

Durable Medical Equipment/ Home Medical Equipment



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NOTE — The revision date appears in the footer of the document.

I. Predetermination of Service or Item

Predetermination is recommended for coverage of a service or an item when:

1. The service may be denied as not medically necessary, or as experimental or investigational. In this case the patient should sign a Limited Patient Waiver form published on the Blue Cross and Blue Shield of Kansas (BCBSKS) website.
2. The service or item is too costly for the patient to bear financial responsibility if it should be denied as non-covered patient responsibility.
3. The claim will be denied for more information if the total charge or billed service differs from the predetermination.

When asking for predetermination of a service or item, complete the BCBSKS

Predetermination Request Form. Include:

- History and findings from prescribing physician
- Medical rationale for treatment or item
- Invoice, if appropriate (Direct Cost)
- Descriptive information
- FDA approval information
- Studies substantiating the efficacy of the treatment or item
- Potential cost savings of the treatment or item

Pre-Certification (Required by Certain Members' Contracts)

Certain members' contracts require home medical equipment to be pre-certified by writing BCBSKS. This pre-approval must be received before delivery. Suppliers will be told of such requirements when the provider calls to verify member benefits.

II. Coding Your Claim

Procedure Codes are in the HCPCS listing. Review all possible codes for an item before making the selection for a particular item.

Modifiers that must be used for new, rental or used equipment:

NU — New Durable Medical Equipment/Home Medical Equipment purchase – must be in the first field.

DME/HME – Guidelines

RR — Rental of Durable Medical Equipment/Home Medical Equipment – must be in the first field.

Modifiers that must be used in addition to NU or RR when appropriate:

UE — Used Durable Medical Equipment/Home Medical Equipment purchase.

NR — New when rented.

RA — Replacement of Durable Medical Equipment/Home Medical Equipment purchase.

RB — Replacement part of a Durable Medical Equipment/Home Medical Equipment furnished as a part of a repair.

KC — Replacement of Special Power Wheelchair interface.

GA — Limited Patient Waiver (signed by patient) on file in provider's office.

Notes for FEP

- Waivers are only accepted for “not medically necessary” DME/HME.
- Deluxe and Experimental/

Investigational DME/HME will be denied as a provider write-off even if a Limited Patient Waiver has been signed.

Modifiers must be reported for BiPAP/CPAP supplies:

EY — No physician or licensed health care provider order for this item or service.

GZ — Item or service expected to be denied as not reasonable and necessary.

KX — Requirements specified in the medical policy have been met.

Modifiers must be reported for diabetic supplies:

EY — Indicates no physician or licensed health care provider order for this item or service.

KS — For diabetic patients not treated with insulin (or receive three or less shots per day), when reporting glucose monitor (modifier NU) and other diabetes related supply codes.

KX — For diabetic patients treated with insulin (four or more shots per day), when reporting glucose monitor (modifier NU) and other diabetes related supply codes.

Reminder — File claims as quickly as possible.

Dates of Service — The date the item was dispensed/delivered is the date that should be shown on the claim form, *not* the date the item was ordered.

Units of Service

For monthly rental, units of service should equal one month (units field 24G would reflect 001).

The exceptions would be:

1. E0202, phototherapy light, units are daily.
2. The procedure codes, B4034, B4035, B4036, B4216, B4220, B4222 and B4224, require the correct number of days in the units field (i.e., 031) when using a range of dates (i.e., 1-12 through 1-31-12).

Multiple units are required in Box 24G only if more than one unit must be ordered to obtain correct quantity. For example:

- Two arm rests = 002
- 50 Test Strips = 001 (One box includes 50 test strips)

Electronically, these units would be reported in the loop and segment 2400 SV104.

Invoices should be submitted when a miscellaneous/NOC code is billed (i.e. A4421, A9900, E1399).

III. Certificate of Medical Necessity (CMN)

Certificates of Medical Necessity (CMNs) are fillable PDFs and need to be filed only with the initial claim. The following are published under the forms section on the BCBSKS website:

- Form 15-405 — For supplies/medical equipment without specific CMN
- Form 15-406 — Oxygen. This CMN is not required with the claim. It is completed by the ordering physician and maintained in file by the oxygen provider.
- Form 15-503 — Seat lift chair/patient lift and sit to stand/standing frame systems.
- Form 15-506 — Hospital Bed
- Form 15-508 — Lymphedema Compressor
- Form 15-509 — Manual Wheelchair
- Form 15-510 — Motorized Wheelchair
- Form 15-513 — Power Operated Vehicle
- Form 15-514 — Pulse Oximeter
- Form 15-515 — Support Surfaces (Mattresses and Pads)

IV. Claims Filing Guidelines

Generally, as a health care provider you should file claims for your BCBSKS patients to the local Blue Plan. However, there are unique circumstances when claims filing directions will differ based on the type of provider and service.

