Durable Medical Equipment (DME): Bill for DME

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This section contains information about billing for Durable Medical Equipment (DME).

Along with this section, providers should refer to additional DME information as follows:

Table of Durable Medical Equipment Manual Locations

Topic	Provider Manual Section
General policy information	*Durable Medical Equipment (DME): An Overview*
Billing for DME on the *CMS-1500 claim form*	*Durable Medical Equipment (DME): Billing Examples*
DME codes reimbursed by Medi-Cal	‹‹*Durable Medical Equipment (DME): Billing Codes*››
Frequency limits for DME purchases	*Durable Medical Equipment (DME) Billing Codes: Frequency Limits*

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

Pursuant to *Welfare and Institutions Code* (W&I Code), Section 14105.395, the provisions contained herein have the force and effect of regulations and shall prevail over any inconsistent provisions in CCR sections relating to DME.

The "date of delivery" to the recipient is the "date of service." This means that when the recipient takes receipt of the DME item, that date is considered the "date of service." Charges for shipping and handling are not reimbursable.

Reference

Refer to the appropriate section in this manual for details about the following DME:

- Infusion Equipment
- Oxygen Contents, Oxygen Equipment and Respiratory Equipment
- Speech Generating Devices
- Therapeutic Anti-Decubitus Mattresses and Bed Products
- Wheelchairs and Wheelchair Accessories
- Other DME

This DME section includes the following items:

- General Billing Information
  - Net Purchase Price
  - Upper Billing Limits
- Reimbursement for Wheelchair DME
  - Sales Tax
  - Pricing Discounts
  - Purchase Frequency Limits
- Billing for Unlisted Codes
  - Unlisted Equipment, Non-Wheelchair
  - Unlisted Supplies, Accessories and Service Components, Non-Wheelchair
  - Unlisted Wheelchair and Wheelchair Accessory Items

- Pricing Documentation for By Report Codes
  - General Documentation Requirements
  - Documentation Requirements for Provider/Manufacturer
  - MSRP Documentation
- Rentals
  - Non-Wheelchair Rentals Subsequently Rented to Recipients
  - Rental Reimbursement Cap
  - Non-Wheelchair Accessories and Supplies
- Repairs and/or Maintenance
  - Labor
  - Repair of Listed Non-Wheelchair Items
  - Repair or Replacement; Listed Wheelchair Items
  - Repair or Replacement: Unlisted Items
  - Repair of Accessories or Supplies
- Medicare/Medi-Cal Crossovers
  - Reimbursement
  - Authorization
  - Billing Procedures for Supplemental Reimbursement
  - Pricing the Supplemental Reimbursement

General Billing Information

Net Purchase Price

The net purchase price is the actual cost to the provider to purchase the item from the seller, including any rebates, refunds, discounts, or any other price reducing allowances known by the provider at the time of billing the Medi-Cal program for the item, that reduces the item's invoice amount, pursuant to CCR, Title 22, Section 51008.1(a)(2)(A).

It shall reflect the price reductions guaranteed by any contract to be applied to the item(s) billed to the Medi-Cal program, pursuant to CCR, Title 22, Section 51008.1(a)(2)(B).

It shall not include provider costs associated with late payment penalties, interest, inventory costs, taxes or labor, pursuant to CCR, Title 22, Section 51008.1(a)(2)(C).

Providers shall not submit bills for items obtained at no cost, pursuant to CCR, Title 22, Section 51008.1(b).

Claims for items of rented DME are excluded from the Upper Billing Limit provisions regarding "net purchase price" of an item as noted above, pursuant to CCR, Title 22, Section 51008.1(c).

Upper Billing Limit

Claims for DME and accessories should not exceed an amount that is 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, pursuant to CCR, Title 22, Section 51008.1.

