



An Independent Licensee of the Blue Cross and  
Blue Shield Association

# Home Medical Equipment, Orthotics, and Prostheses Guide

[Preface](#)

[Summary of Changes](#)

[Table of Contents](#)

[Service Contacts](#)

***November 2011***

*Replaces: September 2011*

# Preface

The *Wellmark Provider Guide* and specialty guides are billing resources for providers doing business with Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Health Plan of Iowa, Inc., and Wellmark Blue Cross and Blue Shield of South Dakota. The guides are referenced in your provider agreement, and include information that applies to all benefit plans in Iowa and South Dakota unless specified within the text.

## Explanation of Terminology

Wellmark	Throughout the guides, the term Wellmark indicates Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Health Plan of Iowa, Inc., and Wellmark Blue Cross and Blue Shield of South Dakota.
Member	Individuals with health coverage through Wellmark are referred to as members.

## Provider Guide Updates

Wellmark's provider guides are continually updated to bring you the most current information. The following items identify when the guide or section was last changed.

- The most current date is printed on the front cover and inside pages. The date of the version replaced is also printed on the front cover.
- A *Summary of Changes* page lists all the substantial changes made in the most current update. The page(s) affected and a brief explanation of the change is linked from the *Summary of Changes* page to the change within the document.
- Changed text is in blue type.

## How to Order Paper Copies of Provider Guides

We invite you to print Wellmark's provider guides from the website. However, if you prefer to order a paper copy, simply complete a Provider Forms Order (IA: B-0002; SD: B-3001) found on [Wellmark.com > Provider > Communication & Resources > Forms](#), or in the Member and Service Information section of the *Wellmark Provider Guide*. If you do not have a forms order blank, contact a Provider/Customer Service representative for assistance. We will inform you of guide updates in the *Blue Ink* newsletter or on the Provider page of our website.

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# HME, Orthotics, and Prostheses

## Summary of Changes

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**Updated: April, August, September, and November 2011**

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**Changes** (each description links to full text):

**Throughout:** Updated URLs and instructions for finding tools and information on the redesigned [Wellmark.com](http://Wellmark.com). While these updates appear in blue print, they are merely navigational changes, and are not listed individually on this page.

Phone numbers are also updated throughout the guide, but not noted on this page.

**Page 3:** Updated information on billing compression stockings.

**Page 7:** Any member receiving an initial PAP (positive airway pressure) device must have a sleep study test interpreted by a Wellmark approved board certified sleep specialist.

Bill PAP (positive airway pressure) devices with KX modifier when appropriate.

**Page 8:** Updated information on CPAP (continuous positive airway pressure) devices.

Wellmark's policy on BiPAP (bi-level positive airway pressure) and autoadjusting CPAP (APAP) devices.

**Page 9:** Language on reimbursement for oxygen updated to coincide with Medicare policy.

Wellmark allows payment for oxygen claims dated up to 30 days prior to the date the oxygen assessment is performed.

**Page 15:** Updated information on billing HME with nonspecific HCPCS codes.

Please identify items with their corresponding HCPCS code when submitting invoices or statements containing multiple items.

**Page 16:** Shipping and handling of HME is not reimbursed, except for FEP members.

Beginning November 1, 2011, Wellmark will follow the coding guideline used by the Centers for Medicare and Medicaid Services (CMS) when processing all claims for certain durable medical equipment. For these items, "office" will no longer be accepted as place of service.

**Page 17:** Link to the list of CMS codes affected, and a table of acceptable place of service codes.

# Home Medical Equipment, Orthotics and Prostheses Guide

## Contents

I. Introduction.....	1
II. Orthotics .....	2
III. Prostheses.....	4
IV. Home Medical Equipment .....	5
Positive Airway Pressure (PAP) Devices .....	7
CPAP (Continuous Positive Airway Pressure) Devices.....	8
BiPap and APAP.....	8
CPM (Continuous Passive Motion) Devices .....	9
Oxygen Rental .....	9
Dispensing Recurrent HME/DME Items .....	10
Automatic Delivery of HME Supplies or Equipment.....	10
Wheelchairs .....	11
Manual Wheelchairs.....	11
Motorized Wheelchairs and Other Power Operated Vehicles.....	11
V. Replacements and Repairs .....	12
Billing Repairs of HME.....	13
Temporary Replacement (Submit paper claim) .....	13
VI. Claims Filing Information .....	14
VII. Summary .....	17

**Scope** Information in this guide applies to networks and products offered or administered by Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Blue Cross and Blue Shield of South Dakota, and Wellmark Health Plan of Iowa, Inc. The guidelines may also apply to Select First, but as guidelines will vary, please check Select First coverage at <http://www.firstadministrators.com/> or call the phone number on the back of the member's ID card for details.

