2024 Manual

Durable Medical Equipment/ Home Medical Equipment

BlueCross BlueShield Kansas

bcbsks.com

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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 in the Professional Provider Manual, located on our website, https://www.bcbsks.com/providers/professional/publications/manuals. 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.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 possibly 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

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 purchase of 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 purchase of 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 purchase of 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 purchase of oxygen systems; purchase would require review.
S1030	Continuous noninvasive glucose monitoring device, purchase	A. Individuals with Type 1 Diabetes 1. Long-term continuous glucose monitoring (CGM) device monitoring of glucose levels in interstitial fluid, as a technique of diabetic monitoring, may be considered medically necessary when the following situations occur, despite use of best practices: a. Individuals with type 1 diabetes who have demonstrated an understanding of the technology, are motivated to use the device correctly and consistently, are expected to adhere to a comprehensive diabetes treatment plan supervised by a qualified provider, and are capable of using the device to recognize alerts and alarms, OR b. Individuals with type 1 diabetes who have recurrent, unexplained, severe (generally blood glucose levels less than 50 mg/dL) hypoglycemia or impaired awareness of hypoglycemia that puts the patient or others at risk; OR c. Individuals with poorly controlled type 1 diabetes who are pregnant. Poorly controlled type 1 diabetes includes unexplained hypoglycemic episodes, hypoglycemic unawareness, suspected postprandial hyperglycemia, and recurrent diabetic ketoacidosis; OR d. Individuals with type 1 diabetes who have recurrent diabetic ketoacidosis (DKA) requiring emergency room visits and admissions 2. Short-term continuous glucose monitoring, of glucose levels in interstitial fluid may be considered medically necessary in individuals with type 1 diabetes whose

DME/HME PURCHASE-ONLY LIST

Note: Please use appropriate modifier when applicable.

HCPCS	Nomenclature	Guideline
		diabetes is poorly controlled, despite current use of best practices (see Policy Guidelines). Poorly controlled type 1 diabetes includes the following clinical situations: a. Unexplained hypoglycemic episodes b. Hypoglycemic unawareness c. Suspected postprandial hyperglycemia; and d. Recurrent diabetic ketoacidosis. B. Individuals with Type 2 Diabetes 1. Long-term continuous glucose monitoring of glucose levels in interstitial fluid may be considered medically necessary in individuals with type 2 diabetes when: a. Patients who are willing and able to use the device; AND b. Patients who have adequate medical supervision; AND c. Patients who experience significant hypoglycemia on 4 or more daily doses of insulin or on an insulin pump in the setting of insulin deficiency. 2. Short-term continuous glucose monitoring of glucose levels in interstitial fluid may be considered medically necessary in individuals with type 2 diabetes who require multiple daily doses of insulin whose diabetes is poorly controlled, despite current use of best practices (see Policy Guidelines Section). Poorly controlled type 2 diabetes includes the following clinical situations: a. Unexplained hypoglycemic episodes OR b. Hypoglycemic unawareness OR c. Persistent hyperglycemia OR d. A1c levels above target 3. Short-term continuous glucose monitoring of glucose levels in interstitial fluid may be considered medically necessary in individuals with type 2 diabetes who require multiple daily doses of insulin to determine basal insulin levels prior to insulin pump initiation. C. Other uses of long-term or and short-term continuous glucose monitoring of glucose levels in interstitial fluid as a technique of diabetic monitoring, including use in gestational diabetes, are considered experimental / investigational. D. The use of implantable CGM devices is considered experimental / investigational.

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	Stationary gaseous monthly service fee includes rental of equipment, and all associated supplies, and fills. Criteria for use: 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 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 All oxygen claims with diagnosis other than those listed above are to be denied due to lack of medical necessity. CMN 15-406 required, retain in file
E0431	Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing	Portable gaseous or liquid monthly service fee includes rental of equipment, and all associated supplies, and fills. Criteria for use: 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 Limited to emphysema, chronic bronchitis and bronchiectasis (this excludes uncomplicated asthma) 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, includes portable containers, regulator, flowmeter, humidifier, cannula or mask and tubing, with or without supply reservoir and contents gauge	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 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
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	Stationary gaseous monthly service fee includes rental of equipment, and all associated supplies, and fills. Criteria for use: 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 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 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

Note: Please use appropriate modifier when applicable.

HCPCS	Nomenclature	Guideline
E1392	Portable oxygen concentrator, rental	Portable oxygen concentrator monthly service fee includes rental of equipment, and all associated supplies, and fills. Criteria for use: 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 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 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
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.
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	Portable gaseous or liquid monthly service fee includes rental of equipment, and all associated supplies, and fills. Criteria for use: 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 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 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.
S1031	Continuous noninvasive glucose monitoring device, rental, including sensor, sensor replacement, and	A. Individuals with Type 1 Diabetes 1. Long-term continuous glucose monitoring (CGM) device monitoring of glucose levels in interstitial fluid, as a technique of diabetic monitoring, may be considered medically necessary when the following situations occur, despite use of best practices: a. Individuals with type 1 diabetes who have demonstrated an understanding of the technology, are motivated to use the device correctly and consistently, are expected

DME/HME RENTAL-ONLY LIST

Note: Please use appropriate modifier when applicable.

