 <b>JOHNS HOPKINS</b> <small>HEALTH PLANS</small>	<b>Johns Hopkins Health Plans            Provider Relations and Network Innovation            Reimbursement Policy</b>	<i>Policy Number</i>	RPC.005
		<i>Effective Date</i>	10/08/2024
		<i>Approval Date</i>	10/08/2024
	<i>Subject</i> <b>Durable Medical Equipment Capped Rental Items</b>	<i>Supersedes Date</i>	02/15/2022
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This document applies to the following Participating Organizations:

EHP    Johns Hopkins Advantage MD                          Priority Partners    US Family Health Plan

**Keywords:** DME, Rental

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## **I. ABOUT OUR REIMBURSEMENT POLICIES**

The most current version of the reimbursement policies can be found on [www.hopkinsmedicine.org](http://www.hopkinsmedicine.org).

Johns Hopkins Health Plan LLC (JHHP) reimbursement policies serve as a guide to assist in accurate claim submissions and outline the basis for reimbursement of services covered by a member's JHHP benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a guarantee that you will be reimbursed. Services must meet prior authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence. Providers are expected to and must follow proper billing and submission guidelines. Providers are required to use industry standard, compliant codes on all claim submissions. Services must be billed with valid ICD-10 diagnosis codes, Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, place of service (POS) codes, and/or revenue codes as defined by the Centers for Medicare & Medicaid Services (CMS) and in the American Medical Association's (AMA's) "CPT Manual".

The codes billed should denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the patient's medical record and/or office notes and JHHP reserves the right to request the records. Issues related to inconsistent, missing, conflicting, or unclear documentation must be resolved by the provider submitting the claim. If a corrected claim is filed, it must comply with timely filing to be reprocessed through the claims system. Corrected claims are for administrative errors on the claim (i.e., misspelled name, CPT/HCPCS code transposed, wrong DOB, missing modifier, etc.). Intentionally changing the CPT/HCPCS or diagnosis code in order to get the claim paid, after the billed service was denied, is not a correction. The medical records must match the services billed. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

JHHP policies apply to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. JHHP reimbursement policies are developed based on nationally accepted industry standards, coding principles, and follows the CMS guidelines, and the CMS developed National Correct Coding Initiative (NCCI) program to

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prevent inappropriate payment of services that should not be reported together. These policies may be superseded by regulatory mandates in provider or state contracts, or state, federal or CMS contracts and/or requirements. If appropriate, when coding/billing guidelines or current reimbursement policies are not followed, JHHP may:

- Reject or deny the claim
- Recover and/or recoup claim payment

JHHP reserves the right to modify policies at any time and publish new versions when necessary. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, JHHP strives to minimize these modifications. When there is an update, policies will be published on our website.

## **II. PURPOSE**

The purpose of this policy is to provide basic guidance on the appropriate reimbursement of capped rentals for Durable Medical Equipment and Supplies (DME) rendered by network and non-network providers, who submit claims on a CMS-1500 or UB-04, or their electronic equivalents. When required, prior authorization must be obtained by the supplier/provider, prior to submitting the claim to JHHP for reimbursement. However, authorization does not guarantee payment as providers/suppliers must bill all covered items and/or services within the provider's scope of practice, and in accordance with the members' covered plan benefits, and under state and federal law.


## **III. POLICY STATEMENT**

This policy is applicable to certain DME rental items/services/supplies only. JHHP will align with regulatory, state and federal guidance to process claims as applicable to the member's plan. Each line of business possesses its own unique contract and guidelines for benefit and payment purposes. As such, there could be various factors that may impact reimbursement, including but not limited to legislative mandates, provider contracts, and/or the member's benefit coverage, prior authorization, including provisions addressing services rendered by non-participating providers, which may supplement, modify, or supersede this policy. This policy does not apply to direct purchase of DME items/supplies/services.

