REIMBURSEMENT POLICY

DME and Supplies

Active

Policy Number: Durable Medical Equipment - 001
Policy Title: DME and Supplies
Section: DME
Effective Date: 06/09/16

Description

The following policy addresses Blue Cross and Blue Shield of Minnesota's (Blue Cross) durable medical equipment (DME) and supply requirements.

Definitions

Blue Cross defines DME and supplies as items deemed necessary for the treatment of an illness or injury.

DME are further defined as equipment and related health care items and services that are:

- able to withstand repeated use; and
- used primarily for a medical purpose; and
- generally, not useful in the absence of illness or injury; and
- determined to be reasonable and necessary; and
- prescribed by a practitioner operating within the scope of his/her license; and
- represents the most cost-effective alternative.

Supplies are normally items that are designed for a single use only.

Policy Statement

DME Coding

DME suppliers and others who bill DME or supply items should use the appropriate HCPCS level II codes describing the item.

If the supply is furnished during the same visit as an evaluation and management (E/M) service, the supply is normally part of the E/M and will be denied as incidental to the E/M.

Unlisted codes, such as E1399 and K0108, should be used ONLY when there is no code listed in the HCPCS manual for the equipment. Do not use this code for supplies or equipment that can be coded with a specific code or combination of codes.

Unlisted codes (such as K0108 or E1399) require submission of a narrative describing the equipment along with the Manufacturers Suggested Retail Price (MSRP).

Additional identification of the product or supply can be entered in the electronic claim in the NTE segment:

- 837P: Loop 2400, Segment NTE
- 837I: Loop 2300, Segment NTE

Breast Pumps
E0602, manual breast pumps and **E0603,** personal electric breast pumps, are purchase only. The purchase of an electric breast pump is limited to one every three years. Bill with modifier NU. The DME provider is responsible for repairs or replacement during the one year warranty.

E0604, heavy-duty hospital grade electric breast pumps are rental only. Bill with modifier RR. Bill accessory kits for E0604 breast pumps with modifier RA. The rental period of heavy-duty hospital grade electric breast pumps (E0604) is three months. The DME provider is responsible for repairs or replacement during the rental period.

DME Rental Guidelines
The cumulative DME rental allowance will not exceed the then-current Blue Cross fee schedule purchase allowance. No additional claims for rental or purchase of the same device should be submitted after the Blue Cross allowed amount for the purchase price of that item has been met.

The following items are rental only:

- Ventilators
- Negative-pressure ventilators
- CPM machines
- Oximeters
- Airway-pressure monitors oxygen concentrators
- Hospital grade electric breast pumps

Rental Unit Submission
Service counts must be submitted on a monthly basis only and generally submitted as one (1) service per month, instead of 30 units or services. Do not submit claims for more than a thirty-day supply of any related supplies. Rental is on a monthly basis only.

Coding Modifiers
Blue Cross requires all DME providers to submit procedure code modifiers to differentiate rental, purchase and repair or replacement of DME. Modifiers include the following:

Rental Modifiers:

- BR The beneficiary has been informed of the purchase and rental options and has elected to rent the item
- LL Lease/rental (Use the LL modifier when DME equipment rental is to be applied against the purchase price)
- RR Rental (Use the RR modifier when DME is to be rented)

Purchase Modifiers:

- BP The beneficiary has been informed of the purchase and rental options and has elected to purchase the item
- NR New when rented. (Use the NR modifier when DME which was new at the time of rental is subsequently purchased. Providers should bill the purchase price of the equipment.)
- NU New equipment
- RA Replacement of a DME, orthotic or prosthetic item
- RB Replacement of a part of DME, orthotic or prosthetic item furnished as part of a repair

Note: The modifiers BU or UE are not recognized in processing.

Supply Coding

Supply items should be submitted with the HCPCS Level II code that most appropriately describes the item. Unlisted supply codes should be used only if there is no other code that describes the item. A narrative must be submitted with every unlisted code.

Supplies are generally allowed separately only in conjunction with approved home health care. Reimbursement for supplies used in the office is already included in the overhead component of the professional service (such as an E/M). Office supplies, such as, but not limited to, Betadine or alcohol wipes, will be denied.

Payment for supplies is based per narrative description (for example, each, per pair, per 100, etc.). It is necessary to identify the total number of each supply in the "units" field of the 837P claim format.

It is important to assure the units submitted correctly correspond to the code chosen to ensure appropriate reimbursement. For example, disposable gloves can be reported per 100 (a single box) or per pair. Code A4927 reflects billing per 100. HCPCS code A4930 reflects billing per pair. The unit descriptions for each code differ significantly.

