Billing Guidelines for:

33 Durable Medical Equipment (DME), Disposable and Prosthetics

Durable Medical Equipment (DME) is medical equipment that can withstand repeated use. Disposable medical supplies are not reusable. DME and disposable supplies are usually used to serve a medical purpose related to an illness or injury.

For all items, the least cost alternative must be used.

Prior authorization requests and provider records must fully support the medical necessity of all items billed.

Refer to MSM Chapter 1300 for complete DME program requirements. State policy for dispensing and delivery of items/supplies is in MSM Chapter 1300, sections 1301.2 and 1301.3.

Covered / Non-Covered Items

Covered and non-covered codes are listed in the DME Fee Schedule. Non-covered codes have "999" in the "Flag Code" column. All other listed codes are covered.

New Codes

New 2006 HCPCS codes covered effective January 1, 2006 are below. Refer to a HCPCS book or the CMS website at www.cms.hhs.gov for code descriptions.

A4218	A6540	E2218	L0628	L3763	L5971
A4363	A6541	E2219	L0629	L3764	L6621
A4411	A6542	E2220	L0630	L3765	L6677
A4412	A6543	E2221	L0631	L3766	L6883
A4604	A6544	E2222	L0632	L3905	L6884
A5120	A6549	E2223	L0633	L3913	L6885
A5512	E0705	E2224	L0634	L3919	L7400
A5513	E0911	E2225	L0635	L3921	L7401
A6457	E0912	E2226	L0636	L3933	L7402
A6513	E2207	E2371	L0637	L3935	L7403
A6530	E2208	E2372	L0638	L3961	L7404
A6531	E2209	L0491	L0639	L3967	L7405
A6532	E2210	L0492	L0640	L3971	L7600
A6533	E2211	L0621	L0859	L3973	L8623
A6534	E2212	L0622	L2034	L3975	L8624
A6535	E2213	L0623	L2387	L3976	K0730
A6536	E2214	L0624	L3671	L3977	
A6537	E2215	L0625	L3672	L3978	
A6538	E2216	L0626	L3673	L5703	
A6539	E2217	L0627	L3702	L5858	

Deleted Codes

HCPC codes that are not billable effective January 1, 2006 are:

A4254	E1210	K0106	K0635	K0647	L8140
A5119	E1211	K0452	K0636	K0648	L8150
A5509	K0064	K0618	K0637	K0649	L8160
A5511	K0066	K0619	K0638	K0671	L8170
A6551	K0067	K0620	K0639	L0860	L8180
E0972	K0068	K0628	K0640	L1750	L8190
E1001	K0074	K0629	K0641	L2039	L8195
E1019	K0075	K0630	K0642	L3963	L8200
E1021	K0076	K0631	K0643	L8100	L8220
E1025	K0078	K0632	K0644	L8110	L8230
E1026	K0102	K0633	K0645	L8120	L8239
E1027	K0104	K0634	K0646	L8130	

Prior Authorization Requirements

Prior authorization (PA) requirements are shown in the "PA Type" column on the fee schedule. In the "PA Type" column:

- "00" means that PA is not required.
- "01" means that PA is always required.
- "02" means that PA is required to exceed the service limitations.

On the fee schedule, service limits are listed for some codes (see the "Limits" column). If you have questions regarding a particular code and its service limits are not listed in the fee schedule, refer to State policy in MSM Chapter 1300 or call the Prior Authorization Department at (800) 525-2395 for assistance.

Submitting Your Request

The recommended way to submit a PA request is through our Online Prior Authorization System (OPAS) at https://hcm.fhsc.com. When submitting suporting medical documentation online, you must indicate the name and credentials of the provider who supplied the information. A request can also be submitted by fax or mail using form FH-1.

It is critical that you submit complete and accurate clinical documentation when requesting a PA. Documentation must fully support medical necessity of the item.

See MSM Chapter 1300, Appendix B for specific documentation requirements or contact the Prior Authorization Department at (800) 525-2395.

Use the OPAS or form FH-1 to request **continued services for CPAP devices** no sooner than 61 days and no later than 120 days after initiation of therapy. Attach form FH-1A or a physician's note containing 1) the hours a day the machine is used, 2) the number of months the recipient has used the machine, 3) whether the recipient will continue to use the machine and 4) the name of the person who answered these questions (it can not be the DME supplier). You may enter information from FH-1A or the physician's note directly into OPAS as long as the name and credientials of the provider are stated.

