Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 9: Durable Medical Equipment (DME)

Effective July 1, 2023

Link: Look for possible **updates and corrections** to these payment policies on L&I's website.

Table of Contents

Definitions

The following terms are utilized in this chapter and are defined as follows:

Bundled codes: Are procedure codes that are not separately payable because they are accounted for and included in the payment of other procedure codes and services.

Pharmacy and DME providers can bill HCPCS codes listed as bundled on the fee schedules because, for these provider types, there's not an office visit or a procedure into which supplies and/or equipment can be bundled.

Link: For the legal definition of Bundled codes, see WAC 296-20-01002.

By Report (BR): A code listed in the fee schedule as BR doesn't have an established fee because the service is too unusual, variable, or new. When billing for the code, the provider must provide a report that defines or describes the services or procedures. The insurer will determine an appropriate fee based on the report.

Link: For the legal definition of By Report, see WAC 296-20-01002.

Durable medical equipment (DME): DME means equipment that:

- Can withstand repeated use, *and*
- Is primarily and customarily used to serve a medical purpose, *and*
- Generally isn't useful to a person in the absence of illness or injury, *and*
- Is appropriate for use in the client's place of residence.

Supplies used during or immediately after surgery and not sent home with the worker don't meet the definition of DME and won't be reimbursed as DME.

Pneumatic compression devices: Pneumatic compression devices, sometimes referred to as vasopneumatic devices, are comprised of inflatable garments for the arms or legs and an electrical pneumatic pump that fills the garments with compressed air. The garments intermittently inflate and deflate with cycle times and pressures that vary. The Food and Drug Administration (FDA) classifies these devices as Cardiovascular Therapeutic Devices, Compressible limb sleeve.

Portable oxygen systems: Portable oxygen systems, sometimes referred to as ambulatory systems, are lightweight (less than 10 pounds) and can be carried by most patients. These systems may be appropriate for patients with stationary oxygen systems who are ambulatory within the home and occasionally go beyond the limits of the stationary system tubing. Some portable oxygen systems, while lighter in weight than stationary systems, aren't designed for patients to carry.

- Small gas cylinders are available as portable systems. Some are available that weigh less than five pounds.
- Portable liquid oxygen systems that can be filled from the liquid oxygen reservoir are available in various weights.

Stationary oxygen systems: Stationary oxygen systems include gaseous oxygen cylinders, liquid oxygen systems, and oxygen concentrators.

- Oxygen gas cylinders contain oxygen gas stored under pressure in tanks or cylinders.
- Liquid oxygen systems store oxygen in a reservoir as a very cold liquid that converts to gas when released from the tank. Liquid oxygen is more expensive than compressed gas, but takes up less space and can be transferred more easily to a portable tank.
- Oxygen concentrators are electric devices that extract oxygen from ambient air and compress it to 85% or greater concentration. A backup oxygen cylinder is used in the event of a power failure for patients on continuous oxygen using concentrators.

Modifiers

The following CPT®, HCPCS, and/or local code modifiers apply to this chapter:

–NU (New purchased DME)

Use the **–NU** modifier when a new DME item is to be purchased.

–RR (Rented DME)

Use the **–RR** modifier when DME is to be rented.

–LT (Left side)

Although this modifier doesn't affect payment, it should be used when billing for bilateral services. This will help reduce duplicate bills and minimize payment delays.

–RT (Right side)

Although this modifier doesn't affect payment, it should be used when billing for bilateral services. This will help reduce duplicate bills and minimize payment delays.

Payment policy: Hot or cold therapy DME

Services that can be billed

Ice cap or collar (HCPCS code **A9273**) is payable for **DME** providers only and is **bundled** for all other provider types.

Services that aren't covered

Hot water bottles, heat and/or cold wraps aren't covered.

Hot or cold therapy **DME** isn't covered. Examples include heat devices for home use, including heating pads. These devices either aren't covered or are **bundled**.

Cryotherapy **DME** with or without compression used in a clinical setting aren't payable separately. These modalities are considered to be **bundled** into existing physical medicine services billable under CPT® **97010** and **1044M**. HCPCS code **E1399** isn't appropriate for cryotherapy **DME** in any setting.

Link: For more information, see WAC 296-20-1102.

Payment limits

Application of hot or cold packs (CPT® code **97010**) is **bundled** for all providers.

Payment policy: Oxygen and oxygen equipment

Requirements for billing

Pharmacies and **DME** providers must bill their usual and customary charge for supplies and equipment with appropriate HCPCS and local codes.

Delivery charges, shipping and handling, tax, and fitting fees aren't payable separately. Include these charges in the total charge for the supply.

Link: For more information on purchasing or renting **DME**, see WAC 296-20-1102.

