University of Michigan Health Plan

PAYMENT REIMBURSEMENT POLICY

Title: PRP-25 Durable Medical Equipment, Prosthetics, Orthotics and Supplies

Category: UMHP_PAYMENT REIMBURSEMENT (PR)

Effective Date: 10/1/2024

1.0 Guidelines:

This policy applies to all network and non-network physicians and other qualified healthcare professionals, including but not limited to percent of charge contracts physicians and other qualified healthcare professionals. This policy does not guarantee benefits or solely determine reimbursement. Benefits are determined and/or limited by an individual member's benefit coverage document (COC, SPD, etc.). The Health Plan reserves the right to apply clinical edits to all medical claims through coding software and accuracy of claim submission according to industry billing standards. Clinical edits are derived from nationally recognized billing guidelines such as the Centers for Medicare and Medicaid Services (CMS), National Correct Coding Initiative (NCCI), the American Medical Association (AMA), and specialty societies. The Plan may leverage the clinical rationale of CMS or other nationally sourced edits and apply this rationale to services that are not paid through CMS, but which are covered by the Plan to support covered benefits available through one of the Plan's products. Prior approval does not exempt adherence to the following billing requirements. The provider contract terms will take precedence if there is a conflict between this policy and the provider contract.

2.0 Description:

The Health Plan provides coverage for medically necessary Durable Medical Equipment (DME), medical supplies, orthotics and prosthetics as defined in the member coverage document. The purpose of this reimbursement policy is to provide billing and reimbursement guidelines regarding durable medical equipment, medical supplies, orthotics, and prosthetics.

3.0 Policy:

This policy applies to professional billing of Durable Medical Equipment, Medical Supplies, Orthotics, and Prosthetics as determined to be medically necessary for the treatment of an illness or injury.

4.0 Coding and Billing:

DME suppliers and other qualified health professionals that dispense DME items must report the appropriate HCPCS level II codes and any applicable modifier, on claim.

Rental vs Purchase

Some DME items are eligible for rental as well as for purchase, while others may only be eligible for rental. DME rental fees will cover the cost of maintenance, repairs, replacement, supplies and accessories. Equipment delivery services and set-up, education and training for patient and family, and nursing visits, are not eligible for separate reimbursement. Total reimbursement of fees reported for a single code (appended with modifier RR and/or NU) from a single vendor is limited to either the purchase price of the item or a maximum number of rental months, whichever is less. These rental limits do not apply to oxygen equipment or to ventilators.

Capped Rentals

The Health Plan aligns with Centers for Medicare and Medicaid Services (CMS) guidelines for “capped rental” items. Items in the “capped rental” category are paid on a monthly rental

basis not to exceed a period of continuous use of 13 months, unless otherwise specified in the provider agreement. At that time (end of 13-month rental) ownership of the equipment passes to

the member and no further payments will be made towards that item by the Health Plan. Items that are eligible for a “capped rental” are assigned a “CR” designation on the CMS DMEPOS fee schedule.

Modifiers

Rental Modifier

The following modifiers indicate that an item has been rented:

- RR Rental (use the 'RR' modifier when DME is to be rented) *
- KH Initial claim, purchase, or first month rental*
- KI Second or third-month rental*
- KJ Parenteral enteral nutrition (pen) pump or capped rental, months four to fifteen*
- KR Rental item, billing for a partial month

Purchase Modifiers

The following modifiers indicate that an item has been purchased:

- NU New equipment*
- UE Used durable medical equipment
- NR New when rented (use the 'nr' modifier when DME which was new at the time of rental is subsequently purchased)
- KM Replacement of facial prosthesis including new impression/moulage
- KN Replacement of facial prosthesis using previous master model

Modifier RT (right side) and Modifier LT (left side)

RT and LT modifiers are appropriate for certain HCPCS codes.

- These modifiers are used to identify the side of the body that DME item will be applied to
- The right (RT) and left (LT) modifiers must be used when billing two of same item or accessory on the same date of service and the items are being used bilaterally.

*Pricing modifiers must be applied to the first modifier position

Medically Unlikely Edit (MUE)

The Health Plan aligns with the CMS published DME Medically Unlikely Edit (MUE) unit limitations for Durable Medical Equipment, Prosthetics, Orthotics and Supplies as a minimum standard. In some instances, PHP may allow for units greater than the CMS DME MUE maximum.

Non-Covered Services

- PHP will not separately reimburse for the delivery, set-up and/or dispensing service component of another HCPCS code (i.e., A9901).
- Excluded services as defined in the member coverage document.

Date of Service

The DOS for DME delivered in-person to a beneficiary is the date the beneficiary received the DME. If the DME is mailed or shipped to the beneficiary, then the DOS is either the shipping date or date of delivery.

