Priority Health

MEDICAL POLICY
No. 91110-R19

DURABLE MEDICAL EQUIPMENT

Effective Date: August 23, 2023	**Review Dates: 1/93, 10/95, 6/99, 12/01, 10/02, 6/03, 9/03, 9/04, 9/05, 8/06, 7/07, 6/08, 6/09, 6/10, 6/11, 6/12, 6/13, 8/14, 8/15, 8/16, 8/17, 8/18, 8/19, 8/20, 8/21, 2/22, 2/23, 8/23**
Date Of Origin: June 30, 1988	**Status: Current**

Summary of Changes

- Clarification: Non-pneumatic compression devices are not medically necessary due to insufficient evidence of effectiveness.

I. POLICY/CRITERIA

A. Durable medical equipment is medically necessary when applicable InterQual®criteria are met. Restrictions and limitations, some of which are described below, apply.

1. The decision to purchase or rent DME (and the supplies and accessories necessary for their functioning) will be at the discretion of the Health Management Department.
2. If quality and effectiveness are comparable, the least costly equipment will be covered.
3. Professional fees related to dispensing or customizing the item, educating or training the member are covered as part of the equipment cost. These services are the responsibility of the vendor or provider and are not reimbursable as a separate fee.
4. The decision to repair or replace DME will be at the decision of the Health Management Department. A one-month rental period will be covered for a beneficiary-owned unit when the unit is sent in for repair / replacement estimate (except for Medicaid/Healthy Michigan Plan products). The following guidelines apply:
   a. Repair of DME for Customer Owned DME
      - Repairs or maintenance as a result of normal use are a covered benefit.
      - Repairs or maintenance as a result of misuse or abuse are not a covered benefit and are the responsibility of the member.
      - For repairs greater than 60% of the cost of new, replacement will be at the discretion of Priority Health.
      - Claims for repairs should include an itemized invoice.
   b. Replacement of DME
      - Replacement of DME damaged by normal use or required due to body growth is a covered benefit.
      - Replacement of DME is covered if equipment is past the useful lifetime period. Useful lifetime is considered to be no less than 5 years

beginning with the date of delivery. Obsolescence of electronic components (e.g., CPAP compliance monitoring) qualifies for DME replacement. Functioning DME that meets the clinical need is not eligible for replacement, regardless of the age of the equipment.
- Replacement will be at the discretion of Priority Health if cost of repairs is greater than 60% of the cost of new.
- Replacement of DME as a result of misuse or abuse is not a covered benefit and is the responsibility of the member.
- Replacement of lost or stolen DME is not a covered benefit.

5. Supplies and accessories, including disposable supplies, necessary for the proper functioning or application of covered DME are a covered benefit.
6. Loaner Equipment:
   a. Priority Health will pay for loaner equipment on member owned equipment outside the capped rental period.
   b. Payment will not be made for the rental of equipment on supplier owned equipment (within the 10-month capped rental period).
7. Transfer of capped rental equipment: In the event that the member changes carriers during a 10-month capped rental period a new rental period will not begin. Priority Health will allow coverage for capped rental equipment and will pay the number of months remaining on the capped rental amount up to 10 months on new members to the plans or on members who have lost a primary carrier, therefore making Priority Health their primary carrier.
8. Ownership of capped rental items shall be transferred to the beneficiary after the capped-rental period of 10 months has been completed.
9. In the event that the member requires an upgrade of equipment during the capped rental period (i.e.: CPAP to BIPAP) Priority Health will apply the amount already paid on the capped rental toward the balance of the upgraded item.
10. Preauthorization of DME >$1,000.00 is required (>$500.00 is required for Medicaid and Healthy Michigan Plan members).
11. Member compliance with use of equipment is required, and compliance may be reviewed to determine continued authorization and coverage. The following are example of devices and compliance criteria that may be reviewed:
    a. Secretion Clearance Devices (e.g., mechanical percussor, intrapulmonary percussive ventilation, high-frequency chest wall oscillation) require a device trial of 4-6 weeks with use daily or as prescribed, and documentation of increased sputum production (See InterQual® criteria)
    b. Electrical Stimulator (e.g., NMES) authorization beyond the 2-month initial trial requires review of a compliance log when it is an integral part of the equipment.
12. Continuous Passive Motion (CPM) devices are covered DME as follows:
    a. CPMs are a covered benefit in the immediate post-operative rehabilitation period following rotator cuff repair or total knee replacement.
    b. CPMs are a covered benefit for 21 days for the conditions specified above.
    c. Applies to HCPCS codes E0935–E0936.

Note: Excluding above indications CPMs are not a covered benefit for any other condition at any anatomic location (e.g., hip, ankle).

13. Pneumatic compression devices are covered DME as follows:
    a. Segmental or non-segmental pneumatic compression devices with non-calibrated or calibrated gradient pressure, in the home setting, are considered medically necessary when InterQual criteria are met.
    b. Segmental or non-segmental pneumatic compression devices with non-calibrated or calibrated gradient pressure, in the home setting, are not medically necessary for all other indications including but not limited to:
        i. Active cellulitis.
        ii. Ischemic vascular disease.
        iii. Lymphedema only in the head, neck, trunk, chest, or abdomen.
        iv. Prevention of deep venous thrombosis in the home setting.
        v. Severe peripheral neuropathy.
    c. There is insufficient literature demonstrating the superiority of calibrated gradient pressure devices over non-calibrated pressure devices, therefore, the least costly equipment will be covered.

Requests for calibrated gradient pressure devices require documentation of failure with non-calibrated gradient pressure devices to improve treatment.

14. Non-pneumatic compression devices (e.g. Koya DaySpring) are not medically necessary due to insufficient evidence of effectiveness in improving long-term health outcomes.

B. EXCLUSIONS

1. Personal or household items are not a covered benefit, including but not limited to:
    a. Personal comfort or convenience items
    b. Household fixtures or equipment, or home modifications (e.g., bath bars, ramps, air conditioners, pillows, elevators)
    c. Furnishing such as lift chairs, whirlpools and safety beds
2. Self-help and adaptive aids are not a covered benefit, including assistive communication devices and training aids.
    a. Medicaid members: See Augmentative Communication / Speech Generating Devices for Medicaid Members for coverage.
    b. Medicare members: See plan documents for coverage of speech generating devices.
3. Coverage is limited to one (1) piece of same-use equipment (e.g., mobilization, suction), unless replacement is covered under the replacement guidelines in this policy. Duplicate or back up equipment is not a covered benefit. Multiple devices (e.g., electric wheelchair for home and manual

wheelchair for transportation, or wheelchair and buggy) are not a covered benefit.

4. Upgrades of equipment for outdoor use, or equipment needed for use outside of the home that is not needed for in-home use, are not covered.
5. Deluxe equipment
6. Physical fitness equipment such as treadmills, stationary bikes
7. First aid or precautionary equipment such as standby portable oxygen units
8. Maintenance and Service fee for capped-rental items (*example: CPT E0601MS)*

II. MEDICAL NECESSITY REVIEW

Prior authorization for certain drug, services, and procedures may or may not be required. In cases where prior authorization is required, providers will submit a request demonstrating that a drug, service, or procedure is medically necessary. For more information, please refer to Priority Health prior authorization guidance or the Durable Medical Equipment, Prosthetics and Orthotics guidance on the provider manual.

III. APPLICATION TO PRODUCTS

Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable.

- **HMO/EPO:** ***This policy applies to insured HMO/EPO plans.***
- **POS:** ***This policy applies to insured POS plans.***
- **PPO:** ***This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.***
- **ASO:** ***For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.***
- **INDIVIDUAL:** ***For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.***
- **MEDICARE:** ***Coverage is determined by the Centers for Medicare and Medicaid Services (CMS) and/or the Evidence of Coverage (EOC); if a coverage determination has not been adopted by CMS, this policy applies.***
- **MEDICAID/HEALTHY MICHIGAN PLAN:** ***For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html, the Michigan Medicaid Provider Manual will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.***

SPECIAL NOTES

See applicable InterQual® Criteria

IV. DESCRIPTION

Durable Medical Equipment (DME) is defined as equipment which:

- Can withstand repeated use,
- Is primarily used to serve a medical purpose,
- Is generally not useful to a person in the absence of illness, injury, or disease
- Is appropriate for use in the member's home. A member's home may be defined as the member's own dwelling, relative's home, apartment, home for the aged or other type of institution.

V. CODING INFORMATION

See specific policies or reference document for detailed coding information where indicated.

Capped Rental modifiers

- KH (DMEPOS item, initial claim, first month rental) is only to be used for the initial claim of the capped rental period
- KI (DMEPOS item, second- or third-month rental) is only to be used for the second and third months of the capped rental period
- KJ (DMEPOS item, parenteral enteral nutrition (PEN) pump or capped rental, months 4 to 15) is only to be used for the fourth through final month of the capped rental period

Wheelchair modifiers

- KX Modifier – Modifier should be appended to indicate that policy criteria has been met for all wheelchair DME items (includes base, seating, power devices, and additional accessories). Claims reported without KX modifier will deny as non-payable per medical policy. (Commercial, Medicaid products)
- KX, GA, GY, GZ Modifiers – Per CMS local coverage determinations, one of these modifiers are required for claim processing all wheelchair DME items (includes base, power bases, seating, and additional accessories). Please review applicable LCD for additional guidelines. (Medicare)
- RT, LT Modifiers – Laterality modifiers should be utilized to identify the right or left side when a bilateral accessory is supplied. Missing modifiers will result in a claim denial

<u>Equipment and supplies requiring pre-authorizations</u>

- Enteral feedings and supplies (S*ee policy 91278 Enteral Nutritional Therapy)*
- Ventilators

E0465 Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)
E0466 Home ventilator, any type, used with noninvasive interface, (e.g., mask, chest shell)
E0467 Home ventilator, multi-function respiratory device, also performs any or all of the additional functions of oxygen concentration, drug nebulization, aspiration, and cough stimulation, includes all accessories, components and supplies for all functions *(Not covered for Medicaid)*

- Compression appliances - *(Not separately payable when billed for use in conjunction with a procedure in office, OP facility or ambulatory surgical center).*

A4600 Sleeve for intermittent limb compression device, replacement only, each *(No prior authorization required; Not covered for Medicaid)*
A9900 Miscellaneous DME supply, accessory, and/or service component of another HCPCS code *(Explanatory notes must accompany claim)*

E0650 Pneumatic compressor, nonsegmental home model
E0651 Pneumatic compressor, segmental home model without calibrated gradient pressure
E0652 Pneumatic compressor, segmental home model with calibrated gradient pressure
E0655 Nonsegmental pneumatic appliance for use with pneumatic compressor, half arm
E0656 Segmental pneumatic appliance for use with pneumatic compressor, trunk *(Covered for Medicaid and Medicare only)*
E0657 Segmental pneumatic appliance for use with pneumatic compressor, chest *(Covered for Medicaid and Medicare only)*
E0660 Nonsegmental pneumatic appliance for use with pneumatic compressor, full leg
E0665 Nonsegmental pneumatic appliance for use with pneumatic compressor, full arm
E0666 Nonsegmental pneumatic appliance for use with pneumatic compressor, half leg
E0667 Segmental pneumatic appliance for use with pneumatic compressor, full leg
E0668 Segmental pneumatic appliance for use with pneumatic compressor, full arm
E0669 Segmental pneumatic appliance for use with pneumatic compressor, half leg
E0670 Segmental pneumatic appliance for use with pneumatic compressor, integrated, 2 full legs and trunk
E0671 Segmental gradient pressure pneumatic appliance, full leg
E0672 Segmental gradient pressure pneumatic appliance, full arm
E0673 Segmental gradient pressure pneumatic appliance, half leg
E0675 Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or bilateral system) (*Not covered for any plan)*
E0676 Intermittent limb compression device (includes all accessories), not otherwise specified (*Explanatory notes must accompany claims billed with unlisted codes.) (Not covered for Medicaid)*
E0677 Nonpneumatic sequential compression garment, trunk *(Covered For Medicaid only)*

E0678 Non-pneumatic sequential compression garment, full leg *(Covered For Medicaid Only)*
E0679 Non-pneumatic sequential compression garment, half leg *(Covered For Medicaid Only)*
E0680 Non-pneumatic compression controller with sequential calibrated gradient pressure *(Covered For Medicaid Only)*
E0681 Non-pneumatic compression controller without calibrated gradient pressure *(Covered For Medicaid Only)*
E0682 Non-pneumatic sequential compression garment, full arm *(Covered For Medicaid Only)*

- Implanted and external Stimulator devices (*See policy Stimulation Therapy and Devices Medical Policy #91468 or Peripheral Nerve Stimulation # 91634)*

- Wound pumps
  A6550 Wound care set, for negative pressure wound therapy electrical pump, includes all supplies and accessories
  A7000 Canister, disposable, used with suction pump, each (*No prior authorization required.)*
  A9272 Wound suction, disposable, includes dressing, all accessories and components, any type, each *Not Covered*
  E2402 Negative pressure wound therapy electrical pump, stationary or portable

- Speech Synthesizer *(Medicare and Medicaid Plans Only) (See policy 91499 Augmentative Communication / Speech Generating Devices for Medicaid Members)*

- Power Vehicles
  E1230 Power operated vehicle (3- or 4-wheel nonhighway), specify brand name and model number
  K0800 Power operated vehicle, group 1 standard, patient weight capacity up to and including 300 pounds
  K0801 Power operated vehicle, group 1 heavy-duty, patient weight capacity 301 to 450 pounds
  K0802 Power operated vehicle, group 1 very heavy-duty, patient weight capacity 451 to 600 pounds
  K0806 Power operated vehicle, group 2 standard, patient weight capacity up to and including 300 pounds *Not Covered Medicare*
  K0807 Power operated vehicle, group 2 heavy-duty, patient weight capacity 301 to 450 pounds *Not Covered Medicare*
  K0808 Power operated vehicle, group 2 very heavy-duty, patient weight capacity 451 to 600 pounds *Not Covered Medicare*
  K0812 Power operated vehicle, not otherwise classified (*Explanatory notes must accompany claims billed with unlisted codes.)*

- Shoe Inserts (*See policy 91420 Orthotics: Shoe Inserts, Orthopedic Shoes)*

- Bilirubin Light *(Prior authorization after 7 days rental)*
  E0202 Phototherapy (bilirubin) light with photometer

- Infusion/TPN Supplies and Services (all service lines for Home Infusion providers require prior authorization) (*See policy 91517 Parenteral Nutritional Therapy)*

- Infusion Pumps, Implantable & External (*See policy 91414 Infusion Pumps-Implantable And External*

Capped rental – authorization required:

- Mattresses, specialized sleep surfaces
  - E0193 Powered air flotation bed (low air loss therapy)
  - E0194 Air fluidized bed
  - E0371 Nonpowered advanced pressure reducing overlay for mattress, standard mattress length and width
  - E0372 Powered air overlay for mattress, standard mattress length and width
  - E0373 Nonpowered advanced pressure reducing mattress

- PAP devices (*See policy 91333 Obstructive Sleep Apnea & Upper Airway Resistance Syndrome) (auth after 3 units billed within 999 days)*

- Pulse oximeter (prior authorization required after 3 months rental)
  - E0445 Oximeter device for measuring blood oxygen levels noninvasively (*Not Covered Medicare See policy 91452 Pulse Oximetry for Home Use)*

- Hospital and specialty beds
  - E0250 Hospital bed, fixed height, with any type side rails, with mattress
  - E0251 Hospital bed, fixed height, with any type side rails, without mattress
  - E0255 Hospital bed, variable height, hi-lo, with any type side rails, with mattress
  - E0256 Hospital bed, variable height, hi-lo, with any type side rails, without mattress
  - E0260 Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress
  - E0261 Hospital bed, semi-electric (head and foot adjustment), with any type side rails, without mattress
  - E0265 Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, with mattress (*Not Covered Medicare)*
  - E0266 Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, without mattress (*Not Covered Medicare)*
  - E0270 Hospital bed, institutional type includes: oscillating, circulating and Stryker frame, with mattress (*Not covered for Medicaid or Medicare)*
  - E0290 Hospital bed, fixed height, without side rails, with mattress
  - E0291 Hospital bed, fixed height, without side rails, without mattress
  - E0292 Hospital bed, variable height, hi-lo, without side rails, with mattress
  - E0293 Hospital bed, variable height, hi-lo, without side rails, without mattress
  - E0294 Hospital bed, semi-electric (head and foot adjustment), without side rails, with mattress
  - E0295 Hospital bed, semi-electric (head and foot adjustment), without side rails, without mattress
  - E0296 Hospital bed, total electric (head, foot, and height adjustments), without side rails, with mattress (*Not Covered Medicare)*
  - E0297 Hospital bed, total electric (head, foot, and height adjustments), without side rails, without mattress (*Not Covered Medicare)*

E0300 Pediatric crib, hospital grade, fully enclosed, with or without top enclosure (*Not covered for Medicaid or Medicare)*
E0301 Hospital bed, heavy-duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, without mattress
E0302 Hospital bed, extra heavy-duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress
E0303 Hospital bed, heavy-duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, with mattress
E0304 Hospital bed, extra heavy-duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress
E0328 Hospital bed, pediatric, manual, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 in above the spring, includes mattress
E0329 Hospital bed, pediatric, electric or semi-electric, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 in above the spring, includes mattress

- Lifts
  E0170 Commode chair with integrated seat lift mechanism, electric, any type *(Not Covered for Medicaid)*
  E0171 Commode chair with integrated seat lift mechanism, nonelectric, any type
  E0172 Seat lift mechanism placed over or on top of toilet, any type (*Not Covered)*
  E0627 Seat lift mechanism, electric, any type (*Not covered for Medicaid)*
  E0629 Seat lift mechanism, non-electric, any type (*Not covered for Medicaid)*
  E0630 Patient lift, hydraulic or mechanical, includes any seat, sling, strap(s), or pad(s)
  E0635 Patient lift, electric, with seat or sling
  E0636 Multipositional patient support system, with integrated lift, patient accessible controls
  E0637 Combination sit-to-stand frame/table system, any size including pediatric, with seat lift feature, with or without wheels
  E0638 Standing frame/table system, one position (e.g., upright, supine or prone stander), any size including pediatric, with or without wheels
  E0639 Patient lift, moveable from room to room with disassembly and reassembly, includes all components/accessories
  E0640 Patient lift, fixed system, includes all components/accessories
  E0641 Standing frame/table system, multi-position (e.g., 3-way stander), any size including pediatric, with or without wheels
  E0642 Standing frame/table system, mobile (dynamic stander), any size including pediatric
  E1035 Multi-positional patient transfer system, with integrated seat, operated by care giver, patient weight capacity up to and including 300 lbs. (*Not covered for Medicaid)*
  E1036 Multi-positional patient transfer system, extra-wide, with integrated seat, operated by caregiver, patient weight capacity greater than 300 lbs. (*Not covered for Medicaid)*

- TENS Units *(see policy Peripheral Nerve Stimulation # 91634)* Authorization not required for Dx codes: M51.36 - M51.37, M53.2x7 - M532x8, M53.3, M53.86 - M53.88, M54.5, M54.89 - M54.9 for Medicaid and commercial plans. All other diagnoses require prior auth after 2 months rental. Medicare requires prior authorization from start of rental period.

- Manual and power wheelchairs
  - E1037 Transport chair, pediatric size *(No prior authorization required)*
  - E1038 Transport chair, adult size, patient weight capacity up to and including 300 pounds *(No prior authorization required)*
  - E1039 Transport chair, adult size, heavy duty, patient weight capacity greater than 300 pounds (*No prior authorization required)*
  - E1050 Fully-reclining wheelchair, fixed full-length arms, swing-away detachable elevating leg rests (*Not covered for Medicaid or Medicare)*
  - E1060 Fully-reclining wheelchair, detachable arms, desk or full-length, swing-away detachable elevating leg rests (*Not covered for Medicaid or Medicare)*
  - E1070 Fully-reclining wheelchair, detachable arms (desk or full-length) swing-away detachable footrest (*Not covered for Medicaid or Medicare)*
  - E1083 Hemi-wheelchair, fixed full-length arms, swing-away detachable elevating leg rest (*Not covered for Medicaid or Medicare)*
  - E1084 Hemi-wheelchair, detachable arms desk or full-length arms, swing-away detachable elevating leg rests (*Not covered for Medicaid or Medicare)*
  - E1085 Hemi-wheelchair, fixed full-length arms, swing-away detachable footrests (*Not covered for Medicaid or Medicare)*
  - E1086 Hemi-wheelchair, detachable arms, desk or full-length, swing-away detachable footrests (*Not covered for Medicaid or Medicare)*
  - E1087 High strength lightweight wheelchair, fixed full-length arms, swing-away detachable elevating leg rests (*Not covered for Medicaid or Medicare)*
  - E1088 High strength lightweight wheelchair, detachable arms desk or full-length, swing-away detachable elevating leg rests (*Not covered for Medicaid or Medicare)*
  - E1089 High-strength lightweight wheelchair, fixed-length arms, swing-away detachable footrest (*Not covered for Medicaid or Medicare)*
  - E1090 High-strength lightweight wheelchair, detachable arms, desk or full-length, swing-away detachable footrests (*Not covered for Medicaid or Medicare)*
  - E1092 Wide heavy-duty wheel chair, detachable arms (desk or full-length), swing-away detachable elevating leg rests (*Not covered for Medicaid or Medicare)*
  - E1093 Wide heavy-duty wheelchair, detachable arms, desk or full-length arms, swing-away detachable footrests (*Not covered for Medicaid or Medicare)*
  - E1100 Semi-reclining wheelchair, fixed full-length arms, swing-away detachable elevating leg rests (*Not covered for Medicaid or Medicare)*
  - E1110 Semi-reclining wheelchair, detachable arms (desk or full-length) elevating leg rest (*Not covered for Medicaid or Medicare)*
  - E1130 Standard wheelchair, fixed full-length arms, fixed or swing-away detachable footrests (*Not covered for Medicaid or Medicare)*
  - E1140 Wheelchair, detachable arms, desk or full-length, swing-away detachable footrests (*Not covered for Medicaid or Medicare)*
  - E1150 Wheelchair, detachable arms, desk or full-length swing-away detachable elevating leg rests (*Not covered for Medicaid or Medicare)*

