

## DME Fee Schedule Key and Changes updated January 22, 2016

The Wheelchair Fee Schedule has been deleted. All wheelchair codes and their fees are incorporated into the DME Fee Schedule dated 1/22/2016. Distinct Electric, Manual, and Replacement fees are listed in a separate row instead of in multiple columns.

### New Codes effective 1/1/2016

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)
E1012	WHEELCHAIR ACCESSORY, ADDITION TO POWER SEATING SYSTEM, CENTER MOUNT POWER ELEVATING LEG REST/PLATFORM, COMPLETE SYSTEM, ANY TYPE, EACH

### PA Indicator Change

B to E	E1014	RECLINING BACK, ADDITION TO PEDIATRIC SIZE WHEELCHAIR
B to E	E1230	POWER OPERATED VEHICLE (3 OR 4 WHEEL, NON-HIGHWAY), SPECIFY BRAND NAME AND MODEL NUMBER
B to E	K0010	STANDARD -WEIGHT FRAME MOTORIZED/POWER WHEELCHAIR
B to E	K0011	STANDARD-WEIGHT FRAME MOTORIZED/POWER WHEELCHAIR WITH PROGRAMMABLE CONTROL PARAMETERS FOR SPEED ADJUSTMENT, TREMOR DAMPENING, ACCELERATION CONTROL AND BRAKING
B to E	K0012	LIGHTWEIGHT PORTABLE MOTORIZED/POWER WHEELCHAIR
N to Y	E0782	INFUSION PUMP, IMPLANTABLE, NON-PROGRAMMABLE, (INCLUDES ALL COMPONENTS, PUMP, CATHETER, CONNECTORS, ETC.)

### Changed LTC and MCR indicator

S9001	HOME UTERINE MONITOR WITH OR WITHOUT ASSOCIATED NURSING SERVICES LTC: N MCR: N
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### Corrected COS

048	T4544	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, ABOVE EXTRA LARGE, EACH
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### Deleted Codes Effective 12/31/15

E0450 E0463	Use E0465
E0460 E0461 E0464	Use E0466

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<p>Complete List Sorted by HCPCS</p> <p>The Wheelchair Fee Schedule has been deleted. All wheelchair codes and their fees are incorporated into the DME Fee Schedule dated 1/22/2016. Distinct Electric, Manual, and Replacement fees are listed in a separate row instead of in multiple columns.</p>	
<b>Column Heading</b>	<b>Description</b>
HCPCS	Procedure Code.
Note	<p>W – Wheelchair (electric/manual not specified)</p> <p>E – Electric Wheelchair</p> <p>M – Manual Wheelchair</p> <p>NR– The 2.7% rate reduction does not apply to this code.</p>
Description	Procedure Description.
COS	<p>Category of Service.</p> <p>041 – Equipment and Prosthesis</p> <p>048 – Supplies</p>
Prior Approval Required	<p>Indicates whether Prior Approval is Required.</p> <p>N – No PA required</p> <p>Y – PA required</p> <p>R – Continuous Rental - PA required</p> <p>B – Rent to Purchase - PA required</p> <p>E – Requires PA for Purchase or Modifications. Repairs require prior approval when the sum of the repair is \$400 or more.</p>
H/P	Indicates if the item is hand priced.
LTC	<p>Indicates whether the item is the responsibility of the Long Term Care Facility.</p> <p>Y – LTC responsibility</p> <p>N – Not LTC responsibility</p>
Medicare Covered	<p>Indicates whether Medicare covers the items and if Medicare should be billed prior to HFS.</p> <p>Y – Bill Medicare prior to HFS</p> <p>N – Not covered by Medicare, bill HFS directly 180 days from the date of service</p> <p>If Medicare coverage policy is situational, bill Medicare.</p>
2.7% Reduced Purchase Price	<p>Maximum allowable price HFS will reimburse for the item. Public Act 097-0689 required the Department to reduce reimbursement rates by 2.7%. The posted rates are reduced unless noted with “NR” in the Note column.</p>
2.7% Reduced Rent Price	Any rate charged lower than the maximum.
Max Quantity	Maximum quantity limit HFS will allow within the Max number of days.
Max Days	Quantity limit time frame.