

Title: DME Continuous Rental
Policy #: RB.007.B
Type: Claim Payment
Sub-Type: RB (Reimbursement)

Original Implementation Date: 11/1/2015
Version [B] Effective Date: 5/25/2018
Last Reviewed: 2/2/2018
Notification Release: 3/26/2018

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PRODUCT VARIATIONS

This policy applies only to those Health Partners Plan product lines checked below.

Please note that differences may exist between product lines. When variations exist, they will be summarized in the table below and — if necessary — explained in greater detail in appropriate sections of this policy bulletin document.

<input checked="" type="checkbox"/> Medicaid	Policy applies to Health Partners (Medicaid).
<input checked="" type="checkbox"/> Medicare	Where Medicare coverage documents address services/conditions, they supersede this policy. For Medicare products, Medicare guidance documents (Internet-only manuals, national and local coverage determinations) supersede this policy.
<input checked="" type="checkbox"/> CHIP	Policy applies to KidzPartners.

NOTE: This policy only applies when a specific HPP medical necessity policy addressing the item/service does not exist.

POLICY STATEMENT

The intent of this Claim Payment Policy Bulletin is to explain our position on durable medical equipment (DME) rentals and to communicate the Health Partners Plans (HPP) list of DME items that are rented on a continuous basis and not subject to a rent-to-purchase cap limit.

- All DME rental items require prior authorization to establish medical necessity.
- The DME items listed in this policy are rented on a continuous basis and are not subject to a rent-to-purchase maximum.

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POLICY GUIDELINES

DME is a covered service according to the individual's eligibility and HPP benefit plan. DME may be eligible for reimbursement consideration when ordered by a physician, considered a medically necessary treatment, and provided by an eligible DME provider.

As determined by HPP and based on contracts, DME items may be:

- purchased without a rental period
- rented until the rental cost of the item equals the purchase price
- always rented on a continuous basis

CODING

Inclusion of a code in this section does not imply reimbursement. Eligibility, benefits, limitations, exclusions, precertification/referral requirements, provider contracts may apply.

The codes that may be listed below are updated on a regular basis, in accordance with nationally accepted coding guidelines. Therefore, this policy applies to any and all future applicable coding changes, revisions, or updates. In order to ensure optimal reimbursement, all health care services, devices, and pharmaceuticals should be reported using the billing codes and modifiers that most accurately represent the services rendered.

The coding table that follows only lists HCPCS codes related to this specific policy.

HCPCS Code	Description
B9000	Enteral nutrition infusion pump - without alarm
B9002	Enteral nutrition infusion pump - with alarm
E0193	Powered air flotation bed (low air loss therapy)
E0194	Air fluidized bed
E0371	Nonpowered advanced pressure reducing overlay for mattress, standard mattress length and width
E0372	Powered air overlay for mattress, standard mattress length and width
E0373	Nonpowered advanced pressure reducing mattress
E0424	Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
E0431	Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing
E0434	Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge, cannula or mask, and tubing

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HCPCS Code	Description
E0439	Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, & tubing
E0443	Portable oxygen contents, gaseous, 1 month's supply = 1 unit
E0445	Oximeter device for measuring blood oxygen levels non-invasively
E0465	Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)
E0466	Home ventilator, any type, used with non-invasive interface, (e.g., mask, chest shell)
E0471	Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)
E0472	Respiratory assist device, bi-level pressure capability, with backup rate feature, used with invasive interface, e.g., tracheostomy tube (intermittent assist device with continuous positive airway pressure device)
E0604	Breast pump, hospital grade, electric (ac and / or dc), any type
E0619	Apnea monitor, with recording feature
E0675	Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or bilateral system)
E1353	Regulator (Included with oxygen authorization)
E1390	Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate
E1391	Oxygen concentrator, dual delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate, each
E1392	Portable oxygen concentrator, rental
E1405	Oxygen and water vapor enriching system with heated delivery
E1406	Oxygen and water vapor enriching system without heated delivery
E2402	Negative pressure wound therapy electrical pump, stationary or portable
K0455	Infusion pump used for uninterrupted parenteral administration of medication, (e.g., epoprostenol or treprostinol)
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

BENEFIT APPLICATION

Medical policies do not constitute a description of benefits. This medical necessity policy assists in the administration of the member's benefits which may vary by line of business. Applicable benefit documents govern which services/items are eligible for coverage, subject to benefit limits, or excluded completely from coverage. This policy is invoked only when the requested service is an eligible benefit as defined in the Member's applicable benefit

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contract on the date the service was rendered. Services determined by the Plan to be investigational or experimental, cosmetic, or not medically necessary are excluded from coverage for all lines of business.

DESCRIPTION OF SERVICES

DME is equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally not useful in the absence of illness or injury, and appropriate for use in the home

CLINICAL EVIDENCE

N/A

DEFINITIONS

N/A

DISCLAIMER

Approval or denial of payment does not constitute medical advice and is neither intended to guide nor influence medical decision making.

POLICY HISTORY

This section provides a high-level summary of changes to the policy since the previous version.

Summary	Version	Version Effective Date
New policy bulletin. Please note that this was originally identified as Policy Bulletin #00-04.	A	11/1/2015
E0470 - Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device), aka "BiPap", <u>no longer eligible</u> for rental on a continuous basis and is now subject to a rent-to-purchase maximum (10 months).	B	5/25/2018

REFERENCES

- <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf>