Humana will be updating its professional claim policies and code-editing software on Nov. 8, 2014.

Special announcement about Humana Medicare Advantage (MA) HMO claims processing:
Effective Nov. 8, 2014, Humana will begin realigning Medicare Advantage (MA) Health Maintenance Organization (HMO) claims processing and editing processes to be more consistent with those of MA Preferred Provider Organization (PPO) and Private Fee-for-Service (PFFS) plans. This will ensure that Humana MA claims are reviewed based on the same correct coding and coding policy rules and will create greater consistency in processing among all Humana MA plans. This shift in processing philosophy will result in multiple changes to how Humana processes MA HMO claims.

These changes are included in the chart that follows the General Reminders section of this notification and are identified by the category "MA HMO Alignment." Examples of changes that will occur because of this alignment follow below. Please note that these examples do not include all changes due to the realignment of MA HMO plans' payment processing rules.

- **MA HMO Alignment – Assistant at Surgery**
  Assistant at surgery services will be allowed only for procedures defined by the Centers for Medicare & Medicaid Services (CMS) as requiring the services of an assistant. Assistants at surgery will be reimbursed according to the CMS assistant at surgery policy and indicators on the Medicare Physician Fee Schedule.
- **MA HMO Alignment – National Correct Coding Initiative (NCCI)**
  Claims processed for Medicare HMO plans will be subject to editing and rules outlined by the NCCI. This includes the application of code pairs identified in the procedure-to-procedure tables (Column I/Column II), as well as coverage and processing rules outlined in the NCCI policy manual.

General reminders:

- Edits associated with new or revised American Medical Association (AMA) Current Procedural Terminology (CPT®), International Classification of Diseases, Ninth Revision (ICD-9), modifier and Healthcare Common Procedure Coding System (HCPCS) codes will be added.
- Edits for CPT, ICD-9, modifier and HCPCS codes deleted by the AMA and/or CMS will be removed.
- In order to adjudicate claims accurately and in a timely manner, Humana will identify inappropriately coded claims and, when possible, reimburse using the correct code. Humana will do so based only on facts known to Humana, such as the age and gender of the member. For example, if Humana's records indicate the age of the member does not match the description of the CPT code, the claim will be considered based on the CPT code that properly reflects the member's age. If a claim is submitted for CPT code 42825 (tonsillectomy, primary or secondary; younger than age 12) and the member is 15 years old, that code will be denied, and CPT code 42826 (tonsillectomy, primary or secondary; age 12 or over) will be added to the claim. When the correct code cannot clearly be identified, the claim will be returned to the health care provider for correction and resubmission, if applicable.
- Diagnosis codes that are not coded to the highest specificity, are incomplete or have invalid codes may cause the claim to be denied.
- Claim lines submitted with an unlisted or not otherwise classified code must be submitted with a description of services provided; claim lines submitted without a description, with a generic description or with an incomplete description may be denied.
- As noted in the AMA CPT manual, procedure codes that are designated add-on codes are intended to report additional service beyond the related primary code. The add-on code must be reported in conjunction with a related primary code. Therefore, add-on codes will not be reimbursed when the primary code is absent or has been denied for other reasons.
- Humana is continuing to automate its medical coverage policies. Our claim code-editing logic will be updated to include the diagnosis and procedure codes that are covered per our policies. Procedure codes and/or diagnosis codes not allowed per our policies will not be reimbursed. For a complete list of medical coverage policies, please visit Humana.com/provider and choose "Medical and Pharmacy Coverage Policies" under "Resources."
- Humana is committed to remaining consistent with CMS claims processing guidelines. To further that effort, as Medicare payment policies change, Humana continuously updates code-editing logic on all Humana Medicare Advantage (MA) products. Health care providers must follow applicable claims submission guidelines, including local coverage determinations (LCDs) and national coverage determinations (NCDs), to facilitate accurate claims processing results.
- Per Humana's provider contract language, claims shall include the physician's national provider identifier (NPI) and the valid taxonomy code that most accurately describes the health care services reported on the claim. Submitting this information on claims will allow more accurate and timely processing of claims through Humana's systems.
- For California health care providers, this notification does not affect any contractual relationship you may have with a contracted independent physician association (IPA) for a Humana MA HMO product. This notification solely pertains to your participation with Humana under your ChoiceCare Network contract.