An ancillary provider is a Durable/Home Medical Equipment and Supplier provider. The local Blue Plan as defined for ancillary services is the Plan in the state the equipment was shipped to or purchased at a retail store. If you contract with more than one Plan in a state for the same product type (i.e., PPO or Traditional), you may file the claim with either Plan.

- The ancillary claim filing rules apply regardless of the provider's contracting status with the Blue Plan where the claim is filed. A helpful charge is located in the Professional Provider Manual, located on our website. FEP does not follow ancillary claims filing guidelines.
- Providers should use place of service 12 when equipment is shipped to the patient's home. Equipment picked up in a retail store should be submitted with place of service 99 and the retail store address must be included in box 32 and NPI in box 32a of the CMS 1500 claim form. Electronically, this information must be submitted in the 2310C Loop.
- Providers are encouraged to verify Member Eligibility and Benefits via Availity Essentials or by contacting the phone number on the back of the Member ID card or call 800-676-BLUE before providing any ancillary service.
- Providers that utilize outside vendors to provide services should utilize in-network participating in Ancillary Providers to reduce the possibility of additional member liability for covered benefits.
- Members are financially liable for ancillary services not covered under their benefit plan. It is the provider's responsibility to request payment directly from the member for non-covered services.
- If you have any questions about where to file your claim, please contact Customer Service, 800-432-3990 or 785-291-4180, or email csc@bcbsks.com.

V. Rental vs. Purchase

Purchased DME equals 10 months of rental. For rented and purchased DME equipment, and/or replacement equipment and/or parts billed, BCBSKS will look at claim history.

VI. Supply Limits

Edits are in place to set supply limits based on national standards and require the use of specific modifiers (see pages 5 and 6).

VII. Non-covered Services

Contract exclusions

This agreement excludes certain services such as professional services that the contracting provider is not licensed/certified to perform.

Member contract exclusions

Some member contracts may exclude an item or service in its entirety or parts of the service thereof. An example would be total enteral nutrition (TEN).

Indemnified amounts

Some member contracts limit the actual dollar amount that can be reimbursed for a given service. Balances on these amounts are the member's responsibility.

Deluxe features

The company will base reimbursement on the standard item, and any member's choice of deluxe features is the member's financial responsibility. The contracting provider must have the appropriate waiver signed before the service is rendered.

VIII. Member's Coverage is Terminated

If the member drops coverage or switches carriers at any time, the obligation of BCBSKS ends and the supplier can bill the patient or pick up the item or equipment.

IX. Availability of Equipment and Performance Criteria

The contracting supplier agrees to provide members with medical equipment and other supplies. Such supplies will be immediately available in the contracting supplier's warehouse. Additionally, items not routinely available will be obtained as rapidly as possible, not to exceed ten days, by the contracting supplier (unless delayed by manufacturer). Additional responsibilities include:

- A. Accept orders for medical equipment, related products and services on a 24-hour basis.

DME/HME – Guidelines

- B. Deliver and service medical equipment and related products ordered for or furnished to members.
- C. If required, perform in-service training to employees of BCBSKS to provide an understanding of the equipment and types of services provided.
- D. Maintain an adequate inventory of medical equipment and related products and supplies.
- E. The contracting supplier agrees to provide full medical liability, accident, automobile, workers compensation, comprehensive general liability and professional malpractice insurance for its employees, or to undertake the obligations for coverage which would ordinarily be contained within a standard form of such policies.
- F. Before billing for ongoing supplies and rental of DME/HME, ensure items are still in use and meet medical necessity requirements.
- G. Automatic shipment of supplies is not permitted without prior written consent of the member.

X. Billing for Compression Stockings

Please see medical policy, Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers (for Home Use), found on our website, www.bcbsks.com.

XI. DME/HME for Take-Home Use

If a prosthetic or orthotic is provided during an inpatient encounter and then subsequently taken home, the item is considered take-home DME/HME and must be billed on a CMS 1500 claim form.