*Providers are responsible to review the **"EXCEPTIONS & EXCLUSIONS"** Sections below for specific plan guidance, as some guidelines in this policy may not be applicable to all health plans/products.*

## **IV. GENERAL BILLING GUIDELINES AND PAYMENT METHODOLOGY**


1. The reimbursement of capped rentals for DME is subject to the DME fee schedule amount, or contracted rate, on a monthly rental basis (unless identified as daily) not to exceed the cap rental period (a period of continuous use of 13 months) or purchase price, whichever is less.
  - The maximum allowable amount is limited to the lowest of the billed charges, the negotiated rate (network providers) or the DME fee schedule amount.
2. Prior authorization and/or referral may be required for certain DME rental items. The billing provider is responsible to obtain the applicable referral and/or authorization prior to submitting the claim to JHHP for reimbursement, or the claim may be denied.
3. For all capped rentals, the appropriate modifier must be appended to the applicable CPT/HCPCS code and assigned in the correct modifier position, in order for the claim to be processed. Modifiers that are reported incorrectly and/or are missing, may cause a delay in processing or a denial of payment.
4. Capped rental payment includes all related costs for the effective use of the equipment by the member. During the rental period, these items and/or services are inclusive of the rental rate and are not separately reimbursable; this includes (but is not limited to):
  - Equipment

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- Accessories
  - Supplies
  - Delivery fees
  - Shipping and handling charges
  - Labor
  - Setup and/or installation
  - Visits
  - Patient education
  - Maintenance
  - Repairs
  - Replacement parts
5. Once the capped rental period or the purchase price is reached, ownership of the item passes to the member.
  6. Consistent with CMS guidelines, reimbursement of certain DME items is limited to a place of service (POS) that qualifies as the member's "home". JHHP considers the following POS codes (01, 04, 09, 12, 13, 14, 16, 31, 32, 33, 54, 55, 56, and 65) that would qualify as the member's "home".
  7. In alignment with CMS guidelines, JHHP will reimburse HCPCS code E0935 on a daily basis, when all requirements are met.
  8. The appropriate diagnosis code(s) is required to be used and reported at the highest number of characters available and to the highest level of specificity documented in the medical record, to support the DME item/service billed.
    - When ICD-10 codes are submitted incorrectly or when an inappropriate diagnosis is pointed to or linked as primary on the claim form, JHHP will deny the associated claim line.
  9. JHHP may conduct medical record documentation reviews on a randomly selected sample of suppliers or providers who bill for items or services outside their regular scope of practice or assigned specialty.
    - Refer to the JHHP [resources and guidelines for all of our health plans](#) for additional information for Medical Record Standards Documentation.
  10. When DME is lost, stolen or destroyed by fire, the provider must obtain, in a timely manner, a completed police or insurance report describing the specific medical equipment which was stolen or destroyed and submit upon request for authorization of replacement equipment.
  11. JHHP asks providers to refer to the [DMEPOS Fee Schedule Files](#), maintained by CMS, for additional guidance.

## **V. INAPPROPRIATE BILLING of DME**

1. JHHP does not reimburse for the following unless there is a benefit exception, which includes (but is not limited to):
  - Aesthetic appearance of DME for the preference of the member or caregiver
  - Clinically unproven equipment
  - Dentures
  - Disposable supplies customarily provided as part of a nursing or personal care service or a medical diagnostic or monitoring procedure
  - DME considered to be experimental or investigational
  - DME provided by a skilled nursing facility when the equipment is part of the facility per diem and is not separately reimbursable, unless otherwise stated by a provider contract
  - Electric lifts (manual lifts are covered)
  - Emergency and nonemergency alert devices
  - Enhancements or upgraded of DME for the convenience of members or caregivers
  - Environmental modifications (e.g. home, bathroom, ramps, etc.)


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- Equipment designed for use by a physician or trained medical personnel
- Experimental equipment
- Facilitated communications (FC)
- Furniture and other items which do not serve a medical purpose
- Handheld showers
- Items used for cosmetic purposes
- Physical fitness equipment
- Precautionary-type equipment (e.g., power generators)
- Provision of DME that exceeds the benefit limit
- Purchase or rental of common household items that are not medically indicated
- Rehabilitation equipment
- Reimbursement for delivery or delivery mileage of medical supplies
- Repair or replacement of DME during the warranty period
- Repair or replacement of DME necessitated by abuse or neglect
- Routine and first aid items
- Safety alarms and alert systems/buttons
- Scooters
- Seat lifts and recliner lifts
- Standard car seats
- Televisions, telephones, VCR machines and devices designed to produce music or provide entertainment
- Training equipment or self-help equipment
- Van lifts
- Wheelchair lifts
- Wheelchair ramps

## **VI. EXCEPTIONS and EXCLUSIONS**


For the purposes of this policy, the 13-month rental limit does not apply to: Prosthetics, Orthotics, Oxygen, Oxygen equipment, or Ventilators (specifically codes E0465 and E0466).

