curative

TITLE:	DURABLE MEDICAL EQUIPMENT, PROSTHETICS AND ORTHOTICS
DEPARTMENT:	PAYMENT POLICY
ORIGINAL EFF. DATE:	11/12/2026
REVISION DATE:	N/A

1. PURPOSE

This Payment Policy outlines clear and consistent reimbursement guidelines to ensure compliant, transparent, and timely payment for medically necessary, cost-effective care.

2. SCOPE

This policy applies to the reimbursement of covered services for all members and providers. Curative will allow reimbursement for services according to the criteria outlined in this policy, unless modified or superseded by contractual language.

3. DEFINITIONS

The following terms are defined as follows regarding this policy.

3.1. **Durable Medical Equipment** Equipment prescribed by a licensed practitioner intended for repeated use in the home to serve a medical condition

3.2. **Place of Service** A code represented by a two-digit numeric character that is used on a professional claim to report where a service(s) was provided. The place of service code set list is maintained by The Centers for Medicare & Medicaid Services (CMS)

3.3. **Provider** An accredited, licensed, or certified hospital, non-hospital facility, or physician operating within their legal scope of practice

3.4. **Other Professional Provider** An approved, licensed non-physician practitioner or entity (e.g., Physician Assistants, Nurse Practitioners) recognized by the health plan and practicing within their legal scope of certification

3.5. **Same Specialty Providers** Physicians and/or Other Qualified Health Care Professionals of the same group and same primary specialty reporting the same Federal Tax Identification number.

4. POLICY

Disclaimer: These Payment Policies serve as a comprehensive guide for all providers, assisting in submitting accurate claims and outlining the essential framework for reimbursement. The determination that a service, procedure, or item is covered under a Curative member's benefit plan does not constitute a guarantee of payment. Services must meet medical necessity and authorization guidelines appropriate to the procedure and diagnosis and, where mandated, the members state of residence. Services rendered must be within the legal scope of practice for the specific type of provider and align with the professional credentials and training in the state where the care is furnished.

To ensure proper processing, providers are required to adhere to industry-standard, compliant codes and follow proper coding, billing, and submission guidelines. To ensure accurate reimbursement and proper claims adjudication, all services provided to the same member, by the same provider, and on the same date of service must be reported on a single claim. Current Procedure Terminology (CPT®*) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or relevant revenue codes must be used for billing. Codes submitted must be fully supported by corresponding documentation in the medical

record. Unless noted otherwise within a policy, these payment policies apply to both participating and non-participating providers and facilities.

Curative reserves the right to take corrective action, which may include the rejection or denial of the claim, or the recovery and/or recoupment of any previous claim payment if proper coding, billing guidelines, or these established payment policies are not followed. Providers may refer to the Provider Manual for guidance on addressing such actions, including the formal claim reconsideration, appeals, and dispute resolution processes.

These policies may be superseded by mandates within provider contracts, state or federal laws, or requirements issued by the Centers for Medicare & Medicaid Services (CMS). Curative retains the right to revise these policies as deemed necessary and will publish the most current version on the Curative website.

Reimbursement Guidelines

General Information

This policy outlines Curative's reimbursement criteria for the provision, rental, or purchase of designated Durable Medical Equipment, Prosthetics, and Orthotics (DMEPOS). This policy applies to Same Specialty Providers as well as vendors. The items must be appropriate for use in the home, be reusable, be able to withstand repeated use, be medically necessary due to a medical condition, be therapeutically beneficial to the patient as well as meet eligibility requirements according to the member's benefit plan.

Reimbursement is determined by the participating vendor's contracted rate or the applicable out-of-network fee schedule or payment methodology and may be subject to the application of other Curative policies. Exceptions may apply only where mandated by state, federal, CMS, or specific provider contracts.

To be considered for reimbursement, take-home DMEPOS and supply claims must be prescribed by a physician or other eligible provider and submitted by an authorized DMEPOS/supply vendor, Provider or Other Professional Provider under their legal scope of licensure or certification. Items must be reported on a CMS-1500 professional claim forms or its electronic equivalent. The appropriate HCPCS code(s) identifying the item and any applicable modifiers indicating the item is new, rented or used must be reported. The place of service reported on the claim should be where the device is intended to be used and must qualify as a patient's home as defined by CMS (Centers for Medicare and Medicaid Services). DME dispensed for use in a POS not recognized as a home will not be reimbursed.

Reimbursement is standardly denied for take-home DMEPOS and medical supplies issued by inpatient or outpatient hospital facilities, including any facility claims billed under take-home revenue codes. To report these services, the date of discharge must be used as the date of service on a professional claim with place of service 12, home.

The allowed units for an item will be determined according to the Centers for Medicare and Medicaid Services (CMS) established maximum units, industry standards, data analysis and standard practice guidelines standards.