BCBSKS will adhere to the following questions and answers as guidelines when determining if the DME/HME, prosthetic, or orthotic qualifies as separately billable as take-home DME/HME:

- Is the item medically necessary for use in the patient's home?
- Was the item ordered by the physician?
- Did the supplier deliver the item to the patient in the facility solely for the purpose of fitting and training of the item for use in the home?

Was the patient discharged to the patient's home and not to another facility (e.g., SNF, Rehab facility, etc.)?

XII. Rental In Lieu of Purchase

On items or equipment designated by BCBSKS, monthly rental will be allowed toward the normal retail price up to the MAP or provider's charge, whichever is less. Once rental allowables have met the purchase price, the obligations of BCBSKS and the supplier end for that item (this provision does not apply to ventilators or oxygen/oxygen equipment. Monthly rental may continue).

DME/HME PURCHASE-ONLY LIST

Note: Please use appropriate modifier when applicable.

HCPCS	Nomenclature	Guideline
E0425	Stationary compressed gas system, purchase; includes regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing	BCBSKS does not recommend purchasing oxygen systems; purchase would require review.
E0430	Portable gaseous oxygen system, purchase, includes regulator, flowmeter, humidifier, cannula or mask, and tubing	BCBSKS does not recommend purchasing oxygen systems; purchase would require review.
E0435	Portable liquid oxygen system, purchase; includes portable container, supply reservoir, flowmeter, humidifier, contents gauge, cannula or mask, tubing and refill adaptor	BCBSKS does not recommend purchasing oxygen systems; purchase would require review.
E0440	Stationary liquid oxygen system, purchase; includes use of reservoir, contents indicator, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing	BCBSKS does not recommend purchasing oxygen systems; purchase would require review.
S1030	Continuous noninvasive glucose monitoring device, purchase	Please see medical policy, Continuous Glucose Monitoring, found on our Medical Policy web page.

DME/HME – Guidelines

The following list of rental-only DME/HME needs to be monitored by our providers for not only the service component of the equipment but for the health of our members. We take the health of our members very seriously. When this equipment is rented, we know our providers are actively checking on the equipment as well as checking on our members to be sure they are using the equipment appropriately and if not, or if the patient receives medical attention, we know our providers will contact the patient's next of kin or guardian. Note: This is not an all-inclusive list.

DME/HME RENTAL-ONLY LIST

Note: Please use appropriate modifier when applicable.

HCPCS	Nomenclature	Guideline
E0424	Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing	<p>Stationary gaseous monthly service fee includes rental of equipment, and all associated supplies, and fills.</p> <p>Criteria for use:</p> <ol style="list-style-type: none">1. P02 is 60 or less on room air, or 02 sat is 89 percent or less on room air.2. Chronic obstructive lung disease <p>Limited to emphysema, chronic bronchitis and bronchiectasis (this excludes uncomplicated asthma)</p> <ol style="list-style-type: none">3. Chronic interstitial pneumonia4. Chronic interstitial pulmonary infiltrate-type pulmonary disease such as pulmonary fibrosis from extensive tuberculosis, eosinophilia granuloma, idiopathic fibrosis and pneumoconiosis5. Pulmonary hypertension6. Secondary polycythemia7. Chronic congestive heart failure8. Primary or metastatic carcinoma of the lung9. Sleep apnea with hypoxia10. Cystic fibrosis <p>All oxygen claims with diagnosis other than those listed above are to be denied due to lack of medical necessity.</p> <p>CMN 15-406 required, retain in file</p>
E0431	Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing	<p>Portable gaseous or liquid monthly service fee includes rental of equipment, and all associated supplies, and fills.</p> <p>Criteria for use:</p> <ol style="list-style-type: none">1. P02 is 60 or less on room air, or 02 sat is 89 percent or less on room air.2. Chronic obstructive lung disease <p>Limited to emphysema, chronic bronchitis and bronchiectasis (this excludes uncomplicated asthma)</p> <ol style="list-style-type: none">3. Chronic interstitial pneumonia

DME/HME RENTAL-ONLY LIST

Note: Please use appropriate modifier when applicable.

