Durable Medical Equipment, Prosthetics, Orthotics and Disposable Medical Supplies (DMEPOS)

Medicaid policy

The Durable Medical Equipment (DME), Disposable Supplies and Supplements program covers medically necessary durable medical equipment, prosthetics, orthotics and disposable medical supplies, which includes oxygen and related supplies, parenteral and enteral nutrition and medical foods.

The Medicaid Services Manual (MSM) is on the Nevada Medicaid website at nevadamedicaid.nv.gov/resources/medicaid-services-manual/.

MSM Chapter 1300 provides the DME, Disposable Supplies and Supplements policy including but not limited to:

- Documentation requirements
- Dispensing and delivery of items
- Recipient qualifications, coverage and limitations

MSM Chapter 100 contains important information applicable to all provider types.

Products and services must be medically necessary and appropriate for the course and severity of the recipient's condition, using the least costly and equally effective alternative to meet the recipient's needs. InterQual is the proprietary, nationally recognized standard utilized by Nevada Medicaid's QIO-like vendor in support of medical necessity determinations.

Providers are responsible to know the policies that are in effect on the date they provide services.

Check the Nevada Medicaid Provider website medicaid.nv.gov and the Nevada Medicaid website nevadamedicaid.nv.gov at least weekly for updates, notices, Fee Schedules, policy changes and Web Announcements.

For your records, retain copies of the aforementioned documents. In the event of a future claims audit, these copies may be useful to show why a claim was billed the way it was. In accordance with MSM Chapter 3300, records supporting claims processing must be maintained for six years after payment.

DMEPOS fee schedule

The Provider Type 33 DMEPOS Fee Schedule identifies Healthcare Common Procedure Coding System (HCPCS), Level II codes which may be covered under the DME, Disposable Supplies and Supplements program. It is available online at nevadamedicaid.nv.gov/programs/rates/. For questions related to rates in the Fee Schedule, refer to MSM Chapter 700, *Rates.* For DMEPOS equipment with a $0 or unassigned rate, the provider must submit an invoice or quote with the PA or, if no PA is required, with the claim.

Reimbursement will be the lowest of:

a) manufacturer's suggested retail price (MSRP) less 25%, verifiable with quote or manufacturer's invoice that clearly identifies MSRP;
b) acquisition cost plus 20%, verifiable with manufacturer's invoice; or
c) the actual charge submitted by the provider.
    - **It is the provider's responsibility to provide both the invoice/quote of MSRP and cost verifying the lower of, per state plan section 4.19-B.7.d.3 page 2.**

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Treatment history

The Provider Web Portal (PWP) allows DMEPOS providers, or their delegates, the ability to search recipient treatment history online through the secured areas of the Provider Web Portal.

- Click here medicaid.nv.gov/hcp/provider/Home/tabid/135/Default.aspx to log in to the Provider Web Portal and then click on "Treatment History" under the "Claims" tab.
- Instructions are available in PWP User Manual Chapter 9: Treatment History.

Prior authorization

Some DMEPOS services/items require prior authorization (PA). All zero rate items require a prior authorization and invoice/quote.

PA requests must be submitted at least *three* business days prior to service.

A PA request should be submitted only for the units that exceed the assigned limitation, not for the total order. For example, if a prescription for diapers is for 200 units, but the limitation is 186, then the PA should request 14 units.

Requests may be submitted through the Nevada Medicaid provider website at medicaid.nv.gov/hcp/provider/Home/tabid/135/Default.aspx using the following forms located at medicaid.nv.gov/providers/forms/forms.aspx:

- Form FA-1A to request continuing use of Bi-level and Continuous Positive Airway Pressure (BiPAP and CPAP) devices
- Form FA-1B to request mobility products with a per item reimbursement rate of $500 or more
- Form FA-1C to request oxygen equipment and supplies
- Form FA-1D to request wheelchair repair or modification
- Form FA-1E to request continuing use of Speech Generating Device
- Form FA-1 for all other services

It is critical to submit complete and accurate clinical documentation on prior authorization requests.

Documentation must include a physician's/practitioner's prescription or order and must fully support medical necessity of the item and components.

When submitting supporting medical documentation using the website, the name and credentials of the provider who supplied the information are required. Failure to provide this information may result in a denied request and/or may delay the determination.