Use the OPAS or form FH-1 to request **continued services for BIPAP devices** no sooner than 61 days and no later than 120 days after initiation of therapy. Attach form FH-1A or a physician's note containing a signed and dated statement declaring that 1) the recipient is compliantly using the device an average of 4 hours per 24 hour period and 2) that the recipient is benefiting from its use.

Enteral Nutrition

State policy for enteral nutrition supplies and equipment is in MSM Chapter 1300, section 1303.2.

When billing code B4150, **do not span more than one month on a claim line**. Please note that this also applies to claims with Third Party Liability (TPL) and you may need to bill Medicaid differently than you billed the primary payor. The exception to this is Medicare. If Medicare is the primary payor, you may bill Medicaid the same as you billed Medicare, i.e., spanning months on the same claim line is acceptable.

For the following codes, 1 unit equals 100 calories. Enter the appropriate number of units in Field 24G on the CMS-1500 claim form.

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

If a **Gastrostomy diagnosis** (ICD-9 code V44.1 or V55.1) is entered in Field 21 of the CMS-1500 claim form, PA is not required for enteral nutrition codes B4150, B4152, B4153, B4154 and B4155. This change was effective January 1, 2006.

Catheter/tube anchoring devices (code A5200) and **dressings used in conjunction with a gastrostomy or enterostomy tube** (code A4462) are included in the supply kit codes B4034-B4036 and should not be billed separately.

An **enteral feeding supply kit; gravity fed** (code B4035) is limited to 31 units per month (1 unit equals 1 day). When billing code B4035 follow these instructions:

- **Billing Code B4035 for a Partial Month**

  Enter the first date of the billing cycle as the From date in Field 24A. Enter the same date in the To area of Field 24A. Enter the correct number of units you are billing for in Field 24G (one unit per day). For example, to bill for March 12–31, enter a From date of March 12 and a To date of March 12. Then, enter 20 in Field 24G.

  The From and To dates must always be in the same month on a given claim line.

- **Billing Code B4035 for Continued Services**

  The following billing scenario shows you how to bill continuing services from February 3 to July 7.

  Your billing frequency for continuing services must be every 31 days.

a) **You begin your billing cycle on February 3.** February has 28 days in it, so 31 days from February 3 would be March 5. March 5 will be the last day of your billing cycle. On the claim form, enter "February 3" (the first day of the billing cycle) as the From date and as the To date (Field 24A). Enter "31" in Field 24G.

b) **The next 31-day billing cycle would start on March 6.** March has 31 days in it, so 31 days from March 6 would be April 5. April 5 will be the last day of your billing cycle. On the claim form, enter "March 6" (the first day of the billing cycle) as the From date and as the To date (Field 24A). Enter "31" in Field 24G.

c) **The next 31-day billing cycle would start on April 6.** April has 30 days in it, so 31 days from April 6 would be May 6. May 6 will be the last day of your billing cycle. On the claim form, enter "April 6" (the first day of the billing cycle) as the From date and as the To date (Field 24A). Enter "31" in Field 24G.

d) **The next 31-day billing cycle would start on May 7.** May has 31 days in it, so 31 days from May 7 would be June 6. June 6 will be the last day of your billing cycle. On the claim form, enter "May 7" (the first day of the billing cycle) as the From date and as the To date (Field 24A). Enter "31" in Field 24G.

e) **The next 31-day billing cycle would start on June 6.** June has 30 days in it, so 31 days from June 6 would be July 7. July 7 will be the last day of your billing cycle. On the claim form, enter "June 6" (the first day of the billing cycle) as the From date and as the To date (Field 24A). Enter "31" in Field 24G.

Additional Notes

Intravenous therapy supplies (including all HCPCS "S" codes listed on the DME Fee Schedule) are billed through the DME program (provider type 33, not provider type 37).

Diabetic supplies are billed via the pharmacy program (provider type 28).

Effective January 1, 2006, use code B4086 with modifier BA to bill for a MIC-KEY® Low-Profile Gastrostomy Feeding Tube (**MIC-KEY Button**) and code B9998 to bill for extension sets. When billing for any **other type of Gastrostomy Feeding Tube**, it is required to use HCPCS code B4086 without a modifier. PA is required to exceed 1 unit every 3 months.