Reimbursement for Non-Wheelchair DME

Listed Codes

In compliance with *Welfare and Institutions Code* (W&I Code), Section 14105.48 (d)(4), claims reimbursement for DME, except wheelchairs and wheelchair accessories, is the least of the following:

- The amount billed pursuant to *California Code of Regulations* (CCR), Title 22, Section 51008.1
- An amount that does not exceed 80 percent of the lowest maximum allowance for California, established by the federal Medicare program for the same or similar item
- A contracted rate

"By Report" Codes

For dates of services on or after January 1, 2013, in compliance with W&I Code, Section 14105.48 (d)(4), reimbursement for all DME, with no specified maximum allowable rate ("By Report"), except wheelchairs and wheelchair accessories, is the least of the following:

- The amount billed pursuant to CCR, Title 22, Section 51008.1.
- Eighty (80) percent of the MSRP. The MSRP must be an amount that was published by the manufacturer on or prior to the date of service.
- The manufacturer's purchase invoice amount, plus a 67 percent markup.

For dates of service prior to January 1, 2013, in compliance with W&I Code, Section 14105.48, reimbursement for all DME, with no specified maximum allowable rate ("By Report"), except wheelchairs and wheelchair accessories, is the least of the following:

- The amount billed pursuant to CCR, Title 22, Section 51008.1
- Eighty (80) percent of the MSRP. For dates of service on or after September 1, 2006, the MSRP must be an amount that was published by the manufacturer prior to June 1, 2006. If the item was not available prior to June 1, 2006, the date of availability must be documented in the Additional Claim Information field (Box 19) of the claim and the catalog page that initially published the item and the MSRP must be attached.
- The manufacturer's purchase invoice amount, plus a 67 percent markup.

“By Report” Supplies and Accessories

In compliance with *Welfare and Institutions Code* (W&I) Code, Section 14105.48, reimbursement for supplies and accessories billed “By Report” are reimbursed at a lesser of:

- The amount billed (pursuant to CCR, Title 22, Section 51008.1) or;
- The manufacturer’s purchase invoice amount, plus a 23 percent markup.

For more information regarding the maximum allowable DME purchase billing amounts, refer to “Net Purchase Price” above.

Reimbursement For Wheelchair DME

Listed Codes

In compliance with *Welfare and Institutions Code* (W&I Code), Section 14105.48, claims billed for wheelchairs, wheelchair accessories and replacement part for patient-owned equipment billed with listed codes are reimbursed the lesser of:

- The amount billed pursuant to *California Code of Regulations* (CCR), Title 22, Section 51008.1, or
- An amount that does not exceed 100 percent of the lowest maximum allowance for California, established by the federal Medicare program for the same or similar item

For more information regarding the maximum allowable DME purchase billing amounts, refer to “Net Purchase Price” above.

"By Report" Codes

In compliance with W&I Code, Section 141105.48, claims billed for wheelchairs, wheelchair accessories and/or replacement parts for patient-owned equipment using codes with no specific maximum allowable rate ("By Report") are reimbursed the least of:

- Amount billed pursuant to CCR, Title 22, Section 51008.1, or
- Manufacturer's purchase invoice (cost) amount, plus a 67 percent markup, or
- The percentage of the Manufacturer's Suggested Retail Price (MSRP), as follows:
  - 85 percent of the MSRP for unlisted wheelchairs, wheelchairs accessories and/or replacement parts is allowed if the provider documents on the claim that (s)he has on staff, either as an employee or independent contractor, one of the following qualified rehabilitation professionals and that qualified rehabilitation professional was directly involved in determining the specific wheelchair equipment needs of the patient and directly involved with or closely supervised the final fitting and delivery of the wheelchair:
    - ❖ Rehabilitation Engineering and Assistive Technology Society of North America (RESNA)-certified technician
    - ❖ Certified Rehabilitation Technology Supplier (CRTS)
    - ❖ Licensed California physical therapist
    - ❖ Licensed California occupational therapist

Note: The name and title of the employed or contracted qualified rehabilitation professional must be entered in the *Additional Claim Information* field (Box 19).

  - 80 percent of the MSRP, if the claim does not provide documentation that the provider employs or contracts with a qualified rehabilitation professional as noted above.

