Durable Medical Equipment (DME): Other DME Equipment

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This section contains information about Durable Medical Equipment (DME) items not included in the following DME groups: infusion equipment, oxygen and respiratory equipment, speech generating devices, therapeutic anti-decubitus mattresses and bed products and wheelchairs and wheelchair accessories.

Per *California Code of Regulations*, Title 22, Section 51321(g): Authorization for durable medical equipment (DME) equipment shall be limited to the lowest cost item that meets the patient's medical needs.

Pursuant to *Welfare and Institutions Code* (W&I Code), Section 14105.395, the provisions contained herein have the force and effect of regulations and shall prevail over any inconsistent provisions in CCR sections relating to DME.

The "date of delivery" to the recipient is the "date of service." This means that when the recipient takes receipt of the DME item, that date is considered the "date of service." Charges for shipping and handling are not reimbursable.

Along with this section providers should refer to additional DME information as follows:

Table of Where to Find Additional DME Information

Topic	Provider Manual Section
General policy information	*Durable Medical Equipment (DME): An Overview*
Billing guidelines and documentation requirements	*Durable Medical Equipment (DME): Bill for DME*
Billing for DME on the *CMS-1500* claim form	*Durable Medical Equipment (DME): Billing Examples*
DME codes reimbursed by Medi-Cal	‹‹*Durable Medical Equipment (DME): Billing Codes*››
Frequency limits for DME purchases	*Durable Medical Equipment (DME) Billing Codes: Frequency Limits*

Reference

Refer to the appropriate section in this manual for details about the following DME:

- Infusion Equipment
- Oxygen Contents, Oxygen Equipment and Respiratory Equipment
- Speech Generating Devices
- Therapeutic Anti-Decubitus Mattresses and Bed Products
- Wheelchairs and Wheelchair Accessories

This DME section includes the following items:

- Ambulation Devices
- Bathroom Equipment
- DME For Disabled Parent
- Hospital Beds and Accessories
- Patient Lifts and Standing Frames
- Patient Transfer Systems
- ‹‹Phototherapy››
- Pneumatic Compressors
- Miscellaneous Equipment, Accessories and Supplies
  - Blood Glucose Monitors
  - Blood Pressure Equipment
  - Breastfeeding: Lactation Management Aids
  - Cough Stimulating Device
  - Electrodes and Lead Wires
  - Haberman Feeder
  - Negative Pressure Wound Therapy Devices
  - Osteogenesis Stimulator
  - Pulsed Irrigation Enhanced Evacuation (PIEE)
  - Positioning Seat
  - Ramps, Portable

- Scales
- Theratogs
- Transcutaneous Electrical Nerve Stimulators (TENS)
- Tumor Treating Field Devices
- Wearable Cardiac Defibrillator

Ambulation Devices

Walkers

HCPCS codes E0130 to E0149 are used for walkers. Claims for reimbursement of walkers include accessories which should not be billed separately at the initial purchase time. Column II codes are included in the reimbursement for the corresponding Column I code when provided at the time of purchase.

Code Descriptions for Walker Accessories Not Separately Reimbursable

Column I	**Column II**
Walker, rigid (pickup), adjustable or fixed height (E0130)	A4636, A4637
Walker, folding (pickup), adjustable or fixed height (E0135)	A4636, A4637
Walker, with trunk support, adjustable or fixed height, any type (E0140)	A4636, A4637, E0155, E0159
Walker, rigid, wheeled, adjustable or fixed height (E0143)	A4636, A4637, E0155, E0159
Walker, enclosed, four-sided frame, rigid or folding, wheeled with posterior seat (E0144)	A4636, A4637, E0155, E0156, E0159
Walker, heavy duty, multiple braking system, variable wheel resistance (E0147)	A4636, E0155, E0159
Walker, heavy duty, without wheels, rigid or folding, any type, each (E0148)	A4636, A4637
Walker, heavy duty, wheeled, rigid or folding, any type (E0149)	A4636, A4637, E0155, E0159

‹‹For DME accessory product detail and purchase and rental information, see the *Durable Medical Equipment (DME): Billing Codes* section of this manual.››

Gait Trainer

Definition

A gait trainer is a mobile external, fixed base of support that also provides either extensive trunk/postural supports and/or pelvic stability supports in order to allow mobility

Coverage

Coverage of gait trainer devices is limited to those recipients meeting the medical necessity criteria.

Medical Necessity

‹‹A copy of the written prescription signed by the treating practitioner (or electronic equivalent) must be submitted to the Medi-Cal office.›› Adequate documentation in the medical records for the recipient must clearly indicate the need for a gait trainer device based on the recipient's medical condition.

TAR Requirement

A *Treatment Authorization Request* (TAR) must be submitted by the recipient's provider to the TAR Processing Center. A copy of the written prescription (or electronic equivalent) must accompany the TAR. Adequate documentation in the recipient's medical records that accompany the TAR must include the following:

- Evaluation must be done by a licensed physical therapist.
- Recipient must be able to use the gait trainer in a purposeful manner.
- Recipient must be able to partially bear weight and advance lower extremities.
- Recipient requires greater structural and balance assistance than provided by a walker.
- Recipient must have satisfactory head control.
- Recipient does not have any other form of self-initiated mobility.

The following are other related criteria that must be taken into consideration for gait training devices:

- Recipient may need attendant assistance to be positioned in a gait training device.
- Recipient must have support and willingness to comply with safety considerations and any self-directed programs.
- Recipient may need supervision when using the device.
- Recipient may require ample space for use of the equipment.
- Recipient's parents or guardians (for pediatric recipients) must demonstrate that they are compliant with all considerations in a prescribed home-walking program.
- Recipient's upper extremity weight-bearing ability, joint stability, and ability to maneuver must be given consideration in choosing a possible gait trainer type.

Gait trainers and walkers serve different purposes for the recipients. Submitted TARs will be reviewed based on medical necessity.

HCPCS Codes

Providers must bill for gait trainer devices with HCPCS codes E8000 (gait trainer, pediatric size, posterior support, includes all accessories and components), E8001 (gait trainer, pediatric size, upright support, includes all accessories and components) and E8002 (gait trainer, pediatric size, anterior support, includes all accessories and components).

Bathroom Equipment

Coverage

Bathroom equipment such as rails, seats, stools, benches, and shower hoses and accessories are not covered by Medicare.

Providers may bill Medi-Cal for bathroom equipment without having to first obtain a denial from Medicare. For more information, see the *Medicare Non-Covered Services: HCPCS Codes* section in this manual.

Commode Chairs

HCPCS codes E0170 (commode chair with integrated seat lift mechanism, electric, any type) and E0171 (commode chair with integrated seat lift mechanism, nonelectric, any type) must include documentation on the TAR that the patient has a neuromuscular dysfunction or disease, or arthropathy of the hips and/or knees. E0170 and E0171 are not separately reimbursable in the same month of service.

DME For Disabled Parent

Coverage

DME items may be covered to assist a disabled recipient to care for a child for whom the disabled recipient is a parent, stepparent, foster parent or legal guardian.

The DME item must be medically necessary for the parent to care for their child (for example, a wheelchair baby carrier). DME items cannot include common household items such as strollers, wraps, slings or soft-structured carriers.

Authorization

A TAR is required for DME for a disabled parent. The following documentation must be submitted with each TAR:

- ‹‹A prescription from the treating practitioner for the specific DME item, and››
- Documentation from the recipient's physician, nurse practitioner, clinical nurse specialist or physician assistant of the recipient's medical disability that justifies the need for the DME item.

