widths. Weight capacity 450 lbs.</p>	<p>BRAND Tracer® IV Heavy Duty Bariatric Wheelchair Mfr: Invacare Mfr #: T4X22RDAP McKesson #: 831325</p>
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WHEELCHAIR, BARIATRIC, TAMPER RESISTANT

	<p>DESCRIPTION Reinforced frame, adjustable seat height, heavy-duty pull-to-lock brake. Full length armrests bolted down for non-removal. All screws replaced with security screws to prevent tampering. All threaded bolts covered to prevent removal. All rubber and plastic components are glued. Weight capacity up to 500 lbs. Seat depth 18". Seat width 18" (16" seat depth) to 24" (32" overall width). Folded width 12-1/2".</p>	<p>BRAND Classic™ 500 Wheelchair, Full Arms Mfr: ALCO Sales & Service Co. Mfr #: AL-85524-24F</p>
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WHEELCHAIR, TRANSPORTATION, TAMPER RESISTANT

	<p>DESCRIPTION Wheelchair for occupant transportation. Requires an attendant for movement and braking. Lifting armrests of steel oval tubing covered with a nonporous sleeve. Steel nonremovable lifting footrests. No removable parts. Non folding frame. Handlebar braking. Width 27", length 28", back height 22", seat width 20". Weight 64 lbs. Maximum occupant weight capacity 600 lbs.</p>	<p>BRAND Guest Services Transportation Wheelchair Mfr: Staxi Mfr #: AP010</p>
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PODIATRY

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


Indication(s):


For non-ambulatory patients

1. Ankle contracture splints – Medically necessary if ALL of 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 (AFO) – 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 six 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.

<p>AFO Male Right/Left One Size</p> 	<p>DESCRIPTION Ankle/foot orthosis. Hook and loop closure. Provides static dorsiflexion assistance and lateral stability area. Thicker polyethylene on the vertical aspect for rigidity; thinner footplate may be trimmed to fit with scissors. Available in female shoe size up to 9 1/2, male shoe size 12, right or left foot.</p>	<p>BRAND Freedom® Swedish Ankle Foot Orthosis (AFO) Mfr: Alimed Mfr #: 2970004476 McKesson #: 567554</p>
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<p>Knee Ankle Foot Orthosis</p> 	<p>DESCRIPTION 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. Made up of three components: thigh component, ankle foot orthosis (AFO) component, and choice of either drop-lock or polycentric knee joint component. All sold separately.</p>	<p>BRAND Ottobock (Medline.com). Components sold separately. Prefabricated carbon fiber thigh component, size L Mfr #: ALI66700LG Prefabricated carbon fiber polycentric knee joint size A6 Mfr #: ALI66703A6</p>
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ANKLE – SUPPORT


Indication(s): 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 one month after injury compared with standard elastic support. It is also suitable for severe ankle sprains.

<p>Support Ankle Universal</p> 	<p>DESCRIPTION Ankle Support Surround® with Gel, Large, Hook and Loop Closure, Left or Right Foot, 8 ½” or 9” length, white. Rigid thermoplastic shells with adjustable heel strap. Air and gel bladder may be used for cold therapy.</p>	<p>BRAND DJO Surround® with Gel Ankle Support, Large, Hook and Loop Closure, Left or Right Foot. Mfr: DJO Mfr #: 79-97863 McKesson #: 362644</p>
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BOOT WALKER

Indication(s): Severe ankle sprain, stable fracture of the foot/ankle/lower leg, and post-operative immobilization.

<p>Boot Ankle Walker Standard Unisex Large</p> 	<p>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.</p>	<p>BRAND Aircast AirSelect Walker Boot, Standard, Large, Hook and Loop Closure; Male 10 to 13/Female 11 to 15, Left or Right Foot. Mfr: DJO Mfr #: 01EF-L McKesson #: 835871</p>
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<p>Boot Ankle Walker Short Unisex Large</p> 	<p>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.</p>	<p>BRAND Aircast AirSelect Walker Boot, Short, Large, Hook and Loop Closure; Male 10 to 13/Female 11 to 15, Left or Right Foot. Mfr: DJO Mfr #: 01ES-L McKesson #: 835885</p>
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CUSTOM FOOT ORTHOSES

Indication(s): 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.

SLIPPER SOCKS, FALL PREVENTION

Indication(s): Fall Prevention slipper socks for patients with high fall risk.

<p>Slipper Double Tread Red One Size Fits Most</p> 	<p>DESCRIPTION Medline Risk Alert Fall Prevention Patient Slippers with double-sided, nonslip treads. Available in red or yellow. Inside slipper material: terry. Also available in M, L, XL, 2XL, Bariatric.</p>	<p>BRAND Medline Risk Alert Fall Prevention Patient Slippers Item #: MDT211218RH (one pair) or MDT211250R (4 pairs/pack)-one size fits most</p>
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THERAPEUTIC SHOES

Indication(s):


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 $\geq 1.5''$

<p>Therapeutic Shoes –White</p> 	<p>DESCRIPTION Life Walker Strap Men's Orthopedic Leather Sneaker. EVA midsole with herringbone tread rubber outsole. Leather upper with brushed nylon lining and firm heel counter. Diabetic friendly, orthotic friendly. Sizes available: 7-18, Widths: Medium-XX Wide.</p>	<p>BRAND Propet Life Walker Strap-Men's Orthopedic Walking Shoes SKU #: M3705</p>
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WASH BASIN


Indication(s): Soaking limbs/feet/hands, rinsing, washing. Emesis basin.