Effective Nov. 8, 2014, the following changes will apply to professional claims submitted for Humana commercial fully insured, including Health Maintenance Organization Exchange (HMOx) and select self-funded* members, Medicaid and Medicare Advantage (MA) Health Maintenance Organization (HMO), Preferred Provider Organization (PPO) and Private Fee-for-Service (PFFS) members:

Category	Topic	Policy Statement	Impacted Products
MA HMO Alignment	Assistant at Surgery	Assistant at surgery services will be allowed only for procedures defined by CMS as requiring the services of an assistant. Assistants at surgery will be reimbursed according to the CMS assistant at surgery policy and indicators on the Medicare Physician Fee Schedule.	Medicare Advantage HMO Products
MA HMO Alignment	National Correct Coding Initiative (NCCI)	Claims processed for Medicare HMO plans will be subject to editing and rules outlined by the NCCI. This includes the application of code pairs identified in the procedure-to-procedure tables (Column I/Column II), as well as coverage and processing rules outlined in the NCCI policy manual.	Medicare Advantage HMO Products
Surgery – Maternity Care and Delivery	Global Obstetric (OB)	Reimbursement for global obstetric packages (CPT codes that include delivery as well as antepartum and postpartum services) will be reduced when a component of the global obstetric package has previously been billed and allowed. This reduction will be consistent with the previously allowed amount, making the sum of payments equal to the total allowed amount for the global obstetric package.	Commercial Fully Insured, Select Self-funded*, Medicaid (Fla. and Ill.) and All Medicare Advantage Products
Correct Coding	Assistant at Surgery Mismatch	Assistant at surgery services that do not match a procedure code billed on the same date of service by any other health care provider will not be reimbursed. Assistant services should be consistent with at least one service billed by, and performed by, a surgeon.	Commercial Fully Insured, Select Self-funded*, Medicaid (Fla. and Ill.) and All Medicare Advantage Products
Evaluation and Management (E/M) Services	Hospital Outpatient Clinic Visit (G0463)	Hospital outpatient clinic visit for assessment and management of patient (HCPCS code G0463) will not be reimbursed when billed by a physician. According to CMS policy, it is not valid for a physician to bill for an outpatient clinic visit HCPCS code.	All Medicare Advantage Products
Evaluation and Management Services	Correct Place of Service – E/M	According to CMS, AMA and Humana policies, evaluation and management services will not be reimbursed when billed with an inappropriate place of service. The descriptions of these codes dictate the appropriate place of service.	Commercial Fully Insured, Select Self-funded*, Medicaid (Fla. and Ill.) and All Medicare Advantage Products
Assistant Surgeon Policy	CMS Assistant Surgeons Not Allowed	The physician fee schedule developed by CMS indicates that some procedures do not require an assistant at surgery or that the concept does not apply. Services inappropriately submitted with an assistant surgeon modifier (80, 81, 82 or AS) will not be reimbursed.	Medicare Advantage HMO Products
CMS Physician Fee Schedule	Physician Fee Schedule Status Indicator "P"	Bundled/excluded codes with the status indicator “P” will not be separately reimbursed when performed on the same date of service as other payable services that are payable under the Medicare Physician Fee Schedule. According to CMS policy, bundled/excluded codes (status indicator P) are considered incidental to other payable services when performed on the same date of service and are not separately payable.	Medicare Advantage HMO Products

GCHHYTFEN 1593ALL0714-A Claim edits do not supersede the necessity to obtain preauthorization. Preauthorization requirements are still applicable.

*Note: These, and all edits previously published or posted on Humana.com/providers for Humana fully insured commercial members, may be applied to self-funded members, when requested by the self-funded group.

