Priority Health	BILLING POLICY No. 060
DURABLE MEDICAL EQUIPMENT (DME) / PROSTHETICS & ORTHOTICS MODIFIERS	
Date of origin: Dec. 30, 2024	**Review dates: 12/24, 2/25**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise stated
- Medicaid follows MDHHS unless otherwise stated

DEFINITION

Durable medical equipment (DME) is any reusable object or device that provides therapeutic benefits to a patient in the home. DME is used to serve a medical purpose. It's not useful to a person in the absence of illness, disability or injury, and must be ordered or prescribed by a physician.

MEDICAL POLICY

- Durable Medical Equipment (#91110)
- Orthotics: Shoe Inserts, Orthopedic Shoes (#91420)
- Orthotics/Support Devices (#91339)
- Prosthetics - External (#91306)

POLICY SPECIFIC INFORMATION

Capped rental modifiers

Reminder – Capped rentals must include the RR modifier to identify the capped rental along with modifiers to identify the capped rental period:

- **KH** (DMEPOS item, initial claim, first month rental) is only to be used for the initial claim of the capped rental period
- **KI** (DMEPOS item, second- or third-month rental) is only to be used for the second and third months of the capped rental period
- **KJ** (DMEPOS item, parenteral enteral nutrition (PEN) pump or capped rental, months 4 to 15) is only to be used for the fourth through final month of the capped rental period

Functional modifiers K0-K4

Functional Modifiers have been developed to define ability (DME Medical Review Policy). When a lower limb prosthesis is billed without one of the functional modifiers, the prosthesis will be denied.

- **K0** indicates the prosthesis does not enhance the member's quality of life or mobility and medical policy (or for Medicare, LCD) will drive coverage when modifier is appended.
- **K1** identifies the prosthesis creates a functional level of 1 (see HCPCS for modifier definition)
- **K2** identifies the prosthesis creates a functional level of 2 (see HCPCS for modifier definition)
- **K3** identifies the prosthesis creates a functional level of 2 (see HCPCS for modifier definition)
- **K4** identifies the prosthesis creates a functional level of 2 (see HCPCS for modifier definition)

HCPCS codes that require modifier K2, K3 or K4:

- L5972 (Flexible keel foot)

- L5978 (Multiaxial ankle/foot)
- L5982-L5986 (Axial rotation unit)

HCPCS codes that require K3 or K4:

- L5610, L5613, L5614, L5722-L5780, L5814, L5822-L5840, L5848, L5856-L5858, L5859 (Fluid, pneumatic or electronic knee)
- L5961, L5973 (Endoskeletal ankle foot system)
- L5976, L5979-L5981, L5987 (All lower extremity prosthesis, foot system)

HCPCS code that requires K3:

- L5859

HCPCS code that requires K4:

- HCPCS Code - L5930

Modifier KF

According to CMS policy, external defibrillator (E0617, K0606) and osteogenesis stimulators (E0747-E0748, E0760, E0766) are classified as class III devices which must be submitted with modifier KF.

Wheelchair modifiers

- **KX** – Modifier should be appended to indicate that policy criteria has been met for all wheelchair DME items (includes base, seating, power devices, and additional accessories). Claims reported without KX modifier will deny as non-payable per medical policy. (Commercial, Medicaid products)
- **KX, GA, GY, GZ** – Per CMS local coverage determinations, one of these modifiers are required for claim processing all wheelchair DME items (includes base, power bases, seating, and additional accessories). Please review applicable LCD for additional guidelines. (Medicare)
- **RT, LT** – Laterality modifiers should be utilized to identify the right or left side when a bilateral accessory is supplied. Missing modifiers will result in a claim denial.