<p>Wash Basin</p> 	<p>DESCRIPTION Rectangular plastic wash basin. Rolled rim. 7 quart. Width 10" x 13" length x 5" depth. No graduations. Accommodating for limb soaking. Packaged 50/case.</p>	<p>BRAND Wash Basin 7-quart Rectangle Nonsterile Mfr: McKesson Brand Mfr #: 56-80342 McKesson #: 1028129</p>
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POST-OPERATIVE CARE


ABDOMINAL BINDER

Indication(s): 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.

<p><i>Binder Abdominal</i></p> 	<p>DESCRIPTION Abdominal Binder provides compression and support for post-abdominal surgery or abdominal strains. Constructed with multi-panel elastic and flannel lined with contact closure. One size fits most. Has 3 panels, 9" height, 45"-62" waist circumference.</p>	<p>BRAND ProCare® Premium One Size Fits Most Hook and Loop Closure. Mfr: DJO Mfr #: 79-99431 McKesson #: 412880</p>
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POST-SURGICAL BRA, SHORT TERM USE

Indication(s): To provide appropriate support after surgical procedures involving the upper body such as breast, heart or lung surgery.

<p><i>Post-Surgical Bra, Short Term Use</i></p> 	<p>DESCRIPTION Intended to be worn during the immediate post-operative period (up to 6 weeks) following surgery. Suitable for use after surgical procedures such as mastectomy with or without reconstruction, lumpectomy, other breast surgery and cardiac surgery. Front closure and shoulder releases; adjustable side openings to prevent pinching of JP tubing. Loops and rings can hold JP drain bulbs. Nylon/Lycra® Spandex. Chest sizes 27"-30" to 57"-60".</p>	<p>BRAND Elizabeth Pink Surgical Bra® Mfr: BFFL Co. Mfr #: 042LB McKesson #: 1260981</p>
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POST-SURGICAL BRA

Indication(s): To provide appropriate support after surgical procedures involving the upper body such as breast, heart or lung surgery.

<p><i>Post-Surgical Bra</i></p> 	<p>DESCRIPTION Designed for women in post-op recovery who no longer have drains or do not require drains after breast, heart or lung surgery, as well as shoulder and other upper body surgery. Adjustable front closure and shoulder straps. Mesh pockets for puffs (pair included), ice or breast insert/form. Nylon/spandex. Chest sizes 28" to 55"-60".</p>	<p>BRAND Serena Mfr: heart&core Sports and Medical LLC Mfr #: HC00003BL McKesson #: 1245508</p>
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HOW TO MEASURE

heartcore

Larissa, Serena & Shirl Bra Measurements

It's easy to find your heartcore size. Simply look your current bra where you normally wear it, lay it flat and measure the band from left to right. Then match it to the measurements below. (If you're in-between sizes, order the next larger size.)

Measurements in Inches

SIZE	BAND LENGTH	BAND LENGTH (Hooked & Flat)
XS	28	11
S	30 - 32	12
M	32 - 34	13
L	36 - 38	14
XL	40 - 42	15.5
XXL	44 - 48	16.5
3XL QUEEN	50 - 54	17
4XL SUPER QUEEN	56 - 60	18

PROSTHETIC LIMBS

LOWER EXTREMITY


Indication(s): 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

Indication(s): The patient has an amputation or missing limb at the wrist or above and has demonstrated sufficient neurological and cognitive function to operate prosthesis effectively. Functional evaluation indicates that the use of the prosthesis will meet the functional needs of the individual when performing activities of daily living.


PROSTHETIC SOCK

Indication(s): Proper adjustment of a limb into a prosthesis socket, compensation for shrinkage and swelling of the limb and to cushion and support the residual limb. The prosthetic sock is also meant to manage perspiration, prevent blisters, abrasions and ulcers due to friction and provide comfort for the wearer.

<p>Prosthetic Sock</p> 	<p>DESCRIPTION</p> <p>Prosthetic sock made of stretchy polyester/spandex knit fabric. Launderable for repeated long term use. Contoured cup offers protection for the amputation site; fabric keeps cover in place. To select size, measure circumference 2" above the amputation site. Available in 8"-10", 10"-12", 12"-15", 15-18" and 18"-22" sizes.</p>	<p>BRAND</p> <p>Prosthetic Sock Dermasaver™ Mfr: Alimed Mfr #: 2970005914 McKesson #: 681842</p>
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SHOE

Indication(s): Management of broken toes, metatarsal fractures, foot, and ankle sprains, and in the treatment of diabetic ulcers.

<p>Shoe Post-Op Open Toe Velcro</p> 	<p>DESCRIPTION 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. Available in female shoe sizes 4-10 and male shoe sizes 7-13+.</p>	<p>BRAND Post-op Shoe Procare® Mfr: DJO Mfr #: 79-90185 McKesson #: 410158</p>
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SUPPORT (ATHLETIC)


Indication(s): Post-operative care

<p>Support – Athletic</p> 	<p>DESCRIPTION Athletic Supporter. 3" waistband. Measure about waist for size. Small 26"-32", Medium 32"-38", Large 38"-44", Extra Large 44"-50" waist.</p>	<p>BRAND Sportaid Athletic Supporter Mfr: Scott Specialties Mfr #: SA1503 WHIXL (extra-large) McKesson #: 697372 (extra-large)</p>
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PULMONOLOGY

BUBBLE HUMIDIFIER

Indication(s): For patients complaining of dryness of nose and throat after getting continuous oxygen supplementation at four liters per minute for more than 24 hours.

