MEDICAL BILLING INFO · PRACTICE RESOURCE

DME Billing Guide

HCPCS coding, modifiers, documentation standards, and the 2026 Medicare DMEPOS prior authorization expansion — for durable medical equipment suppliers and billing teams.

Edition: 2026 · Covers the CMS DMEPOS prior authorization final rule phase-in
For: DME suppliers, billing and prior-auth staff, RCM teams
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1. How to use this guide

DME billing fails less often on the code itself and much more often on the supporting pieces around it — the order, the delivery proof, the modifier, the prior authorization — not lining up with what was actually billed. This guide is organized around that reality: get the code right, then make sure everything attached to it tells the same consistent story.

2. HCPCS coding basics for DME

DME suppliers bill almost exclusively with **HCPCS Level II** codes rather than CPT codes. A few common categories:

Category	Example codes
Respiratory	`E0601 (CPAP), E1390 (oxygen concentrator), E0431 (portable oxygen)`
Mobility	`K0001 (standard wheelchair), K0005 (ultralightweight wheelchair), E0143 (folding walker)`
Diabetes management	`E0784 (insulin pump), E0607 (blood glucose monitor), A4253 (test strips)`
Hospital beds/support surfaces	`E0260 (semi-electric bed), E0277 / E0371–E0373 (pressure-reducing support surfaces)`
Orthotics/prosthetics	`L-codes for lower/upper limb orthoses and lower limb prosthetics`

Codes are only ever as good as what's attached to them — a correct HCPCS code with the wrong modifier, or without proof of delivery, denies just as often as the wrong code entirely.

3. Modifiers: what they mean and why claims fail without them

Modifier	Meaning
RR	Rental equipment
NU	New equipment, purchase
UE	Used equipment, purchase
RA	Replacement equipment
KX	Coverage/documentation requirements specific to the item have been met
KH / KI / KJ	Capped-rental billing phases (first month, months 2–3, months 4–15)

COMMON FAILURE POINT

A rental-versus-purchase mismatch is one of the most frequent, entirely preventable DME denials: the modifier has to match what actually happened to the equipment (rented vs. purchased vs. capped-rental phase), not just what the original order said at intake. If the arrangement changes mid-course, the modifier has to change with it.

4. Documentation that has to match the code, every time

Every DME claim component needs to describe the **same equipment lifecycle**: the order, the medical necessity, and the delivery all have to agree with each other and with the code billed.

- ☐ **Valid written order** (often called a WOPD — Written Order Prior to Delivery, required before delivery for many items).
- ☐ **Diagnosis and medical necessity documentation** supporting the specific item, not just a general diagnosis.
- ☐ **Prior authorization**, where the item is on CMS's required list (see next section) or the specific payer requires it.
- ☐ **Proof of delivery** — signed and dated confirmation the patient actually received the item, matching the billed date of service.

Equipment-specific requirements vary meaningfully by payer beyond this baseline — always check the specific item's Local Coverage Determination (LCD) for Medicare, or the payer's own DME policy.

5. 2026 Medicare DMEPOS prior authorization expansion

CMS has been expanding its required prior authorization list for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Suppliers must obtain prior authorization *before delivery* for any item on the current list — billing without it is one of the most avoidable denial causes in DME.

Items and effective dates (recent phase-in)

Effective date	Items added
April 13, 2026	Seven codes: additional orthoses and pneumatic compression devices (`E0651, E0652`)
October 28, 2026	Eight codes: additional orthoses, pressure-reducing support surfaces, and manual wheelchair base (`K0005`)

Rollout for a given item is often **phased by state/MAC jurisdiction** rather than nationwide on day one. For example, one recent upper-limb orthoses rollout ran:

- **Phase 1:** California, Florida, Michigan, New York
- **Phase 2** (about 3 months later): adds Arizona, Georgia, Illinois, Massachusetts, Ohio, Oregon, Pennsylvania, Texas
- **Phase 3** (about 6 months later): all remaining states

> **ACTION ITEM**
>
> Check your state's specific phase for each item on the required list before assuming a code is or isn't subject to prior authorization — "not required yet in my state" can flip to "required" between phases with only a few months' notice.

Review timeframes and the exemption program

- Standard prior authorization review: no more than 7 calendar days.
- Expedited review (medically urgent): 2 business days.
- Suppliers achieving a 90%+ provisional affirmation rate on prior authorization requests can apply for an optional exemption from the prior-authorization requirement for that item — the exemption process runs on an annual cycle.

6. Common denial reasons, and how to prevent them

Denial reason	Prevention
Missing prior authorization	Check the current required list and your state's phase-in status before delivery, not after the claim denies.
Medical necessity not supported	Documentation should support the specific item billed, not a general category ("a wheelchair" vs. the specific mobility limitations that justify *this* wheelchair).
Incorrect rental/purchase modifier	Confirm the modifier matches the current stage of the equipment's actual rental/purchase lifecycle, not just the original order.
Incomplete proof of delivery	Signed and dated delivery confirmation, matching the billed date of service, filed before the claim goes out.
Unmet item-specific coverage criteria	Check the item's LCD (Medicare) or payer-specific DME policy — generic "medical necessity" language is often not enough on its own.

7. Appeals workflow

- ☐ Identify the specific denial reason from the remittance advice — don't appeal generically.
- ☐ Attach the written order, delivery proof, and any additional medical necessity documentation the original claim lacked.
- ☐ For a missing prior authorization denial, confirm whether the item was actually on the required list for your state/date of service before appealing — sometimes the denial itself is the error.
- ☐ Track every appeal with a follow-up date; DME appeals with the Medicare Administrative Contractor (MAC) follow a defined redetermination timeline — know your MAC's current turnaround before assuming a claim is dead.

8. Quick-reference checklist

- ☐ Confirm HCPCS code and category against the item actually supplied.
- ☐ Confirm the rental/purchase modifier matches the equipment's current lifecycle stage.
- ☐ Written order (WOPD) on file before delivery.
- ☐ Check the current CMS required prior-authorization list and your state's phase-in status before delivery.
- ☐ Proof of delivery signed, dated, and matching the billed date of service.
- ☐ Medical necessity documentation specific to the item, not just the general diagnosis.
- ☐ Track prior authorization affirmation rate — a sustained 90%+ rate may qualify you for the annual exemption program.

This guide reflects the CMS DMEPOS prior authorization program and general DME billing practice as of September 2026, including recently published effective dates for specific HCPCS codes and MAC jurisdiction phase-ins. Prior authorization requirements, phase-in schedules, and coverage criteria change on CMS's own timeline and vary by state/MAC jurisdiction — always confirm the current required list and your jurisdiction's status directly with CMS or your MAC before relying on this guide for a specific claim. Published by Medical Billing Info as a free practice resource.