HCPCS – Durable Medical Equipment (DME) and Supplies	Oxygen and Oxygen Equipment	Oximeters and oximeter replacement probes will not be eligible for reimbursement. According to CMS policy, although oximeters and replacement probes are monitoring devices that provide information to physicians to assist in managing the patient's treatment, they do not meet the definition of DME.	Medicare Advantage HMO Products
Modifiers	Bilateral Indicator "2"	A procedure with a bilateral indicator of "2" will be recoded to its counterpart unilateral code when billed with modifier RT (right side) or LT (left side). CMS has identified procedures that are bilateral in nature. These codes are designated in the CMS Physician Fee Schedule with a bilateral indicator of "2." The procedure code description specifically states that the procedure is bilateral. Each procedure has a separate code representing its unilateral counterpart. When one of these procedures is billed with a single anatomic modifier (LT or RT), then the bilateral procedure will be recoded to the unilateral procedure.	All Medicare Advantage Products
Modifiers	Bilateral Policy	When ophthalmic biometry by ultrasound echography or ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation is billed twice on the same date of service, modifier 26 (professional component) will be added to the second billing. Certain codes have been designated by CMS as having unilateral professional components payable at 100 percent for each side (indicator 3) as well as bilateral-in-nature global and technical components (indicator 2). When these codes are billed twice on the same date of service, modifier 26 is appended to one of the lines.	All Medicare Advantage Products
Place of Service	Physical and Occupational Therapy	Certain casting and strapping procedures provided by a physical or occupational therapist in a skilled nursing facility (SNF) will not be eligible for reimbursement. According to CMS and Humana policies, certain casting and strapping procedures provided by a physical or occupational therapist in a SNF are bundled into payment to the SNF through the Prospective Payment System.	Commercial Fully Insured, Select Self-funded*, Medicaid (Fla. and Ill.) and All Medicare Advantage Products
Place of Service	Evaluation and Management	Nursing facility evaluation and management visits will be eligible for reimbursement only when billed with a place of service of 31 (skilled nursing facility), 32 (nursing facility), 34 (hospice), 54 (intermediate care facility) or 56 (psychiatric residential treatment facility). According to the AMA CPT Manual, nursing facility evaluation and management visits must be billed in a place of service of skilled nursing facility, nursing facility, hospice, intermediate care facility or psychiatric residential treatment facility.	Commercial Fully Insured, Select Self-funded*, Medicaid (Fla. and Ill.) and All Medicare Advantage Products

Modifiers	Laboratory Pass-thru Billing (Modifier 90)	Humana plans do not allow professional claim pass-thru billing. Humana will not reimburse a laboratory procedure performed by an outside laboratory, but billed by a treating or reporting physician or nonphysician practitioner (NPP). An outside laboratory that performs such a procedure must submit the charge for that service. A physician or NPP should refer to participating laboratories, such as LabCorp and Quest Diagnostics. Both labs offer extensive test menus to assist practices.	Commercial Fully Insured, Select Self-funded*, Medicaid (Va.) and All Medicare Advantage Products
Laboratory/ Pathology	General Health Panel (80050)	For contracted health care providers, Humana will bundle charges for individual components of the general health panel, submitted by the same contracted health care provider, for the same patient, for the same date of service, into CPT code 80050 and reimburse as appropriate for 80050. *Note:* This group health panel bundling was previously implemented for Humana's other products, including Humana MA HMO, and is being expanded to include MA PPO and MA PFFS products with this notification.	Medicare Advantage PPO and PFFS Products
HCPCS – Medical Services	External Counter-pulsation (G0166)	External counterpulsation (ECP) will be reimbursed only for patients who have been diagnosed with disabling angina (Class III or Class IV, Canadian Cardiovascular Society Classification or equivalent classification). According to CMS policy, coverage is provided for the use of ECP for patients who have been diagnosed with disabling angina.	All Medicare Advantage Products
Duplicate Claims	Range Duplicate Services	Only one evaluation and management code will be allowed per date of service when submitted by the same health care provider or different providers of the same specialty. According to CMS and Humana policies, when the same health care provider performs multiple E/M services, one code with the appropriate level to represent all the services should be billed. When different health care providers of the same specialty bill, only one will be reimbursed.	Commercial Fully Insured, Select Self-funded*, Medicaid (Fla. and Ill.) and Medicare Advantage HMO Products
Correct Coding	NCCI	According to the CMS Correct Coding Initiative (CCI), Column I codes include the items identified by codes in Column II. When a Column II code is billed with a Column I code, the Column II code will not be reimbursed.	Medicare Advantage HMO Products
Correct Coding	Ambulatory Surgery Center (ASC) Approved Procedures	Only procedures listed on the CMS ASC approved list will be reimbursed when billed in the ASC setting (type of bill 083X or place of service 24). CMS has established a list of procedures that may be performed safely in an ASC setting. These procedures are those that generally do not exceed 90 minutes in length and do not require more than four hours recovery or convalescent time.	Medicare Advantage HMO and PPO Products
Radiology	Ambulatory Surgery Center (ASC) Approved Procedures	Radiology services will be reimbursed only when billed with an approved ASC surgical procedure in the ASC setting (type of bill 083X or place of service 24). According to CMS and Humana policies, separate payment may be made for certain radiology services that are provided integral to a covered surgical procedure. These services will not be reimbursed when billed without an ASC approved surgical procedure for the same date of service.	Medicare Advantage HMO and PPO Products