<p>Bubble Humidifier</p> 	<p>DESCRIPTION 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. 350 ml reservoir volume. 50/case.</p>	<p>BRAND Salter Labs® Black Lid Bubble Humidifier Mfr: Sun Med Mfr #: 7600-0-50 McKesson #: 313942</p>
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NON-INVASIVE AIRWAY ASSISTIVE DEVICES

BILEVEL POSITIVE AIRWAY PRESSURE (BiPAP)

Indication(s):

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 mm Hg 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 (one 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 one or more of the following:
 - a. Chronic hypercapnia with PaCO₂ of 50-52 mmHg and:
 - i. Arterial O₂ saturation < 88% for five consecutive minutes during nocturnal oximetry while on at least two liters of oxygen per minute AND/OR Invasive or non-invasive ventilation for acute exacerbation required during > two 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 one 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 five to 15 determined by polysomnography and one 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 one 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-tidal 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.


<p>BiPAP <i>With Heated Humidifier</i></p> 	<p>DESCRIPTION DreamStation Auto BiPAP System with Heated Humidifier 3.3" x 7.6" x 11.7". Pressure relief based on expiratory flow. Allows user to fall asleep on lower pressure and gradually raise pressure when needed during sleep events. Mask fit check displays if leaks are detected in mask. Filter change reminder every 30 days.</p>	<p>BRAND DreamStation Auto BiPAP Mfr: Respiration Mfr #: DSX700H11 McKesson #: 1027931</p>
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CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP)

Indication(s):

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. OSA indicated by
- a. Mild OSA defined as AHI between five to 15 determined by polysomnography and one or more of the following:
 - i. Cardiovascular disease (CVD) (hypertension, heart failure, 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 (ALS)
8. Severe thoracic cage abnormalities such as post-thoracoplasty for tuberculosis

<p>CPAP (Continuous Positive Airway Pressure) Auto-Heated Humidifier</p> 	<p>DESCRIPTION</p> <p>Resvent iBreeze™ CPAP unit with standard tubing. Integrated humidifier adjusts to ambient temperature and humidity; monitors water level to stop heating if water level is too low. Humidifier relieves dry mouth, congested or runny nose, chapped lips and nosebleeds and improves compliance with CPAP use. Indicated in patients with the above symptoms or who are taking oral medications which can cause dry mouth.</p>	<p>BRAND</p> <p>Resvent iBreeze™ CPAP Machine Mfr: Apex-Carex Mfr #: IBREEZE20A-W McKesson #: 1230228</p>
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CPAP ACCESSORIES

CPAP MASK KIT – NASAL PILLOW WITH HEADGEAR

Nasal Pillow CPAP with Headgear is a 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.


<p>CPAP Mask Kit <i>Nasal pillow style</i></p> 	<p>DESCRIPTION CPAP Starter Kit AirFit™ P10 Nasal Pillow Style. Includes frame, pillows and Quick Fit elastic headgear. Small/medium/large cushions included. Mask seals on contact and allows movement without compromising the mask's seal.</p>	<p>BRAND AirFit™ P10 Nasal Pillow Style CPAP Mask Kit Mfr: ResMed Corp Mfr #: 62900 McKesson #: 873001</p>
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OXYGEN CONCENTRATOR

Indication(s):

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%.

<p>Oxygen Concentrator <i>5LPM</i></p> 	<p>DESCRIPTION Oxygen Concentrator 5L with Oxygen Sensor. Flow meter knob can be locked for patient safety. Pressure compensated flow meter permits use of a long cannula. System is comprised of both visible and audible alerts which signal if a malfunction occurs.</p>	<p>BRAND DeVilbiss Oxygen Concentrator, 5 Liter with oxygen sensor Mfr: Drive Medical Mfr #: 525DS McKesson #: 699609</p>
<p>Oxygen Concentrator <i>Portable</i></p> 	<p>DESCRIPTION iGo® Portable Oxygen Concentrator with DLX rolling case. Includes DeVilbiss Oxygen Sensing Device and service alerts. Charger can fully charge battery in 3 hours. Can be used with 50-foot tubing/cannula in continuous flow mode of 1-3 LPM or 35-foot tubing in PulseDose® mode. 11" W x 8" D x 15"H, 19 lbs. Comes with battery, AC power adapter, mains lead and DC power adapter.</p>	<p>BRAND iGo® Portable Oxygen Concentrator Mfr: Drive Medical Mfr #: 306DS-C McKesson #: 854771</p>

<p>Oxygen Concentrator Portable</p> 	<p>DESCRIPTION SeQual Eclipse 5 - Portable Oxygen Concentrator with continuous flow and pulse dose therapy. Continuous flow doses 0.5-3 LPM in increments of 0.5. Pulse doses in nine settings from 16-192 mL. 19.3”H x 12.3” W x 7.1” D. 18.4 lbs. Eclipse 5 unit comes with rechargeable battery, AC power adapter, DC power adapter, carrying bag, nasal cannula, and carrying cart.</p>	<p>BRAND Caire SeQual Eclipse 5 Portable oxygen concentrator Mfr: Caire Mfr #: 6900BT-SEQ (oxygenconcentratorstore.com)</p>
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TRACHEOSTOMY CARE SUPPLIES

Indication(s):

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 PROSTHESIS/AUGMENTATIVE COMMUNICATION/SPEECH GENERATING DEVICE

Indication(s): 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 eight minutes recording time.
3. May have digitized speech output using pre-recorded messages greater than eight 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 (TE) 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 the larynx 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 three to six 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.