## I Introduction

This guide provides you with benefit and claims filing information for home medical equipment (HME), orthotics, and prostheses for Wellmark Blue Cross and Blue Shield of Iowa,<sup>1</sup> Wellmark Health Plan of Iowa, Inc. (WHPI),<sup>2</sup> and Wellmark Blue Cross and Blue Shield of South Dakota.<sup>3</sup>

**Written prescription**



To consider benefits for HME, orthotics, or prostheses, Wellmark requires a physician's written prescription. Keep a copy of the prescription *in the patient's medical record*. Usually, a prescription includes the patient's diagnosis and prognosis, the reason the item is required, and the physician's estimate of the number of months the patient will need the item.

**Deluxe features  
patient liability**

Wellmark covers *medically necessary* HME, orthotics, and prostheses. Deluxe features and upgrades for aesthetic or convenience purposes are not payable. Code upgrades using HCPCS code A9270 (noncovered item or service). The noncovered item will be denied as member liability.

**Medical necessity**

For a definition of medical necessity, please see the "Claims Filing" section of the *Wellmark Provider Guide* at [Wellmark.com](http://Wellmark.com) > Provider > Communication & Resources > Billing Guides.

**Referrals**

A referral from the patient's primary care provider (PCP) or the ordering specialist is no longer required for HME (home medical equipment), orthotics, and prostheses, regardless of cost.

**Prior approvals**

Wellmark recommends a prior approval before providing certain treatments, procedures, services, and supplies, regardless of cost. Wellmark's prior approval list may be found at [Wellmark.com](http://Wellmark.com) > Provider > Medical Policies & Authorizations > Authorizations.

<sup>1</sup>Includes: Alliance Select<sup>SM</sup>, Classic Blue<sup>®</sup>, Senior Blue<sup>®</sup>, MedicareBlue Supplement<sup>®</sup>, and the Federal Employee Program (unless otherwise noted) in Iowa

<sup>2</sup>Includes: Blue Access<sup>®</sup>, *hawk-i* Blue Access, Blue Advantage<sup>®</sup>, Blue Choice<sup>®</sup>

<sup>3</sup>Includes Blue Select<sup>®</sup>, Classic Blue, Senior Blue, MedicareBlue Supplement<sup>®</sup>, and the Federal Employee Program (unless otherwise noted) in South Dakota

*Prior approvals for Federal Employee Program*

The Federal Employee Program (FEP) requires Plans to review prior approval requests *only when the service specifically requires a prior approval under the FEP contract*. FEP **does not** require prior approvals for HME.

*Submitting prior approval requests online*

If you have access to Wellmark's secure Web tools, you can submit prior approval requests online at [Wellmark.com](http://Wellmark.com) > [Provider](#) > [Medical Policies & Authorizations](#) .

*Forms*

Forms are also available on our website at [Wellmark.com](http://Wellmark.com) under [Provider](#) > [Communication & Resources](#) > [Forms](#). You may also order a prior approval form by using the Forms Order blank found in the Member and Service Information section of the *Wellmark Provider Guide*. To order a Prior Approval form, request form number

**P-4602**..... for Iowa members

**N-3612**..... for South Dakota members

If you need assistance, call our Provider/Customer Service department (see back cover for a complete list).

Send completed Prior Approval forms to:

Utilization Management 5W 198<sup>1</sup>  
Wellmark Blue Cross and Blue Shield of Iowa  
P.O. Box 9232  
Des Moines IA 50306-9232

*Fax* Or, fax prior approvals to the number on the Prior Approval form.

Prior approvals are valid for six months from the date signed by our medical department unless otherwise noted on the approval form. The approval is good as long as the member's benefits do not change between the time the approval is granted and when the service or supply is actually provided or purchased.

## **O**Orthotics

*Definition of orthotics*



Orthotics are usually rigid or semirigid devices that support movement in a weak or deformed body part. Orthotics may also be used to restrict or eliminate body movement in a diseased or injured part of the body. Wellmark covers leg, arm, back and neck braces, trusses, and artificial legs, arms, and eyes, provided the services are medically necessary. Back braces include special corsets and sacroiliac, sacrolumbar, and dorsolumbar corsets and belts.

<sup>1</sup>Includes: Alliance Select<sup>SM</sup>, Classic Blue<sup>®</sup>, Senior Blue<sup>®</sup>, MedicareBlue Supplement<sup>®</sup>, Blue Access<sup>®</sup>, Blue Advantage<sup>®</sup>, Blue Choice<sup>®</sup> in Iowa; includes Blue Select<sup>®</sup>, Classic Blue<sup>®</sup>, Senior Blue<sup>®</sup>, MedicareBlue Supplement<sup>®</sup> in South Dakota

- Terminal device* A terminal device, such as a shoe or an artificial hand or hook, is covered if medical necessity is documented in the patient's record. Stump stockings and harnesses, needed to use an artificial limb effectively, are also covered supplies.
- Adjustments* If an artificial limb or other appliance needs adjustment because of wear or a change in the patient's condition, Wellmark will cover the adjustment if ordered by the patient's physician.
- Orthotic devices normally not covered* We normally do not cover ace bandages, elastic stockings, support hose, Spenco boots, leotards, knee supports, surgical leggings, gauntlets, and pressure garments that are for the arms and hands, and other similar devices, because they do not fall within the definition of an orthotic appliance.

