

Durable Medical Equipment

Introduction

Purpose

The purpose of this module is to provide an overview of Durable Medical Equipment (DME) and program coverage.

Module Objectives

- Discuss changes in Medi-Cal
- Understand *Treatment Authorization Request* (TAR) requirements
- Discuss oxygen services
- Identify “By Report” attachment requirements
- Understand repair and maintenance policy
- Prevent common denials

Resource Information

Medi-Cal Subscription Service (MCSS)

MCSS is a free subscription service that enables providers and others interested in Medi-Cal to receive subject-specific links to Medi-Cal news, *Medi-Cal Update* bulletins, urgent announcements and/or System Status Alerts via email. For more information and subscription instructions, visit the MCSS Subscriber Form at (www.medi-cal.ca.gov/mcss).

Provider Manual References

The following reference materials provide Medi-Cal billing and policy information:

Part 2

Durable Medical Equipment (DME): An Overview (dura)

Durable Medical Equipment (DME): Bill for DME (dura bil dme)

Durable Medical Equipment (DME): Bill for Oxygen and Respiratory Equipment (dura bil oxy)

Durable Medical Equipment (DME): Bill for Wheelchairs and Wheelchair Accessories (dura bil wheel)

Durable Medical Equipment (DME) Billing Codes: Frequency Limits (dura cd fre)

Durable Medical Equipment (DME): Billing Examples (dura ex)

Durable Medical Equipment (DME): Wheelchair and Wheelchair Accessories Guidelines (dura wheel guide)

ICD-10 Implementation Billing Guide

The *ICD-10 Implementation Billing Guide* can be found on the ICD-10 page of the Medi-Cal website (www.medi-cal.ca.gov).

Acronyms

A list of current acronyms is located in the *Appendix* section of this workbook.

Program Coverage

Medi-Cal covers DME when provided on a written prescription of a licensed practitioner, within the scope of the practitioner's practice, as defined by California laws.

The Medi-Cal definition of medical necessity limits health care services to those necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. Therefore, prescribed DME items may be covered as medically necessary only to preserve bodily functions essential to activities of daily living or to prevent significant physical disability.

NOTE

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

Nursing Facility Coverage

Canes, crutches, wheelchairs and walkers for Nursing Facility (NF) Level A and B recipients are only separately reimbursable when the item must be custom-made or modified to meet the unusual need of the recipient and the need is expected to be permanent.

DME Policies and Clarifications

2016 Policies

- New codes and deleted codes: when a code is no longer valid and a TAR is required, providers must send in a new TAR with the new code
 - New ventilator codes as of October 1, 2016
- Changes are date-of-service driven
- NCCI – National Correct Coding Initiative
- Medi-Cal must follow Medicare frequency limits
- New wheelchair coverage criteria to provide clarification for wheelchairs and applicable seating and positioning components

Policy Clarification and Changes

Wheelchairs and Accessories

A new section regarding wheelchairs and wheelchair accessories, *Durable Medical Equipment (DME): Wheelchair and Wheelchair Accessories Guidelines* (dura wheel guide), has been added to the Part 2 provider manual. For required information for wheelchairs on TARs, refer to the *Durable Medical Equipment (DME): Bill for Wheelchairs and Wheelchair Accessories* (dura bil wheel) section in the appropriate Part 2 provider manual.

Rental Reimbursement Cap Is Approved

When previously paid rental charges equal the maximum allowable purchase price of the rented item, the item is considered to have been purchased and no further reimbursement to the provider shall be made unless repair or maintenance of the item is separately authorized. When the Department of Health Care Services (DHCS) determines it is medically necessary to purchase an unlisted item of Durable Medical Equipment that had been rented for a Medi-Cal patient, DHCS and the provider shall determine the purchase price and the amount of the rental charges that may be applied to the purchase price.