TRANSGENDER


EPILATOR

Indication(s): Presence of facial or body hair which leads to clinically significant distress that qualifies for a diagnosis of gender dysphoria which has been confirmed by a Mental Health provider. Presence of hair creates a barrier for the patient to participate in desired or necessary activities.

<p>Epilator</p> 	<p>DESCRIPTION</p> <p>Includes epilator, body trimmer, trimmer comb, shaver head, skin contact cap, cleaning brush and pouch. Wide pivoting head catches short hairs (0.5 mm). Wet and dry usage but not water resistant. Lithium ion battery powered.</p>	<p>BRAND</p> <p>Braun Silk-epil 9 Epilator, Wet and Dry Mfr: Proctor and Gamble Mfr #: 4354626792 Item #: SES9-441</p>
<p>Epilator</p> 	<p>DESCRIPTION</p> <p>Epilator series 8000 wet and dry epilator. Thirty-two ceramic tweezers remove hairs as short as 0.5 mm. Wide epilator head with embedded light. Accessories include cleaning brush, body exfoliation glove, bikini trimmer head, bikini trimmer comb, trimming comb, shaving heads, delicate area cap, optimal contact cap, pouch. Lithium-ion battery with 2 hour charging time. Usage time up to 40 minutes.</p>	<p>BRAND</p> <p>Philips Epilator Series 8000 Wet and Dry Epilator Mfr: Philips Mfr #: BRE 720/14</p>

VAGINAL DILATOR




Indication(s): 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.

<p>Vaginal Dilator</p> 	<p>DESCRIPTION</p> <p>Plastic vaginal dilators with smooth ovoid tip. Vary in diameter from 5/8" to 1 1/2" and length from 2 3/4" to 6 1/4". Set of four dilators.</p>	<p>BRAND</p> <p>Amielle Comfort Vaginal Dilator Set Mfr: Owen Mumford Mfr #: SM 2100 McKesson #: 488143</p>
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WAX STRIPS

Indication(s):

1. Hair removal may be part of the therapeutic treatment of gender dysphoria. It is medically necessary to better align physical characteristics with gender identity in a patient with a confirmed diagnosis of gender dysphoria.
2. Wax strips can be used for hair removal on the face, chin, upper lip, arms, legs, back and body in patients with gender dysphoria.
3. Wax strips are not indicated for hair removal to treat tissue donor sites for a planned phalloplasty or vaginoplasty.

<p>Wax Strips, Body Hair</p> 	<p>DESCRIPTION Made with Beeswax, adheres to unwanted hair to remove it from the root. No heat needed for use. For use on body, face, arms, legs. 24 strips/pack. 6.69" x 4.02" x 1.26". Ready to use wax strips and four post-wax calming oil wipes.</p>	<p>BRAND Nads Hair Removal Sensitive Body Wax Strips Mfr: Nads Mfr #: 4309EN06</p>
<p>Wax Strips, Facial</p> 	<p>DESCRIPTION No heat needed for use. For use on face, chin, upper lip. 24 strips/pack. 1.06" x 2.56" x 5.13". Facial wax strips and four post-wax calming oil wipes.</p>	<p>BRAND Nads Hair Removal Facial Wax Strips Mfr: Nads Mfr #: 0790EN24</p>
<p>Wax Strips, Body Hair (Men)</p> 	<p>DESCRIPTION No heat needed to use. For coarse male hair. For use on legs, arms, back, body. 20 waxing strips (10 double sided). 6.4" x 5.8" x 1.2".</p>	<p>BRAND Nads for Men Hair Removal Body Waxing Strips Mfr: Nads Mfr #: 3494EN06</p>



UROLOGY

INCONTINENCE SUPPLIES

Indication(s): Patients with an underlying medical condition that involves loss of bladder or bowel control.

URINAL

Indication(s): For patients having difficulty reaching the bathroom to urinate.

