Durable Medical Equipment

Introduction

Purpose

The purpose of this module is to provide an overview of Durable Medical Equipment (DME) and program coverage.

Module Objectives

- Discuss policy and clarifications in Medi-Cal
- Understand *Treatment Authorization Request* (TAR) requirements
- Identify DME modifiers
- Review “By Report” attachment requirements
- Explain repair and maintenance policy
- Provide claim examples
- Review common denials

Acronyms

A list of current acronyms is located in the *Appendix* section of each complete workbook.

Program Coverage

Medi-Cal covers DME when provided on a written prescription (or electronic equivalent) of a physician, nurse practitioner, clinical nurse specialist, or physician assistant. A recipient's need for DME items must be reviewed annually by a physician, nurse practitioner, clinical nurse specialist, or physician assistant. For all DME items that require replacement or replacement parts, a new prescription for the DME item is required annually.

The Medi-Cal definition of medical necessity limits health care services to those necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. Therefore, prescribed DME items may be covered as medically necessary only to preserve bodily functions essential to activities of daily living or to prevent significant physical disability.

A wheelchair is medically necessary if the beneficiary's medical condition(s) and mobility limitations are such that without the use of the wheelchair, the beneficiary's ability to perform one or more mobility related activities of daily living (ADL) or instrumental activities of daily living in or out of the home, including access to the community, is impaired and the beneficiary is not ambulatory or functionally ambulatory without static supports such as a cane, crutches or walker.

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

Nursing Facility Coverage

Canes, crutches, wheelchairs and walkers for Nursing Facility (NF) Level A and B recipients are only separately reimbursable when the item must be custom-made or modified to meet the unusual need of the recipient and the need is expected to be permanent.

DME Policies and Clarifications

Policies

- New codes and deleted codes: when a code is no longer valid and a TAR is required, providers must send in a new TAR with the new code.
- Changes are date-of-service driven.
- NCCI – National Correct Coding Initiative.
- Medi-Cal must follow Medicare frequency limits.

Policy Clarification and Changes

Face-to-Face Encounter

For all DME items a face-to-face encounter with a physician, nurse practitioner, clinical nurse specialist or physician assistant that is related to the primary reason the recipient requires the DME item is required. Face-to-face encounters may be done via telehealth. For all DME items that require repair or replacement parts, a new prescription for the DME item is required annually.

The following conditions must be met in order for the face-to-face encounter to be satisfied:

- The provider performing the face-to-face encounter must communicate the clinical findings of the face-to-face encounter to the prescribing practitioner.
- The clinical findings from the face-to-face encounter must be incorporated into a written or electronic document included in the recipient's medical record.
- Practitioner prescribing the DME must document that the face-to-face encounter, which is related to the primary reason the patient requires the DME, has occurred within six months prior to the date on the DME prescription.
- Practitioner writing the DME prescription must document who conducted the face-to-face encounter and the date of the encounter.

Rental Reimbursement Cap

When previously paid rental charges equal the maximum allowable purchase price of the rented item, the item is considered to have been purchased and patient owned after 10 months of rental and no further reimbursement to the provider shall be made unless repair or maintenance of the item is separately authorized

- Repairs after the code has achieved "patient-owned" status is covered by Medi-Cal when providers use modifier **RB** for repair and document the code is "patient-owned."
- Claims for these items require a statement in the *Additional Claim Information* field (Box 19) or an attachment that the item is "patient-owned."

Note: The exception is for ventilator codes (E0465, E0466, and E0467), which are under continuous rental policy. Effective for dates of service on or after April 1, 2023, codes E0431, E0433, E0434, E0439, E0465, E0466, E0467, E1390, E1391 and E1392 are rental only and exempt from the 10-month rental cap.

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

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.

Heated Humidifiers and Breathing Circuits Not Reimbursable with Ventilator Rentals

Effective for dates of service on or after July 1,2023, Medi-Cal will not provide a separate reimbursement payment for humidifiers, options, accessories or supplies when ventilator HCPCS codes E0465, E0466 or E0467 are used.

The Department of Health Care Services (DHCS) is updating the Medi-Cal rental policy for ventilators to coincide with Medicare’s policy for ventilator rentals.

Note: A9900 and S8189 should not be used to bill ventilator/heated circuits as they are included with the reimbursement of the ventilator (E0465/E0466/E0467).

Purchased only policy:

- Modifier **NU** is required for codes that are purchase-only.
- During the month of purchase, Medi-Cal does not pay for supplies or repairs.
- Purchased DME items have a warranty period in which the manufacturer is to pay for any repairs/replacements.
- After the warranty period expires, providers must use required modifier **RB** when repairs are needed.
- The frequency limit policy must be observed before the same item can be purchased again. The exception is medical necessity under unforeseen circumstances by submitting a *Treatment Authorization Request* (TAR).
- Some DME items can either be rented (if it is a short period of time), or purchased (for long term use).
- Codes are given “required” modifier **RR** for rental, required modifier **NU** for purchase, and required modifier **RB** for repairs.
- A code cannot be reimbursed if modifier **RR** is used during the same month as modifier **NU**. The item cannot be repaired during its rental period and the provider is responsible for all supplies associated with the code along with any repairs during its rental period.

Rental Policy for Intrapulmonary Percussive Ventilators/Devices

Rental policy for HCPCS code E0481 (intrapulmonary percussive ventilation system and related accessories) requires modifier RR on the claim during the rental period. Following ten consecutive months of rental, the device will be considered patient owned. After the device is patient-owned, providers must use modifier RB when repairs are required, and modifier NU must be used for supplies.

Medical Criteria for Respiratory Durable Medical Equipment Codes

The medical criteria for HCPCS Codes E0481 (intrapulmonary percussive ventilators and devices), E0482 (cough stimulating device) and E0483 (high frequency chest wall oscillation system) has been updated. Updates include:

- E0481: An intrapulmonary percussive ventilator is not reasonable nor necessary in a home setting and will be denied as not medically necessary.
- E0482: A Treatment Authorization Requests will be denied if the patient does not have a neuromuscular disease diagnosis and a condition causing significant impairment of the chest wall and/or diaphragmatic movement.
- E0482, E0483: It is not reasonable or necessary for a patient to use both a cough stimulating device (E0482) and a high frequency chest wall oscillation device (E0483).
- E0483: A confirmed diagnosis of bronchiectasis must be present in order to meet the criteria. Chronic bronchitis and chronic obstructive pulmonary disease (COPD) in the absence of a confirmed diagnosis of bronchiectasis do not meet this criterion.

Rental Policy for Oscillation System

The rental policy is updated for HCPCS code E0483 (high frequency chest wall oscillation system, includes all accessories and supplies, each). Modifier RR is required on the claim during the rental period. Following ten months of rental, the device will be considered patient owned. Modifier RB is not allowed or reimbursable during rental period. Any allowed repairs or supplies can be reimbursed after ten months of rental when provider indicates that the item is patient-owned.