Claims for DME for a disabled parent must be submitted using HCPCS code A9999 (miscellaneous DME supply or accessory, not otherwise specified), ICD-10-CM diagnosis code Z73.6 and modifier SC.

Reimbursement

DME items that are prescribed to assist a disabled recipient care for their child may be reimbursed according to the reimbursement policy associated with each specific DME item (wheelchair equipment, non-wheelchair equipment, or DME supply/accessory pricing policy). For more information regarding reimbursement of DME, refer to the *Durable Medical Equipment (DME): An Overview* section of this manual.

Hospital Beds and Accessories

Billing Restriction

HCPCS codes E0271 (mattress, inner spring), E0272 (mattress, foam rubber), E0305 (bedside rails; half length) and E0310 (bedside rails; full length) are not reimbursable if billed with code 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), code E0304 (hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress), code 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) or code 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). If any combination of the mattress and/or bedrail codes is billed separately, no more than the allowed amount for bed codes E0303, E0304, E0328 or E0329 will be paid.

‹‹For purchase and rental information, see “Hospital Beds and Accessories” in the *Durable Medical Equipment (DME): Billing Codes* section of this manual.››

Note: HCPCS codes E0303 and E0304 are semi-electric, as are all heavy duty beds. Semi-electric beds electronically control the head and knee sections and manually adjust the height.

Pediatric Crib

HCPCS code E0316 (safety enclosure frame/canopy for use with hospital bed, any type) is not separately reimbursable to any provider if billed for the same recipient with HCPCS code E0300 (pediatric crib, hospital grade, fully enclosed).

Criteria for Pediatric Beds

Most pediatric medical conditions do not require specialized home furnishings as prescribed medical treatment. It is reasonable to expect parents or legal caregivers of infants and children to provide an appropriate bed and bed care items necessary for comfort and positioning. However, a hospital or specialized bed and related accessories may be medically necessary for pediatric recipients when the nature and severity of their illness, injury, or disease meets all of the following medical criteria:

- The hospital bed is necessary to treat the medical condition as documented in the medical record.
- The hospital bed is expected to produce a positive medical outcome which would not occur without the bed, or will prevent complications or worsening of the medical condition for which it is prescribed.
- The desired medical benefit is not attainable by use of an ordinary bed.
- An ordinary bed cannot be modified or adapted by commercially available items to meet the medical need.

Enclosed cribs or enclosed pediatric beds may be medically necessary for recipients with diagnosis of developmental delay when the nature and severity of their illness, injury, or disease meets all of the following medical criteria:

- The behavioral necessity for an enclosed bed is documented and described in the medical record.
- There is clinical documentation that underlying behavioral issues have been proactively addressed with appropriate behavioral interventions and modification without success.
- Other less restrictive forms of bed restraint/accommodations have been employed without adequate success (such as increased caregiver monitoring, alarm systems, padding bedrails or placing mattress on the floor).
- An ordinary bed cannot be modified or adapted by commercially available items to meet the child’s needs.
- There is no other appropriate and reasonably feasible alternative method for providing safe bed/sleep care.
- The request for the enclosed bed is not for caregiver convenience or due to lack of caregiver monitoring of recipient’s safety.

California Children's Services Program Clients

Requests for hospital beds and accessories for children case managed by California Children's Services (CCS) are reviewed by CCS for medical necessity for treatment of a CCS-eligible medical condition per *California Code of Regulations*, Title 22, Sections 41515.1 thru 41518.9.

Adult Hospital Beds and Accessories

Hospital beds and accessories are covered for recipients who meet medical necessity criteria. The medical records for the recipient must clearly reflect the medical necessity. Some examples of hospital bed accessories are: trapeze equipment, bed cradle, side rails and safety enclosures.

Types of Hospital Beds

Following are the different types of hospital beds:

- Fixed height
- Variable height
- Semi-electric
- Heavy-duty extra-wide
- Extra heavy-duty
- Total electric

Coverage Criteria for Hospital Beds

Fixed Height

Recipient must meet at least one of the following criteria for fixed height hospital beds:

- Recipient's positioning of body is not feasible in non-hospital beds.
- Recipient needs promotion of body alignment to prevent contractures and has a history of contractures or a documented medical condition that causes risk of contractures.
- Recipient with a documented history of pain related to positioning needs alleviation of such pain.
- Recipient with a documented history of respiratory infection needs avoidance of respiratory infections related to positioning.
- Recipient needs more than 30 degrees elevation of the bed's head due to certain medical conditions such as congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD) or has a documented history of aspiration.
- Recipient needs use of special attachments or traction equipment.

Note: The hospital bed is not covered if elevation of the head/upper body is less than 30 degrees. Pillows and wedges must have been ruled out as an option.

Variable Height

The following criteria must be met for variable-height hospital beds:

- Recipient must meet the coverage criteria for fixed-height hospital bed, and
- Recipient requires height adjustment to transfer to chair, transfer to wheelchair, or get up to a standing position.

Semi-Electric

Following are the coverage criteria for semi-electric hospital beds:

- Recipient must meet the coverage criteria for fixed-height hospital bed, and
- Recipient requires frequent body position change, and/or
- Recipient requires immediate body position change.

Heavy-Duty Extra-Wide

Following are the coverage criteria for heavy-duty extra-wide hospital beds:

- Recipient must meet the coverage criteria for fixed height hospital bed, and
- Recipient's weight is 351 to 600 pounds

Extra Heavy-Duty

Following are the criteria that must be met for extra heavy-duty hospital beds:

- Recipient must meet the coverage criteria for fixed-height hospital bed, and
- Recipient's weight exceeds 600 pounds

Total Electric

This item is mostly for convenience purposes and is not a Medi-Cal benefit.

Certification of Medical Necessity

Medical necessity must be clearly documented by the licensed practitioner. A prescription signed by the prescribing practitioner (or electronic equivalent) must accompany the TAR for the hospital bed. Clinical documentation must describe the medical condition, severity and frequency of symptoms that necessitate a hospital bed. The therapeutic outcome expected to be achieved with the use of the hospital bed, availability of a caregiver, and recipient's level of independence to operate the bed must also be included in the clinical documentation.

‹‹Providers must submit the Department of Health Care Services (DHCS) form 6181 Certificate of Medical Necessity for All Durable Medical Equipment (DME) (Except Wheelchairs and Scooters) or equivalent form or document if it contains all information requested on the form for that item.

Note: Providers can view all of the above forms on the Forms page of the Med-Cal website. From the Medi-Cal home page, providers click the "References" tab and then the "Forms" tab.››

Patient Lifts and Standing Frames

Standing Systems and Standing Frames

Standers and standing frames to allow wheelchair dependent patients to achieve a passive standing position are Medi-Cal benefits subject to authorization. The equipment is billed with HCPCS codes E0637 (combination sit to stand system, any size including pediatric, with seatlift feature, with or without wheels), E0638 (standing frame system, one position, any size including pediatric, with or without wheels), E0641 (standing frame system, multi-position, any size including pediatric, with or without wheels) or E0642 (standing frame system, mobile [dynamic stander], any size including pediatric).