<p>Urinal – Female</p> 	<p>DESCRIPTION Female urinal without cover. Can be used in several positions by patient. Graduation marks to measure output. Can hold 32 oz (946 ml). Sturdy grip designed to prevent spills. Lightweight, durable and easy to clean. Packaged 1/box, 6/case.</p>	<p>BRAND McKesson Female Urinal without closure Mfr: McKesson Brand Mfr #: 146-RTLPC23201-F McKesson #: 1103384</p>
<p>Urinal – Male</p> 	<p>DESCRIPTION Male urinal with cover. Can be used in several positions by patient. Graduation marks to measure output. Can hold 32 oz (946 ml). Sturdy grip designed to prevent spills. Lightweight, durable and easy to clean. Cap helps confine odors. Packaged 1/box, 6/case.</p>	<p>BRAND McKesson Male Urinal with Closure Mfr: McKesson Brand Mfr #: 146-RTLPC23201-M McKesson #: 1103369</p>

UROLOGIC SUPPLIES

Indication(s): 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 vesicoureteral 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 one 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 five 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 one unit of service (16 oz.) per month is rarely medically necessary.
2. One external urethral clamp or compression device is appropriate every three 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 (one unit = 18 sq. in.; 10 units = 180 sq. in. = five yards of one inch 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 (three per week) and catheter leg straps (one per month) for indwelling

APPENDIX

NON-DURABLE MEDICAL EQUIPMENT AND OVER-THE-COUNTER (OTC) ITEMS

READING GLASSES

Indication(s): Presbyopia, the inability to focus on objects viewed at arm's length or closer. Typically, this is due to the normal aging process as the lens of the eye loses its normal accommodating power.

Treatment: OTC reading glasses which are available free of charge from the canteen.

Reading glasses provided through the canteen can be utilized for most patients with presbyopia. Patients may obtain one pair of reading glasses every 12 months, but a replacement pair shall be provided if lost or damaged at no fault of the patient. If OTC reading glasses do not meet the patient's needs, a referral for further evaluation is recommended. Snellen Visual Acuity should be checked prior to the referral and specify if measured with or without corrective lenses.

[Effective July 1, 2023, Title 22](#) was amended to allow all incarcerated persons (IP) to obtain over-the-counter (OTC) reading glasses through the normal canteen services program without cost or the need for a health care provider's prescription.

SUNGLASSES

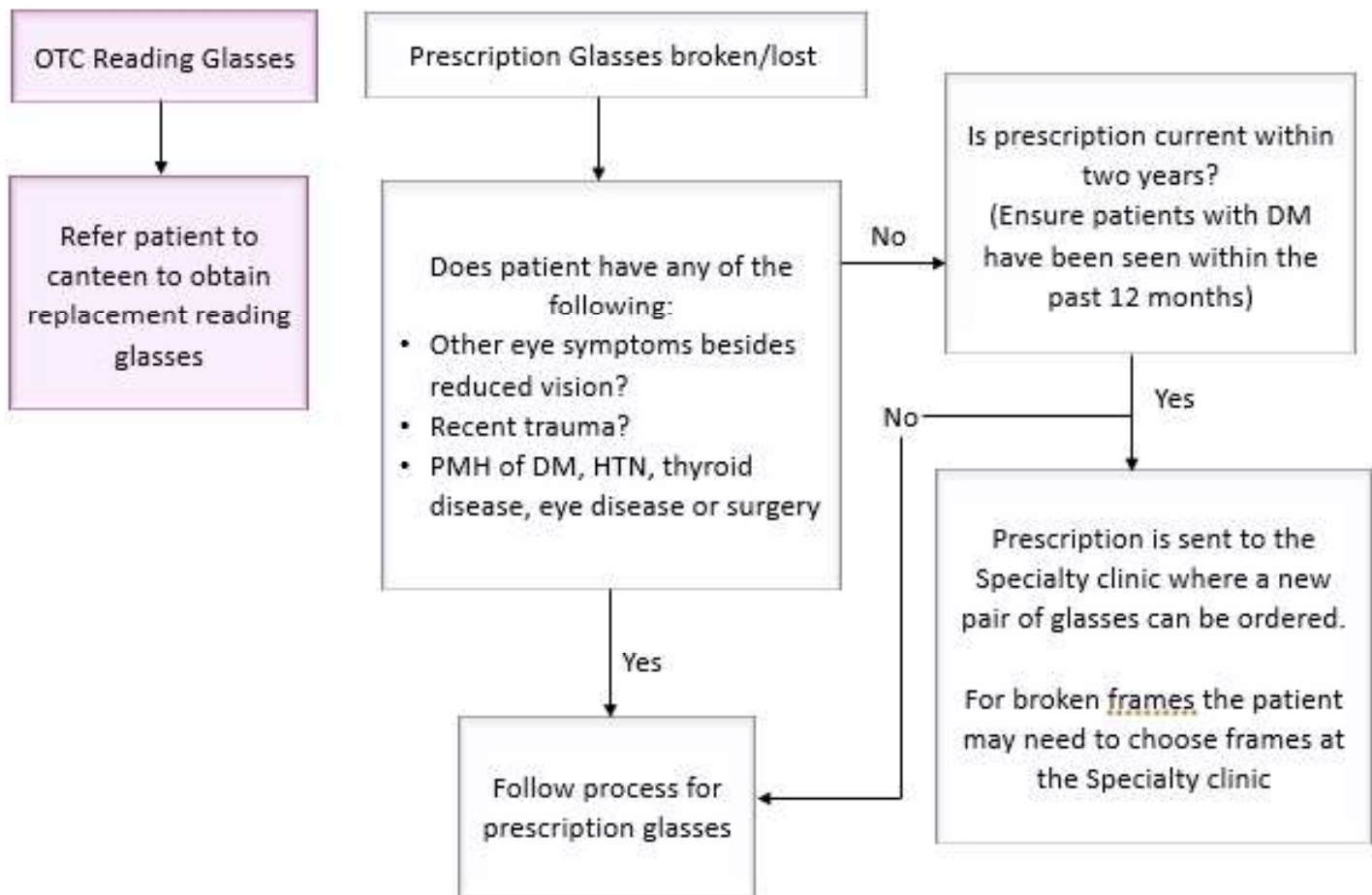
Indication(s):