Following are the narratives for each glove code along with a unit coding example:

- Code: A4927 Narrative: Glove, non-sterile, per 100
  Unit example: One 100-count box of non-sterile gloves, submit one (1) unit in the units field on the 837P claim format.
- Code: A4930 Narrative: Gloves, sterile, per pair
  Unit example: One 100-count box of sterile gloves, submit 50 units in the units field on the 837P claim format.

Gloves are restricted to home use only (for approved home health, home infusion, or home dialysis services). Eligibility for reimbursement is subject to subscriber benefits.

The following quantities of ostomy and urology-related supplies are considered to be reasonable for a monthly (30-day) period. When quantities in excess of these amounts are supplied to the same patient for use during the same month, the claim(s) must contain an explanation of the medical necessity for such quantities. If the documentation is not on the claim, there may be a delay in processing the claim or the claim may be denied.

- Indwelling catheters - two per month
- Catheter insertion trays - two per month
- Sterile irrigation tray/kit - four per month
- Irrigation syringe, bulb or piston - four per month
- Bottles of irrigation solution - four per month
- Bedside drainage bags - four per month
- Leg drainage bags - four per month
- Bedside drainage bottle, rigid or expendable - one per month
- Leg strap, foam or fabric - one per month
- Urinary catheters (straight catheter) - 31 per month
- Ostomy Pouches - 70 per month

If a subscriber signs a waiver accepting responsibility for supplies billed in excess of recommended guides, bill two lines of service. The first line will include the HCPCS supply code and the second line should be submitted with the same HCPCS code with a –GA modifier. See "Waivers and Upgraded/Deluxe DME" for additional waiver sample and submission information.

Claims Filing Requirements

1. Use the 837P electronic claim format to report your services to Blue Cross.
2. Submit ICD-10-CM codes to report an appropriate diagnosis for your patient.
3. Use HCPCS level II codes to report your services.
4. Appropriate modifiers are required to indicate rental or purchase of DME, for example, NU, RR.
5. The place of service must be a valid CMS two-digit place of service code.
6. Submit units based on narrative description

Waivers and Upgraded/Deluxe DME

The following is Blue Cross' policy for provision of upgraded or deluxe equipment. This policy does not apply to Minnesota Health Care Program subscribers because only medically necessary DME may be provided and billed to these subscribers.

Providers may bill subscribers for an equipment upgrade or deluxe charge if a waiver is on file and the DME charges are billed correctly to Blue Cross. Blue Cross will continue to reimburse only for medically necessary standard DME. Providers must ask for a signed, written waiver that includes the cost for the deluxe features or upgrade. (A sample waiver form follows.)

The waiver must state ALL of the following:

- The standard piece of equipment or least costly alternative was offered to the subscriber; and
- The subscriber is aware and agrees that Blue Cross will only pay the standard allowance; and
- The subscriber will be responsible for the deluxe or upgrade charge in addition to his or her contractual obligation

Providers must keep all signed waivers on file. Do not send waiver forms to Blue Cross. Blue Cross reserves the right to request waiver forms from a provider's office when necessary.

Waiver Claim Submission

Two lines of services must be billed. The first line will include the HCPCS code and the charge for the standard (non-deluxe) equipment with the GK modifier (in addition to any other appropriate modifier). This dollar amount will be subject to contract benefits and allowed amounts.

The second line must include the same HCPCS code with the –**GA** modifier (waiver of liability statement issued as required by payer policy, individual case) and the amount charged for the upgrade or deluxe feature.

For example:

- E0202 NU GK $550.00 (standard, charge that will be subject to standard allowance and subscriber contract benefits)
- E0202 GA $150.00 (deluxe/upgrade charge that will be denied as subscriber liability)

The **-GA** modifier must be submitted as the first modifier on the second service line. Other applicable modifiers should be submitted on the first service line only.

Sample Waiver Form

As a participating provider with Blue Cross, we are obligated to notify you of services that are medically unnecessary. This notification will allow us to hold you financially responsible for the upgrade to the DME that you are purchasing.

> We have offered you the standard _____
> (list type of equipment)
> at the customary price of $_____.
>
> We have informed you of the least costly alternative, which is the charge for the upgrade or deluxe features is $_____.
>
> By signing and dating this waiver, you are acknowledging that:
>
> - You are aware of and agree that Blue Cross will allow only standard equipment.
> - Only the allowed amount for the standard equipment will apply to deductible and coinsurance amounts.
> - You will be financially responsible for the deluxe or upgrade charge.
> - The upgrade charge is in addition to any contractual obligations you have such as deductible and coinsurance amounts.
>
> Signature_____Date: _____

Sales Tax

Sales tax should generally be included in your charge for the item and not reported separately. If submitted, sales tax must be reported using code S9999 for the tax and must be billed on the same claim as the related taxable service. Code S9999 will be denied as provider liability.

Handling/Conveyance

Handling, conveyance, and/or any other service in connection with the implementation of an order involving devices (code 99002) is not separately reimbursable. These charges should be included in the charge for the item.

