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This document is provided as a supplement to the Blue Cross and Blue Shield of Illinois (BCBSIL) Contract Agreement with all Durable Medical Equipment (DME) Providers to familiarize you with BCBSIL policies concerning DME, particularly life sustaining and non-life sustaining equipment as specified in your contract. All DME Providers are required to abide by these policies and are accountable to deliver services and bill accordingly. Electronic billing of claims is required. In addition, all DME Providers must have facility accreditation by a nationally recognized accreditation organization (JCAHO, ACHC or CHAP) in order to contract with BCBSIL.

## **DME Definition**

DME is defined as equipment which consists of items that primarily and customarily serve a medical rather than a comfort or convenience purpose, are not useful to a person in the absence of illness or injury, withstand repeated use (are reusable), are appropriate for home use, and are ordered or prescribed by the attending physician.

Coverage for DME may include:

- Repair, adjustment or replacement parts and accessories necessary for the normal and effective functioning of the equipment;
- Rental charges for the equipment if it can be rented for a cost less than the purchase of the equipment;
- Purchased equipment when the purchase of the DME would be less expensive than the rental of the equipment.

All DME suppliers must obtain signed physician orders and/or a Certificate of Medical Necessity (CMN) prior to billing of any equipment. All orders/CMN's must contain the following information to be considered for payment:

- Date of order/CMN
- Patient, address and BCBSIL member #
- Supplier name, address, telephone #
- Physician name, address and telephone #
- Patient diagnosis(es)
- Equipment/supplies ordered
- Duration of need
- Statement of medical necessity for equipment (include patient's PO2 level for oxygen)
- Physician signature and date

## Life Sustaining DME

The following equipment is considered life sustaining and will not be purchased:

1. **E0424:** Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing.
2. **E0431:** Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing.
3. **E0434:** Portable liquid oxygen system, rental, includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge, cannula or mask, and tubing.
4. **E0439:** Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing.
5. **E0450:** Volume ventilator, stationary or portable, with backup rate feature, used with invasive interface (e.g., tracheostomy tube).
6. **E0457:** Chest shell (cuirass)
7. **E0460:** Negative pressure ventilator; portable or stationary
8. **E0461:** Volume ventilator, stationary or portable, with backup rate feature, used with non-invasive interface.
9. **E0463:** Pressure support ventilator with volume control mode, may include pressure control mode, used with invasive interface, e.g. tracheostomy tube.
10. **E0464:** Pressure support ventilator with volume control mode, may include pressure control mode, used with non-invasive interface, e.g. mask.
11. **E0618:** Apnea monitor, without recording feature
12. **E0619:** Apnea monitor, with recording feature
13. **E1390:** Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate.
14. **E1391:** Oxygen concentrator, dual delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate, each
15. **E1392:** Portable oxygen concentrator, rental
16. **E1590:** Hemodialysis machine
17. **E1592:** Automatic intermittent peritoneal dialysis system
18. **E1594:** Cycler dialysis machine for peritoneal dialysis
19. **K0738:** Portable gaseous oxygen system, home compressor used to fill portable oxygen cylinders

## Oxygen Use Policy

Home oxygen therapy and supplies are considered medically necessary when ALL the following coverage conditions are met:

- A. The treating physician has determined that the patient has a severe lung disease or hypoxia related symptoms that might be expected to improve with oxygen therapy, AND
- B. The qualifying blood gas study was performed by a physician or by a qualified provider or supplier of laboratory services, AND
- C. The qualifying blood gas study was obtained under the following conditions:
  - If the qualifying blood gas study is performed during an inpatient hospital stay, the reported test must be the one obtained closest to, but no earlier than 2 days prior to the hospital discharge date, OR
  - If the qualifying blood gas study is not performed during an inpatient hospital stay, the reported test must be performed while the patient is in a chronic stable state – i.e., not during a period of acute illness or an exacerbation of their underlying disease, AND
- D. Alternative treatment measures have been tried or considered and deemed clinically ineffective, AND
- E. The patient's blood gas study must fall into one of the following group criteria ranges:
  - **Group I criteria:**
    - PO<sub>2</sub> at or below 55mm Hg or O<sub>2</sub> saturation at or below 88 percent taken:
      - At rest (awake) OR
      - During sleep for a patient who doesn't meet # 1 above. (Coverage will be provided for nocturnal use only), OR
      - During sleep with a decrease in arterial PO<sub>2</sub> more than 10 mm Hg, or a decrease in arterial oxygen saturation more than 5 percent, associated with symptoms attributable to hypoxemia (e.g., cor pulmonale, "P" pulmonale on EKG, documented pulmonary hypertension and erythrocytosis), OR
      - During exercise for a patient who doesn't meet #1 above. (Oxygen would be covered during exercise if it is documented that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the patient was breathing room air).

▪ **Group II criteria:**

An arterial PO<sub>2</sub> of 56-59 MM Hg, or O<sub>2</sub> saturation at or below 89 percent at rest (awake), during sleep for at least 5 minutes (does not have to be continuous), or during exercise (as described under Group I criteria), AND any of the following:

-Dependent edema suggesting congestive heart failure, OR

-Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or “P” pulmonale on EKG (P wave greater than 3 mm in standard leads II, III, or AVF), OR

-Erythrocythemia with a hematocrit greater than 56 percent.

**NOTE:** Initial coverage for patients meeting Group I and II criteria is limited to 12 months or the physician specified length of need, whichever is shorter. Prescription must be renewed on an annual basis.