Medical Necessity

Standers and standing frames are considered medically necessary when there is documentation of the following:

- The device would allow the recipient to become more independent in one or more of the activities of daily living, and
- For a recipient with a pressure sore, the device would provide pressure relief/off-loading of the pressure sore that cannot be accomplished by other means, or
- Lower body strength is increased by maintaining a standing position for recipients with spastic quadriplegia or other neuromuscular conditions who are unable to rise from a seated to standing position without assistance and have some residual strength in the hips or legs, or
- Lower body strength is increased by maintaining a standing position for recipients with paraplegia and other neuromuscular conditions who are unable to rise from a seated to a standing position without assistance and have some residual strength in the hips or legs, and
- There is documentation that the recipient has tried the system through an ongoing outpatient therapy program and the physical therapist has witnessed the use of the system and recommends it.

Standers and standing frames are not considered medically necessary for recipients with complete paralysis of the hips and legs, such that lower body range of motion is not improved or maintained by the standing position, or if using the stander/frame would create an unsafe situation for the recipient.

‹‹Prescribing Practitioner››

‹‹When ordering standing equipment billed with codes E0637, E0638, E0641 or E0642, the prescribing practitioner must provide medical documentation that the recipient has had sufficient training with the system and does not have a fracture risk or does not develop vertigo or become nauseous by standing. The prescribing practitioner must also document that the recipient is willing and able to stand and that there are suitable facilities and assistance available (when needed) in the recipient's home for standing.››

TAR Requirements

A TAR may be authorized only for those recipients who have had an adequate case management assessment of their overall needs for ambulation, positional changes and other essential activities of daily living, including an onsite evaluation as necessary.

TARs requesting authorization of HCPCS codes E0637, E0638, E0641 or E0642 must include the following information.

- Diagnosis, age, height and weight, or other information regarding size
- Description of functions (sitting ability, standing ability, mobility)
- Description of transfers, functional goals, current program directed toward functional goals
- Daily activities, relevant impairment (range of motion, bowel/bladder/intestinal function, history of fractures or risk for bone density issues, respiratory status)

A three-month rental period is mandatory before purchase of any stander/standing frame unless the recipient has participated in a community program of standing three to four times per week, for at least three months.

Additionally, the TAR must provide answers to the following questions:

- What is the recipient's history of standing or efforts to stand?
- What is the recipient's current standing program? Does the recipient stand in any other setting (school, work setting, etc.)?
- Is the recipient able to stand by any method other than a stander (against furniture, with assist of caregiver, with a strap or support, with a walker, etc.)?
- How is the use of a stander related to the functional goals for this recipient?
- What specific activities for this recipient require a stander?
- Is there a home program or therapy program that requires regular use of a stander?
- Has this recipient experienced a trial of the proposed stander or any other stander and what were the results?
- What other standing devices were considered, and why were they rejected?
- What other less costly alternatives were considered, and why were they rejected (other approaches to identified needs – range of motion, stretching, splints, respiratory activities, other methods of weight-bearing, etc.)?

Patient Transfer Systems

Multi-positional Patient Transfer Systems

HCPCS code E1035 (multi-positional patient transfer system, with integrated seat, operated by care giver, patient weight capacity up to and including 300 lbs.)

HCPCS code E1036 (multi-positional patient transfer system, extra-wide, with integrated seat, operated by care giver, patient weight capacity greater than 300 lbs.)

‹‹For purchase and rental information, see "Wheelchairs, Modifications and Accessories, Transport Chairs" in the *Durable Medical Equipment (DME): Billing Codes* section of this manual. These codes are nontaxable.››

Code E1036 requires a *Treatment Authorization Request* (TAR).

HCPCS codes E1035 and E1036 are not separately payable within the same month as code E0240 (bath/shower chair, with or without wheels, any size).

The frequency limit for codes E1035 and E1036 is once in five years.

Stairway Chairlifts

A stairway chairlift is a Medi-Cal benefit, subject to authorization. Providers must bill using HCPCS code E1399.

TAR Requirements

Each TAR will be reviewed on a case-by-case basis. Medical necessity, cost considerations, less costly options available and the ability of the recipient or caregiver to independently and safely operate the stairway chairlift will be taken into consideration.

Required Documentation

The following documentation must accompany the TAR:

- A description of all rooms available to the recipient on the residence level used by the recipient
- A description of other rooms on other levels of the residence that the recipient must access for activities of daily living
- The treating practitioner's prescription
- An explanation of why the stairway chairlift is medically necessary for the recipient, including which less costly options have been tried or considered, and why these options did not meet the medical needs of the recipient

Adjudication of TARs for stairway chairlifts is conducted by the San Francisco Medi-Cal Field Office.

Reimbursement

Reimbursement for code E1399 is "By Report."

‹‹Phototherapy

HCPCS code E0202 (phototherapy [bilirubin] light with photometer) is covered when medically necessary for infants as a daily rental only. Modifier RR is required.

The following criteria must be met.

- The infant's total serum bilirubin is in the "optional range" as defined by the American Academy of Pediatrics Subcommittee on Hyperbilirubinemia; and
- The infant is feeding, voiding and stooling well and appears well; and
- Close follow-up evaluation can be accomplished››

Claims submitted to bill for the phototherapy light may be submitted under the mother's Medi-Cal ID if the infant's Medi-Cal eligibility has not yet been established. Claims that use the mother's Medi-Cal ID for the infant, must indicate in the *Patient Relationship to Insured* field (Box 6) that the "patient is the child of the insured."

The frequency limit for HCPCS code E0202 is 10 days per lifetime, per infant. A TAR can override the frequency limit when more than one infant born to the same mother (for example, twins, or infant from subsequent birth) requires phototherapy. When phototherapy is needed for more than one infant, claims for phototherapy require a statement in the *Additional Claim Information* field (Box 19) specifying the number of infants needing phototherapy at this time or that a previous claim was submitted for a sibling who also required phototherapy.

Pneumatic Compressors

Lymphedema Pumps/Pneumatic Compression Devices

Coverage of lymphedema pumps/pneumatic compression devices is limited to mastectomy patients and patients with upper and lower extremity conditions. One of the following ICD-10-CM diagnosis codes is required on the TAR but is not required on the claim: I89.0, I97.2 or Q82.0.

All lymphedema pumps/compression devices (HCPCS codes E0650, E0651, E0655 thru E0657, E0660, E0665 thru E0669, E0671 thru E0673, E0678 thru E0682) require authorization. They must be prescribed by a licensed practitioner within the scope of his/her practice and are subject to appropriate physician oversight. The ideal situation would be for these patients to be under case management. An initial 60-day trial rental may be authorized and must establish clinical effectiveness.

‹‹Code Descriptions and Corresponding "Do Not Report" Policy Table

Code	Description	Do not reimburse within the same month
E0650	Pneumatic compressor, nonsegmental home model	E0651, E0652, E0656, E0657, E0667 thru E0673, E0678 thru E0682
E0651	Pneumatic compressor, segmental home model without calibrated gradient pressure	E0650, E0652, E0655, E0660, E0665, E0666, E0675, E0676, E0680, E0681
E0655	Nonsegmental pneumatic appliance for use with pneumatic compressor, half arm	E0651, E0652, E0656, E0657, E0667 thru E0673, E0678 thru E0682››

‹‹**Code Descriptions and Corresponding "Do Not Report" Policy Table (continued)**