Reimbursement of items are determined by the applicable HCPCS code, Curative payment methodology, member benefit plan, provider contract, and applicable state or federal requirements. Reimbursement of certain DME items as a purchased item or as a rental item is based on what is most cost-effective and clinically appropriate.

Purchase of DME

Purchasing DME items is approved under specific classifications. If the retail purchase price is $200 or less, purchasing is appropriate. Items that are commercially purchased 75% of the time may also be purchased such as blood glucose monitors or standard therapeutic braces. Items for expected long-term use should also be purchased if the purchase allowance, based on the contracted allowable or fee schedule, is below the projected rental total.

Non-routine, high-cost items over $200 may be purchased if it is anticipated to be a long-term item and the projected rental cost exceeds the purchase price and a trial period verifies member need, tolerance, compliance and benefit. Any maintenance is included in the purchase agreement. Total reimbursement is limited to the lesser of either the purchase price or the maximum number or rental months. The following modifiers may be applied to eligible codes according to the corresponding CMS DMEPOS Fee Schedule should be used as appropriate to indicate an item is being purchased:

- NU
- UE
- NR
- KM
- KN

Rental of DME

Rental may be appropriate when equipment is needed temporarily, is furnished for a trial period, continued use is clinically uncertain, or the equipment requires frequent and substantial servicing. Rental classification as either continuous or capped.

Rental reimbursement includes required maintenance, servicing, repairs, replacement equipment, parts, and standard accessories unless otherwise specified by the member's benefit plan, provider contract, or applicable law. The following modifiers may be applied to eligible codes according to the corresponding CMS DMEPOS Fee Schedule should be used as appropriate to indicate an item is being rented:

- RR
- KH
- KI
- KJ
- KR

Continuous Rental

Equipment requiring frequent and substantial servicing, including qualifying ventilators, may be reimbursed as a continuous rental for as long as it remains medically necessary, authorized, and covered. The supplier retains ownership of continuous-rental equipment.

Rentals are billed by calendar month. The date the rental begins should be entered in the "From" field on the claim and the corresponding date of the next month should be entered in the "Through" field. Multiple monthly periods should be reported on separate lines.

Example: E0601-RR From 6/15 To 7/14

E0601-RR From 7/15 To 8/14

If a rental period is interrupted by an inpatient stay, the date of discharge becomes the new "From" date.

Modifiers RT and LT may be applied to the code on separate claim lines to communicate separate items being used for each side of the body.

Capped Rental

Certain equipment, including CPAP devices and qualifying hospital beds, may be reimbursed as capped-rental equipment. Unless otherwise specified, capped-rental reimbursement is limited to 13 continuous monthly rental periods. Upon completion of the applicable capped-rental period, title to the equipment transfers to the member, and no additional rental charges for that equipment may be submitted to Curative or the member. Curative may authorize purchase before completion of the rental period when purchase is more cost-effective and clinically appropriate.

After capped-rental equipment becomes member-owned, subsequent maintenance and repair are governed by Curative's requirements for purchased or member-owned DME.

Initiation, Maintenance and Service

Codes identifying the delivery, technical set-up, clinical/nursing visits, and member/caregiver training are not eligible for separate reimbursement. Items excluded from coverage of DME include any non-standard modifications, mechanical or electrical add-ons, or unique materials that do not serve a therapeutic purpose such as decorative trims, customized wheels, backpacks, trays or auxiliary batteries.

The maintenance, repair and replacement of DME items and related supplies may be eligible for reimbursement under a maintenance agreement. The repair allowance cannot exceed the estimated cost of purchasing or renting an alternative item for the duration of the need for the item. The amount of the repair reimbursement is inclusive of any use of temporary loaned equipment. If a purchased unit requires substitution during servicing, replacement coverage will be negotiated via a standard rental-versus-purchase review or determined by the active maintenance contract. Modifier MS, Maintenance and Service, should be reported to be considered separate from the rental or purchase amount.

5. REFERENCE DOCUMENTS AND MATERIALS

5.1 Centers for Medicare and Medicaid Services (CMS), CMS Manual System, MedicareClaims Processing Manual 100-04, Chapter 20 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)Claims

5.2 Centers for Medicare and Medicaid Services (CMS), Fee Schedules, DMEPOS Fee Schedule Files

6. COLLABORATING DEPARTMENTS

6.1. Compliance

6.2. Medical Management

6.3. Network

6.4. System Configuration

7. POLICY & PROCEDURE CONTROL

This Policy will be reviewed at least annually and as necessary.

REVISION HISTORY			
Date	**Author**	**Version**	**Comments**
11-12 -2026	CJ Wisecarver	001	Initial Version