

Durable Medical Equipment (DME): Oxygen and Respiratory Equipment

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This section contains information about Durable Medical Equipment (DME) in the oxygen contents, oxygen equipment, and respiratory equipment group.

Per *California Code of Regulations (CCR)*, Title 22, Section 51321(g): Authorization for durable medical equipment (DME) equipment shall be limited to the lowest cost item that meets the patient's medical needs.

Pursuant to *Welfare and Institutions Code (W&I Code)*, Section 14105.395, the provisions contained herein have the force and effect of regulations and shall prevail over any inconsistent provisions in CCR sections relating to DME.

The "date of delivery" to the recipient is the "date of service." This means that when the recipient takes receipt of the DME item, that date is considered the "date of service." Charges for shipping and handling are not reimbursable.

Along with this section, providers should refer to additional DME information as follows:

Topic	Provider Manual Section
General policy information	<i>Durable Medical Equipment (DME): An Overview</i>
Billing guidelines and documentation requirements	<i>Durable Medical Equipment (DME): Bill for DME</i>
Billing for DME on the CMS-1500 claim form	<i>Durable Medical Equipment (DME): Billing Examples</i>
DME codes reimbursed by Medi-Cal	« <i>Durable Medical Equipment (DME): Billing Codes</i> »
Frequency limits for DME purchases	<i>Durable Medical Equipment (DME) Billing Codes: Frequency Limits</i>

Reference

This DME section includes the following items:

- Aerosol Masks
- Airway Clearance Devices
 - Cough stimulating devices
 - High frequency oscillation systems
 - Intrapulmonary percussive ventilators/devices
 - Oscillatory positive expiratory pressure devices
 - Percussors
- Apnea Monitors and Supplies
- Continuous Positive Airway Pressure (CPAP) and Bi-Level Positive Airway Pressure (Bi-PAP) Equipment
- Bi-Level Positive Airway Pressure ST (Bi-PAP ST) Equipment
- Humidifiers
- Nebulizers and Air Compressors
- Oral Appliances for Obstructive Sleep Apnea
- Oximeters
- Oxygen Contents, Equipment and Supplies
- Suction Machines
- Ventilators (primary and back-up)
- Unlisted Oxygen Equipment and Respiratory Equipment
- Unlisted Supplies, Accessories and Service Components

Definitions

The following definitions shall apply to all oxygen contents, oxygen equipment and respiratory equipment:

- “Activities of Daily Living” means those activities essential to daily living, such as bathing, eating, toileting, ambulation, dressing and transferring.
- “Apnea” means cessation of breathing.
- “Arterial Blood Gas” or “ABG” means a blood sample obtained from an artery that provides measures of the blood pH (acid-base balance), partial pressures of oxygen and carbon dioxide, and the concentration of bicarbonate.
- “Bi-Level Positive Airway Pressure” or “Bi-Pap” means ventilatory assistance equipment that has the capability of providing two different levels of continuous positive airway pressure, with or without oxygen, which is intended to assist in keeping the patient’s airway open to allow breathing.
- “Bi-Level Positive Airway Pressure ST” or “Bi-PAP ST” means ventilatory assistance equipment that has the capability of providing two different levels of continuous positive airway pressure, with or without oxygen, which is intended to assist in keeping the patient’s airway open to allow breathing and includes a back-up rate feature to ensure continuing ventilation.
- “Concentrator” means an oxygen delivery system that operates electrically to concentrate oxygen from room air.
- “Continuous Positive Airway Pressure” or “CPAP” means ventilatory assistance equipment that provides continuous positive airway pressure, with or without oxygen, which is intended to assist in keeping the patient’s airway open.
- “Cough Stimulating Devices” means ventilator assistance equipment that inflates the lung with positive pressure and assists coughing with negative pressure.
- “Gaseous Oxygen Delivery System” means an oxygen delivery system that uses oxygen in the gaseous state.

- “Hand-Held Positive Expiratory Pressure Device” means a hand-held device that transmits a vibratory action to the patient’s airway to assist in the loosening and expelling of airway secretions.
- “High Frequency Chest Wall Oscillation System” means a specially fitted vest that contains air chambers connected to a portable machine that generates high frequency air vibrations, which are exerted externally on the chest wall. These vibrations are transmitted through the chest wall to the patient’s lungs, creating a vibration of the tracheobronchial tree, which is intended to assist in the loosening and expelling of airway secretions.
- “Humidifier” means a device that increases the moisture content of the inspired air, which is intended to facilitate clearance of secretions and to decrease irritation of the airway tissues.
- “Hypoxemia” means deficient oxygenation of blood.
- “Instrumental Activities of Daily Living” means those activities that support activities of daily living, such as outside mobility, shopping, transportation, housework, hygiene, laundry, meal preparation and medication management.
- “Invasion Ventilation” means mechanical ventilation utilizing an invasion interface between the ventilatory device and the patient, for example, an invasive artificial airway such as an endotracheal or tracheostomy tube.
- “Licensed Practitioner” means a health care provider licensed in the State of California, functioning within his/her scope of practice.
- “Liquid Oxygen Delivery System” means an oxygen delivery system that uses oxygen in its liquid state.
- “Metered Dose Inhaler” or “MDI” means a manually activated portable device that delivers medicated aerosol to the airway.
- “Nebulizer” means a device that delivers medication to the airway in the form of a continuous fine mist.
- “Non-Invasive Ventilation” means mechanical ventilation utilizing a non-invasive mask-type interface between the ventilatory device and the patient.
- “Oral Appliance for Obstructive Sleep Apnea” means a custom fabricated oral appliance used for the treatment of obstructive sleep apnea.
- “Oscillatory Positive Expiratory Pressure Device” means a high frequency intrapulmonary percussive device that transfers high frequency vibrations into the patient’s airway, which is intended to assist in the loosening and expelling of airway secretions.

- “Oxygen Concentrator” means the same as “concentrator.”
- “Oxygen-Conserving Device” means a device that increases the efficiency of the oxygen delivery system, thus extending the life of the oxygen tank contents.
- “Oxygen Delivery System” means the method by which oxygen is delivered to the patient.
- “Portable Oxygen Delivery System” means an oxygen delivery system that can be easily moved with the patient on a frequent basis.
- “Regulator” means a device that regulates or controls the flow of oxygen.
- “Spacer” means a device, usually a plastic chamber that attaches to the mouthpiece of a metered dose inhaler, which is intended to increase drug delivery into the airway.
- “Stationary Oxygen Delivery System” means an oxygen delivery system that cannot be easily moved with the patient on a frequent basis.
- “Suction Machine” means a device that provides negative pressure for removing airway secretions.
- “Supplemental Oxygen” means oxygen provided to a patient in excess of room air (21 percent oxygen).
- “Ventilator” means a device to assist or control ventilation in a patient who is unable to maintain spontaneous ventilation.

Coverage

Oxygen contents, oxygen equipment and respiratory equipment are covered pursuant to the provisions herein and CCR, Title 22, Section 51321. To the extent of conflict, the provisions contained herein shall prevail over any inconsistent provision in the CCR.

Authorization for oxygen contents, oxygen equipment and respiratory equipment shall be granted for the lowest cost item that meets the patient's medical need(s) [see CCR, Title 22, Sections 51003(f) and 51321(g)].

Patients eligible for the following programs must access services available under these programs prior to receiving services under the Medi-Cal program. A letter of denial from the program(s) must accompany the *Treatment Authorization Request* (TAR) submitted to Medi-Cal.

- The California Children's Services (CCS) program, which provides authorization of services and case management (CCR, Title 22, Section 51013) when a person under 21 years of age has a CCS-eligible condition, as specified in CCR, Title 22, Sections 41800-41876.
 - Requests for authorization of oxygen contents, oxygen equipment and respiratory equipment for children with medical conditions covered by CCS shall be submitted to the appropriate CCS county office for approval.
 - Refer to the *Durable Medical Equipment (DME): Billing Codes for California Children's Services* (CCS) section in this manual for the procedure codes used for CCS items.
- The Genetically Handicapped Persons Program (GHPP), which provides authorization of services and case management when a person 21 years of age and older has a GHPP-eligible condition specified in CCR, Title 17, Section 2932.
- The Department of Rehabilitation, which provides evaluation, consultation, case management and authorization of services when the provision of oxygen contents, oxygen equipment and/or respiratory equipment is the basis for vocational rehabilitation or employment.

Authorization Required

All oxygen contents, oxygen equipment and respiratory equipment listed on a previous page under “Oxygen Contents, Oxygen Equipment and Respiratory Equipment Group” require authorization with a TAR form 50-1, or an electronic TAR (eTAR), except for the following, which require authorization only for quantities exceeding the stated billing limit:

- A7005 (administration set, with small volume nonfiltered pneumatic nebulizer, nondisposable) – billing limit of one every six months
- E0484 (oscillatory positive expiratory pressure device, non-electric, any type, each) – billing limit of two per 12 months

The TAR shall include documentation that demonstrates that the patient meets the criteria under the sub-heading “Criteria,” found in the following pages under each oxygen contents, oxygen equipment and respiratory equipment item.

TARs for apnea monitors, oxygen contents and nebulizers shall be submitted with the appropriate Department of Health Care Services (DHCS) form or equivalent information. See the *Durable Medical Equipment (DME): An Overview* section in this manual for information about these forms.