Guidance for Respiratory DME Codes E0482 and E0483

- The medical criteria for HCPCS codes E0482 (cough stimulating device) and E0483 (high frequency chest wall oscillation system) has been updated.
- Previously providers were told “It is not reasonable or necessary for a patient to use both a cough stimulating device (E0482) and a high frequency chest wall oscillation (HFCWO) device (E0483)”. This guidance has since been amended to “It is generally not necessary for a patient to use both a cough stimulating device (E0482) and a high frequency chest wall oscillation (HFCWO) device (E0483).
- However, if both devices are needed for a patient, a TAR/SAR is required and must indicate the specific medical necessity that the use of both a cough stimulating device (E0482) and a high frequency chest wall oscillation (HFCWO) device (E0483) are necessary.

Continuous Glucose Monitoring and Disposable Insulin Delivery Devices

Effective for dates of service on or after December 1, 2022, the following HCPCS codes for CGM and DIDD are no longer covered by DME policy:

HCPCS Code	Description
A9276	Sensor; invasive (e.g., subcutaneous) disposable, for use with interstitial continuous glucose monitoring system, 1 unit = 1 day supply
A9277	Transmitter; external, for use with interstitial continuous glucose monitoring system
A9278	Receiver (monitor); external, for use with interstitial continuous glucose monitoring system
K0553	Supply allowance for therapeutic continuous glucose monitor (CGM), includes all supplies and accessories, 1 month supply = 1 unit of service
K0554	Receiver (monitor), dedicated, for use with therapeutic glucose monitor system

Scales

HCPCS code E1639 (scale, each), claim. For reimbursement, documentation must indicate that the recipient does not have access to a scale and meets one of the following criteria:

- Enrolled in the Medi-Cal Diabetes Prevention Program.
- Recipient is pregnant.
- Recipient has a medical condition which requires ongoing monitoring of weight from home such as: CHF (Congestive Heart Failure), ESRD (End Stage Renal Disease) and on dialysis, peripheral vascular disease/lymph edema, and hypertension on diuretic medication.

Refer to the *Durable Medical Equipment (DME): Other DME Equipment* section (dura other) of the Part 2 provider manual.

Phototherapy Light for Infants

HCPCS code E0202 (phototherapy[bilirubin] light with photometer) is a Medi-Cal benefit for infants as a daily rental only. Because the light is rented, modifier RR is required. For reimbursement, documentation must indicate that the recipient meets the following criteria:

- 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 *Treatment Authorization Request* (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.

Refer to the *Durable Medical Equipment (DME): Other DME Equipment* section (dura other) of the Part 2 provider manual.

Portable Ramps

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.

Breastfeeding

When submitting claims for the **purchase** or **rental** of lactation management aids and replacement supplies, follow the criteria and documentation requirement guidelines listed in the *Durable Medical Equipment (DME): Other DME Equipment* section (dura other) of the Part 2 provider manual. Replacement supplies cannot be purchased the same month of the purchase of a pump. All supplies are included in the rental or initial purchase of a breast pump.

Supplies for Cough Stimulating Device

When submitting TARs or claims for supplies or replacement parts for HCPCS code E0482 (cough stimulating device, alternating positive and negative airway pressure), providers must use code A7020 (interface for cough stimulating device, includes all components, replacement only). Claims that bill with codes A7027 through A7046 (CPAP and BI-PAP) with code E0482 will be denied, regardless of whether the recipient owns the device or if Medi-Cal is renting the device. HCPCS code A7020 is not separately reimbursable when billed with the rental and/or purchase (within the same month of service) of the cough stimulating device.

Shipping and Handling

Shipping and handling costs for Durable Medical Equipment and Orthotics and Prosthetics (O&P) are not reimbursed by Medi-Cal.

Date of Service

The delivery date of the DME equipment to a recipient is the date of service. This means that when the recipient receives the DME item delivered by the provider, that date is considered the date of service.

Product Classification

Medi-Cal approximates Medicare's product classification and equipment policies on coverage for medical equipment.

Product Classification

Topic	Website Location
Local Medical Review Policies	*(www.noridianmedicare.com)* *(www.dmepac.com)*

Code Frequency Limits

- Frequency limits for each code are listed in the *Durable Medical Equipment (DME) Billing Codes: Frequency Limits* section (dura cd fre) of the Part 2 provider manual.
- Service Authorization Requests (SARs), TARs and/or a CCS authorization can override these limits.
- Limits cannot be exceeded on the same date of service even with an authorization. The provider must submit the claim with different dates of service.

Warranties

- It is the provider's responsibility to check all warranties on a piece of equipment. If the equipment is still under warranty, the provider must work with the manufacturer for replacement or repair of that item at no charge to the Medi-Cal program.
- Pursuant to CCR, Title 22, Section 51321 (i) and (j), rendering providers of DME shall ensure that all devices and equipment are appropriate to meet the recipient's medical needs. Providers shall instruct recipients in appropriate use and care of DME and notify recipients that they are responsible for appropriate use and care of DME purchased for their use under the Medi-Cal program. If a piece of equipment or a device when in actual use fails to meet the recipient's needs, and the recipient's medical condition has not significantly changed since the device/equipment was dispensed, the rendering provider shall adjust or modify the equipment, as necessary, to meet the recipient's needs. The rendering provider, at no cost to the Medi-Cal program, shall replace any equipment or device that cannot be adjusted or modified.

Reimbursement Limit – Upper Billing Limit

Reimbursement for DME is subject to the Upper Billing Limit defined in CCR, Title 22, Section 51008.1. Bills submitted are not to exceed an amount that is the lesser of:

- The usual charges made to the general public, or
- The net purchase price of the item, which must be documented in the provider's books and records, plus no more than a 100 percent markup.

For procedure codes that have a listed maximum allowable DME purchase billing amount, the amount billed should not exceed the net purchase price of the item, plus 100 percent markup.

California Children's Services (CCS) Only Benefits

The following Healthcare Common Procedure Coding System (HCPCS) codes are not Medi-Cal benefits and must be approved through the CCS branch for children younger than 21 years of age. See the *Durable Medical Equipment (DME): Billing Codes for California Children's Services* section (dura cd ccs) in the appropriate Part 2 provider manual for a complete list.

Table of Non Medi-Cal Benefit HCPCS Codes

Code	Description
E0635	Patient lift, electric, with seat or sling
E0639	Patient lift, movable from room to room with disassembly and reassembly, includes all components/accessories

If a Medi-Cal recipient requires one of the above items, use the appropriate code when submitting a request to the Medi-Cal field offices. If an age restriction exists, a TAR may override it.

Accessing the Medi-Cal Providers Homepage

The Medi-Cal Providers website home page can be accessed by opening an internet browser, typing *mcweb.apps.prd.cammis.medi-cal.ca.gov* in the address bar and pressing **Enter**.