- Eye conditions which can worsen with exposure to UV light such as:
 - Cataracts
 - Glaucoma
 - Macular degeneration
 - Pterygium
- Post eye procedures or surgeries
- Recommendation of an optometrist and/or ophthalmologist

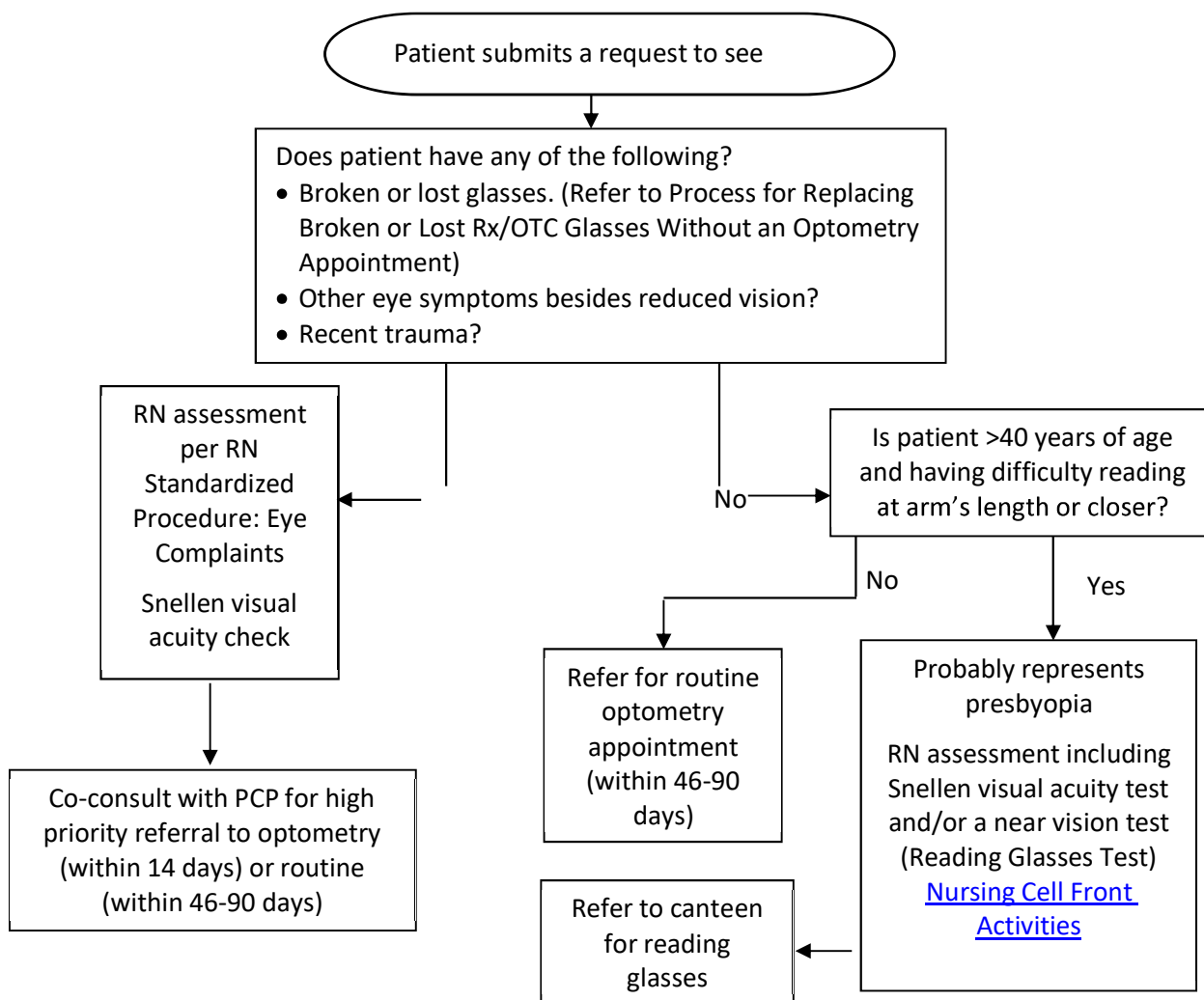
Treatment: Wraparound, slip-in, and clip-on sunglasses are available to all incarcerated persons (IP) without need for a clinical diagnosis or referral. Apart from replacement for damaged glasses, patients are eligible for issuance of glasses once per year. A replacement pair of sunglasses shall be provided if it is determined there has not been repeated, deliberate actions resulting in damage to the IP's sunglasses.

Pursuant to the [July 19, 2023, memorandum](#), each institution's Medical Supply Warehouse is to maintain appropriate levels of wraparound, slip-in and clip-on sunglasses. Prison Canteen Managers shall make them available free of charge to all incarcerated persons via the canteen.