CMS Coverage Policies	Chiropractic Manipulation	Chiropractic manipulation will be eligible for reimbursement only when billed with the requisite modifier. According to CMS policy, chiropractic manipulation requires billing with the appropriate modifier.	Medicare Advantage HMO and PPO Products
Correct Coding	Arthroscopy of the Knee	Diagnostic or surgical knee arthroscopy will not be reimbursed when submitted with a diagnosis of osteoarthrosis. According to CMS policy, diagnostic or surgical knee arthroscopy is not considered reasonable or necessary for treatment of the osteoarthritic knee.	Medicare Advantage HMO Products
HCPCS – Durable Medical Equipment (DME) and Supplies	Blood Glucose Monitoring	Supplies will not be reimbursed when billed with glucose monitoring devices or accessories. Supplies are not covered by CMS when billed with glucose monitoring devices or accessories, as these items are not required for the proper functioning of the device.	Medicare Advantage HMO Products
Modifiers	Modifiers 26 and TC on the Same Line	When modifier 26 (professional component) and TC (technical component) are billed on the same service line, both modifiers will be removed. According to the AMA Principles of CPT Coding, it is inappropriate to bill modifier 26 and modifier TC on the same claim line. These modifiers should be used only to indicate that less than the complete service was rendered. Therefore, when a health care provider bills both modifier 26 and TC on the same claim line, it is assumed that the entire service is being billed and both modifiers will be removed.	Medicare Advantage PPO and PFFS Products
Modifiers	Bilateral Modifiers	Modifier LT (left side) and/or RT (right side) will be removed from a procedure when billed on the same claim line with modifier 50 (bilateral procedure). Bilateral procedures may be represented by modifier 50 or modifiers LT and RT. It is not necessary or appropriate for a health care provider to append modifiers LT and/or RT on the same line as modifier 50. Modifier LT and/or RT will be removed in this scenario.	All Medicare Advantage Products
Modifiers	Bilateral Indicator "0"	When procedures with a bilateral indicator of "0" are billed with modifier 50 (bilateral procedure), the modifier will be removed. CMS has identified procedures that are not payable at 150 percent when billed bilaterally. These codes are designated in the CMS Physician Fee Schedule with a bilateral indicator of "0." The appropriate billing method for these services is to bill the procedure on a single claim line without procedural modifiers.	All Medicare Advantage Products
Modifiers	Bilateral Indicator "1"	Procedures with a bilateral indicator of "1" will be reimbursed up to 150 percent per date of service. CMS has identified procedures that are payable at 150 percent when billed bilaterally. These codes are designated in the CMS Physician Fee Schedule with a bilateral indicator of "1." When billed bilaterally, the recommended payment amount for these services will not exceed 150	All Medicare Advantage Products

