Chapter 5 Contents

Introduction – DMEPOS Fee Schedule Categories

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §30

Reimbursement for most durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) is established by fee schedules. Payment is limited to the lower of the actual charge or the fee schedule amount. See Chapter 10 of this manual for more information about fee schedules and pricing.

The fee schedule classifies most DMEPOS into one of the six categories explained below:

- Inexpensive or other routinely purchased DME (IRP)
- Items requiring frequent and substantial servicing
- Customized items
- Other prosthetic and orthotic devices
- Capped rental items
- Oxygen and oxygen equipment

To determine in which category a specific HCPCS code is classified, see *Appendix-A HCPCS* at the end of this manual.

NOTE: For claims with dates of service on or after January 1, 2023, you no longer need to submit CMNs or DIFs with claims. Due to electronic filing requirements, claims received with these forms attached will be rejected and returned.

For claims with dates of service prior to January 1, 2023, if a CMN or DIF is required, it must be submitted with the claim or be on file with a previous claim.

1. Inexpensive or Other Routinely Purchased DME (IRP)

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual,* Chapter 20, §30.1

Payment for this type of equipment is made for rental or lump sum purchase, depending on the beneficiary's choice. The total payment amount may not exceed the actual charge or the fee for a purchase.

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

- Other Routinely Purchased DME
  This category consists of equipment that is purchased at least 75 percent of the time.

Modifiers used in the IRP category are as follows*:

RR	Rental
NU	Purchase of new equipment. Only use if new equipment was delivered.
UE	Purchase of used equipment. Used equipment is any 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).

*These modifiers are not all-inclusive.

Transcutaneous Electrical Nerve Stimulator (TENS)

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual,* Chapter 20, §30.1.2

TENS devices constitute an exception to the IRP category. Up to two months rental is allowed prior to the purchase of a TENS in order to permit an attending physician time to determine whether the purchase of a TENS is medically appropriate for a particular beneficiary. The purchase price is determined under the same rules as any other frequently purchased item, except that there is no reduction in the allowed amount for purchase due to the two months rental.

2. Items Requiring Frequent and Substantial Servicing

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §30.2

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.

Supplies and accessories are not allowed separately.

Modifiers used in the Frequent and Substantial Servicing category are as follows*:

RR	Rental

*These modifiers are not all-inclusive.

3. Certain Customized Items

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §30.3

Coverage and allowable amounts for custom equipment will be decided by individual evaluation based on medical indication.

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

Payment with respect to a covered item that is uniquely constructed or substantially modified to meet the specific needs of an individual beneficiary will be paid in a lump-sum amount. The payment amount for the purchase of a customized item is based upon the DME MAC's individual consideration for that item.

You must submit the following information with the claim in order for coverage to be considered:

1. Detailed description of the item
2. Description of feature(s) that make the item unique
3. Acquisition or production cost of the item (i.e., line item cost of materials and/or labor)

The date of service for custom-made equipment is the actual date the beneficiary receives the item. Do not use the date the item was ordered when billing Medicare.

4. Other Prosthetic and Orthotic Devices

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §30.4

These items consist of all prosthetic and orthotic devices excluding:

- Items requiring frequent and substantial servicing;
- Certain customized items;
- Parenteral/enteral nutritional supplies and equipment; and,
- Intraocular lenses.

Other than these exceptions, prosthetic and orthotic devices will be paid on a lump-sum purchase basis.

The date of service for custom-made equipment is the actual date the beneficiary receives the item. Do not use the date the item was ordered when billing Medicare.

Artificial Limbs, Braces, and Other Custom-Made Items Ordered but Not Furnished

If a custom-made item was ordered but not furnished to a beneficiary because the individual died or because the order was canceled by the beneficiary or because the beneficiary's condition changed and the item was no longer reasonable and necessary or appropriate, payment can be made either on an assigned or unassigned claim basis, based on your expenses. If the beneficiary, for any other reason, canceled the order, payment can be made to the supplier only. In such cases, the expense is considered incurred on either:

- The date the beneficiary died;
- The date that you learned of the cancellation of the item; or
- The date that you learned that the item was no longer reasonable and necessary or appropriate for the beneficiary's condition.

The allowed amount is based on the services furnished and materials used, up to the date you learned of the beneficiary's death or of the cancellation of the order or that the item was no longer reasonable and necessary or appropriate. The DME MAC determines the services performed and the allowable amount appropriate in the particular situation, taking into account any salvage value of the device. Where you breach an agreement to make a prosthesis, brace, or other custom-made device for a Medicare beneficiary, e.g., an unexcused failure to provide the article within the time specified in the contract, payment may not be made for any work or material expended on the item. Whether a particular supplier has lived up to its agreement, of course, depends on the facts in the individual case.

5. Capped Rental Items

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §30.5

Items in this category are paid on a monthly rental basis not to exceed a period of continuous use of 13 months.

Rental Fee Schedule

For the first three rental months, the rental fee schedule is calculated so as to limit the monthly rental of 10 percent of the average of allowed purchase prices on assigned 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 percent of the average allowed purchase price (in other words, the payment is reduced by 25% beginning in the fourth month of rental). After paying the rental fee schedule amount for 13 months, no further payment may be made. *Note that for power wheelchairs and parenteral/enteral pumps, the monthly rental percentage may differ (see below for more information).*

Modifiers used in the Capped Rental category are as follows*:

RR	Rental
KH	First rental month
KI	Second and third rental months
KJ	Fourth to the fifteenth months
BR	Beneficiary has elected to rent
BP	Beneficiary has elected to purchase

BU	Beneficiary has not informed supplier of decision after 30 days
MS	Maintenance and Servicing
NU	New Equipment
UE	Used Equipment

*These modifiers are not all-inclusive.

Payments during a Period of Continuous Use

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §30.5.4
CMS Change Requests (CR) 5010 & 5370

After 13 months of rental, the title for the capped rental item must be transferred to the beneficiary. Once the beneficiary owns the item, Medicare pays for reasonable and necessary maintenance and servicing (i.e., for parts and labor not covered by a supplier's or manufacturer's warranty) of the item. You must follow applicable state and federal laws when transferring the title for the item to the beneficiary. This transfer must occur on the first day after the last rental month.

Note that parenteral (or enteral) nutrition (PEN) pumps follow different capped rental rules. Refer to the Parenteral/Enteral Pumps section below for details.

Additional information about these rules can be found in the MLN Matters articles MM5010 and MM5370. MLN Matters articles can be found on the CMS website at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html.

