DME Coordination for Dual Eligible Members

PAYMENT FOR DURABLE MEDICAL EQUIPMENT

Medicare payment is available for rental or purchase of durable medical equipment used in an enrollee's home.

- A beneficiary's home may be their own dwelling, an apartment, a relative's home, a home for the aged or other type of institution.
- An institution may not be considered an enrollee's home if it is a hospital or a skilled nursing facility.

If an individual is a patient in an institution or a distinct part of an institution that meets the definition of a hospital or Skilled Nursing Facility (SNF), the individual is not entitled to have separate Part B payment made for rental or purchase of Durable Medical Equipment (DME). This concept applies even if the patient resides in a bed or portion of the institution not certified for Medicare.

Centers for Medicare and Medicaid Services (CMS) Places of Service Descriptions		
31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than individuals with intellectual disabilities.
33	Custodial Care Facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.

For detailed instructions on SNF payment bans, or denial of payment for new admission see the Medicare Claims Processing Manual 100-04, Chapter 6 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf.

Per 100-04 (Medicare Claims Processing Manual), Chapter 6 (SNF Inpatient Part A Billing and SNF Consolidated Billing):

> **20.1.1.1 - Correct Place of Service (POS) Code for SNF Claims (Rev. 1, 10-01-03)**
> Per chapter 26, of this manual, POS code 31 should be used with services for patients in a Part A covered stay and POS code 32 should be used with services for beneficiaries in a noncovered stay.

Carriers should adjust their prepayment procedure edits as appropriate.

Medicare payment of SNF Part A claims is made on the basis of a bundled prospective payment made to the SNF. However, there are certain services that are separately payable and they are defined by Medicare. DME is not separately payable for enrollees in a covered Part A stay. A list

of services that are separately payable in POS 31 for enrollees in a covered Part A stay can be found at the following web address: https://cms.gov/Medicare/Billing/SNFConsolidatedBilling/ The consolidated billing requirement confers on the SNF the billing responsibility for the entire package of care that residents receive during a covered Part A SNF stay and physical, occupational, and speech therapy services received during a non-covered stay.

Exception: There are a limited number of services specifically excluded from consolidated billing, and therefore, separately payable. For Medicare beneficiaries in a covered Part A stay, these separately payable services include:

- physician's professional services;
- certain dialysis-related services, including covered ambulance transportation to obtain the dialysis services;
- certain ambulance services, including ambulance services that transport the beneficiary to the SNF initially, ambulance services that transport the beneficiary from the SNF at the end of the stay (other than in situations involving transfer to another SNF), and roundtrip ambulance services furnished during the stay that transport the beneficiary offsite temporarily in order to receive dialysis, or to receive certain types of intensive or emergency outpatient hospital services;
- erythropoietin for certain dialysis patients;
- certain chemotherapy drugs;
- certain chemotherapy administration services;
- radioisotope services; and
- customized prosthetic devices.

For Medicare beneficiaries in a non-covered stay, only therapy services are subject to consolidated billing. All other covered SNF services for these beneficiaries can be separately billed to and paid by the Medicare contractor.

Location DME is provided	Medicare policy	Medicaid policy
31 – Skilled Nursing Facility Part A Skilled Stay (within the first 100 Medicare Skilled days)	Services are subject to SNF consolidated billing. The consolidated billing requirement confers on the SNF the billing responsibility for the entire package of care. Services are not separately payable.	Services are not separately payable due to being considered included in the SNF package of care.
32 – Skilled Nursing Facility Part B Skilled Stay (100 Medicare Skilled days are exhausted)	Services are considered non-covered and will deny to patient liability.	Medicaid will process as primary.
33 – Nursing Facility Custodial Care (considered patients home for payment purposes)	Services will process as primary	Medicaid will coordinate benefits with Medicare