E1160 Wheelchair, fixed full-length arms, swing-away detachable elevating leg rests (*Not covered for Medicaid or Medicare)*
E1161 Manual adult size wheelchair, includes tilt in space
E1170 Amputee wheelchair, fixed full-length arms, swing-away detachable elevating leg rests (*Not covered for Medicaid or Medicare)*
E1171 Amputee wheelchair, fixed full-length arms, without footrests or leg rest (*Not covered for Medicaid or Medicare)*
E1172 Amputee wheelchair, detachable arms (desk or full-length) without footrests or leg rest (*Not covered for Medicaid or Medicare)*
E1180 Amputee wheelchair, detachable arms (desk or full-length) swing-away detachable footrests (*Not covered for Medicaid or Medicare)*
E1190 Amputee wheelchair, detachable arms (desk or full-length) swing-away detachable elevating leg rests (*Not covered for Medicaid or Medicare)*
E1195 Heavy-duty wheelchair, fixed full-length arms, swing-away detachable elevating leg rests (*Not covered for Medicaid or Medicare)*
E1200 Amputee wheelchair, fixed full-length arms, swing-away detachable footrest (*Not covered for Medicaid or Medicare)*
E1220 Wheelchair; specially sized or constructed, (indicate brand name, model number, if any) and justification (*Not covered for Medicaid or Medicare*)
E1221 Wheelchair with fixed arm, footrests (*Not covered for Medicaid or Medicare)*
E1222 Wheelchair with fixed arm, elevating leg rests (*Not covered for Medicaid or Medicare)*
E1223 Wheelchair with detachable arms, footrests (*Not covered for Medicaid or Medicare)*
E1224 Wheelchair with detachable arms, elevating leg rests (*Not covered for Medicaid or Medicare)*
E1231 Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, with seating system
E1232 Wheelchair, pediatric size, tilt-in-space, folding, adjustable, with seating system
E1233 Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, without seating system
E1234 Wheelchair, pediatric size, tilt-in-space, folding, adjustable, without seating system
E1235 Wheelchair, pediatric size, rigid, adjustable, with seating system
E1236 Wheelchair, pediatric size, folding, adjustable, with seating system
E1237 Wheelchair, pediatric size, rigid, adjustable, without seating system
E1238 Wheelchair, pediatric size, folding, adjustable, without seating system
E1240 Lightweight wheelchair, detachable arms, (desk or full-length) swing-away detachable, elevating leg rest (*Not covered for Medicaid or Medicare)*
E1250 Lightweight wheelchair, fixed full-length arms, swing-away detachable footrest (*Not covered for Medicaid or Medicare)*
E1260 Lightweight wheelchair, detachable arms (desk or full-length) swing-away detachable footrest (*Not covered for Medicaid or Medicare)*
E1270 Lightweight wheelchair, fixed full-length arms, swing-away detachable elevating leg rests (*Not covered for Medicaid or Medicare)*
E1280 Heavy-duty wheelchair, detachable arms (desk or full-length) elevating leg rests (*Not covered for Medicaid or Medicare)*
E1285 Heavy-duty wheelchair, fixed full-length arms, swing-away detachable footrest (*Not covered for Medicaid or Medicare)*

E1290 Heavy-duty wheelchair, detachable arms (desk or full-length) swing-away detachable footrest (*Not covered for Medicaid or Medicare)*
E1295 Heavy-duty wheelchair, fixed full-length arms, elevating leg rest (*Not covered for Medicaid or Medicare*)
K0001 Standard wheelchair
K0002 Standard hemi (low seat) wheelchair
K0003 Lightweight wheelchair
K0004 High strength, lightweight wheelchair
K0005 Ultralightweight wheelchair
K0006 Heavy-duty wheelchair
K0007 Extra heavy-duty wheelchair
K0008 Custom manual wheelchair/base (*Not covered for Medicaid)*
K0009 Other manual wheelchair/base *(Explanatory notes must accompany claims billed with unlisted codes.)*
K0010 Standard-weight frame motorized/power wheelchair (*Not covered for Medicaid or Medicare)*
K0011 Standard-weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking (*Not covered for Medicaid or Medicare)*
K0012 Lightweight portable motorized/power wheelchair (*Not covered for Medicaid or Medicare)*
K0013 Custom motorized/power wheelchair base (*Not covered for Medicaid)*
K0014 Other motorized/power wheelchair base (*Not covered for Medicaid or Medicare)*
K0813 Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds
K0814 Power wheelchair, group 1 standard, portable, captain's chair, patient weight capacity up to and including 300 pounds
K0815 Power wheelchair, group 1 standard, sling/solid seat and back, patient weight capacity up to and including 300 pounds
K0816 Power wheelchair, group 1 standard, captain's chair, patient weight capacity up to and including 300 pounds
K0820 Power wheelchair, group 2 standard, portable, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0821 Power wheelchair, group 2 standard, portable, captain's chair, patient weight capacity up to and including 300 pounds
K0822 Power wheelchair, group 2 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0823 Power wheelchair, group 2 standard, captain's chair, patient weight capacity up to and including 300 pounds
K0824 Power wheelchair, group 2 heavy-duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0825 Power wheelchair, group 2 heavy-duty, captain's chair, patient weight capacity 301 to 450 pounds
K0826 Power wheelchair, group 2 very heavy-duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0827 Power wheelchair, group 2 very heavy-duty, captain's chair, patient weight capacity 451 to 600 pounds
K0828 Power wheelchair, group 2 extra heavy-duty, sling/solid seat/back, patient weight capacity 601 pounds or more