Period of Continuous Use

A period of continuous use allows for temporary interruptions in the use of equipment. In order for a new rental period to begin, interruptions must exceed 60 consecutive days plus the days remaining in the rental month in which the use ceases (not calendar month, but the 30-day rental period). When an interruption continues beyond the end of the rental month in which use ceases, no additional payment will be made until the use of the item resumes. A new date of service will be established when use resumes. Unreimbursed months of interruption will not apply toward the 13 (or 15) month limit.

If an interruption does exceed 60 plus consecutive days, a new rental period may begin even though the original capped rental has been exhausted. In these situations, you must obtain from the ordering physician a new prescription, a new Certificate of Medical Necessity (CMN) and a statement describing the reasons for the interruption. Please be thorough, as the documentation will be reviewed carefully.

Change of Address

If the beneficiary moves during or after the rental period, either permanently or temporarily, it does not result in a new rental period.

Modification or Substitutions of Equipment

If equipment is changed to different but similar equipment, and the beneficiary's condition has substantially changed to support the medical necessity for the new item, a new rental period will begin. Otherwise (if the beneficiary's condition has not changed), the rental will continue to count against the current rental period and payment will be based on the least expensive medically appropriate equipment. If the rental period has already expired, no additional rental payment will be made for modified or substituted equipment in the absence of substantial change in medical need.

If modification is added to existing equipment and there is a substantial change in medical need, the rental period for the original equipment continues and a new rental period begins for the added equipment.

Change in Suppliers

If the beneficiary changes suppliers during the rental period, a new rental period will not begin

Purchase Options of Capped Rental Items

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §§30.5.2-3

Standard Power Wheelchairs (HCPCS codes K0813-K0831 and K0898)

Prior to January 1, 2011, beneficiaries had the option to either rent or purchase standard power wheelchairs; however, Section 3136 of the Affordable Care Act of 2010 eliminated the lump sum purchase option for standard power wheelchairs (HCPCS codes K0813-K0831 and K0898). Standard power wheelchairs with dates of service on or after January 1, 2011 must be rented following standard capped rental rules.

For power wheelchair rentals beginning on or after January 1, 2011, monthly rental payment amounts under the DMEPOS fee schedule are calculated using a different percentage of the purchase price than the percentage used for regular capped rental items. Payment for the first three months of rental is 15 percent (instead of 10 percent) of the purchase price of the power wheelchair, and payment for months 4 through 13 is 6 percent (instead of 7.5 percent).

Note: There is an exception to these rules for beneficiaries residing in any of the nine Competitive Bidding Areas (CBAs) for the Round One Rebid of the DMEPOS Competitive Bidding Program. For information about competitive bidding, refer to the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/index.html or the Competitive Bidding Implementation Contractor (CBIC) website at https://www.dmecompetitivebid.com.

Complex Rehabilitative Power Wheelchairs (HCPCS codes K0835-K0843 and K0848-K0864) and Wheelchair Options/Accessories Furnished for Use with a Complex Rehabilitative Power Wheelchair

Complex rehabilitative power wheelchairs (HCPCS codes K0835-K0843 and K0848-K0864) and options/ accessories furnished for use with a complex rehabilitative power wheelchair can be either rented or purchased. You must give beneficiaries entitled to these power wheelchairs and options/accessories the option of purchasing at the time you first furnish the item. No rental payment will be made for the first month until you notify the DME MAC that the beneficiary has been given the option to either purchase or rent. If the beneficiary chooses to purchase, payment will be made on a lump sum purchase basis. In this case, the modifiers billed on the claim for purchase must be NU (or UE, if used), KH, and BP (in addition to any modifiers required by the Local Coverage Determination). If the beneficiary declines the purchase in the first month, payment will be made on

a rental basis. Effective for dates of service on and after October 1, 2018, the KH modifier is no longer required for purchased (NU or UE) wheelchairs and accessories.

For power wheelchair rentals beginning on or after January 1, 2011, monthly rental payment amounts under the DMEPOS fee schedule are calculated using a different percentage of the purchase price than the percentage used for regular capped rental items. Payment for the first three months of rental is 15 percent (instead of 10 percent) of the purchase price of the power wheelchair, and payment for months 4 through 13 is 6 percent (instead of 7.5 percent). The purchase fee schedule amount for complex rehabilitative power wheelchairs is equal to the monthly rental fee schedule amount divided by 0.15.

Parenteral/Enteral Pumps

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §30.7.1

Parenteral/enteral pumps can be either rented or purchased. When rented, they are processed similarly to capped rental items, with a few notable exceptions. First, they are not subject to the 25% reduction payment for the fourth rental month and after. Second, a beneficiary may elect to purchase a parenteral/enteral pump at any time, but must be offered the opportunity to do so by the tenth month if he/she has not already done so. If the beneficiary decides to purchase the pump once rentals have been paid, the purchase allowance will consist of the used purchase allowance less the amount allowed to date for rentals. If the beneficiary elects to continue to rent the pump, rental payments will continue up to 15 months.

Additional rental payments after the 15-month limit has been reached or after the pump has been purchased will only be considered if the attending physician changes the prescription between parenteral and enteral nutrients.

A change in suppliers during the 15-month rental period does not begin a new 15-month rental period. The new supplier is entitled to the balance remaining on the 15-month rental period.

The supplier that collects the last month of rental (i.e., the 15th month) is responsible for ensuring that the beneficiary has a pump for as long as it is medically necessary and for maintenance and servicing of the pump during the period of medical necessity.

All Other Capped Rental Items

For capped rental items, rental payments will continue until a total of 13 continuous rental months have been paid (except for parenteral and enteral pumps). No additional payment beyond the 13th month will be made. On the first day after 13 continuous months have been paid, you must transfer title of the equipment to the beneficiary.

Modifiers used for the rent/purchase option are as follows:

BR	Beneficiary has elected to rent
BP	Beneficiary has elected to purchase
BU	Beneficiary has not informed supplier of decision after 30 days

You must use one of these modifiers to notify the DME MAC of the beneficiary's decision. Since HCPCS modifiers are used, it is not necessary for you to submit documentation signed by the

beneficiary that he/she has been offered the rent/purchase option; however, you must maintain documentation in the files supporting the HCPCS modifier entered on the claim form.

Maintenance and Service

Maintenance and Servicing of Parenteral/Enteral Pumps

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §40.3

Necessary maintenance and servicing of parenteral/enteral pumps after the 15-month rental limit is reached may include repairs and extensive maintenance that involve the breaking down of sealed components, or performing tests that require specialized testing equipment not available to the beneficiary or nursing home. Payment will only be made for actual incidents of maintenance, servicing, or replacement. For enteral pumps, maintenance and servicing may be considered for payment every six months, beginning six months after the last rental month for the pump. For parenteral pumps, maintenance and servicing may be considered for payment every three months, beginning three months after the last rental month for the pump. Claims for replacement of parenteral/enteral pumps purchased more than eight years ago will be considered for payment.

