BlueCross BlueShield of Vermont
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Corporate Payment Policy 33
FREQUENCY OF SUPPLIES (DIABETIC AND CPAP/BIPAP)
Updated Effective July 1, 2021

Description

BCBSVT intends to pay for quantities of Durable Medical Equipment (DME) supplies that are necessary for patients based on their condition(s). This policy outlines the frequency limits for diabetic supplies and for Continuous Positive Airway Pressure (CPAP) or Bilevel Positive Airway Pressure (BiPAP) supplies.

Policy

BCBSVT utilizes Centers for Medicare and Medicaid Services (CMS) frequency guideline for diabetic supplies, as listed in Table 1, below.

Table 1. Diabetic Supplies and Frequencies.
NOTE: Where there are no entries in the third and fourth columns, it means we do not allow the codes to be billed for non-insulin dependent members.
NOTE: While the quantity limits for A4230, A4231, and A4232 are 20 units for every 30 days, this does not prohibit the issuance of a 90-day supply (so long as no more than 60 units are supplied within that 90-day period).

Procedure Code	DESCRIPTION	QUANTITY FOR INSULIN	DAYS FOR INSULIN	QUANTITY FOR NON INSULIN	DAYS FOR NON INSULIN
A4210	Needle free injection device each	2	365		
A4230	Infusion set for external insulin pump, non-needle cannula type	20	30		
A4231	Infusion set for external insulin pump, needle type	20	30		
A4232	Infusion set for external insulin pump, non-needle type	20	30		
A4244	Alcohol or peroxide per pint	12	90		
A4245	Alcohol wipe per box	8[1]	30	8	30
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

[1] A 90-day supply may be issued so long as no more than 24 units are supplied within the 90-day period.

Procedure Code	DESCRIPTION	QUANTITY FOR INSULIN	DAYS FOR INSULIN	QUANTITY FOR NON INSULIN	DAYS FOR NON INSULIN
A4257	Replacement lens shield cartridge for use with laser skin piercing device	1[2]	30	1	90
A4258	Spring-powered device for lancet	2	365	2	365
A4259	Lancets per box of 100	3	90	1	90
A9275	Home glucose disposable monitor includes test strips	4[3]	30		
A9276	Sensor, invasive, sub-cutaneous disposable for use with interstitial CGMS one unit = one day supply	90	90		
A9277	Transmitter, external for use with interstitial CGMS	4	365		
A9278	Receiver (monitor) external for use with interstitial CGMS	4	365		
K0553	Supply allowance for therapeutic CGMS includes all supplies and accessories 1-month supply 1 unit	1[4]	30		
K0554	Receiver monitor, dedicated for use with the therapeutic CGMS	1	365		

BCBSVT utilizes CMS replacement guidelines for CPAP and BiPAP supplies, as listed in Table 2, below. Many CPAP/BiPAP supplies associated with sleep therapy are designed to be disposable including but not limited to masks, tubing, filters, and headgear.

Table 2. CPAP/BiPAP Supplies and Frequencies.

PROCEDURE CODE	DESCRIPTION	QUANTITY	DAYS
A4604	Tubing with integrated heating element for use with positive airway pressure device	1	90
A7027	Combination oral/nasal mask, used with continuous positive airway pressure device, each	1	90
A7028	Oral cushion for combination oral/nasal mask, replacement only, each	6	90

[2] A 90-day supply may be issued so long as no more than 3 units are supplied within the 90-day period.
[3] A 90-day supply may be issued so long as no more than 12 units are supplied within the 90-day period.
[4] A 90-day supply may be issued so long as no more than 3 units are supplied within the 90-day period.

PROCEDURE CODE	DESCRIPTION	QUANTITY	DAYS
A7029	Nasal pillows for combination oral/nasal mask, replacement only, pair	6	90
A7030	Full face mask used with positive airway pressure device, each	1	90
A7031	Face mask interface, replacement for full face mask, each	3	90
A7032	Cushion for use on nasal mask interface, replacement only, each	6	90
A7033	Pillow for use on nasal cannula type interface, replacement only, pair	6	90
A7034	Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap	1	90
A7035	Headgear used with positive airway pressure device	1	180
A7036	Chinstrap used with positive airway pressure device	1	180
A7037	Tubing used with positive airway pressure device	1	90
A7038	Filter, disposable, used with positive airway pressure device	6	90
A7039	Filter, non disposable, used with positive airway pressure device	1	180
A7046	Water chamber for humidifier, used with positive airway pressure device, replacement, each	1	180

BCBSVT will apply these guidelines through application of our claim editing software, ClaimsXten-Select™. 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.

Not Eligible for Payment

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

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

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

Benefit Determination Guidance

Payment for DME supplies 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 DME supplies 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 (BCBSVT 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.

Provider Billing Guidelines and Documentation

All claims for diabetic supplies must:

- 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 injections) or
  - -KS (Glucose monitor supply for diabetic beneficiary not treated with insulin; used where the member is not being treated with insulin injections)
- Include a diagnosis of diabetes, using the appropriate ICD-10-CM code

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

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 patient is testing, or it could be a copy of the

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

All claims for CPAP/BiPAP supplies must be submitted with modifier -KX (requirements specified in the medical policy have been met).

CPAP/BiPAP 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 and CPAP/BiPAP supplies, as appropriate:

- Modifier- GZ – item or services expected to be denied as not reasonable and necessary
- Modifier -KX (requirements specified in the medical policy have been met) – must be reported for members treated with insulin when reporting glucose monitor and other diabetes-related supply codes
- Modifier -KS (Glucose monitor supply for diabetic beneficiary not treated with insulin) – must be reported for diabetic members not treated with insulin when reporting glucose monitor and other diabetes-related supply codes
- Modifier – EY – no physician or other licensed health care provider order for this item or service
- Modifier -NU – New equipment
- Modifier – RA – Replacement of a DME, orthotic or prosthetic item
- Modifier – RR – Rental (use RR when DME is being rented)
- Modifier -UE – Used durable medical equipment

National Drug Code(s)

Health Care Procedure Coding System (HCPCS) codes related to chemotherapy drugs, drugs administered other than oral method, and enteral/parenteral formulas may be subject to National Drug Code (NDC) processing and pricing. The use of NDC on medical claims helps facilitate more accurate payment and better management of drug costs based on what was dispensed and may be required for payment. For more information on BCBSVT requirements for billing of NDC please refer to the provider portal at http://www.bcbsvt.com/provider-home for the latest news and communications.

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:

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the payment policy. If an audit identifies instances of non-compliance with this payment policy, BCBSVT reserves the right to recoup all non-compliant payments.

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 and Blue Shield of Vermont ("BCBSVT") Payment Policy Manual was developed to provide guidance for providers regarding BCBSVT payment practices and facilitates the systematic application of BCBSVT member contracts and employer benefit documents, provider contracts, BCBSVT 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 BCBSVT 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 BCBSVT 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 BCBSVT Payment Policy Manual and corporate medical policy, the corporate medical policy takes precedence.
4) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and the Plan's claim editing solution, the Plan's claim editing solution shall take precedence.

Policy Implementation/Update Information

New Policy Effective January 1, 2021
Revised 10.12.2020 (removed Appendix A and edited language on page 4 indicating claims with certain modifiers would be denied)
Revised Effective May 4, 2021 (changed the quantity limits for A9277 (from 2 units to 4 units every 365 days) and A9278 (from 1 unit to 4 units every 365 days)
Revised effective 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).

Approved by **Date Approved: 7/1/2021**

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