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Origination: October 12, 2020
Last Review: October 17, 2024
Next Review: October 17, 2025
Effective Date: February 01, 2025

Description

Provide a policy statement for billing diabetic and positive airway pressure (PAP) supplies to define quantity limits.

Policy & Guidelines

Diabetic and PAP supplies are considered medically necessary for use by a member with a medically diagnosed condition.

Policy Statement

Effective with dates of service on or after October 12, 2020, Blue Cross and Blue Shield of Vermont (Blue Cross VT) payment for services associated with diabetic and PAP supplies will be subject to a quantity limit as defined in the payment policy.

Table 1: Diabetic Supplies Per Month (Up to a 90-Day Supply Defined by Table Below)

HCPCS Code	Description	Quantity for Insulin Dependent	Days for Insulin Dependent	Quantity for Non-Insulin Dependent	Days for Non-Insulin Dependent
A4210	Needle free injection device each	2	365	*	*
A4230	Infusion set for external insulin pump, non-needle cannula type	60	90	*	*
A4231	Infusion set for external insulin pump, needle type	60	90	*	*

HCPCS Code	Description	Quantity for Insulin Dependent	Days for Insulin Dependent	Quantity for Non-Insulin Dependent	Days for Non-Insulin Dependent
A4232	Infusion set for external insulin pump, non-needle type	60	90	*	*
A4250	Urine test or reagent strips or tablets (100 tablets or strips)	6	90	*	*
A4253	Blood Glucose test or reagent strips for home blood glucose monitor per 50 strips	6	90	2	90
A4257	Replacement lens shield cartridge for use with laser skin piercing device	3	90	1	90
A4258	Spring-powered device for lancet	2	365	2	365
A4259	Lancets per box of 100	3	90	1	90

***NOT** available for non-insulin dependent members.*

Table Examples:

- 6 units of A4253 per 90 days are allowed for an insulin dependent member.
- 2 units of A4253 per 90 days are allowed for a non-insulin dependent member.

Blue Cross VT will apply the above quantity limits guidelines through application of our claim editing software, ClaimsXtenSelect™. Note that the claim editing software does allow for a grace period for eligible claim lines submitted with a diabetic supply code to account for delivery time. For example, if a diabetic supply code has a limitation of one every 90 days, a refill would need to be shipped prior to the 91st day, to account for delivery time. Applying the grace period will ensure there is no gap due to delivery time.

Table 2: PAP Supplies (Up to a 90- Day Supply of Usual Maximum Quantity Per Month(s) Defined by Table Below)

HCPCS Code	DESCRIPTION	Usual Maximum Quantity Per Month(s)
A4604	Tubing with integrated heating element for use with positive airway pressure device	1 Per (3) Months
A7027	Combination oral/nasal mask, used with continuous positive airway pressure device, each	1 Per (3) Months
A7028	Oral cushion for combination oral/nasal mask, replacement only, each	2 Per Month
A7029	Nasal pillows for combination oral/nasal mask, replacement only, pair	2 Per Month
A7030	Full face mask used with positive airway pressure device, each	1Per (3) Months
A7031	Face mask interface, replacement for full face mask, each	1 Per Month
A7032	Cushion for use on nasal mask interface, replacement only, each	2 Per Month
A7033	Pillow for use on nasal cannula type interface, replacement only, pair	2 Per Month
A7034	Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap	1 Per (3) Months
A7035	Headgear used with positive airway pressure device	1 Per (6) Months
A7036	Chinstrap used with positive airway pressure device	1 Per (6) Months
A7037	Tubing used with positive airway pressure device	1 Per (3) Months
A7038	Filter, disposable, used with positive airway pressure device	2 Per Month
A7039	Filter, non- disposable, used with positive airway pressure device	1 Per (6) Months
A7046	Water chamber for humidifier, used with positive airway pressure device, replacement, each	1 Per (6) Months

Not Eligible

Claim lines containing diabetic supply codes submitted prior to the determined renewal interval will be denied.

Claims for diabetic supplies where no diabetic diagnosis code is present on the claim.

Claim lines where the quantity of the supply is greater than the maximum allowed number of units will be denied.

Supplies used with PAP devices are covered when the coverage criteria for the device are met. If the coverage criteria are not met, the supplies will be denied as not reasonable and necessary.

Regardless of utilization, a supplier may NOT dispense or auto-ship more than a three (3) month quantity of supplies at a time.

Provider Billing Guidelines and Documentation

Diabetic Supplies Guidelines

Diabetic Supplies may only be dispensed per order of a physician or other licensed health care provider.

The following modifiers are required on claim lines for diabetic supplies, as appropriate:
Include the appropriate modifier to ensure the appropriate frequency edit applies, either

- -**KX** [Requirements specified in the medical policy have been met]; used for situations where the member is being treated with insulin) **OR**
- -**KS** [Glucose monitor supply for diabetic beneficiary not treated with insulin]; used when the member is not being treated with insulin)

- If all four modifier positions are blank on a submitted claim form and a diabetic supply code is reported, the claim line will be denied as diabetic supply codes must, at a minimum, be reported with either modifier -KX or modifier -KS.
- If modifier -EY [No physician or other licensed health care provider order for this item or service] is reported with a diabetic supply code, the claim line will be denied as modifier -EY indicates that there was no physician order for the diabetic supply code reported.
- If modifier -KS is reported with an insulin dependent diabetic supply code, the current claim line will be denied.
- Include a diagnosis of diabetes, using the appropriate ICD-10-CM code, coding to the highest level of specificity.