The following is a list of orthotic devices Wellmark *normally does not cover* **unless** it is a benefit of the member's contract.

- arch supports
- custom molded space shoes (*covered if the patient has had an amputation*)
- durable plantar foot orthotics
- inlays and impression casting
- corrective (orthopedic) shoes
- plaster impressions
- shoe padding
- splinting or strapping

Wellmark contracts do provide benefits for the following items in these situations:

- orthopedic shoes and other supportive devices of the feet when an integral part of a leg brace
- custom molded space shoes with amputation
- specified orthotics if the patient's coverage includes benefits for them
- compression stockings, when they are fitted to the patient for the treatment of:
  - ♦ burns
  - ♦ lymphedema
  - ♦ thrombophlebitis
  - ♦ severe edema
  - ♦ venous stasis ulcers
  - ♦ post venous stasis ulcer treatment

Wellmark allows coverage for up to 6 stockings per leg per year for codes A6530–A6538 and A6549. These codes require the use of an LT or RT modifier. In addition, A6549 requires supporting price documentation in the form of an invoice or the manufacturer's suggested retail price (MSRP) see p. 15. Wellmark also covers 6 pairs of stockings per year for codes A6539–A6541.

*Diabetic shoes and multiple-density inserts* Wellmark provides benefits for diabetic shoes (shoes, fitting, and modifications), and for multiple-density inserts used in conjunction with diabetic shoes, when a medical condition of the foot related to diabetes is present. Payable conditions are represented by the following ICD-9-CM codes. Please bill the appropriate fifth-digit subclassification (0–3) code in addition to the 250 series.

<i>Payable conditions for diabetic shoes and multiple-density inserts</i>	<b>ICD-9-CM</b>	<b>Description</b>
	250.6	Diabetes with neurological manifestations
	250.7	Diabetes with peripheral circulatory disorders
	250.8	Diabetes with other specified manifestations

*Billing instructions* **Diabetic shoes:** To bill for diabetic shoes and the fitting and modification of those shoes, submit HCPCS codes **A5500–A5507**. Wellmark allows benefits for two pairs of diabetic shoes per calendar year. We will not allow benefits for deluxe features code **A5508**.

**Multiple-density inserts:** To bill multiple density inserts, use HCPCS code **A5512** or **A5513**. Wellmark allows benefits for two pair of multiple-density inserts per year. We will not allow benefits for multiple-density inserts when code A5510 is submitted.

## III Prostheses

*Prostheses defined* Prosthetic devices or prostheses replace all or part of a body organ or replace all or part of the function of a permanently inoperative or malfunctioning body organ. Some examples of prosthetic devices are cardiac pacemakers, breast prostheses (including a surgical brassiere) for post-mastectomy patients, maxillofacial devices, and devices that replace all or part of the ear or nose.



*Urinary and ostomy supplies* Urinary supplies, including catheters and collection devices, are considered prosthetic devices when provided for reasons of permanent urinary incontinence. Colostomy and other ostomy supplies are also covered items. This includes irrigation and flushing equipment and all other supplies directly related to ostomy care.

*Prosthetic lenses* Prosthetic lenses are covered for a patient who doesn't have an organic lens, or to replace the lens of an eye following cataract surgery.

# IV Home Medical Equipment

*Requirements for coverage*

Home medical equipment (HME) items must be:

- durable enough to withstand repeated use,
- primarily and customarily used to serve a medical purpose
- not generally useful to a person in the absence of illness, injury, or disease, and must not serve as a comfort or convenience item.

Effective for dates of service on or after October 1, 2008, Wellmark uses the CMS DMEPOS categories as follows:

- IN Inexpensive and Routinely Purchased Items\*
- FS Frequently Serviced Items
- OX Oxygen and Oxygen Equipment
- OS Ostomy, Tracheostomy, and Urological Items
- SD Surgical Dressings
- PO Prosthetics and Orthotics
- SU Supplies
- TE Transcutaneous Electrical Nerve Stimulators
- CR Capped Rental Items\*\*
- TS Therapeutic Shoes

\*Wellmark will continue to utilize a 10-month capped rental for items in the IN category. Rental price will be set at 10 percent of the IN purchase price for items that allow rental.

\*\* Wellmark will continue to utilize a 10-month capped rental policy (rather than the CMS 13-month capped rental policy).

*Monthly/daily rentals*

All rentals are considered monthly with the following exceptions, which as of July 1, 2009, are daily rentals:

- E0202 Phototherapy (bilirubin) light with photometer
- E0935 Continuous passive motion exercise device for use on knee only
- E2402 Negative pressure wound therapy electrical pump, stationary or portable

The CMS DMEPOS categories and the corresponding codes can be found at [www.cms.hhs.gov/DMEPOSFeeSchd/LSDMEPOSFEE](http://www.cms.hhs.gov/DMEPOSFeeSchd/LSDMEPOSFEE).