For more information regarding the maximum allowable DME purchase billing amounts, refer to "Net Purchase Price" in this section.

Sales Tax

Refer to the *Taxable* and *Non Taxable* Items section in this manual.

Pricing Discounts

Only discounts known to the provider at the time the claim is submitted will be used when pricing claims.

Purchase Frequency Limits

Select DME items and accessories are subject to purchase frequency limits. These frequency restrictions are applied to any provider billing the procedure code within the designated time frame(s). For additional information about frequency limits for DME purchases, refer to the Durable Medical Equipment (DME): Purchase Frequency Limits section in this manual.

Billing For Unlisted Codes

Unlisted Equipment: Non-Wheelchair

Unlisted equipment (excluding wheelchairs and wheelchair accessories) is billed as a "By Report" code with HCPCS code ‹‹E1399›› (DME, miscellaneous). All of the following are required in the *Additional Claim Information* field (Box 19) of the claim, or on an attachment to the claim for unlisted equipment:

- Itemization of the equipment (including the manufacturer's name, model number of the item and the catalog number of the item)
- An attachment of a catalog page and invoice showing the items being billed
- A statement next to each item indicating whether the item is "taxable" or "nontaxable"
- If more than one item requires billing with code E1399, providers enter code E1399 on one claim line and indicate the total number of items being billed in the *Days or Units* field (Box 24G)
- Providers must handwrite the claim line number (for example, "Line 1") next to each item being billed with code E1399
- Manufacturer's purchase invoice and the manufacturer's suggested retail price (MSRP)
- Items approved on separate TAR forms must be billed on separate claim forms

Claims that do not include all required documentation will be denied.

Unlisted Supplies, Accessories and Service Components: Non-Wheelchair

Unlisted miscellaneous supplies, accessories and service components (excluding wheelchair accessories) are billed as a “By Report” code with HCPCS code A9900 (miscellaneous DME supply, accessory, and/or service component or another HCPCS code).‹‹All of the following are required in the *Additional Claim Information* field (Box 19) of the claim, or on an attachment to the claim for unlisted supplies, accessories and service components.››

- Itemization of supplies, accessories or service components
- Documentation that the equipment is “patient-owned” and the HCPCS code or description of the owned equipment
- A statement next to each item indicating whether the item is “taxable” or “nontaxable”

Claims that do not include the required documentation will be denied.

‹‹Assistive Robotic Arm Device

An assistive arm is a robotic device that is attached to a power wheelchair used to assist an individual with upper arm disabilities to perform tasks independently. A qualified health care practitioner who recommends the assistive arm as medically necessary for the recipient is ultimately responsible for overseeing the beneficiary's condition. The assistive arm may be medically necessary to enable or restore the recipient's ability to use their upper extremity/extremities to meet daily functional needs, including performing activities of daily living (ADLs) or instrumental activities of daily living (IADLs).

- ADLs include but are not limited to dressing, bathing, eating, drinking, toileting, hygiene and activities specified in a medical treatment plan.
- IADLs allow or an individual to live independently and include but not limited to shopping, housekeeping, accounting, food preparation, taking medication, opening doors and accessing public transportation.

Note: Since all assistive arm devices are durable medical equipment (DME), all existing Medi-Cal DME policy requirements and limitations apply.

Coverage Criteria

The following criteria must be true:

- The assistive arm is medically necessary.
- The assistive arm is prescribed by a qualified, licensed health care practitioner acting within their scope of practice.
- The specialty evaluation(s) for the assistive arm is/are performed by both:
  - A qualified licensed health care practitioner acting within their scope of practice (such as a physical therapist (PT) or occupational therapist (OT), or other medical individual with training or experience with upper extremity function, impairment, and treatment) who has no financial relationship to the health care practitioner of complex rehabilitation technology; and
  - A qualified professional who is certified by a manufacturer of assistive arms
- The treatment goals of the assistive arm agreed to by the beneficiary are being met.››