The modifier used in for maintenance and servicing is as follows:

MS	Maintenance and servicing (six-month maintenance and servicing fee for reasonable and necessary parts and labor that are not covered under any manufacturers or supplier warranty).

Starting a New Capped Rental Period

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §30.5.4

This defines two major reasons a new rental period would begin for a similar (same code) or related (different code) item of durable medical equipment (DME) that is in the Capped Rental payment category. These statements reflect current national policy and are provided as a clarification in response to inquiries from suppliers.

1. **For an item described by the same code, a new capped rental period would begin if there has been an interruption in the medical necessity for the item and that interruption lasted for 60-plus consecutive days.**

   If there is an interruption in the billing of a capped rental DME item to the DME MAC because the beneficiary is in a hospital and/or nursing facility, a new capped rental period does not automatically begin if/when billing to the DME MAC resumes. If the billing is for the same item, or for a similar item using the same code, a new capped rental period would begin if there has been an interruption in the medical necessity for the item and that interruption lasted for 60-plus consecutive days.

   The CMS defines a 60-plus consecutive day interruption as a period including two full rental months **plus** whatever days are remaining in the rental month during which the need ends. An interruption in medical necessity is defined as a resolution of the condition that created the first period of medical necessity and the subsequent development of a second event that creates a new period of medical necessity.

   For example, a beneficiary has a wheelchair following a major injury to his legs. Rental starts on January 15 and rentals are billed on the 15th of the subsequent months (e.g., February and March). The beneficiary recovers and does not need the wheelchair anymore, and returns the wheelchair on March 25. The beneficiary subsequently has another injury and

again needs a similar wheelchair (same code). A new capped rental period would begin if the wheelchair is provided in the home on or after June 15. This is an interruption of two full rental months, April and May, plus the remainder of the month of discontinuation, March 25 through April 14. Note: In this example, if a similar wheelchair (same code) is needed and is provided in the home prior to June 15, a new capped rental period would not start because there is not a 60-plus consecutive day interruption of medical necessity.

A new capped rental period does not start just because there is an interruption in billing to the DME MAC. For example, if the beneficiary is in the middle of a capped rental period for a wheelchair that was needed because of permanent hemiplegia from a stroke and is admitted to a hospital and/or nursing facility for 60-plus days or enrolls in a hospice program for 60-plus days, the capped rental period for the wheelchair resumes where it left off once the beneficiary returns home or disenrolls from the hospice program, even if it is from a different supplier. Even though billing to the DME MAC was interrupted, there was no interruption in the medical necessity for the wheelchair.

2. **For an item described by a different code, a new capped rental period would begin if there is a substantive change in the beneficiary's condition that necessitates a significantly different item.**

   For example, a beneficiary has a K0001 wheelchair for short-term use following an injury. The beneficiary then has a stroke, which results in a dense hemiplegia and, after a one-month stay in a hospital and skilled nursing facility, it is determined that a K0004 wheelchair is needed. A new capped rental period would begin for the K0004 wheelchair because there had been a substantive change in the beneficiary's condition and a significantly different item was provided.

   In another example, a beneficiary who meets the criteria for a group II support surface is provided a powered mattress overlay (E0372). After three months, the pressure ulcers heal and the beneficiary is switched to a group I mattress (e.g., E0186). A new capped rental period would begin for the group I mattress because there has been a substantive change in the beneficiary's condition and a significantly different item was provided.

   Note: The following groups of support surfaces will be considered "significantly different" for purposes of starting a new capped rental period: group 1 overlays, group 1 mattresses, group 2 overlays, group 2 mattresses and beds, and group 3 beds.

   If the beneficiary again develops a Stage IV pressure ulcer, restarts the powered mattress overlay (E0372), and meets the criteria for a group II support surface, the capped rental period would restart at the month in which it had been discontinued. If a significantly different item (e.g., E0277) in group II was started, a new capped rental period would begin.

   For support surfaces, a new capped rental period does not start just because an item with another code was provided, if that item is not significantly different from the prior item (see groupings above). An example would be a beneficiary who has a Stage IV pressure ulcer, meets coverage criteria for a group II support surface, and is furnished with a powered mattress overlay (E0372). If the ulcer worsens and the beneficiary is switched to a non-powered group II overlay (E0371), a new capped rental period does *not* start, even if it is a different supplier. This is because even though the beneficiary's condition changed, the new item is not significantly different from the previous item. However, if the beneficiary had been switched to a group II mattress (e.g., E0277), a new capped rental period would start because there had been a substantive change in the beneficiary's condition *and* a significantly different item was provided.

The following guidelines pertain to claim submission for both situations 1 and 2 above. If you are billing for a new capped rental period, the code must have the KH modifier (indicating the first month of rental) and, if a Certificate of Medical Necessity (CMN) is required for the code, an *initial* CMN must accompany the claim. When the DME MAC receives a claim for a capped rental code that has been previously approved and there has been any interruption of billing to the DME MAC, the presumption is that there has been no interruption in medical necessity for the item unless it is clearly documented. Therefore, if there is a 60-plus day interruption of billing for a code and you think that starting a new capped rental period is justified, narrative documentation must accompany the claim. The documentation must include, but is not limited to:

1. A description of the beneficiary's prior medical condition that necessitated the previous item,
2. A statement explaining when and why the medical necessity for the previous item ended, and
3. A statement explaining the beneficiary's new or changed medical condition and when the new need began.

This information must be entered in the NTE segment/line note of an electronic claim or attached to a paper claim.

6. Oxygen and Oxygen Equipment

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §30.6

Reimbursement for oxygen equipment is made on a rental basis only. The total number of continuous rental months for which Medicare will pay for oxygen equipment is limited to 36 months.

Fee schedule payments for stationary oxygen system rentals are all-inclusive and represent a monthly allowance per beneficiary. This allowance includes payment for the equipment, contents, and accessories furnished during a rental month.

After the 36-Month Cap

After the 36-month rental period has ended, the title of the equipment remains with the supplier of the equipment. Under no circumstances will a new rental period start following the completion of the 36-month rental period unless the equipment is replaced because it is lost, stolen, or irreparably damaged or is replaced after the reasonable, useful lifetime expires.

As the supplier of the oxygen equipment, you are required to continue furnishing the equipment, supplies, and accessories for any period of medical need for the remainder of the reasonable, useful lifetime of the equipment. This requirement includes use of equipment following temporary breaks of in-home oxygen services (e.g., due to a hospital or other facility stay) of any duration after the 36-month rental cap.