MSM Chapter 1300, including Appendix B, lists specific prior authorization and documentation requirements. If you have any questions, please contact the Gainwell Technologies Prior Authorization Department at (800) 525-2395.

See MSM Chapter 500 for Nursing Facility coverage and limitations.

Authorization does not guarantee payment of a claim. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program.

DME Rent-to-Purchase Option

Items identified in the DMEPOS Fee Schedule with a rental and purchase option require prior authorization to determine if the recipient's needs justify rental or purchase based on the item prescribed, the individual's anticipated length of need and prognosis (as determined by the prescriber) and cost effectiveness to the Nevada Medicaid and Nevada Check Up.

a. Nevada Medicaid allows rental of certain DMEPOS items up to the provider's manufacturer's invoice for purchase, or the maximum Medicaid allowable purchase price of the item; whichever is less.

b. Unless the item is identified per Nevada Medicaid as a rental only, once the total cumulative rental payments have reached the lower of the manufacturer's invoice or maximum Medicaid allowable purchase rate, the item is considered purchased in full and recipient-owned.

DMEPOS Prior Authorizations in Emergency Situations:

1. In an emergency situation, when an order is received by the supplier after the Quality Improvement Organization (QIO)-like vendor's (Gainwell Technologies) working hours or over weekends or on State holidays, dispensing of a 72-hour supply of those DMEPOS items that require prior authorization (PA) will be allowed only when:
    - A delay of 24 hours of treatment could result in very severe pain, loss of life or limb, loss of eyesight or hearing, injury to self, or bodily harm to others; and
    - The treating physician/practitioner indicates a diagnosis/International Classification of Diseases (ICD) code on the prescription that supports the use of the emergency policy.
2. The provider/supplier must submit the PA the next business day with all required supportive documentation. The documentation must include proof of the date and time the order was received by the supplier and documentation to support both MSM Chapter 1300, Section 1303.4(a.)(1.) and (2.).

Expediting DME PA to avoid delaying movement to lower level of care:

Call the Gainwell Technologies Prior Authorization Customer Service unit at (800) 525-2395 and notify a representative of the need to expedite a PA. Information you will be required to present:

1. PA number
2. Rationale for need to expedite

Staff will review the information as soon as possible and expedite review if necessary to avoid delaying movement to a lower level of care, i.e., discharge from the acute setting to a lower level such as home or to a nursing facility.

DME Manufacturer's Invoice Requirements

Manufacturer's Suggested Retail Pricing (MSRP) or cost invoice for certain items, especially where a Nevada Medicaid rate has not been established, is required to be submitted with the prior authorization (PA) request per Medicaid Services Manual (MSM) Chapter 1300 Appendix B, INTRODUCTION AND GENERAL INFORMATION, FORMS AND DOCUMENTATION REQUIREMENTS.

For items with no rate assigned and no prior authorization required, claims must be submitted with the manufacturer's invoice or quote.

The invoice/quote must include:

- Manufacturer's itemized bill for DME items.
- Name and address of the manufacturer providing the item.
- Invoice number, date and identification of the equipment utilizing the Healthcare Common Procedure Coding System (HCPCS) code, including any miscellaneous HCPCS codes, if appropriate.
- Name, address and National Provider Identifier (NPI) of the DME provider submitting the invoice.

For enteral nutrition codes with no rate assigned, a breakdown to determine the number of units is required to be added on the invoice.

Invoices that are altered or tampered with in any way will be denied as they are not valid. The invoice must not be for equipment with a delivery date after the date of service and must be no more than six months (180 days) prior to the date of service.

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Institutional settings

Institutional settings include hospitals, nursing facilities (NFs) or intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs).

Prior authorization for institutional settings

DMEPOS provided or supplied to recipients in an ICF/IID or NF are included in the facility's per diem rate and are not separately payable by Medicaid. The facility's per diem rate is all-inclusive to cover all items needed during the stay.

The exceptions are as follows:

- Items provided in preparation for discharge to the community
- Custom-fitted devices that are not suitable for use by any other individual
- Total Parenteral Nutrition (TPN)
- Enteral formulas administered via a feeding tube

Prior authorization is always required when any DMEPOS item is provided in an institutional setting and will be billed by a DMEPOS provider to Nevada Medicaid or Nevada Check Up.

Place of service codes

The appropriate 2-digit place of service code must be used on prior authorization requests to identify where the service was provided and if the recipient was in an institutional setting.