HCPCS	Nomenclature	Guideline
E0433	Portable liquid oxygen system, rental; home liquefier used to fill portable liquid oxygen containers, including portable containers, regulator, flowmeter, humidifier, cannula or mask and tubing, with or without supply reservoir and contents gauge	<p>4. Chronic interstitial pulmonary infiltrate-type pulmonary disease such as pulmonary fibrosis from extensive tuberculosis, eosinophilia granuloma, idiopathic fibrosis and pneumoconiosis</p> <p>5. Pulmonary hypertension</p> <p>6. Secondary polycythemia</p> <p>7. Chronic congestive heart failure</p> <p>8. Primary or metastatic carcinoma of the lung</p> <p>9. Sleep apnea with hypoxia</p> <p>10. Cystic fibrosis</p> <p>All oxygen claims with diagnosis other than those listed above are to be denied because of lack of medical necessity.</p> <p>CMN 15-406 required, retain in file</p>
E0434	Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge, cannula or mask, and tubing	
E0439	Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing	<p>Stationary gaseous monthly service fee includes rental of equipment, all associated supplies and fills.</p> <p>Criteria for use:</p> <ol style="list-style-type: none"> 1. P02 is 60 or less on room air, or O2 sat is 89 percent or less on room air. 2. Chronic obstructive lung disease Limited to emphysema, chronic bronchitis and bronchiectasis (this excludes uncomplicated asthma) 3. Chronic interstitial pneumonia 4. Chronic interstitial pulmonary infiltrate-type pulmonary disease such as pulmonary fibrosis from extensive tuberculosis, eosinophilia granuloma, idiopathic fibrosis and pneumoconiosis 5. Pulmonary hypertension 6. Secondary polycythemia 7. Chronic congestive heart failure 8. Primary or metastatic carcinoma of the lung 9. Sleep apnea with hypoxia 10. Cystic fibrosis <p>All oxygen claims with diagnosis other than those listed above are to be denied because of lack of medical necessity.</p> <p>CMN 15-406 required, retain in file</p>

DME/HME RENTAL-ONLY LIST

Note: Please use appropriate modifier when applicable.

HCPCS	Nomenclature	Guideline
E1392	Portable oxygen concentrator, rental	<p>Portable oxygen concentrator monthly service fee includes rental of equipment, all associated supplies and fills.</p> <p>Criteria for use:</p> <ol style="list-style-type: none"> 1. P02 is 60 or less on room air, or 02 sat is 89 percent or less on room air. 2. Chronic obstructive lung disease <ul style="list-style-type: none"> Limited to emphysema, chronic bronchitis and bronchiectasis (this excludes uncomplicated asthma) 3. Chronic interstitial pneumonia 4. Chronic interstitial pulmonary infiltrate-type pulmonary disease such as pulmonary fibrosis from extensive tuberculosis, eosinophilia granuloma, idiopathic fibrosis and pneumoconiosis 5. Pulmonary hypertension 6. Secondary polycythemia 7. Chronic congestive heart failure 8. Primary or metastatic carcinoma of the lung 9. Sleep apnea with hypoxia 10. Cystic fibrosis <p>All oxygen claims with diagnosis other than those listed above are to be denied because of lack of medical necessity.</p> <p>Portable concentrators will be allowed in lieu of the other type of oxygen systems. If member is requesting both a stationary and portable concentrator the stationary concentrator will be denied not medically necessary.</p> <p>CMN 15-406 required, retain in file</p>
K0462	Temporary replacement for patient owned equipment being repaired, any type	<p>Covered for medically necessary repairs to medically necessary equipment for 1 to 2 months. If repair takes more than 2 months, explanation is required.</p> <p>Submit itemization to include what is being repaired and the charge for each item. Indicate on claim attachment when original equipment was purchased and by whom.</p>
K0738	Portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders; includes portable containers, regulator, flowmeter, humidifier, cannula, or mask, and tubing	<p>Portable gaseous or liquid monthly service fee includes rental of equipment, and all associated supplies, and fills.</p> <p>Criteria for use:</p> <ol style="list-style-type: none"> 1. P02 is 60 or less on room air, or 02 sat is 89 percent or less on room air. 2. Chronic obstructive lung disease <ul style="list-style-type: none"> Limited to emphysema, chronic bronchitis and bronchiectasis (this excludes uncomplicated asthma) 3. Chronic interstitial pneumonia 4. Chronic interstitial pulmonary infiltrate-type pulmonary disease such as pulmonary fibrosis from extensive tuberculosis, eosinophilia granuloma, idiopathic fibrosis and pneumoconiosis 5. Pulmonary hypertension 6. Secondary polycythemia 7. Chronic congestive heart failure 8. Primary or metastatic carcinoma of the lung 9. Sleep apnea with hypoxia 10. Cystic fibrosis <p>All oxygen claims with diagnosis other than those listed above are to be denied because of lack of medical necessity.</p> <p>CMN 15-406 required, retain in file</p>
S1031	Continuous noninvasive glucose monitoring device, rental, including sensor, sensor replacement, and download to monitor	<p>Please see medical policy, Continuous Glucose Monitoring, found on our Medical Policy web page.</p>

DME/HME STRONGLY RECOMMEND PURCHASE LIST

Note: Please use appropriate modifier when applicable.