Where to Submit TARs

TARs for procedure codes within the oxygen contents, oxygen equipment and respiratory equipment group must be submitted to the TAR Processing Center.

Repair of Equipment

The stated authorization period for each item under oxygen equipment and respiratory equipment item does not preclude repair of the item within that authorization period or its replacement should the cost of repair exceed the cost of replacement.

Aerosol Masks

Coverage

Medi-Cal covers aerosol masks for patients who meet the established criteria.

Criteria

The patient meets the criteria for a nebulizer and a nebulizer has been authorized for the patient, and the patient is unable to use the standard mouthpiece and requires an aerosol mask for effective delivery of aerosol medication.

Authorization

As medically necessary, purchase for disposable aerosol masks may be authorized for up to three masks per month.

Documentation Requirements

Documentation that the patient meets the criteria specified above must be submitted with the TAR.

If the aerosol mask is for a child (20 years of age or younger), and the child has a CCS-eligible condition, a CCS denial must accompany the TAR.

Billing

«HCPCS Code for Aerosol Masks»

HCPCS Code	Description
A7015	Aerosol mask, used with DME nebulizer

Claims must be billed with modifier NU (purchase, new).

Multiple masks may be reimbursed for the same patient on the same date or service up to the monthly limit.

HCPCS code A7015 is limited to disposable masks.

Airway Clearance Devices

E0482-Cough Stimulating Devices

Coverage

Medi-Cal covers cough stimulating devices for patients who meet the established criteria.

Criteria

The patients must meet both of the following criteria:

- The patient has one of the following neuromuscular disease diagnoses (see diagnosis codes that support medical necessity):
 - Post-polio
 - Acid maltase deficiency
 - Anterior horn cell diseases
 - Multiple sclerosis
 - Quadriplegia
 - Hereditary muscular dystrophy
 - Myotonic disorders
 - Other myopathies
 - Paralysis of the diaphragm
- This condition is causing a significant impairment of chest wall and/or diaphragmatic movement, such that it results in an inability to clear retained secretions.

Note: If both of these criteria are not met, the Treatment Authorization Requirement (TAR) will be denied as not reasonable or necessary

«ICD-10-CM diagnosis codes that may be billed with HCPCS code E0482 to indicate medical necessity include B91, G12.0, G12.1, G12.20 thru G12.25, G12.29, G12.8, G12.9, G14, G35, G71.00 thru G71.02, G71.09, G71.11, G71.20, G71.21, G71.29, G71.220, G71.228, G72.41 and G82.50 thru G82.54.»

It is generally not necessary for a patient to use both a cough stimulating device (E0482) and a high frequency chest wall oscillation (HFCWO) device (E0483). However, if both devices are needed for a patient, a TAR/SAR is required and must indicate the specific medical necessity that the use of both a cough stimulating device (E0482) and a high frequency chest wall oscillation (HFCWO) device (E0483) are necessary.

Authorization

HCPCS code E0482 may be reimbursed when medically necessary by monthly rental only and must be billed with modifier RR (rental). Initial authorization may be granted for a three-month trial and subsequent authorizations may be granted in increments of up to three months. After 10 months of rental, the device will be considered patient owned. After the device is patient owned, providers must use modifier RB when repairs are required.

The frequency limit for this code is once in five years, any provider.

Documentation Requirements

Initial coverage of HCPCS code E0482 requires a *Treatment Authorization Request* (TAR) with the following documentation:

- «A face-to-face clinical evaluation by the treating licensed practitioner for the condition requiring the cough stimulating device».
- Documentation that the patient meets the criteria specified above.
- A prescription for a cough stimulating device signed and dated by the treating practitioner (or electronic equivalent)

If the cough stimulating device is for a child (20 years of age or younger), and the child has a California Children's Services (CCS)-eligible condition, a CCS denial must accompany the TAR.

Continued coverage for HCPCS code E0482 beyond the first three months of therapy requires documentation of a face-to-face clinical reevaluation by the treating licensed practitioner with documentation that the use of the cough stimulating device has improved the clinical condition being treated and the patient is compliant with use.

Billing

HCPCS Code for Cough Stimulating Devices

HCPCS Code	Description
E0482	Cough stimulating device, alternating positive and negative airway pressure

Supplies for Cough Stimulating Device

When billing for supplies or replacement parts for a cough stimulating device, alternating positive and negative airway pressure (HCPCS code E0482), providers must use code A7020 (interface for cough stimulating device, includes all components, replacement only).

HCPCS code A7020 is not separately reimbursable when billed with the rental of a cough stimulating device. Claims that bill codes A7027 thru «A7046» with code E0482 will be denied, regardless of whether the recipient owns the device or if Medi-Cal is renting the device.

«E0483-High Frequency Chest Wall Oscillation Devices»

Coverage

Medi-Cal covers high frequency chest wall oscillation devices for patients who meet the established criteria.

Criteria

«The patient must meet a criterion A, B or C as well as D»:

A. There is a diagnosis of cystic fibrosis (see diagnosis codes that support medical necessity below).

B. There is a diagnosis of bronchiectasis (see diagnosis codes that support medical necessity below), which has been confirmed by a high resolution, spiral or standard computerized tomography (CT) scan and which is characterized by:

- Daily productive cough for at least six continuous months, or
- Frequent (more than two per year) exacerbations requiring antibiotic therapy

«**Note:** Chronic bronchitis and chronic obstructive pulmonary disease (COPD) in the absence of a confirmed diagnosis of bronchiectasis do not meet these criteria»

C. The patient has one of the following neuromuscular disease diagnoses (see diagnosis codes that support medical necessity):

- Post-polio
- Acid maltase deficiency
- Anterior horn cell diseases
- Multiple sclerosis
- Quadriplegia
- Hereditary muscular dystrophy
- Myotonic disorders
- Other myopathies
- Paralysis of the diaphragm

D. There must be well-documented failure of standard treatments to adequately mobilize retained secretions

Note: If the criteria are not met as stated, the TAR will be denied as not reasonable or necessary.

«The following ICD-10-CM codes may be billed with code E0483 to indicate medical necessity: A15.0, B91, D81.810, D84.1, E84.0, E84.9, G12.0, G12.1, G12.20 thru G12.9, G14, G35, G71.0, G71.11 thru G71.19, G71.20, G71.21, G71.29, G71.220, G71.228», G71.3, G71.8G72.0 thru G72.2, G72.89, G73.7, G82.50 thru G82.54, J47.0 thru J47.9, J98.6, M33.02, M33.12, M33.22, M33.92, M34.82, M35.03 and Q33.4.»

It is generally not necessary for a patient to use both a cough stimulating device (E0482) and a high frequency chest wall oscillation (HFCWO) device (E0483). However, if both devices are needed for a patient, a TAR/SAR is required and must indicate the specific medical necessity that the use of both a cough stimulating device (E0482) and a high frequency chest wall oscillation (HFCWO) device (E0483) are necessary.

Authorization

As medically necessary, code E0483 may be reimbursed by monthly rental only and must be billed with modifier RR (rental). After ten months of rental, the device is considered patient owned. After the device is patient owned, providers must use modifier RB when repairs are required. Authorization for rental may be granted in increments of up to six months both for the initial authorization and for reauthorization.

Documentation Requirements

Documentation that the patient meets the criteria specified above must be submitted with the TAR.

If the high frequency chest wall oscillation device is for a child (20 years of age or younger), and the child has a CCS-eligible condition, a CCS denial must accompany the TAR.

Billing

HCPCS Code for High Frequency Chest Wall Oscillation System

HCPCS Code	Description
E0483	High frequency chest wall oscillation system, includes all accessories and supplies, each

Modifier RB is not allowed or reimbursed during rental period. Any allowed repairs or supplies can be reimbursed after ten months of rental when the provider indicates that the item is patient owned. The claim must indicate E0483 is patient owned as a statement in the *Additional Claim Information* field (Box 19) or as an enclosure.

E0481-Intrapulmonary Percussive Ventilators/Devices

Coverage

Medi-Cal covers intrapulmonary percussive ventilators/devices for patients who meet the established criteria.

Note: An intrapulmonary percussive ventilator (IPV) (E0481) has not been demonstrated to be reasonable and necessary in the home setting. It will be denied as not medically necessary.

Criteria

The patient has a medical condition that results in the patient's inability to adequately expectorate or clear intrapulmonary secretions and at least one of the following:

- Failure of the patient to benefit from or inability to utilize both chest physiotherapy and a hand-held positive expiratory pressure device or,
- The patient requires the administration of moisture or medications as part of the attempt to mobilize and remove airway secretions.

Authorization

«As medically necessary, HCPCS code E0481 may be reimbursed by a monthly rental only and must be billed with modifier RR (rental). After 10 months of rental, the device will be considered patient owned. After the device is patient-owned, providers must use modifier RB when repairs are required. Documentation of patient-owned equipment must be included in the *Additional Claim Information* field (Box 19) of the claim. Modifier NU must be used for supplies only.

The frequency limit for this code is once in five years.»

Documentation Requirements

Documentation that the patient meets the criteria specified above must be submitted with the TAR.

If the intrapulmonary percussive ventilator/device is for a child (20 years of age or younger), and the child has a CCS-eligible condition, a CCS denial must accompany the TAR.

Billing

Code for Intrapulmonary Percussive Ventilators/Devices

HCPCS Code	Description
E0481	Intrapulmonary percussive ventilation system and related accessories

Supplemental Oxygen

Authorization of supplemental oxygen for the patient authorized for code E0481 will be granted only when the criteria listed under “Oxygen Contents, Oxygen Equipment and Respiratory Equipment” are met as specified above.