‹‹An assistive arm is covered as medically necessary when all following criteria are met:

- The beneficiary has met the criteria for a powered wheelchair.
- The beneficiary's power wheelchair accommodates the assistive arm.
- The beneficiary has an upper extremity mobility functional limitation that significantly impairs their ability to meet daily functional needs, including performing ADLs or IADLs.
- The beneficiary's upper extremity mobility functional limitation cannot be equally and effectively addressed by the use of an arm support or other less costly equipment.
- Use of an assistive arm will improve the beneficiary's ability to meet daily functional needs, including performing ADLs or IADLs, and the beneficiary will use it on a daily basis.
- Other, less costly treatments options have failed or would be futile, as determined and explained by a qualified health care practitioner.
- The beneficiary has expressed a willingness to use the assistive arm that is provided.
- The beneficiary has sufficient function and other physical and mental capabilities needed to operate the assistive arm during a typical day.

TAR/SAR Criteria

To determine if the assistive arm is a medical necessity, submission and adjudication of a *Treatment Authorization Request/ Service Authorization Request* (TAR/SAR) with sufficient supporting documentation is required.

HCPCS code K0108 must be submitted with the appropriate supporting documentation. TAR/SAR authorization requires all of the following documentation

:Beneficiary training.

- Beneficiary assessment and evaluation.
- Medical diagnoses and record of significant medical history.
- Specialty evaluation performed by a licensed, qualified health care practitioner acting within their scope of practice and a qualified professional who is certified by a manufacturer of assistive arms.››

- ‹‹Any relevant functionality conditions that would impair the beneficiary from safely using the device.
- Explanation of why the assistive device is the most effective both for ability and cost for the beneficiary.

Proof that the beneficiary assessment occurred must be included with the TAR/SAR submission.››

Documentation for TAR/SAR

- Beneficiary Training: As part of the provision (rental or purchase) of an assistive arm, a provider must appropriately train the beneficiary on the use of the equipment, including any required adjustments to the equipment. A provider may not be separately reimbursed for any beneficiary training costs, as those costs are included in the reimbursement to the provider for the equipment. Proof that this beneficiary training occurred must be included with the TAR/SAR submission.
- Beneficiary Assessment/Evaluation: As part of the provision of an assistive arm, a face-to-face evaluation by the ordering health care practitioner (physician, physician assistant, certified nurse practitioner, or clinical nurse specialist) must occur. Please note that the face-to-face evaluation may be conducted utilizing clinically appropriate telehealth modalities, including audio/visual (video) technology, consistent with Medi-Cal's telehealth policy. This beneficiary assessment must include all of the following:
  - Medical diagnoses and record of significant medical history, which includes upper extremity impairments or disabilities and their impact on the beneficiary's upper extremity mobility, including interference with meaningful participation in ADLs or IADLs
- A specialty evaluation performed by a licensed, qualified health care practitioner, such as a PT or OT, or other individual with training or experience with upper extremity function, impairment, and treatment. The specialty evaluation must include the following:
  - Any functionally relevant conditions that could potentially impair beneficiary from safely using the assistive arm and ameliorative steps to address potential impairments and
  - Demonstration of the beneficiary's ability to use the assistive arm safely and independently; and››

- ‹‹An explanation of why the assistive arm is the most effective and least costly alternative available to enable or restore the beneficiary's ability to use their upper extremities to meet daily functional needs, including performing ADLs or IADLs.

Proof that the beneficiary assessment occurred must be included with the TAR/SAR submission.

Purchase and Rental

Assistive arms may be rented or purchased with an approved TAR/SAR using HCPCS code K0108 and consistent with existing DME policies.

Purchase: Assistive arms may be purchased with an approved TAR/SAR if determined to be medically necessary as described in this policy.

Note: If the rental costs exceed the purchase cost, then the qualified health care practitioner should be purchasing rather than renting.

