



Durable Medical Equipment/ Home Medical Equipment



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Table of Contents

| | | |
|-------|--|----|
| I. | Predetermination of Service or Item..... | 3 |
| II. | Coding Your Claim | 4 |
| III. | Certificate of Medical Necessity (CMN) | 5 |
| IV. | Case Management | 6 |
| V. | Claims Filing Guidelines..... | 7 |
| VI. | Rental vs. Purchase | 7 |
| VII. | Supply Limits | 8 |
| VIII. | Billing for Compression Stockings..... | 8 |
| IX. | DME/HME for Take-Home Use | 9 |
| | DME/HME Purchase-Only List..... | 10 |
| | DME/HME Rental-Only List..... | 11 |
| | Deluxe List..... | 17 |
| | Miscellaneous Supplies..... | 19 |
| | Revisions..... | 20 |

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NOTE — The revision date appears in the footer of the document. Links within the document are updated as changes occur throughout the year.

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 Policy Memo No. 1 [Limited Patient Waiver](#).
2. The service or item is too costly for the patient to bear the 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

BlueCard Predeterminations

When the patient has coverage through another Blue Plan there are two steps to the predetermination process:

1. Contact the member's Home Plan to determine the member's health insurance benefits. The Home Plan must provide the benefits in writing.
2. After verifying DME/HME coverage for the member, submit to BCBSKS a copy of the benefits attached to the [Predetermination Request Form](#) to request the write-off amount for the particular piece of equipment or service. BCBSKS will respond in writing.

All of the above information must be attached to the claim form when submitting for payment.

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.

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 3 or less shots per day), when reporting glucose monitor (modifier NU) and other diabetes related supply codes.

KX — For diabetic patients treated with insulin (4 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., 1-1-12 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. They are available at bcbsks.com. Following are links to each of the CMNs:

[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. Case Management

Case management is a voluntary program for the management of severe injuries, catastrophic illnesses and some chronic conditions by a team of professionals who can collaborate with the patient and/or physician regarding the efficient use of benefits and may provide information on cost effective alternatives.

It is a program that assists the patient and family with complex health care decisions, with no additional cost to the patient for the service.

Why is case management important?

Through case management, current and future health care needs can be evaluated. The program also coordinates services for:

- Traditional intermittent home health care.
- Specialty home care services such as infusion therapy and respiratory care support.
- Durable Medical Equipment/Home Medical Equipment needed to provide care in the home.
- Other alternative care services.

It has access to networks of providers and vendors to conserve resources and can identify information about community resources and support groups.

The case management program may negotiate special rates on home health care, medical equipment, rehabilitation services, etc., and can determine how to best allocate benefit resources.

Examples that may benefit from the program:

- High-risk pregnancies
- Mental illness/substance abuse
- Multiple traumas
- Organ transplants
- Spinal cord injuries
- Strokes
- Premature infants
- AIDS
- Brain injuries

For more information about case management services, call 785-291-6628 in Topeka or 800-432-3990 ext. 6628. FEP members, call 800-782-4437 ext. 6611.

V. Claims Filing Guidelines

Generally, as a health care provider you should file claims for your Blue Cross and Blue Shield 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 on page 25 of the [Professional Provider Manual](#).
- 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.com](#) 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 Ancillary Providers to reduce the possibility of additional member liability for covered benefits. A list of in-network participating providers may be obtained at <https://bcbsks.vitalschoice.com/>.
- 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.

VI. Rental vs. Purchase

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

VII. 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).

VIII. Billing for Compression Stockings

Prescription grade compression stockings — pre- or custom-made pressure gradient support stockings (e.g., Jobst, Sig Varus, Venes, Juzo, etc.) that have pressure of 18-30 mmHg or more and require a physician's prescription — are considered medically necessary for members who have any of the following medical conditions:

1. Treatment of any of the following complications of chronic venous insufficiency:
 - Varicose veins (except spider veins)
 - Stasis dermatitis (venous eczema)
 - Venous ulcers (stasis ulcers)
 - Venous edema
 - Lipodermatosclerosis
2. Prevention of thrombosis in immobilized persons (e.g., immobilization because of surgery, trauma, general debilitation, etc.)
3. Post thrombotic syndrome (post-phlebitic syndrome)
4. Selected persons with chronic lymphedema
5. Edema following surgery, fracture, burns, or other trauma
6. Post-sclerotherapy
7. Postural hypotension
8. Severe edema in pregnancy
9. Edema accompanying paraplegia, quadriplegia, etc.

Compression garments for the legs are considered experimental and investigational for all other indications not listed above.

Stockings of less than 18 mmHG are considered non-covered whether purchased with a prescription or over the counter.