A recipient's *home* for DMEPOS purposes is not an institutional setting. For a list of codes, see cms.gov/Medicare/Coding/place-of-service-codes/index.html

Claims/billing instructions

- Claims must be submitted in accordance with the Healthcare Common Procedure Coding System (HCPCS) and national industry standards.
- For HCPCS code descriptions that identify multiple components, the Nevada Medicaid rate includes all items in the description. Individual components may not be billed separately.
- Claims must include the appropriate physician's diagnosis code in accordance with policy.
- Providers must bill their usual and customary charges.
- Providers may not include additional charges for delivery, set-up or training and education to recipient/caregivers as these services are included in the established rates.
- Only bill for the actual number of medically necessary units dispensed/delivered to a recipient, regardless of the number of units allowed by policy and/or prior authorization.

Ordering, Prescribing or Referring (OPR) Provider Requirements

The Patient Protection and Affordable Care Act and the Centers for Medicare & Medicaid Services (CMS) require all ordering, prescribing and referring physicians to be enrolled in the state Medicaid program (§455.410 Enrollment and Screening of Providers). The Affordable Care Act (ACA) requires physicians or other eligible practitioners to enroll in the Medicaid program to order, prescribe and refer items or services for Medicaid recipients, even when they do not submit claims to Medicaid. Physicians or other eligible professionals who are already enrolled in Medicaid as participating providers and who submit claims to Medicaid are not required to enroll separately as OPR providers.

For any services or supplies that are ordered, prescribed or referred, the National Provider Identifier (NPI) of the Nevada Medicaid-enrolled Ordering, Prescribing or Referring (OPR) provider must be included on Nevada Medicaid/Nevada Check claims or those claims will be denied. To prevent claim denials for this reason, please confirm that the OPR provider is enrolled with Nevada Medicaid; this can be done on the Provider Web Portal by using the Search Providers feature: medicaid.nv.gov/hcp/provider/Resources/SearchProviders/tabid/220/Default.aspx

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Electronic Claims instructions: When reporting the provider who ordered services such as diagnostic and lab, use Loop ID-2310A. For ordered services such as Durable Medical Equipment, use Loop ID-2420E. For detailed information, refer to the 837P FFS Companion Guide located at: medicaid.nv.gov/providers/edi.aspx

Direct Data Entry/Provider Web Portal instructions: On the Service Detail line enter the OPR provider's NPI in the Referring/Ordering Provider ID field, and select "Yes" or "No" to indicate it if is an Ordering Provider. For further instructions, see the PWP User Manual Chapter 3.

The ordering/referring provider's NPI must also be listed when a prior authorization is required.

Rental items

Rental rates (identified by modifier *RR* in the DMEPOS Fee Schedule) are *monthly* unless otherwise indicated on the Fee Schedule and/or by the HCPCS code definition.

Bill at monthly intervals beginning with the date item was dispensed/delivered to the recipient; subsequent claims would be on the same date of the following months. The *From* and *To* dates of service must be the same date.

Billing example

The DMEPOS item was delivered to the recipient on April 27.

- For the time period of April 27-May 27, bill one claim line with *April 27* in the *From* and *To* dates of service.
- The next month's claim would be for equipment rental between May 27 and June 27. Bill one claim line with *May 27* as the *From* and *To* dates of service.

Complex Rehabilitative Technology (CRT) items

Complex Rehabilitative Technology (CRT) items, which are NU, RR and UE, can be billed with the KU modifier (DMEPOS item subject to DMEPOS competitive bidding program number 3). The billing process matches Medicare in that the combinations will be NU/KU, RR/KU and UE/KU.

The KE modifier (Bid under round one of the DMEPOS competitive bidding program for used with noncompetitive bid base equipment) can also be billed with the following combinations: NU/KE, RR/KE and UE/KE.

Special instructions for common products/services

Inclusion of a code below does not certify coverage. See the DMEPOS Fee Schedule for coverage and limitations.

Bi-level and Continuous Positive Airway Pressure (BiPAP and CPAP) devices

Use the Provider Web Portal or submit form FA-1A to request continued services for BiPAP or CPAP devices no sooner than 31 days and no later than 91 days after initiation of therapy:

Form FA-1A or an attached physician's note must contain a signed and dated statement declaring:

- The number of hours a day the machine is used;
- The number of months the recipient has used the machine;
- Whether the recipient will continue to use the machine;
- Whether the recipient is benefiting from the machine's use; and
- The name of the person who answered these questions (cannot be the DMEPOS supplier).