Fixed Height Hospital Bed

Recipients must meet at least one of the following criteria for fixed height hospital beds:

- Positioning of body is not feasible in non-hospital beds.
- Recipient needs promotion of body alignment to prevent contractures and has a history of contractures or a documented medical condition that causes risk of contractures.
- Recipient needs alleviation of pain with a documented history of such pain related to positioning.
- Recipient needs avoidance of respiratory infections with a documented history of respiratory infection related to positioning.
- Recipient needs elevation of the head of the bed more than 30 degrees due to certain medical conditions such as congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD) or documented history of aspiration.
- Recipient needs use of special attachments or traction equipment.

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Portable Ramps

A fixed, modular or in any way attached ramp is considered a non-portable ramp and is not a Medi-Cal benefit. Portable ramps are those that are foldable or collapsible, not attached, suitcase types, which can be easily and readily carried and transported by the recipient for use in multiple locations. The portable ramp usually weighs no more than 90 pounds or measures no more than 10 feet in length.

Shipping and Handling

Shipping and handling costs for Durable Medical Equipment and Orthotics and Prosthetics (O&P) are not reimbursed by Medi-Cal.

Date of Service

The delivery date of the DME equipment to a recipient is the date of service. This means that when the recipient receives the DME item delivered by the provider, that date is considered the date of service.

NOTES

Product Classification

Medi-Cal approximates Medicare's product classification and equipment policies on coverage for medical equipment.

Topic	Website Location
Local Medical Review Policies	www.noridianmedicare.com www.dmepac.com

Code Frequency Limits

- Frequency limits for each code are listed in the *Durable Medical Equipment (DME) Billing Codes: Frequency Limits* section (dura cd fre) of the Part 2 provider manual.
- Service Authorization Requests (SARs), TARs and/or a CCS authorization can override these limits.
- Limits cannot be exceeded on the same date of service even with an authorization. The provider must submit the claim with different dates of service.

Warranties

- It is the provider's responsibility to check all warranties on a piece of equipment. If the equipment is still under warranty, the provider must work with the manufacturer for replacement or repair of that item at no charge to the Medi-Cal program.
- Pursuant to CCR, Title 22, Section 51321 (i) and (j), rendering providers of DME shall ensure that all devices and equipment are appropriate to meet the recipient's medical needs. Providers shall instruct recipients in appropriate use and care of DME and notify recipients that they are responsible for appropriate use and care of DME purchased for their use under the Medi-Cal program. If a piece of equipment or a device when in actual use fails to meet the recipient's needs, and the recipient's medical condition has not significantly changed since the device/equipment was dispensed, the rendering provider shall adjust or modify the equipment, as necessary, to meet the recipient's needs. The rendering provider, at no cost to the Medi-Cal program, shall replace any equipment or device that cannot be adjusted or modified.

Reimbursement Limit – Upper Billing Limit

Reimbursement for DME is subject to the Upper Billing Limit defined in CCR, Title 22, Section 51008.1. Bills submitted are not to exceed an amount that is the lesser of:

- The usual charges made to the general public, or
- The net purchase price of the item, which must be documented in the provider's books and records, plus no more than a 100 percent markup

For procedure codes that have a listed maximum allowable DME purchase billing amount, the amount billed should not exceed the net purchase price of the item, plus 100 percent markup.

CCS-Only Benefits

The following Healthcare Common Procedure Coding System (HCPCS) codes are not Medi-Cal benefits and must be approved through the California Children's Services (CCS) branch for children younger than 21 years of age. See the *Durable Medical Equipment (DME): Billing Codes for California Children's Services* section (dura cd ccs) in the appropriate Part 2 provider manual for a complete list.

Code	Description
E0482	Cough stimulating device, alternating positive and negative airway pressure
E0635	Patient lift, electric, with seat or sling
E0639	Patient lift, movable from room to room with disassembly and reassembly, includes all components/accessories

If a Medi-Cal recipient requires one of the above items, use the appropriate code when submitting a request to the Medi-Cal field offices. If an age restriction exists, a TAR may override it.