Rental

- Rental rate includes supplies and repairs. Supplies are not separately reimbursable, unless otherwise noted.
- Rental period for an assistive arm is three calendar months, with the beginning date of rental as the date of service unless otherwise noted.
- Following the three-month rental, a provider must submit a TAR/SAR for purchase demonstrating that the assistive arm is medically necessary for permanent use by the recipient.

Note: If a TAR for purchase is approved, then the cost of the three-month rental period will be deducted from the total purchase price of the assistive arm.

HCPCS code K0108 is reimbursed "By Report", which means the reimbursement rate is priced manually by DHCS based upon documentation required to be submitted by the provider with the claim for reimbursement. For information about billing for unlisted wheelchair accessory items refer to the appropriate section of this manual.

Frequency Limit

Assistive arms are limited to one per beneficiary during a five-year period.››

‹‹Maintenance, Modifications, Replacement or Repair

Purchased assistive arms have a warranty period in which the manufacturer is to pay for maintenance or repair. Medi-Cal will only reimburse for one month of rental while the assistive arm is being repaired or in maintenance. After the warranty has expired, Medi-Cal will only pay for repair or maintenance if it is less costly to replace the assistive arm.

All of the following information must be attached to the TAR/SAR for repairs:

- A statement that the labor is performed on "patient-owned equipment" in the *Additional Claim Information field* (Box 19) or on an attachment to the claim.
- The reason or justification for the repair service.
- The labor time involved to repair the equipment in 15-minute units; and
- The manufacturer's name and catalog number for part(s) to be used.

Note: When adding a new arm to an existing wheelchair the provider is responsible for the replacement of the powerchair's joystick controls or interface controls or electronics needed for the operation of the assistive arm if needed. Refer to the appropriate section of the manuals: Durable Medical Equipment (DME): Bill for Wheelchairs and Wheelchair Accessories (dura bil wheel) and Durable Medical Equipment (DME): Billing Codes and Reimbursement Rates (dura cd).

TARs/SARs for modifications or replacements of previously approved assistive arms must include a specific, detailed justification for the modification or replacement. The following reasons constitute justification:

- The beneficiary's current assistive arm malfunctions or is no longer operational.
- A significant change has occurred in the beneficiary's current assistive arm.
- A significant technological change in the characteristics, features, or abilities of available assistive arms may measurably improve the beneficiary's ability to participate in ADLs or IADLs with the proposed modification or replacement.

Modifiers

Providers must use modifier RR for rentals, NU for purchases, and RB for repairs.››

Billing

Billing for assistive arms must be claimed on multiple lines if the total cost and reimbursement amount requested exceeds $99,999.99.

Split the price of HCPCS code K0108 on multiple lines on the claim and put half on one line and the other half on the second line. The following is an example:

- Provider submits a TAR/SAR for an assistive arm for a Medi-Cal recipient that costs $150,000.00
  - ‹‹Line one: Date of Service (DOS) – HCPCS code K0108 assistive arm - *$99.999.99* (part one of two); and
  - Line two: DOS – HCPCS code K0108 assistive arm - *$50,000.01* (part two of two)››

Note: In this example the claim needs to be on two lines due to the total cost and reimbursement amount requested, which is necessary to avoid the appearance of requesting two assistive arms. The maximum amount allowed per individual claim line is $99,999.99.

Assistive Arm-Related Services

Assistive arm-related services, including assessments and post-purchase services are covered and included in the reimbursement rate for the device. These services are not separately billable by the provider.

Medicare/Medi-Cal Crossovers

When billing for Medicare and or Medi-Cal crossover items, providers must obtain authorization for DME items before dispensing or billing the item. Additional information is available in this section under: Medicare/Medi-Cal Crossovers” and Medicare/Medi-Cal Crossover Claims: CMS-1500 (medi cr cms). A TAR/SAR for a dually eligible Medi-Cal beneficiary will be processed in the same manner as a Medi-Cal-only beneficiary, regardless of whether Medicare (or any other health coverage) has authorized the equipment or been billed.