«E0469-Lung Expansion High Oscillation/Nebulization Devices

Coverage

Medi-Cal covers high frequency chest wall oscillation devices for patients who meet the established criteria.

Criteria

The patient must meet a criterion A, B or C as well as D:

- A. There is a diagnosis of cystic fibrosis (see diagnosis codes that support medical necessity below).
- B. There is a diagnosis of bronchiectasis (see diagnosis codes that support medical necessity below), which has been confirmed by a high resolution, spiral or standard computerized tomography (CT) scan and which is characterized by:
 - Daily productive cough for at least six continuous months, or
 - Frequent (more than two per year) exacerbations requiring antibiotic therapy

Note: Chronic bronchitis and chronic obstructive pulmonary disease (COPD) in the absence of a confirmed diagnosis of bronchiectasis do not meet these criteria

- C. The patient has one of the following neuromuscular disease diagnoses (see diagnosis codes that support medical necessity):
 - Post-polio
 - Acid maltase deficiency
 - Anterior horn cell diseases
 - Multiple sclerosis
 - Quadriplegia»

- «Hereditary muscular dystrophy
- Myotonic disorders
- Other myopathies
- Paralysis of the diaphragm

D. There must be well-documented failure of standard treatments to adequately mobilize retained secretions

Note: If the criteria are not met as stated, the TAR will be denied as not reasonable or necessary.

The following ICD-10-CM codes may be billed with code E0469 to indicate medical necessity: A15.0, B91, D81.810, D84.1, E84.0, E84.9, G12.0, G12.1, G12.20 thru G12.9, G14, G35, G71.0, G71.11 thru G71.19, G71.20, G71.21, G71.29, G71.220, G71.228, G71.3, G71.8G72.0 thru G72.2, G72.89, G73.7, G82.50 thru G82.54, J47.0 thru J47.9, J98.6, M33.02, M33.12, M33.22, M33.92, M34.82, M35.03 and Q33.4.

Authorization

As medically necessary, code E0469 may be reimbursed by monthly rental only and must be billed with modifier NU (new equipment) and RR (rental). After ten months of rental, the device is considered patient owned. After the device is patient owned, providers must use modifier RB when repairs are required. Authorization for rental may be granted in increments of up to six months both for the initial authorization and for reauthorization.

It is generally not necessary for a patient to use both a cough stimulating device (E0482) and a continuous high frequency oscillation and nebulization device (E0469). However, if both devices are needed for a patient, a TAR/SAR is required and must indicate the specific medical necessity that the use of both a cough stimulating device (E0482) and a continuous high frequency oscillation, and nebulization device (E0469) are necessary.

Documentation Requirements

Documentation that the patient meets the criteria specified above must be submitted with the TAR.

If the high frequency chest wall oscillation device is for a child (20 years of age or younger), and the child has a CCS-eligible condition, a CCS denial must accompany the TAR.»

<<Billing**HCPCS Code for Lung Expansion High Oscillation/Nebulization Devices**

HCPCS Code	Description
E0469	Lung expansion airway clearance, continuous high frequency oscillation, and nebulization device

Modifier RB is not allowed or reimbursed during rental period. Any allowed repairs or supplies can be reimbursed after ten months of rental when the provider indicates that the item is patient owned. The claim must indicate E0469 is patient owned as a statement in the *Additional Claim Information* field (Box 19) or as an enclosure.

Supplies for High Oscillation/Nebulization Devices

HCPCS code A7021 is a supply code used with equipment under code E0469. Do not reimburse when E0469 is rented. Do not reimburse with A7005, A7015, A7020, A7025, or A7026 within the same month.>>

E0484-Oscillatory Positive Expiratory Pressure DevicesCoverage

Medi-Cal covers hand-held positive expiratory pressure devices for patients who meet the established criteria.

Criteria

The patient has a medical condition that results in the patient's inability to adequately expectorate or clear intrapulmonary secretions and at least one of the following:

- Failure of the patient to benefit from, or inability to utilize manual chest physiotherapy or,
- The patient does not have a caregiver(s) available to regularly administer manual chest physiotherapy.

Authorization

Purchase of the hand-held positive expiratory pressure devices may be billed directly to Medi-Cal without a TAR for up to two devices every 12 months. Additional devices require a TAR.

Documentation Requirements

Documentation that the patient meets the criteria specified above must be submitted with the TAR.

If the hand-held positive expiratory pressure device is for a child (20 years of age or younger), and the child has a CCS-eligible condition, a CCS denial must accompany the TAR.

Billing**HCPCS Code for Oscillatory Positive Expiratory Pressure Devices**

HCPCS Code	Description
E0484	Oscillatory positive expiratory pressure device, nonelectric, any type, each

This code is a stand-alone item. Claims for this equipment must be billed with modifier NU. Labor charges (HCPCS code K0740) are not separately reimbursable.

PercussorsCoverage

Medi-Cal covers percussors for chest physiotherapy for patients who meet the established criteria.

Criteria

The patient has a medical condition that results in the patient's inability to adequately expectorate or clear intrapulmonary secretions.

Authorization

As medically necessary:

- Authorization of rental may be granted in increments of up to four months, both for the initial authorization and for reauthorization.
- Authorization for purchase may be granted for one device every five years.

Documentation Requirements

Documentation that the patient meets the criteria specified above must be submitted with the TAR.

If the percussor for chest physiotherapy is for a child (20 years of age or younger), and the child has a CCS-eligible condition, a CCS denial must accompany the TAR.

Billing**HCPCS Code for Percussors**

HCPCS Code	Description
E0480	Percussor, electric or pneumatic, home model

Apnea Monitors and Supplies

Coverage

Except as noted below under “Non-Coverage,” Medi-Cal covers apnea monitors for use in the patient’s home for patients who meet the established criteria.

Non-Coverage

Medi-Cal does not cover either of the following:

- Apnea monitors after an infant is 12 months old, or after one month beyond the sibling’s age at the time of death (for an apparently normal sibling of a sudden infant death syndrome [SIDS] victim), whichever time frame is longest, unless there is documentation of medical necessity from the licensed practitioner
- Back-up apnea monitors

Criteria

The patient has a diagnosis of at least one of the following:

- Apnea of prematurity; or,
- An apparent life threatening event; or,
- A near-miss SIDS; or,
- The apparently normal sibling of a SIDS victim; or,
- A medical condition(s) for which continuous monitoring is medically necessary.

Authorization

As medically necessary:

- Authorization for rental may be granted in increments of up to four months, both for the initial authorization and for reauthorization.
- Authorization for purchase may be granted for one device every five years.

Documentation Requirements

TARs require documentation of a history and physical examination or a discharge summary, supporting the medical necessity for an apnea monitor.

A completed DHCS form – *Certificate of Medical Necessity for Apnea Monitors* (MC 4600) or equivalent information must be submitted with the TAR.

Reauthorization TARs require documentation from a licensed practitioner showing the continued need of the apnea monitor, in addition to the information requested on the DHCS form – *Certificate of Medical Necessity for Apnea Monitors* (MC 4600). If the apnea monitor is for a child (20 years of age or younger), and the child has a CCS-eligible condition, a CCS denial must accompany the TAR in addition to the above requirements.

Billing

HCPCS Code for Apnea Monitors and Supplies

HCPCS Code	Description
E0618	Apnea monitor, without recording feature
E0619	Apnea monitor, with recording feature
A4556	Electrodes (e.g., apnea monitor), per pair
A4557	Lead wires (e.g., apnea monitor), per pair
A9900	Miscellaneous DME supply, accessory, and/or service component of another HCPCS code

Reimbursement for rental of apnea monitors includes all necessary supplies and accessories, including patient cable.

Codes A4556 and A4557 are not separately reimbursable with the rental or same-day initial purchase of codes E0618 or E0619.

For patient-owned monitors, electrodes and lead wires may be separately authorized. Codes A4556 and A4557 must be billed with modifier NU. Modifiers RB and RR are not allowed. Claims for this code must include either the appropriate HCPCS code or a description of the apnea monitor and a statement that the apnea monitor is patient-owned in the *Additional Claim Information* field (Box 19). Labor charges (HCPCS code K0740) for these items are not separately reimbursable.

Code A9900 (miscellaneous DME supply) must be used to bill for the purchase of all other related unlisted supplies that are not reusable by subsequent patients

Continuous Positive Airway Pressure (CPAP) and Bi-Level Positive Airway Pressure (Bi-PAP) Equipment

CPAP Coverage for Patients Ages 18 and Older

Medi-Cal covers CPAP equipment for patients ages 18 and older who meet the established criteria for obstructive sleep apnea (OSA) or who have another medical condition(s) for which CPAP equipment is medically necessary.

Criteria for Diagnosis of OSA for Patients Ages 18 and Older

To be diagnosed with OSA, patients ages 18 and older must have a complete polysomnogram (CPT® code 95811) or home sleep apnea test, (referenced in the [Medicine: Neurology and Neuromuscular](#) manual section). These tests must be performed within the previous year in which the respiratory disturbance index (RDI) or apnea-hypopnea index (AHI) is based on a minimum of two hours of actual recorded sleep and is not extrapolated or projected; and at least one of the following criteria is met:

- The RDI or AHI is equal to or greater than 15, or
- The RDI or AHI is equal to or greater than five and less than 15 with at least one of the following associated symptoms or conditions:
 - Excessive daytime sleepiness, non-restorative sleep, fatigue or insomnia symptoms, or
 - Waking up with breath holding, gasping or choking, or
 - Habitual snoring, breathing interruptions or both noted by a bed partner or observer, or
 - Hypertension, mood disorder, cognitive dysfunction, coronary artery disease, stroke, congestive heart failure, atrial fibrillation or type 2 diabetes.