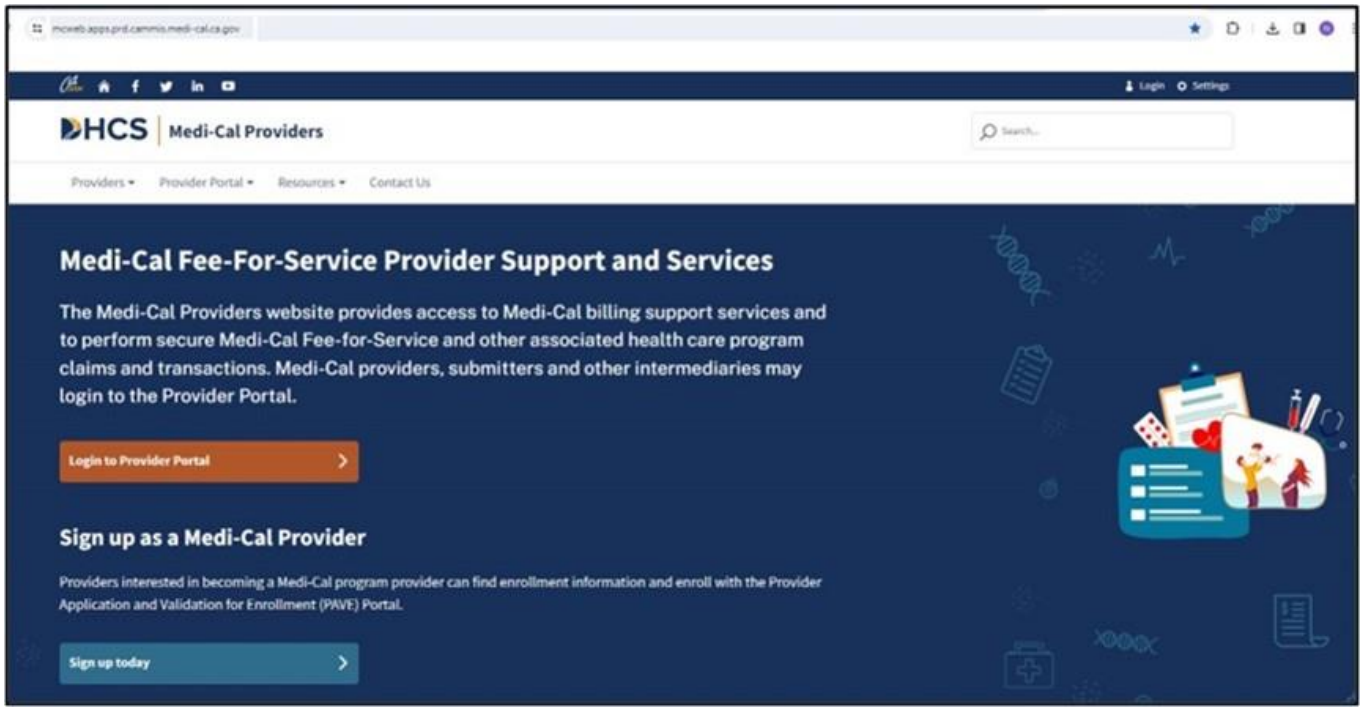


Figure 1.1: Medi-Cal Provider Homepage.

To access provider communities and their associated reference materials, navigate to Publications from the Providers drop-down menu.

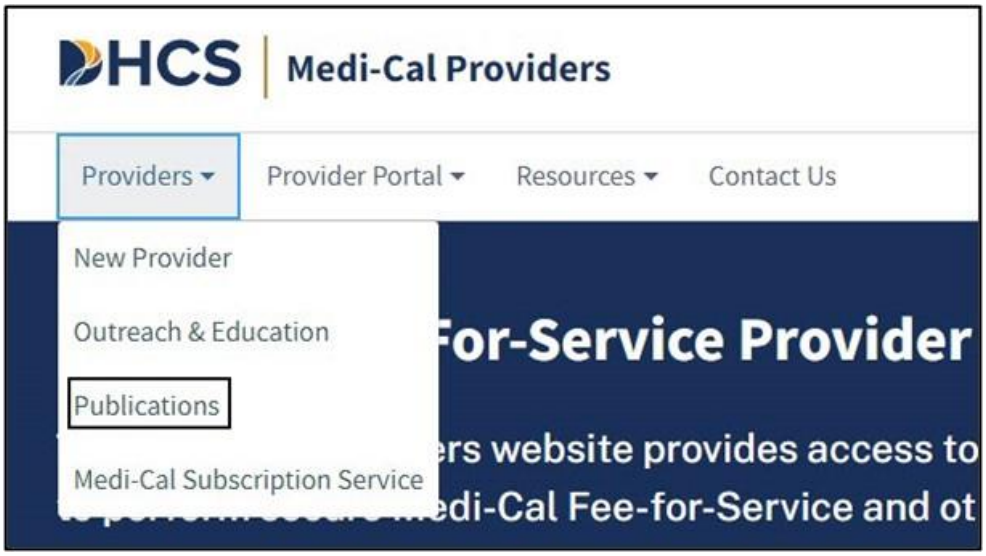


Figure 1.2: The Providers drop-down menu on the Medi-Cal Provider homepage.

The services offered within Medi-Cal are shown on the Publications page. Under **Allied Health Communities**, select **Durable Medical Equipment and Medical Supplies.**