Services that can be billed

To bill for oxygen, if the worker owns a:

- **Portable oxygen system**, bill using either **E0443** (gaseous contents) or **E0444** (liquid contents), *or*
- **Stationary oxygen system**, bill using either **E0441** (gaseous contents) or **E0442** (liquid contents).

Payment limits

The insurer primarily pays for rental of oxygen equipment and no longer rents to purchase.

If the worker **rents** the oxygen system:

- 1 monthly fee is paid for oxygen equipment. This fee includes payment for the equipment, contents, necessary maintenance, and accessories furnished during a rental month, *and*
- Oxygen accessories are included in the payment for rented systems. The supplier must provide any accessory ordered by the provider. (See Examples of oxygen accessories, below.)

If the worker **owns** the oxygen system:

- The fee for oxygen contents must be billed once a month, not daily or weekly. 1 unit of service equals 1 month of rental, *and*
- Oxygen accessories are payable separately only when they are used with a patient owned system.

Examples of oxygen accessories

Oxygen accessories include but aren't limited to:

- Cannulas (**A4615**),
- Humidifiers (**E0555**),
- Masks (**A4620**, **A7525**),
- Mouthpieces (**A4617**),
- Regulators (**E1353**),
- Nebulizer for humidification (**E0580**),
- Stand/rack (**E1355**),
- Transtracheal catheters (**A4608**),
- Tubing (**A4616**).

Payment policy: Pneumatic compression devices

General information

Pneumatic compression devices are used in the following ways:

- During surgery only, *or*
- During and after surgery, either in the facility or at home, *or*
- At home only.

Pneumatic compression devices used during surgery and subsequently sent home with the worker are considered surgical supplies. The cost of the device is **bundled** into the surgical service fee and isn't separately payable. **DME** providers won't be reimbursed for pneumatic compression devices used in this capacity.

Services that can be billed

Pneumatic compression devices are considered **DME** and are separately billable using HCPCS code **E0650** when **all** of the following criteria are met:

- The device isn't used during surgery in any capacity, *and*
- The worker is being treated for lymphedema or is at risk for developing venous thromboembolism (VTE). If at risk for VTE, the worker has been evaluated and the risk has been documented using a validated thrombosis risk factor assessment tool, *and*
- The provider documents a statement of medical necessity indicating the device is medically necessary to prevent VTE based on the results of the screening tool or treat lymphedema and the device being supplied is intended for home use only.

Services that aren't covered

Pneumatic compression devices are considered surgical supplies and aren't separately billable when any of the following conditions are met:

- The device is used during surgery in any capacity, *or*
- The device is used following surgery while the worker is in the facility, *or*
- The device isn't prescribed by the provider.

CPT® code **99070** isn't covered.

HCPCS code **E0676** isn't covered.

Link: For more information on the use of pneumatic compression devices in a clinical setting, see Chapter 25: Physical Medicine Services.

Payment policy: Prosthetic and orthotic services

Prior authorization

Required

Prior authorization is required for:

- Prosthetics, surgical appliances, and other special equipment described in WAC 296-20-03001, *and*
- Replacement of specific items on closed claims as described in WAC 296-20-124.

Note: If **DME** or orthotics requires prior authorization and it isn't obtained, then bills may be denied.

For prior authorization for:

- **State fund** claims, contact the Provider Hotline at **1-800-848-0811**.
- **Self-insured** claims, contact the self-insured employer or their third party administrator for prior authorization on self-insured claims.

Link: The HCPCS section of the Professional Services Fee Schedule has a column designating which codes require prior authorization.

Not required

Providers aren't required to obtain prior authorization for orthotics or **DME** when:

- The provider verifies that the claim is open/allowed on the date of service, *and*
- The orthotic/**DME** is prescribed by the attending provider (or the surgeon) for an accepted condition on the correct side of the body, *and*
- The fee schedule prior authorization indicator field is blank (see fee schedule).

Who qualifies for payment for custom made devices

The insurer will only pay for custom made (sometimes called “custom fabricated”) prosthetic and orthotic devices manufactured by these providers specifically licensed to produce them:

- Prosthetists,
- Orthotists,
- Occupational therapists,
- Certified hand specialists, *and*
- Podiatrists.

Link: To determine if a prosthetic or orthotic device is in this category, see the “license required” field in the fee schedule.

Requirements for billing

An itemized invoice showing total cost for the item must be submitted to support charges for any custom prosthetic or orthotic device paid **By Report**. Each **By Report** code billed should be listed with its individual price. Sales tax and shipping and handling charges aren’t paid separately and must be included in the total charge. Bills without an invoice may be denied.

Link: For information on where to send bills and invoices, see Chapter 2: Information for All Providers.