K0829 Power wheelchair, group 2 extra heavy-duty, captain's chair, patient weight 601 pounds or more
K0830 Power wheelchair, group 2 standard, seat elevator, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0831 Power wheelchair, group 2 standard, seat elevator, captain's chair, patient weight capacity up to and including 300 pounds
K0835 Power wheelchair, group 2 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0836 Power wheelchair, group 2 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds
K0837 Power wheelchair, group 2 heavy-duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0838 Power wheelchair, group 2 heavy-duty, single power option, captain's chair, patient weight capacity 301 to 450 pounds
K0839 Power wheelchair, group 2 very heavy-duty, single power option sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0840 Power wheelchair, group 2 extra heavy-duty, single power option, sling/solid seat/back, patient weight capacity 601 pounds or more
K0841 Power wheelchair, group 2 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0842 Power wheelchair, group 2 standard, multiple power option, captain's chair, patient weight capacity up to and including 300 pounds
K0843 Power wheelchair, group 2 heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0848 Power wheelchair, group 3 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0849 Power wheelchair, group 3 standard, captain's chair, patient weight capacity up to and including 300 pounds
K0850 Power wheelchair, group 3 heavy-duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0851 Power wheelchair, group 3 heavy-duty, captain's chair, patient weight capacity 301 to 450 pounds
K0852 Power wheelchair, group 3 very heavy-duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0853 Power wheelchair, group 3 very heavy-duty, captain's chair, patient weight capacity 451 to 600 pounds
K0854 Power wheelchair, group 3 extra heavy-duty, sling/solid seat/back, patient weight capacity 601 pounds or more
K0855 Power wheelchair, group 3 extra heavy-duty, captain's chair, patient weight capacity 601 pounds or more
K0856 Power wheelchair, group 3 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0857 Power wheelchair, group 3 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds
K0858 Power wheelchair, group 3 heavy-duty, single power option, sling/solid seat/back, patient weight 301 to 450 pounds
K0859 Power wheelchair, group 3 heavy-duty, single power option, captain's chair, patient weight capacity 301 to 450 pounds
K0860 Power wheelchair, group 3 very heavy-duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds

K0861 Power wheelchair, group 3 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0862 Power wheelchair, group 3 heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0863 Power wheelchair, group 3 very heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0864 Power wheelchair, group 3 extra heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 601 pounds or more
K0868 Power wheelchair, group 4 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0869 Power wheelchair, group 4 standard, captain's chair, patient weight capacity up to and including 300 pounds
K0870 Power wheelchair, group 4 heavy-duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0871 Power wheelchair, group 4 very heavy-duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0877 Power wheelchair, group 4 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0878 Power wheelchair, group 4 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds
K0879 Power wheelchair, group 4 heavy-duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0880 Power wheelchair, group 4 very heavy-duty, single power option, sling/solid seat/back, patient weight 451 to 600 pounds
K0884 Power wheelchair, group 4 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0885 Power wheelchair, group 4 standard, multiple power option, captain's chair, patient weight capacity up to and including 300 pounds
K0886 Power wheelchair, group 4 heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0890 Power wheelchair, group 5 pediatric, single power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds
K0891 Power wheelchair, group 5 pediatric, multiple power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds
K0898 Power wheelchair, not otherwise classified *(Explanatory notes must accompany claims billed with unlisted codes.)*

- Percussion vests
  E0483 High frequency chest wall oscillation air-pulse generator system, (includes hoses and vest), each

- Enteral pumps (*See policy 91278 Enteral Nutritional Therapy)*

<u>Loaner Equip – *no auth – 1 months rental only*</u>

- K0462 Temporary replacement for patient-owned equipment being repaired, any type *(Not covered for Medicaid)*
- Not Covered:
  E0190 - Positioning cushion/pillow/wedge, any shape or size, includes all components and accessories

Non-Covered

K1036 Supplies and accessories (e.g., transducer) for low frequency ultrasonic diathermy treatment device, per month

E2001 Suction pump, home model, portable or stationary, electric, any type, for use with external urine management system

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