CPAP Coverage for Patients Ages 17 and Younger

Medi-Cal covers CPAP equipment for patients ages 17 and younger who meet the established criteria for OSA and who meet any of the following criteria:

- Minimal adenotonsillar tissue is present
- Adenoidectomy or tonsillectomy is contraindicated
- Adenoidectomy or tonsillectomy is delayed
- Adenoidectomy or tonsillectomy is unsuccessful in relieving symptoms of OSA
- A non-surgical approach is strongly preferred
- Craniofacial abnormalities are present

Medi-Cal considers CPAP medically necessary for treatment of tracheomalacia.

Criteria for Diagnosis of OSA for Patients Ages 1-17

To be diagnosed with OSA, patients ages 1–17 must have a complete polysomnogram (CPT code 95782, 95783 or 95811) performed within the previous year that demonstrates one or both of the following:

- One or more obstructive apneas, mixed apneas, or hypopneas, per hour of sleep. These respiratory events are defined according to the *American Academy of Sleep Medicine (AASM) Manual for the Scoring of Sleep and Associated Events*.
- A pattern of obstructive hypoventilation, defined as at least 25 percent of total sleep time with hypercapnia (PaCO₂ greater than 50 mmHg) in association with one or more of the following:
 - Snoring
 - Flattening of the nasal pressure waveform
 - Paradoxical thoracoabdominal motion

The patient must also have at least one of the following symptoms:

- Frequent snoring (at least three nights per week)
- Labored, paradoxical or obstructed breathing during sleep
- Sleep enuresis
- Sleeping in a seated position or with the neck hyperextended
- Cyanosis
- Headaches on awakening
- Sleepiness, hyperactivity, behavioral problems or learning problems
- Underweight or overweight
- Tonsillar hypertrophy
- Adenoidal facies
- Micrognathia/retrognathia
- High-arched palate
- Failure to thrive
- Hypertension

Bi-PAP Coverage

Medi-Cal covers Bi-PAP equipment for patients who meet the criteria below.

The patient meets the criteria for CPAP and has been documented to have failed CPAP due to at least one of the following reasons:

- Patient intolerance or
- Pressure discomfort due to high pressures (usually greater than 10 cm H₂O in the CPAP) or
- CPAP fails to improve the condition for which it was prescribed

Authorization

As medically necessary:

- Initial authorization for rental of CPAP or Bi-PAP may be granted for a three-month trial and reauthorization may be granted in increments of up to four months.
- Authorization for purchase may be granted only after the initial three-month rental if reauthorization documentation requirements are met as specified below. Authorization for purchase may be granted for one device every five years.

The provider of the CPAP or Bi-PAP unit cannot be the same provider that performs and/or interprets the polysomnogram. These two providers must be financially separate from one another. This prohibition does not apply if the sleep test is an attended facility-based polysomnogram.

Documentation Requirements

Initial authorization of CPAP or Bi-PAP requires the following documentation:

- A face-to-face clinical evaluation by the treating licensed practitioner prior to the sleep study test to assess the patient for OSA
- Documentation that the patient meets the clinical criteria for OSA specified above
- A prescription for CPAP or Bi-PAP signed and dated by the treating practitioner (or the electronic equivalent)
- Documentation that the patient and/or their caregiver have received instruction from the supplier of the CPAP or BIPAP device and accessories in the proper use and care of the equipment must be submitted with the TAR.

If the CPAP or Bi-PAP equipment is for a child (younger than 20 years of age) and the child has a CCS-eligible condition, a CCS denial must accompany the *Treatment Authorization Request* (TAR).

Reauthorization for HCPCS codes E0470 and E0601 beyond the first three months of therapy requires the following documentation:

- A face-to-face clinical re-evaluation by the treating licensed practitioner with documentation that the symptoms of OSA are improved, and
- Objective evidence of adherence to use (defined as use of CPAP or Bi-PAP devices for four or more hours per night on 70 percent of nights during a consecutive 30-day period any time during the first three months of initial use) of the CPAP or Bi-PAP device, reviewed by the treating practitioner.

Note: Documentation of adherence to CPAP or Bi-PAP therapy shall be accomplished through direct download or visual inspection of usage data with documentation provided in a written report format to be reviewed by the treating licensed practitioner and included in the patient's medical record.

Patients who fail the initial three-month trial are eligible to requalify for a CPAP or Bi-PAP device must have both:

- A face-to-face clinical re-evaluation by the treating practitioner to determine the etiology of the failure to respond to CPAP or Bi-PAP therapy, and
- Repeat sleep study test in a facility-based setting

For patients who received a CPAP or Bi-PAP device prior to enrollment in Medi-Cal and are seeking Medi-Cal coverage of either rental of the device, a replacement CPAP or Bi-PAP device and/or accessories, both of the following coverage requirements must be met:

- The patient had a documented sleep test prior to Medi-Cal enrollment that meets the Medi-Cal AHI/RDI coverage criteria in effect at the time that the patient seeks Medi-Cal coverage of a replacement CPAP or Bi-PAP device and/or accessories, and
- The patient had a face-to-face clinical evaluation following Medi-Cal enrollment by the treating practitioner who documented in the patient's medical record that:
 - The patient has a diagnosis of OSA; and
 - The patient continues to use the CPAP or Bi-PAP device.

If either criteria above are not met, the authorization will be denied as not medically necessary.

In these situations, there is no requirement for a clinical re-evaluation or for objective documentation of adherence to use of the device.

Reimbursement of accessory replacements for CPAP or Bi-PAP devices for HCPCS codes A4604, A7027 thru A7039 and A7044 thru A7046 (listed below) requires a TAR every 12 months. Documentation of the following criteria must be submitted with the TAR:

- A new detailed written order obtained prior to delivery of accessory replacements
- Documentation of a face-to-face re-evaluation by the treating medical provider within 12 months prior to the date of the order which states that CPAP or Bi-PAP continues to be medically necessary, and the patient continues to use the device
- Documentation that the replacement of specific accessories or furnishing of new accessories is medically necessary and essential for the effective use of the device

Billing

HCPCS Code for CPAP and Bi-PAP Equipment

HCPCS Code	Description
E0470	Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device
E0601	Continuous positive airway pressure (CPAP) device

The following procedure codes represent accessories or supplies reimbursable only if they are billed for positive airway pressure devices owned by the patient. These codes must be billed with modifier NU. Modifiers RB and RR are not allowed. Claims for these codes must include either the appropriate HCPCS code or a description of the specific positive airway pressure device and a statement that the positive airway pressure device is patient-owned in the *Additional Claim Information* field (Box 19). Labor charges (HCPCS code K0740) for these items are not separately reimbursable.

HCPCS Code for CPAP and Bi-PAP Supplies

HCPCS Code	Description
A4604	Tubing with integrated heating element for use with positive airway pressure device.
A7027	Combination oral/nasal mask, used with continuous positive airway pressure device, each
A7028	Oral cushion for combination oral/nasal mask, replacement only, each
A7029	Nasal pillows for combination oral/nasal mask, replacement only, pair
A7030	Full face mask used with positive airway pressure device, each
A7031	Full mask interface, replacement for full face mask, each
A7032	Cushion for use on nasal mask interface, replacement only, each
A7033	Pillow for use on nasal cannula type interface, replacement only, each
A7034	Nasal interface (mask or cannula type) used with positive airway pressure device, with or without headstrap
A7035	Headgear used with positive airway pressure device
A7036	Chinstrap used with positive airway pressure device
A7037	Tubing used with positive airway pressure device
A7038	Filter, disposable, used with positive airway pressure device
A7039	Filter, nondisposable, used with positive airway pressure device
A7044	Oral interface used with positive airway pressure device, each
A7045	Exhalation port with or without swivel used with accessories for positive airway pressure devices, replacement only
A7046	Water chamber for humidifier, used with positive airway pressure device, replacement, each
A7049	Expiratory positive airway pressure intranasal resistance valve

Supplemental Oxygen

Authorization of supplemental oxygen for the patient using CPAP or Bi-PAP equipment will be granted only when the criteria listed under the “Oxygen Contents, Oxygen Equipment and Respiratory Equipment” heading are met.

Bi-Level Positive Airway Pressure ST (Bi-PAP ST) Equipment

Coverage

Medi-Cal covers Bi-PAP ST equipment for patients who meet the established criteria.

Criteria

The patient has insufficient spontaneous respirations necessitating ventilator support and one of the following:

- A current ABG demonstrating chronic hypercapnia (PaCO₂ greater than 50 mm Hg with appropriately compensated pH) or,
- A diagnosis of central sleep apnea

Authorization

As medically necessary:

- Authorization for rental may be granted in increments of up to four months, both for the initial authorization and for reauthorization.
- Authorization for purchase may be granted for one device every five years.

The provider of the Bi-PAP ST unit cannot be the same provider that performs and/or interprets the polysomnogram. These two providers must be financially separate from one another. This prohibition does not apply if the sleep test is an attended facility-based polysomnogram.

