KAISER PERMANENTE®

PAYMENT POLICY

DURABLE MEDICAL EQUIPMENT (DME)

Scope

This policy applies to:

☒ Kaiser Permanente Health Plan of Washington	☒ Kaiser Permanente Health Plan of Washington Options, Inc.	
☒ Commercial	☒ Medicare	☐ Medicaid

Policy

Original Effective Date: 06/15/2014

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (Kaiser Permanente) will reimburse the most appropriate DME item including prosthetic and orthotic devices that meets a member's medical needs when benefits allow and medical necessity is met. DME items, including prosthetic and orthotic devices, may not be reimbursed when treating physician orders are not included in the patient record.

KPWA will apply commonly accepted standards when administering DME benefits. Sources of commonly accepted standards include CMS, the National Uniform Billing Committee (NUBC), the National Correct Coding Initiative, and professional and academic journals and publications.

DME items must be furnished by authorized DME vendors and maintenance services must be performed by authorized technicians to be reimbursable. DME utilized during an inpatient stay (hospital or skilled nursing facility) is considered bundled into the facility payment and is not separately reimbursable unless contracted rates apply.

DME is categorized into the following payment classes by Centers for Medicare & Medicaid Services (CMS):

- Inexpensive or other routinely purchased – reimbursement for rentals or lump-sum purchases.
- Items requiring frequent and substantial servicing – reimbursement on a rental basis until medical necessity ends.
- Certain customized items – reimbursement on a lump-sum purchase.
- Other prosthetic and orthotic devices – reimbursement on a lump-sum purchase.
- Capped rental items – reimbursement on a monthly rental basis not to exceed a period of continuous use of 15 months.
- Oxygen and oxygen equipment – reimbursement on a monthly fee schedule amount.

Items that Kaiser Permanente will not reimburse include but are not limited to:

- Items with mechanical parts that do not include a service and maintenance component.
- Upgrades while the equipment is still functioning, or the warranty is still in effect.

- Back-up or spare equipment.
- Second hand or refurbished equipment purchased directly or over the internet.
- Replacement of lost or damaged items.
- Shipping and handling or restocking fees.
- Maintenance and servicing of purchased equipment in the payment classes of inexpensive or other routinely purchased, customized items, other prosthetic and orthotic devices, and capped rental items as defined by CMS.

Billing/Coding Guidelines

All claims must be billed according to Centers for Medicare & Medicaid Services guidelines.

Rental equipment must be billed consecutively with the same billing date every month and appropriate rental or purchase modifiers.

DME claims submitted for the same procedure code on the same date of service for the same member may be denied.

Policy Definitions

Durable Medical Equipment (DME) – Equipment that can withstand repeated use and is primarily and customarily used for medical purposes in the home.

Prosthetics and Orthotics – Internal devices replace all or part of an internal body organ or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ.

Prerequisite(s)

DME must be ordered by a treating practitioner and must be medically necessary

Treating physician orders should be included in the patient record.

References

Medicare Claims Processing Manual, Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

CMS Manual System Pub 100-04 Medicare Claims Processing, Transmittal 2678, Section 120.3, Suspect Duplicates

Medicare Claims Processing Manual, Chapter 1 – General Billing Requirements, Sections 120.1 to 130.6

Frequently Asked Questions

Q1: A member receives a pair of crutches directly from the physician's office after breaking his/her ankle. The provider bills for the crutches along with the office visit. Will the crutches be allowable?

A1: Yes. Kaiser Permanente will allow DME items when ordered by a treating physician and the item is medically necessary.

Q2: A member receives a CPAP device from a DME supplier. The supplier received the prescription from member's primary care office and the health plan approved the review for medical necessity prior to the item being dispensed. The DME supplier bills for the device. Will the CPAP device be allowable?

A2: Yes. Kaiser Permanente will allow DME items when ordered by a treating physician and the item is medically necessary.

Q3: A member is in a skilled nursing facility and is provided a DME item. The facility bills for the DME item separate from the inpatient stay. Will the DME item be allowable?

A3: No. Kaiser Permanente will not generally carve out separate reimbursement for DME items furnished during an inpatient stay. The skilled nursing facility should include the DME item with all charges furnished during the stay.

Q4: A member receives medically necessary prosthetic device through a non-contracted DME supplier. The supplier has the order by the treating physician, the member has out-of-network benefits, and the device met Kaiser Permanente's medical necessity criteria. The supplier bills for the purchase of the device. Will the device be allowable?

A4: Yes. Kaiser Permanente will allow the prosthetic device when ordered by a treating physician and the item is medically necessary.

Revision History

09/08/2023 – Added language regarding physician orders; added links to CMS processing manuals.

01/20/2023 – Added commonly accepted standards language.

04/20/2022 – Updated to remove Medicaid from "This policy applies to" field, corrected hyperlinks and formatting.