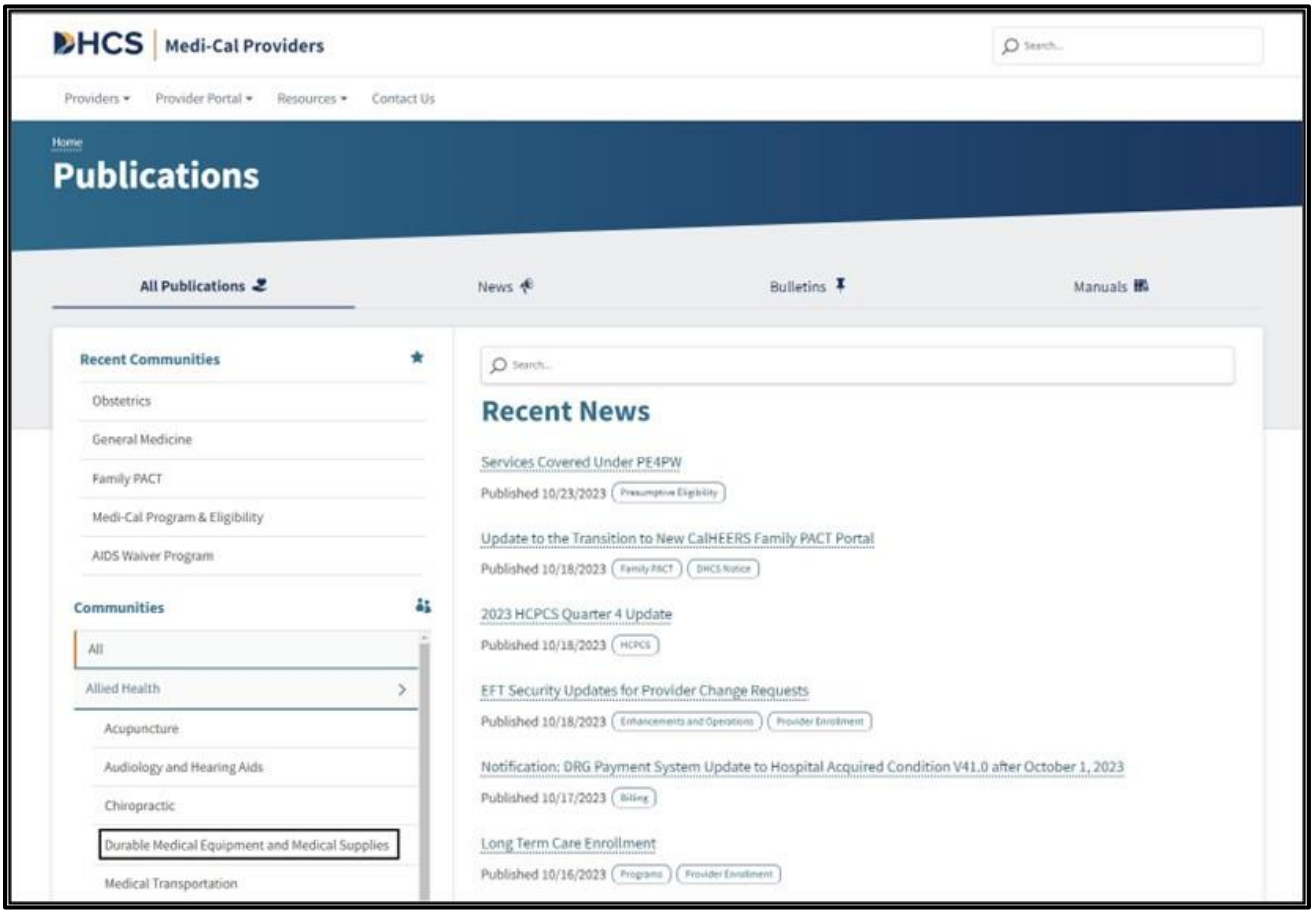


Figure 1.3: All provider communities may be accessed individually from the Medi-Cal Provider Publications homepage.

Once you have clicked on your desired provider community, the community-specific page will appear. Every provider community page contains:

- Bulletins.
- News.
- Provider Manuals.

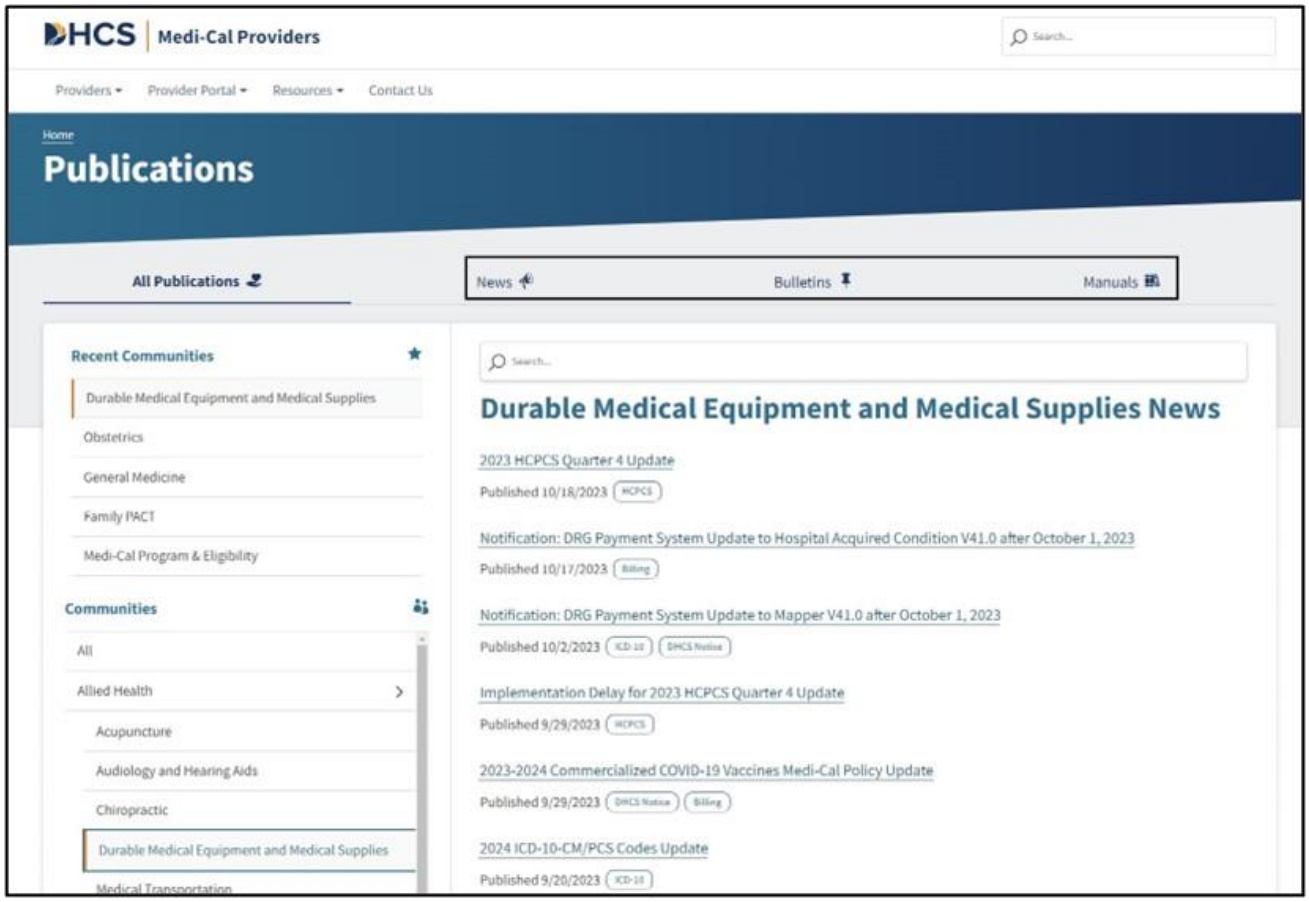


Figure 1.4: Publications Navigation Bar serves as a starting point for providers to access published materials for all communities.

Billing

DME Modifiers

Table of DME Modifiers

Modifier	Modifier and Description
NU	New equipment
RR	Rental
RB	Replacement as part of repair
KC	Replacement of special power wheelchair interface
KF	Item designed by FDA as Class III device
QA	Prescribed amounts of stationary oxygen for daytime use while at rest and nighttime use differ and the average of the two amounts is less than one liter per minute (LPM)
QB	Prescribed amounts of stationary oxygen for daytime use while at rest and nighttime use differ and the average of the two amounts exceeds four LPM and portable oxygen is prescribed
QE	Prescribed amount of stationary while at rest is less than one LPM
QF	Prescribed amount of stationary oxygen while at rest exceeds four LPM and portable oxygen is prescribed
QG	Prescribed amount of stationary oxygen is greater than four LPM
QR	Prescribed amounts of stationary oxygen for daytime use while at rest and nighttime use differ and the average of the two amounts is greater than four LPM
SC	Medically necessary service or supply (used for second unit of oxygen content)

Tax Status for DME Codes

In accordance with California Department of Tax and Fee Administration (CDTFA) regulation 1591, tax status is updated for the following Durable Medical Equipment (DME) HCPCS codes:

Providers should refer to the *tax* section in the *Durable Medical Equipment and Medical Supplies* (DME) manual for a complete list.

When billing for an unlisted code that is “By Report,” indicate whether or not the item is taxable in the *Additional Claim Information field* (Box 19) of the *CMS-1500* claim form or on an attachment. When using a listed code with an allowable rate, the system will pay the tax, if applicable. Providers must include sales tax on Medi-Cal claims for taxable supplies and equipment. If sales tax is not included in the billed amount, the sales tax amount will not be included in the reimbursement.

Rentals

All accessories are included in the rental reimbursement. Billing separately for accessories while billing for the rental will cause the accessories to deny or the amount to deduct from the rental. The accessories may be reimbursed separately after the recipient owns the piece of equipment.