Unlisted Wheelchair and Wheelchair Accessory Items

Unlisted wheelchair or wheelchair accessory items are billed with HCPCS code K0108 (wheelchair component or accessory, not otherwise specified). All of the following are required in the *Additional Claim Information field* (Box 19) of the claim, or on an attachment to the claim for unlisted equipment:

- Itemization of the equipment (including the manufacturer's name, model number of the item and the catalog number of the item).
- The catalog page and invoice showing the items being billed.
- If more than one item requires billing with code K0108, providers enter code K0108 on one claim line and indicate the total number of items being billed in the *Days or Units field* (Box 24G).
- Providers must handwrite the claim line number (for example, "Line 1") on the catalog page and invoice next to each item being billed with code K0108.
- Manufacturer's purchase invoice and the manufacturer's suggested retail price (MSRP).
- Items approved on separate TAR/SAR forms must be billed on separate claim forms.

Note: Claims that do not include all required documentation will be denied.››

Pricing Documentation For “By Report” Codes

General Documentation Requirements

DME items, including replacement parts for all equipment and wheelchair accessories and replacement parts, and accessories, for all patient-owned DME with no specified maximum allowable rate will be reimbursed “By Report” and require the following information (see appropriate DME section for requirements for the specific group of DME products):

- Manufacturer’s purchase invoice and the MSRP (See the following for documentation of MSRP)
- Item description
- Manufacturer name
- Model number
- Catalog number
- If the code is unlisted, the reason a listed code was not used
- If applicable, completion of the *Additional Claim Information* field (Box 19) with the name and title of the employed or contracted qualified rehabilitation professional.

DME supplies and accessories for all patient-owned DME (except wheelchairs, wheelchair modifications and wheelchair accessories) with no specified maximum allowable rate will be reimbursed “By Report” and require the following information (see appropriate DME section for requirements for the specific group of DME products):

- Manufacturer’s purchase invoice
- Item description
- Manufacturer name

Claims that do not include all required information will be denied.

Documentation Requirements for Provider/Manufacturer

Providers who also manufacture DME items, including replacement parts, supplies and accessories for patient-owned equipment, must submit the MSRP with claims only for items they manufacture.

MSRP Documentation

Acceptable documentation of the MSRP includes the following:

For dates of service on or after December 1, 2015:

- MSRP catalog page dated on or prior to the date of service along with the manufacturer purchase showing cost dated on or prior to the date of service;
- Written manufacturer quote on manufacturer's letterhead, email or invoice dated prior to the date of service along with manufacturer purchase invoice showing cost dated on or prior to the date of service; or
- Manufacturer purchase invoice that includes both MSRP and cost dated on or prior to the date of service.

For date of service on or after January 1, 2013, submit the catalog page showing MSRP published on or prior to the date of service.

For dates of service on or after September 1, 2006, MSRP must be an amount published by the manufacturer prior to June 1, 2006. If the item was not available prior to these dates, providers must submit the following:

- Date of availability in the *Additional Claim Information* field (Box 19) of the *CMS-1500* claim
- Catalog page that initially published the item
- MSRP

Rentals

Non-Wheelchair Rentals Subsequently Rented to Recipients

Claims for reimbursement of non-wheelchair items that DME providers rent from a manufacturer and subsequently rent to recipients must be submitted with the appropriate non-wheelchair item HCPCS code and modifier RR. Both the manufacturer's rental invoice and a catalog page with the MSRP must be submitted with the claim.

Rental Reimbursement Cap

Pursuant to *California Code of Regulations* (CCR), Title 22, Section 51321(c)(5C), except for life support equipment, such as ventilators, and other equipment that requires ongoing service or maintenance, when previously paid rental charges equal the maximum allowable purchase price of the rented item, as specified in Section 51521(i), 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 has 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.

Non-Wheelchair Accessories and Supplies

The rental reimbursement rate for non-wheelchair DME equipment includes all associated accessories and supplies. Non-wheelchair DME accessories and supplies are reimbursable only when they are billed for equipment owned by the patient using modifier NU. Modifiers RB and RR are not allowed.

