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, 2024

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: 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: A code listed in the fee schedule as "By Report" which 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 worker'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, specifically 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 appear in this chapter:

Use	Payment Information
–LT (Left side)	
Use this modifier to indicate when a procedure or service was performed on the left side of the body. Specifically for procedures or services that can be performed on contralateral sites, paired organs, or extremities.	This modifier doesn't affect payment but is necessary to describe the service. Its use will help reduce duplicate bills and minimize payment delays.
–NU (New purchased DME)	
Use this modifier to indicate when the DME dispensed is being purchased and doesn't need to be returned to the supplier. **Note**: DME codes that are applicable to purchasing are listed in the L&I Professional Services Fee Schedules.	These services are represented by their own line on the professional services fee schedule. Payment will be made at **100%** of the modifier **–NU** rate for each specific DME provided or billed charge, whichever is less.
–RR (Rented DME)	
Use this modifier to indicate when the DME dispensed will be rented and returned to the supplier. **Note**: DME codes that are applicable to rental are listed in the L&I Professional Services Fee Schedules	These services are represented by their own line on the professional services fee schedule. Payment will be made at **100%** of the modifier **–RR** rate for each specific DME provided or billed charge, whichever is less.
–RT (Right side)	
Use this modifier to indicate when a procedure or service was performed on the right side of the body. Specifically for procedures or services that can be performed on contralateral sites, paired organs, or extremities.	This modifier doesn't affect payment but is necessary to describe the service. Its use will help reduce duplicate bills and minimize payment delays.

Note: Many factors contribute to the resulting allowed amount. Therefore, there may be other factors aside from modifier usage that reduce or affect payment. Refer to the applicable payment policies and fee schedules for the service(s) being provided for more information.

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.

Link: See L&I's coverage decision for additional details.

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 is not covered for home use. This modality used in a clinical setting is considered to be **bundled** into existing physical medicine services billable under CPT® **97010** and/or **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: Negative pressure wound therapy (NPWT)

General information

Negative Pressure Wound Therapy (NPWT) is a method of wound treatment involving the use of a device that creates subatmospheric pressure around a wound to enhance healing.

NPWT devices are rental only. They won't be purchased even if rented for periods of 12 months or more.

Prior authorization

Rental of NPWT **DME** is covered when the wound is related to an injury or illness allowed on the claim. See the L&I coverage decision for authorization requirements.

Prior authorization is required before starting NPWT and every 30 days thereafter during a given episode of care.

Billing requirements

Unlike most other forms of rented **DME**, NPWT devices are rented by day. Each rental day equals 1 unit.

Payment limits

If the item is a…	And the code is…	Then the payment limits are…
Wound therapy device	**E2402**	Limit 1 pump per episode. Limit 4 months of treatment per episode; see below.
Wound therapy device dressing kit	**A6550**	Limit 15 kits per month.
Wound therapy device canister	**A7000**	Limit 10 canisters per month.

NPWT devices are limited to 4 months (120 days or 120 units) of treatment per episode of care. See L&I's coverage decision for more information.

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 has 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).

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**), *and*
- Tubing (**A4616**).

Payment limits

Except on rare occasions, oxygen equipment is always rented and never purchased. Oxygen equipment may only be purchased for a worker with explicit authorization from the insurer. The reason for purchase should be explained in detail in the claim file.

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

- A 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.

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 codes **E0650-E0675** 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

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.

For **State Fund** claims, contact the Provider Hotline at **1-800-848-0811**.

For **Self-insured** claims, contact the self-insured employer or their third party administrator for prior authorization on self-insured claims.

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

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

Who must perform these services to qualify for payment

Pre-fabricated orthotics that are off-the-shelf and given to the worker as-is or are customized to fit the worker are billable. 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 listed as **By Report** in the fee schedule. To find out which codes pay **By Report**, see the Professional Services Fee Schedule.

Each **By Report** code billed should be listed individually. 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.