		percent per date of service. Specifically, for fragmented claims processed on different days, lines will be denied or recoded to remove modifier 50, LT or RT, to ensure not more than 150 percent is paid.	
Modifiers	Bilateral Indicator "2"	CMS has identified procedures that are bilateral in nature. These codes are designated in the CMS Physician Fee Schedule with a bilateral indicator of "2." When these procedures are billed with modifiers LT, RT and/or 50, the modifier(s) will be removed. According to CMS, the appropriate billing method for these services is to bill the procedure on a single claim line without procedural modifiers, such as 50, LT or RT, and with one unit of service.	All Medicare Advantage Products
Modifiers	Bilateral Indicator "2"	Modifier 52 will be appended to procedures with a bilateral indicator of "2" when the procedure is submitted with RT (right side) or LT (left side) and a counterpart unilateral code does not exist. CMS has identified procedures that are bilateral in nature. These codes are designated in the CMS Physician Fee Schedule with a bilateral indicator of "2." When these procedures do not have a unilateral counterpart and are billed with a single anatomic modifier (LT or RT), then modifier 52 (reduced service) will be appended.	All Medicare Advantage Products
Modifiers	Bilateral Indicator "3"	Procedures with a bilateral indicator of "3" will be reimbursed according to the following scenario: • When billed with modifier 50 on a single line for one unit of service, the modifier 50 will be removed and the units increased to 2. • When billed with modifiers RT and LT on the same line and one unit of service, the modifiers will be removed and the units increased to 2. • When billed with modifier 50 and two units, the modifier 50 will be removed. CMS has identified procedures that are payable at 100 percent for each side when billed bilaterally. These codes are designated in the CMS Physician Fee Schedule with a bilateral indicator of "3." In all of these instances, the total recommended payment is 200 percent.	All Medicare Advantage Products
Modifiers	Bilateral Indicator "9"	Procedures with a bilateral indicator of "9" billed with modifier 50 (bilateral procedure), RT (right side) and/or LT (left side) will have the procedural modifier(s) removed. CMS policy indicates that the bilateral concept does not apply to procedures with a bilateral indicator of "9" on the CMS Physician Fee Schedule. When these services are billed with modifiers 50, LT and RT, these modifiers will be removed.	All Medicare Advantage Products
Modifiers	Bilateral Policy	When ophthalmic biometry by ultrasound echography or ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation is billed globally, it will be recoded to the technical component (modifier TC) when the same procedure has been billed with modifier 26 (professional component) for the same date of service. According to CMS and Humana policies, when the professional component is separately billed with LT and RT modifiers, it is not appropriate to additionally bill the global procedure. In these	All Medicare Advantage Products

		circumstances, the global procedure will be changed to the technical component.	
Place of Service Policy	Ambulance	Critical care services delivered by a physician, face-to-face, during interfacility transport of a critically ill or critically injured pediatric patient will be eligible for reimbursement only when billed in place of service 41 (ambulance, land) or 42 (ambulance, air or water). According to the AMA CPT Manual, critical care services delivered by a physician, face-to-face, during interfacility transport of a critically ill or critically injured pediatric patient will be eligible for reimbursement only when billed in an ambulance place of service.	Commercial Fully Insured, Select Self-funded*, Medicaid (Fla. and Ill.) and All Medicare Advantage Products
HCPCS – DME	Respiratory Assist Devices	When billed on the same date of service or within the same month, multiple mutually exclusive respiratory assist devices will not be eligible for reimbursement. Respiratory assist devices are mutually exclusive items. It would not be expected that more than one of these items would be billed for the same date of service or within the same month.	Commercial Fully Insured, Select Self-funded*, Medicaid (Fla. and Ill.) and All Medicare Advantage Products
HCPCS – DME	Blood Glucose Monitoring	Home blood glucose monitors will be reimbursed up to one time per date of service by any health care provider. According to CMS and Humana policies, only one home blood glucose monitor should be reimbursed per date of service.	Commercial Fully Insured, Select Self-funded*, Medicaid (Fla. and Ill.) and All Medicare Advantage Products
HCPCS – DME	Hospital Beds and Accessories	Hospital beds will be reimbursed up to one time per month. Per Humana policy, only one hospital bed may be billed per month by any health care provider.	Commercial Fully Insured, Select Self-funded*, Medicaid (Fla. and Ill.) and All Medicare Advantage Products
HCPCS – DME	Parenteral Nutrition	Parenteral pumps will be reimbursed up to one time per month. According to CMS and Humana policies, parental pumps are covered for patients for whom parenteral nutrition is covered. Only one pump (stationary or portable) will be covered at any one time. Additional pumps will not be eligible for reimbursement.	Commercial Fully Insured, Select Self-funded*, Medicaid (Fla. and Ill.) and All Medicare Advantage Products
HCPCS – DME	Osteogenesis Stimulators	Electrical osteogenesis stimulator, other than spinal, will be eligible for reimbursement only when billed with one of the following required diagnoses: • Fracture of clavicle • Fracture of humerus, radius, ulna • Fracture of metacarpal bone(s) • Fracture of femur • Fracture of tibia, fibula, ankle • Closed fracture metatarsal bone(s) • Open fracture metatarsal bone(s) • Failed fusion of a joint other than in the spine • Congenital pseudarthrosis According to CMS and Humana policies, a nonspinal electrical	Commercial Fully Insured, Select Self-funded*, Medicaid (Fla. and Ill.) and All Medicare Advantage Products