Repairs and/or Maintenance

Labor

Repair or maintenance of equipment is billed with applicable HCPCS codes for replacement parts and one of the following codes for labor:

Table of HCPCS Codes for Repair or Maintenance

HCPCS Code	Description
K0739	Repair or non-routine service for DME other than oxygen equipment requiring the skill of a technician, labor component per 15 minutes
K0740	Repair or non-routine service for oxygen equipment requiring the skill of a technician, labor component per 15 minutes

Documentation

Claims for labor for patient-owned equipment require the following documentation:

- HCPCS code K0739 or K0740 (no modifier required or allowed).
- A statement that the labor is performed on “patient-owned equipment” in the *Additional Claim Information* field (Box 19) or on an attachment.
- A notation detailing the equipment that was repaired or serviced (either the specific procedure code for the equipment or a description).
- Reason/justification for repair
- Labor time to accomplish the work (HCPCS code K0739 or K0740) is billed in 15-minute units: labor time may be rounded to the nearest quarter hour for the total repair. For example, one hour and 20 minutes equals six units.

Note: Separate reimbursement for labor charges (HCPCS codes K0739 and K0740) are not allowed for the delivery, installation, setup, or instruction for use of rented or newly purchased DME items, or for the repair, maintenance or routine servicing of rented DME items (*California Code of Regulations* [CCR], Title 22, Section 51521[f]). Labor charges also are not separately reimbursable during the warranty period following the purchase or repair of DME equipment (CCR, Title 22, Section 51521[g]). For more information about warranties, refer to “Guarantees” in the *Durable Medical Equipment (DME): Billing Codes* section of this manual.

Labor Rate

Refer to *Durable Medical Equipment (DME): Billing Codes* section of this manual.

Repair of Listed Non-Wheelchair Items

Claims for repair must be billed with the HCPCS code for the item being repaired and modifier RB (only) (Example: E0295RB). The following documentation is required in the *Additional Claim Information* field (Box 19) or on an attachment to the claim:

- Description of the service provided.
- Reason/justification for repair.
- Manufacturer name.
- List of parts used with their catalog number and cost.
- A statement that the repairs are being made to equipment that is patient-owned.

Repair or Replacement: Listed Wheelchair Items

Claims for repair or replacement of items for which there is a specific HCPCS code must be billed with that code and modifiers RB and NU on the same claim line.

Repair or Replacement: Unlisted Items

Claims for repair or replacement of unlisted items require the following. When two modifiers are used on the claim, both modifiers must be entered on the same claim line.

- Unlisted wheelchair items: HCPCS code K0108 (wheelchair component or accessory, not otherwise specified) and modifiers RBNU or NURB.
- Unlisted repair for non-wheelchair equipment: Use appropriate HCPCS code and modifier RB.
  - For HCPCS code E1399, indicate whether the item is “taxable” or “nontaxable” in the *Additional Claim Information* field (Box 19) or on an attachment to the claim
- The following documentation in the *Additional Claim Information* field (Box 19) or on an attachment to the claim:
  - Description of the service provided
  - Manufacturer name
  - List of parts used with their catalog number and cost
  - A statement that the repairs/replacement items are for equipment that is patient-owned

Repair of Accessories or Supplies

Labor charges are not separately reimbursable for any DME accessories or supplies.

Medicare/Medi-Cal Crossovers

Reimbursement

Providers of DME items may bill Medi-Cal for reimbursement of the difference between Medicare's rate and Medi-Cal's rate for items provided to Medicare/Medi-Cal dually entitled recipients. This method of reimbursement is the result of a permanent injunction in the case of *Charpentier* v. *Belshe* in which the court has mandated that for Medicare Part B items and services (excluding physician services), DHCS may not limit reimbursement to 20 percent of Medicare's "reasonable charge" limit. For items meeting approval by Medi-Cal for medical necessity criteria but denied by Medicare, Medi-Cal is responsible for full payment commensurate with Medi-Cal's reimbursement rates, except for any share of cost to be paid by the member.