Code	Description	Do not reimburse within the same month
E0656	Segmental pneumatic appliance for use with pneumatic compressor, trunk	E0650, E0660, E0665, E0666, E0670, E0678 thru E0682
E0657	Segmental pneumatic appliance for use with pneumatic compressor, chest	E0650, E0655, E0660 thru E0666, E0678 thru E0682
E0660	Nonsegmental pneumatic appliance for use with pneumatic compressor, full leg	E0651, E0652, E0656, E0657, E0667 thru E0673, E0678 thru E0682
E0665	Nonsegmental pneumatic appliance for use with pneumatic compressor, full arm	E0651, E0652, E0656, E0657, E0667 thru E0673, E0678 thru E0682
E0666	Nonsegmental pneumatic appliance for use with pneumatic compressor, half leg	E0651, E0652, E0656, E0657, E0667 thru E0673, E0678 thru E0682
E0667	Segmental pneumatic appliance for use with pneumatic compressor, full leg	E0650, E0655, E0660 thru E0666, E0678 thru E0682
E0668	Segmental pneumatic appliance for use with pneumatic compressor, full arm	E0650, E0655, E0660 thru E0666, E0678 thru E0682
E0669	Segmental pneumatic appliance for use with pneumatic compressor, half leg	E0650, E0655, E0660 thru E0666, E0678 thru E0682
E0670	Segmental pneumatic appliance for use with pneumatic compressor, integrated, two full legs and trunk	E0650, E0655, E0656, E0660 thru E0667, E0669, E0671, E0673, E0678 thru E0682
E0671	Segmental gradient pressure pneumatic appliance, full leg	E0650, E0655, E0660 thru E0666, E0670, E0678 thru E0682
E0672	Segmental gradient pressure pneumatic appliance, full arm	E0650, E0655, E0660 thru E0666, E0678 thru E0682
E0673	Segmental gradient pressure pneumatic appliance, half leg	E0650, E0655, E0660 thru E0666, E0670, E0678 thru E0682››

Code Descriptions and Corresponding "Do Not Report" Policy Table (continued)

Code	Description	Do not reimburse within the same month
E0678	Nonpneumatic sequential compression garment, full leg	‹‹E0650 thru E0652, E0660, E0666, E0667, E0669 thru E0671, E0673, E0679››
E0679	Nonpneumatic sequential compression garment, half leg	‹‹E0650 thru E0652, E0660, E0666, E0667, E0669 thru E0671, E0673, E0678››
E0680	Nonpneumatic compression controller with sequential calibrated gradient pressure	E0650 thru E0652, E0675, E0676, E0681
E0681	Nonpneumatic compression controller without calibrated gradient pressure	E0650 thru E0652, E0675, E0676, E0680
E0682	Nonpneumatic sequential compression garment, full arm	E0650, E0668, E0672

Lymphedema pumps and pneumatic compression devices are not covered when the following medical guidelines are not met or for other indications such as venous insufficiency. Pumps or sequential pneumatic compression devices are contraindicated in the presence of active infection or deep vein thrombosis in the affected limb.

Criteria

Lymphedema pumps/compression devices are subject to the following criteria:

- The recipient has a confirmed diagnosis of primary or secondary lymphedema, and
- Lymphedema has been shown to be associated with functional impairment of the recipient.
- Conservative medical therapies, such as elevation of the affected limb, exercise, massage and/or use of an appropriate compression bandage system or compression garment, have been tried for at least 30 days and failed to reduce prolonged lymphedema, and
- The recipient has demonstrated compliance with the past recommended medical treatment(s).

Lymphedema pumps and pneumatic compression devices may be purchased (modifier NU) or rented (modifier RR). Purchase or continued rental may be authorized when there is documented effectiveness of the pump (a decrease in edema is documented by pre- and post-treatment measurements and/or documentation of functional improvement).

Segmental Pneumatic Appliances

Reimbursement for HCPCS codes E0656 (segmental pneumatic appliance, trunk) and E0657 (segmental pneumatic appliance, chest) requires authorization and must be billed using modifier NU for purchase, RR for rental or RB for repair/replacement. The TAR must include one of the following:

Required Diagnosis Code Descriptions Table

ICD-10-CM Diagnosis Code	Description
I89.0	Lymphedema, not elsewhere classified
I97.2	Postmastectomy lymphedema syndrome
Q82.0	Hereditary lymphedema

Codes E0656 and E0657 are restricted to once-in-a-lifetime reimbursement per recipient, any provider.

Codes E0680 and E0681 must be billed using modifier NU for purchase, RR for rental, or RB for repair. Codes E0678, E0679 and E0682 must be billed using modifier NU for purchase. Codes E0678 thru E0682 require authorization and the TAR must include one of the following ICD-10 codes: I89.0 or Q82.0.

Miscellaneous Equipment, Accessories and Supplies

Blood Glucose Monitors

Blood glucose monitors (glucometers), with or without special features, may be prescribed for the purpose of monitoring a recipient's blood glucose levels at home when the recipient has any of the following conditions:

- Type I insulin-dependent diabetes
- Type II non-insulin-dependent diabetes
- Diabetes Mellitus complicating pregnancy
- Gestational diabetes

‹‹Home blood glucose monitors are billed with HCPCS codes E0607 and E2104. Home blood glucose monitors for use with integrated lancing/blood sample testing cartridges are billed with HCPCS code E2104.›› Blood glucose monitors with special features (for example, integrated voice synthesizers) are billed with HCPCS codes E2100 and E2101. Adjunctive blood glucose alert systems are billed with HCPCS code E2102 with required modifiers NU for purchase and modifier RB for repair, and a minimum age of two years.

Documentation Requirements

Claims for any blood glucose monitor must include the ICD-10-CM diagnosis codes (including all relevant digits) related to the type of diabetes for which the instrument is being prescribed. Claims for HCPCS code E0607 must contain documentation that the recipient or caregiver is competent to monitor the equipment and that the device is designed for home rather than clinical use.

Authorization

Authorization is always required for glucometers with special features (HCPCS codes E2100 and E2101). Authorization is required for code E0607 only when the cost exceeds the established TAR threshold limits for rental or purchase of DME. The TAR must contain the following documentation:

- The following ICD-10-CM diagnosis codes:
  - Diagnosis of drug or chemical induced diabetes (E09.8, E09.9)
  - Type I diabetes (E10.10 thru E10.9)
  - Type II diabetes (E11.00 thru E11.9)
  - Other specified diabetes (E13.00 thru E13.9)
  - Diabetes complicating pregnancy (O24.011 thru O24.33, O24.811 thru O24.93)
  - Gestational diabetes (O24.111 thru O24.439, O99.810 thru O99.815, O99.891, thru O99.893) with intent to monitor blood glucose at home, and
- Written statement that the requested glucometer is the least costly item available that will meet the recipient's medical needs, and
- For codes E2100 and E2101, written explanation of the severity of the impairment justifying a special feature for the effective use of the equipment, and
- For codes E2100 and E2101, written statement that the recipient requesting a glucometer with special features is capable of using the equipment in the home setting and is not dependent upon a caregiver for blood glucose testing. (If the recipient is dependent upon a caregiver, the caregiver's need for any requested special features must be justified.)

Supplies

‹‹Integrated lancing and blood sample testing cartridges for use with home blood glucose monitor HCPCS code E2104 are to be billed with HCPCS code A4271 (integrated lancing and blood sample testing cartridges for home blood glucose monitor, per 50 tests).››

Glucometer test strips, lancets and other monitoring supplies are billed using specific medical supply codes. For information about specific codes, refer to the *Medical Supplies List* sections in the appropriate Part 2 manual.

Blood Pressure Equipment

HCPCS codes A4660 (sphygmomanometer/blood pressure apparatus with cuff and stethoscope), A4663 (blood pressure cuff only) and A4670 (automatic blood pressure monitor) do not require documentation for reimbursement except for pricing information. These may be billed with any ICD-10-CM diagnosis code that justifies medical necessity.