The supplier who furnished the liquid or gaseous oxygen equipment during the 36-month rental period is responsible for furnishing the oxygen contents used with the supplier-owned oxygen equipment for any period of medical need following the 36-month rental cap for the remainder of the reasonable, useful lifetime of the equipment. Medicare will pay for oxygen contents for any gaseous or liquid (stationary or portable) oxygen equipment. You should use HCPCS codes E0441 through E0444 in order to bill and receive payment for furnishing oxygen contents (see the section on oxygen contents below).

Medicare can pay for one general maintenance and servicing (MS) visit for concentrators or transfilling equipment every six months beginning six months after the end of the 36-month rental period. Other than this general maintenance and servicing payment, payment is not allowable for any repair or maintenance and servicing of supplier-owned oxygen equipment, including any replacement part furnished as part of any repair or maintenance and servicing of oxygen equipment. Claims for maintenance and servicing of concentrators or transfilling equipment must be billed with the MS modifier.

You are responsible for furnishing all of the same items and services after the 36-month rental period as you furnished during the 36-month rental period. With the exceptions of oxygen contents and the general maintenance and servicing visit, you must furnish these items and services without charging Medicare or the beneficiary.

Payment is not allowable for supplier pickup or disposal of oxygen tanks or cylinders that are no longer needed.

Replacement of Oxygen Equipment

If oxygen equipment is replaced because the equipment has been in continuous use by the beneficiary for the equipment's reasonable, useful lifetime or is lost, stolen, or irreparably damaged, the beneficiary may elect to obtain a new piece of equipment. In these situations, a new 36-month rental period and a new reasonable, useful lifetime is started on the date that the new replacement item is furnished.

Note: Irreparable damage refers to a specific incident of damage to equipment, such as equipment falling down a flight of stairs, as opposed to equipment that is worn out over time.

When billing the first month of rental for replacement oxygen equipment, you should append the RA modifier to the appropriate HCPCS code for the equipment. You also must include a narrative explanation of the reason why the equipment was replaced and maintain supporting documentation in your files. For example, if equipment is stolen, you should keep a copy of the police report in your files. For lost or irreparably damaged equipment, you should maintain any documentation that supports the narrative account of the incident. For reasonable, useful lifetime replacements, the narrative explanation should include the date that the beneficiary received the equipment being replaced. *Note: Please do not include the RA modifier on the second or subsequent months of rental.*

When submitting claims electronically for replacement of oxygen equipment, you may use, for the narrative explanation, loop 2400 (line note), segment NTE02 (NTE01=ADD) of the ASC X12, version 5010A1 professional electronic claim format. If you are billing a paper claim using the Form CMS-1500, you may report this information in item 19 of the claim form. For more information about claim submission, please see Chapter 6 of this manual.

A new certificate of medical necessity (CMN) is required in situations where oxygen equipment is replaced because the equipment has been in continuous use by the beneficiary for the equipment's reasonable, useful lifetime or is lost, stolen, or irreparably damaged. New testing, however, is not required unless it is necessary in order to meet existing medical review guidelines for oxygen and oxygen equipment. You should continue to follow the existing guidelines requiring recertification CMNs for all situations in which oxygen equipment is being replaced. The most recent qualifying value and testing date should be entered on the CMN.

As is the case for all DME items, you must maintain proof of delivery documentation in your files for replacement oxygen equipment. In addition, for equipment that is being replaced because it has been in continuous use by the beneficiary for the reasonable, useful lifetime and the beneficiary has

elected to obtain new equipment, you must also have proof of delivery documentation in your files for the item being replaced that documents that the oxygen equipment has been in use for at least five years.

Change in Oxygen Equipment during the Reasonable, Useful Lifetime Period

The reasonable, useful lifetime for stationary or portable oxygen equipment begins when the oxygen equipment is first delivered to the beneficiary and continues until the point at which the stationary or portable oxygen equipment has been used by the beneficiary on a continuous basis for five years. Computation of the reasonable, useful lifetime is not based on the age of the equipment.

If there is a change in oxygen equipment modalities (e.g., from a concentrator to a stationary liquid oxygen system) prior to the end of the reasonable, useful lifetime period, this does **not** result in the start of a new reasonable, useful lifetime period or a new 36-month payment period. In addition, if you have to replace oxygen equipment that is not functioning properly prior to the end of the reasonable, useful lifetime period, this does not result in the start of a new reasonable, useful lifetime period or a new 36-month payment period. Finally, if the beneficiary switches to a new supplier and new equipment prior to the end of the reasonable, useful lifetime period, this does not result in the start of a new reasonable, useful lifetime period or a new 36-month payment period.

A beneficiary may elect to obtain new oxygen equipment at the end of the five-year reasonable, useful lifetime period in these situations.

Continuous Use of Oxygen and Oxygen Equipment

The instructions pertaining to payments for capped rental items during a period of continuous use also apply to the monthly payment amounts for oxygen and oxygen equipment and the portable oxygen equipment add-on payments.

A period of continuous use allows for temporary interruptions in the use of the equipment. For breaks in need (beneficiary no longer needs or uses the equipment) of less than 60 days plus the days remaining in the last paid rental month, the period of continuous use does not start over and so the count of continuous months picks up where it left off before the break. For example, if the last paid rental month is month #31 and there is a 50-day break in need, the next paid rental month would be month #32.

If, however, there is a break in need more than 60 days plus the days remaining in the last paid rental month, and the need for the equipment resumes at a later date, a new period of continuous use, a new 36-month payment period, and a new reasonable, useful lifetime period would begin provided that you have submitted the following:

- New medical necessity documentation (i.e., a new CMN) and retesting for oxygen and oxygen equipment and/or portable oxygen equipment; AND
- A narrative explanation describing the reason for the interruption which shows that medical necessity in the prior episode ended. When submitting claims electronically for replacement of oxygen equipment, you may use, for the narrative explanation, loop 2400 (line note), segment NTE02 (NTE01=ADD) of the ASC X12, version 5010A1 professional electronic format. If you are billing a paper claim using the Form CMS-1500, you may report this information in item 19 of the claim form. You are not to use modifier RA on these claims.

Note: If medical necessity for the equipment continues during a break in billing/Part B payment (e.g., the beneficiary is hospitalized for 70 days but continues to use oxygen equipment during the hospital stay), this DOES NOT constitute a break in need, and therefore, a new period of continuous use

DOES NOT begin. In these situations, the count of continuous months picks up where it left off before the break.

Beneficiary Relocation Issues

If the beneficiary relocates before the end of the 36-month rental period, he/she should work with his or her supplier to make arrangements to continue receiving oxygen and oxygen equipment from a new supplier at his or her new place of residence.

If the beneficiary relocates after the 36-month rental period, the supplier is required to continue furnishing oxygen and oxygen equipment, and therefore must make arrangements for the beneficiary to continue receiving oxygen services at his or her new place of residence.