Diabetic supplies

Effective January 6, 2020, diabetic equipment and supplies including but not limited to: glucometers, test strips, lancets/lancet devices, insulin syringes, reagents, insulin pumps and supplies, insulin systems and supplies, and Continuous Glucose Monitors (CGM) must be billed through the pharmacy program (provider type 28), not through the

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DME, Disposable Supplies and Supplements program (provider type 33). Exceptions to this are diabetic shoes/fittings/modifications (A5500-A5507, A5512-A5513). Refer to MSM Chapter 1200 (Pharmacy) and MSM Chapter 1300 (DME, Disposable Supplies and Supplements) for additional information. Inappropriate payments issued to a DMEPOS provider are subject to post payment recoupment.

Enteral/gastrostomy

Enteral Nutrition/Formula procedure codes require prior authorization when indicated per Nevada Medicaid. Use the Authorization Criteria search function in the Provider Web Portal at www.medicaid.nv.gov to verify which services require authorization. Authorization Criteria can be accessed on the Provider Login webpage under Resources (you do not need to log in).

For **non-institutionalized recipients**, the appropriate ICD code must be entered. See PWP Chapter 3 Claims for billing instructions.

The **Enteral Feeding Supply Kit, Pump fed** (code B4035) is limited to 31 units per month (1 unit equals 1 day). The Enteral Feeding Supply Kit, **Gravity fed** (code B4036) is limited to 30 units per month.

To **bill a partial month** for an Enteral Feeding Supply Kit, enter the first date of the billing cycle in the *From* date. Enter the same date for the *To* date. Enter one unit for each day. For example, to bill for March 12-31, enter a *From* date of March 12, a *To* date of March 12 and a *20* for number of days.

The following scenario shows how to **bill continued services (rolling months)** for code B4035 (a 31-day billing frequency). The same instructions would apply to code B4036, except a 30-day billing frequency would be used.

a) You begin your billing cycle on February 3. February has 28 days in it and 31 days from February 3 is March 5. Therefore, March 5 will be the last day of your billing cycle. On the claim form enter *February 3* (the first day of the billing cycle) as the From date *and* as the To date. Enter *31* for number of days.

b) The next 31-day billing cycle would start on March 6. March has 31 days in it and 31 days from March 6 is April 5. Therefore, April 5 will be the last day of your billing cycle. On the claim form, enter *March 6* as the From date *and* as the To date. Enter *31* for number of days.

c) The next 31-day billing cycle would start on April 6. April has 30 days in it and 31 days from April 6 is May 6. Therefore, *May 6* will be the last day of your billing cycle. On the claim form, enter *April 6* as the From date *and* as the To date. Enter *31* for number of days.

For the following Enteral Formula codes, **100 calories equals 1 unit**. Enter the units on the claim.

B4149	B4157
B4150	B4158
B4152	B4159
B4153	B4160
B4154	B4161
B4155	B4162

For **Feeding Tubes**, use code B4087 to bill standard gastrostomy/jejunostomy tubes and code B4088 without a modifier to bill for a low-profile gastrostomy/jejunostomy feeding tube. For the **Low Profile Gastrostomy** Feeding Tube, MIC-KEY® Button only, use B4088 with modifier BA.

Percutaneous Catheter/Tube Anchoring Devices (code A5200) and dressing holders (A4461 or A4463) used in conjunction with a gastrostomy or enterostomy tube are included in supply kit codes B4034-B4036 and may not be billed separately.

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Incontinent products

Prior authorization (PA) requests and claims must include a physician's diagnosis of urinary or bowel incontinence and, when applicable, the primary diagnosis causing the incontinence. See MSM Chapter 1300 for details.

The prescriber's order must also indicate the *number* of changes required per day or per month.

Providers must use the appropriate HCPCS *T codes* for incontinent care products; the use of *A codes* is no longer acceptable.

Supporting documentation must be maintained by the supplier for auditing purposes. A prior authorization is always required for ages 0-3 and only if exceeding limits for all others.

Limitations

The maximum allowable quantities for incontinent supplies are as follows and may only be supplied in accordance with established policies based on medical necessity:

Diapers and briefs are limited to 186 units in a rolling month and include any combination of codes T4521-T4524, T4529-T4530, T4533 and T4543.