		osteogenesis stimulator is appropriate for use in the treatment of nonunion of long bone fractures, nonspinal failed fusion or congenital pseudarthrosis.	
HCPCS – DME	Pneumatic Compression Devices	Only one type of pneumatic compressor (lymphedema pump) will be eligible for reimbursement per month. Pneumatic compression devices are used for the treatment of lymphedema and, in certain instances, treatment for chronic venous insufficiency with chronic venous stasis ulcers. There are three different pumps that can be used for this treatment, each with its own distinct sleeves. Only one rental per month is appropriate.	Commercial Fully Insured, Select Self-funded*, Medicaid (Fla. and Ill.) and All Medicare Advantage Products
HCPCS – DME	Lower Limb Prostheses	Replacement sockets will not be reimbursed when billed with lower limb prosthesis or a preparatory lower limb prosthesis. According to CMS and Humana policies, replacement sockets are intended to be billed as a replacement and should not be billed at the time a lower limb prosthesis or preparatory lower limb prosthesis has been billed.	Commercial Fully Insured, Select Self-funded*, Medicaid (Fla. and Ill.) and All Medicare Advantage Products
HCPCS – DME	Eye Prostheses	Ocular prosthesis enlargement will be reimbursed up to once every five years. According to CMS and Humana policies, the reasonable useful lifetime of an ocular prosthesis is five years. One enlargement is allowed per lifetime of the prosthesis.	Commercial Fully Insured, Select Self-funded*, Medicaid (Fla. and Ill.) and All Medicare Advantage Products
HCPCS – DME	Eye Prostheses	Ocular prosthesis reduction will be reimbursed up to once every five years. According to CMS and Humana policy, the reasonable useful lifetime of an ocular prosthesis is five years. One reduction is allowed per lifetime of the prosthesis.	Commercial Fully Insured, Select Self-funded*, Medicaid (Fla. and Ill.) and All Medicare Advantage Products
HCPCS – DME	Oxygen and Oxygen Equipment	Procedures appended with modifier QE (prescribed amount of oxygen is less than 1 liter per minute) will be reimbursed at 50 percent. According to Humana policy, the monthly payment amount for stationary oxygen is subject to adjustment depending on the amount of oxygen prescribed (liters per minute) and whether portable oxygen has been prescribed.	Commercial Fully Insured, Select Self-funded*, Medicaid (Fla. and Ill.) and All Medicare Advantage Products
HCPCS – DME	Oxygen and Oxygen Equipment	Procedures appended with modifier QG (prescribed amount of oxygen is greater than 4 liters per minute) or QF (prescribed amount of oxygen exceeds 4 liters per minute (LPM) and portable oxygen is prescribed) will be reimbursed at 150 percent. According to Humana policy, the monthly payment amount for stationary oxygen is subject to adjustment depending on the amount of oxygen prescribed (liters per minute) and whether portable oxygen has been prescribed.	Commercial Fully Insured, Select Self-funded*, Medicaid (Fla. and Ill.) and All Medicare Advantage Products
HCPCS – DME	DME Quality of Care	Any procedure billed by a DME provider that is not a DME code will not be eligible for reimbursement.	Commercial Fully Insured, Select Self-funded*, Medicaid