*Rental and Purchase Policies*

Since our rental allowances are based on 10 percent of the MAF or charge (whichever is less), at the end of ten months we consider this equipment to be purchased. To avoid a claim denial, HME providers should submit rental charges with an RR modifier for each rental month.

If rental charges extend beyond ten months, you will see the following message (U005) on your Wellmark remittance:

*HME rental allowances are based on 10 percent of the purchase price. We consider rental items purchased at the end of ten months.*

Charges denied for this reason cannot be billed to the member unless he or she has rented the same equipment from more than one provider.

For example, a member rents an air pressure pad from one provider for four months, then returns the item. Three months later, the member rents the same item from you. We allowed the first provider four months of rental charges; we will allow your rental services for six months. Rental charges beyond ten months will deny with the message U005—even if there is a break in the patient’s rental of that item.

To identify these situations, ask members about their prior use of equipment. You may request that our members sign a waiver, similar to the sample below, indicating that they will be responsible for rental amounts beyond ten months when they have rented the same item from two or more providers. A waiver will also keep your customers informed of their potential liability. Keep this information in the customer’s file.

**Prior Use of Equipment Information/Waiver**

1. How long have you had this illness?
2. Do you recall ever using this type of equipment/service for your illness? If yes, provide dates.
3. What type of equipment did you use?
4. Did you rent or purchase the equipment?
5. Where did you obtain the equipment (supplier or vendor name)?
6. Do you have a copy of the pick-up ticket for the equipment you previously used?

I understand that my health insurance carrier allows rental of covered equipment for a period of 10 months, at which point they have made full payment for the cost of the item. However, if I use two or more providers to rent the same equipment, I understand that I will be personally responsible for rental charges that extend beyond a cumulative total of 10 months. Once this item is purchased, I understand my carrier may not pay for this same item for another 5 years. If I purchase the item before 5 years have passed, I will be personally responsible for the purchase price if my insurance denies the service.

Signature

Date

The following codes are in the CMS DMEPOS Capped Rental (CR) category. Due to prior authorization requirements by Wellmark Blue Cross and Blue Shield, we will also allow purchase of these items. The purchase price will be set at ten times the rental price.

*Capped rental category*

HCPCS	HCPCS	HCPCS	HCPCS
E0480	K0822	K0837	K0853
E0482	K0823	K0838	K0854
E0483	K0824	K0839	K0855
E0749	K0825	K0840	K0856
K0010	K0826	K0841	K0857
K0011	K0827	K0842	K0858
K0012	K0828	K0843	K0859
K0813	K0829	K0848	K0860
K0814	K0830	K0849	K0861
K0815	K0831	K0850	K0862
K0816	K0835	K0851	K0863
K0820	K0836	K0852	K0864
K0821			

*Items for rent/purchase*

- E0570 Nebulizer, with compression
- E0720 Transcutaneous electrical nerve stimulation (TENS) device, 2 lead, localized stimulation
- E0730 Transcutaneous electrical nerve stimulation (TENS) device, 4 or more leads, for multiple nerve stimulation

*Medicare as Primary*

If a 15-month HME limit applies to a member covered by Medicare as the primary payer, we will follow Medicare guidelines.

*Sleep test required*

**Positive Airway Pressure (PAP) Devices**

Any member receiving an initial PAP device must have a sleep study test interpreted by a Wellmark approved board certified sleep specialist. You may locate a specialist on [Wellmark.com](http://Wellmark.com) > Find a Doctor or Hospital. (Medical policy reference follows on the next page.)

*Modifier KX*

When submitting a claim for a medically necessary positive airway pressure (PAP) device, include modifier KX if appropriate.

MODIFIER	DEFINITION
KX	Requirements specified in the medical policy have been met.

Including the modifier signifies that:

- our member meets the medical necessity requirements as specified in our medical policy.
- you would, if asked, be able to supply documentation supporting the medical necessity based on our medical policy guidelines.

**CPAP (Continuous Positive Airway Pressure) Devices**

*CPAP* Continuous positive airway pressure (CPAP) may be considered medically necessary in adult or pediatric patients with clinically significant obstructive sleep apnea.

*CPAP compliance policy* To be considered a benefit, a CPAP device must have **memory and adjustable ramp pressure** to measure compliance. After the first 30 days of rental, the HME provider should download data from the unit and send a copy of the report to the prescribing physician or lab. The HME provider should keep a copy of the data in the customer's prescription file.

Wellmark will request this data on a periodic basis. Also, the prescribing physician may request data at different intervals to monitor patient progress. Therefore, the data needs to be collected and maintained for review.

*Compliance* A member is considered compliant in usage of the CPAP if data indicates an average of four hours daily use. Wellmark will not cover CPAP devices for members who remain noncompliant after the second month.