Oxygen therapy and associated supplies are not considered medically necessary if any of the following conditions exist:

- Angina pectoris in the absence of hypoxemia.
- Dyspnea without cor pulmonale or evidence of hypoxemia.
- Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities but in the absence of systemic hypoxemia.
- Terminal illnesses that do not affect the respiratory system.

A portable oxygen system is considered medically necessary:

- When the patient is mobile within the home and the qualifying blood gas study was performed while at rest (awake) or during exercise.
- As a backup system (i.e. compressed gas cylinders) in the event of an extended power failure for patients using oxygen concentrators.

A qualifying blood gas study (arterial blood gas (ABG) test or an oximetry test) must be performed by a qualified provider (a laboratory, an independent diagnostic testing facility, or a physician). Blood gas studies performed by a supplier are not acceptable.

For coverage of Pulse Oximeters for Home Use see medical policy DME101.047.

Oxygen set-up or installation of respiratory support systems, patient/caregiver instruction on equipment use and safety, and equipment maintenance/monitoring are included in the rental fee.

### **Oxygen Contents**

Oxygen contents are included in the allowance for rented oxygen systems and are not separately billable.

### **Oxygen Accessories**

Oxygen accessories which are included in the allowance for rented systems include: cannulas, humidifiers, masks, mouthpieces, nebulizer for humidification, oxygen conserving devices, regulators, transtracheal catheters and tubing, charges for oxygen carts, racks or stands. These accessories may not be billed separately.

### **Ventilator Accessories**

The rental allowance for Ventilators (E0450, E0460, E0461, E0463, E0464) includes: battery, battery cables, battery charger, breathing circuit components, and filters. These accessories should not be billed separately.

### **Bi-Level Respiratory Assist Device/Non Invasive Ventilator**

The rental allowance for the Respiratory Assist Device, Bi-Level (E0471 and E0472) pressure capability includes the following accessories which should not be billed separately: masks, face mask or nasal interface, headgear, chinstrap, tubing, filters and oral interface.

### **Home Apnea Monitors**

Monitoring may be considered medically necessary for premature infants who are at high risk of recurrent episodes of apnea, bradycardia, and hypoxemia, for up to three months after hospital discharge, or after the cessation of serious episodes for 14 consecutive days, whichever comes last.

The rental allowance is to include all supplies needed for the use of the apnea monitor. These items include, but are not limited to, belts, electrodes, wires, ambu bag. Also included in the rental allowance is retrieval of recorded data from the event recorder and parental training sessions (instructions on monitor use, CPR, etc). These items may not be billed separately from the apnea monitor.

The following services for patients who require Home Apnea Monitoring are considered **not medically necessary**.

- A back-up electrical system or alterations to the living quarters required for the monitor
- Home apnea monitoring is considered **not medically necessary** when prescribed for Sudden Infant Death Syndrom (SIDS), or for infants who have any siblings with a history of SIDS.

The following services are considered part of the rental/purchase fee for the monitor:

- Retrieval of recorded data from the monitor event recorder
- Parental training sessions (e.g., cardiopulmonary resuscitation [CPR] classes and/or instructions on monitor use)

## Non-Life Sustaining DME

All other equipment not listed as life sustaining (as above) will be paid as rental up to the allowed purchase price.

### Continuous Positive Airway Pressure (CPAP)

All initial billing for CPAP devices must be accompanied by sleep lab study results (home studies not covered or acceptable). CPAP's may not be converted to a purchase until after 3 months of patient usage (exception: HMO medical group approval). DME providers must obtain evidence of continued CPAP usage/compliance from the patient and/or treating physician before converting to purchase price. This information must be retained in the supplier's files and be available to BCBSIL upon request.

CPAP masks must be fitted to individual patients by a qualified professional. The CPAP machine should include the necessary carrying case. This carrying case may not be billed separately.

### Continuous Passive Motion (CPM) Device

The CPM device may be eligible for coverage for use postoperatively, as an adjunct to conventional physical therapy, in the following instances:

- Total Knee Arthroplasty (TKA), or
- Reconstruction of the anterior cruciate ligament (ACL); or
- Open reduction and internal fixation (ORIF) of tibial plateau or distal femur fracture involving the knee joint.

Documentation of the preceding surgical interventions must be available upon request.

Outpatient use of the CPM device must begin within 48 hours of the surgical procedure and **may be considered medically necessary for ONLY up to twenty one (21) days postoperatively.**

All other uses of a CPM device **are considered experimental, investigational, and unproven.**

### Orthotics and Prosthetics

Any custom orthotic or prosthetic services rendered by a DME Provider are subject to the state law governing disbursement of these services. Services must be rendered by an Illinois State licensed orthotist, prosthetist and/or pedorthist. In addition, the DME Provider must have dual facility accreditation to include the American Board for Certification in Orthotics and Prosthetics (ABC), and/or each licensed professional must be credentialed and certified by the American Board for Certification in Orthotics and Prosthetics, or the Board for Certification in Pedorthics (BCP), as applicable.

All providers are encouraged to review relevant BCBSIL medical policies (found on the BCBSIL Web site at [www.bcbsil.com](http://www.bcbsil.com)) prior to rendering services. It may be appropriate in some cases to complete a Predetermination Request Form for predetermination of benefit and medical necessity which may be submitted along with the appropriate medical necessity documentation.

*BCBSIL reserves the right to update this handbook as necessary*