Pressure reducing support surfaces (Groups I, II, III)

- **KX** – Modifier should be appended to indicate that policy criteria has been met. Claims reported without KX modifier will deny as non-payable per medical policy. (Commercial, Medicaid products)
- **KX, GA, GY, GZ** – Per CMS local coverage determinations, one of these modifiers are required for claim processing. Please review applicable LCD for additional guidelines. (Medicare)
- **Group I** – E0181, E0182, E0184-E0189, E0196-E0199
- **Group II** – E0193, E0277, E0371- E0373
- **Group III** – E0194

Oxygen and associated equipment modifiers

- **KX** – Modifier should be appended to indicate that policy criteria has been met. Claims reported without KX modifier will deny as non-payable per medical policy. (Commercial, Medicaid products)
- **KX, GA, GY, GZ** – Per CMS local coverage determinations, one of these modifiers are required for claim processing. Please review applicable LCD for additional guidelines. (Medicare)

Respiratory assist devices, airway pressure devices and oral appliance or devices modifiers

- **KX** – Modifier should be appended to indicate that policy criteria has been met. Claims reported without KX modifier will deny as non-payable per medical policy. (Commercial, Medicaid products)
- **KX, GA, GY, GZ** – Per CMS local coverage determinations, one of these modifiers are required for claim processing. Please review applicable LCD for additional guidelines. (Medicare)

Glucose monitors modifiers

- **KS** – reported to identify if member is treated with insulin when billing for home glucose monitors. Claims without applicable modifier will be denied.
- **KX** – reported to indicate if member is insulin dependent and policy criteria is met. Claims without applicable modifier will be denied.

Prosthetics and orthotics modifiers

- **KX** – Modifier should be appended to indicate that policy criteria has been met. Claims reported without KX modifier will deny as non-payable per medical policy. (Commercial, Medicaid products)
- **KX, GA, GY, GZ** – Per CMS local coverage determinations, one of these modifiers are required for claim processing. Please review applicable LCD for additional guidelines. (Medicare)

Orthotic footwear modifiers

- **KX** – Modifier should be appended to indicate that policy criteria has been met. Claims reported without KX modifier will deny as non-payable per medical policy. (Commercial, Medicaid products)
- **KX, GA, GY** – Per CMS local coverage determinations, one of these modifiers are required for claim processing. Please review applicable LCD for additional guidelines. (Medicare)
- Diabetic shoes/inserts HCPCS A5500-A5507 or A5512-A5514 – **KX or GY**
- **RT or LT** (Diabetic shoes/inserts) HCPCS A5500 - A5514

Surgical dressing modifiers

- Modifiers **A1-A9** are utilized to identify surgical dressings used for primary or secondary dressing on surgical and debrided wounds. These modifiers also indicate the number of wounds in which the surgical supply is utilized (total number based on wounds with dressings)
- A6010-A6011, A6021-A6024, A6196-A6224, A6228-A6248, A6251-A6259, A6261-A6262, A6266, A6402-A6404, A6407, A6441-A6456, A4461, A4463, A6154 and miscellaneous surgical dressings (A4649) when applicable

Other DME related supplies modifiers

- **KX** – HCPCS codes A4310-A4328, A4332-A4360, or A5102-A5114 (Commercial and Medicaid)
- **KX** – HCPCS codes A6550, A7000 or E2402 (Urological supplies) (Commercial and Medicaid)
- **GA, GY, GZ or KX** – HCPCS codes A4310-A4328, A4332-A4360, or A5102-A5114 (Medicare)
- **GA, GY, GZ or KX** – HCPCS codes A6550, A7000 or E2402 (Medicare)

ESRD supplies modifiers

- When ESRD items are utilized for non-ESRD treatment, HCPCS codes should be reported with **AY** modifier
- HCPCS codes – A4215-A4218, A4244-A4248, A4450-A4452, A6204, A6215-A6216, A6250, A6260, A6402, E0210

Documentation requirements

We align with the Centers for Medicare & Medicaid Services (CMS) standard documentation requirements for supplies and DME. Reference CMS Article A55426 – Standard Documentation Requirements for All Claims Submitted to DME MACs.

Related billing policies

- Miscellaneous DME
- Positive airway pressure (PAP) devices for treatment of sleep apnea
- Prosthetic Orthotics and Footwear

RESOURCES

- CMS Medicare Coverage Database

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

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

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Dec. 30, 2024	This policy is comprised of information that has been available on the *Durable medical equipment (DME), Prosthetics and Orthotics* page in our online Provider Manual.
Feb. 14, 2025	Added “Disclaimer” section