Modifiers

The monthly payment amount for stationary oxygen is subject to adjustment depending on the amount of oxygen prescribed (liters per minute, or LPM) and whether or not portable oxygen is also prescribed.

QE	Use if the prescribed amount of oxygen is **less** than 1 LPM.
QF	Use if the prescribed amount of oxygen **exceeds** 4 LPM and portable oxygen is prescribed.
QG	Use if the prescribed amount of oxygen is **greater** than 4 LPM.
QH	Use if an oxygen conserving device is being used with an oxygen delivery system.
RR	Rental
MS	Maintenance and Service

Oxygen Contents

When a stationary oxygen system is being rented, the monthly allowance includes payment for all required contents (during the 36-month rental period). It would be considered “unbundling” if you billed the beneficiary separately for contents in this scenario. If the beneficiary owns an oxygen stationary system other than an oxygen concentrator or uses a portable system only, payment may be made for contents.

If a patient owns both a stationary gaseous or liquid system and a portable gaseous or liquid system, bill two codes—one for the stationary contents (E0441, E0442) and one for the portable contents (E0443, E0444).

These contents codes are a monthly allowance. Contents may only be billed once a month, not daily or weekly.

Contents after the 36-Month Cap

If you furnished liquid or gaseous oxygen equipment during the 36-month rental period, you are responsible for furnishing the oxygen contents used with the oxygen equipment for any period of medical need following the 36-month rental cap for the remainder of the reasonable, useful lifetime of the equipment. In these situations, you can bill for and receive a monthly payment for furnishing oxygen contents (see chart below).

Payment for both oxygen contents used with stationary oxygen equipment and oxygen contents used with portable oxygen equipment is included in the 36 monthly payments for oxygen and oxygen equipment (stationary oxygen equipment payment) made for codes E0424, E0439, E1390, or E1391. Beginning with dates of service on or after the end date of service for the month representing the 36th payment, you may bill on a monthly basis for furnishing oxygen contents (stationary and/or portable), but only in accordance with the following chart:

Equipment Furnished in Month 36	Monthly Contents Payment after Stationary Cap
Oxygen Concentrator (E1390, E1391, or E1392)	None
Portable Gaseous Transfilling Equipment (K0738)	None
Portable Liquid Transfilling Equipment (E1399)	None
Stationary Gaseous Oxygen System (E0424)	Stationary Gaseous Contents (E0441)
Stationary Liquid Oxygen System (E0439)	Stationary Liquid Contents (E0442)
Portable Gaseous Oxygen System (E0431)	Portable Gaseous Contents (E0443)
Portable Liquid Oxygen System (E0433, E0434)	Portable Liquid Contents (E0444)

You may not bill for stationary oxygen contents if the beneficiary uses a stationary concentrator and you may not bill for portable oxygen contents if the beneficiary uses a portable concentrator or transfilling equipment.

If the beneficiary began using portable gaseous or liquid oxygen equipment (E0431, E0433, or E0434) more than one month after they began using stationary oxygen equipment, monthly payments for portable gaseous or liquid oxygen contents (E0443 or E0444) may begin following the stationary oxygen equipment payment cap AND prior to the end of the portable equipment payment cap (code E0431 or E0434). As long as the beneficiary is using covered gaseous or liquid portable oxygen equipment, payments for portable oxygen contents may begin following the stationary oxygen equipment payment cap. This will result in a period during which monthly payments for E0431 and E0443, in the case of a beneficiary using portable gaseous oxygen equipment, or E0434 and E0444, in the case of a beneficiary using portable liquid oxygen equipment, overlap. In these situations, after the 36-month portable oxygen equipment payment cap for E0431, E0433, or E0434 is reached, monthly payments for portable oxygen contents (E0443 or E0444) would continue.

If the beneficiary began using portable gaseous or liquid oxygen equipment (E0431, E0433, or E0434) following the 36-month stationary oxygen equipment payment period, payments may be made for both the portable equipment (E0431 or E0434) and portable contents (E0443 or E0444).

In all cases, separate payment for oxygen contents (stationary or portable) would end in the event that a beneficiary receives new stationary oxygen equipment and a new 36-month stationary oxygen equipment payment period begins (i.e., in situations where stationary oxygen equipment is replaced because the equipment has been in continuous use by the beneficiary for the equipment's reasonable, useful lifetime or is lost, stolen, or irreparably damaged). Again, the monthly payment for stationary oxygen equipment includes payment for BOTH stationary AND portable oxygen contents. Therefore, under no circumstances can you receive both the monthly stationary oxygen equipment payment and payment for either stationary OR portable oxygen contents.

The following are some examples:

Example #1

The beneficiary has a stationary liquid oxygen system (E0439) which has capped out and a portable liquid oxygen system (E0434) which has not capped out. You may bill for liquid stationary contents (E0442), the portable liquid system (E0434), and portable liquid contents (E0444) simultaneously. Once the portable liquid system (E0434) has also capped out, you would bill both contents codes (E0442 and E0444) for the remainder of the reasonable, useful lifetime of the equipment.

Example #2

The beneficiary has a portable liquid system (E0434) which has capped out and a stationary liquid system (E0439) which has not capped out. In this case, the only code that you may bill is the E0439. Contents would not be payable until the E0439 has also capped out. Once the E0439 has capped out, then you may bill contents for both stationary and portable (E0442 and E0444).

Following the stationary oxygen equipment payment cap, you may bill for oxygen contents (stationary and/or portable in accordance with the chart above) on the anniversary date of the oxygen equipment billing. For example, if the 36th month of continuous use of the stationary oxygen equipment begins on March 11th and ends on April 10th, you may begin billing for monthly oxygen contents that the beneficiary will use after the cap on April 11th.

For subsequent months, you do not need to deliver the oxygen contents every month in order to continue billing for the contents on a monthly basis. A maximum of three months of oxygen contents can be delivered at one time. In these situations, the delivery date of the oxygen contents does not have to be the date of service (anniversary date) on the claim; however, in order to bill for contents for a specific month, you must have previously delivered quantities of oxygen that are sufficient to last for one month following the date of service on the claim. You are required to have proof of delivery for each actual delivery of oxygen, but as discussed above, this may be less often than monthly. For example, if you deliver 30 oxygen tanks on April 11th and the beneficiary only uses 15 tanks from April 11th through May 10th and 15 tanks from May 11th through June 10th, you may bill for contents on April 11th and again on May 11th for contents delivered on April 11th that were used for two months.

Oxygen Equipment and Contents Billing Chart

The following chart indicates what oxygen fee schedule component is billable/payable under various transaction scenarios.