Place of Service

Per the Centers for Medicare & Medicaid Services (CMS), for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) claims, the place of service (POS) is the place where the beneficiary will primarily use the DMEPOS item. Appropriate places of service include

- 12 - Home
- 13 - Assisted Living Facility
- 14 - Group Home
- 33 - Custodial Care Facility
- 54 - Intermediate Care Facility
- 55 - Residential Substance Abuse Treatment Facility
- 56 - Psychiatric Residential Treatment Center
- 65 - End Stage Renal Disease (ESRD) Treatment Facility (valid POS for Parenteral Nutritional Therapy)

The Health Plan also allows for POS 11- office, to be reported when covered services are dispensed in the office setting. If an item is not billed with an appropriate place of service code, the service will be denied. Coverage consideration for DMEPOS items in a Skilled Nursing Facility (31) unless the beneficiary is in a covered inpatient stay, or a Nursing Facility (32) is limited to specific items and supplies.

DME Repairs & Replacements

Coverage of DME repairs is based on member benefit document plan conditions. Billing of repair time must be reported with K0739 for equipment other than oxygen equipment and K0740 for repair of oxygen equipment requiring the skill of a technician in one-unit increments per 15 minutes of labor.

Unlisted Codes

Unlisted codes such as E1399 and K0108 should only be reported when there is no other HCPCS code that represents the item(s) provided. Please see PHP PRP-03 Unlisted CPT-HCPCS Codes for additional information and documentation requirements.

5.0 Documentation Requirements:

Prescription/Order

An order is required to be on file for DME, Prosthetics, Orthotics and Supplies. Orders must be from a licensed provider that has evaluated the patient. Complete order must be available for review if requested and include the date of or date prior to the service but within 365 days of service, description of service/item, and signature.

Proof of Delivery:

The Health Plan follows CMS proof of delivery documentation guidelines for verification of coding and receipt of billed items. Proof of delivery may be requested for any supply items not considered a professional service.

- Complete proof of delivery must identify the supplier, date of delivery, name of recipient/patient, detailed description that identifies the item(s) delivered, and signature.
- The date of service on the claim must match the date on the signed proof of delivery.
- Recognized delivery methods include delivery to the member/patient or authorized representative directly (pick-up), shipping or delivery service, or delivery to the home/nursing facility.
- Proof of delivery must be documented, including deliveries directly to the patient, picked-up, or shipped. Documentation must include detailed description of the item(s) being delivered, the date of delivery/receipt, signature/tracking number, and a clearly identifiable delivery method.
- Proof of delivery for items shipped using a delivery service such as FedEx or USPS with a tracking number must include an invoice with item descriptions and a matching tracking number. The tracking number alone will be considered insufficient proof of delivery.

6.0 Verification of Compliance:

Claims are subject to audit, prepayment and post payment, to validate compliance with the terms and conditions of this policy. Pre-payment editing applied by the Health Plan, includes but not limited to MUE Limits, missing/invalid modifiers, NCCI edits, procedure to diagnosis mismatch, and Plan policy.

7.0 Terms & Definitions:

Calendar Month: A Calendar Month is the period of duration from a day of one month to the corresponding day of the next month and is determined based on the "From" date reported on the claim. If a code is submitted with modifier RR and/or modifiers KH, KI, KJ, KR with units greater than 1, or multiple times during the same Calendar Month, the Health Plan will only reimburse one unit.

Cost: The cost to the provider to purchase the item from the seller. This includes application of rebates, refunds, discounts, or any other priced reductions given to the provider at the time of invoicing that reduces the retail price.

Durable Medical Equipment (DME): Equipment and related health items or services that are ordered by a health care provider for everyday or extended use, able to withstand repeated use; medically necessary, and not generally useful in the absence of illness or injury.

Invoice: Billing receipt of the cost for a billable item such as a drug, supplies, or implantable device. This record of receipt must include the name of the supplier, the purchaser, the patient or patient identifier, item/supply description, the date of invoice, units billed, cost per line item, total cost, and discounts if applicable.

Orthotic: An external appliance such as a brace or splint that prevents or assists movement of the spine or limbs. A brace is used for the purpose of supporting a weak or deformed body part of a customer or restricting or eliminating motion in a diseased or injured part of the body.

Medical Supplies: Article that is intended for diagnosis, treatment, mitigation or prevention of a disease, disorder, abnormal physical or mental state, or symptoms. This includes but is not limited to items such blood glucose strips, ostomy pouch, skin barrier, tubing, and continue positive airway pressure device mask.

Prosthetic: A device that replaces all or part of an external body organ or all or part of the function of a permanently inoperative or malfunctioning external body organ.

Unlisted HCPCS Codes: Represents an item, service, or procedure for which there is no specific CPT or Level II alphanumeric HCPCS code.

8.0 References, Citations, Resources & Associated Documents:

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

CMS Internet Only Manual (IOM), Publication 100-04, Medicare Claims Processing Manual, Chapter 20

PRP-03 Unlisted CPT-HCPCS Codes

PRP-05 Medical Record Request Standards

PRP-13 Oral Sleep Apnea Device EO485, E0486

9.0 Revision History:

Original Effective Date:

Next Revision Date: 12/18/2025

10.0 Document Evaluation Panel:

Revision Date	Reason for Revision