Authorization

Providers are encouraged but not required to obtain authorization from DHCS or the managed care plan for DME items for dually eligible members before dispensing the item and billing Medicare. DHCS and MCPs will process an authorization request for a dually eligible patient in the same manner as a Medi-Cal-only patient, regardless of whether Medicare (or any other health coverage) has authorized the equipment or been billed.

A *Treatment Authorization Request* (TAR) or electronic TAR (eTAR) shall be completed and submitted using the Medi-Cal DME code(s) that most accurately describe the item provided. The TAR must include all medical justification and documentation that would normally accompany a Medi-Cal-only TAR and include the message "Medi/Medi: Charpentier/Rates," "Medi/Medi: Charpentier/Benefit Limitation," or "Medi/Medi: Charpentier/Both Rates and Benefit Limitation" in the *Medical Justification* area.

The DHCS Clinical Assurance Division will review the TAR and return an *Adjudication Response* (AR) to the provider.

A DME supplier is required to submit a TAR for DME items over $100 or when the cumulative rental of the item exceeds $250. The authorization process for these DME items typically proceeds according to the following steps:

- The DME supplier submits a TAR to DHCS or prior authorization request to the managed care plan.
- DHCS or the plan reviews the TAR for medical necessity, confirms member's eligibility, and returns an Adjudication Response (AR) to the DME supplier. DHCS or the plan will process the request for prior authorization regardless of whether Medicare (or any other health coverage) has authorized the equipment or been billed.

- If the TAR or prior authorization request is approved, the DME supplier orders and delivers the equipment to the member.
- The DME supplier bills Medicare (or other primary insurance), if applicable.
- The DME supplier then bills Medi-Cal with documented proof of costs Medicare (or other primary insurance) does not cover, up to the maximum Medi-Cal amount, if applicable.

A TAR is not required when billing for crossover items/services not affected by the *Charpentier* v*. Belshe* court case.

Billing Procedures for Supplemental Reimbursement

After receipt of the AR, providers should follow normal Medicare/Medi-Cal billing procedures. Currently, some claims automatically cross over to Medi-Cal for reimbursement of residuals while others require hard copy billing. There is no change to this process. However, to receive the difference, if any, between the Medicare and Medi-Cal rate, providers must bill using the *CMS-1500* claim and follow these billing instructions:

- The provider must bill using the Medi-Cal DME code(s) that most accurately describe the item being provided. The code(s) used must be the same as the code(s) used on the TAR. The words “Medi/Medi: Charpentier/Rates” must appear in the *Additional Claim Information* field (Box 19) of the claim.
- The 11-digit number from the AR must be entered on the claim in the *Prior Authorization Number* field (Box 23).
- The sum of previous reimbursement from Medicare, Medi-Cal and any other health insurance carrier(s) must be indicated on the claim in the *Other Coverage* field (Box 11D).
- The residual billing must be billed with a delay reason code “7” in the bottom, unshaded area of the *EMG* field (Box 24C) if it is billed more than six (6) months after the month of service.

Note: If an emergency code is also needed in Box 24C, the emergency code is entered in the unshaded area and the delay reason code is entered in the shaded area.

- The Explanation of Medicare Benefits (EOMB)/Medicare Remittance Notice (MRN), Remittance Advice Details (RAD) and proof of payment or denial from any other health insurance carrier(s) must be included as attachments.
- Providers should place an “R” (rate limitation), “L” (benefit limitation) or “T” (for both rate and benefit limitation) in the *Resubmission Code* field (Box 22).

Pricing the Supplemental Reimbursement

The DME item will be priced as is currently done with straight Medi-Cal claims, and the supplemental reimbursement to providers, if any, will be determined.

For more information about Medicare/Medi-Cal crossover billing procedures and the Charpentier v. Belshe (Coye/Kizer) court case, see the *Medicare/Medi-Cal Crossover Claims* section in this manual.

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.