Documentation Requirements

Documentation that the patient meets the criteria specified above must be submitted with the TAR.

If the Bi-PAP ST equipment is for a child (20 years of age or younger), and the child has a CCS-eligible condition, a CCS denial must accompany the TAR.

Billing

HCPCS Code for Bi-PAP ST Equipment

HCPCS Code	Description
E0471	Respiratory assist device, bi-level pressure capability, with back up rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)
E0472	Respiratory assist device, bi-level pressure capability, with back up rate feature, used with invasive interface, e.g., tracheostomy tube (intermittent assist device with continuous positive airway pressure device)

See “Continuous Positive Airway Pressure (CPAP) Equipment” for information on accessories and supplies for positive pressure devices.

Supplemental Oxygen

Authorization for supplemental oxygen for the patient using Bi-PAP ST equipment will be granted only when the criteria listed under “Oxygen Contents, Oxygen Equipment and Respiratory Equipment” are met.

Humidifiers

Coverage

Medi-Cal covers humidifiers for patients who meet the established criteria.

Criteria

The patient demonstrates at least one of the following:

- Has been authorized for ventilator; or,
- Has been authorized for the use of other respiratory equipment
- Has a tracheostomy and is symptomatic in the absence of humidification.

Authorization

As medically necessary:

- Authorization for rental may be granted in increments of up to six months, both for the initial authorization and for reauthorization
- Authorization for purchase may be granted for one device every five years

Documentation Requirements

Documentation that the patient meets the criteria specified above must be submitted with the TAR.

If the humidifier is for a child (20 years of age or younger), and the child has as CCS-eligible condition, a CCS denial must accompany the TAR.

Billing

HCPCS Code for Humidifiers

HCPCS Code	Description
E0555	Humidifier, durable, glass or autoclavable plastic bottle type, for use with regulator or flowmeter
E0561	Humidifier, nonheated, used with positive airway pressure device
E0562	Humidifier, heated, used with positive airway pressure device
E1399	Durable medical equipment, miscellaneous

HCPCS code E0555 must be used for humidifiers used with oxygen delivery systems (patient-owned only). This code must be billed with modifier NU. Modifiers RB and RR are not allowed. Claims for this code must include either the appropriate HCPCS code or a description of the oxygen delivery system and a statement that the oxygen delivery system is patient-owned in the *Additional Claim Information* field (Box 19). Labor charges (HCPCS code K0740) for this item are not separately reimbursable.

Code E0561 must be used for humidifiers used with CPAP, Bi-PAP or Bi-PAP ST equipment (patient-owned only).

Code E1399 must be used for humidifiers used with ventilators and is reimbursed “By Report” (rental or patient-owned). This code is separately reimbursable whether rental or patient-owned.

Nebulizers and Compressors

Coverage

Medi-Cal covers nebulizers and compressors for patients who meet the established criteria.

Criteria

The patient has one of the following:

- A diagnosis of chronic pulmonary disease and has recurrent episodes of reversible airflow obstruction, and has demonstrated ineffective use of, or is unable to use, metered dose inhalers with a spacer and/or dry powder inhalers; or,
- Another medical condition(s) or situation(s) for which a nebulizer is medically necessary.

Authorization

As medically necessary:

- Authorization for rental of code E0570 may be granted in increments of up to three months, both for the initial authorization and for reauthorization.
- Authorization for purchase of code E0570 may be granted for one device every five years.

Purchase of A7005 (administration set, with small volume nonfiltered pneumatic nebulizer, nondisposable) may be billed directly to Medi-Cal without a TAR for one device every six months. Additional devices require a TAR.

Documentation Requirements

A completed DHCS form – *Certificate of Medical Necessity for Nebulizers* or equivalent information must be submitted with the TAR.

If the nebulizer is for a child (20 years of age or younger), and the child has a CCS-eligible condition, a CCS denial must accompany the TAR in addition to the above requirement.

Billing

HCPCS Code for Nebulizers and Compressors

HCPCS Code	Description
A7005	Administration set, with small volume nonfiltered pneumatic nebulizer, nondisposable
E0570	Nebulizer, with compressor

Code A7005 is to be used for nondisposable administration sets. Disposable administration sets are billed with medical supply codes only when the nebulizer is patient-owned. Refer to the *Medical Supplies Billing Codes, Units and Quantity Limits* spreadsheet.

Code A7005 may be billed only when the nebulizer is patient-owned. This code must be billed with modifier NU. Modifiers RB and RR are not allowed. Claims for this code must include either the appropriate HCPCS code or a description of the nebulizer and a statement that the nebulizer is patient-owned in the *Additional Claim Information* field (Box 19). Labor charges (HCPCS code K0740) for this item are not separately reimbursable.

Claims for code E0570 must include modifier NU (purchase, new) or RR (rental).

Oral Appliances for Obstructive Sleep Apnea

Coverage

Medi-Cal covers oral appliances for obstructive sleep apnea (OSA) for patients who meet the established criteria.

Criteria

The patient must be 18 years of age or older and must meet the Medi-Cal criteria for diagnosis of OSA (refer to “Criteria for Diagnosis of OSA for patients ages 18 and older” in this manual). In addition, if the apnea-hypopnea index (AHI) is greater than 30 or the respiratory disturbance index (RDI) is greater than 30, the patient must also meet at least one of the following criteria:

- The patient is not able to tolerate a positive airway pressure (PAP) device; or
- The treating practitioner determines that the use of a PAP device is contraindicated.

Authorization

Authorizations for purchase of HCPCS code E0486 may be granted to physicians or DME providers as medically necessary. The frequency limit is one device every five years.

Medi-Cal will not authorize HCPCS code E0486 if a CPAP or BIPAP device (HCPCS codes E0470, E0471, E0472 or E0486) has been authorized within the previous five years unless there is medical documentation explaining why the CPAP or BIPAP device does not adequately treat the patient’s OSA.

Documentation Requirements

Authorization of oral appliances for OSA requires the following documentation:

- A face-to-face clinical evaluation by the treating licensed practitioner prior to the sleep study test to assess the patient for OSA; and
- Documentation that the patient meets the clinical criteria for OSA specified; and
- A prescription for an oral appliance for OSA signed and dated by the treating practitioner (or the electronic equivalent); and
- Documentation that the oral appliance is ordered by the treating practitioner following a review of the report of the sleep test.

If the oral appliance is for a child (younger than 20 years of age) and the child has a CCS-eligible condition, a CCS denial must accompany the TAR.

Billing

HCPCS Code for Aerosol Masks

HCPCS Code	Description
E0486	Oral device/appliance used to reduce upper airway collapsibility, adjustable or nonadjustable, custom fabricated, includes fitting and adjustment.

Claims for this equipment must be billed with modifier NU.

Oximeters

Coverage

Pulse oximeters are not reimbursable under Medi-Cal except when the patient:

- Is transitioning from CCS to Medi-Cal upon turning 21 years of age, and
- Requires a home ventilator, any type, used with invasive interface (E0465) and is using an uncuffed tracheostomy tube.

Authorization

An approved TAR is required for reimbursement for Medi-Cal patients. The oximeter may be authorized for use as long as the patient requires a home ventilator, any type, used with invasive interface (E0465) and is using an uncuffed tracheostomy tube.

These devices may be authorized and reimbursed also through CCS.

Billing

HCPCS code E0445 (oximeter device for measuring blood oxygen levels non-invasively).

Oxygen Contents, Equipment and Supplies

Criteria

Medi-Cal covers home oxygen contents, oxygen equipment and oxygen supplies when all of the following criteria are met:

- The treating licensed practitioner has examined the patient and determined that he or she has one of following conditions that might be expected to improve with oxygen:
 - A severe lung disease such as chronic obstructive pulmonary disease, diffuse interstitial lung disease (known or unknown etiology), cystic fibrosis, bronchiectasis and widespread pulmonary neoplasm, or
 - Hypoxia-related symptoms or findings such as pulmonary hypertension, recurring congestive heart failure due to cor pulmonale, erythrocytosis, impairment of cognitive process, nocturnal restlessness and morning headache
- A qualifying blood gas study has been conducted by the treating licensed practitioner or a qualified provider or supplier of laboratory services. Only a certified qualified provider or supplier of laboratory services may conduct the blood gas studies, and they must be able to submit claims to either the Medi-Cal or Medicare programs.

A supplier of oxygen contents, oxygen equipment or oxygen supplies cannot conduct the qualifying blood gas study for a recipient they supply with oxygen.

Medi-Cal recognizes that the arterial partial pressure of oxygen (PO₂) levels and the arterial oxygen saturation percentages specified below may be altered due to variations in oxygen measurements resulting from factors such as the patient's age, the altitude level, or the patient's decreased oxygen carrying capacity.

- The qualifying blood gas study was obtained under the following conditions:
 - During an inpatient hospital stay, as close to, but no earlier than, two days prior to the hospital discharge date, with home oxygen therapy beginning immediately following discharge, or
 - During an outpatient encounter, within 30 days of the date of initial certification while the patient is in a chronic stable state, that is, when the patient is not in a period of acute illness or an exacerbation of his or her underlying disease.
- The treating licensed provider has tried or considered alternative treatments and they were deemed clinically ineffective.