1. **AdvantageMD & EHP:** JHHP aligns with CMS billing and reimbursement methodologies. Please consult the authoritative guidance found in the CMS Manuals to obtain specific information on policy, benefits, and coverage for DME capped rental, not listed in this policy.
2. **PPMCO:** DME capped rental items/supplies/services are reimbursed in accordance to the Maryland Medicaid Administration Professional Services Provider Manual.
  - JHHP requires all providers (i.e., ordering, referring, rendering, servicing, billing) delivering services to Maryland Medicaid members to have an active enrollment status in the electronic Provider Revalidation and Enrollment Portal (ePREP) on the date of service.
  - Claims submitted by individual providers, provider groups and facilities who are inactive or unregistered in ePREP will not be reimbursed.
  - Providers are solely responsible for ensuring their information in the ePREP portal is valid and active.
3. **USFHP:** JHHP will process and reimburse DME capped rental items/supplies/service claims in accordance with TRICARE guidance. Please consult the authoritative guidance found in the TRICARE Manuals to obtain additional specific information on policy, benefits, and coverage not addressed in this reimbursement policy.


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## VII. CODES, TERMS and DEFINITIONS

Term	Definition
Back-Up Equipment	Back-up medical equipment is defined by CMS as an identical or similar device that is used to meet the same medical need for a patient but is provided for precautionary reasons to deal with an emergency when the primary piece of equipment malfunction.
Break in Service (BIS)/Break in Need (BIN)	For the purposes of this policy, when there is a break in service due to medical need, such as equipment returned due to no longer being medically necessary, medical necessity will need to be reestablished if the equipment is ordered again after the interruption. In these situations, suppliers must obtain a new order and medical records to substantiate the need.
Capped Rental	<p>A specific category of DME for which the plan pays a fee schedule amount, which is capped after 13 consecutive months of rental to a beneficiary, and are paid on a monthly rental basis not to exceed a period of continuous use of 13 months.</p> <p>Examples of this type of equipment include, but is not limited to; Hospital beds, wheelchairs, alternating pressure pads, air-fluidized beds, nebulizers, suction pumps, continuous airway pressure (CPAP) devices, patient lifts, and trapeze bars.</p> <p>See the Coding Information section for the current full listing from the CMS DMEPOS.</p>
Customized DME Items	Per 42 Code of Federal Regulations (CFR) Section 414.224(a), in order to be considered a customized DME item, a covered item (including a wheelchair) must be: 1) Uniquely constructed or substantially modified for a specific beneficiary according to a physician's description and orders; and 2) So different from another item used for the same purpose that the two items cannot be grouped together for pricing purposes.

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Custom Fitted	<p>1) Are measured, assembled, fitted, or adapted in consideration of a patient's body size, weight, disability, period of need, or intended use; or 2) Have been assembled by a supplier, or ordered from a manufacturer, who makes available customized features, modification or components for wheelchairs that are intended for an individual patient's use in accordance with instructions from the patient's physician do not meet the definition of customized items. These items are not uniquely constructed or substantially modified and can be grouped with other items for pricing purposes. The use of customized options or accessories or custom fitting of certain parts does not result in a wheelchair or other equipment being considered as customized.</p>
Durable Medical Equipment (DME)	<p>Medical equipment that is all of the following:</p> <ul style="list-style-type: none"> <li>• Prescribed by a licensed physician/practitioner.</li> <li>• Suitable for use in any setting in which normal life activities take place.</li> <li>• Can withstand repeated use.</li> <li>• Generally not useful to a person without a disability, illness, or injury.</li> <li>• Can be reusable or removable</li> <li>• Is not implantable within the body</li> <li>• Primarily and customarily used to serve a medical purpose rather than convenience or comfort.</li> <li>• Meets the federal and/or state definition of DME and/or Prosthetic Orthotic and related Supplies.</li> </ul>
Face-To-Face Encounter	<p>Section 6407 of the Affordable Care Act established a face-to-face encounter requirement for certain items of DME. The law requires that a physician must document that a physician, nurse practitioner, physician assistant or clinical nurse specialist has had a face-to-face encounter with the patient. The encounter must occur within the 6 months before the order is written for the DME.</p> <p>*Note that the date of the written order must not be prior to the date of the face-to-face encounter.</p>