These codes are for purchase only. If these codes are billed with modifier RR (rental), the claim will be denied.

Breastfeeding: Lactation Management Aids

Lactation management aids include breast pumps and breast pump supplies that may be purchased or rented if medically necessary. Breast pumps (HCPCS codes E0602, E0603 and E0604) must include all supplies necessary for use of the breast pump (tubing, adapter, breast pump bottle and cap, breast shield and splash protector and locking ring).

Follow these guidelines when billing for breast pumps:

Billing Guidelines for Breast Pumps Table

HCPCS Code	Item	TAR
E0602	Breast pump, manual, any type	Required if the cumulative cost within the calendar month for the purchase of lactation management aids exceeds $100
E0603	Breast pump, electric (AC and/or DC), any type. This is also known as a personal grade (single-user) electric breast pump.	Required if the cumulative cost within the calendar month for the purchase of lactation management aids exceeds $100
E0604	Breast pump, hospital grade, electric (AC and/or DC), any type. This is also known as a hospital grade (multi-user) electric breast pump.	Refer to “Hospital Grade (Multi-User) Electric Breast Pumps” following

Note: Code E0602 may be used to bill either a manual breast pump or a breast pump kit.

Hospital Grade (Multi-User) Electric Breast Pumps

Hospital grade (multi-user) electric breast pumps (HCPCS code E0604) are covered when medically necessary for daily rental only. If there are no other relevant rentals, a TAR is not required until the rental amount exceeds $164 in a 15-month period. See criteria below for establishing medical necessity.

Documentation When TAR is Required

A TAR must be accompanied by documentation establishing that the item is medically necessary in either of the two following situations:

- If direct nursing at the breast is established during the neonatal period (the period immediately following birth and continuing through the first 28 days of life) and nursing is interrupted, medical necessity for code E0604 is defined as the existence of any of the following medical conditions:
  - The mother has a medical condition that requires treatment of her breast milk before infant feeding; or
  - The mother is receiving chemotherapy or other therapy with pharmaceutical agents that render her breast milk unsuitable for infant feeding; or
  - The infant developed a medical condition or requires hospitalization that precludes direct nursing at the breast on a regular basis.
- If direct nursing at the breast is not established during the neonatal period, medical necessity for code E0604 is defined as the existence of any of the following medical conditions:
  - Any maternal medical condition that precludes direct nursing at the breast; or
  - The infant has a congenital or acquired neuromotor or oral dysfunction that precludes effective direct nursing at the breast; or
  - The infant has a congenital or acquired condition that precludes effective direct nursing at the breast; or
  - The infant continues to be hospitalized and the mother is no longer an inpatient.

TAR Requirements

TARs for the rental or purchase of electric pumps must include the following:

- A complete, detailed description of the medical necessity (see situations listed above) for the requested equipment.
- An explanation of why an electric pump or other specialized equipment must be used instead of a less expensive manual device.

When a TAR is required, it must be accompanied by a prescription signed by the treating practitioner (or electronic equivalent).

TARs are submitted to the TAR Processing Center.

Durable Medical Equipment (DME) coverage is limited by the *California Code of Regulations* (CCR), Title 22, Section 51321, to the lowest cost item that meets the patient's medical needs. Once the cumulative rental of a hospital grade (multi-user) electric breast pump exceeds the pump's maximal allowable purchase price, no further rental shall be authorized and the item shall be deemed to have been purchased.

Replacement Breast Pump Supplies

Purchase of the following replacement breast pump supplies for patient-owned breast pumps and storage bags are reimbursable.

Reimbursable Code Descriptions for Breast Pump Supplies Table

HCPCS Code	Description
A4281	Tubing for breast pump, replacement
A4282	Adapter for breast pump, replacement
A4283	Cap for breast pump bottle, replacement
A4284	Breast shield and splash protector for use with breast pump, replacement
A4285	Polycarbonate bottle for use with breast pump, replacement
A4286	Locking ring for breast pump, replacement
A4287	Disposable collection and storage bag for breast milk, any size, any type, each

These items are not to be rented or repaired and they must be billed with modifier NU (purchase) only. Reimbursement is “By Report.” Claims for these items require a statement in the *Additional Claim Information* field (Box 19) that the patient owns a breast pump. Labor charges (HCPCS code K0739 or K0740) for these items are not separately reimbursable.

HCPCS codes A4281 thru A4286 are only covered when the specific replacement part no longer functions properly. Medi-Cal will reimburse HCPCS codes A4281 thru A4286 for up to two replacements per recipient per 12 months. An approved TAR is not required. Providers must document in the Medi-Cal recipient’s records the specific item(s) that need(s) to be replaced and the details of the malfunction. These records are subject to post audit review.

HCPCS codes A4281 thru A4286 are not separately reimbursable within the same month of purchase of HCPCS codes E0602 and E0603.

HCPCS code A4287 (disposable collection and storage bags for breast milk) are reimbursable when medically necessary, e.g., when the infant is unable to latch on sufficiently to breastfeed. The frequency limit for HCPCS code A4287 is 120 bags per infant without a TAR. The mother’s Medi-Cal ID may be used initially if the infant’s Medi-Cal ID has not yet been established.

If additional bags are medically necessary, a TAR may be submitted using the infant’s Medi-Cal ID. For instructions on submitting a claim for an infant using the mother’s Medi-Cal ID, refer to the *CMS-1500 Completion* section of this manual.

Claims for these items require a statement in the *Additional Claim Information* field (Box 19) or as an attachment that the breast pump is patient-owned.

Pasteurized Donor Human Breast Milk

HCPCS code T2101 (human breast milk processing, storage and distribution only), to be billed per three ounces per unit, 35 ounces per day, only good for 30 days; can be used for medically necessary pasteurized donor human milk (PDHM) when obtained from a licensed and approved facility. Coverage may be up to 12 months of age. For more information, refer to the *Pregnancy: Postpartum and Newborn Referral Services* section in this manual.

HCPCS code A4287 (disposable collection and storage bag for breast milk, any size, any type, each).

Cough Stimulating Device Supplies

When billing for supplies or replacement parts for a cough stimulating device, alternative positive and negative airway pressure (HCPCS code E0482), providers must use code A7020 (interface for cough stimulating device, includes all components, replacement only).

HCPCS code A7020 is not separately reimbursable when billed with the rental code and/or initial purchase of a cough stimulating device. Claims that bill codes A7027 thru A7046 with code E0482 will be denied, regardless of whether the recipient owns the device or if Medi-Cal is renting the device.

Electrodes and Lead Wires: HCPCS Codes A4556 and A4557

HCPCS code A4556 (electrodes [e.g., apnea monitor], per pair) is reimbursable for electrodes for any appropriate patient-owned DME item, except transcutaneous electrical nerve stimulators (TENS) units.

HCPCS code A4557 (lead wires [e.g., apnea monitor], per pairs) is reimbursable for electrodes for any appropriate DME item, except TENS units.

Providers must document in the *Additional Claim Information* field (Box 19) of the claim or on an attachment included with the claim that the equipment the lead wires/electrodes are for is owned by the patient.

Haberman Feeder: HCPCS Code S8265

HCPCS code S8265 (Haberman Feeder) is reimbursable with the following restrictions:

- Maximum age is one year of age.
- Frequency limit:
  - Diagnosis code is limited to ICD-10-CM codes G52.7, P92.1 thru P92.9 or Q35.1 thru Q37.9.

Negative Pressure Wound Therapy (NPWT) Devices

Negative Pressure Wound Therapy (NPWT) devices include pumps and wound care sets. They are typically used after other appropriate wound treatment modalities have failed to heal skin wounds or ulcers.