Situation: Beneficiary Uses a Stationary System Only

1. Rental

Type of System	Stationary Contents Code	Portable System Code	Portable Contents Code
Concentrator	No	No	No
Gaseous	No*	No	No
Liquid	No*	No	No

* Contents are included in the allowance for rented oxygen stationary system during the 36-month rental period

2. Purchase (or Capped)

Type of System	Stationary Contents Code	Portable System Code	Portable Contents Code
Concentrator	No	No	No
Gaseous	E0441	No	No
Liquid	E0442	No	No

Situation: Beneficiary Uses Both a Stationary and Portable System

1. Rents Stationary/Rents Portable

Type of System	Stationary Contents Code	Portable System Code	Portable Contents Code
Concentrator	No	E1392	No
Gaseous	No*	E0431	No*
Liquid	No*	E0433, E0434	No*

* Contents are included in the allowance for rented oxygen stationary system during the 36-month rental period

2. Rents Stationary/Owns (or Capped) Portable

Type of System	Stationary Contents Code	Portable System Code	Portable Contents Code
Concentrator	No	No	No
Gaseous	No*	No	No*
Liquid	No*	No	No*

* Contents are included in the allowance for rented oxygen stationary system during the 36-month rental period

3. Owns (or Capped) Stationary/Owns (or Capped) Portable

Type of System	Stationary Contents Code	Portable System Code	Portable Contents Code
Concentrator	No	No	No
Gaseous	E0441	No	E0443
Liquid	E0442	No	E0444

4. Owns (or Capped) Stationary/Rents Portable

Type of System	Stationary Contents Code	Portable System Code	Portable Contents Code
Concentrator	No	E1392	No
Gaseous	E0441	E0431	E0443
Liquid	E0442	E0433, E0434	E0444

Situation: Beneficiary Uses a Portable System Only

1. Rents Portable System

Type of System	Stationary Contents Code	Portable System Code	Portable Contents Code
Concentrator	No	E1392	No
Gaseous	No	E0431	E0443
Liquid	No	E0433, E0434	E0444

2. Owns (or Capped) Portable System

Type of System	Stationary Contents Code	Portable System Code	Portable Contents Code
Concentrator	No	No	No
Gaseous	No	No	E0443
Liquid	No	No	E0444

Supplier Exit from the Oxygen Equipment Business

CMS issued instructions to the DME MACs to process claims for replacement oxygen and oxygen equipment in the event that a supplier exits the Medicare oxygen business, whether voluntarily or due to revocation of billing privileges, and is no longer able to continue furnishing oxygen and oxygen equipment. This applies to both competitive bid and non-competitive bid areas.

In these situations, CMS considers the equipment "lost" under the Medicare regulations at 42 CFR §414.210(f), which provides that a patient may elect to obtain a new piece of equipment if the equipment has been in continuous use by the patient for the equipment's reasonable useful lifetime or has been lost, stolen, or irreparably damaged. When considering "lost" equipment, the DME MACs will establish a new 36-month rental period and reasonable useful lifetime for the new supplier furnishing replacement oxygen and oxygen equipment on the date that the replacement equipment is furnished to the beneficiary.

Obligations of Exiting Supplier

Suppliers voluntarily exiting the Medicare program are reminded that they are in violation of their regulatory and statutory obligations. Section 1834(a)(5)(F)(ii)(I) requires that the supplier that received the 36th month rental payment continue furnishing the oxygen equipment during any period of medical need for the remainder of the equipment's reasonable useful lifetime. Further, 42 CFR

414.226(g)(1) requires, barring a few exceptions, that the supplier that furnishes oxygen equipment in the first month during which payment is made must continue to furnish the equipment for the entire 36-month period of continuous use, unless medical necessity ends. As such, oxygen suppliers that do not fulfill their oxygen obligations and voluntarily exit the Medicare oxygen business are not in compliance with the DMEPOS supplier standards set forth at 42 CFR 424.535(c). Violations of the supplier standards are reported to the National Supplier Clearinghouse.

Suppliers voluntarily exiting the program are strongly encouraged to provide a minimum of 30 days notice to the beneficiary of their intention to no longer provide oxygen therapy services. This should be provided in writing and may take one of two forms:

- A letter to the beneficiary notifying them of the supplier's intention to discontinue oxygen therapy services. The letter must specify a date upon which this will occur; or,
- Working with the beneficiary, a letter to a new supplier selected by the beneficiary, transferring provision of oxygen therapy services to the new supplier as of a specific date.

Suppliers exiting through revocation are not subject to the notification requirements suggested above.

Obligations of New Supplier

For suppliers who receive beneficiaries from providers who have exited the Medicare oxygen business, claims for replacement equipment must:

- For the first month claim, append the RA modifier (Replacement of a DME item) on the claim line(s) for the replacement equipment; and,
- Document in the narrative field of the claim that "Beneficiary acquired through supplier voluntarily exiting Medicare program" or similar statement.
    - When submitting claims electronically, use loop 2400 (line note), segment NTE02 (NTE01+ADD) of the ASC X12, version 5010A1 electronic claim format.
    - When billing using the Form CMS-1500 paper claim, include the narrative information in item 19 of the claim form.
    - Home health agencies billing using the UB-04 paper claim may report this information in Form Locator 80 (Remarks).

In addition to providing the above information on the replacement equipment claim, in the event of an audit, suppliers should be prepared to provide documentation demonstrating that the beneficiary was transferred from a supplier exiting the Medicare oxygen program. Examples of documentation to meet this requirement include:

- Copy of notice sent to the beneficiary from the old supplier indicating that the supplier's services were being terminated; or,
- Letter from the old supplier to the new supplier indicating transfer of the beneficiary due to the voluntary exit from the Medicare program; or,
- Attestation statement from the beneficiary indicating that the beneficiary (or their caregiver) has attempted to contact their existing supplier and has been unable to obtain service.

If the new supplier is unable to obtain the documentation required above, the supplier may not append the RA modifier to the claim and may not initiate a new 36-month capped rental period.

Suppliers accepting transfer of beneficiaries are reminded that all Medicare rules apply. This includes obtaining:

1. New order
2. New initial Certificate of Medical Necessity (CMN)
    a. Repeat blood gas testing is not required. Enter the most recent qualifying value and test date. This test does not have to be within 30 days prior to the Initial Date. It could be the test result reported on the most recent prior CMN.
    b. There is no requirement for a physician visit that is specifically related to the completion of the CMN for replacement equipment.
3. Medical necessity documentation as outlined in the Oxygen LCD

Be sure to review the entire Oxygen LCD Policy Article for additional information on coding, coverage, and documentation requirements.