Authorization Requirements

Authorization is required under the following circumstances:

- Cumulative cost within the calendar month for purchase of DME within a group exceeds $100.00.
- Cumulative cost within a 15-month period for rental of DME within a group exceeds $50.00.
- Respiratory equipment and accessories require authorization regardless of dollar amount.
- Cumulative cost within the calendar month for repair or maintenance exceeds $250.00.
- Request is for any unlisted or “By Report” item, regardless of dollar amount.

Prescriptions

The following must be supplied with the prescription for DME rental or purchases:

- Full name, address, telephone number and license number of prescribing practitioner.
- Date of prescription.
- Items being prescribed.
- Medical condition necessitating the particular DME item.
- Estimated length of need.
- For wheelchair and wheelchair accessories, refer to the *Durable Medical Equipment (DME): Wheelchair and Wheelchair Accessories Guidelines* section (dura wheel guide) of the Part 2 provider manual.

Certificates of Medical Necessity

Certificates of Medical Necessity are available online and in the appropriate Part 2 provider manual.

- Respiratory
  - Apnea monitors – MC 4600
  - Nebulizers – MC 4601
  - Oxygen – MC 4602
- DME Equipment
  - Non-wheelchairs – DHCS 6181
- Wheelchairs
  - Manual wheelchairs – DHCS 6181A
  - Power wheelchairs – DHCS 6181B
  - Power Operated Vehicles (POVs) – DHCS 6181C

TARs

The following items must be included on the TAR. See the *TAR Completion* section (tar comp) in the appropriate Part 2 provider manual for a complete list:

- Date of request.
- Recipient's address.
- HCPCS code and item description.
- Justification for using an unlisted code.
- Copy of prescription.
- Medical necessity documentation for item being requested.
- If a "By Report" item, attach appropriate Manufacturer's Suggested Retail Price (MSRP) catalog page.
- Rendering provider and contact information (name and phone number).

Documentation Requirements

Documentation submitted with the TAR for wheelchairs must include the following:

- The mobility and seating impairment to be accommodated.
- Equipment currently owned by the recipient, detailed features of the DME item and the date of purchase.
- Verification and documentation that other treatments of lesser mobility devices do not safely accommodate the recipient's mobility impairment.
- Verification and documentation that the requested equipment fits and is usable in all living areas used by recipient.
- An explanation describing how the living areas will be accessed by the recipient with the requested equipment.
- Verification and documentation that the recipient and/or caregiver understands how to care for and use the requested equipment.

- Seating evaluation by a qualified therapist (Occupational Therapist (OT)/ Physical Therapist (PT)/Assistive Technology Professional (ATP) for the following:
  - Neurological conditions
  - Complex orthopedic along with neurological conditions
  - Pediatric wheelchairs

Refer to the *Durable Medical Equipment (DME): Bill for Wheelchairs and Wheelchair Accessories* section (dura bil wheel) and *Durable Medical Equipment (DME): Wheelchair and Wheelchair Accessories Guidelines* section (dura wheel guide) in the appropriate Part 2 provider manual for information.

Bundle all accessories with the basic piece of equipment under the main code. For example:

- Gait trainers: Codes E8000 through E8002
- Bath bench: Code E0240
- Standing frames: Codes E0637, E0641 and E0642
- Position seat: Code T5001

Do not use the main code and then add all accessories under code E1399 (durable medical equipment, miscellaneous). This can cause problems when billing the claim.

The information on the invoice must match the information on the MSRP catalog page.

Refer to the Durable Medical Equipment (DME): Therapeutic Anti-Decubitus Mattresses and Bed Products (dura thp) in the appropriate Part 2 provider manual for information.

In addition to the documentation requirements specified above, all initial and reauthorization TARs for support surfaces must be accompanied by the appropriate flowcharts(s), based upon the patient's medical condition and the specific support surface needed to meet the patient's medical need(s).

- The provider must indicate (circle or highlight) the appropriate answer to all questions on the flowchart(s), based upon the documentation in the patient's medical record.
- If the appropriate flowchart(s) is not submitted or the information provided on the flowchart(s) and TAR is not sufficient to determine medical necessity for the requested support surface, the TAR shall be deferred for the required information. If the TAR has been previously deferred and the required information has not been submitted by the provider, the medical consultant shall deny the TAR.
- For unlisted procedure codes, the provider must submit the most appropriate flowchart(s), based upon the documentation in the patient's medical record. The flowchart(s) must be completed to the extent possible, along with justification for the requested unlisted procedure code.

Equipment

Oxygen/Respiratory Therapy

Criteria Expansion for Oxygen and Respiratory Equipment

The criteria for DME oxygen contents and oxygen equipment and respiratory equipment has been revised to align Medi-Cal policy with Medicare policy. The revision includes requirements for blood gas studies and other clinical criteria that must be met to qualify for supplemental oxygen. Blood Gas studies, Arterial Blood Gas (ABG), is a partial criterion that is used to qualify for either a ventilator, or a BiPap ST. This test shows that the patient is in respiratory failure. An ABG or an external pulse oximetry are the tests that are used to qualify for oxygen (either one), with the latter being used exclusively for a nighttime oxygen request. Portable oxygen systems have also been revised. For more information, refer to the *Durable Medical Equipment (DME): Bill for Oxygen and Respiratory Equipment* section (dura oxy) in the Part 2 provider manual.

Reimbursement for listed oxygen therapy service codes will not exceed 80 percent of the California Medicare reimbursement rates.

A TAR/SAR is required for all respiratory DME except for the following, which require authorization only for quantities exceeding the stated billing limit:

- A7005 (administration set, with small volume nonfiltered pneumatic nebulizer, non-disposable) – billing limit of one in six months.
- E0484 (oscillatory positive expiratory pressure device, non-electric, any type, each) – billing limit of two in 12 months.

Portable Oxygen

Code E0443: Oxygen Contents (Gas)

Portable oxygen contents, gaseous (for use only with portable gaseous systems when no stationary gas or liquid system is used), a one-month supply = one unit.

- For Medi-Cal purposes, code E0443 can be used to bill for portable gaseous oxygen contents, whether the portable system is rented or purchased.

Note: One unit is defined as “250 cubic feet” for the first supply of contents and any amount for the second supply of contents (second unit).

- Modifier NU must be used when billing code E0443 for the first unit and modifier SC must be used for the second unit. A maximum of two units is allowed per month.

For example:

Table of Modifier and Billing Code Example

Billing Code	Quantity
E0443NU	quantity of 1
E0443SC	quantity of 1

Code E0444: Oxygen Contents (Liquid)

Portable oxygen contents, liquid (for use only with portable liquid systems when no stationary gas or liquid system is used), a one-month supply = one unit.

- For Medi-Cal purposes, code E0444 can be used to bill for portable liquid oxygen contents whether the portable system is rented or purchased.
- Modifier NU must be used when billing code E0444 for the first unit and modifier SC must be used for the second unit. A maximum of two units is allowed per month.

Note: One unit is defined as “110 pounds” for the first supply of contents and any amount for the second supply of contents (second unit).

For example:

Table of Modifier and Billing Code Example

Billing Code	Quantity
E0444NU	quantity of 1
E0444SC	quantity of 1

- Only two units can be approved per month. A TAR/SAR will not override this limit.