HCPCS	Nomenclature	Guideline
E0747	Osteogenesis stimulator, electrical, non-invasive, other than spinal applications	Please see medical policy, Electrical Bone Growth Stimulation of the Appendicular Skeleton, found on our Medical Policy web page.
E0748	Osteogenesis stimulator, electrical, non-invasive, spinal applications	Please see medical policy, Electrical Stimulation of the Spine as an Adjunct to Spinal Fusion Procedures, found on our Medical Policy web page.
E0760	Osteogenesis stimulator, low intensity ultrasound, non-invasive	Please see medical policy, Low Intensity Pulsed Ultrasound Fracture Healing Device, found on our Medical Policy web page.

DME/HME STRONGLY RECOMMEND RENTAL LIST

Note: Please use appropriate modifier when applicable.

HCPCS	Nomenclature	Guideline
E0202	Phototherapy (bilirubin) light with photometer	<ol style="list-style-type: none"> 1. Home phototherapy should be considered for a healthy infant (lacks major risk factors) at 37 weeks or more gestation with neonatal jaundice and a serum bilirubin level as indicated: <ol style="list-style-type: none"> a. 24 hours old with a level between 10 mg/dl to 12 mg/dl b. 48 hours old with a level between 13 mg/dl to 15 mg/dl c. 72 hours old with a level between 15 mg/dl to 17.5 mg/dl d. 96 hours old with a level between 17 mg/dl to 20 mg/dl 5 days and older with a level between 18 mg/dl to 21 mg/dl These levels are for the initial determination for initiation of therapy and do not apply to subsequent days. 2. Infants with levels greater than those listed above consider hospitalization for phototherapy, as well as infants with major risk factors as listed: <ol style="list-style-type: none"> a. Jaundice observed in the first 24 hours or, b. Blood group incompatibility with positive direct antiglobulin test, other known hemolytic disease (e.g. G6PD deficiency) or, c. Gestational age 35-36 weeks or less. 3. Bilirubin level: <ol style="list-style-type: none"> a. Done at 72 hours of age on all infants at risk. b. Done daily if the level is climbing. c. Done at least every 48 hours when the bilirubin is dropping or stable. 4. Home health nurse visit for bilirubin levels blood draws is not medically necessary with home phototherapy. Training/instructions on the proper use of home phototherapy equipment is the responsibility of the vendor and is not separately reimbursable. If billed, this service/charge will be denied as not medically necessary. <p>DOCUMENTATION -- Medical record must contain information surrounding co-morbidities, gestational age, weight and feeding history for BCBSKS Medical Director or consultant to make a determination.</p>
E0465	Home ventilator, any type, used with invasive interface (e.g. tracheostomy tube)	BCBSKS does not recommend purchase of oxygen systems. Use appropriate rental HCPCS code. CMN 15-406 required must be submitted with claim.
E0466	Home ventilator, any type, used with noninvasive interface (e.g. mask, chest shell)	BCBSKS does not recommend purchase of oxygen systems. Use appropriate rental HCPCS code. CMN 15-406 required must be submitted with claim.
E0467	Home ventilator, multi-function respiratory device, also performs any or all of the additional functions of oxygen concentration, drug nebulization, aspiration, and cough stimulation, including all accessories, components and supplies for all functions	Please see medical policy, Home Non-invasive Positive Airway Pressure Devices for the Treatment of Respiratory Insufficiency and Failure, found on our Medical Policy web page.
E0935	Passive motion exercise device (CPM) knee only	Please see medical policy, Continuous Passive Motion in the Home Setting, found on our Medical Policy web page.

DME/HME STRONGLY RECOMMEND RENTAL LIST

Note: Please use appropriate modifier when applicable.

