Durable Medical Equipment (DME) Payment Policy

Applicability

This Policy applies to the following Fallon Health products:

☒ Fallon Medicare Plus, Fallon Medicare Plus Central (Medicare Advantage)
☒ MassHealth ACO
☒ NaviCare HMO SNP
☒ NaviCare SCO (Medicaid-only)
☒ Summit Eldercare PACE
☒ Fallon Health Weinberg PACE
☒ Community Care (Commercial/Exchange)

Policy

The Plan reimburses contracted suppliers for medically necessary covered durable medical equipment (DME), and supplies and accessories that are necessary for the effective use of medically necessary covered DME.

The Centers for Medicare and Medicaid Services (CMS) has established the following payment categories for DME:

- Inexpensive and other routinely purchased items
- Frequently serviced items. These Items require frequent and substantial servicing (equipment in this category is reimbursed on a rental basis only. The monthly rental payment includes supplies and accessories, maintenance and servicing and repairs. This category includes ventilators and continuous passive motion devices.)
- Other covered items. These are supplies that are necessary for the effective use of DME.
- Certain customized items
- Oxygen and oxygen equipment
- Capped rental items

Noridian Healthcare Solutions, LLC is the Medicare Durable Medical Equipment Medicare Administrative Contractor (DME MAC) with jurisdiction in the Plan's service area (Jurisdiction A). Current, active Noridian Healthcare Solutions, LLC Local Coverage Determinations (LCDs) can be found by searching the Medicare Coverage Database at: https://www.cms.gov/medicare-coverage-database/search.aspx.

Capped Rental Items

For capped rental items for all products except MassHealth ACO* the Plan will pay 10 monthly payments equal to the allowed amount for the purchase of the item, when the item is in continuous use by the plan member.

* Effective December 1, 2020, for capped rental items for MassHealth ACO plan members, the Plan will pay 13 monthly payments equal to the allowed amount for the purchase of the item, when the item is in continuous use by the plan member, unless otherwise specified in the supplier's contract. Capped rental items for MassHealth ACO plans must include the appropriate capped rental modifier: KH (for the 1st rental month), KI (for the 2nd and 3rd rental months) and KJ (for the 4th through 13th rental months).

The capped rental payment is inclusive of all costs for the effective use of the equipment by the plan member including maintenance and services, repairs or replacement, and supplies and accessories needed to use the equipment.

At the end of the capped rental period the plan member owns the equipment. The supplier will transfer ownership and any warranties to the plan member.

Continuous use
A period of continuous use allows for temporary interruptions in the use of equipment. Interruptions must exceed 60 consecutive days, plus the days remaining in the rental month in which the use ceases (not calendar month, but the 30-day rental period) in order for a new capped rental period to begin.

Modification or substitutions of capped rental items
If an item is changed to different but similar item and the plan member's condition has substantially changed to support the medical necessity for the new item, a new capped rental period will begin. Otherwise, the rental will continue to count against the current capped rental period. If the capped rental period has already expired, no additional rental payment will be made for modified or substituted items in the absence of substantial change in medical need. If a modification is added to existing equipment and there is a substantial change in medical need, the capped rental period for the original equipment continues and a new capped rental period begins for the added equipment.

Payment for Maintenance and Servicing
Payment for all maintenance, servicing, and repair of capped rental DME is included in the capped rental payment amounts. Therefore, under no circumstances will separate payment be made for these services prior to the end of the capped rental period.

The Plan will pay for reasonable and necessary maintenance, servicing and repair of member-owned capped rental items. Reasonable and necessary maintenance and servicing includes parts and labor not otherwise covered under a manufacturer’s or supplier’s warranty.

The supplier must maintain detailed records describing the need for and nature of all repairs including a detailed explanation of the justification for any component or part replaced as well as the labor time to restore the item to its functionality.