Oxygen Specific Modifiers

Rented Equipment

Codes E0424, E0439, E1390, E1391: Oxygen Flow Rate

The following modifiers are billed only with stationary gaseous (E0424) or liquid (E0439) systems or with a non-portable oxygen concentrator (E1390, E1391).

Table of Oxygen Specific Modifiers

Modifier	Oxygen Flow Rate	Reimbursement Rate
RR	1 thru 4 LPM	$136.87
QE or QA	Less than 1 LPM	$68.44 (reduced by 50 percent)
QF or QB	Greater than 4 LPM Portable oxygen is prescribed	$205.31
QG or QR	Greater than 4 LPM Portable oxygen is not prescribed	$205.31

Use only one modifier when billing with the above modifiers. Multiple modifiers will result in a denied claim.

For example:

- E1390RR
- E1390QG

Notes:

Wheelchairs

Claim Requirements for "By Report" Wheelchairs

Claims must include the information about the technician involved in the evaluation, delivery and final fitting of the wheelchair. In the *Additional Claim Information* field (Box 19) or by attachment, include the following:

- The name and title of the employed or contracted qualified rehabilitation professional. Acceptable titles include:
  - Rehabilitation Engineering and Assistive Technology Society of North America (RESNA)-certified technician.
  - Certified Rehabilitation Technology Supplier (CRTS).
  - Licensed California physical therapist (PT).
  - Licensed California occupational therapist (OT).

For example: *Additional Claim Information* field Box 19 – Tom Smith, RESNA.

Reimbursement Conditions

Reimbursement will be the lesser of:

- 85 percent of MSRP catalog dated on or prior to the date of service, or
- Manufacturer's purchase invoice (cost), amount, plus 67 percent markup, or
- Amount billed pursuant to CCR, Title 22, Section 51008.1.

If the claim does not provide documentation that the provider employs or contracts with a qualified rehabilitation professional, reimbursement will be the lesser of:

- 80 percent of MSRP catalog dated on or prior to the date of service, or
- Manufacturer's invoice, plus 67 percent markup, or
- The billed amount.

Wheelchair "Replacement Only" Parts

Wheelchair parts that include a description of "replacement only" should be billed using NU not RBNU/NURB.

- The claim will be denied when using the wrong modifiers. Providers need to check each code on the repairs to see what modifier to use.

Unlisted DME Non-Wheelchairs Claim Reimbursement Conditions

Reimbursement will be the lesser of:

- 80 percent of MSRP catalog dated on or prior to the date of service or
- Manufacturer's invoice plus 67 percent markup or
- The billed amount

Claim Requirements for Unlisted DME Supply HCPCS “A” Codes

Claims must include the following information to receive reimbursement:

- In the *Additional Claim Information* field (Box 19), a statement that the equipment is “patient owned” and either the description of the equipment or the procedure code of the owned equipment must be included.

For example:

Patient-owned nebulizer with compressor E0570.

When to Bill A9900 and E1399

HCPCS code E1399 is used when an active HCPCs code does not exist for **non-wheelchair miscellaneous equipment or the repairs** of E1399 equipment.

E1399 is not to be used for medical supplies, it is for DME only. Even if they have a TAR/SAR the claim will be denied.

A9900 is used for **miscellaneous supplies** that do not have an active HCPCS code.

Reimbursement Conditions A9900

Reimbursement will be the lesser of:

- Manufacturer’s purchase invoice, plus a 23 percent markup or
- The billed amount

Non-Wheelchair Miscellaneous Equipment E1399 and Blood Pressure Monitors HCPCS A4670

Reimbursement will be the lesser of:

- 80 percent of MSRP catalog dated on or prior to the date of service or
- Manufacturer’s invoice plus 67 percent markup or
- The billed amount

"By Report" Attachment

- For custom-made equipment with no MSRP available, submit the manufacturer's purchase invoice. If the invoice does not indicate that the item is "custom," handwrite a statement on the invoice "custom and no MSRP available."
- If there is no MSRP available for the item billed, submit the manufacturer's invoice and explain the lack of MSRP.
- If the provider writes "No MSRP available" but the medical review team knows the manufacturer has an MSRP the claim will be denied.
- If the provider is renting the piece of equipment from another provider or manufacturer, and unable to purchase, submit the rental invoice showing the rental cost and the appropriate MSRP catalog page.
- When the provider and the manufacturer are the same, attach the MSRP or catalog page with the appropriate date.

Approved attachments for DME claims

- MSRP catalog page dated on or prior to the date of service.
- Manufacturer's invoice dated prior to the date of service.
- Manufacturer quotes if MSRP is not available along with a manufacturer purchase invoice.
- Manufacturer's invoice dated prior to date of service, with MSRP on the same page.

Equipment Repair/Maintenance

- Medi-Cal only repairs equipment owned by the Medi-Cal patient.
- Labor codes:
  - K0739: all equipment except oxygen.
  - There is no separate reimbursement for K0739 with the Power Wheelchair battery replacement.
  - K0740: oxygen.
- Do not use a modifier with the labor code.
- Bill the labor time needed to accomplish the work in 15-minute units. The labor time may be rounded to the nearest half-hour for the total repair job.

For example:

1 hour and 20 minutes = 6 units.

- Hourly labor payment rate for DME repair is $65.88 (one 15-minute "unit" is $16.47).

Patient-Owned Equipment

Wheelchairs

Claims for the repair of wheelchairs (modifiers NU and RB) require the following information:

- In the Additional Claim Information field (Box 19) provide a description of the equipment and that the equipment is patient owned.

For example:

Box 19: Repair of patient-owned manual wheelchair K0005 (ultralightweight wheelchair).

- Use modifiers NU and RB for replacement of wheelchair parts.

Note: Use modifier NU only if the part has “replacement” only in the description.

Example of Modifiers used for Replacement of Wheelchair Parts

Billing Code	Wheelchair Parts
E2211NURB	Pneumatic tires
K0739	Labor

Non-Wheelchairs

Claims for the repair of non-wheelchair equipment (modifier RB) requires the following information:

- Box 19: Statement that the equipment is owned by the patient, e.g. “Repair of patient owned patient lift or patient owned E0630.”
- Description of service provided.
- Reason/justification for repair.
- Manufacturer’s name.

Do not bill for more than the quantity of (1) when repairing a non-wheelchair piece of equipment. The claim will be denied for exceeding the NCCI edit. Bill with (1) unit and include all the pieces of the parts you replaced on the attachment.

List of parts used, including catalog numbers and cost for “By Report” items.

For example:

Example Table for Non-Wheelchair Equipment Billing Codes

Billing Code	Parts Used
E0630RB	Patient Lift
K0739	Labor

Oxygen

Claims for repair of oxygen equipment (modifier RB), require the following information.

- Box 19: Statement that the oxygen equipment is owned by the patient.
- Description of service provided.
- Reason/justification of repair.
- Manufacturer’s name.
- List of parts used, including catalog numbers and cost for “By Report” items.