Billing

DME Modifiers

Modifier	Description
NU	New equipment
RR	Rental
RB	Replacement as part of repair
KC	Replacement of special power wheelchair interface
QE	Prescribed amount of oxygen is less than one liter per minute (LPM)
QF	Prescribed amount of oxygen exceeds four LPM and portable oxygen is prescribed
QG	Prescribed amount of oxygen is greater than four LPM (and portable oxygen is <u>not</u> prescribed)
SC	Medically necessary service or supply (used for second unit of oxygen content)
LT	Left Side
RT	Right Side

Tax

When billing for an unlisted code that is "By Report," indicate whether or not the item is taxable in the *Additional Claim Information* field (Box 19) of the *CMS-1500* claim form or on an attachment. When using a listed code with an allowable rate, the system will pay the tax, if applicable.

Rentals

All accessories are included in the rental reimbursement. Billing separately for accessories while billing for the rental will cause the accessories to deny or the amount to deduct from the rental. The accessories may be reimbursed separately after the recipient owns the piece of equipment.

Authorization Requirements

Authorization is required under the following circumstances:

- Cumulative cost within the calendar month for purchase of DME within a group exceeds \$100.00
- Cumulative cost within a 15-month period for rental of DME within a group exceeds \$50.00
- Respiratory equipment and accessories require authorization regardless of dollar amount
- Cumulative cost within the calendar month for repair or maintenance exceeds \$250.00
- Request is for any unlisted or "By Report" item, regardless of dollar amount

Prescriptions

The following must be supplied with the prescription for DME rental or purchases:

- Full name, address, telephone number and license number of prescribing practitioner
- Date of prescription
- Items being prescribed
- Medical condition necessitating the particular DME item
- Estimated length of need

Certificates of Medical Necessity

Certificates of Medical Necessity are available online and in the appropriate Part 2 provider manual.

- Respiratory
 - Apnea monitors – MC 4600
 - Nebulizers – MC 4601
 - Oxygen – MC 4602
- DME Equipment
 - Non-wheelchairs – DHCS 6181
- Wheelchairs
 - Manual wheelchairs – DHCS 6181A
 - Power wheelchairs – DHCS 6181B
 - Power Operated Vehicles (POVs) – DHCS 6181C

TARs

The following items must be included on the TAR. See the *TAR Completion* (tar comp) section in the appropriate Part 2 provider manual for a complete list:

- Date of request
- Recipient's address
- HCPCS code and item description
- Justification for using an unlisted code
- Copy of prescription
- Medical necessity documentation for item being requested
- If a "By Report" item, attach appropriate Manufacturer's Suggested Retail Price (MSRP) catalog page
- Rendering provider and contact information (name and phone number)

Documentation Requirements

Documentation submitted with the TAR for wheelchairs must include the following:

- The mobility and seating impairment to be accommodated
- Equipment currently owned by the recipient, detailed features of the DME item and the date of purchase
- Verification and documentation that other treatments of lesser mobility devices do not safely accommodate the recipient's mobility impairment
- Verification and documentation that the requested equipment fits and is usable in all living areas used by recipient
- An explanation describing how the living areas will be accessed by the recipient with the requested equipment
- Verification and documentation that the recipient and/or caregiver understands how to care for and use the requested equipment
- Seating evaluation by a qualified therapist/Assistive Technology Professional (ATP) for the following:
 - Neurological conditions
 - Complex orthopedic along with neurological conditions
 - Pediatric wheelchairs

Refer to the *Durable Medical Equipment (DME): Bill for Wheelchairs and Wheelchair Accessories* (dura bil wheel) section in the appropriate Part 2 provider manual for information.

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Bundle all accessories with the basic piece of equipment under the main code. For example:

- Gait trainers: Codes E8000 – E8002
- Bath bench: Code E0240
- Standing frames: Codes E0630, E0641 and E0642
- Position seat: Code T5001

Do not use the main code and then add all accessories under code E1399 (durable medical equipment, miscellaneous). This can cause problems when billing the claim.

The information on the invoice must match the information on the MSRP catalog page.