For covered prosthetics that pay **By Report**, providers must bill their usual and customary fees.

Links: For more information on billing usual and customary fees, see WAC 296-20-010 (2).

To find out which codes pay **By Report**, see the HCPCS section of the Professional Services Fee Schedule.

Payment limits

For **By Report** prosthetic items, the insurer will pay 80% of the billed charge.

Payment policy: Purchasing or renting DME

General information

Purchased DME

Purchased **DME** belongs to the worker.

State fund and Crime Victims Compensation Program won't purchase used **DME**.

Self-insured employers may purchase used **DME**.

Rented DME

During the authorized rental period, the **DME** belongs to the provider.

When the **DME** is no longer authorized:

- It will be returned to the provider.
- If unauthorized **DME** isn't returned to the provider within 30 days, the provider can bill the worker for charges related to **DME** rental, purchase, and supplies that accrue after the insurer denies authorization for the **DME**.

Link: For more information on purchasing or renting **DME**, see WAC 296-20-1102.

Prior authorization

Required

If prior authorization is required but isn't obtained, then bills may be denied. Prior authorization is required for:

- Prosthetics, surgical appliances, and other special equipment (see WAC 296-20-03001).
- Replacement of specific items on closed claims (see WAC 296-20-124).

Link: The HCPCS section of the Professional Services Fee Schedule has a column designating which codes require prior authorization; these codes include the HCPCS E codes and the HCPCS K codes.

For prior authorization for:

- **State fund** claims, contact the Provider Hotline at **1-800-848-0811**.
- **Self-insured** claims, contact the self-insured employer or their third party administrator for prior authorization on self-insured claims.

Not required

Providers aren't required to obtain prior authorization for orthotics or **DME** when:

- The provider verifies that the claim is open/allowed on the date of service, *and*
- The orthotic/**DME** is prescribed by the attending provider (or the surgeon) for an accepted condition on the correct side of the body, *and*
- The fee schedule prior authorization indicator field is blank.

Requirements for billing

All providers must submit documentation to support billing for the purchase or rental of any DME. Documentation must include a full description of the item(s) dispensed. Pharmacies and **DME** providers must bill their usual and customary charge for supplies and equipment with appropriate HCPCS and local codes. Errors will result in suspension and/or denial of payment.

Delivery charges, shipping and handling, tax, and fitting fees aren't separately payable.

If the **DME** is rented for:

- **1 day**: use the same date for the first and last dates of service.
- **More than 1 day**: use the actual first and last dates of service.

Always include a modifier with a **DME** HCPCS code. Bills submitted without the correct modifier will be denied payment. Providers may continue to use other modifiers, for example **–LT** or **–RT**, in conjunction with the mandatory modifiers if appropriate (up to 4 modifiers may be used with any 1 HCPCS code).

The HCPCS/CPT® code column of the Professional Services Fee Schedule specifies which **DME** items can be:

- Only purchased (use modifier **–NU**), *or*
- Only rented (use modifier **–RR**), *or*
- Either purchased (use modifier **–NU**) or rented (use modifier **–RR**).
    - **Example**: **E0117-NU** (Underarm spring-assist crutch) is only purchased (there isn't an **–RR** modifier for that code).

Modifier exception

Repair codes **K0739** and **K0740** don't require modifiers.

Payment limits

Rented DME

The maximum allowable rental fee is based on a per month period. Rental of 1 month or less is equal to 1 unit of service.

Rental payments won't exceed 12 months because:

- At 6 months:
    - The insurer may review rental payments and decide to purchase the equipment at that time, *and*
    - If purchased, the **DME** belongs to the worker.
- At the 12th month of rental, the worker owns the equipment.

Negative Pressure Wound Therapy (NPWT) is covered when the wound is related to an injury or illness allowed on the claim. Prior authorization is required before starting NPWT, and every 30 days thereafter. See the L&I coverage decision for the requirements of authorization.

Equipment limits for E2402: Patients are allowed 1 NPWT pump per episode (a pump may be used for more than 1 wound at the same time). Supplies should be limited to 15 dressing kits (**A6550**) per wound per month, and 10 canister sets (**A7000**) per month.

Miscellaneous DME (**E1399**) will be paid **By Report**:

- The miscellaneous item must be appropriate relative to the injury or type of treatment received by the worker.
- **E1399** is payable only for **DME** that doesn't have a valid HCPCS code.
- All bills for **E1399** items must have either the modifier **–NU** (for purchased) or **–RR** (for rented).
- A description must be on the paper bill or in the remarks section of the electronic bill.

Rental exceptions

Continuous passive motion exercise devices, **E0935** (for use on knee only) and **E0936** (for use other than knee), are rented on a per diem basis up to 14 days, with 1 unit of service = 1 day.