PROCESS FOR REPLACING BROKEN OR LOST PRESCRIPTION OR OTC GLASSES WITHOUT AN OPTOMETRY APPOINTMENT



PROCESS FOR PRESCRIPTION OR OTC GLASSES



OBTAINING PRESCRIPTION GLASSES FROM THIRD PARTY VENDORS

Patients with an eyeglass prescription documented in the last two years may purchase or have their family/friends purchase and mail prescription eyeglasses to the institution directly or via a third-party vendor. CCHCS staff will not provide any fitting or adjustment services for any eyeglasses purchased from a third-party vendor or mailed in by family or friends. Patients use a CDCR Form 7362, Health Care Services Request, to request their current prescription from healthcare. Upon receipt of a CDCR Form 7362, health care staff will verify there is an active order for eyeglasses. If there is not an order for eyeglasses, the patient shall be educated to see their provider to discuss their potential need for eyeglasses and possible order. A patient's friends, family, or vendor may send prescription eyeglasses through the institution's mailroom. Mailroom staff will forward the eyeglasses to the assigned facility clinic for distribution via nursing staff. Prior to distribution, nursing staff shall document the issuance via [CDCR Form 7536, Durable Medical Equipment \(DME\) and Medical Supply Receipt](#), and add the eyeglasses to the patient's list of approved DME.



CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

Information on Purchasing Prescription Eyeglasses from Third Party Vendors

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If you have an eyeglass prescription less than 2 years old, you can receive prescription eyeglasses mailed directly from family or friends or from a third party (outside) vendor.

”

REQUIREMENTS FOR PURCHASE

Only currently approved frame colors and styles can be ordered. Transitional (photochromic) lenses (those that darken with exposure to sunlight) are approved for third-party purchased prescription eyeglasses but are not available internally.

**NOT
APPROVED**



Mirrored, red, or blue lenses are not approved.

Family or friends can purchase and mail or have the third-party vendor mail prescription eyeglasses to your institution. The outside of the package must be clearly marked "Prescription Eyeglasses." You can possess up to two pairs of eyeglasses.

BE AWARE

California Department of Corrections and Rehabilitation (CDCR) and California Correctional Health Care Services (CCHCS) are not liable for repairs or damage to the eyeglasses.

If these eyeglasses are damaged by staff or other incarcerated person, replacement by CDCR/CCHCS will be with currently approved Prison Industry Authority eyeglasses only.

CDCR/CCHCS is not liable for any replacement costs.

You or your family/friends can mail replacement prescription eyeglasses directly to your institution or through the third-party vendor. CDCR/CCHCS will not provide fitting or adjustment services for any eyeglasses purchased from a third-party vendor or mailed to you by family or friends.

Reading glasses and sunglasses continue to be available at no charge through the canteen.

FREQUENTLY ENCOUNTERED QUESTIONS

What if I'm not sure if my eyeglasses prescription is more than two years old?

Submit a CDCR Form 7362 to request your current prescription. If the prescription is more than two years old, you will be educated to see your provider or an eye care specialist to check your eyes and see if you need a new prescription.

How will I receive prescription eyeglasses purchased by family/friends or from a third-party vendor?

The mailroom staff will forward your eyeglasses to the facility clinic for distribution by the nursing staff. You will receive a Durable Medical Equipment (DME) and Medical Supply Receipt (Form 7536), and the glasses will be added to your list of approved DME.

Released: December 2023

“

¿SABÍA
QUE?

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Si tiene una prescripción para anteojos de menos de 2 años, puede recibir anteojos graduados enviados directamente por correo por sus familiares o amigos o por un proveedor externo.

REQUERIMIENTOS PARA LA COMPRA

Sólo se pueden adquirir los colores y estilos de marcos aprobados actualmente. Las lentes de transición (fotocromáticas) (las que se oscurecen con la exposición a la luz solar) están aprobadas para anteojos graduados adquiridos por otros proveedores, pero no están disponibles internamente.

**NO
APROBADO**

No se autorizan las lentes efecto espejo, rojas o azules.

Los familiares o amigos pueden comprar y enviar por correo o hacer que el proveedor externo envíe por correo los anteojos graduados a su institución. En el exterior del paquete debe figurar claramente "Anteojos Graduados". Puede tener hasta dos pares de anteojos.

PARA TENER EN CUENTA

El Departamento de Correccionales y Rehabilitación de California (CDCR, por sus siglas en inglés) y los Servicios de Atención Médica de las Correccionales de California (CCHCS, por sus siglas en inglés) no son responsables de las reparaciones o daños que sufran los anteojos.

Si estos anteojos resultan dañados por el personal u otra persona privada de libertad, el CDCR/CCHCS los reemplazará únicamente con anteojos aprobados actualmente por la Autoridad del Sector Penitenciario.

CDCR/CCHCS no se hacen responsables de los gastos de reposición.

Usted o sus familiares/amigos pueden enviar por correo los anteojos graduados de reposición directamente a su institución o a través del proveedor externo. CDCR/CCHCS no proveerán servicios de adaptación o ajuste para cualquier antejo comprado directamente de un proveedor externo o que le hayan sido enviados por familiares o amigos.

Las gafas de lectura y de sol continúan disponibles de forma gratuita a través del servicio de comedor.

PREGUNTAS PLANTEADAS CON FRECUENCIA

¿Qué pasa si no estoy seguro de si mi prescripción para anteojos tiene más de dos años?