NOTES

Equipment

New Ventilator Codes

These codes replace the previous ventilator codes, effective October 1, 2016.

- E0465: Home ventilator, any type, used with invasive interface
- E0466: Home ventilator, any type, used with non-invasive interface

Oxygen/Respiratory Therapy

Reimbursement for listed oxygen therapy service codes will not exceed 80 percent of the California Medicare reimbursement rates.

A TAR/SAR is required for all respiratory DME except for the following:

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

Portable Oxygen

Code E0443: Oxygen Contents (Gas)

Portable oxygen contents, gaseous (for use only with portable gaseous systems when no stationary gas or liquid system is used), a one-month supply = one unit.

- For Medi-Cal purposes, code E0443 can be used to bill for portable gaseous oxygen contents, whether the portable system is rented or purchased.

NOTE

One unit is defined as “250 cubic feet” for the first supply of contents and any amount for the second supply of contents (second unit).

- 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 two units is allowed per month.

For example:

E0443NU	quantity of 1
E0443SC	quantity of 1

Code E0444: Oxygen Contents (Liquid)

Portable oxygen contents, liquid (for use only with portable liquid systems when no stationary gas or liquid system is used), a one-month supply = one unit.

- For Medi-Cal purposes, code E0444 can be used to bill for portable liquid oxygen contents whether the portable system is rented or purchased.
- 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 two units is allowed per month.

NOTE

One unit is defined as “110 pounds” for the first supply of contents and any amount for the second supply of contents (second unit).

For example: E0444NU quantity of 1
 E0444SC quantity of 1

- Only two units can be approved per month. A TAR/SAR will not override this limit.

Oxygen Specific Modifiers

Rented Equipment

Modifier	Oxygen Flow Rate	Reimbursement Rate
RR	1 – 4 LPM	\$144.74
QE	< 1 LPM	\$72.37 <i>(reduced by 50 percent)</i>
QF	> 4 LPM Portable oxygen is prescribed	\$217.11 <i>(increased by 50 percent)</i>
QG	> 4 LPM Portable oxygen is <u>not</u> prescribed	\$217.11 <i>(increased by 50 percent)</i>

Use only one modifier when billing with the above modifiers. Multiple modifiers will result in a denied claim.

For example: E1390RR
 E1390QG

NOTES

Wheelchairs

Claim Requirements for “By Report” Wheelchairs

Claims must include the information about the technician involved in the evaluation, delivery and final fitting of the wheelchair. In the *Additional Claim Information* field (Box 19) or by attachment, include the following:

- The first and last name of the technician
 - The title of the technician. Acceptable titles include:
 - Rehabilitation Engineering and Assistive Technology Society of North America (RESNA)-certified technician
 - Certified Rehabilitation Technology Supplier (CRTS)
 - Licensed California physical therapist (PT)
 - Licensed California occupational therapist (OT)
- For example: Box 19 – Tom Smith, RESNA

Reimbursement Conditions

Reimbursement will be the lesser of:

- 85 percent of MSRP catalog dated on or prior to the date of service, or
- Manufacturer’s invoice, plus 67 percent markup, or
- The billed amount

If the claim does not provide documentation that the provider employs or contracts with a qualified rehabilitation professional, reimbursement will be the lesser of:

- 80 percent of MSRP catalog dated on or prior to the date of service, or
- Manufacturer’s invoice, plus 67 percent markup, or
- The billed amount

Claim Requirements for Unlisted DME Non-Wheelchairs

Reimbursement Conditions

Reimbursement will be the lesser of:

- 80 percent of MSRP catalog dated on or prior to the date of service, or
- Manufacturer’s invoice plus 67 percent markup, or
- The billed amount

Claim Requirements for Unlisted DME Supply HCPCS “A” Codes

Claims must include the following information to receive reimbursement:

- In the *Additional Claim Information* field (Box 19), a statement that the equipment is “patient owned” and either the description of the equipment or the procedure code of the owned equipment must be included.