Pull-ons or protective underwear are limited to 100 units per rolling month and include any combination of codes T4525-T4528, T4531-T4532 and T4534.

When diapers/briefs are used in combination with pull-ons/protective underwear, the maximum combined total cannot exceed 186 units in a rolling month.

For example, a recipient uses pull-ons during the day and diapers at night. The recipient changes the pull-ons 3 times per day x a 31 day month = 93 units per rolling month. The same recipient uses 1 diaper/brief during the night x a 31 day month = 31 units per rolling month. The maximum in each category does not exceed the maximum allowed per category; the maximum combined units total 124 and do not exceed 186 units.

Liners/shields, guards, pads, undergarments or underpads are limited to 100 units per rolling month and include any combination of products for codes T4535, T4541 and T4542. These may be billed in addition to diapers/briefs or pull-ons/protective underwear.

Product Sizes

The **size** of the product dispensed must:

- Be in accordance with the recipient's weight, waist/girth measurement and belt-to-belt measurement;
- Be specifically indicated on the prescriber's order; and
- Be in accordance with manufacturer's size recommendations. Refer to a HCPCS book for exact sizing (small, med, large, etc.) for each code.

Code T4543 (bariatric size brief/diaper) is for individuals age 21 years and older with a minimum waist size of 60". This code always requires prior authorization.

PA is required 1) for all individuals less than 4 years of age, 2) for any bariatric-size product (code T4543) or 3) when quantity limits need to be exceeded.

Intravenous therapy supplies

Intravenous therapy supplies including all HCPCS S codes listed on the DMEPOS Fee Schedule are billed through the DME, Disposable Supplies and Supplements program (provider type 33). See the MSM Chapter 1200 Prescribed Drugs for coverage and limitations.

Orthotic and prosthetic devices

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With the exception of *repair* codes and items with $0.00 rates, DMEPOS providers (provider type 33) are not required to request prior authorization for ***L codes*** with a reimbursement rate of less than $250.00. This does not negate the provider or supplier's responsibility to practice within their scope and to follow Nevada Medicaid policy in MSM Chapter 1300.

Oxygen and related services

Oxygen contents (codes E0441, E0443 and E0444) are limited to one unit per month regardless of the actual number of refills provided. Claims submitted with more than one unit will be denied.

Power mobility devices (PMD)

Prescribing physician/practitioners may bill an additional fee using HCPCS code G0372 on the claim for the office visit (CPT 99211) during which the Medicare-required face-to-face examination/evaluation was completed.

For any PMD, exceptions to *included* items listed below must be prior authorized to determine medical necessity for an alternate, non-included substitution. Documentation must specify why the *included* item cannot be utilized to meet the recipient's basic medical needs.

Power operated vehicle (POV), basic equipment package

Upon initial issue, each POV must include all items below; separate billing/payment is not acceptable.

- Battery or batteries required for operation
- Battery charger, single mode
- Weight appropriate upholstery and seating system
- Tiller steering
- Complete set of tires
- All accessories needed for safe operation
- Non-expandable controller with proportional response to input

Power wheelchair (PWC), basic equipment package

The PWC Basic Equipment Package for each power wheelchair code is required to include all these items on initial issue (i.e., no separate billing/payment at the time of initial issue). The statement that an item may be separately billed does not necessarily indicate coverage.

- Lap belt or safety belt. Shoulder harness/straps or chest straps/vest may be billed separately.
- Battery charger, single mode.
- Complete set of tires and casters, any type.
- Legrests. There is no separate billing/payment if fixed, swingaway or detachable non-elevating legrests with or without calf pad are provided. Elevating legrests may be billed separately only if determined medically necessary.
- Footrests/foot platform. There is no separate billing/payment if fixed, swingaway or detachable footrests or a foot platform without angle adjustment are provided. There is no separate billing for angle adjustable footplates with Group 1 or 2 PWCs. Angle adjustable footplates may be billed separately with Group 3, 4 and 5 PWCs when determined medically necessary.
- Armrests. There is no separate billing/payment if fixed; swingaway or detachable nonadjustable height armrests with arm pad are provided. Adjustable height armrests may be billed separately when determined to be medically necessary.
- Any weight-specific components (braces, bars, upholstery, brackets, motors, gears, etc.) as required by patient weight capacity.
- Any seat width and depth. Exception: for Group 3 and 4 PWCs with a sling/solid seat/back, the following may be billed separately when determined medically necessary:

  - For Standard Duty, seat width and/or depth greater than 20 inches;
  - For Heavy Duty, seat width and/or depth greater than 22 inches;
  - For Very Heavy Duty, seat width and/or depth greater than 24 inches;
  - For Extra Heavy Duty, no separate billing.
- Any back width. Exception: for Group 3 and 4 PWCs with a sling/solid seat/back, the following may be billed separately when determined medically necessary:
  - For Standard Duty, back width greater than 20 inches;
  - For Heavy Duty, back width greater than 22 inches;
  - For Very Heavy Duty, back width greater than 24 inches;
  - For Extra Heavy Duty, no separate billing.
- Controller and Input Device. There is no separate billing/payment if a non-expandable controller and a standard proportional joystick (integrated or remote) is provided. An expandable controller, a nonstandard joystick (i.e., non-proportional or mini, compact or short throw proportional) or other alternative control device may be billed separately if determined to be medically necessary.

Ventilators (codes E0465 and E0466)

When one unit is provided, the prior authorization and claim must indicate one unit and the claim must be billed using the provider's usual and customary charge.

Providers who deliver one unit for use and one unit on site as a back-up are required to have an approved prior authorization for 2 units. This is allowed only if it is medically prohibitive for a provider to respond in an emergent situation such as 24-hour ventilation support. Providers must complete the claim form indicating 2 units on the same claim line using their usual and customary charge.

Non-covered items

Nevada Medicaid's DME, Disposable Supplies and Supplements program does not cover the following items as they either do not meet the definition of durable medical equipment, prosthetic, orthotic or disposable medical supplies, or are not considered primarily medical in nature. This list is not all-inclusive and may be revised periodically.

Equipment used for physical fitness or personal recreation, such as but not limited to:

- Bicycles/tricycles
- Electronic devices primarily designed for entertainment
- Exercise equipment
- Hot tubs or Jacuzzis®
- Personal computers
- Playground equipment (swings, jungle gyms, tunnels, parachutes, obstacle courses)
- Printers
- Pulse tachometers
- Swimming equipment (such as earplugs)
- Tape recorders
- Tennis/gym shoes
- Video recorders or digital video (DVD) players

Personal care or hygiene products, such as but not limited to:

- Car seats
- Dental care supplies (toothbrushes, toothpaste, dental floss and toothettes)
- Disposable gloves (non-sterile and sterile)
- Disposable wipes (includes baby wipes and Attends®-type washcloths)
- Enuresis or bed-wetting alarms

- Feeder seats
- Feeding instruments – tableware and/or baby bottles
- First aid products
- Floor sitters
- Foam cushion pads
- Food – table foods (with exception of medical foods as defined in MSM Chapter 1300)
- Glasses (magnifying or reading)
- Heat and massage aids
- Ice packs (disposable)
- Massage devices
- Medical alert bracelets/jewelry
- Menses products
- Scales (bathroom, kitchen, food or diet)
- Strollers (exception: pediatric wheelchair type classified as a medical device by Statistical Analysis DME Regional Center (SADMERC), with a HCPCS code)
- Thermometers and covers
- Travel, activity or corner chairs

Household items, such as but not limited to:

- Air conditioners (includes swamp coolers)
- Appliances (microwave, cutting boards or other adaptive equipment for cooking, cleaning, etc.)
- Food blenders
- Furniture
- High chairs
- Humidifiers or dehumidifiers (room type or central)
- Lift chairs
- Orthopedic mattresses
- Overbed tables
- Safety/canopy Beds
- Telephones (and related items: answering machines, telephone alert systems or telephone arms)
- Vaporizers
- Waterbeds

Household equipment and supplies/home or vehicle modification equipment, such as but not limited to:

- Ceiling fans
- Elevators
- Home security systems
- Intercom monitors
- Medical alert systems
- Motorized lifts for vehicle
- Power door openers
- Ramps or wheelchair ramps
- Trays
- Stair lifts
- Switches

Environmental products such as but not limited to:

- Air filters
- Conditioners

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- Hypoallergenic bedding and linens
- Purifiers

Miscellaneous:

- Erectile Dysfunction equipment and supplies