Durable Medical Equipment (DME): Infusion Equipment

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This section contains information about Durable Medical Equipment (DME) in the infusion equipment group.

Per California Code of Regulations (CCR), Title 22, Section 51321(g): Authorization for durable medical equipment (DME) shall be limited to the lowest cost item that meet 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:

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*

Infusion Equipment Group

The infusion equipment group consists of the following items:

- Ambulatory infusion pumps
- Enteral nutrition infusion pumps
- Implantable infusion pumps
- Insulin infusion pumps
- Mechanical external infusion pumps
- Miscellaneous supplies
- Parenteral infusion pumps
- Unlisted equipment
- Unlisted supplies, accessories and service components

Where to Submit TARs

Treatment Authorization Requests (TARs) for codes within this group must be submitted to the TAR Processing Center.

Authorization

TARs for infusion equipment must include an appropriately signed prescription, along with medical justification that the item(s) selected is appropriate for a recipient's medical needs.

TARs for unlisted infusion pumps must include a clear description of the pump, the cost of the pump and documentation showing that the item(s) selected is the lowest-cost item to meet a recipient's medical needs.

Failure to submit a TAR to the proper location will increase the turnaround time for requests to be processed. See the TAR Deferral/ Denial Policy (Frank v. Kizer) section in this manual for more information.

Infusion Pumps

Infusion pumps (external or implantable, as appropriate) are covered for the controlled administration of therapeutic drugs (for example, chelating agents, approved chemotherapeutic agents, pain control or parenteral nutrition).

Ambulatory Infusion Pumps

Ambulatory infusion pumps are reimbursable with HCPCS code E0781 (ambulatory infusion pump, single or multiple channels, electric or battery operated, with administrative equipment, worn by recipient). The code is covered for therapeutic infusion purposes other than insulin. External pumps are also reimbursable with HCPCS code E0787 (external ambulatory infusion pump, insulin, dosage rate adjustment using therapeutic continuous glucose sensing) when billed with Modifier NU.

TAR Requirement

Providers must indicate on the TAR the requested number of days and on the claim form the number of authorized days (units) the recipient has the pump.

Rental Billing

Medi-Cal reimbursement of code E0781 (as a rental) is at a daily rate and must be billed with modifier RR.

Medicare/Medi-Cal Crossovers

Because Medicare pays a rental reimbursement for HCPCS code E0781 at a monthly rate, Medicare claims and Explanation of Medicare Benefits (EOMBs)/Medicare Remittance Notices (MRNs) automatically crossing over for dually eligible Medicare/Medi-Cal recipients will reflect only one date of service and a quantity of one. Because Medi-Cal reimburses these pumps on a daily basis, the crossover claims are processed for only one day of service, instead of one month.

To request full reimbursement for these claims, providers billing code E0781 will need to submit a Claims Inquiry Form (CIF) stating the actual “from-through” dates of service and the actual number of days in the Remarks area of the CIF. See “Crossover Claims Inquiry Forms (CIFs)” in the Medicare/Medi-Cal Crossover Claims section of this manual.

Enteral Nutrition

Enteral nutrition infusion pumps are reimbursable with HCPCS code B9002 (enteral nutrition infusion pump, any type). Authorization for rental of enteral nutrition infusion pumps may be granted in increments of up to three months, both for the initial authorization and for reauthorization.

Insulin Pumps

‹‹Durable insulin pumps are reimbursed with HCPCS code E0784 for the treatment of insulin-dependent (Type I) diabetes mellitus. Rental reimbursement is at a monthly rate and requires authorization.››

All the following conditions must be documented on a TAR for reimbursement of durable insulin pumps. A recipient must:

- Have hemoglobin A1c that is persistently above individually targeted goal
- Currently perform four or more insulin injections daily
- Currently assess blood glucose levels four or more times daily
- Be willing and intellectually and physically able to undergo the rigors of insulin pump therapy initiation and maintenance
- Complete a comprehensive diabetes education program
- Be motivated to achieve and maintain glycemic control

Physician Services

Physician services related to insulin infusion should be billed with Evaluation and Management (E&M) codes appropriate to the level of service rendered.

Mechanical External Infusion Pumps

Mechanical external infusion pumps are reimbursable with HCPCS code E0780 (ambulatory infusion pump, mechanical, reusable, for infusion less than 8 hours) or E0779 (ambulatory infusion pump, mechanical, reusable, for infusion greater than 8 hours). Authorization is required if the purchase cost to the Medi-Cal program exceeds $100.

Pump Supplies

HCPCS code A4602 (replacement battery for external infusion pump owned by patient, lithium, 1.5 volt, each) is reimbursable with patient-owned documentation on the claim form or attached to the claim. Code A4602 must be billed with modifier NU. Frequency is limited to one in six months.

Replacement syringes for pump codes E0779 thru E0781 require authorization and are reimbursable using appropriate medical supply codes.

Replacement infusion sets/syringes for insulin infusion pump code E0784 must be billed using medical supply HCPCS codes A4230 thru A4232. Refer to the Medical Supplies Billing Codes, Units and Quantity Limits spreadsheet.

‹‹**Note**: A4224 is an all-inclusive code and replaces A4230 and A4231. The provider should bill for either A4230 and A4231 or A4224.››

‹‹HCPCS code K0552 (supplies for external non-insulin drug infusion, syringe type cartridge, sterile, each) is for use with pump codes E0784 and K0455.››

HCPCS codes K0601 thru K0605 (replacement batteries for patient-owned external infusion pumps) are not separately reimbursable with a rental or initial purchase of the infusion pump. Claims for these codes require documentation that the patient owns the infusion pump. Documentation of the specific pump model and number of batteries or a TAR is required for reimbursement of more than one battery per date of service.

Unlisted Equipment

Coverage

Medi-Cal covers unlisted DME for patients who meet the established criteria.

Criteria/Authorization

As medically necessary, unlisted equipment may be authorized by the Medi-Cal consultant based upon documentation submitted with the TAR for the specific item.

Documentation Requirements

TARs submitted for unlisted equipment require all of the following information:

- Justification that the specific item is medically necessary; and,
- Item description; and
- Manufacturer's Suggested Retail Price (MSRP) (copy of catalog page)

If the unlisted DME item is for a child (20 years of age or younger), and the child has a California Children's Services (CCS)-eligible condition, a CCS denial must accompany the TAR in addition to the above requirement.

Billing

HCPCS Code	Description
E1399	Durable medical equipment, miscellaneous

For information about billing for unlisted equipment, refer to the Durable Medical Equipment (DME): Bill for DME section in this manual.

Unlisted Supplies, Accessories and Service Components

Coverage

Medi-Cal covers miscellaneous supplies, accessories and service components only for patient-owned equipment.

Criteria/Authorization

As medically necessary, miscellaneous supplies, accessories and/or service components may be authorized by the Medi-Cal consultant based upon the documentation submitted with the TAR for the specific item.

Documentation Requirements

Documentation that the patient has a medical need for the specific item, and that the patient owns the equipment for which the miscellaneous supply, accessory or service component is being requested, must be submitted with the TAR.

If miscellaneous supplies, accessories, and/or service components are for a child (20 years of age or younger), and the child has a CCS-eligible condition, a CCS denial must accompany the TAR.

Billing

HCPCS Code	Description
A9900	Miscellaneous DME supply, accessory, and/or service component or another HCPCS code

For information about billing for unlisted miscellaneous supplies, accessories and service components refer to the Durable Medical Equipment (DME): Bill for DME section in this manual.

‹‹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.