For example: Patient-owned nebulizer with compressor E0570

Reimbursement Conditions

Reimbursement will be the lesser of:

- Manufacturer’s purchase invoice, plus a 23 percent markup, or
- The billed amount

“By Report” Attachment Exceptions

- For custom-made equipment with no MSRP available, submit the manufacturer’s purchase invoice. If the invoice does not indicate that the item is “custom,” handwrite a statement on the invoice “custom and no MSRP available.”
- If there is no MSRP available for the item billed, submit the manufacturer’s invoice and explain the lack of MSRP.
- If the provider is renting the piece of equipment from another provider or manufacturer, and unable to purchase, submit the rental invoice showing the rental cost and the appropriate MSRP catalog page.
- When the provider and the manufacturer are the same, attach the MSRP or catalog page with the appropriate date.

Approved attachments for DME claims

- MSRP catalog page dated on or prior to the date of service
- Manufacturer’s invoice dated prior to the date of service
- Manufacturer quotes if MSRP is not available along with a manufacturer purchase invoice
- Manufacturer’s invoice dated prior to date of service, with MSRP on the same page

Equipment Repair/Maintenance

- Medi-Cal only repairs equipment owned by the Medi-Cal patient
- Labor codes:
 - K0739: all equipment except oxygen/respiratory equipment
 - K0740: oxygen/respiratory equipment
- Do not use a modifier with the labor code
- Bill the labor time needed to accomplish the work in 15-minute units. The labor time may be rounded to the nearest half-hour for the total repair job.

For example: 1 hour and 20 minutes = 6 units

- Hourly labor payment rate for DME repair is \$65.88 (one 15-minute “unit” is \$16.47)

Patient-Owned Equipment

Wheelchairs

Claims for the repair of wheelchairs (modifiers RB and NU) require the following information:

- In the *Additional Claim Information* field (Box 19) provide a description of the equipment and that the equipment is patient-owned.

For example: Box 19: Repair of patient-owned manual wheelchair
K0005 (ultralightweight wheelchair).

- Use modifiers RB and NU for replacement of wheelchair parts.

For example: E2211RBNU Pneumatic tires
K0739 Labor

Non-Wheelchairs

Claims for the repair of non-wheelchair equipment (modifier RB) require the following information:

- Box 19: Statement that the equipment is owned by the patient, e.g. "Repair of patient-owned patient lift E0630"
- Description of service provided
- Reason/justification for repair
- Manufacturer's name
- List of parts used, including catalog numbers and cost for "By Report" items

For example: E0630RB Patient Lift
K0739 Labor

Oxygen/Respiratory

Claims for repair of oxygen/respiratory equipment (modifier RB), require the following information.

- Box 19: Statement that the respiratory equipment is owned by the patient, e.g. "Repair of patient-owned continuous positive airway pressure (CPAP) – E0601"
- Description of service provided
- Reason/justification of repair
- Manufacturer's name
- List of parts used, including catalog numbers and cost for "By Report" items

For example: E0601RB CPAP
K0740 Labor

DME Common Denials

Remittance Advice Details

Code	Description
0002	The recipient is not eligible for benefits under the Medi-Cal program or other special programs.
0005	The service billed requires an approved TAR (<i>Treatment Authorization Request</i>).
0225	Incorrect procedure code and/or modifier.
9654	Copy of both MSRP catalog and manufacturer's invoice are required.
9098	The attached documentation is invalid.
9713	Date on catalog or invoice is missing or invalid.
9598	Statement of "patient owned" and specific procedure code or description is missing.
9719	Amount paid by the provider is zero, no payment due.
9702	Procedure code is not payable without an invoice.
9051	Indicate the quantity per box/es on the invoice.
9217	Indicate a line number next to the catalog numbers or line on the invoice.
9019	Information on the claim does not match what is being billed.
9056	Indicate poor control, if trainable, and if for home use.
9942	NCCI (National Correct Coding Initiative) quantity billed is greater than the allowed MUE (Medically Unlikely Edit) quantity.

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