Washington State Department of Labor & Industries

Chapter 7: Durable Medical Equipment (DME) and Supplies

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

How to navigate this document

Use the keyboard command **CTRL+F** on Windows (**Command+F** on Mac) to search for specific topics. If you can't find what you're looking for, try different keywords or combinations of words.

The Table of Contents lists each policy. To jump to a policy, click on the page number.

Links to appendices

For definitions of terms used throughout these payment policies, see Appendix A: Definitions.

For explanations of modifiers referenced throughout these payment policies, see Appendix B: Modifiers.

For information about place of service codes, see Appendix C: Place of Service (POS).

Updates and corrections

An annual update of the entire payment policies and fee schedules (MARFS) is published routinely to coincide with the beginning of each state fiscal year (July 1).

Throughout the year, updates and corrections may be needed to modify existing policies and fees or create new ones. Updated and corrected information supersedes the policies in MARFS. Look for possible updates and corrections to these payment policies and fee schedules on L&I's website.

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Payment policy: Acquisition cost and itemized invoices

General information

This policy describes what **acquisition cost** means, how it's calculated, and when charges for supplies are reimbursed at this rate. It also describes when an itemized invoice is required.

This policy doesn't apply to hospital bills. For the hospital **acquisition cost** policy, see Chapter 26: Hospitals and Ambulatory Surgical Centers (ASCs).

For the purposes of this policy, an itemized invoice is an invoice for a supply item that includes **acquisition cost**.

Components of acquisition cost

The **acquisition cost** includes:

- Wholesale cost of the item, *and*
- Shipping and handling if applicable, *and*
- Sales tax.

Services that can be billed

Providers are reimbursed at **acquisition cost** for supply codes that:

- Are listed as **by report** in the Fee Schedule, *and*
- Cost $150 or more.

The following table summarizes the various ways the insurer pays for supplies:

	If the supply has a fee listed in the Fee Schedule…	If the supply is listed as "**by report**" in the Fee Schedule…	If the supply is listed as "**Bundled**" in the Fee Schedule…
You bill less than $150 for the item…	Submit standard documentation. Itemized invoice not required. Payment is made at the amount billed or the maximum fee, whichever is less.	Submit standard documentation. Itemized invoice not required. Payment is made at 80% of the amount billed.	You won't be paid for this item separately from the associated service(s).

	If the supply has a fee listed in the Fee Schedule…	If the supply is listed as "**by report**" in the Fee Schedule…	If the supply is listed as "**Bundled**" in the Fee Schedule…
You bill $150 or more for the item…	Itemized invoice required. Submit with standard documentation. Payment is made at the amount billed or the maximum fee, whichever is less.	Itemized invoice required. Submit with standard documentation. Payment is made at **acquisition cost**.	You won't be paid for this item separately from the associated service(s).

Requirements for billing

The **acquisition cost** must be billed as one charge. Sales tax and shipping and handling charges aren't paid separately and must be included in the total cost for the supply.

Documentation requirements

All supplies require documentation to support purchase regardless of cost. See Chapter 2: Information for All Providers for details.

As described in the table above, an itemized invoice showing **acquisition cost** must also be submitted with bills for all supplies that:

- Cost more than $150, *and*
- Aren't listed as **bundled** in the Fee Schedule.

Providers must keep invoices for all supplies in their office files for a minimum of 5 years. A provider must submit a copy of the itemized invoice to the insurer when required (see table above) and/or upon request. Failure to produce an itemized invoice when required may result in bill denial, payment reduction, or recoupment.

Payment policy: Casting materials

Services that can be billed

Casting materials may be billed with HCPCS codes **Q4001**-**Q4051** in addition to application services.

Services that aren’t covered

No payment will be made for the use of a cast room. Use of a cast room is considered part of a provider’s practice expense.

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 or cold therapy **DME** for home use isn't covered or is **bundled**, including but not limited to:

- Hot or cold water bottles,
- Heating and/or cooling wraps,
- Heating and/or cooling pads, *and*Cryotherapy **DME** with or without compression.

Hot and/or cold modalities used in a clinical setting are 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: Medical and surgical supplies

General information

Supplies must be medically necessary and prescribed by a treating provider for the direct treatment of an accepted condition.

Supplies include, but aren't limited to:

- Drugs administered in a provider's office,
- Medical and surgical supplies, *and*
- Prefabricated orthotics.

Providers must bill the appropriate, most specific HCPCS or local codes for supplies and materials dispensed during an office visit or with other office services.

All covered medical and surgical supplies must be billed using the provider's usual and customary fees, including those that pay **by report**. To find out which codes pay **by report**, see the Medical and Surgical Supplies section of the Professional Services Fee Schedule.

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

Services that can be billed

Bundled supplies

Certain items listed in the Medical and Surgical Supplies fee schedule may be paid separately **for permanent conditions** if they are provided in the physician's office.

If the condition is **acute or temporary**, these items aren't separately payable.

For example:

- Foley catheters and accessories for permanent incontinence or ostomy supplies for permanent conditions may be paid separately when provided in the physician's office.
- The Foley catheter used to obtain a urine specimen, used after surgery, or used to treat an acute obstruction wouldn't be paid separately because it is treating a temporary problem.
- If a patient had an indwelling Foley catheter for permanent incontinence, and a problem developed which required the physician to replace the Foley, then the catheter would be paid separately because the incontinence is permanent.

L&I follows CMS's policy of bundling HCPCS codes for surgical trays and supplies used in a physician's office. Surgical trays and supplies won't be paid separately.