HCPCS	Nomenclature	Guideline
E0936	Passive motion exercise device (CPM) other than knee	<p>Please see medical policy, Continuous Passive Motion in the Home Setting, found on our Medical Policy web page.</p>
E1390	Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate	<p>Oxygen concentrator monthly service fee includes rental of equipment, and all associated supplies, and fills.</p> <p>Criteria for use:</p> <ol style="list-style-type: none"> 1. P02 is 60 or less on room air, or 02 sat is 89 percent or less on room air. 2. Chronic obstructive lung disease <p>Limited to emphysema, chronic bronchitis and bronchiectasis (this excludes uncomplicated asthma)</p> 3. Chronic interstitial pneumonia 4. Chronic interstitial pulmonary infiltrate-type pulmonary disease such as pulmonary fibrosis from extensive tuberculosis, eosinophilia granuloma, idiopathic fibrosis and pneumoconiosis 5. Pulmonary hypertension 6. Secondary polycythemia 7. Chronic congestive heart failure 8. Primary or metastatic carcinoma of the lung 9. Sleep apnea with hypoxia 10. Cystic fibrosis <p>All oxygen claims with diagnosis other than those listed above are to be denied because of lack of medical necessity.</p> <p>CMN 15-406 required, retain in file</p>
E1391	Oxygen concentrator, dual delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate	<p>Oxygen concentrator monthly service fee includes rental of equipment, and all associated supplies, and fills.</p> <p>Criteria for use:</p> <ol style="list-style-type: none"> 1. P02 is 60 or less on room air, or 02 sat is 89 percent or less on room air. 2. Chronic obstructive lung disease <p>Limited to emphysema, chronic bronchitis and bronchiectasis (this excludes uncomplicated asthma)</p> 3. Chronic interstitial pneumonia 4. Chronic interstitial pulmonary infiltrate-type pulmonary disease such as pulmonary fibrosis from extensive tuberculosis, eosinophilia granuloma, idiopathic fibrosis and pneumoconiosis 5. Pulmonary hypertension 6. Secondary polycythemia 7. Chronic congestive heart failure 8. Primary or metastatic carcinoma of the lung 9. Sleep apnea with hypoxia 10. Cystic fibrosis
E1405	Oxygen and water vapor enriching system with heated delivery	
E1406	Oxygen and water vapor enriching system without heated delivery	<p>All oxygen claims with diagnosis other than those listed above are to be denied because of lack of medical necessity.</p> <p>CMN 15-406 required, retain in file</p>
E2402	Negative pressure wound therapy electrical pump, stationary or portable	<p>Please see medical policy, Vacuum Assisted Wound Closure (VAC), found on our Medical Policy web page.</p>

DME/HME – Guidelines

For BCBSKS members, the following DME/HME items are considered deluxe. The allowance for each item will be based on the standard equipment. The amount over the maximum allowable payment for the standard equipment will be considered patient responsibility. A Limited Patient Waiver is needed on file, and GA modifier should be used when submitting a claim.

Note – FEP providers should submit the base rate of the item on line 1 and the deluxe amount on line 2.

DELUXE LIST (NOT an all-inclusive list)

HCPCS	Nomenclature
A4210	Supplies for self-administered injections
A4670	Automatic blood pressure monitor
E0118	Crutch Substitute, lower leg platform, with or without wheels, each
E0265	Hospital bed, total electric (head, foot and height adjustments), with any type of side rails, with mattress
E0266	Hospital bed, total electric (head, foot and height adjustments), with any type of side rails, without mattress
E0296	Hospital bed, total electric (head, foot and height adjustments), without side rails, with mattress
E0297	Hospital bed, total electric (head, foot and height adjustments), without side rails, without mattress
E0462	Rocking bed, with or without side rails
E0574	Ultrasonic/electronic aerosol generator with small volume nebulizer
E0575	Nebulizer, ultrasonic, large volume
E0604	Breast pump, hospital grade, electric (AC and/or DC), any type
E0635	Patient lift, electric, with seat or sling
E0636	Multi-positional patient support system, with integrated lift, patient accessible controls
E0840	Traction frame, attached to headboard, cervical traction
E0849	Traction equipment, cervical, free-standing stand/frame, pneumatic, applying traction force to other than mandible
E0850	Traction stand, freestanding, cervical traction
E0855	Cervical traction equipment not requiring additional stand or frame
E0856	Cervical traction device, cervical collar with inflatable air bladder
E1230	Power operated vehicle (3- or 4-wheel non-highway), specify brand name and model number
E1310	Whirlpool, non-portable (built-in type)
E2214	Manual wheelchair accessory, pneumatic caster tire, any size, each
E2381	Power wheelchair accessory, pneumatic drive wheel tire, any size, replacement only, each
E2382	Power wheelchair accessory, tube for pneumatic drive wheel tire, any size, replacement only, each
E2383	Power wheelchair accessory, insert for pneumatic drive wheel tire (removable), any type, any size, replacement only, each
E2384	Power wheelchair accessory, pneumatic caster tire, any size, replacement only, each
E2385	Power wheelchair accessory, tube for pneumatic caster tire, any size, replacement only, each