*Billing CPAP* Bill CPAP to Wellmark using:

Code	Description
<b>A9270</b>	CPAP, noncompliant member (use after the second month's rental if data indicates less than four hours' daily use)
<b>E0601-RR</b>	CPAP (use for compliant members; after the tenth month of rental, consider purchased)

**BiPap and APAP**

Bi-level positive airway pressure (BiPap) or autoadjusting CPAP (APAP) may be considered medically necessary in patients with clinically significant obstructive sleep apnea who have failed a prior trial of CPAP.

*Medical Policy* To locate the most current medical policy information, including our requirements for sleep studies and related treatment, refer to our medical policies on [Wellmark.com](http://Wellmark.com). Look for "Diagnosis and Medical Management of Obstructive Sleep Apnea Syndrome and Upper Airway Resistance Syndrome" (Provider > Medical Policies and Authorizations > Medical Policy).

*iCap* CMS-1500 billers will find *iCap* specialty policies on our Payment Policy Web page.

**CPM (Continuous Passive Motion) Devices**

*Medical necessity*

CPM devices may be considered medically necessary when initiated within 48 hours following surgery for the following conditions:

- Total knee arthroplasty (TKA)
- Open reduction and internal fixation of tibial plateau or distal femur fractures involving the knee joint
- Knee arthrofibrosis occurring after TKA
- Postoperative rehabilitation after ACL reconstruction

*Investigational*

Wellmark considers CPM devices investigational in the following circumstances:

- Treatment of acute or chronic low back pain
- For any joint other than the knee
- For any condition of the knee other than those described above



*Billing*

Bill the CPM device with HCPCS code E0935. These devices are payable only as rental equipment for 30 days after surgery.

**Oxygen Rental**

*Assessment required*

All Wellmark members who are medically required to use oxygen must have a **respiratory assessment completed before claims are submitted**, except when Wellmark coverage is secondary to Medicare.

Wellmark allows payment for oxygen claims dated up to 30 days prior to the date the oxygen assessment is performed.

A written prescription from the member's prescribing physician must be obtained to perform the respiratory assessment. Assessments must be performed by a licensed clinician (e.g., registered nurse or respiratory therapist) and should include the following:

- Patient's diagnosis
- Date of last physician visit
- Patient's heart rate, respiratory rate, lung sounds, and flow rate
- Home environment/caregiver's support system
- A copy of the prescribing physician's prescription for oxygen

The assessment determines if the patient can maintain adequate oxygen saturations when using a conserving device. Patients who qualify should be placed on a conserving device.

*Three copies*

HME providers must keep a copy of the assessment and prescription in the customer's file. Another copy of the assessment should be sent to the prescribing physician's office. A third copy, along with the prescription, should be faxed to Wellmark at **515-376-9011**.

When our records do not indicate an assessment was performed, claims submitted are denied as provider liability. Please do not submit the assessment and prescription with your claim for payment.

*Follow-up assessments*

Follow-up assessments should be performed every six months. You will not be required to submit a copy of the follow-up assessment to Wellmark unless there has been a change in modality, or the episode of care has been selected for audit.

*New technology*

New technology exists that allows HME providers to deliver oxygen more efficiently to the patient's home. The use of low loss liquid reservoirs, conserving devices for gas and liquid delivery modes, telemonitoring of liquid oxygen, and home systems that allow the patient to fill their own cylinders are some examples. Customers who qualify for a conserving unit will have greater freedom and convenience. The HME provider will benefit by reducing operational costs, thus reducing the need for and frequency of deliveries.

**Dispensing Recurrent HME/DME Items**

When a patient uses certain Home Medical Equipment/Durable Medical Equipment items on an ongoing basis, the general rule is that suppliers may dispense no more than 3 months' supply at any one time. Such items include, but are not limited to, HME/DME accessories or supplies, nebulizer drugs, and urological and ostomy supplies. When a 3-month frequency is allowed, the provider may bill the full 3 month supply at one time.

Exceptions to the 3-month rule are the following items, for which only a 1-month quantity of supplies may be dispensed:

- Surgical dressings
- Enteral and parenteral nutrients and supplies
- Immunosuppressive drugs
- Oral anticancer drugs
- Oral antiemetic drugs

This conforms to the guideline of the Centers for Medicare and Medicaid Services.

**Automatic Delivery of HME Supplies or Equipment**

Suppliers or manufacturers may not automatically deliver HME to members unless the member, the physician, or a designated representative has requested additional supplies or equipment. This ensures that the member actually needs the HME.



**Wheelchairs**

**Manual Wheelchairs**

When submitting a claim for a wheelchair, use the most descriptive HCPCS code.

**Motorized Wheelchairs and Other Power Operated Vehicles**

Wellmark recommends that you obtain a prior approval before submitting a claim for a motorized wheelchair and other power operated vehicles. Include the following information with the Prior Approval form:

- a letter of medical necessity from the prescribing physician
- physical therapy and/or occupational therapy (PT/OT) documentation to support the need for the add-on features.