Replacement of Equipment
The Plan covers replacement of DME (capped rental or purchased items) during the reasonable useful lifetime (RUL) when the equipment is lost, irreparably damaged or the plan member’s condition changes such that the current equipment no longer meets the plan member’s needs. Unless otherwise stated, the RUL for DME is 5 years. The RUL starts on the date of delivery. The age of the equipment at the time of delivery is not a factor. The equipment must be in continuous use by the plan member. A new physician’s order is not required for replacement of capped rental DME due to loss or irreparable damage as long as the equipment originally ordered still meets the needs of the plan member.

- When indicating replacement due to irreparable damage, indicate how the item was damaged (fire, flood, etc.).
- When indicating replacement due to loss, indicate the nature of the loss (theft, fire, etc.).

The term "irreparable damage" is often confused with "irreparable wear." Irreparable damage, like loss or theft, is a rare, unexpected event that is an exception to the RUL rule. The Plan considers irreparable damage to have occurred when an item is damaged beyond repair by a specific incident or accident. If the cost to repair the item exceeds the cost of a replacement, the Plan would cover the replacement.

Irreparable wear refers to deterioration sustained from day-to-day usage over time and a specific event cannot be identified. Replacement of a DME item due to irreparable wear takes into consideration the RUL. The RUL of DME varies, but in no case can it be less than five (5) years. If the item has been in continuous use by the plan member for its RUL, the plan member may elect to obtain a replacement. (This means that replacement due to wear and tear is possible only after the 5-year RUL.) After the supplier transfers title for capped rental DME to the member, the supplier is responsible for furnishing replacement equipment at no cost to the member or the Plan if it is determined that the item will not last until the end of its 5-year reasonable useful lifetime. In making this determination, the Plan will consider whether the accumulated repair costs exceed 60% of the fee schedule amount for the item. Accumulated repair costs refer to all repair claims for a given item after the rental period ends. These repair costs represent the total of all repair costs after the plan member has assumed ownership of the item.

The terms of a provider contract may supercede the content of this policy.

Definitions

Durable medical equipment - An item for external use that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use in a member's home.

Power mobility device - A device that is battery-driven, designed for use by people with mobility impairments, and is used for the main purpose of indoor and/or outdoor locomotion. The term power mobility device (PMD) includes power operated vehicles (POV) and power wheelchairs (PWC).

Medical supplies and surgical dressings - Items which are primarily and customarily used to serve a medical purpose; are ordered or prescribed by a practitioner; and are not useful to a person in the absence of illness or injury. Medical supplies cannot withstand repeated use and are usually disposable in nature. Surgical dressings are therapeutic or protective coverings applied directly to wounds or lesions either on the skin or caused by an opening to the skin.

Reimbursement

The Plan will reimburse:

- The least costly DME that permits the member to perform activities of daily living.
- Rental or purchase of DME based on equipment needed, as set forth in the provider fee schedule.
- Costs associated with replacement parts and labor for DME that is member-owned.

The Plan will **not** reimburse:

- Repair or replacement of items lost or damaged due to abuse or neglect.
- Sales tax, shipping and handling, or restocking charges associated with obtaining DME with the exception of a shipping fee (A9901) for MassHealth members effective for dates of service on or after July 1, 2023.
- Spare or back-up equipment with the exception of a manual wheelchair for a MassHealth member who meets criteria in 409.413 (D) see **Backup manual wheelchair** below).
- Standard "off the shelf" batteries including but not limited to battery sizes AAA, AA, A, C, D, etc.
- Replacement during the reasonable useful lifetime of the equipment. These reasonable useful lifetimes are item-specific and are based on Medicare guidelines.

Equipment that is rented will be reimbursed up to, and not exceeding, the maximum allowed rental period. Providers may not bill the Plan or the member for further rental costs. In the event of a Plan member's death or disenrollment during the rental period, the equipment will be returned to the vDME supplier. In the event of a Plan member's death or disenrollment after the rental period is satisfied or the item is purchased, the equipment becomes the member's or belongs to the member's estate.