		DME providers are limited to billing items and services that are within the scope of their practices. Any code billed by a DME provider that is not on the DME code list will not be eligible for reimbursement.	(Fla. and Ill.) and All Medicare Advantage Products
HCPCS – DME	Gradient Compression Stockings	Gradient compression stockings will be reimbursed up to eight pairs per year. According to Humana policy, gradient compression stockings are limited to up to eight pairs per year.	Commercial Fully Insured, Select Self-funded*, Medicaid (Fla. and Ill.) and All Medicare Advantage Products
HCPCS – DME	Continuous Passive Motion Devices	Continuous passive motion devices will be reimbursed up to 21 units per year. According to CMS and Humana policies, continuous passive motion devices are allowed for a total of 21 days per year.	Commercial Fully Insured, Select Self-funded*, Medicaid (Fla. and Ill.) and All Medicare Advantage Products
HCPCS – DME	Refractive Lenses, Frames and Additional Related Items	Lenses, frames and additional related items will be eligible for reimbursement only when billed with a diagnosis of pseudophakia, aphakia or congenital aphakia. According to CMS and Humana policies, lenses, associated frames and other additions are eligible only when billed with a covered diagnosis, such as pseudophakia, aphakia or congenital aphakia. Lenses or related items provided for other diagnoses are not eligible for reimbursement.	Commercial Fully Insured, Select Self-funded*, Medicaid (Fla. and Ill.) and All Medicare Advantage Products
HCPCS – DME	Transcu-taneous Electrical Nerve Stimulation (TENS)	Transcutaneous electrical nerve stimulation (TENS) device will be reimbursed only if billed with modifier RR (rental item) or NU (new equipment). According to CMS and Humana policies, TENS devices can be rented or purchased only.	Commercial Fully Insured, Select Self-funded*, Medicaid (Fla. and Ill.) and All Medicare Advantage Products
HCPCS – DME	Transcu-taneous Electrical Nerve Stimulation (TENS)	Transcutaneous electrical nerve stimulation (TENS) device will not be reimbursed when a TENS device has been billed with modifier NU (new equipment) within the previous five years by any health care provider. According to CMS and Humana policies, the useful lifetime expectancy for a TENS device is five years.	Commercial Fully Insured, Select Self-funded*, Medicaid (Fla. and Ill.) and All Medicare Advantage Products
HCPCS – DME	Transcu-taneous Electrical Nerve Stimulation (TENS)	Transcutaneous electrical nerve stimulation (TENS) device billed with modifier NU (new equipment) will be eligible for reimbursement only when a TENS device has been billed with modifier RR (rental item) within the previous 60 days by any health care provider. According to CMS and Humana policies, TENS devices can be rented or purchased only. It would not be appropriate to bill a purchased TENS device during the rental period.	Commercial Fully Insured, Select Self-funded*, Medicaid (Fla. and Ill.) and All Medicare Advantage Products
HCPCS – DME	Power Mobility Devices	Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, joystick control or tiller control, will not be reimbursed when billed. According to CMS and Humana policies, an add-on to convert a manual wheelchair to a joystick-controlled power mobility device or to a tiller-controlled power mobility device is not a medical necessity.	Commercial Fully Insured, Select Self-funded*, Medicaid (Fla. and Ill.) and All Medicare Advantage Products

HCPCS – DME	Glucose Monitors	Home blood glucose monitors or transmitter/receivers will be reimbursed up to one time per year when billed by any health care provider. According to CMS and Humana policies, home glucose monitors are limited to once per year. When more than one home glucose monitor is billed on the same date of service or within a year by any health care provider, subsequent billings will not be eligible for reimbursement.	Commercial Fully Insured, Select Self-funded*, Medicaid (Fla. and Ill.) and All Medicare Advantage Products
HCPCS – DME	Wheelchair Options/ Accessories	Wheelchair options or accessories will be reimbursed only if billed with modifier KX (requirements specified in the medical policy have been met). According to CMS and Humana policies, wheelchair options or accessories must be billed with the required modifier.	Commercial Fully Insured, Select Self-funded*, Medicaid (Fla. and Ill.) and All Medicare Advantage Products
HCPCS – DME	Oxygen and Oxygen Equipment	Oxygen equipment rental or oxygen accessories will be reimbursed only if billed with modifier RR (rental item). Per Humana policy, the rental pricing modifier (RR) is required for oxygen equipment charges.	Commercial Fully Insured, Select Self-funded*, Medicaid (Fla. and Ill.) and All Medicare Advantage Products
HCPCS – DME	Tracheostomy Care Supplies	New tracheostomy care kit will be eligible for reimbursement only when an open surgical tracheostomy has been billed in the previous three weeks. According to CMS and Humana policies, a new tracheostomy care kit is considered necessary only for the first two weeks following an open surgical tracheostomy procedure.	Commercial Fully Insured, Select Self-funded*, Medicaid (Fla. and Ill.) and All Medicare Advantage Products
HCPCS – DME	Breast Prostheses	Silicone breast prosthesis will be reimbursed up to one unit per side in a two-year period. According to CMS and Humana policies, the useful lifetime expectancy for silicone breast prostheses is two years.	Commercial Fully Insured, Select Self-funded*, Medicaid (Fla. and Ill.) and All Medicare Advantage Products