Texas | Medicaid

Reimbursement Policy
Durable Medical Equipment (Rent to Purchase)

Policy Number: **G-06052**
Policy Section: **DME and Supplies**
Last Approval Date: **10/6/2025**
Effective Date: **10/6/2025**

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Policy

The health plan allows reimbursement for professional claims billed for Durable Medical Equipment (DME) under specific guidelines, unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

The health plan requires that all DME claims be submitted with the applicable HCPCS code(s) and have the applicable modifier appended.

Reimbursement is based on the rental price up to the maximum allowed for the particular DME. The item is considered purchased once the purchase price has been met. There may be instances in which a particular item may be considered for direct purchase on a case-by-case basis.

Circumstances Affecting Rental Reimbursement

The reimbursement limit for rented DME is 10 months. Once the limit is met, claims submitted for the rental of the item will not be eligible for reimbursement:

- Rental periods that contain a break in coverage of more than 60 days will start the limitation count over.
- On the occasion that a member changes suppliers during the rental period, a new rental period will not start over.

Supplies, contents, and accessory components associated with oxygen rental DME are not separately reimbursed and considered all-inclusive in the rental reimbursement.

The health plan allows reimbursement for oxygen equipment on a monthly rental basis for a maximum of 36 months; however, we will continue to reimburse oxygen contents and supplies up to an additional 24 months, as applicable.

Items Not Considered DME

The following items are not considered DME:

- Prosthetics or orthotics
- Disposable medical supplies (DMS)

Note: This policy does not apply to direct-purchase DME.

Nonreimbursable DME

The health plan does not allow reimbursement for:

- Provision of DME that exceeds the benefit limit unless authorized through medical necessity.
- Repair or replacement of DME necessitated by abuse or neglect.
- Repair or replacement of DME during the warranty period.
- Enhancements or upgrades of DME for the convenience of the member or caregiver.
- The aesthetic appearance of DME for the preference of the member or caregiver.
- DME considered to be experimental or investigational.
- The purchase or rental of common household items that are not medically indicated.
- DME provided by a skilled nursing facility — this equipment is normally included as part of the facility charge and is not separately reimbursable, unless otherwise stated in a provider contract.

Related Coding

Standard correct coding applies.

Definitions

- **Durable Medical Equipment (DME):** Items that meet the following criteria:
  - Are primarily and customarily used to serve a medical purpose rather than convenience or comfort
  - Can withstand repeated use
  - Generally are not useful to a person without an illness or injury
  - Are appropriate for use in the home
  - Are prescribed by a licensed physician/practitioner

  All requirements in the definition must be met before an item can be considered DME.
- **Rent-to-purchase:** A time period where reimbursement is based on a monthly fee up to the amount that the item will be considered purchased.
- **Capped rental:** An amount reimbursed on a monthly rental basis, which will not exceed the applicable number of continuous months. If the service is billed beyond the maximum number of rental months, no additional reimbursement will be allowed.
- **General Reimbursement Policy Definitions**

Related Policies and Materials

- DME Modifiers for New, Rented and Used Equipment
- Reimbursement for Items under Warranty

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- State contract
- State Medicaid

Policy History

- **10/06/2025 -** Review approved and effective: no changes
- **06/13/2023 -** Review approved and effective: policy template updated; added clarification language for oxygen rental
- **10/18/2019 -** Review approved: policy language updated
- **02/01/2018 -** Review approved: policy language updated
- **09/01/2017 -** Review approved: policy language updated
- **01/01/2017 -** Review approved and effective: policy template updated
- **08/15/2007 -** Review approved 08/15/2007 and effective 12/13/2007
- **04/24/2007 -** Review approved and effective 04/24/2007: maximum allowed price clarified as purchase price; consideration for direct purchase clarified; Certificate of

Medical Necessity requirement clarified; non reimbursement of experimental or investigational DME clarified
- **08/09/2006 -** Initial approval and effective

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's benefit plan. The determination that a service, procedure, or item is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

Ensure that you use proper billing and submission guidelines, including industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedural Terminology (CPT®) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may:
- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.