- For initial certifications, the patient's blood gas study values (either an arterial blood gas or an oximetry test) meet one of these criteria:

Group I criteria:

- Patient on room air while at rest (awake) when tested:
 - ❖ An arterial PO₂ at or below 55 mm Hg, or
 - ❖ Arterial oxygen saturation at or below 88 percent.
- Patient tested during exercise and, if during the day while at rest, arterial PO₂ is at or above 56 mm Hg or an arterial oxygen saturation is at or above 89 percent:
 - ❖ Arterial PO₂ is at or below 55 mm Hg or an arterial oxygen saturation is at or below 88 percent and
 - ❖ Documented improvement of hypoxemia during exercise with oxygen
- Patient tested during sleep and if arterial PO₂ is at or above 56 mm Hg or an arterial oxygen saturation is at or above 89 percent while awake, additional testing must show:
 - ❖ Arterial PO₂ is at or below 55 mm Hg or an arterial oxygen saturation is at or below 88 percent for at least five minutes taken during sleep, or
 - ❖ Decrease in arterial PO₂ of more than 10 mm Hg, or a decrease in arterial oxygen saturation more than 5 percent for at least five minutes associated with symptoms or signs more than five percent from baseline saturation for at least five minutes taken during sleep associated with symptoms or signs reasonably attributable to hypoxemia. Some examples of symptoms are impairment of cognitive processes and nocturnal restlessness or insomnia, and some examples of signs are cor pulmonale, "P" pulmonale on electrocardiogram, documented pulmonary hypertension, and erythrocytosis reasonably attributable to hypoxemia
 - ❖ In either of these cases coverage is provided only for use of oxygen during sleep, and only one type of unit will be covered. Portable oxygen will be denied as not medically necessary if the only qualifying blood gas study is performed during sleep.

Group II Criteria:

- Patient on room air while at rest (awake) when tested:
 - ❖ Arterial oxygen saturation of 89 percent at rest (awake), or
 - ❖ Arterial PO₂ of 56 – 59 mm Hg and
 - Dependent edema due to congestive heart failure, or
 - Pulmonary hypertension or cor pulmonale, determined by measurement of either pulmonary artery pressure, gated blood pool scan, echocardiogram or “P” pulmonale on electrocardiogram (with P wave greater than 3 mm in standard leads II, III or AVF), or
 - Erythrocythemia with a hematocrit greater than 56 percent
- Patient tested during sleep for at least five minutes:
 - ❖ Arterial oxygen saturation of 89 percent or
 - ❖ Arterial PO₂ of 56 – 59 mm Hg and
 - Dependent edema due to congestive heart failure
 - Pulmonary hypertension or cor pulmonale, determined by measurement of either pulmonary artery pressure, gated blood pool scan, echocardiogram or “P” pulmonale on electrocardiogram (with P wave greater than 3 mm in standard leads II, III or AVF) or
 - Erythrocythemia with a hematocrit greater than 56 percent

If the arterial PO₂ is equal to or greater than 60 mm Hg or the arterial oxygen saturation is equal to or greater than 90 percent, the medical necessity for oxygen is unlikely to be established. However, TARs submitted with documentation substantiating medical necessity will be evaluated on a case-by-case basis.

Requests for oxygen for pediatric patients with an arterial oxygen saturation of 90 percent or greater will be considered on a case-by-case basis.

Criteria for Portable Oxygen Systems

A recipient meeting the following requirements may qualify for coverage of a portable oxygen system either by itself or to use in addition to a stationary oxygen system.

A portable oxygen system is covered for a particular patient if:

- The claim meets the requirements specified previously in the “Criteria” subheading, and
- The medical documentation indicates that the patient is mobile in their residence or mobile in the community and would benefit from the use of a portable oxygen system.

Portable oxygen systems are not covered for patients who qualify for oxygen solely based on blood gas studies obtained during sleep.

Authorization

As medically necessary:

- Authorization for the rental of an oxygen delivery system may be granted in increments of up to 12 months, both for the initial authorization and for reauthorization.
- Authorization for purchase of E0425, E0430, E0435, E0440 and E1391 may be granted.

Lowest cost delivery system:

Once the medical need for supplemental oxygen has been established, Medi-Cal will authorize only the lowest-cost delivery system that meets the patient’s medical need(s) (see CCR, Title 22, sections 51003[f] and 51321[g]).

Medi-Cal may modify the TAR if the oxygen delivery system requested is not the lowest cost that will meet the patient’s medical needs. If a higher cost delivery system is requested only for the patient’s or provider’s convenience, and the patient’s medical need(s) can be met with a lower cost item, the TAR may be authorized. However, Medi-Cal will only reimburse at the rate of the lower cost oxygen delivery system.

If the oxygen is used for less than 24 hours per day, Medi-Cal may pro-rate the reimbursement to reflect less than 24 hours per day.

Documentation Requirements

A written prescription (or electronic equivalent) from the treating practitioner must be submitted with the TAR for all oxygen contents requests and must include all of the following information:

- The diagnosis(es) for which supplemental oxygen is being requested; and,
- ABG report (see “Laboratory Procedures” on a following page) or the continuous printout of the oximetry study; and,
- A completed DHCS form – *Certificate of Medical Necessity for Oxygen* or equivalent information; and,
- The flow rate of oxygen prescribed; and,
- An estimate of the frequency (hours per day) and duration of use (months).

If the oxygen is for a child (20 years of age or younger), and the child has a CCS-eligible condition, a CCS denial must accompany the TAR in addition to the above documentation requirements.

Note: A prescription for “OXYGEN PRN” or “OXYGEN AS NEEDED” is not acceptable.

If the patient’s clinical condition or need for oxygen changes, a new TAR for adjusted oxygen usage must be submitted with the medical documentation, as specified above.

All requests for oxygen must include a recent ABG or oximetry study report (within the preceding 30 days of the request, or if hospitalized, not more than two days prior to discharge) obtained in a chronic stable state.

Laboratory Procedures

The ABG or oximetry study must be performed on room air unless the licensed practitioner notes that due to severe hypoxemia, the patient cannot tolerate room air. In this case, the ABG or oximetry study may be performed with oxygen being administered and the liter flow rate noted on the ABG or oximetry study report.

Billing for Laboratory Studies

Refer to the appropriate Part 2 provider manual for information about billing outpatient laboratory studies.

Billing for Oxygen Contents and Oxygen Delivery Systems

Gaseous Oxygen Delivery System and Contents

HCPCS Code for Gaseous Oxygen Delivery System and Contents

HCPCS Code	Description
E0424	Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
E0425	Stationary compressed gas system, purchase; includes regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
E0430	Portable gaseous oxygen system, purchase; includes regulator, flowmeter, humidifier, cannula or mask, and tubing
E0431	Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing
E0441	Stationary oxygen contents, gaseous, 1 month's supply = 1 unit. Note: One unit of oxygen equals "one month's supply," regardless of how many pounds or cubic feet of oxygen are supplied.

Providers billing for code E0441 (oxygen contents) must document on the TAR that the patient owns the stationary system for which the contents are requested.

HCPCS Code for Portable Oxygen Contents

HCPCS Code	Description
E0443	Portable oxygen contents, gaseous, 1 month's supply = 1 unit. For Medi-Cal purposes, this code may be used to bill for portable gaseous oxygen contents, whether the portable system is rented or purchased. Note: Medi-Cal allows up to two "supplies" (units) of portable gas oxygen contents per month: The first supply of contents (first unit) is defined as "250 cubic feet" and the second supply of contents (second unit) is "any amount" more than 250 cubic feet. Modifier NU must be used when billing code E0443 for the first unit and modifier SC must be used for the second unit. A maximum of one unit with modifier NU and one unit with modifier SC is allowed per month.
K0738	Portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders; includes portable containers, regulator, flowmeter, humidifier, cannula or mask, and tubing

Liquid Oxygen Delivery Systems and Contents

HCPCS Code for Liquid Oxygen Delivery Systems and Contents

HCPCS Code	Description
E0433	Portable liquid oxygen system, rental; home liquefier used to fill portable liquid oxygen containers, includes portable containers, regulator, flowmeter, humidifier, cannula or mask and tubing, with or without supply reservoir and contents gauge
E0434	Portable liquid oxygen system rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge, cannula or mask, and tubing
E0435	Portable liquid oxygen system, purchase; includes portable container, supply reservoir, flowmeter, humidifier, contents gauge, cannula, or masks, tubing and refill adaptor
E0439	Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
E0440	Stationary liquid oxygen system, purchase; includes use of reservoir, contents indicator, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
E0442	<p>Stationary oxygen contents, liquid, 1 month's supply = 1 unit.</p> <p>Note: One unit of oxygen equals "one month's supply," regardless of how many pounds or cubic feet of oxygen are supplied.</p> <p>Providers billing for code E0442 (oxygen contents) must document on the TAR that the patient owns the stationary system for which the contents are requested.</p>
E0444	<p>Portable oxygen contents, liquid, 1 month's supply = 1 unit.</p> <p>For Medi-Cal purposes, this code may be used to bill for portable liquid oxygen contents, whether the portable system is rented or purchased).</p> <p>Note: Medi-Cal allows up to two "supplies" (units) of portable liquid oxygen contents per month: The first supply of contents (first unit) is defined as "110 pounds" and the second supply of contents (second unit) is "any amount" more than 110 pounds.</p> <p>Modifier NU must be used when billing code E0444 for the first unit, and modifier SC must be used for the second unit. A maximum of one unit with modifier NU and one unit with modifier SC is allowed per month.</p>

Oxygen Concentrator

HCPCS Code for Oxygen Concentrator

HCPCS Code	Description
E1390	Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate
E1391	Oxygen concentrator, dual delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate
E1392	Portable oxygen concentrator, rental

Monthly rental reimbursement for codes E1390 thru E1392 includes all accessories, delivery and setup. «Code E1390 and E1392 are rental-only codes and must be billed with modifier RR (rental).»