The Prior Approval form and a PT/OT Evaluation form are available online at [Wellmark.com](http://Wellmark.com) (Providers > Forms). Therapists may use Wellmark’s online PT/OT Evaluation form or their own form to supply the needed information.

The following codes will be accepted:

HCPCS code	Description
<b>E1230</b>	Power operated vehicle
<b>E2301</b>	Power wheelchair accessory, power standing system
<b>E2331</b>	Power wheelchair accessory, attendant control, proportional, including all related electronics and fixed mounting hardware
<b>K0010</b>	Standard-weight frame motorized/power wheelchair
<b>K0011</b>	Standard-weight frame motorized/power wheelchair with programmable control
<b>K0012</b>	Lightweight portable motorized/power wheelchair
<b>K0014</b>	Other motorized/power wheelchair base
<b>K0800-K0812</b>	Power operated vehicle
<b>K0813-K0898</b>	Power wheelchair

When prior approval is granted, submit the claim for a motorized wheelchair or power operated vehicle on the CMS-1500. Submit any add-on features for the wheelchair or other vehicle with the appropriate HCPCS code[s].

*Billing  
HCPCS K0108*

If an item is billed using HCPCS code K0108 (Wheelchair component or accessory, not otherwise specified), attach to the claim an invoice that includes the direct cost associated with the item supplied.

**No Fee Established**

For HME supplies and/or equipment for which Wellmark does not have an established MAF (maximum allowable fee), attach a detailed invoice to your paper claim form. The pricing statement must meet the requirements listed on page 14 of this guide, and must clearly indicate the item[s] provided to our member.

## V Replacements and Repairs

Wellmark covers the replacement of HME or devices in cases of irreparable damage or wear due to normal usage. They are also covered when the replacement is required because of a change in the patient's medical condition. Wellmark does not cover the replacement of any lost, stolen, or destroyed equipment.

### *Replacement supplies*

Wellmark will cover replacement supplies needed to have equipment or prosthetic devices run effectively (e.g., batteries needed to operate an artificial larynx) *if the prescribing physician specifies on the prescription:*

- the type of supplies needed
- the frequency with which they must be replaced, used, or consumed

### *Replacement limitations*

Once purchased, replacement items are typically not covered for a five-year period. The five-year clock starts on the initial date of use of the equipment. For example, if we allow benefits for a wheelchair purchased by one of our members, we will not provide benefits for its replacement until five years have passed. It should not be necessary for a member to frequently replace purchased equipment that is durable enough to withstand repeated use. However, we will provide benefits for the purchase of a replacement wheelchair *cushion* more frequently because the cushion is not as durable as the wheelchair itself. If a purchased item needs replacing within a five-year period, we recommend submitting a review request with medical documentation before the item is purchased.

### *Repair of purchased items*

When a *purchased* HME, prosthetic, or orthotic item needs repair due to normal usage, Wellmark provides benefits to have a supply fixed so that it is serviceable. The service charge may include the use of "loaner" equipment. If the expense for servicing exceeds the estimated expense of purchasing a replacement for the remaining period of medical need, Wellmark will not provide benefits for the amount of the excess. Wellmark will not pay for repairs that are covered under a manufacturer's warranty or are due to patient negligence or misuse, or if the cost of repair exceeds 75 percent of the purchase cost of new equipment.

*Billing repairs by employee*      **Billing Repairs of HME**  
 The following procedure codes are acceptable when repairs are performed by an employee from your facility, but are not appropriate when repairs are performed by an outside entity. Include a detailed description of the equipment being repaired, along with the serial number.

K0739    Repair or nonroutine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes

K0740    Repair or nonroutine service for oxygen equipment requiring the skill of a technician, labor component, per 15 minutes

*Billing repairs by outside entity*      **Note: If you are billing for repairs performed by an outside entity,** (i.e., the manufacturer, biomedical technician), you must also include a work order (i.e., service order estimate) with the serial number of the patient's equipment. Any **labor charges billed by the outside entity** should be indicated on the invoice and billed using procedure code E1399 (durable medical equipment, miscellaneous). Wellmark accepts work orders because they reflect exact repair costs; quotes are not accepted.

**Temporary Replacement (Submit paper claim)**

When the service charge does not include the use of loaner equipment, bill the temporary replacement using code K0462.

K0462:    Temporary replacement for patient owned equipment being repaired, any type.

*Loaner equipment rental*

Use this code to bill loaner equipment when patient owned equipment is being repaired. Wellmark allows up to 30 days for rental of loaner equipment.

Example: Patient owns a CPAP device in need of repair. Bill the claim as follows:

Code K0462    Loaner CPAP device (E0601)

A narrative description of the service is required with code K0462. The narrative must include the procedure code that would apply if the item were to be purchased new. For additional details on filing claims with code K0462, see Claims Filing information below.

*Trial rentals*      Wellmark does not allow reimbursement for trial rental of HME equipment.