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).

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

Payment limits

For **By Report** prosthetic items, the insurer will pay 80% of the appropriate charges.

Payment policy: Purchasing DME

General information

This policy contains rules regarding when and how **DME** is purchased for a worker.

Purchased **DME** belongs to the worker, not the provider or insurer. Purchased **DME** doesn't need to be returned to the provider or insurer even after treatment is complete.

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

Prior authorization

Prior authorization is required for some **DME**. If prior authorization is required but isn't obtained, bills may be denied. The Professional Services Fee Schedule has a column designating which codes require prior authorization. These codes include (but aren't limited to):

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

To obtain prior authorization for State Fund claims, contact the Provider Hotline at **1-800-848-0811**. For self-insured claims, contact the self-insured employer or their third party administrator.

Requirements for billing

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

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.

Modifiers for purchased DME

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 a modifier **–RR** for that code).

Always include a modifier with a **DME** HCPCS code (except repair codes **K0739** and **K0740**). Bills submitted without the correct modifier will be denied. 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).

Miscellaneous DME

Bills for miscellaneous **DME** (**E1399**) are payable only for **DME** that doesn't have a valid HCPCS code. The item must be appropriate relative to the injury or type of treatment received by the worker. A description of the item must be on the paper bill or in the remarks section of the electronic bill.

All bills for **E1399** items must have either the modifier **–NU** (for purchased) or **–RR** (for rented).

Documentation requirements

All providers must submit documentation to support billing for the purchase of any **DME**. Documentation must include (for each item):

- Worker's name,
- Type of item,
- Name of the item's manufacturer,
- Item's model name and model number (if applicable),
- Item's serial number (if applicable),
- Full description of the item,
- Date the item was dispensed,
- Copy of the manufacturer's warranty (see details below), *and*
- Itemized list of all costs charged to the insurer.

Warranties

Upon purchase of any **DME**, the supplier must send a copy of the manufacturer's warranty to the claim file as part of their documentation to support their bill. Payment may be denied if no warranty is filed.

The insurer doesn't purchase or provide additional or extended warranties beyond the manufacturer's initial warranty (or any other provider's warranty).

Different types of **DME** require different warranty specifications. Where a manufacturer provides a warranty greater than what is required below, the manufacturer's warranty will apply. The following table outlines required warranty specifications:

If the **DME item type** is…	Then the **required warranty coverage** is…
DME purchased new (excluding disposable and non-reusable supplies)	Limited to the manufacturer's warranty
Power-operated vehicles (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 limits

Supplies used during or immediately after surgery and not sent home with a worker aren't **DME** and won't be reimbursed as **DME**.

If any **DME** item is rented for 6 months or more, the insurer may review rental payments and decide to purchase the equipment at that time. Rental payments won't exceed 12 months. After the 12th month of rental, the equipment is considered "purchased" and is now owned by the worker. No additional rental fees are payable (with the exception of oxygen equipment; see the Oxygen and oxygen equipment payment policy for details).

DME purchase after rental period of less than 12 months

For equipment rented for less than 12 months that is determined after rental to be permanently needed by the worker:

- For **State Fund** claims, the worker may be asked to return the rented **DME** and the provider may issue new **DME** to be purchased by the insurer. The provider should bill their usual and customary charge for the new **DME** and append modifier **–NU**. L&I will pay the fee schedule amount for the new **DME** or billed charge, whichever is less.
- For **self-insured** claims, self-insurers may purchase the equipment and receive rental credit toward the purchase.

Used DME

State Fund and Crime Victims Compensation Program won’t purchase used **DME**.

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

Payment policy: Renting DME

General information

This policy contains rules regarding when and how **DME** is rented for a worker.

