

Durable Medical Equipment Claims – Tips on Using Diagnosis Codes

Below is information on filing durable medical equipment claims for members of our **Blue Cross Community Health PlansSM**. When coding and reporting DME claims, the focus is on ensuring that the diagnosis codes submitted justify the medical necessity of the equipment or supplies.

While [ICD-10-CM guidelines](#) don't have a DME-specific section, here are important practices to consider when billing DME claims:

- Use diagnosis codes that support the medical necessity of the equipment or supplies by selecting ICD-10-CM codes that accurately reflect the member's needs.
- Use the most specific ICD-10-CM codes. Avoid unspecified codes when more specific codes are available.
- Always verify if diagnosis codes are included in the [Local Coverage Determinations](#) and [National Coverage Determinations](#) list for billed equipment or supplies.
- Use Centers for Medicare & Medicaid Services tools to match diagnosis codes to covered DME items.
- Ensure you are using the most current [ICD-10-CM guidelines](#).

Use the appropriate LCD: LCDs outline the coverage criteria for specific DME items, including the ICD-10-CM codes that justify medical necessity. It's important to reference the [appropriate LCD](#) to guarantee compliance with coverage requirements.

The material presented here is for informational/educational purposes only, is not intended to be medical advice or a definitive source for coding claims and is not a substitute for the independent medical judgment of a physician or other health care provider. The information presented isn't intended to replace or supersede any requirements set forth in your contract with Blue Cross and Blue Shield of Illinois. In the event of a conflict between this information and your contract or our coverage contract with your patient, your contract or our coverage contract with your patient, as applicable, will control. Health care providers are encouraged to exercise their own independent medical judgment based upon their evaluation of their patients' conditions and all available information, and to submit claims using the most appropriate code(s) based upon the medical record documentation, coding guidelines and reference materials. References to other third-party sources or organizations are not a representation, warranty or endorsement of such resources or organizations. The fact that a service or treatment is described in this material, is not a guarantee that the service or treatment is a covered benefit and members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any service or treatment is between the member and their health care provider.