IX. 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.)?

DME/HME PURCHASE-ONLY LIST

| HCPCS | Nomenclature | Guideline |
|-------|---|---|
| E0747 | Osteogenesis stimulator, electrical, non-invasive, other than spinal applications | <p>Covered if one of the following is applicable to the case:</p> <ol style="list-style-type: none"> 1. Non-invasive electrical bone growth stimulation is considered medically necessary for the treatment of fracture and osteotomy non-union of long bones after at least 3 months of fracture care. (Long bones as defined as the clavicle, humerus, radius, ulna, femur, tibia, fibula, metacarpal and metatarsal). 2. Non-invasive electrical bone growth stimulation is considered medically necessary as a treatment for congenital (infantile) pseudoarthrosis in the appendicular skeleton (the appendicular skeleton includes the bones of the shoulder girdle, upper extremities, pelvis and lower extremities). 3. Noninvasive electrical bone growth stimulation is considered medically necessary for the treatment of fracture non-union of the scaphoid or navicular bones after at least 3 months of fracture care. 4. Non-invasive electrical bone growth stimulation is considered medically necessary for the treatment of joint fusion secondary to failed arthrodesis of the ankle, knee or foot. <p>The application of electric bone growth stimulation is considered not medically necessary for the treatment of fresh fractures, delayed union fractures, or any other indications not listed above.</p> <p>There may be times that a physician intraoperatively determines that the bone quality, blood supply or other factors may exist that would prevent healing of the fracture or osteotomy site and may require a stimulator. The medical necessity can be reviewed post-operatively based on the operative note or other documentation that supports medical need.</p> |
| E0748 | Osteogenesis stimulator, electrical, non-invasive, spinal applications | <p>Non-invasive methods of electrical bone growth stimulation are considered medically necessary as an adjunct to spinal fusion surgery for individuals at high risk for pseudoarthrosis (fusion failure) including, but not limited to, those with one or more of the following risk factors:</p> <ol style="list-style-type: none"> 1. One or more previous failed spinal fusion(s) 2. Grade III or worse spondylolisthesis 3. Fusion to be performed at more than one level 4. Current smoking habit 5. Diabetes 6. Renal disease 7. Alcoholism 8. Medically significant steroid use <p>Non-invasive electrical bone growth stimulation is considered medically necessary as a treatment for individuals with failed spinal fusion. Failed spinal fusion is defined as a spinal fusion which has not healed for a minimum of six months after the original surgery.</p> |

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

| 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 <p style="margin-left: 20px;">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.</p> 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 on a daily basis 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> |

DME/HME RENTAL-ONLY LIST

| 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 O2 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 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 due to lack of medical necessity.</p> <p>CMN 15-406 required, retain in file</p> |
| E0425 | Stationary compressed gas system, purchase; includes regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing | BCBSKS does not purchase oxygen systems. Use appropriate rental HCPCS code. |
| E0430 | Portable gaseous oxygen system, purchase, includes regulator, flowmeter, humidifier, cannula or mask, and tubing | BCBSKS does not purchase oxygen systems. Use appropriate rental HCPCS code. |
| 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 O2 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> |

DME/HME RENTAL-ONLY LIST

| HCPCS | Nomenclature | Guideline |
|-------|---|---|
| E0433 | Portable liquid oxygen system, rental; home liquefier used to fill portable liquid oxygen containers, includes portable containers, regulator, flowmeter, humidifier, cannula or mask and tubing, with or without supply reservoir and contents gauge | <ol style="list-style-type: none"> 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> |
| E0434 | Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge, cannula or mask, and tubing | |
| 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 purchase oxygen systems. Use appropriate rental HCPCS code. |
| 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, 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 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

| HCPCS | Nomenclature | Guideline |
|-------|--|---|
| E0440 | Stationary liquid oxygen system, purchase; includes use of reservoir, contents indicator, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing | BCBSKS does not purchase oxygen systems. Use appropriate rental HCPCS code. |
| E0465 | Home ventilator, any type, used with invasive interface (e.g. tracheostomy tube) | BCBSKS does not purchase 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 purchase oxygen systems. Use appropriate rental HCPCS code. CMN 15-406 required, must be submitted with claim. |
| E0935 | Passive motion exercise device (CPM) knee only | See Medical Policy, Continuous Passive Motion in the Home Setting . |
| E0936 | Passive motion exercise device (CPM) other than knee | See Medical Policy, Continuous Passive Motion in the Home Setting . |
| E1390 | Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate | Oxygen concentrator monthly service fee includes rental of equipment, and all associated supplies, and fills. Criteria for use: <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 |
| E1391 | Oxygen concentrator, dual delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate | All oxygen claims with diagnosis other than those listed above are to be denied because of lack of medical necessity. CMN 15-406 required, retain in file |

DME/HME RENTAL-ONLY LIST

| HCPCS | Nomenclature | Guideline |
|-------|--|--|
| E1392 | Portable oxygen concentrator, rental | <p>Portable 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 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. 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. CMN 15-406 required, retain in file</p> |
| E1405 | Oxygen and water vapor enriching system with heated delivery | <p>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 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. CMN 15-406 required, retain in file</p> |
| E1406 | Oxygen and water vapor enriching system without heated delivery | <p>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 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. CMN 15-406 required, retain in file</p> |
| E2402 | Negative pressure wound therapy electrical pump, stationary or portable | See Medical Policy, Vacuum Assisted Wound Closure (VAC) . |
| K0462 | Temporary replacement for patient owned equipment being repaired, any type | Covered for medically necessary repairs to medically necessary equipment for 1 to 2 months. If repair takes more than 2 months, explanation is required. 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. |

DME/HME RENTAL-ONLY LIST

| HCPCS | Nomenclature | Guideline |
|-------|--|--|
| 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 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. CMN 15-406 required, retain in file</p> |

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 side rails, with mattress |
| E0266 | Hospital bed, total electric (head, foot, and height adjustments), with any type 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 |

DELUXE LIST (NOT an all-inclusive list)

| HCPCS | Nomenclature |
|-------|--|
| 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 |
| 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, myoelectronic 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, myoelectronic 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, myoelectronic 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, myoelectronic 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, myoelectronic 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 |

DELUXE LIST (NOT an all-inclusive list)

| HCPCS | Nomenclature |
|-------|--|
| 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, myoelectronic 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 |
| 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, myoelectronically controlled |
| L7191 | Electronic elbow, child, Variety Village or equal, myoelectronically 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

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|------------|---|
| 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 |



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