DME/Supply Internet Purchases
DME or supplies purchased from Internet auction sites (such as e-Bay) or private parties are generally not covered. If a DME supply company is the actual supplier, that provider's number will be assigned and the claim will be processed per the subscriber's benefits. If the provider is not a DME/supply company (for example, private party, estate sale), the claim will be denied.

Ineligible Items
The following lists of some items that are considered ineligible DME. There is no need to submit pre-authorization requests for ineligible items. Note: This is not an all-inclusive list

• Abdominal support belts for pregnant women	• Drionic devices (sweating devices)	• Positioning aids (for example, bolsters, wedges)
• Adaptive eating equipment • Air conditioners • Air filters • Back huggers • Balls for therapy • Bedpans and urinals • Biofeedback device, purchase • Blood pressure cuffs and accessories • Car seats • Computer software & hardware • Copes scoliosis brace total recovery program • Croup tent • Cryocuff (icing device)	• Elevators/stairlifts • Exercise equipment (for example, bicycles, tricycles, treadmills and ski machines) • Feeding chairs • Floor sitters • Formula, infant • Grab bars • Heating pads • Home monitors • Incontinence supplies (for example, diapers, underpants and underpads, such as the product Attends) • Lifeline medical alert • Maternity belts • Overbed tables	• Reachers • Roman chairs • Scales • Telephone communication device (TTDY) [teletypewriter device] • Thera cane • Tub stool or bench • Vehicle modifications (hand controls, lifts and car seats) • Vitrectomy, seated support system (special chair for eye surgery patients) • Wheelchair vehicle lift/ramps • Whirlpools/ Jacuzzi/hot tubs

Reimbursement of Unlisted Codes

Provider agrees to use unlisted procedure codes only when no code exists for the service being provided. Reimbursement for unlisted codes will be determined on one of the following methodologies:

- Allowance of similar code
- Percentage of Provider's Regular Billed Charge (55% of charge for Commercial and 35% of charge for Medicare)
- Invoice cost.

Medicare Advantage Policy and Medicare Cost Plan

Medicare Advantage DME Rental Guidelines

Medicare Advantage DME claims are subject to Original Medicare claims processing supplier guidelines. The total number of months of capped rental DME payment is based on the date of service of the initial capped rental. In all instances, when billing capped rentals, use the modifiers as outlined in Medicare's claims processing manuals.

- For capped rentals, Blue Cross will reimburse monthly rental claims of continuous use for *13 months*. The option to purchase at the 10th month of rental no longer applies. After 13 months of continuous rental, ownership of the equipment is transferred to the subscriber. The first three rental months will be reimbursed based on the fee schedule amount. For the remaining rental months, the fee schedule amount will be reduced by 25 percent. For oxygen, see Reimbursement Policy- DME-002 – Oxygen Aiding Equipment.
- Electric wheelchairs are an exception to this process. A purchase option must be given to the subscriber at the time the electric wheelchair is first provided, regardless of the initial date of service. Blue Cross recommends a pre-authorization be completed for all wheelchair purchases. If the subscriber chooses to rent and not purchase the electric wheelchair at the time the item is provided, the length of rental (13 or 15 months) is dependent upon the date of the initial rental.
- In accordance with Medicare, maintenance and service will be allowed on capped rental and where the subscriber chose the rental option only. Providers should bill for maintenance and services using the appropriate HCPCS code and the modifier –MS.
- For capped rentals bill for replacement or repair using modifier RA or RB with the HCPCS code for the item serviced.
- RA Replacement of a DME, orthotic or prosthetic item.
- RB Replacement of a part of DME, orthotic or prosthetic item furnished as part of a repair.

Documentation Submission

Documentation must identify and describe the DME or supply item supplied prescribed to the subscriber. The necessity for the item need must also be documented.

Coverage

Coverage for DME and supplies are subject to the subscriber's contract benefits.

The following applies to all claim submissions.

All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in Provider Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be reimbursed according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated, if appropriate, using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only, and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement.

CPT/HCPCS Modifier:	BP, BR, BU, GA, GK, LL, NR, NU, RA, RB, RR, MS, UE
ICD Diagnosis:	N/A
ICD Procedure:	N/A
HCPCS:	A4206-A9999, E0100-E8002, K0001- K1012, L0112- L9900, S9999, 99002
Revenue Codes:	N/A
Deleted Codes:	N/A

Policy History

Initial Committee Approval Date:	June 9, 2016
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Cross Reference:	DME: Oxygen Aiding Equipment 002 DME: DME Repairs, Maintenance, and Replacement 003 DME: Passive Motion and NPWT Billing 004 DME: Medicare Guides for DME in SNF or NF 005 DME: DME and Specialty Pharmacy 006 DME: Hearing Aids 007