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Physician or Other Qualified Health Care Professional	A Physician or Other Qualified Health Care Professional is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.
Ordering Provider	The Ordering Provider is the individual who requested the services, non-physician services, or items for their patient. Examples include, but are not limited to, provider ordering diagnostic tests and medical equipment or supplies, within their legal scope of practice.
Referring Provider	The Referring Provider is the individual who directed the patient for care to the provider rendering the services being reported. Examples include, but are not limited to, primary care provider referring to a specialist; physician referring to a physical therapist; provider referring to a home health agency.
Rendering Provider	The Rendering Provider is the person or company (laboratory or other facility) who rendered the care. In the case where a substitute provider (locum tenens) was used, enter that provider's information on the claim. The Rendering Provider does not include individuals performing services in support roles, such as lab technicians or radiology technicians.

HCPCS/CPT Codes

Code	Definition
E0465	Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube) as maintained by CMS falls under Oxygen Delivery Systems and Related Supplies.
E0466	Home ventilator, any type, used with non-invasive interface, (e.g., mask, chest shell) as maintained by CMS falls under Oxygen Delivery Systems and Related Supplies.
E0935	Continuous passive motion exercise device for use on knee only, as maintained by CMS falls under Traction and Other Orthopedic Devices.

Modifiers

Modifier	Definition
BP	Beneficiary has elected to rent

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BR	Beneficiary has elected to purchase
KH	First month rental
KI	Second and third rental months
KJ	Fourth to the thirteenth rental months
NU	New Equipment
RR	Rental
UE	Used DME

### VIII. REFERENCES

This policy has been developed through consideration of the following:

- [CMS Durable Medical Equipment, Prosthetics, Orthotics, and Supplies \(DMEPOS\)](#)
- [CMS Transmittal 12183](#)
- [CMS Master List of DMEPOS Items Subject to Conditions of Payment](#)
- [CMS MLN SE20007 - Standard Elements for DMEPOS Order, and Master List of DMEPOS Items Potentially Subject to a Face-to-Face Encounter and Written Orders Prior to Delivery and, or Prior Authorization Requirements](#)
- [COMAR- Maryland Department of Health- Maryland Medicaid Administration](#)
- CPT Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association
- [Maryland Medicaid DME/DMS/Oxygen Approved List of Items](#)
- [Maryland Medicaid Ordering, Referring, and Prescribing \(ORP\) Providers](#)
- [Medicare Benefit Policy Manual CH.15- Covered Medical and Other Health Services](#)
- [Medicare Claims Processing Manual CH. 23 - Fee Schedule Administration and Coding Requirements](#)
- [Medicare Claims Processing Manual CH. 26- Completing and Processing Form CMS-1500 Data Set](#)
- [Medicare National Coverage Determinations \(NCD\) Manuals](#)
- [Medicare NCD 280.1- Durable Medical Equipment Reference List](#)
- [TRICARE Reimbursement Manual](#)

### IX. APPROVALS

Date	Review/Revision	Reason for Modification	Approved By
10/08/2024	Revision	Policy formatting and language updated.	Reimbursement Policy Committee (RPC)
2/15/2022	Review	Policy language and guidance updated	Reimbursement Policy Committee (RPC)
1/10/2017	Review	Policy language and guidance updated	Reimbursement Policy Committee (RPC)
8/12/2016	Review	Policy language and guidance updated	Reimbursement Policy Committee (RPC)

Review Dates: 12/19/2016, 2/15/2022