Chapter 1 Section 11

Claims For Durable Equipment (DE) And Durable Medical Equipment, Prosthetics, Orthotics, And Supplies (DMEPOS)

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Authority: 32 CFR 199.4(d)(3)(ii), (d)(3)(iii), (d)(3)(vii), and (d)(3)(viii)
Revision:

1.0 APPLICABILITY

1.1 This policy is mandatory for DE, such as wheelchairs, iron lungs, and hospital beds.

1.2 This policy is mandatory for reimbursement of DMEPOS provided by either network or non-network providers. Alternative network reimbursement methodologies are also permitted when approved by the Defense Health Agency (DHA) and specifically included in the network provider agreement.

2.0 ISSUE

How are claims for DE and DMEPOS to be reimbursed?

3.0 POLICY

3.1 Reimbursement for DE and DMEPOS is established by fee schedules. The fee schedule is referred to, all-inclusively, as the DMEPOS fee schedule. The maximum allowable amount is limited to the lower of the billed charge, the negotiated rate (network providers) or the DMEPOS fee schedule amount.

3.2 The DMEPOS fee schedule is categorized by state. The allowed amount shall be that which is in effect in the specific geographic location at the time covered services and supplies are provided to a beneficiary. For DMEPOS delivered to the beneficiary's home, the home address is the controlling factor in pricing and the home address shall be used to determine the DMEPOS allowed amount.

3.3 Payment for an item of DE/Durable Medical Equipment (DME) may also take into consideration:

3.3.1 The lower of the total rental cost for the period of medical necessity or the reasonable purchase cost; and

3.3.2 Delivery charge, pick-up charge, shipping and handling charges, and taxes.

3.4 The fee schedule classifies most items into one of six categories.

3.4.1 Inexpensive or other routinely purchased DE/DME.

3.4.2 Items requiring frequent and substantial servicing.

3.4.3 Customized items.

3.4.4 Other prosthetic and orthotic devices.

3.4.5 Capped rental items.

3.4.6 Oxygen and oxygen equipment.

3.5 Inexpensive or routinely purchased DE/DME.

3.5.1 Payment for this type of equipment is for rental or lump sum purchase. The total payment may not exceed the actual charge of the fee for a purchase.

3.5.2 Inexpensive DE/DME. This category is defined as equipment whose purchase price does not exceed $150.

3.5.3 Other routinely purchased DE/DME. This category consists of equipment that is purchased at least 75% of the time.

3.5.4 Modifiers used in this category are as follows (not an all-inclusive list):

RR Rental

NU Purchase of new equipment. Only used if new equipment was delivered.

UE Purchase of used equipment. Used equipment that has been purchased or rented by someone before the current purchase transaction. Used equipment also includes equipment that has been used under circumstances where there has been no commercial transaction (e.g., equipment used for trial periods or as a demonstrator).

3.6 Items requiring frequent and substantial servicing.

3.6.1 Equipment in this category is paid on a rental basis only. Payment is based on the monthly fee schedule amounts until the medical necessity ends. No payment is made for the purchase of equipment, maintenance and servicing, or for replacement of items in this category.

3.6.2 Supplies and accessories are not allowed separately.

3.6.3 For oxygen and oxygen supplies see Section 12 and the TRICARE Policy Manual (TPM), Chapter 8, Section 10.1.

3.7 Certain customized items.

3.7.1 The beneficiary's physician must prescribe the customized equipment and provide information regarding the patient's physical and medical status to warrant the need for the equipment.

3.7.2 See the TPM, Chapter 9, Section 15.1 for further information regarding customization of DME.

3.8 Capped rental items. Items in this category are paid on a monthly rental basis not to exceed a period of continuous use of 15 months or on a purchase option basis not to exceed a period of continuous use of 13 months.

3.9 Upgrade DE/DME (Deluxe, Luxury, or Immaterial Features).

3.9.1 The allowable charge for standard equipment or item of DE/DME may be applied toward any upgraded item, when the beneficiary chooses to upgrade a covered DE/DME, to include additional features that are intended primarily for comfort or convenience, or features beyond those required by the beneficiary's medical condition. Under this arrangement, charges for an upgraded DE/DME are the sole responsibility of the beneficiary. Beneficiary's cost-shares and deductible will apply to the basic DE/DME.

3.9.2 The DE/DME provider is to identify non-payable upgrades to DE/DME using the appropriate Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) modifiers.

Example: A beneficiary requests an upgrade DE/DME - the DE/DME provider bills beneficiary for non-payable upgrade, modifier **GA** on first line for item that is provided and modifier **GK** on second line for item that is covered. TRICARE cost-shares medically necessary item only (**GK** line item). The claim line with **GA** modifier will be denied as not medically necessary with the beneficiary responsibility (**PR**) message on the Explanation of Benefits (EOB). The claim line with the **GK** modifier will continue through the usual claims processing.

3.9.3 When the beneficiary upgrades an item of DE/DME, the upgrade charge is not managed by TRICARE, but calculated by the provider or supplier issuing the equipment. As a result, upgraded charges, clerical or calculation errors in connection with the upgraded equipment are not subject to appeal but are subject to administrative review by the contractor upon request from the beneficiary.

Note: The upgrade charge is the difference between the provider's or supplier's charge for the deluxe or upgraded item, and the allowable charge amount for the "covered" (standard) item.

3.9.4 Upgraded items of DE/DME do not count toward the beneficiary's catastrophic cap. However, the beneficiary's responsibility for the standard DE/DME equipment will count towards the catastrophic cap. Charges for deluxe or upgraded items are the beneficiary's responsibility even after the out-of-pocket maximum has been met for covered services.

