Durable Medical Equipment (DME) for TRICARE

Major features include

- Durable Medical Equipment (DME) refers to supplies that are necessary for the treatment, habilitation or rehabilitation of a beneficiary. The equipment should provide the medically appropriate level of performance and quality for the medical condition present.
- **Note:** Some Durable Medical Equipment, Prosthetics, Orthotics and medical Supplies (DMEPOS) are a limited benefit.
- **Note:** Breast pumps and supplies services are determined by patient/newborn need. Please refer to the breast pump and supplies page at HumanaMilitary.com/BreastPumps for more information physician order/CMN requirements apply.
- **Certificate of Medical Necessity (CMN):** A document signed by the prescribing provider containing clinical information that supports the need for each item/services/supplies requested for a beneficiary.
- A physician's order or prescription itself can take the place of the CMN as long as it includes the necessary elements and signature. It is very important that the CMN or physician order be complete and current for the services/supplies/equipment to be covered. A copy of the CMN or order must be submitted with the claim or may be faxed to (608) 221-7542. Be sure to keep the CMN on file for at least one year.

At a minimum, the CMN must include:

- Type of equipment
- Diagnosis or reason
- Length of need*
- Beginning date
- Physician signature (nurse practitioner and physician assistant signatures are accepted)

***Length of need:** The length of need for DME is based on the doctor's determination; however, capped rental DME items should not exceed 15 months. capped rental items are capped at 13 months for a purchase and 15 months for a rental. Length of need can be more than 15 months for non-capped rental items. Lifetime use DME, for example, oxygen, would exceed the 15 month rule.

If there is no length of need on the CMN, the claim will be processed using a 15 month period.

Anytime there is a change in the prescription, the physician must provide an updated or new prescription or CMN for the DME to be submitted for claims.

Upgraded DME (deluxe, luxury or immaterial features)

An upgraded item of DME, which otherwise meets the DME benefit requirement and is medically necessary, is covered if the prescription specifically states the medical reason why an upgrade is necessary. For example, the beneficiary does not have the physical strength or balance required to lift a standard walker and therefore, one with wheels is required.

Equipment lacking documentation of medical necessity for the deluxe, luxury or immaterial feature device may have the TRICARE-allowed amount for the base model applied to the upgraded equipment, with the beneficiary responsible for the difference between the allowed amount for the base model and the provider's billed charges.

For a wheelchair, the upgrade must be required for the beneficiary to maintain basic mobility. (Reference *TRICARE Operations Manual, Chapter 8, Section 2.1* at TRICARE.mil)

DME providers must obtain a TRICARE specific noncovered service waiver form signed by the beneficiary in advance in order to collect from the beneficiary without fear of holding the beneficiary harmless for the additional cost due to upgrading. You can find a copy of the noncovered services waiver form at HumanaMilitary.com/provider/resources/#forms.

Referral/Authorization guidelines for DME

All TRICARE Prime, TRICARE Prime Remote and TRICARE Young Adult Prime beneficiaries require a referral for any DME billed under code E1399 or for any other miscellaneous code. Billed charge is the charge amount or negotiated amount submitted on the claim. E1399 should only be used for special and/or customized equipment for which no other HCPCS code has been assigned.

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- Active Duty Service Members require an authorization for all DMEPOS items
- Predetermination is available for non-prime beneficiaries

To determine if a specific DMEPOS is covered, or if a referral or authorization is required, go to the code lookup feature in provider self-service at HumanaMilitary.com.

An approved authorization does not take the place of a CMN or physician's order. A completed and current CMN or physician's order is required to submit with the claim.

Referrals and authorizations are generally considered valid for one year. The beneficiary should return to his or her Primary Care Manager (PCM) annually for assessment of his or her condition and ongoing treatment/needs and obtain a new referral, if needed.

Disclaimer: Codes, modifiers and suggested billing tips are as current as 01/2018. DME claims require the appropriate modifiers. Please refer to the TRICARE Policy and Reimbursement manuals to ensure claims are submitted with the appropriate modifiers. (*TPM Chapter 8, TRM Chapter 1*)

Rental vs. purchase

Depending on which is the least expensive for TRICARE, DMEPOS may be leased or purchased. When receiving claims for extended rentals, TRICARE evaluates the cost benefit of purchasing the equipment and will pay only up to the allowable purchase amount.

Repairs: Benefits are allowed for repair of beneficiary owned DME when it is necessary to make the equipment serviceable. This includes the use of a temporary replacement item provided during the period of repair.

Replacements: Benefits are allowed for replacement of beneficiary owned DME when the DME is not serviceable due to normal wear, accidental damage, a change in the beneficiary's condition or the device has been declared adulterated by the FDA. Exceptions exist for prosthetic devices.

Modifications: A wheelchair, or an approved alternative, which is necessary to provide basic mobility, including reasonable additional cost to accommodate a particular disability, is covered.

A duplicate item of DME, which otherwise meets the DME benefit requirement that is essential to provide a fail-safe in-home life support system, is covered.

MUE vs DUT and date spans

Medically Unlikely Edit (MUE) indicates that it is unlikely that more than X number of an item would be used in a day. This causes confusion as so many items are ordered on a 30-day or even a 90-day basis. DHA has a list of MUEs at TRICARE.mil. It is important to note that not all codes have a DHA determined MUE. Supplies should be filed using the date of service, not a date span, and should indicate the Day Units Time (DUT). (Code A7033 billed with 90 DUTs) Providers need to verify all information on TRICARE.mil before sending to claims processing. This field represents the number of units of an item you are submitting. For example, in the observation world one unit = one hour.

Note: Do not file claims with future dates.

Not all service units represent the same measure. Please be sure you know what, if any, units are associated with the code you are submitting on a claim. There are specific supplies that are distributed in a measure greater than a daily supply. These items are date spanned. There are very few of these and you should check before submitting a date spanned claim. (Example: Date span 01/01/18-01/31/18 for code B4035, and 31 as the DUT).

DME reimbursement/claims tips and guidelines

DMEPOS fee schedule: TRICARE uses the reimbursement rates established by the Centers for Medicare and Medicaid Services (CMS) or the CMAC state prevailing price for items of DMEPOS. CMS updates these rates quarterly during the year. Inclusion or exclusion of a reimbursement rate does not imply TRICARE coverage.

Note: If submitting claims electronically, you can fax the supporting documentation (CMN and or physician order) to (608) 221-7542. Please indicate on a coversheet enough information so the supporting documentation can be matched to the claim. Please be sure to send in within two to four days of submitting the claim.

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If you submit on paper, you may include the supporting documentation with the claim; however, there is no guarantee the documentation will be kept with the claim once it arrives in the mailroom.

Claims denied/rejected due to exceeding MUE/DUT limitations

Requests for reconsideration are an option for providers when services or supplies are denied or rejected due to units or services exceeding the daily limit. Reconsideration will not be considered for luxury or upgraded DME items. Reconsiderations must include documentation that supports the units billed, with as much clinical support as possible. Please follow the "reconsideration process" instructions. The coversheet and tips for filing a reconsideration are also available under the forms section of provider self-service at HumanaMilitary.com. Please do not confuse this with the initial claim filing and supporting documentation. This is a reconsideration process after claims have been denied.

Disclaimer: Codes, modifiers and suggested billing tips are as current as 01/2018

Billing guidelines regarding upgraded DME

Effective 03/03/2013, TRICARE allows the GA and GK modifiers for DME claims processing. This change allows for the recognition, but not payment of, upgraded DME items, except under certain circumstances. Providers are to bill codes with the GA and GK modifiers to indicate which service is the actual equipment ordered and the upgraded equipment ordered.

GA: This is the modifier to indicate the upgraded equipment.

GK: This is the modifier to indicate the actual equipment.

If the patient is not an ADSM, there must be both a GA and a GK modifier on the claim to indicate which service is the actual equipment and which service is the upgraded equipment. Providers will only be paid for the actual equipment.

Note: This change in policy affects all DME including eyeglasses and hearing aids. If only one modifier is present the line will deny as needing both modifiers. If both modifiers are present then we will issue payment on the line with the GK modifier as we normally do, and reject the line with the GA modifier indicating it is not medically necessary. This information will also be seen on the Explanation of Benefits (EOB) and remit.

If the patient is an ADSM and there is an authorization, the claim will process as it does today, even if the GA modifier is present. Cost for repairs for upgraded items that TRICARE did not purchase are also the responsibility of the beneficiary.

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