Extension/flexion devices (**E1800-E1818**, **E1825-E1840**) are rented for 1 month. If needed beyond 1 month, the insurer's authorization is required.

Wound Therapy devices (**E2402**) are rented per day. 1 unit of service = 1 day.

Services that aren't covered

Supplies used during or immediately after surgery and not sent home with the worker don't meet the definition of **DME** and won't be reimbursed as **DME**.

Pneumatic compression devices used during surgery and sent home with the worker are considered surgical supplies. The cost of the device is bundled into the surgical service fee and isn't separately payable, even to **DME** suppliers.

DME purchase after rental period of less than 12 months

For equipment rented for less than 12 months and permanently required by the worker:

- For **State fund** claims, the provider will retrieve the rental equipment and replace it with the new **DME** item.
    - The provider should bill the usual and customary charge for the new replacement **DME** item. The billed HCPCS code requires a **–NU** modifier.
    - L&I will pay the provider the new purchase price for the replacement **DME** item up to no more than the maximum fee in the **DME** fee schedule.
- For **self-insured** claims, self-insurers may purchase the equipment and receive rental credit toward the purchase.

Payment policy: Repairs and non-routine services, and warranties

Requirements for billing

Repairs and non-routine services

DME repair codes (**K0739**, **K0740**) must be billed per each 15 minutes. 1 unit of service in the Units field equals 15 minutes.

- **Example**: 45 minutes for a repair or non-routine service of equipment requiring a skilled technician would be billed with 3 units of service.

Submitting a warranty to the insurer

A copy of the original warranty is required on each repair service completed and must be submitted to the insurer. **Payment will be denied** if no warranty is received or if the item is still under warranty. Only equipment out of warranty will be considered for repair, non-routine service, and maintenance coverage.

When submitting the warranty to the insurer, write the claim number in the upper right hand corner of the warranty document, and send a copy:

- **State fund** claims to:

  Department of Labor and Industries
  PO Box 44291
  Olympia, WA 98504-4291

- **Self-insured** claims to the SIE/TPA.

Link: For more information on miscellaneous services and appliances, see WAC 296-23-165.

Payment limits

Purchased equipment repair

Repair or replacement of **DME** is the responsibility of the worker when the item is:

- Damaged due to worker abuse, neglect, misuse, *or*
- Lost or stolen.

Rented equipment repair

Repair, non-routine service, and maintenance are included as part of the monthly rental fee on **DME**. No additional payment will be provided. This doesn't include disposable and nonreusable supplies. (See required warranty coverage in table below.)

Warranty coverage requirements

If the **DME item type** is…	Then the **required warranty coverage** is:
DME purchased new (excluding disposable and nonreusable supplies)	Limited to the manufacturer's warranty
Rented **DME**	Complete repair and maintenance coverage is provided as part of the monthly rental fee
Power operated vehicle (3-wheel or 4-wheel non-highway Scooter)	Minimum of 1 year or manufacturer's warranty, whichever is greater
Wheelchair frames (purchased new) and wheelchair parts	
Wheelchair codes **K0004**, **K0005**, and **E1161**	Lifetime warranty on side frames and cross braces

Payment policy: Ventilator management services

Services that can be billed

The insurer pays for **either but not both** of the:

- Ventilation management service code (CPT® codes **94002-94005**, **94660**, and **94662**), *or*
- E/M service (CPT® codes **99202-99499**),

Payment limits

The insurer doesn't pay for ventilator management services when the same provider reports an E/M service on the same day. If a provider bills a ventilator management code and an E/M service for the same day, payment:

- Will be made for the E/M service, *and*
- Won't be made for the ventilator management code.

Payment policy: Virtual reality devices and services

Services that can be billed

Virtual reality devices are allowed as a delivery mechanism for a covered therapeutic service, such as physical therapy exercises delivered with virtual reality tasks or cognitive behavioral therapy with virtual reality exposure therapy.

Services that aren’t covered

The cost of the virtual reality **DME** is **bundled** into the cost of therapy services and isn’t separately payable.

Providers can’t charge an additional fee for the use of virtual reality devices as part of a service.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules (Washington state laws) for purchasing or renting DME	Washington Administrative Code (WAC) 296-20-1102
Administrative rules for miscellaneous services and appliances	WAC 296-23-165
Administrative rules for payments for rejected and closed claims	WAC 296-20-124
Administrative rules for treatments requiring authorization	WAC 296-20-03001
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Negative Pressure Wound Therapy coverage and treatment	Negative Pressure Wound Therapy coverage decision
Professional Services **Fee Schedules**	Fee schedules on L&I's website

Need more help?

Call L&I's Provider Hotline at **1-800-848-0811** or email **PHL@lni.wa.gov**