NPWT devices and supplies are billed with the following codes:

Billing Codes for NPWT Devices Table

HCPCS Code	Description	Limitations
A6550	Wound care set, for negative pressure wound therapy electrical pump, includes all supplies and accessories	Reimbursable for purchase only. Frequency is limited to 15 per month (all may be dispensed on the same date of service).
A7000	Canister, disposable, used with suction pump, each	Reimbursable for purchase only. Frequency is limited to 10 per month (all may be dispensed on the same date of service).
A7001	Canister, non-disposable, used with suction pump, each	Reimbursable for purchase only. Frequency is limited to one in six months.

Billing Codes for NPWT Devices Table (continued)

HCPCS Code	Description	Limitations
E2402	Negative pressure wound therapy electrical pump, stationary or portable	Reimbursable for daily rental only. Must be capable of accommodating more than one wound dressing set, for multiple wounds on a patient.
K0743	Suction pump, home model, portable, for use on wounds	Reimbursement is “By Report.” Maximum rental period is 120 days.
K0744	Absorptive wound dressing for use with suction pump, home model, portable, pad size 16 square inches or less	Reimbursement is “By Report.” Frequency is limited to two per day with a maximum of 10 in 30 days.
K0745	Absorptive wound dressing for use with suction pump, home model, portable, pad size more than 16 square inches but less than or equal to 48 square inches	Reimbursement is “By Report.” Frequency is limited to two per day with a maximum of 10 in 30 days.
K0746	Absorptive wound dressing for use with suction pump, home model, portable, pad size greater than 48 square inches	Reimbursement is “By Report.” Frequency is limited to two per day with a maximum of 10 in 30 days.

TAR Requirement

NPWT pumps and supplies require a TAR. The initial TAR for the pump will be granted for a period of no more than 15 days. Reauthorization TARs may be granted in increments of up to 15 days, not to exceed a total treatment duration of 120 calendar days. Only one pump may be authorized for the 120-day period. In an inpatient setting, the NPWT devices are included in the per diem payment and are not separately reimbursable. For non-inpatient places of service, the pump code E2402 and wound care set code A6550 are reimbursable only to DME providers.

Documentation Requirements

The following documentation must be submitted with each TAR:

- Written prescription form signed by the treating practitioner (or electronic equivalent) that details medical necessity of the NPWT, including all of the following:
  - Summary of the patient's medical condition
  - Relevant wound history, including prior treatments, such as: debridement, offloading, turning, detection and treatment of wound infection, presence of osteomyelitis and others. Surgery dates and operative reports should be included. For dehisced wounds, date of original surgery and chronology of dehiscence, possible cause and initial treatment should be documented.
  - Documentation of the medical condition necessitating the NPWT
  - Duration of time the patient is expected to require the NPWT
- Documentation of the treatment plan, including all of the following:
  - A detailed description of each wound, including wound care notes, precise measurements, and description of exudates, necrotic tissue and granulation tissue as well as evidence of tunneling, slough, eschar infection and odor, if present.
  - Comorbid conditions
    - ❖ If patient is diabetic, status of diabetic control, HbA1c value
  - Nutritional status
  - Operative note if the request is for the use of NPWT in surgical and/or traumatic wounds
  - Wound care plan (must document that appropriate wound care is being provided)
  - Nursing care plan (must document that appropriate nursing care is being provided)
  - Concurrent issues relevant to wound therapy (debridement, nutritional status, support surfaces in use, positioning and incontinence control).
- Documentation, at least every 15 calendar days, of quantitative wound characteristics, including wound surface area (length, width and depth)

Requirements by Wound Type

For all wounds there should be documentation of a moist wound environment for at least two weeks or greater without progression or healing and surgical debridement as appropriate.

- Stage III or IV pressure ulcer: Documentation should include previous therapies and appropriate pressure reducing positions and surfaces.
- Diabetic ulcer: Treatment with a comprehensive diabetic management program. If treating a foot ulcer, documentation of reduction in pressure with appropriate modalities.
- Venous: Leg elevation has been encouraged. Compression garments have been consistently applied.
- Acute/Traumatic: Evidence of significant traumatic tissue loss. Primary wound closure not possible. Wound must be left open or was reopened due to an infection.

Contraindications

NPWT coverage will be denied as not medically necessary if any of the following contraindications are present:

- Necrotic tissue with eschar in the wound.
- Untreated osteomyelitis within the vicinity of the wound.
- Malignancy in the wound.
- Inadequate circulation to the wound site.

Continued Authorization

Evidence of significant wound improvement must be demonstrated. Date of assessment and description of the wound must be provided, together with interventions implemented.

Osteogenesis Stimulators

Authorization is required for the following osteogenesis stimulator devices. Additionally, a dated order for the osteogenesis stimulator and related supply items, signed by the treating practitioner, must be kept on file by the supplier of the equipment.

Code Descriptions for Osteogenesis Stimulator Devices Table

HCPCS Code	Description
E0747	Osteogenesis stimulator; electrical, non-invasive, other than spinal applications
E0748	Osteogenesis stimulator, electrical, non-invasive, spinal applications
E0760	Osteogenesis stimulator, low intensity ultrasound, non-invasive

All claims for an osteogenesis stimulator, electrical or ultrasound and related supplies must include an ICD-10-CM code that describes the condition and location requiring the device.

For nonunion condition of fractures, the claim must include both the ICD-10-CM code for nonunion of fracture and the specific fracture site.

Even though osteogenesis stimulators are returned and reused following completion of treatment, they must be authorized as a purchase item and billed with modifier NU, regardless of the period of use. These items may not be rented. The purchase-only reimbursement is all-inclusive of the following:

- All accessories necessary to use the unit (for example, electrodes, wires, gel, cables, etc.).
- Patient education on the proper use and care of the equipment.
- Routine servicing and all necessary repairs or replacement to make the unit functional.

These codes must also be billed with modifier KF as designated by Food and Drug Administration (FDA) as a class III device that supports or sustains life.

Non-Spinal, Electrical Device

Non-spinal electrical osteogenesis stimulator devices are billed with HCPCS code E0747. These devices are composed of two basic parts: the coils that wrap around the patient's cast and the pulse generator that produces an electric current. The devices are built based on measurements specified by a recipient's treating practitioner.

Non-spinal electrical osteogenesis stimulator devices are covered for nonunion fractures only if the following criteria are met:

- Nonunion of a long bone fracture, defined as radiographic evidence that fracture healing has ceased.
- Six months or more have passed since the fracture.
- Bone X-rays over the last three months show no sign of continued healing.
- Six months or more have passed since the alternative treatment was initiated.
- The fracture gap is one centimeter or less.
- The patient can be adequately immobilized and is able to comply with non-weight bearing.
- For infantile (congenital) pseudarthrosis (ICD-10-CM code Q74.8).
- There is evidence of skeletal maturity or the patient is 20 years of age or older.

Note: Nonunion of the long bone must be documented by a minimum of two sets of radiographs obtained prior to starting treatment with the osteogenesis stimulator, separated by a minimum of 90 days, each including multiple views of the fracture site, and with a written interpretation by the treating practitioner stating that there has been no clinically significant evidence of fracture healing between the two sets of films.

A non-spinal electrical osteogenesis stimulator will be denied as not medically necessary if none of the above criteria are met.