Presente un Formulario 7362 del CDCR para solicitar su prescripción actual. Si la prescripción tiene más de dos años, se le indicará que acuda a su proveedor o a un especialista en cuidado ocular para que le revise los ojos y determine si necesita una nueva prescripción.

¿Cómo recibiré los anteojos graduados comprados por familiares/amigos o de un proveedor externo?

El personal de correos enviará sus anteojos a la clínica de la institución para que sean distribuidos por el personal de enfermería. Recibirá un recibo de Equipo Médico Duradero (DME, por sus siglas en inglés) y Suministros Médicos (formulario 7536), y las gafas se añadirán a su lista de DME aprobado.

MEMORANDUM

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CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

MEMORANDUM

Date: October 11, 2023

To: Associate Directors, Division of Adult Institutions
Regional Health Care Executives
Wardens
Chief Executive Officers

From:

DocuSigned by:
Ronald Broomfield

RONALD BROOMFIELD
Director
Division of Adult Institutions

DocuSigned by:
Joseph Bick

JOSEPH BICK, M.D.
Director
Health Care Operations

DocuSigned by:
JOSEPH J WILLIAMS

JOSEPH (JASON) WILLIAMS*
Director (A)
Corrections Services

Subject: CORRECTED: AUTHORIZATION FOR INCARCERATED PERSONS TO PURCHASE AND RECEIVE PRESCRIPTION EYEGLASSES FROM THIRD PARTY VENDORS

The purpose of this memorandum is to supersede the memorandum titled, "Authorization for Incarcerated Persons to Purchase and Receive Prescription Eyeglasses from Third Party Vendors", dated May 12, 2023.

Incarcerated Persons are authorized to receive prescription eyeglasses mailed directly from their family and friends, or a third party vendor. This directive will supersede Health Care Department Operations Manual 3.6.1 (e) (5) which states in part: Patients shall not have the option to order Durable Medical Equipment (DME) from third party vendors. Additionally, this directive only applies to prescription eyeglasses and is a voluntary option.

Specifically, incarcerated persons with an eyeglass prescription documented in the last two years, may purchase or have their family or friends purchase and mail prescription eyeglasses to the institution directly, or via a third party vendor. California Department of Corrections and Rehabilitation (CDCR)/California Correctional Health Care Services (CCHCS) does not assume any liability for repairs or damage to the eyeglasses. Additionally, if the prescription eyeglasses are deemed to have been damaged by staff or another incarcerated person, the only option for replacement by CDCR/CCHCS will be with the currently approved Prison Industry Authority (PIA) eyeglasses, and the issuance of reading glasses and/or sunglasses through the canteens at no charge to the incarcerated person. The incarcerated person, or their family and friends may, at their expense, mail replacement prescription eyeglasses directly to the institution, or via a third party vendor. CDCR/CCHCS will not be liable for any replacement costs associated with the replacement. The CDCR/CCHCS staff will not provide any fitting or adjustment services for any eyeglasses purchased from a third party vendor or mailed in by family or friends.

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

P.O. Box 588500
Elk Grove, CA 95758

MEMORANDUM

Page 2 of 2

Any eyeglasses mailed to the institution shall be limited to the institution's currently approved frame colors and styles provided by PIA, specifically only various shades of black, brown, and tortoise shell with plastic frames are approved. Incarcerated persons may possess up to two pairs of eyeglasses. Additionally, transitional (photochromic) and tinted lenses (non-mirrored, no red or blue lenses) are approved on third party purchased prescription eyeglasses. Due to the vast assortment of individual eyeglass prescriptions and varying costs associated with an individual need, there is not a set maximum dollar value allowed for these prescription eyeglasses.

The incarcerated person shall use a CDCR Form 7362, Health Care Services Request, to request their current prescription from healthcare. Upon receipt of a CDCR Form 7362, health care staff will verify there is an active order for eyeglasses. If there is not an order for eyeglasses, the incarcerated person shall be educated to see their provider to discuss their potential need for eyeglasses and possible order. An incarcerated person's friends, family, or vendor may send prescription eyeglasses through the institution's mailroom. The outside of the package must be clearly marked, "Prescription Eyeglasses".

Once identified as prescription eyeglasses, mailroom staff will forward the eyeglasses to the incarcerated person's assigned facility clinic for distribution via nursing staff. Prior to distribution, nursing staff shall document the issuance via CDCR Form 7536, Durable Medical Equipment (DME) and Medical Supply Receipt, and add the eyeglasses to the incarcerated person's list of approved DME.

Wardens and Chief Executive Officers (CEO), or designees, shall ensure all appropriate staff are made aware of this directive. In addition, this directive shall be shared with all incarcerated persons and the Inmate Advisory Council (IAC) at both the Warden's and CEOs next IAC meetings. Wardens and CEOs, or designees, shall update their Local Operating Procedures (LOP) to reflect the direction included in this memorandum, and provide proof of practice to their respective Mission Associate Director and Regional Health Care Executive within 60 days of the release date of this memorandum. The revision may be incorporated as an addendum, to be included in the next scheduled revision of the LOP.

All health care questions shall be directed to Lieutenant Jason Anderson, Corrections Services, at Jason.Anderson@cdcr.ca.gov. All custody operations questions shall be directed to Captain Mark Tillotson, Standardized Procedures Unit, at Mark.Tillotson@cdcr.ca.gov.