Priority Health	BILLING POLICY No. 017

MISCELANEOUS DURABLE MEDICAL EQUIPMENT

Date of origin: Aug. 2024	Review dates: 10/2024, 11/2024, 1/2025, 2/2025

APPLIES TO*

- Commercial
- Medicare follows CMS unless otherwise stated
- Medicaid follows MDHHS unless otherwise stated

**Except for Hearing aid and cochlear implant replacement parts and accessories. See that section for specific plan details.*

DEFINITION

This policy identifies the payment and documentation requirements associated with various durable medical equipment (DME) items.

MEDICAL POLICY

- Durable Medical Equipment (#91110) – reference for coverage details

DOCUMENTATION REQUIREMENTS

We align with the Centers for Medicare & Medicaid Services (CMS) standard documentation requirements for supplies and DME. Reference CMS Article A55426 – Standard Documentation Requirements for All Claims Submitted to DME MACs for documentation requirements.

NAVIGATE POLICY-SPECIFIC INFORMATION

WHEELCHAIR OPTIONS AND ACCESSORIES

- Up to two batteries with code E2359, E2361, E2363, E2365, E2371 or K0733 at any one time are allowed.
- A non-sealed battery with code E2358, E2360, E2362, E2364 or E2372 will be denied.
- A single mode battery charger (E2366) is appropriate for charging a sealed lead acid battery. If a dual mode battery charger (E2367) is provided as a replacement, it will be denied as not reasonable and necessary.

WHEELCHAIR SEATING

- A powered seat cushion (E2610) hasn't been proven effective. This will be denied.
- Pediatric seating system codes E2291, E2292, E2293, E2294 may only be billed with pediatric wheelchair base codes.
- A manual swingaway (E1028) should not be reported in addition to E0960 for mounting hardware.
- Wheelchair seat and back cushion codes are all-inclusive. Use of HCPCS codes to separately bill for added components such as the foam blocks, gel packs, air cells or equivalent material is incorrect coding.
- The right (RT) and left (LT) modifiers must be used when applicable.

WALKERS

A walker with an enclosed frame (E0144) hasn't been identified as medically necessary. If an enclosed frame walker is provided, it will be denied.

Brakes other than hand operated brakes, provided at the same time as a walker (E0141, E0143, E0149), may not be billed separately. However, if billed separately upon initial issue, the brakes must be billed using A9900, and the brakes will deny as not separately payable. HCPCS code E0159 (Brake attachment for wheeled walker, replacement, each) is applicable for replacement brakes only.

A Column II code is included in the allowance for the corresponding Column I code when provided at the same time and must not be billed separately at the time of billing the Column I code.

Column I	Column II
E0130	A4636, A4637
E0135	A4636, A4637
E0140	A4636, A4637, E0155, E0159
E0141	A4636, A4637, E0155, E0159
E0143	A4636, A4637, E0155, E0159
E0144	A4636, A4637, E0155, E0156, E0159
E0147	A4636, E0155, E0159
E0148	A4636, A4637
E0149	A4636, A4637, E0155, E0159

HEARING AID AND COCHLEAR IMPLANT REPLACEMENT PARTS AND ACCESSORIES

Applies to:

- Commercial, except for Cochlear implants, limits may be subject to Hearing Rider language. Some items are considered not covered per the Hearing Rider language.
- Medicaid, Priority Health follows limits outlined by MDHHS.

Policy details:
Below are specified limits that Priority Health will apply to supplies, parts and replacement parts for hearing aids and cochlear implants. Authorization rules may apply.

Anatomical modifiers to describe specific side of the body will be required.

Item	Maximum limit
Battery - Alkaline (CPT L8622)	150 per 6 months (per device)
Battery - Zinc Air (CPT L8621)	150 per 6 months (per device)
Battery - Lithium Ion (CPT L8623/L8624)	2 per year (per device)
Battery Charger (CPT L8625)	1 per 2 years (per device)
External Controller (CPT L8628)	1 per 4 years (per device)
Sound/Speech Processor (CPT L8627)	1 per 4 years (per device)
Speech Processor and Controller- Integrated (CPT L8619)	1 per 4 years (per device)
Microphone (CPT L8616)	1 per year (per device)
Headpiece/Headset (CPT L8615)	1 per 3 years (per device)
Transmitter Cable (CPT L8618)	1 per year (per device)
Transmitter Coil (CPT L8617)	1 per 3 years (per device)
Transmitting Coil and Cable - Integrated (CPT L8629)	1 per 3 years (per device)
Disposable Battery (CPT V5266)	36 per day (per aid) up to 72 per year (per aid)
Auditory osseointegrated device, external sound processor,excludes transducer/actuator, replacement only, each (L8691)	1 per 4 years
Auditory osseointegrated device, external sound processor, used without osseointegration, body worn, includes headband or other means of external attachment (L8692)	1 per 4 years

HOSPITAL BEDS AND ACCESSORIES

When mattress or bedside rails are provided at the same time as a hospital bed, use the single code that combines these items.

Examples:

- When E0271, E0272: Mattress, innerspring/foam rubber is combined with E0251, bill as E0250
- When E0305, E0310: Bedside rails, half-length/full-length is combined with E0297, bill as E0266

A Column II code is included in the allowance for the corresponding Column I code when provided at the same time and must not be billed separately at the time of billing the Column I code.

Column I	Column II
E0250	E0271, E0272, E0305, E0310
E0251	E0305, E0310
E0255	E0271, E0272, E0305, E0310
E0256	E0305, E0310
E0260	E0271, E0272, E0305, E0310
E0261	E0305, E0310
E0265	E0271, E0272, E0305, E0310
E0266	E0305, E0310
E0290	E0271, E0272
E0292	E0271, E0272
E0294	E0271, E0272
E0296	E0271, E0272
E0301	E0305, E0310

E0302	E0305, E0310
E0303	E0271, E0272, E0305, E0310
E0304	E0271, E0272, E0305, E0310
E0328	E0271, E0272, E0305, E0310
E0329	E0271, E0272, E0305, E0310

PLACE OF SERVICE

Review specific information regarding DME place of service billing requirements in our Durable Medical Equipment (DME) place of services (POS) billing policy.

MODIFIERS

As indicated in our Durable Medical Equipment medical policy, the below modifiers will be required:

HCPCS modifiers

- **KX modifier**: Modifier should be appended to indicate that policy criteria has been met for all wheelchair DME items (includes base, seating, power devices, and additional accessories). Claims reported without KX modifier will deny as non-payable per medical policy. (Commercial, Medicaid products)

- **KX, GA, GY, GZ modifiers**: Per CMS local coverage determinations, one of these modifiers are required for claim processing all wheelchair DME items (includes base, power bases, seating, and additional accessories). See more information about this modifiers in our Provider Manual.

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

Change / review history

Date	Update(s) made
Sept. 10, 2024	Added "Wheelchair seating" section
Oct. 3, 2024	Added "Hearing aid and cochlear implant replacement parts and accessories" section. *Note: The limits will apply to commercial products on Dec. 23, 2024. They already apply to Medicaid.*
Nov. 8, 2024	• Updated "Applies to" section to note that Medicare follows CMS and Medicaid follows MDHHS, unless otherwise stated • Added "Hospital beds and accessories" section • Added "Place of service" section
Jan. 14, 2025	Added limit information for L8691 and L8692
Feb. 5, 2025	Added "Disclaimer" section