For example:

Example Table of Oxygen Equipment Modifier

Billing Code	Parts Used
E1354RB	Wheeled O2 Cart
K0740	Labor

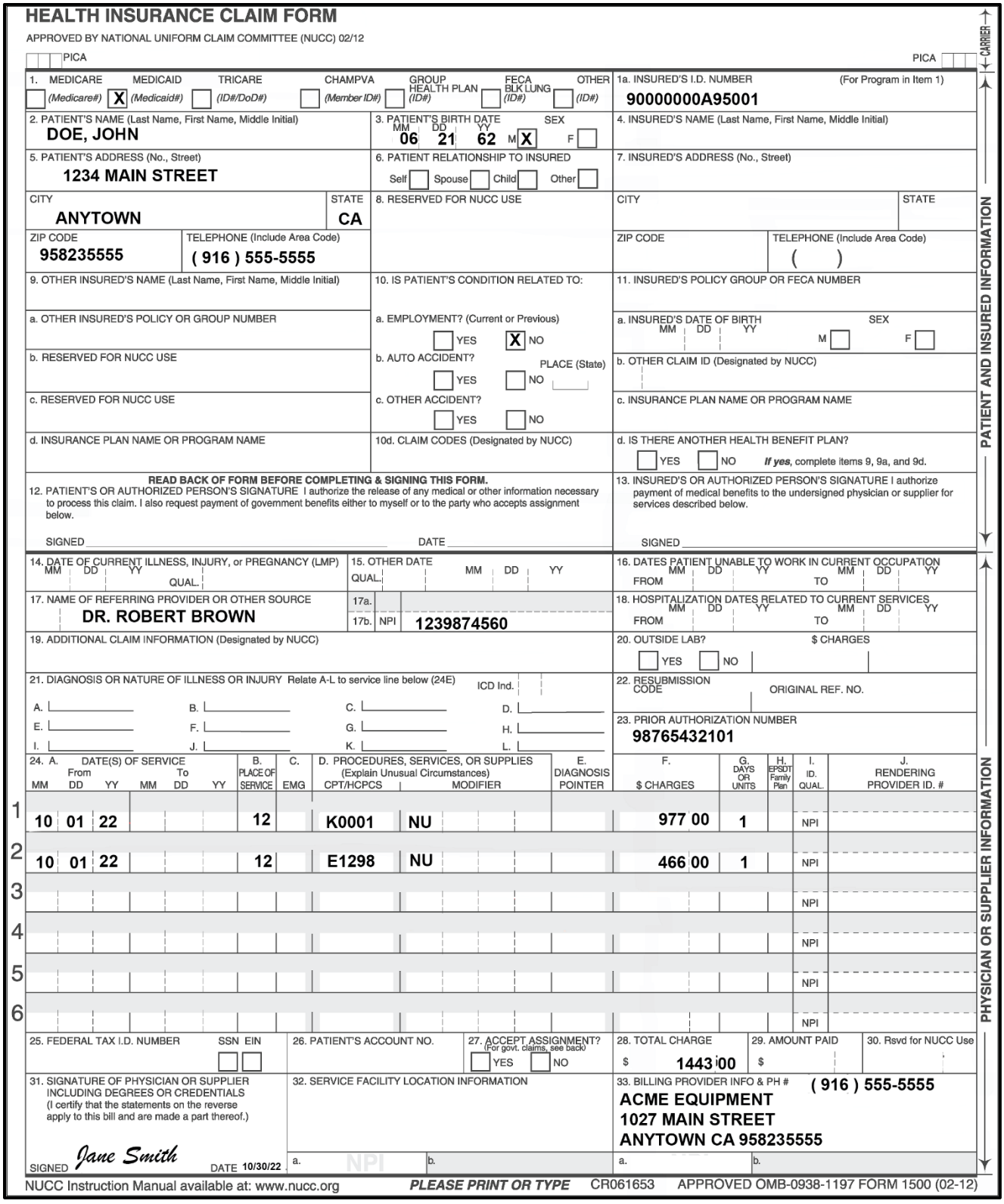
DME Billing Example

Scenario 1: Listed DME

This is a sample only. Please adapt to your billing situation.

- Referring physician's name and NPI number are entered in the *Name of Referring Provider* or *Other Source* field (Box 17) and *NPI* field (Box 17B) because a written prescription is required for all DME rental and purchases.
- The DME company is billing for a wheelchair exceeding the cumulative cost of $100, authorization is required; therefore, the TAR number is entered in the *Prior Authorization Number* field (Box 23).
- The DME company is billing for the purchase of a standard wheelchair and an extra wide seat. HCPCS codes K0001 (standard wheelchair) and E1298 (special wheelchair seat) are billed with modifier NU (new equipment purchase) and entered in the *Procedures, Services or Supplies* field (Box 24D).
- Enter the usual and customary charges in the *Charges* field (Box 24F).

Note: Wheelchairs, their modifications and/or accessories are nontaxable.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE [ ] (Medicare#) MEDICAID [X] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 90000000A95001

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE, JOHN

3. PATIENT'S BIRTH DATE MM DD YY: 06 21 62 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 1234 MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: CA

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 958235555 TELEPHONE (Include Area Code): (916) 555-5555

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DR. ROBERT BROWN

17a.

17b. NPI 1239874560

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 98765432101

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 10 01 22		12		K0001	NU		977 00	1		NPI	
2 10 01 22		12		E1298	NU		466 00	1		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ 1443 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Jane Smith DATE 10/30/22

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (916) 555-5555
ACME EQUIPMENT
1027 MAIN STREET
ANYTOWN CA 958235555

a. b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

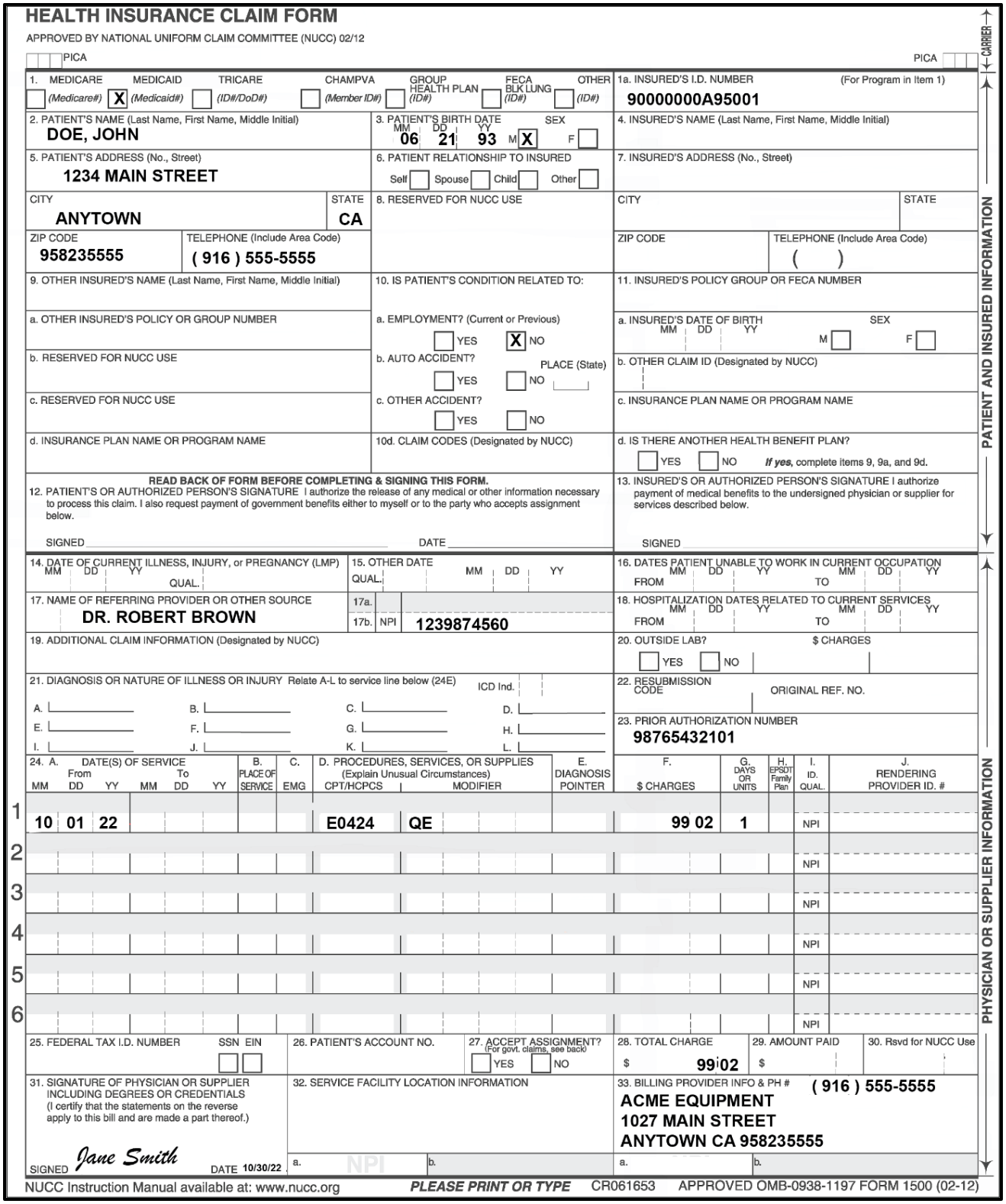
Figure 2.1: Listed DME.