# VI Claims Filing Information

## Timely filing

According to our Wellmark provider agreement, participating providers must file claims with Wellmark within twelve months following the last date of service provided to the patient. If a claim is not submitted within this timely filing period, Wellmark may not allow benefits for the claim. Electronic claims filing is the preferred method. Contact EC Solutions (see the phone number on the back page of this *Guide*) for electronic filing information and formats which comply with HIPAA-AS requirements.

The following information must be present on the patient's bill or claim form:

## Provider Identification

- **A valid supplier identification.** Nonparticipating providers must have a valid way of identifying themselves on a patient's statement.

Valid identification includes personalized letterhead, an office logo, or a rubber stamp having the supplier's complete name and address. (We cannot accept handwritten, typed, or computer generated claims from our members that do not show valid identification of the supplier.)

Participating providers should bill us directly on a CMS-1500 and include their NPI (national provider identifier), full name and address, and tax identification number.

## Coding

- **The appropriate HCPCS code or a complete narrative description of the rented or purchased item if billing code E1399.** As a supplier, if you are filing the claim for the patient, use codes identified in this section or a current HCPCS manual to properly identify and code HME or orthotic and prosthetic devices. Note: We receive code E1399 (durable medical equipment, miscellaneous) for many services. Often, a more appropriate HCPCS code is available. Be sure to check a current coding manual before using E1399 or other "miscellaneous" or "not otherwise specified" codes.

If you cannot find a specific code, please submit a *complete* narrative description with the nonspecific code.

The narrative description must include whether the item is purchased or rented. If you are billing for oxygen, identify whether the oxygen is liquid or gas, and the amount being purchased, in either cubic feet or pounds.

If a patient receives two of the same item, it is helpful to use the modifiers "RT" (right side) and "LT" (left side) with the procedure code to indicate that the item is being purchased or rented for both sides.

*Use specific HCPCS codes*

- Always bill home medical equipment (HME) using a valid, specific HCPCS code when available. Wellmark will deny items billed with a “not otherwise classified” code if a valid code is available.
- For items appropriately billed with a nonspecific HCPCS code, Wellmark requires either the Manufacturer’s Suggested Retail Price (MSRP) or a manufacturer’s invoice submitted with the claim. Invoices indicating the cost as a quote or estimate will **be treated as an MSRP**. For details, see below.

*Submit MSRP or invoice*

- **Invoice requirements.** If HME provided does not have a valid HCPCS code, or if the item has been customized so that no CMS price is available, providers may submit either the MSRP or the invoice associated with the item(s). A true invoice is defined as follows:

- Must be supplied on the manufacturer’s, wholesaler’s, or biomedical technician’s letterhead
- Must provide the price or cost of the item(s) or part(s)
- Must provide the description of the item(s) or part(s) being purchased, rented, or repaired
- Cannot be handwritten or altered.

*MSRP documentation*

- **MSRP documentation** must include a description of the item(s) or part(s) purchased, rented, or repaired, as well as the cost.
- **Invoice or MSRP statements containing multiple items:** In order to expedite processing, providers are encouraged to clearly identify items with their corresponding HCPCS code on the submitted invoice or MSRP statement.

*Charge and sales tax*

- **The charge for each item, including applicable sales tax.** HME or medical supplies that require a prescription are exempt from sales tax. Items purchased without a prescription are considered OTC (over-the-counter) products, and are subject to sales tax. Wellmark does not reimburse sales tax. This charge is the member’s liability and should be billed with HCPCS code A9270.

Each payable item is settled according to our maximum allowable fee (MAF). Details on how invoice or MSRP items are paid are outlined in *Provider’s Annual Notice*. Any amounts exceeding the MAF cannot be billed to the member by a participating provider.

*Shipping and handling*

- **Shipping and Handling:** Wellmark does not reimburse these services, *except when provided to FEP members*. With other coverages, these charges are the member’s liability, and should be reported with HCPCS code A9270.

*Waiver for noncovered service*

- When billing A9270, noncovered item or service, request that the member sign a waiver for noncovered service/patient liability. Keep this waiver in the patient’s file.

*Dates of service for HME purchase, rentals*

- **The date an item is purchased or rented.** List the item and the date rented (with an RR modifier) or purchased on a separate line with 1 (one) unit of service, as shown in the example below.

	24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. ICD-9-CM	D. PROCEDURES, SERVICES, OR SUPPLIES			E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OF UNITS	H. SPEC. PER	I. ID. QUAL.	J. RENDERING PROVIDER ID #
	From MM	DD	YY	To MM	DD	YY			(Explain Unusual Circumstances)	ICPT/HCPCS	MODIFIER						
1	06	10	..XX	06	10	XX			E0296	RR		1	(amount)	1		NPI	
2	07	11	..XX	07	11	XX			E0296	RR		1	(amount)	1		NPI	

Remember, if the RR modifier is not present for a Category I item, we will deny the item.