If a provider dispenses a quantity of supplies that exceed the utilization guidelines, the provider must document in the medical record (for example, this could be a specific narrative statement

that adequately documents the frequency at which the member is actually testing, or a copy of the member's personal testing log). If a member is regularly using quantities of supplies that exceed the utilization guidelines, new documentation must be generated at least every six months.

PAP Supply Guidelines

PAP supplies may only be dispensed per order of a physician or other licensed health care provider.

All claims for PAP supplies must be submitted with modifier -KX [Requirements specified in the medical policy have been met].

The following modifiers are required on claim lines for PAP Supplies, as appropriate:
Modifier – **GZ** [Item or services expected to be denied as not reasonable and necessary].

Benefit Determination Guidance

Payment for services is determined by the member's benefits. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Eligible services are subject to applicable member cost sharing such as co-payments, co-insurance, and deductible.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information, please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Inter Plan Programs (IPP): In accordance with the Blue Cross and Blue Shield Association's Inter-Plan Programs Policies and Provisions, this payment policy governs billing procedures for goods or services rendered by a Vermont-based provider (Blue Cross VT is the local Plan), including services rendered to out-of-state Blue members. Provider billing practices, payment policy and pricing are a local Plan responsibility that a member's Blue Plan must honor. A member's Blue Plan cannot dictate the type of claim form upon which services must be billed, codes and/or modifiers, place of service or provider type, unless it has its own direct contract with the provider (permitted only in limited situations). A member's Blue Plan cannot apply its local billing practices on claims rendered in another Plan's service area. A member's Blue Plan can only determine whether services rendered to their members are eligible for benefits. To understand if a service is eligible for payment, it is important to verify the member's benefits **prior** to providing services. In certain circumstances, the member may be financially responsible for services beyond the benefit provided for eligible services.

Claims are subject to payment edits that are updated at regular intervals and generally based on Current Procedural Terminology (CPT®), Health Care Procedural Coding System (HCPCS), Internal Classification of Diseases, CMS National Correct Coding Initiative Edits, Specialty Society guidelines, etc.

Eligible Providers

This policy applies to all providers/facilities contracted with the Plan's Network (participating/in- network) and any non-participating/out-of-network providers/facilities.

Audit Information

Blue Cross VT reserves the right to conduct audits on any provider and/or facility to ensure adherence with the guidelines stated in the payment policy. If an audit identifies instances of non-adherence with this payment policy, Blue Cross VT reserves the right to recover all non-adherence payments.

Legislative and Regulatory Guidelines

Vermont 8 V.S.A. § 4089c

Related Policies

Medical Equipment and Supplies/ Durable Medical Equipment Corporate Medical Policy
Sleep Disorders Diagnosis and Treatment Corporate Medical Policy

Document Precedence

The Blue Cross VT Payment Policy Manual was developed to provide guidance for providers regarding Blue Cross VT payment practices and facilitates the systematic application of Blue Cross VT member contracts and employer benefit documents, provider contracts, Blue Cross VT corporate medical policies, and Plan's claim editing logic. Document precedence is as follows:

1) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and the member contracts or employer benefit documents, the member contract or employer benefit document language takes precedence.
2) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and provider contract language, the provider contract language takes precedence.

3) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and corporate medical policy, the corporate medical policy takes precedence.

References

The above policy is based on the following references:

Centers for Medicare & Medicaid (CMS). Glucose Monitors (L33822) - Policy Article. DME MAC Jurisdiction(A). Effective October 2015. (Revised 04/01/2024).

Centers for Medicare & Medicaid (CMS) . Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea. (L33718). DME MAC Jurisdiction (A). Effective October 2015. (Revised 01/01/2024).

Policy Implementation/Update Information

This policy was originally implemented on January 2, 2021.

Date of Change	Effective Date	Overview of Change
October 12, 2020	January 1, 2021	Removed Appendix A and edited language on page 4 indicating claims with certain modifiers would be denied.
May 4, 2021	May 4, 2021	Changed the quantity limits from A9277 from 2 units to 4 units every 365 days and A9278 from 1 unit to 4 units every 365 days.
July 1, 2021	July 1, 2021	Moved the “Document Precedence” section to the end of the policy and clarified that while the quantity limits for certain supplies are 20 per 30 days that does not prohibit a provider from supplying or a member from receiving 60 units for a 90-day period.
October 17, 2024	February 01, 2025	Payment policy updated new template format, references added. Minor editorial refinements to policy statements; intent unchanged. Coding tables revised: Codes A4244, A4245, A9275, A9276, A9277, A9278, K0553, K0554 removed from coding table.

Approved by **Update Approved: 10/17/2024**

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