Oxygen Flow Rate Modifiers

The following modifiers are billed only with stationary gaseous (E0424) or liquid (E0439) systems or with a non-portable oxygen concentrator (E1390, E1391). If the prescribed liter flow rate is different for stationary versus portable, the flow rate for stationary must be used. If the prescribed liter flow rate is different at rest versus with exercise, the flow rate at rest must be used. If the prescribed flow rate is different for nighttime versus daytime use, the flow rates are averaged. These modifiers are not reimbursable with any other codes.

Modifier Codes for Oxygen Flow Rate

Code	Description
QA	Prescribed amounts of stationary oxygen for daytime use while at rest and nighttime use differ and the average of the two amounts is less than one liter per minute (LPM)
QB	Prescribed amounts of stationary oxygen for daytime use while at rest and nighttime use differ and the average of the two amounts exceeds four LPM and portable oxygen is prescribed
QE	Prescribed amount of stationary oxygen while at rest is less than one LPM. The reimbursement amount is reduced by 50 percent.
QF	Prescribed amount of stationary oxygen while at rest exceeds four LPM and portable oxygen is prescribed
QG	Prescribed amount of stationary oxygen while at rest is greater than four LPM
QR	Prescribed amounts of stationary oxygen for daytime use while at rest and nighttime use differ and the average of the two amounts exceeds four LPM

Note: The rental rates for E0424, E0439, E1390 and E1391 will vary when billed with modifier QA, QB, QE, QF, QG, QR or RR depending on the prescribed oxygen flow. For oxygen flow rates equal to or greater than one and equal to or less than four liters per minute, modifier RR is to be used as a single modifier. For claims submitted with modifier QE, QF or QG, it is not necessary to include modifier RR. Only one modifier may be used per HCPCS code. The reimbursement rates are listed below. When modifier QB, QF, QG or QR is used, the reimbursement rate is increased by 50 percent.

Reimbursement Rates for Oxygen Flow Rate Modifiers

Code	Modifier RR	Modifier QE or QA	Modifier QF or QB	Modifier QG or QR
E0424, E0439, E1390, E1391	\$107.77	\$53.88	\$161.65	\$161.65

Billing Guidelines Chart

The “Billing Guidelines Chart” below lists codes that are not reimbursable in the same month of service as the initial purchase or rental.

Billing Guidelines for Non-Reimbursable Codes in the Same Month of Service

System Type	Modifier	Not Reimbursable in Same Month as Initial Purchase or Rental
Stationary Gas (Purchase) E0425	NU	A4615, A4619, A4620, A9900*, E0424, E0433, E0434, E0435, E0439, E0440, E0442, E0444, E0555, E1353, E1390, E1391, K0738
Portable Gas (Purchase) E0430	NU	A4615, A4619, A4620, A9900*, E0431, E0433, E0434, E0435, E0439, E0440, E0442, E0444, E0555, E1353, E1392, K0738
Portable Liquid (Purchase) E0435	NU	A4615, A4619, A4620, A9900*, E0424, E0425, E0430, E0431, E0433, E0434, E0441, E0443, E0555, E1353, E1392, K0738
Stationary Liquid (Purchase) E0440	NU	A4615, A4619, A4620, A9900*, E0424, E0425, E0430, E0431, E0433, E0439, E0441, E0443, E0555, E1353, E1390, E1391, K0738
Concentrator (Purchase) E1391	NU	A4615, A4619, A4620, A9900*, E0424, E0425, E0439, E0440, E0441, E0442, E1353
Stationary Gas (Rental) E0424	QA, QE, RR	A4615, A4619, A4620, A9900*, E0424, E0425, E0433, E0439, E0440, E0441, E0442, E0555, E1353, E1390, E1391, K0738
Stationary Gas (Rental) E0424	QB, QF, QG, QR	A4615, A4619, A4620, A9900*, E0424, E0425, E0430, E0431, E0433, E0434, E0435, E0439, E0440, E0441, E0442, E0443, E0444, E0555, E1353, E1390, E1391, E1392, K0738
Portable Gas (Rental) E0431	RR	A4615, A4619, A4620, A9900*, E0430, E0433, E0434, E0435, E0439, E0440, E0442, E0444, E0555, E1353, E1392, K0738
Portable Liquid System, Home Liquefier (Rental) E0433	RR	A4615, A4619, A4620, A9900*, E0424, E0425, E0430, E0431, E0434, E0435, E0439, E0440, E0441, E0442, E0443, E0444, E0555, E1353, E1392, K0738

**Billing Guidelines for Non-Reimbursable Codes in the Same Month of Service
(continued)**

Stationary Liquid (Rental) E0439	QA, QE, RR	A4615, A4619, A4620, A9900*, E0424, E0425, E0433, E0439, E0440, E0441, E0442, E0555, E1353, E1390, E1391, K0738
Stationary Liquid (Rental) E0439	QB, QF, QG, QR	A4615, A4619, A4620, A9900*, E0424, E0425, E0430, E0431, E0433, E0434, E0435, E0439, E0440, E0441, E0442, E0443, E0444, E0555, E1353, E1390, E1391, E1392, K0738
Concentrator (Rental) E1390, E1391	QA, QE, RR	A4615, A4619, A4620, A9900*, E0424, E0425, E0439, E0440, E0441, E0442, E0555, E1353, E1390, E1391
Concentrator (Rental) E1390, E1391	QB, QF	A4615, A4619, A4620, A9900*, E0424, E0425, E0430, E0431, E0434, E0435, E0439, E0440, E0441, E0442, E0443, E0444, E0555, E1353, E1390, E1391, E1392
Concentrator (Rental) E1390, E1391	QG, QR	A4615, A4619, A4620, A9900*, E0424, E0425, E0430, E0431, E0434, E0435, E0439, E0440, E0441, E0442, E0443, E0444, E0555, E1353, E1390, E1391, E1392, K0738
Concentrator (Rental) E1392 (Portable)	RR	A4615, A4619, A4620, A9900*, E0430, E0431, E0433, E0434, E0435, E0441, E0442, E0443, E0444, E1353, K0738
Portable Gas (Rental) K0738	RR	A4615, A4619, A4620, A9900*, E0433, E0441, E0443, E0555, E1353

Billing Limitations

Codes A4615, A4619 and A4620 are included in the reimbursement for rental of the oxygen concentrator (E1390 or E1391) and are not separately reimbursable. They may be separately reimbursed only when the concentrator is patient-owned. These codes must be billed with modifier NU. Modifiers RB and RR are not allowed. Claims for these codes must include either the appropriate HCPCS code or a description of the oxygen concentrator and a statement that the oxygen concentrator is patient-owned in the *Additional Claim Information* field (Box 19). Labor charges (HCPCS code K0740) for these codes are not separately reimbursable.

If a patient qualifies for additional provider reimbursement for greater than four liters per minute of oxygen and meets the requirements for both stationary and portable oxygen (E0431 or E0434), payment (at the higher allowance using modifier QB or QF) will be made only for the stationary system. Payment for the portable system will be denied.

Oxygen Conserving Devices

Coverage

Oxygen conserving devices may be authorized for patients that meet the established criteria. For those patients for whom Medicare has authorized and reimbursed for the use of oxygen with a portable delivery system, Medi-Cal may authorize and reimburse for the oxygen-conserving device, as medically necessary.

Criteria

The patient meets the criteria for supplemental oxygen and requires the oxygen tank to be extended in its usage, such as in extended periods of time away from home.

Authorization

As medically necessary:

- Authorization for rental of demand oxygen pulsing devices may be granted in increments of up to three months, both for the initial authorization and for reauthorization.
- Authorization for purchase of demand oxygen pulsing devices may be granted for one device every three years for a patient-owned oxygen delivery system.
- Authorization for purchase for reservoir cannula devices may be granted for one device every 12 months.

Documentation Requirements

Documentation that the patient meets the criteria specified above must be submitted with the TAR.

If the oxygen-conserving device is for a child (20 years of age or younger), and the child has a CCS-eligible condition, a CCS denial must accompany the TAR.

Billing

HCPCS Code for Oxygen Conserving Devices

HCPCS Code	Description
E1399	Durable medical equipment, miscellaneous

Regulators

Coverage

Medi-Cal covers regulators for patients who meet the established criteria.

Criteria

The patient meets the criteria for supplemental oxygen and owns an oxygen delivery system or an oxygen concentrator, and the regulator requires replacement.

Authorization

As medically necessary, authorization for purchase may be granted for one device every five years.

Documentation Requirements

Documentation that the patient meets the criteria specified above must be submitted with the TAR.

If the regulator is for the child (20 years of age or younger), and the child has a CCS-eligible condition, a CCS denial must accompany the TAR.

Billing

HCPCS Code for Regulators

HCPCS Code	Description
E1353	Regulator

Oxygen Stand/Rack

Coverage

Medi-Cal covers an oxygen stand/rack for patients who meet the established criteria.