Surgical dressings and other items dispensed for home use

Surgical dressings and other items dispensed for home use are separately payable when billed with local modifier **–1S**.

Payment limits

Some supplies are considered **bundled** into the cost of other services (associated office visits or procedures) and won't be paid separately. These include:

- Supplies used in the course of an office visit, *and*
- Fitting fees that are **bundled** into the office visit or into the cost of the supply.

For medical and surgical supplies that pay **by report** (except **E1399**), see Payment policy: Acquisition cost and itemized invoices.

For more information on **E1399**, see Payment policy: Miscellaneous supplies.

To see which billing codes are **Bundled**, see L&I's Professional Services Fee Schedule; in the dollar value column, such items show the word **Bundled** (instead of a dollar amount).

Payment policy: Miscellaneous supplies

Services that can be billed

HCPCS billing code **E1399** can only be billed for a miscellaneous supply that meets both of these criteria:

- The supply or **DME** item doesn't have a valid HCPCS code assigned, *and*
- The item is appropriate relative to the covered injury or type of treatment being received by the worker.

Services that aren't covered

The insurer won't pay CPT® code **99070** for miscellaneous supplies and materials used or dispensed by the provider.

Requirements for billing

All bills for **E1399** items must have:

- Either modifier **–NU** or **–RR**, *and*
- A description of the **DME** must be on the paper bill or in the remarks section of the electronic bill.

See Payment policy: Acquisition cost and itemized invoices for more details.

These specific miscellaneous supplies must be billed using HCPCS code **E1399**:

- Therapy putty and tubing, *and*
- Anti-vibration gloves.

Payment limits

When billing for items with multiple components where parts of the item have distinct HCPCS codes but the whole item doesn't, you can't bill **E1399** and must bill for each component using the most appropriate HCPCS code.

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

General information

Two primary forms of oxygen systems exist and are covered under this policy.

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.

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).

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. The insurer won't reimburse separately 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 includes a statement indicating the device is medically necessary and FDA approved for the prevention of 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 20: 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 by providers who may dispense orthotics.

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.

For more information on responsibilities, requirements, and **AP**-specific services for Podiatrists, see Chapter 3: Attending Providers.

Requirements for billing

Providers must bill their usual and customary fees for covered prosthetics, including those that pay **by report**. Any procedure represented by its own CPT®, HCPCS, or local code must be billed separately (for example, **97760**, **97761** or **97763**).

Each **by report** CPT®, HCPCS, or local 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.

A detailed invoice must be submitted to the claim file along with your bill to support charges for any custom prosthetic or orthotic device listed as **by report** in the fee schedule. Invoices for **by report** codes must include:

- Total charges for all items and services combined, *and*
- The **acquisition cost** for the item(s), broken down into wholesale cost, shipping/handling, and sales tax, *and*
- Administrative charges and/or markups, *and*
- An itemized list of services provided to the worker, such as fittings, education, travel expenses, or counseling, including the dates of service and the amount of time spent performing each service.

Bills without a detailed invoice may be denied.

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.

To find out which codes pay **by report**, see the Professional Services Fee Schedule.

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 or recouped. 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.

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 must 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: Surgical dressings dispensed for home use

Requirements for billing

Providers must bill the appropriate HCPCS code for each dressing item, along with the local billing code modifier **–1S** for each item.

Payment limits

Primary surgical dressings and secondary surgical dressings dispensed for home use are payable at **acquisition cost** when all of these conditions are met:

- They are dispensed to a patient for home care of a wound, *and*
- They are medically necessary, *and*
- The wound is due to an accepted work related condition.

The cost for surgical dressings applied during a procedure, office visit, or clinic visit is included in the practice expense component of the RVU (overhead) for that provider. Separate payment isn't allowed.

Items such as elastic stockings, support hose, and pressure garments aren't secondary surgical dressings and must be billed with the appropriate HCPCS code.

Surgical dressing **supplies** and codes billed without the local modifier **–1S** are considered **Bundled** and won't be paid.

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 is not separately payable, even to **DME** suppliers. For details on coverage of **pneumatic compression devices**, see Payment policy: Pneumatic compression devices.

Payment policy: Urinary catheterization

Services that can be billed

Separate payment is allowed for placement of a temporary indwelling catheter when treatment is:

- Performed in a provider's office, *and*
- Used to treat a temporary obstruction.

Link: For more information about catheterization to obtain specimen(s) for lab tests, see the Specimen collection and handling payment policy in Chapter 13: Pathology and Laboratory Services.

Payment limits

Separate payment isn't allowed when placement of a temporary indwelling catheter is performed:

- On the same day as a major surgical procedure, *or*
- During the postoperative period of a major surgical procedure that has a follow up period.

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.

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
Fee schedules for all healthcare facility services (including ASCs)	Fee schedules on L&I's website
Negative Pressure Wound Therapy coverage and treatment	Negative Pressure Wound Therapy coverage decision
Payment policies for **catheterization to obtain specimens for lab tests**	Chapter 13: Pathology and Laboratory Services
Payment policies for **durable medical equipment (DME)**	Chapter 7: Durable Medical Equipment
Payment policies for **hospital acquisition cost policy**	Chapter 26: Hospitals and Ambulatory Surgery Centers (ASCs)

Need more help?

Contact Provider Hotline with billing and authorization questions by emailing PHL@Lni.wa.gov or calling **1-800-848-0811** between 8 am and 12 pm PT Monday through Friday.

