

## Slide 1: Utilization Management Process: Durable Medical Equipment

Implementation Council

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United Healthcare

## Slide 2: DME Utilization Management Process

- DME requests are evaluated based on simultaneous consideration of Medicare, Medicaid, UHC established policies, and the member's Individualized Care Plan (ICP)
- Requests are decided based on application of the least restrictive criteria among those policies

## Slide 3: DME Contractual Definition

Products that:

- (a) are fabricated primarily and customarily to fulfill a medical purpose;
- (b) are generally not useful in the absence of illness or injury;
- (c) can withstand repeated use over an extended period of time; and
- (d) are appropriate for home use. Includes but not limited to the purchase of medical equipment, replacement parts, and repairs for such items as: canes, crutches, wheelchairs (manual, motorized, custom fitted, & rentals), walkers,

commodes, special beds, monitoring equipment, and the rental of Personal Emergency Response Systems (PERS).

#### Slide 4: Utilization Management Process: Durable Medical Equipment

- Licensed provider (e.g. MD, PT/OT/SLP) submits order/prescription for equipment
- Clinical rationale must meet DME definition and medically necessary requirements
- DME vendor must be in-network or in-network services not available
- Request is reviewed by RN reviewers in UM department
  - Approval—member and provider notified
  - Criteria not met—request is reviewed by UM medical director
    - Approval after UM Medical Director review—member and requesting provider notified
    - Approval cannot be issued after UM Medical Director review:
      - **Consultation with Care Coordination team for discussion of extenuating circumstances prior to final determination**
      - **Flexible spending benefit may be available for DME that is necessary to meet the goals of the ICP**
      - Request for additional information
    - If approval is not possible after review with Care Coordination team, denial is issued
- Denials may be appealed to the plan (1<sup>st</sup> level) and OPP (2<sup>nd</sup> level), if necessary

## Slide 5: Requests for Equipment that do not meet DME definition

- No billing code available for the equipment
- Provider is not a contracted DME vendor
- Care Coordinator in consultation with medical director evaluates request in context of the ICP
- When DME meets goals of ICP, equipment can be covered under flexible benefit

## Slide 6: Case example: Air Conditioner

- Air conditioners do not meet the DME definition because they can be used in absence of illness or injury and not made primarily to serve a medical purpose
- Interdisciplinary Care Team (ICT) has determined that a window unit is necessary to manage exacerbations of moderate asthma and documents this information in the Individualized Care Plan (ICP)
- Care coordinator—in consultation with medical director—approves request based on the ICT input
- Equipment is covered as a flexible benefit

## Slide 7: Health Equity

- UHC is building reporting capability that sorts the population based on race, ethnicity, socioeconomic status, gender identity, disability, language, housing status, chronic illness, SUD, SMI and geography
- Gaps in care, UM decisions, and outcomes will be analyzed through multiple variables to detect and address patterns of care

## Slide 8: Appendix

Definitions per member handbook

## Slide 9: Benefit Design

- **Medicare** — services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and Part B.
- **Medicaid** — a program run by the federal and state governments that helps people with limited incomes and resources pay for long-term services and supports and medical costs. It covers extra services and drugs not covered by Medicare.
- **N.B.—Utilization Management decisions for all services are based on the least restrictive benefit**

## Slide 10: Medically Necessary Definition

- **Medically necessary** — services that are reasonable and necessary:  
For the diagnosis and treatment of your illness or injury; **or**  
To improve the functioning of a malformed body member; **or**  
Otherwise medically necessary under Medicare law.
- In accordance with Medicaid law and regulation, and per MassHealth, services are medically necessary if:  
  
They could be reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions that endanger your life, cause you suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity; **and**  
  
There is no other medical service or place of service that is available, works as well, and is suitable for you that is less expensive. The quality of medically necessary services must meet professionally recognized standards of health care, and medically necessary services

## Slide 11: DME Definition

**Durable medical equipment (DME)** — certain items that your doctor orders for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

### Slide 12: Flexible Benefit Definition

- There is no definition for flexible benefits in the UHC Connected for One Care Member Handbook
- Benefit exists for services/items that are not routinely considered as medically necessary or included in benefit definition
- Flexible benefits may be covered for services/items that are consistent with the individual care plan; necessary to meet the goals/objectives of the plan; and for which there are no less expensive—equally effective—alternatives.