

**Payment Policies for Healthcare Services
 Provided to Injured Workers and Crime Victims**

Chapter 9: Durable Medical Equipment (DME)

Effective July 1, 2021



Link: Look for possible **updates and corrections** to these payment policies at

<https://lni.wa.gov/patient-care/billing-payments/fee-schedules-and-payment-policies/policy-2021>



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Definitions

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.

HCPCS code modifiers mentioned in 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.

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.



Note: The fee schedules for DME, supplies, materials, drugs and injections reimburses the same for all providers.



Note: 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.



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**.



Note: 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.



Note: See definition of **Bundled** in Definitions at the beginning of this chapter.



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).



Note: See definitions of **Portable oxygen system** and **Stationary oxygen system** in Definitions at the beginning of this chapter.

▶ Payment limits

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

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

- One 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 physician. (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. One unit of service equals one 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: 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. See <https://lni.wa.gov/insurance/self-insurance/look-up-self-insured-employers-tpas/index>



Link: The HCPCS section of the Professional Services Fee Schedule has a column designating which codes require prior authorization; the fee schedule is available at <https://lni.wa.gov/patient-care/billing-payments/fee-schedules-and-payment-policies/>

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,
- Podiatrists.



Link: To determine if a prosthetic or orthotic device is in this category, see the “license required” field in the fee schedule; the fee schedule is available at <https://lni.wa.gov/patient-care/billing-payments/fee-schedules-and-payment-policies/>

Requirements for billing

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



Notes: Also see Payment limits for **By report** prosthetics, below. See definition of **By report** in Definitions at the beginning of this chapter.



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, available at <https://lni.wa.gov/patient-care/billing-payments/fee-schedules-and-payment-policies/>

▶ Payment limits

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



Note: Also see Requirements for billing for **By report** prosthetics, above.



Payment policy: Purchasing or renting DME

▶ General policies on purchased or rented DME

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. The fee schedule is available at <https://lni.wa.gov/patient-care/billing-payments/fee-schedules-and-payment-policies/>



Note: 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. See <https://lni.wa.gov/insurance/self-insurance/look-up-self-insured-employers-tpas/index>

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

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.

If the DME is rented for:

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



Note: Errors will result in suspension and/or denial of payment.

Always include a modifier with a DME 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).



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

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 four modifiers may be used with any one HCPCS code).

▶ Payment limits

Rented DME

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

Rental payments won't exceed 12 months because:

- At six 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.



Note: For more details on equipment rented for less than 12 months and permanently required by the worker, see DME purchase after rental period of less than 12 months, below.



Note: 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 one month. If needed beyond one month, the insurer's authorization is required.
- **Wound Therapy devices (E2402)** are rented per day. 1 unit of service = 1 day.

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 Department's [coverage decision](#) on the requirements for authorization.

Equipment limits for E2402: Patients are allowed one NPWT pump per episode (a pump may be used for more than one 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.



Note: See definition of **By report** in Definitions at the beginning of this chapter.

▶ **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. One 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.



Note: Repair, non-routine service, and maintenance on purchased equipment that is out of warranty will be paid **By report** (see definition of **By report** in Definitions at the beginning of this chapter).

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. A SIE/TPA contact list is available at <https://lni.wa.gov/insurance/self-insurance/look-up-self-insured-employers-tpas/index>



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 one 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.



Links: Related topics

If you're looking for more information about...	Then go here:
Administrative rules (Washington state laws) for purchasing or renting DME	Washington Administrative Code (WAC) 296-20-1102: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-1102
Administrative rules for miscellaneous services and appliances	WAC 296-23-165: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-23-165
Administrative rules for payments for rejected and closed claims	WAC 296-20-124: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-124
Administrative rules for treatments requiring authorization	WAC 296-20-03001: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-03001
Becoming an L&I provider	L&I's website: https://lni.wa.gov/patient-care/provider-accounts/become-a-provider/
Billing instructions and forms	Chapter 2: Information for All Providers
Negative Pressure Wound Therapy coverage and treatment	L&I's website: https://lni.wa.gov/patient-care/treating-patients/conditions-and-treatments/?query=Negative+Pressure+Wound+Therapy+%28NPWT%29
Professional Services Fee Schedules	L&I's website: https://lni.wa.gov/patient-care/billing-payments/fee-schedules-and-payment-policies/

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