Spinal, Electrical Device

Spinal electrical osteogenesis stimulator devices are billed with HCPCS code E0748. These devices are covered only if any of the following applies:

- Failed spinal fusion (pseudarthrosis ICD-10-CM codes M96.0, Z98.1 joint following fusion) and a minimum of nine months have elapsed since the last surgery, or
- Following a multi-level spinal fusion surgery involving three or more vertebrae (for example, L3-5, L4-S1, etc.), or
- Following spinal fusion surgery where there is a history of a previously failed spinal fusion at the same site, or
- The patient has one or more risk factors for high risk of spinal fusion failure such as smoking, obesity (BMI greater than 35), diabetes, renal disease, alcoholism, grade II or worse Spondylolisthesis, or other metabolic disease where bone healing is poor.

Note: The device should be applied within 30 days as an adjunct to spinal fusion surgery. The patient should use the device for at least two hours per day and the treatment period continued for nine months (270 consecutive days). The device is programmed to cease operation at the end of 270 days.

Low-Intensity Ultrasound Device

Non-invasive, low intensity ultrasound osteogenesis devices are billed with HCPCS code E0760 (osteogenesis stimulator, low intensity ultrasound, non-invasive) and are reimbursable at a “per treatment” rate. Providers must bill for purchase of the device even through it is returned to the manufacturer when the treatment is completed. This device is covered only if the following criteria are met:

- Nonunion of a fracture other than the skull or vertebrae in a skeletally mature person, documented by a minimum of two sets of radiographs obtained prior to starting treatment with the osteogenesis stimulator, separated by a minimum of 90 days each, including multiple views of the fracture site, and with a written interpretation by the treating practitioner stating that there has been no clinically significant evidence of fracture healing between the two set of radiographs, and
- The fracture is not tumor-related.
- Fresh (fewer than seven days), closed or grade I open, tibial diaphyseal fractures, or
- Fresh (fewer than seven days), closed fractures of the distal radius (Colles fracture).

An ultrasonic osteogenesis stimulator will be denied as not medically necessary if the criteria above are not met. An ultrasonic osteogenesis stimulator may not be used concurrently with other noninvasive stimulators.

Pulsed Irrigation Enhanced Evacuation (PIEE)

Pulsed Irrigation Enhanced Evacuation (PIEE) may be authorized for patients with neuropathic bowel due to underlying neurologic problems that dispose them to severe fecal impaction and who have failed all traditional and conservative attempts at bowel control.

Authorization

The PIEE equipment and supplies require authorization. They are billed with the following codes:

PIEE Billing Codes Table

HCPCS Code	Description
E0350	Control unit for electronic bowel irrigation/evacuation system
E0352	Disposable pack (water reservoir bag, speculum, valving mechanism and collection bag/box) for use with the electronic bowel irrigation/evacuation system

The PIEE control unit (code E0350) includes one (1) battery charger, one (1) remote control assembly and PIEE cart or traveler and one (1) PIEE fill system. The therapy kit (code E0352) includes one (1) B-Valve circuit, two (2) containment bags, one (1) lubricating jelly, one (1) bed pad, one (1) tray liner-waste disposable bag and two (2) hose clamps. Each case of 15 kits contains two (2) replacement fill tubes and 15 adult inflatable cuffed speculums.

Related supplies other than the disposable pack are billed with code A9900 (miscellaneous DME supply, accessory, and/or service component of another HCPCS code).

Separate *Treatment Authorization Requests* (TARs) may be required for the approval of services related to PIEE and for the equipment and/or supplies.

The PIEE device will have an initial two-month trial of rental to provide documentation that long-term use will be medically necessary and effective. Following this two-month rental, a TAR must be submitted for the purchase of the PIEE device by the Medi-Cal program for permanent use by the recipient. The initial authorization for all services related to the PIEE procedure may be approved for no more than two months of treatment, through the last date of the month, to permit better utilization and ensure PIEE safety and efficacy for the recipient. Subsequent TARs for services related to the PIEE procedure and the treatment pack supplies may be approved for up to six-month increments, if there is medical documentation that indicates the recipient continues to require the procedure and that the procedure continues to provide effective evacuation for the recipient.

Documentation Requirements

The treating practitioner's documentation of the medical necessity for PIEE must include a complete history and physical exam; documentation of adequate caregiver support for training in the use of PIEE; and arrangement of skilled nursing home health visits to provide assistance and support for this service.

Positioning Seat

HCPCS code T5001 (special orthotic positioning seat) requires authorization. Reimbursement is "By Report." Code T5001 must be billed with modifier NU (purchase), RR (rental) or RB (replacement of a part of DME furnished as part of a repair). Separate reimbursement for labor is allowed for the repair of patient-owned equipment. Claims billing code T5001 with modifier RB must document that the patient owns the positioning seat. This device is a nontaxable item.

Ramps, Portable

Claims for portable ramps must be billed with HCPCS code E1399 (durable medical equipment, miscellaneous). A fixed, modular or in any way attached ramp is considered a non-portable ramp and is not a Medi-Cal benefit. Portable ramps are those that are foldable or collapsible, not attached, suitcase types, which can be easily and readily carried and transported by the recipient for use in multiple locations. The portable ramp usually weighs no more than 90 pounds or measures no more than 10 feet in length.

TARs for portable ramps must include medical justification and supporting documentation. Medical necessity documentation must be submitted by the recipient's health care provider. The following documentation must be submitted with each TAR:

- What the recipient has used for wheelchair access prior to this request.
- The schematic drawing of the recipient's residence and measurements comparing all possible access sites for portable ramps.
- Documentation demonstrating the door site selected as the least-costly access site for ramp use.
- Documentation demonstrating the ramp type requested as the lowest cost item to meet the recipient's medical needs.
- The catalog pages for ramp type requested.
- An invoice for the ramp.
- Documentation demonstrating the ramp's intended use for occupied or unoccupied wheelchair.
- Details of the mock-up trial for the requested ramp or similar ramp.
- Documentation of the weight of the recipient, weight of the wheelchair, maximum rise of the ramp and maximum weight capacity of the ramp for power wheelchairs.

Alterations or improvements to real property (for example, a non-portable wheelchair ramp to front door) are not covered. A portable wheelchair ramp is not home or vehicle modification. It should be considered an extension of the recipient's wheelchair and follows the recipient in his or her wheelchair to assist in accessibility to the community.

The following medical necessity criteria are taken into consideration for portable ramps:

- The recipient requires wheelchair (manual or power) for home and community mobility.
- The recipient requires access to vehicles for community mobility, and/or for accessibility in/out of the recipient's primary entrance into the home.
- The ramp can be used to load wheelchair into the back of a truck/van for transport.
- Onsite evaluation should be performed to ensure:
  - Caretaker can transport and set up ramp.
  - The chair can be driven or pushed by the caretaker up and down the ramp safely.

Scales

A scale is a Medi-Cal benefit for recipients that meet the following criteria. A *Treatment Authorization Request* (TAR) is not required for reimbursement unless the purchase is $100.00 or more.

Coverage Criteria

The recipient must lack access to a scale and meet at least one of the following criteria:

- Recipient is enrolled in the Medi-Cal Diabetes Prevention Program.
- Recipient is pregnant.
- Recipient has a medical condition which requires ongoing monitoring of weight from home.

Documentation Requirements

Adequate documentation in the medical records for the recipient must clearly indicate the need for a scale to monitor weight based on the recipient's medical condition and indicate the recipient's lack of access to a scale.