HCPCS	Nomenclature	Guideline
	download to monitor	to adhere to a comprehensive diabetes treatment plan supervised by a qualified provider, and are capable of using the device to recognize alerts and alarms, OR b. Individuals with type 1 diabetes who have recurrent, unexplained, severe (generally blood glucose levels less than 50 mg/dL) hypoglycemia or impaired awareness of hypoglycemia that puts the patient or others at risk; OR c. Individuals with poorly controlled type 1 diabetes who are pregnant. Poorly controlled type 1 diabetes includes unexplained hypoglycemic episodes, hypoglycemic unawareness, suspected postprandial hyperglycemia, and recurrent diabetic ketoacidosis; OR d. Individuals with type 1 diabetes who have recurrent diabetic ketoacidosis (DKA) requiring emergency room visits and admissions 2. Short-term continuous glucose monitoring, of glucose levels in interstitial fluid may be considered medically necessary in individuals with type 1 diabetes whose diabetes is poorly controlled, despite current use of best practices (see Policy Guidelines). Poorly controlled type 1 diabetes includes the following clinical situations: a. Unexplained hypoglycemic episodes b. Hypoglycemic unawareness c. Suspected postprandial hyperglycemia; and d. Recurrent diabetic ketoacidosis. B. Individuals with Type 2 Diabetes 1. Long-term continuous glucose monitoring of glucose levels in interstitial fluid may be considered medically necessary in individuals with type 2 diabetes when: a. Patients who are willing and able to use the device; AND b. Patients who have adequate medical supervision; AND c. Patients who experience significant hypoglycemia on 4 or more daily doses of insulin or on an insulin pump in the setting of insulin deficiency. 2. Short-term continuous glucose monitoring of glucose levels in interstitial fluid may be considered medically necessary in individuals with type 2 diabetes who require multiple daily doses of insulin whose diabetes is poorly controlled, despite current use of best practices (see Policy Guidelines Section). Poorly controlled type 2 diabetes includes the following clinical situations: a. Unexplained hypoglycemic episodes OR b. Hypoglycemic unawareness OR c. Persistent hyperglycemia OR d. A1c levels above target 3. Short-term continuous glucose monitoring of glucose levels in interstitial fluid may be considered medically necessary in individuals with type 2 diabetes who require multiple daily doses of insulin to determine basal insulin levels prior to insulin pump initiation. C. Other uses of long-term or and short-term continuous glucose monitoring of glucose levels in interstitial fluid as a technique of diabetic monitoring, including use in gestational diabetes, are considered experimental / investigational. D. The use of implantable CGM devices is considered experimental / investigational.

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	Covered if one of the following is applicable to the case: 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 nece4ssary 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. 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. 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.
E0748	Osteogenesis stimulator, electrical, non-invasive, spinal applications	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: One or more previous failed spinal fusion(s) Grade III or worse spondylolisthesis Fusion to be performed at more than one level Current smoking habit Diabetes Renal disease Alcoholism Medically significant steroid use 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.
E0760	Osteogenesis stimulator, low intensity ultrasound, non-invasive	A. Low-intensity pulsed ultrasound is considered not medically necessary as a treatment of fresh fractures (surgically managed or nonsurgically managed). B. Low-intensity pulsed ultrasound is considered not medically necessary as a treatment of fracture nonunion and delayed union fractures. Low-intensity pulsed ultrasound is considered not medically necessary as a treatment of stress fractures, osteotomy, and distraction osteogenesis.

DME/HME STRONGLY RECOMMEND RENTAL LIST

Note: Please use appropriate modifier when applicable.

HCPCS	Nomenclature	Guideline
E0202	Phototherapy (bilirubin) light with photometer	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: 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: 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: 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. **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.
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, includes all accessories, components and supplies for all functions	BCBSKS does not recommend purchase of oxygen systems. Use appropriate rental HCPCS code. CMN 15-406 required, must be submitted with claim.

DME/HME STRONGLY RECOMMEND RENTAL LIST

Note: Please use appropriate modifier when applicable.

HCPCS	Nomenclature	Guideline
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: 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 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 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
E1391	Oxygen concentrator, dual 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: 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 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 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
E1405	Oxygen and water vapor enriching system with heated delivery	
E1406	Oxygen and water vapor enriching system without heated delivery	

DME/HME STRONGLY RECOMMEND RENTAL LIST

Note: Please use appropriate modifier when applicable.

HCPCS	Nomenclature	Guideline
E2402	Negative pressure wound therapy electrical pump, stationary or portable	See Medical Policy, Vacuum Assisted Wound Closure (VAC).

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
E2384	Power wheelchair accessory, pneumatic caster tire, any size, replacement only, each

DELUXE LIST (NOT an all-inclusive list)

HCPCS	Nomenclature
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
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

DELUXE LIST (NOT an all-inclusive list)

HCPCS	Nomenclature
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

01/01/2019	Redesigned manual.
	Page 6 – Updated to include box 32a instructions and Availity 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

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