Priority Health	BILLING POLICY No. 106
MISCELLANEOUS DURABLE MEDICAL EQUIPMENT (DME) SUPPLIES	
Effective date: Aug. 25, 2025 **Date of origin: June 19, 2025**	**Review dates: None yet recorded**

APPLIES TO

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

DEFINITION

This policy identifies the payment and documentation requirements associated with various durable medical equipment (DME) supplies.

MEDICAL POLICY

- Durable Medical Equipment (#91110) – reference for coverage details

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

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 for documentation requirements.

Frequency limits

Usual maximum quantity of supplies:
Capped rental devices should be billed with a date span that encompass the month being billed for the DME rental. The "from" date will identify the date the item was furnished to the member and the "to" date should reflect the last date of the date span for the item or supply. Accurately defining this date span will allow for accurate processing of the claim.

- Claims with dates of service that overlap will result in a denial.
- Supplies that are billed for a date span should also follow the "From" / "To" date guidelines.
- A Calendar Month is the period of duration from a day of one month to the corresponding day of the next month.
- To receive separate reimbursement for bilateral items, appropriate laterality modifiers must be used. Up to one unit per side, with a maximum of two rental rates within the same calendar month. Modifiers RT and LT should be submitted on separate lines for the same HCPCS code.

Code	Frequency limit
A4244	8 Per Month
A4245	2 Per Month

A4246	8 Per Month
A4247	4 Per Month
A4250	1 Per Month
A4265	6 Per 6 Months
A4281	1 Per Year
A4282	1 Per Year
A4283	1 Per Year
A4284	1 Per Year
A4285	1 Per Year
A4286	1 Per Year
A4330	10 Per Month
A4364	10 Per Month
A4450	240 Per Month
A4452	240 Per Month
A4455	1 Per Month
A4458	30 Per Month
A4657	10 Per Month
A4663	1 Per 2 Years
A4927	4 Per Month
A4930	200 Per Month
A7000	4 Per Month
A7002	4 Per Month
E0275	1 Per Year; 10 Per Year with Modifier RR
E0276	1 Per Year; 10 Per Year with Modifier RR

Modifiers

As indicated in our Durable Medical Equipment medical policy, the below modifiers will be required:

HCPCS modifiers

- **KX modifier**: 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 modifiers**: 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). See more information about modifiers in our Provider Manual.

Place of service

Review specific information regarding DME place of service billing requirements in our Durable Medical Equipment (DME) place of services (POS) billing policy.

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. See our fee schedules (login required).

Related policies

- Miscellaneous durable medical equipment (DME)

REFERENCES

- MDHHS

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