| **Elite Health Plan**<br>**POLICY AND PROCEDURE** | Elite Health |
|---|---|
| **Name**: Elite Health Plan Policy for Durable Medical Equipment Services | Policy Number: **UM-MED-12** |
| **Department**: Utilization Management Department | Effective Date: 07/07/2026<br>Date Revised: 07/07/2026<br>Date Reviewed: 10/05/2026 |
| **Reviewed and Accepted By:** Sunil Shivaram, M.D. Sri Gorty, M.D., Kristina Fletcher UM Manager | **Chief Medical Officer Signature:**<br><br>Page **1** of 4 |

**PURPOSE:**

The purpose of this policy is to establish standardized guidelines and procedures for the review, authorization, coordination, and management of Home Medical Equipment (HME) and Durable Medical Equipment (DME) requests for Elite Health Plan members. This policy ensures that equipment is medically necessary, appropriately authorized, and provided in accordance with applicable health plan requirements and utilization management standards.

**SCOPE:**

This policy applies to:

- Elite Health Plan Utilization Management (UM) staff;
- Delegated Independent Practice Associations (IPAs) and Medical Groups;
- Participating physicians and practitioners;
- Provider office staff involved in the ordering of DME; and
- Contracted vendors supplying DME.

This policy establishes the process for ordering, reviewing, authorizing, coordinating, and monitoring DME requests for Elite Health Plan members.

**DEFINITIONS:**

| Term | Description |
|---|---|
| CMS | Centers for Medicare and Medicaid Services – The agency within the US Federal Government that is charged with the execution and maintenance of the law definingthe prescription drug program for senior citizens, the disabled, and the infirm. |
| MA | Medicare Advantage |
| Concurrent review decision | Extension of previously approved ongoing treatment, typically inpatient or ambulatory care. |
| Contracted Provider | A healthcare provider or vendor with an active agreement with Elite Health Plan. |
| Supplemental Benefit | A benefit offered by Elite Health Plan that is not covered under Original Medicare. |
| EOC | Evidence of Coverage |
| Medically Necessary | Services or supplies that are reasonable and necessary for the diagnosis or treatment of illness or injury and meet accepted standards of medical practice. |

**POLICY:**

Durable Medical Equipment (DME) is covered when it meets all applicable coverage requirements, is medically necessary, and is reasonable for the diagnosis or treatment of an illness, injury, or malformed body member.
To be considered DME, an item must meet all of the following criteria:

1. Be durable and capable of withstanding repeated use.
2. Be primarily and customarily used for a medical purpose.
3. Not be generally useful to a person in the absence of illness or injury.
4. Be appropriate for use in the home setting.

Failure to meet any one of these criteria will result in the item not qualifying as DME.

All requests for Home Medical Equipment (HME) and Durable Medical Equipment (DME) shall be reviewed and coordinated through the Utilization Management Department or delegated entity, as applicable.

DME services shall be authorized only when determined to be medically necessary and covered under the member's benefit plan.

Requests for equipment shall include sufficient clinical information to support the medical necessity of the item requested.

**Policy Guidelines**

**1. Required Forms**

The following documentation will be required:

- Referral Request Form
- Physician Order/Prescription
- Documentation of medical necessity:
- Inclusion in the physician's treatment plan; and
- Ongoing physician supervision of use

**2. Completion of Referral Request**

The ordering physician shall complete the referral request and include all necessary information, including:

- A complete description of the equipment being requested.
- Specific settings and clinical parameters, when applicable. Examples: CPAP, BIPAP, Oxygen, Lymphedema pumps, etc.
- For rehabilitation equipment, including: Wheelchairs, Walkers, Canes, Traction equipment, Other mobility devices the physician shall provide the member's: Height, Weight, any additional measurements required for proper fitting
- The completed referral request and supporting documentation shall be submitted to Elite Health Plan Utilization Management staff or the member's delegated entity for review.

**3. Clinical Review**

The complete request gets assigned to the Utilization Management clinician in HEALTHsuite for medical necessity review.

Review the request and supporting clinical documentation using established Elite Health Plan medical necessity criteria and utilization management guidelines based on the Hierarchy referenced in ***UM-06 Elite Health Plan Policy for Clinical Criteria and Medical Necessity Determination.***

Authorize medically necessary equipment in accordance with benefit coverage and utilization management criteria. Coverage is limited to equipment that is reasonable and necessary for the patient's condition. Medical necessity exists when the equipment is expected to: 1. Contribute meaningfully to treatment of a disease or injury; or 2. Improve the functioning of a malformed body member. Coverage may be reviewed periodically to determine continued medical necessity.

**4. Vendor Coordination**

Coordinate delivery of approved equipment through an Elite Health Plan contracted vendor: this includes providing a list of preferred providers to the delegated entity for coordination, and or a facility providing discharge planning to the member.

**5. Member and Provider Notification**

Elite Health Plan or its delegated entity shall notify the member and the member's Primary Care Provider (PCP) of all authorization determinations, including approvals, partial approvals, and denials, in accordance with applicable regulatory and contractual requirements.

For notification requirements, processing timeframes, and decision turnaround standards, refer to:

- ***UM-01 Elite Health Plan Expedited Organization Determination Policy***
- ***UM-02 Elite Health Plan Standard Organization Determination Policy***

These policies provide guidance regarding authorization decision timeframes, member and provider notification requirements, and applicable turnaround time (TAT) standards.

**6. Compliance**

All participating providers, delegated entities, contracted vendors, and Elite Health Plan staff shall comply with this policy, applicable federal and state regulations, health plan contractual requirements, and Elite Health Plan utilization management standards.

**References**


- Medicare Benefit Policy Manual Chapter 15 “Covered Medical and Other Health Services”
- National Coverage Determination (NCD) Durable Medical Equipment Reference List **280.1**

| Date of Revision: | Revised by: | General Revision Notes |
|---|---|---|
| 07/07/2026 | Kristina Fletcher | Implementation |