7. Medicare Advantage Plan Beneficiaries Transferring to Fee-For-Service Medicare

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §10.3

A beneficiary who was previously enrolled in a Medicare Advantage Plan, returning to traditional Fee-For-Service (FFS) Medicare, is subject to the same benefits, rules, requirements, and coverage criteria as a beneficiary who has always been enrolled in FFS Medicare. Therefore, if a beneficiary received any items or services from their Medicare Advantage Plan, they may only continue to receive such items and services if they would be entitled to them under FFS Medicare coverage criteria and documentation requirements.

For example, a beneficiary who has obtained a capped rental item (e.g., hospital bed) through a Medicare Advantage Plan must, under traditional FFS Medicare, obtain a Certificate of Medical Necessity (CMN), if applicable, and meet FFS Medicare criteria for the item before a new capped rental period would begin.

A partial exception to this rule involves home oxygen claims. If a beneficiary begins taking oxygen while under a Medicare Advantage Plan, you must obtain an initial CMN and submit it to the DME MAC at the time that FFS coverage begins. In this situation, the beneficiary does not have to obtain the blood gas study on the CMN within 30 days prior to the date on the CMN, but the test must be the most recent study the beneficiary obtained while in the Medicare Advantage Plan, under the guidelines specified in Local Coverage Determination. It is important to note that just because a beneficiary qualified for oxygen under a Medicare Advantage Plan does not necessarily mean that he or she will qualify for oxygen under FFS. These instructions apply whether a beneficiary voluntarily returns to FFS or if he/she involuntarily returns to FFS because their Medicare Advantage Plan no longer participates in the Medicare+Choice program.

You should maintain open communication with beneficiaries and determine, prior to delivery of an item or continued rental, whether there has been a change in enrollment from a Medicare Advantage

Plan to FFS Medicare. You may contact our Interactive Voice Response (IVR) unit at 1.877.299.7900 to determine if a beneficiary is enrolled in a Medicare Advantage Plan.

8. Supplies and Accessories Used with Beneficiary-Owned Equipment

For supplies and accessories used with beneficiary-owned equipment (equipment that is owned by the beneficiary, but was not paid for by the DME MAC/fee-for-service Medicare), all of the following information must be submitted with the initial claim in Item 19 on the CMS-1500 claim form or in the NTE segment for electronic claims:

- HCPCS code of base equipment
- A notation that this equipment is beneficiary-owned
- Date the patient obtained the equipment

Claims for supplies and accessories must include all three pieces of information listed above. Claims lacking any one of the above elements will be denied for missing information.

Medicare requires that supplies and accessories only be provided for equipment that meets the existing coverage criteria for the base item. In addition, if the supply or accessory has additional, separate criteria, these must also be met. In the event of a documentation request from the DME MAC or a redetermination request, you should provide information justifying the medical necessity for the base item and the supplies and/or accessories. Refer to the applicable Local Coverage Determination(s) and related Policy Article(s) for information on the relevant coverage, documentation, and coding requirements at http://www.cgsmedicare.com/jb/coverage/LCDinfo.html.

9. Repairs, Maintenance, and Replacement

CMS Manual System, Pub. 100-02, *Medicare Benefit Policy Manual*, Chapter 15, §§110.2(A) – 110.2(C)

Under the circumstances specified below, payment may be made for repair, maintenance, and replacement of medically required DME, including equipment which had been in use before the beneficiary enrolled in Part B of the Medicare program. **Payments for repair and maintenance may not include payment for parts and labor covered under a manufacturer's or supplier's warranty.**

A – Repairs

To repair means to fix or mend and to put the equipment back in good condition after damage or wear. Repairs to equipment which a beneficiary owns are covered when necessary to make the equipment serviceable. If the expense for repairs exceeds the estimated expense of purchasing or renting another item of equipment for the remaining period of medical need, no payment can be made for the amount of the excess.

Repairs of rented equipment are not covered. This includes items in the frequent and substantial servicing, oxygen equipment, capped rental, and IRP payment categories which are being rented.

A new Certificate of Medical Necessity (CMN) and/or physician's order is not needed for repairs.

When billing for repairs, include the HCPCS code and date of purchase of the item being repaired (if the HCPCS code is not available, include the manufacturer's name, product name, and model

number of the equipment), the manufacturer's name, product name, model number, and supplier price list amount of the repair item provided, and the justification of the repair.

Use the RB modifier on DMEPOS claims to indicate replacement parts of a DMEPOS item (base equipment/device) furnished as part of the service of repairing the DMEPOS item (base equipment/device).

B – Maintenance

Routine periodic servicing, such as testing, cleaning, regulating, and checking of the beneficiary's equipment, is not covered. The beneficiary is expected to perform such routine maintenance rather than the supplier or some other person who charges the beneficiary. Normally, purchasers of DME are given operating manuals which describe the type of servicing an owner may perform to properly maintain the equipment. It is reasonable to expect that beneficiaries will perform this maintenance. Thus, hiring a third party to do such work is for the convenience of the beneficiary and is not covered.

More extensive maintenance which, based on the manufacturers' recommendations, is to be performed by authorized technicians, is covered as repairs for medically necessary equipment which a beneficiary owns. This might include, for example, breaking down sealed components and performing tests which require specialized testing equipment not available to the beneficiary.

Maintenance of purchased items that require frequent and substantial servicing is not covered. Maintenance of rented equipment other than the maintenance and servicing fee established for capped rental items is not covered.

A new CMN and/or physician's order is not needed for covered maintenance.

C – Replacement

Replacement refers to the provision of an identical or nearly identical item. Equipment which the beneficiary owns or is a capped rental item may be replaced in cases of loss or irreparable damage. Irreparable damage refers to a specific accident or to a natural disaster (e.g., fire, flood, etc.).

Irreparable wear refers to deterioration sustained from day-to-day usage over time and a specific event cannot be identified. Replacement of equipment due to irreparable wear takes into consideration the reasonable, useful lifetime of the equipment. If the equipment has been in continuous use by the beneficiary on either a rental or purchase basis for the equipment's useful lifetime, then the beneficiary may elect to obtain a new piece of equipment.

The reasonable, useful lifetime of durable medical equipment is determined through program instructions. In the absence of program instructions, DME MACs determine the reasonable, useful lifetime of equipment, but in no case can it be less than five years.

Computation of the useful lifetime is based on when the equipment is delivered to the beneficiary, not the age of the equipment. Replacement due to wear is not covered during the reasonable, useful lifetime of the equipment. During the reasonable, useful lifetime, Medicare does cover repair up to the cost of replacement (but not actual replacement) for medically necessary equipment owned by the beneficiary.

For a replacement to be covered, a new physician order and/or new CMN (if required) is needed to reaffirm the medical necessity of the item.