DELUXE LIST (NOT an all-inclusive list)

HCPCS	Nomenclature
K0010	Standard-weight frame motorized/power wheelchair
K0011	Standard-weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking
K0012	Lightweight portable motorized/power wheelchair
K0014	Other motorized/power wheelchair base
L2780	Addition to lower extremity orthotic, non-corrosive finish, per bar
L5856	Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing and stance phase, includes electronic sensor(s), any type
L6920	Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal switch, cables, 2 batteries and 1 charger, switch control of terminal device
L6925	Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal electrodes, cables, 2 batteries and one charger, myoelectric control of terminal device
L6930	Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal switch, cables, 2 batteries and one charger, switch control of terminal device
L6935	Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal electrodes, cables, 2 batteries and one charger, myoelectric control of terminal device
L6940	Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, Otto Bock or equal switch, cables, 2 batteries and one charger, switch control of terminal device
L6945	Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, Otto Bock or equal electrodes, cables, 2 batteries and one charger, myoelectric control of terminal device
L6950	Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, Otto Bock or equal switch, cables, 2 batteries and one charger, switch control of terminal device
L6955	Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, Otto Bock or equal electrodes, cables, 2 batteries and one charger, myoelectric control of terminal device
L6960	Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal switch, cables, 2 batteries and one charger, switch control of terminal device
L6965	Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal electrodes, cables, 2 batteries and one charger, myoelectric control of terminal device
L6970	Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal switch, cables, 2 batteries and one charger, switch control of terminal device
L6975	Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal electrodes, cables, 2 batteries and one charger, myoelectric control of terminal device
L7007	Electric hand, switch or myoelectric controlled, adult
L7008	Electric hand, switch or myoelectric, controlled, pediatric
L7170	Electronic elbow, Hosmer or equal, switch controlled

DELUXE LIST (NOT an all-inclusive list)