*Patient details*

- **The correct patient information.** Correct patient information includes the patient’s first and last name, address, birth date, gender, relationship to the member, and Wellmark identification number, including the three-character alpha prefix. Remember, the patient and member addresses are not always the same; make sure the member address field accurately reflects the member’s address when different from the patient’s.

*Additional requirements*

In addition, be sure to include the following items when submitting your claim:

- date of injury, if applicable
- the unit(s) of service for each line item billed
- patient diagnosis
- place of service (see below)

*CMS guideline*

Beginning **November 1, 2011**, Wellmark will follow the coding guideline used by the Centers for Medicare & Medicaid Services (CMS) when processing claims for certain durable medical equipment (DME [HME]), orthotics, or prostheses. For these items, “office” will no longer be accepted as a place of service. Instead, use a place of service code from the list that follows. This applies to all claims filed with Wellmark, including those for Federal Employee Program and BlueCard® members.

*CMS list of affected codes*

The requirement applies only to those codes required by the CMS to be billed to the DME Regional Carrier (DMERC). The list of codes is available at [https://www.noridianmedicare.com/dme/claims/docs/2011\\_jurisdiction\\_list.pdf](https://www.noridianmedicare.com/dme/claims/docs/2011_jurisdiction_list.pdf)

Please use the following place of service codes for the codes on the CMS list:

PLACE OF SERVICE CODES FOR CERTAIN DME [HME], ORTHOTICS, PROSTHESES	
CODE	PLACE OF SERVICE
01	Pharmacy
12	Home
13	Assisted Living Facility
14	Group Home
16	Temporary Lodging
32	Nursing Facility
33	Custodial Care Facility
55	Residential Substance Abuse Treatment Facility

Example:

DATE OF SERVICE	PLACE OF SERVICE	CPT OR HCPCS	DESCRIPTION
11/01/2011	11 (office)	99213	Office visit, established patient
11/01/2011	12 (home)	L1810 RT	Knee Orthotic, elastic w/joints

## VII Summary

If you have questions about claims or benefits, please contact the appropriate Provider/Customer Service department (see phone numbers on the back cover). You may also use our website at [Wellmark.com](http://Wellmark.com) to check our members' claims, benefits, and eligibility.

## Iowa Service Contacts

Wellmark Blue Cross and Blue Shield of Iowa  
Wellmark Health Plan of Iowa, Inc.  
Des Moines, IA 50306-9232\

### Wellmark Blue Cross and Blue Shield of Iowa\* Wellmark Health Plan of Iowa, Inc.\*

#### Provider Service

.....800-362-2218 or 515-376-4688

### Federal Employee Program\*

.....800-532-1537 or 515-376-4784

### Tyson Foods

.....800-526-5710

### Iowa Bankers for benefit questions only

.....800-258-1415 (call 800-362-2218 for claims issues)

### UI Care, UI GradCare, and UI Select

.....800-355-2031

### Ford Retirees

Physicians ... 800-344-8525; Facilities ...800-249-5103

### Admission Notification, Precertification, and Case Management

.....800-552-3993

### Network Engagement

....800-700-9137

Contact to discuss contracting opportunities in your area

### Pregnancy Program\*

.....866-460-9742

### Disease Management Program\*

.....866-816-5264

### Network Administration\*

....800-708-1342 or 515-376-5100

Providing information about:

network participation      provider number  
address change              application status  
credentialing/recredentialing status  
taxpayer identification number change

### BlueCard® Program\*

Out-of-state members' claim status or payment information

.....800-362-2218 or 515-376-4688

Out-of-state members' eligibility information

....800-676-2583

### EC (Electronic Commerce) Solutions\*

.....800-407-0267

Providing electronic claims and reports information

### Pharmacy Department

.....800-600-8065

## South Dakota Service Contacts

Wellmark Blue Cross and Blue Shield of South Dakota  
Sioux Falls, SD 57104

### Wellmark Blue Cross and Blue Shield of South Dakota\*

#### Provider/Customer Service Center

.....800-774-3892 or 605-373-7292

### Federal Employee Program\*

.....800-532-1537

### Tyson Foods

.....800-526-5710

### Admission Notification, Precertification, and Case Management

800-642-9273

### Network Engagement

....800-700-9137

Contact to discuss contracting opportunities in your area

### Pregnancy Program\*

.....866-460-9742

### Disease Management Program\*

.....866-816-5264

### Network Administration\*

....800-708-1342

Providing information about

network participation      provider number  
address change              application status  
taxpayer identification number change

### BlueCard® Program

Out-of-state members' claim status or payment information

.....800-774-3892

### EC (Electronic Commerce) Solutions\*

.....800-407-0267

Providing electronic claims and reports information

### Pharmacy Department

.....800-600-8065



An Independent Licensee of the Blue Cross and  
Blue Shield Association

\*You will find e-mail links to these areas from our website at  
Wellmark.com > *Contact Us* (top right of page). Select  
For Providers and on the next screen, choose your state.