3.10 Rental fee schedule.

3.10.1 For the first three rental months, the rental fee schedule is calculated so as to limit the monthly rental of 10% of the average of allowed purchase prices on claims for new equipment during a base period, updated to account for inflation. For each of the remaining months, the monthly rental is

limited to 7.5% of the average allowed purchase price. After paying the rental fee schedule amount for 15 months, no further payment may be made except for payment for maintenance and servicing.

3.10.2 Modifiers used in this category are as follows:

RR Rental
KH First month rental
KI Second and third month rental
KJ Fourth to fifteenth months
BR Beneficiary elected to rent
BP Beneficiary elected to purchase
BU Beneficiary has not informed supplier of decision after 30 days
MS Maintenance and Servicing
NU New equipment
UE Used equipment

3.10.3 Claims Adjudication Determinations.

3.10.3.1 Adjudication of DE/DME claims involves a two-step sequential process involving the following determinations by the contractor:

Step 1: Whether the equipment meets the definition of DE/DME, is medically necessary, and is otherwise covered; and

Step 2: Whether the equipment should be rented or obtained through purchase (including lease/purchase). To arrive at a determination, the following information is required:

- A statement of the patient's prognosis and the estimated length of medical necessity for the equipment.
- The reasonable monthly rental charge.
- The reasonable purchase cost of the equipment.
- The contractor must determine whether, given the estimated period of medical necessity, it would be more economical and appropriate for the equipment to be rented or purchased.

3.10.3.2 If the beneficiary opts to rent/purchase, the contractor must establish a mechanism for making regular monthly payments without requiring the claimant to submit a claim each month. (It is not required or expected that the contractor will automate the automatic payment; the volume of this type claim will be quite low.) In cases of "indefinite needs," medical necessity must be evaluated after the first three months and every six months thereafter. Special care should be taken to avoid payment after termination of TRICARE eligibility or in excess of the total allowable benefit. In making monthly payments, the contractor will report on the TRICARE Encounter Data (TED) only that portion of the billed charge which is applicable to that monthly payment. (See the TRICARE Systems Manual (TSM),

Chapter 2.) For example, a wheelchair is being purchased for which the total charge is $770. The contractor determines that payments will be made over a 10-month period. The allowed charge is $600. The contractor will show the monthly billed charge as $77 and $60 as the allowed.

3.10.4 Notice To Beneficiary. When the contractor makes a determination to rent or purchase, the beneficiary shall be notified of that determination. The beneficiary is not required to follow the contractor's determination. He or she may purchase the equipment even though the contractor has determined that rental is more cost effective. However, payment for the equipment will be based on the contractor's determination. Because of this, the notice should be carefully worded to avoid giving any impression that compliance is mandatory, but should caution the beneficiary concerning the expenses in excess of the allowed amount. Suggested wording is included in Addendum B.

3.11 Oxygen and oxygen equipment. Oxygen and oxygen equipment is to be reimbursed in accordance with Section 12.

3.12 Parenteral/enteral nutrition therapy. Parenteral/enteral pumps can be either rented or purchased.

3.13 Splints and Casts. The reimbursement rates for these items of DMEPOS shall be based on Medicare's pricing.

3.14 Reimbursement Rates.

3.14.1 The DMEPOS pricing information is available at http://www.health.mil/rates and the claims processors are required to replace the existing pricing with the updated pricing information within 10 calendar days of publication on the Internet.

3.14.2 The pricing for splints and casts is available at http://www.health.mil/rates and will be updated annually.

3.14.3 See the TRICARE Operations Manual (TOM), Chapter 1, Section 4 regarding updating and maintaining TRICARE reimbursement systems.

3.15 Inclusion or exclusion of a fee schedule amount for an item or service does not imply any TRICARE coverage.

3.16 Extensive maintenance which, based on manufacturer recommendations, must be performed by authorized technicians is covered as medically necessary. This may include breaking down sealed components and performing tests that require specialized testing equipment not available to the beneficiary. Maintenance may be covered for patient owned-DME when such maintenance must be performed by an authorized technician.

3.17 Replacement and Repair of DMEPOS. The following modifiers are to be used to identify repair and replacement of an item.

3.17.1 RA - Replacement of an item. The RA modifier on claims denotes instances where an item is furnished as a replacement for the same item which has been lost, stolen, or irreparable damaged.

3.17.2 RB - Replacement of a part of DME furnished as part of a repair. The RB modifier indicates replacement parts of an item furnished as part of the service of repairing the item.

4.0 EXCLUSIONS AND LIMITATIONS

4.1 A cost that is non-advantageous to the Government shall not be allowed even when the equipment cannot be rented or purchased within a "reasonable distance" of the beneficiary's current address. The charge for delivery and pick up is an allowable part of the cost of an item; consequently, distance does not limit access to equipment.

4.2 Line-item interest and carrying charges for equipment purchase shall not be allowed. A lump-sum payment for purchase of an item of equipment is the limit of the Government cost-share liability. Interest and carrying charges result from an arrangement between the beneficiary and the equipment vendor for prorated payments of the beneficiary's cost-share liability over time.

4.3 Routine periodic servicing such as testing, cleaning, regulating, and checking that is generally expected to be done by the owner. Normally, the purchasers are given operating manuals that describe the type of service an owner may perform. Payment is not made for repair, maintenance, and replacement of equipment that requires frequent substantial servicing, oxygen equipment, and capped rental items that the patient has not elected to purchase.

5.0 EFFECTIVE DATES

5.1 September 1, 2005, for the DMEPOS system.

5.2 April 1, 2011, for reimbursement of splints and casts.

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