Cases suggesting malicious damage, culpable neglect, or wrongful disposition of equipment will be investigated and denied where the DME MAC determines that it is unreasonable to make program payment under the circumstances.

The following documentation is required when filing a Medicare claim for replacement:

- Reason for replacement
- New CMN (if required)

Use the RA modifier on DMEPOS claims to denote instances where an item is furnished as a replacement for the same item which has been lost, stolen, or irreparably damaged. *NOTE*: Use of the RA modifier implies that the entire DMEPOS item (base equipment) is being replaced. If a specific part is being replaced, but not the base equipment, the service is considered a repair and the RB modifier should be used on the claim.

Repair Labor Billing and Payment Policy

The following table contains repair units of service allowances for commonly repaired items billed under HCPCS code K0739 (Repair or Nonroutine Service for Durable Medical Equipment Other than Oxygen Equipment Requiring the Skill of a Technician, Labor Component, Per 15 Minutes). This applies to non-rented and out-of-warranty items. Units of service include basic troubleshooting and problem diagnosis. One unit of service = 15 minutes. Please note that there is no Medicare payment for travel time or equipment pick-up and/or delivery.

Type of Equipment	Part Being Repaired/Replaced	Allowed Units of Service (UOS)
Power Wheelchair	Batteries (includes cleaning and testing)	2
Power Wheelchair	Joystick (includes programming)	2
Power Wheelchair	Charger	2
Power Wheelchair	Drive wheel motors (single/pair)	2/3
Power Wheelchair	Shroud/Cowling	2
Power or Manual Wheelchair	Armrest or armpad	1
Power or Manual Wheelchair	Wheel/Tire (all types, per wheel)	1
Manual Wheelchair	Anti-tipping device	1
Hospital Bed	Pendant	2
Hospital Bed	Headboard/footboard	2
CPAP	Blower Assembly	2
Seat Lift	Hand Control	2

Seat Lift	Scissor mechanism	3
Patient Lift	Hydraulic Pump	2

You may only bill the allowable units of service listed in the above table for each repair, regardless of the actual repair time. Claims for repairs must include narrative information itemizing each repair and the time taken for each repair. Please note that Medicare does not pay for repairs to capped rental items during the rental period or items under warranty.

Repair/Replacement Chart

The following chart on repairs and replacements indicates when original or new suppliers need new CMNs or orders, or when the original CMN or order will be adequate for repairing or replacing DME.

CAPPED RENTAL (Rented) EQUIPMENT/DURABLE ACCESSORIES

Original Item Requires CMN				**Original Item Requires Only Order**			
Repair before or after 5 years	Replacement before 5 years (for wear)	Replacement before 5 years (for loss or damage)	Replacement after 5 years	Repair before or after 5 years	Replacement before 5 years (for wear)	Replacement before 5 years (for loss or damage)	Replacement after 5 years
N/A because covered by rental or M/S	N/A because covered by rental or M/S	N-CMN plus doc of why replacement necessary	N-CMN	N/A because covered by rental or M/S	N/A because covered by rental or M/S	N-ORD plus doc of why replacement necessary	N-ORD

INEXPENSIVE/ROUTINELY PURCHASED (IRP) (Rented) EQUIPMENT/DURABLE ACCESSORIES

Original Item Requires CMN				**Original Item Requires Only Order**			
Repair before 5 years	Replacement before 5 years (for wear)	Replacement before 5 years (for loss or damage)	Replacement after 5 years	Repair before or after 5 years	Replacement before 5 years (for wear)	Replacement before 5 years (for loss or damage)	Replacement after 5 years
N/A because covered by rental	N/A because covered by rental	N/A because covered by rental	N/A because not rented for 5 years	N/A because covered by rental	N/A because covered by rental	N/A because covered by rental	N/A because not rented for 5 years

CAPPED RENTAL (Purchased) OR IRP (Purchased) EQUIPMENT/DURABLE ACCESSORIES

Original Item Requires CMN				**Original Item Requires Only Order**			
Repair before or after 5 years	Replacement before 5 years (for wear)	Replacement before 5 years (for loss or damage)	Replacement after 5 years	Repair before or after 5 years	Replacement before 5 years (for wear)	Replacement before 5 years (for loss or damage)	Replacement after 5 years
Doc of why repair, but no order for actual repair; Repair up to $Rplcmnt	N/A - Only Cover Repair	N-CMN and doc of why replacement	N-CMN	Doc of why repair, but no order for actual repair; Repair up to $Rplcmnt	N/A - Only Cover Repair	N-ORD and doc of why replacement	N-ORD

ACCESSORIES FOR DME
Requiring More Frequent Replacement
Same Supplier or New Supplier

Original Item Requires CMN		**Original Item Requires Only Order**	
Repair before or after 5 years	Replacement before 5 years	Repair before or after 5 years	Replacement before 5 years
Doc of why repair, but no order for actual repair; Repair up to $Rplcmnt	O-CMN or N-CMN stating frequency of replacement; Frequency of replacement at discretion of DME MAC	Doc of why repair, but no order for actual repair; Repair up to $Rplcmnt	O-ORD or N-ORD stating frequency of replacement; Frequency of replacement at discretion of DME MAC

N-CMN = New CMN required

N-ORD = New Order required

M/S = Maintenance and service

N/A = Not applicable

DOC = Documentation

$Rplcmnt = Cost (dollar amount) of replacement

Temporary Replacement Items (HCPCS K0462)

Medicare allows a one-month rental payment for temporary replacement (HCPCS K0462) for beneficiary-owned equipment being repaired. When billing temporary replacement equipment under HCPCS code K0462, you must provide information pertaining to both the beneficiary-owned equipment and the temporary replacement equipment.

Claims must include a narrative describing:

- HCPCS code of patient-owned equipment being repaired, including manufacturer, brand name/number, and date of purchase
- Replacement equipment, including manufacturer and brand name/number
- Description of what was repaired
- Description of why the repair took more than one day to complete

When billing HCPCS code K0462, claims will be denied for missing information if the above narrative isn't included. If the claim denies, you will receive the following message: "The claim is missing information needed to make payment. Refer to the Denial Explanation Number for additional assistance. Resubmit the claim with all of the needed information."

Note that there is no fee schedule for code K0462, as payment is based on the type of replacement equipment that is provided. Payment will not exceed the rental allowance for the patient-owned equipment being repaired.

10. DMEPOS Competitive Bidding Program

Some of the rules and regulations discussed in this manual may be affected by the DMEPOS Competitive Bidding Program. For information about the rules and regulations of the DMEPOS Competitive Bidding Program, including exceptions to normal DME MAC guidelines, please refer to the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/index.html or the Competitive Bidding Implementation Contractor (CBIC) website at http://www.dmecompetitivebid.com.