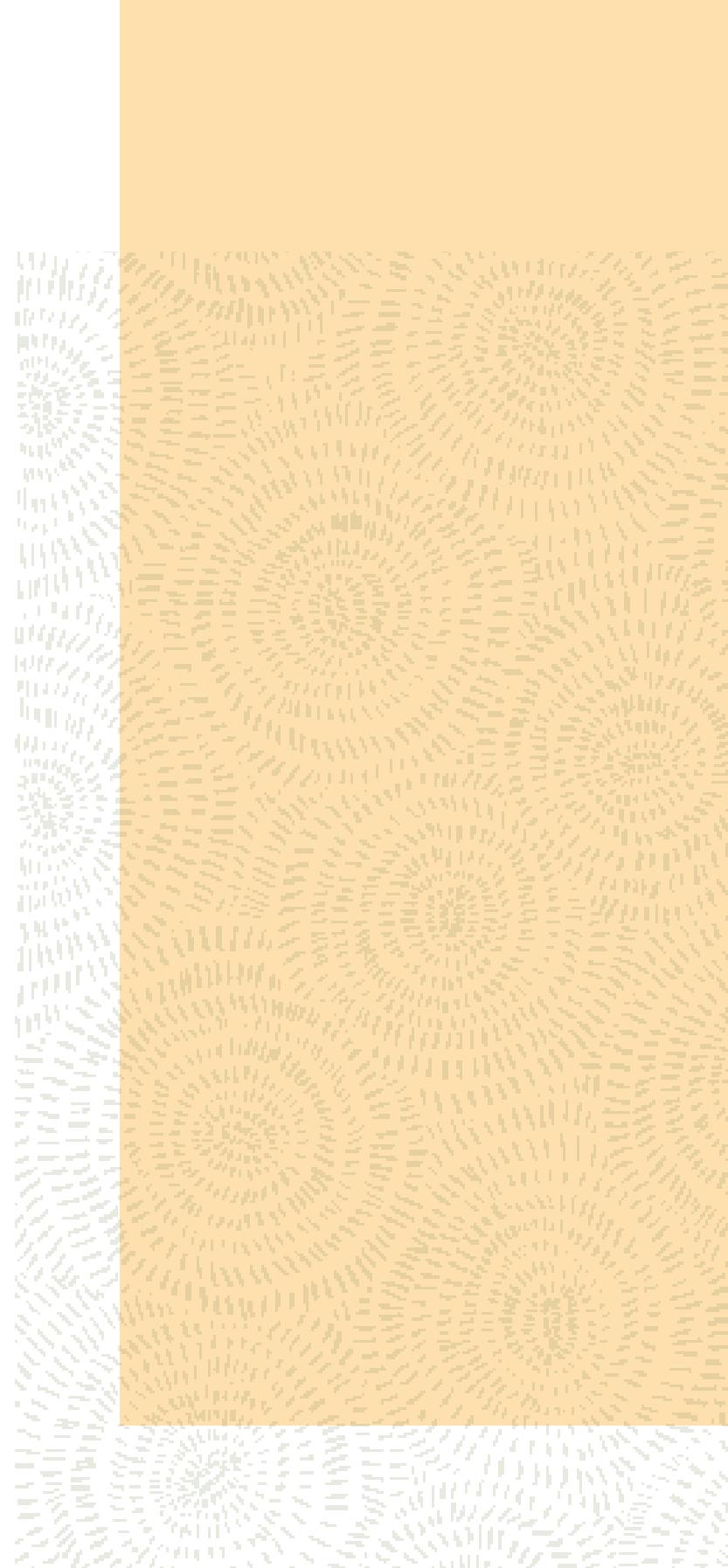
HCPCS	Nomenclature
L7180	Electronic elbow, microprocessor sequential control of elbow and terminal device
L7185	Electronic elbow, adolescent, Variety Village or equal, switch controlled
L7186	Electronic elbow, child, Variety Village or equal, switch controlled
L7190	Electronic elbow, adolescent, Variety Village or equal, myoelectrically controlled
L7191	Electronic elbow, child, Variety Village or equal, myoelectrically controlled
L7900	Male vacuum erection system, battery operated

MISCELLANEOUS SUPPLIES (NOT an all-inclusive list)

ALLOWED CODES	CODES DENIED CONTENT OF SERVICE
A4310	A4332
A4311	A4310, A4332, A4338
A4312	A4310, A4332, A4344
A4313	A4310, A4332, A4346
A4314	A4310, A4311, A4331, A4332, A4338, A4354, A4357
A4315	A4310, A4312, A4331, A4332, A4344, A4354, A4357
A4316	A4310, A4313, A4331, A4332, A4346, A4354, A4357
A4354	A4310, A4331, A4332, A4357
A4357	A4331
A4358	A4331, A5113, A5114
A5105	A4331, A4358, A5112, A5113, A5114
A5112	A5113, A5114

Revisions

01/01/2019	Redesigned manual. Page 6 – Updated to include box 32a instructions and Availability link.
04/14/2020	Page 16 – Removed code E0603 from Deluxe List.
09/11/2020	Page 4- Updated Modifiers KS and KX
12/17/2020	Page 14 – Updated code E1392
01/01/2021	Reviewed – No changes
01/01/2022	Reviewed – No changes
01/01/2023	Page 7 – Updated section V. Claims Filing Guidelines, first bullet, FEP information added
06/28/2023	Page 9 – Updated Purchase Only list - Added codes E0425, E0430, E0435, E0440, E0760, S1030 Page 12 – Updated Rental-Only list – Removed codes E0425, E0430, E0435, E0440 and added code S1031
08/01/2023	Pages 9-18 – Updated Rental and Purchase Only lists, along with adding a Recommend Purchase and Recommend Rental lists.
01/01/2024	Reviewed – No changes
01/01/2025	Reviewed – No changes
01/01/2026	Removed links throughout Page 5 – Added Pre-certification information and removed predetermination information Page 7 – Removed Case Management information Page 10 – Updated Supply Limits section Page 11 – Added Non-covered Services, Member's Coverage is Terminated and Availability and Performance Criteria sections Page 11 – Updated Billin for Compression Stockings to refer to medical policy for specifics Page 12 – Added Rental in Lieu of Purchase section Page 14 to 24 – Updated all DME/HME lists to refer to medical policies for specifics



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