Criteria

The patient meets the criteria for supplemental oxygen and qualifies for either a portable or stationary gaseous oxygen delivery system that requires a stand/rack.

Authorization

As medically necessary:

- Authorization for rental may be granted in increments of up to 12 months, both for initial authorization and for reauthorization.
- Authorization for purchase may be granted for up to one devices every five years

Documentation Requirements

Documentation that the patient meets the criteria specified above must be submitted with the TAR.

If the oxygen stand/rack is for child (20 years of age or younger), and the child has a CCS-eligible condition, a CCS denial must accompany the TAR.

Billing

HCPCS Code for Oxygen Stand/Rack

HCPCS Code	Description
E1355	Stand/rack

Code E1355 is separately reimbursable with the rental or purchase of supplemental oxygen. Claims for this code must be billed with modifier NU. Labor charges (HCPCS code K0740) for the stand/rack are not separately reimbursable.

Suction Machines

Coverage

Medi-Cal covers portable and stationary suction machines for patients who meet the established criteria.

Criteria

The patient has difficulty raising and clearing secretions due to:

- Cancer or surgery of the throat or mouth
- Dysfunction of the swallowing muscles
- Unconsciousness or obtunded state
- Tracheostomy, or
- Neuromuscular conditions.

Authorization

As medically necessary:

- Authorization for rental may be granted in increments of up to six months, both for the initial authorization and for reauthorization,
- Authorization for purchase may be granted for one device every five years.

Documentation Requirements

Documentation that the patient meets the criteria specified above must be submitted with the TAR.

If the suction machine is for a child (20 years of age or younger), and the child has a CCS-eligible condition, a CCS denial must accompany the TAR.

Billing

HCPCS Code for Suction Machines

HCPCS Code	Description
E0600	Respiratory suction pump, home model, portable or stationary, electric

Ventilators (Primary)

Coverage

Except as noted below under “Non-Coverage,” Medi-Cal covers primary ventilators for patients who meet the established criteria.

Non-Coverage

Medi-Cal does not cover purchase of ventilators. The primary ventilator for dual-eligible patients (Medicare/Medi-Cal). The primary ventilator must be billed to Medicare. Medi-Cal may authorize a back-up ventilator in this situation.

Criteria

The patient demonstrates all of the following:

- The inability to be completely weaned from ventilatory support and a medical condition such as:
 - Neuromuscular disorders; or,
 - Chest wall deformity; or,
 - Central hypoventilation syndrome; or,
 - Chronic obstructive pulmonary disease; or,
 - Restrictive lung diseases; and,
- Optimal medical therapy has been provided for the underlying respiratory disorder(s); and,
- Reversible contributing factors have been treated; and,
- Medical and respiratory stability have been achieved; and,
- A diagnosis of chronic respiratory failure (patients who develop symptomatic nocturnal hypercapnia in the absence of daytime hypercapnia may qualify for nocturnal ventilatory support; hypoxemia may or may not be present).

A multi-function ventilator (HCPCS code E0467) is considered medically necessary when the patient meets criteria above for a ventilator and meets criteria for at least one of the four additional functions (oxygen concentrator, cough stimulator, suction pump and nebulizer).

Authorization

As medically necessary, authorization for rental may be granted in increments of up to 12 months, both for the initial authorization and reauthorization.

Medi-Cal will not authorize separately for ventilator accessories that are necessary to operate the ventilator, including but not limited to hose assembly units, humidity and bacteria filters and in-line condensers, in-line temperature measuring devices, ventilator circuits and batteries.

Documentation Requirements

Documentation that the patient meets the criteria specified above, including a description of the patient's clinical condition by the licensed practitioner, must be submitted with the TAR.

If the primary ventilator is for a child (20 years of age or younger), and the child has a CCS-eligible condition, a CCS denial must accompany the TAR.

Billing

HCPCS Code for Primary Ventilators

HCPCS Code	Description
E0465 †	Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)
E0466 †	Home ventilator, any type, used with non-invasive interface, (e.g., mask, chest shell)
E0467 †	Home ventilator; multi-function respiratory device, also performs any or all of the additional functions of oxygen concentration, drug nebulization, aspiration, and cough stimulation, includes all accessories, components and supplies for all functions.

Claims billed for ventilators must list the model number in the *Additional Claim Information* field (Box 19) of the claim or on an attachment. Apnea monitors are not separately reimbursable with pressure control, volume control or electrical stimulator supplies.

Claims billed for any of the following stand-alone devices or their accessories will not be reimbursed when billed in the same calendar month as a multi-function ventilator (HCPCS E0467).

- Oxygen and oxygen equipment (HCPCS codes E0424, E0431, E0433, E0434, E0439, E0441, E0442, E0443, E0444, E1390, E1391, E1392 and K0738)
- Nebulizers and related accessories (HCPCS codes A4619, A7015, A7016, E0565 and E0570)
- Aspirators and related accessories (HCPCS codes A7000, A7001 and E0600)
- Cough stimulating devices, high-frequency chest wall oscillation systems, oscillatory-positive expiratory pressure devices and related accessories (HCPCS codes A7020, E0482, E0483 and E0484)
- Continuous Positive Airway Pressure (CPAP) devices, respiratory assist devices and related accessories (HCPCS codes A4604, A7027, A7028, A7029, A7030, A7031, A7032, A7033, A7034, A7035, A7036, A7037, A7038, A7039, A7044, A7045, A7046, E0601, E0470, E0471, E0472, E0561 and E0562)
- Oral appliance (HCPCS code E0486)
- Home ventilators (HCPCS codes E0465 and E0466)

Supplies and Repairs with Ventilators

Ventilator codes E0465, E0466 and E0467 are rented continuously. Payment for rental codes includes all necessary supplies and repairs. Supplies such as a heated humidifier, breathing circuits equipment, tracheostomy supplies and others will not be paid separately. Breathing circuit code A4618, any miscellaneous codes used for heated humidifier equipment or supplies, and tracheostomy supply codes such as S8189 and T5999 are not covered.

Ventilators (Backup)

Coverage

Medi-Cal covers back-up ventilators for patients who meet the established criteria.

Criteria

The patient demonstrates all of the following:

- Has been authorized for a primary ventilator; and,
- Cannot maintain spontaneous ventilation for four or more hours; and,
- Lives in an area where a replacement ventilator cannot be provided within two hours.

The use of a back-up (second) ventilator in the home setting is considered medically necessary for the following additional indication, when applicable:

- For patients who require mechanical ventilation during mobility, as prescribed in their plan of care, and there is justification for why the primary ventilator cannot be used during mobility.

Authorization

As medically necessary, authorization for rental may be granted in increments of up to 12 months, both for the initial authorization and for reauthorization.

Documentation Requirements

Documentation that the patient meets the criteria specified above must be submitted with the TAR.

If the back-up ventilator is for a child (20 years of age or younger), and the child has a CCS-eligible condition, a CCS denial must accompany the TAR.

Billing

Claims billed for back-up ventilators must list the model number in the *Additional Claim Information* field (Box 19) of the claim or on an attachment. Claims must also include the following statement in the *Additional Claim Information* field (Box 19): "This is a back-up ventilator."

Refer to Ventilators (Primary) above for additional billing information.

Unlisted Oxygen Equipment and Respiratory Equipment

Coverage

Medi-Cal covers unlisted oxygen equipment and respiratory equipment for patients who meet the established criteria.

Criteria/Authorization

As medically necessary, unlisted oxygen equipment and respiratory equipment may be authorized by the Medi-Cal consultant based upon documentation submitted with the TAR for the specific item.

Documentation Requirements

TARs submitted for unlisted oxygen equipment and respiratory equipment require all of the following information:

- Justification that the specific item is medically necessary; and,
- Item description; and,
- Manufacturer's Suggested Retail Price (MRSP) (copy of catalog page).

If the unlisted oxygen equipment and respiratory equipment item is for a child (20 years of age or younger), and the child has a CCS-eligible condition, a CCS denial must accompany the TAR in addition to the above requirement.

Billing

HCPCS Code for Unlisted Oxygen Equipment and Respiratory Equipment

HCPCS Code	Description
E1399	Durable medical equipment, miscellaneous

For information about billing for unlisted equipment, refer to the *Durable Medical Equipment (DME): Bill for DME* section in this manual.

Unlisted Supplies, Accessories and Service Components

Coverage

Medi-Cal covers unlisted oxygen equipment and respiratory equipment for patients who meet the established criteria.

Criteria/Authorization

As medically necessary, unlisted oxygen equipment and respiratory equipment may be authorized by the Medi-Cal consultant based upon documentation submitted with the TAR for the specific item.

Documentation Requirements

Documentation that the patient has a medical need for the specific item, and that the patient owns the equipment for which the miscellaneous supply, accessory or service component is being requested, must be submitted with the TAR.

If miscellaneous supplies, accessories, and/or service components are for a child (20 years of age or younger), and the child has a CCS-eligible condition, a CCS denial must accompany the TAR.

Billing

HCPCS Code for Unlisted Oxygen Equipment and Respiratory Equipment

HCPCS Code	Description
A9900	Miscellaneous DME supply, accessory, and/or service component or another HCPCS code

For information about billing for unlisted miscellaneous supplies, accessories and service components, refer to the *Durable Medical Equipment (DME): Bill for DME* section in this manual.

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
«	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
»	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
*	Applies to code A9900 only if the code is used to bill for a respiratory supply item.
†	Modifier RR is required