Billing

HCPCS code E1639 must be billed with modifier NU (purchase) only. Claims for these items require a statement in the *Additional Claim Information* field (Box 19) or on an attachment that the recipient lacks access to a scale. Refer to the *Durable Medical Equipment (DME): Billing Codes* section in the appropriate Part 2 manual for additional billing information.

TheraTogs

TheraTogs is a medical device used as a garment and strapping application to provide gentle, prolonged muscle stretch and alignment guidance that replicates the manual positioning of supervised therapy. A professional rehabilitation clinician may offer TheraTogs for clients with typical neuromotor or sensory deficits.

Providers should use HCPCS code A9900 (miscellaneous DME supply, accessory, and/or service component of another HCPCS code) when submitting claims for TheraTogs. This code is reimbursable "By Report" and requires a *Treatment Authorization Request* (TAR). To ensure correct reimbursement, the subject "TheraTogs" must be entered in the *Additional Claim Information* field (Box 19) of the *CMS-1500* claim. In addition, TheraTogs is a taxable item, and this detail must be noted on the claim form for code A9900.

Transcutaneous Electrical Nerve Stimulators (TENS)

The following reimbursement guidelines apply when billing for TENS units and supplies.

TENS Supplies and Units

HCPCS codes A4595 (electrical stimulator supplies, 2 lead, per month) is a TENS supply and is reimbursable for "patient owned"only. Codes E0720 (transcutaneous electrical nerve stimulation device, two lead, localized stimulation) and E0730 (transcutaneous electrical nerve stimulation device, four or more leads, for multiple nerve stimulation) are TENS units and are reimbursable for rental only. TENS supplies include the following:

- Electrodes (any type).
- Lead wires (any type).
- Type or other adhesive (if needed, depending on the electrode type).
- After ten months of rental, E0720 and/or E0730 are considered patient owned.

Note: Supplies for E0720 and E0730 or any repairs are not separately paid during the rental period.

Medical Necessity Criteria for TENS Unit

A *Treatment Authorization Request* (TAR) is required for codes E0720 and E0730.

- TAR is only approved for one month of rental post-surgery and not beyond one month.
- A TAR is required for the first one-month use of the TENS devices to establish its effectiveness.
- An additonal TAR is required for the next nine months when the prescribing provider determines the effectiveness and prescribes use of TENS devices.
  - Providers must submit the prescribing provider's note regarding the effectiveness of the TENS device

Note: These codes must follow Medi-Cal's established policy for renting DME equipment. This includes but not limited to the use of required modifier RR for the duration of rental period; coverages of supplies and repairs by providers during the rental period; paying for supplies and repairs only after the equipment is considered "patient-owned," and requirement from providers to document "patient-owned" status of the equipment when requesting supplies or repair.

The medical necessity criteria is as follows:

The practitioner ordering the TENS unit and related supplies must be the treating practitioner for the disease or condition justifying the need for the TENS unit.

A TENS is covered for the treatment of recipients with chronic, intractable pain or acute post-operative pain when one of the following coverage criteria, I or II, are met.

I. Acute Post-operative Pain

TENS is covered for acute post-operative pain. Coverage is limited to 30 days (one month's rental) from the day of surgery. Reimbursement will be made only as a rental.

A TENS unit will be denied as not reasonable and necessary for acute pain (less than three months duration) other than for post-operative pain.

II. Chronic Pain Other than Low Back Pain

TENS is covered for chronic, intractable pain other than chronic low back pain when all of the following criteria are met:

- The presumed etiology of the pain must be a type that is accepted as responding to TENS therapy. Examples of conditions for which TENS therapy is not considered to be reasonable and necessary are (not all-inclusive):
  - headache
  - visceral abdominal pain
  - pelvic pain
  - temporomandibular joint (TMJ) pain
- The pain must have been present for at least three months.
- Other appropriate treatment modalities must have been tried and failed.

TENS therapy for chronic pain that does not meet these criteria will be denied as not reasonable and necessary.

TENS therapy for Chronic Low Back Pain (CLBP) will be denied as not reasonable and necessary.

General Requirements for chronic pain

When used for the treatment of chronic, intractable pain described in section II, the TENS unit must be used by the beneficiary on a trial basis for a minimum of one month (30 days), but not to exceed two months. The trial period will be reimbursed as a rental. The trial period must be monitored by the treating practitioner to determine the effectiveness of the TENS unit in modulating the pain. For coverage of a purchase, the treating practitioner must determine that the recipient is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time.

A 4-lead TENS unit may be used with either two leads or four leads, depending on the characteristics of the recipient's pain. If it is ordered for use with four leads, the medical record must document why two leads are insufficient to meet the recipient's needs.

Supplies

Separate allowance will be made for replacement supplies when they are reasonable and necessary and are used with a covered TENS. Usual maximum utilization is:

- 2 TENS leads - a maximum of one unit of A4595 per month.
- 4 TENS leads - a maximum of two units of A4595 per month.

If the use of the TENS unit is less than daily, the frequency of billing for the TENS supply code should be reduced proportionally.
Replacement of lead wires (A4557) more often than every 12 months would rarely be reasonable and necessary.
Reimbursement for supplies is contingent upon use with a covered TENS unit. Claims for TENS supplies provided when there is no covered TENS unit will be denied as not reasonable and necessary.

Tumor Treating Field Devices

HCPCS code E0766 (electrical stimulation service used for cancer treatment, includes all accessories, any type) is reimbursable for the treatment of newly diagnosed glioblastoma.

Indications

For the treatment of adult patients 18 years of age and older who meet the following criteria:

- Has newly diagnosed, histologically confirmed supratentorial glioblastoma multiforme, and
- Has good performance status, as defined by a Karnofsky Performance Status score of 60 or higher, and Tumor treating field therapy will be delivered in conjunction with temozolomide following maximal debulking surgery, and completion of radiation therapy, and
- Patient or caregiver has been trained and is willing and able to apply the device daily, and
- Patient is willing to wear the device at least 18 hours daily.

Authorization

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

The initial TAR may be authorized for up to three months.

Re-authorization may be granted when all of the following criteria are met:

- MRI scan has been performed within four months prior to request and documents no evidence of disease progression, and
- The Karnofsky Performance Status score is 60 or higher, and
- The patient has been wearing the device at least 18 hours daily.

Billing

HCPCS code E0766 must be billed with modifier RR (rental) and KF.

Wearable Cardiac Defibrillator (WCD) HCPCS code K0606

Code K0606 (automatic external defibrillator, with integrated electrocardiogram analysis, garment type), also known as a wearable cardiac defibrillator (WCD), is reimbursable as rental-only, subject to authorization.

Code K0606 is reimbursable as rental-only, on a monthly basis, and using modifier RR. Reimbursement for purchase, using modifier NU or repair/replacement modifier RB, is not allowed.

The rental rate includes the following equipment: monitor/defibrillator, one garment (electrode belt), electrodes, two batteries, one charger, holster and modem. Separate reimbursement for this equipment, using non-benefit codes K0607 (replacement battery), K0608 (replacement garment), K0609 (replacement electrodes), or other current procedure codes is not allowed. In addition, code A9900 (miscellaneous DME supply, accessory, and/or service component of another HCPCS code) is not separately reimbursable with code K0606 if billed for any of the above equipment items, or for any other item related to a garment-type automatic external defibrillator.

For information regarding the authorization criteria for HCPCS code K0606, refer to “Wearable Cardiac Defibrillator (WCD) HCPCS code K0606” in the *Cardiology* section of the appropriate Part 2 provider manual.

These codes must also be billed with modifier KF as designated by Food and Drug Administration (FDA) as a class III device that supports or sustains life.

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.