During the authorized rental period, the **DME** belongs to the provider. When the **DME** is no longer authorized, the worker must return it 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

Prior authorization is required for some **DME**. If prior authorization is required but isn't obtained, bills may be denied. The Professional Services Fee Schedule has a column designating which codes require prior authorization. These codes include but aren't limited to:

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

To obtain prior authorization for State Fund claims, contact the Provider Hotline at **1-800-848-0811**. For self-insured claims, contact the self-insured employer or their third party administrator.

Requirements for billing

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.

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.

Modifiers for purchased DME

Always include a modifier with a **DME** HCPCS code (except repair codes **K0739** and **K0740)**. Bills submitted without the correct modifier will be denied. 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 (modifier **–RR** can't be used with this code).

Miscellaneous DME

Bills for miscellaneous **DME** (**E1399**) are payable only for **DME** that doesn't have a valid HCPCS code. The item must be appropriate relative to the injury or type of treatment received by the worker. A description of the item must be on the paper bill or in the remarks section of the electronic bill.

All bills for **E1399** items must have either the modifier **–NU** (for purchased) or **–RR** (for rented).

Documentation requirements

All providers must submit documentation to support billing for the rental of any **DME**. Documentation must include (for each item):

- Worker's name,
- Type of item,
- Name of item's manufacturer,
- Item's model name and model number,
- Item's serial number (if applicable),
- Full description of the item,
- Date the item was dispensed, *and*
- Itemized list of all costs charged to the insurer.

Payment limits

For most **DME**, each month of rental should be billed as 1 unit of service. Rental periods of less than 1 month should be billed as 1 unit unless otherwise noted in the rental limit exceptions below or in other policies in this chapter.

If any **DME** item is rented for 6 months or more, the insurer may review rental payments and decide to purchase the equipment at that time. Rental payments won't exceed 12 months. After the 12th month of rental, the worker owns the equipment and no additional fees are payable (with the exception of oxygen equipment; see the Oxygen and oxygen equipment payment policy for details).

Rental limit exceptions

DME item	Code(s)	Rental requirements
Continuous passive motion exercise devices	**E0935-E0936**	Rented on a per diem basis up to 14 days. 1 unit of service = 1 day.
Extension / flexion devices	**E1800-E1818** **E1825-E1840**	Rented for 1 month. If needed beyond 1 month, insurer's authorization is required.
Oxygen equipment	See Payment policy: Oxygen and oxygen equipment for codes.	Rented in perpetuity. Can't be purchased without permission from the insurer.
Wound therapy devices	**E2402**	Rented per day. 1 unit of service = 1 day.

Payment policy: Repairs and non-routine services

Requirements for billing

DME repair codes (**K0739**, **K0740**) must be billed per each 15 minutes. One unit of service 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.

Only equipment out of warranty will be considered for repair, non-routine service, and maintenance coverage. If an item is still under warranty, bills for warranty-covered repairs for that item will be denied.

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

Payment limits

Purchased equipment repair

The insurer won't pay for any repairs (including parts and labor) that are covered by a manufacturer's warranty during the period of warranty coverage.

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

Repairs, non-routine service, and maintenance are included as part of the monthly rental fee for **DME**. No additional payment will be provided.

The insurer won't pay for rental of disposable or non-reusable supplies.

Payment policy: Ventilator management services

Payment limits

Ventilation management service codes (CPT® codes **94002**-**94005**, **94660**, and **94662**) are payable only when an Evaluation and Management (E/M) service (CPT® codes **99202**-**99499**, except for case management services) is not performed on the same day. When an E/M service is performed on the same day, ventilation management is **bundled** into the payment for the E/M service.

Payment policy: Virtual reality devices

General information

Virtual reality devices may be used 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

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

Purchase or rental of virtual reality **DME** isn’t covered for clinical or home use.

Payment limits

The cost of virtual reality as a modality for treatment in a clinical setting is **bundled** into the cost of therapy services and isn’t separately payable.

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?

Email L&I's Provider Hotline at PHL@Lni.wa.gov. If you would prefer a phone call, please email us your name and contact number.