DME Billing Example

Scenario 2: Gas Oxygen System Rental with Modified Oxygen Flow

This is a sample only, please adapt to your billing situation.

- Claim example shows the rental of stationary gas oxygen system at less than 1 liter per minute oxygen flow rate (E0424QE)
- Referring physician’s name and NPI number are entered in the *Name of Referring Provider or Other Source* field (Box 17) and NPI field (Box 17B) because a written prescription is required for all oxygen equipment rentals, purchases, and supplies
- TAR is required for all oxygen equipment and supplies.TAR number) number is entered in the *Prior Authorization Number* field (Box 23)
- The rental of a stationary gas oxygen system (E0424) is entered in the *Procedures, Services, or Supplies* field Box 24D.because the prescribed oxygen flow rate to be delivered by the stationary gas oxygen system is less than 1 liter per minute (LPM)
- Code E0424 is billed with modifier QE
- Enter the usual and customary charges in the *Charges* field (Box 24F)



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE [ ] (Medicare#) MEDICAID [X] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 90000000A95001

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE, JOHN

3. PATIENT'S BIRTH DATE MM DD YY: 06 21 93 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 1234 MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: ANYTOWN STATE: CA

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 958235555 TELEPHONE (Include Area Code): (916) 555-5555

ZIP CODE TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DR. ROBERT BROWN

17a.

17b. NPI 1239874560

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 98765432101

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10	01	22					E0424	QE		99 02	1		NPI	
2														NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ 99 02

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Jane Smith DATE 10/30/22

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (916) 555-5555
ACME EQUIPMENT
1027 MAIN STREET
ANYTOWN CA 958235555

a. b.

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CARRIER

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Figure 3.1: Gas Oxygen System Rental with Modified Oxygen Flow.

DME Common Denials

Remittance Advice Details

Table of Remittance Advice Details

Code	Description
0005	The service billed requires an approved TAR (*Treatment Authorization Request*).
0037	Health Care Plan enrollee, capitated service not billable to Medi-Cal.
0640	Recipient is not eligible for Medi-Cal benefits without complete denial of coverage from the Medicare Health Maintenance Organization (HMO), Competitive Medical Plan (CMP) or Health Care Prepayment Plan (HCPP). Medi-Cal is not obligated for plan services when the recipient chooses not to go to a plan provider.
0008	The provider of service is not eligible for the type of services billed.
0051	Signature is missing or is not an original.
0155	The referring provider's State license number or provider number is missing or invalid.
9670	Claim date of service does not match date of service on SAR (Service Authorization Request) file.
0314	Recipient is not eligible for the month of service billed.
0243	The TAR Control Number submitted on the claim is not found on the TAR master file.
0006	The date(s) of service reported on the claim is not within the TAR (*Treatment Authorization Request*) authorized period.
0672	The claim exceeds the monthly reimbursement limit for incontinence supplies.
9671	Procedure code has not been authorized by CCS/GHPP (California Children’s Services/Genetically Handicapped Persons Program).
9598	A statement that says “the equipment is patient-owned”, and includes the specific procedure code and/or description of the equipment being repaired/serviced, is missing from the Additional Claim Information field (Box 19) of the claim or attachment.
9898	HCPCS Qualifier and NDC (National Drug Code)/UPN (Universal Product Number) is invalid.
9654	Manufacturer invoice and catalog page are required.
9098	The attached **documentation** is invalid.

Table of Remittance Advice Details (continued)

Code	Description
0225	Incorrect procedure code and/or modifier.
9006	This medical supply is not payable without a copy of the supplier's invoice.
9713	The date on the catalog or invoice is missing or invalid.
9217	Indicate a line number next to the catalog number.
9019	Information on the claim does not match what is being billed.
0031	The provider was not eligible for the services billed on the date of service.
0002	The recipient is not eligible for benefits under the Medi-Cal program or other special programs.

Claims checklist to avoid receiving common denials

- Sign your claim – Signature on file or typed in is not acceptable.
- Complete 11-digit TAR/SAR number – although not required, suggest attaching a copy of TAR/SAR so corrections can be made.
- Verify DOS is within the approved dates on TAR/SAR.
- Verify modifier and procedure are correct and match the TAR/SAR.
- Verify all required documentation is attached.
- Verify quantity is within the NCCI frequency limits (cannot be exceeded on the same Date of Service).

Notes:

Resource Information

References

Provider Manual References

The following reference materials provide Medi-Cal billing and policy information:

Part 1

Remittance Advice Details (RAD) and Medi-Cal Financial Summary (remit)

Part 2

Durable Medical Equipment (DME): An Overview (dura)

Durable Medical Equipment (DME): Billing Codes for California Children's Services (dura cd ccs)

Durable Medical Equipment (DME): Bill for DME (dura bil)

Durable Medical Equipment (DME): *Other DME Equipment* (dura other)

Durable Medical Equipment (DME): Bill for Oxygen and Respiratory Equipment (dura oxy)

Durable Medical Equipment (DME): Bill for Wheelchairs and Wheelchair Accessories (dura bil wheel)

Durable Medical Equipment (DME): Billing Codes and Reimbursement Rates (dura cd)

Durable Medical Equipment (DME) Billing Codes: Frequency Limits (dura cd fre)

Durable Medical Equipment (DME): Billing Examples (dura ex)

Durable Medical Equipment (DME): Modifiers: Approved List (modif app)

Durable Medical Equipment (DME): Therapeutic Anti-Decubitus Mattresses and Bed (dur thp)

Durable Medical Equipment (DME): Wheelchair and Wheelchair Accessories Guidelines (dura wheel guide)