If the Plan rents or purchases any DME on behalf of an individual member receiving care within a facility (either purchased from the facility or from an independent DME provider), those items must be sent home with the member upon discharge from the facility. This would apply to any items not typically available within the facility.

Medicare Power Mobility Devices

The Centers for Medicare and Medicaid Services (CMS) classifies power wheelchairs and power operated vehicles collectively as "power mobility devices." The Durable Medical Equipment Medicare Adminstrative Carrier (DME MAC) with jusidiction over the Plan's service area is Noridian Healthcare Solutions. Please refer to Noridian's Local Coverage Determination for Power Mobility Devices (L33789) for coverage guidance and Noridian's Local Coverage Article for Power Mobility Devices (A52498) for billing and coding guidance for power wheelchairs and power operated vehicles.

Consistent with CMS guidelines, the following requirements must be met in order for reimbursement to be made. Supporting documentation must be complete and submitted to the Plan before the request for prior authorization will be considered.

- There must be an in-person (face-to-face) visit with a physician specifically addressing the patient's mobility needs.
- There must be a history and physical examination by the physician or other medical professional focusing on an assessment of the member's mobility limitation and needs. The results of this evaluation must be recorded in the member's medical record.
- A prescription must be written AFTER the in-person visit has occurred and the medical evaluation is completed. This prescription has seven required elements.
- The prescription and medical records documenting the in-person visit and evaluation must be sent to the equipment supplier within 45 days after the completion of the evaluation.

The in-person visit and mobility evaluation together are often referred as the "face-to-face evaluation." For further details regarding the face-to-face evaluation documentation requirements, please visit the following link: Power Mobility Devices (PMDs): Complying with Documentation & Coverage Requirements.

Power wheelchairs – Standard power wheelchairs are capped rental DME. The purchase option is available for complex, rehabilitative power wheelchairs (e.g., power wheelchairs with power seating systems and/or special controls needed by the plan member). Power wheelchairs are not covered for short-term use. The supplier will transfer the title to the plan member at the end of the capped rental period. The supplier must replace a capped rental item free of charge if it does not last the full 5-year period (i.e., is no longer serviceable or needs substantial repairs exceeding 60% of the cost to replace the item). This replacement equipment does not need to be new (42 CFR Section 414.210(e)(4)).

Power Operated Vehicles (POV) – Power Operated Vehicles can rented or purchased.

Replacement of a power mobility device during the 5-year reasonable useful lifetime (RUL) will only be authorized in limited situations involving loss or irreparable damage from a specific accident or natural disaster (e.g., fire, flood, etc.).

Irreparable wear refers to deterioration sustained from day-to-day usage over time and a specific event cannot be identified. Replacement of equipment due to irreparable wear takes into consideration the reasonable useful lifetime of the equipment. (This means that replacement due to wear and tear is possible only after the 5-year reasonable useful lifetime.)

The plan member may elect to obtain a replacement power mobility device, when the power mobility device has been in use on a continuous basis for five years. If a new power mobility device is needed after the 5-year RUL, all requirements for a new power mobility device must be met. Many new products are available, the codes have changed, and a plan member's functional status must be assessed through a new face-to-face evaluation in order to establish need.

Reimbursement for the wheelchair includes all labor charges involved in the assembly of the wheelchair. Reimbursement also includes support services, such as delivery, set-up, and education about the use of the power mobility device.

After ownership of the power mobility device has been transferred to the plan member, the Plan wll pay for parts and labor not otherwise covered under a manufacturer's or supplier's warranty.

Upgrades that are beneficial primarily in allowing the member to perform leisure or recreational activities are noncovered.

A power mobility device only for use outside the home is noncovered.

Backup chairs are denied as not medically necessary with the exception of a manual wheelchair for a MassHealth member who meets criteria in 409.413 (D) see MassHealth Mobility Systems, Backup Manual Wheelchair below) .

One month's rental of a PWC or POV (K0462) is covered if a plan member-owned wheelchair is being repaired. Payment is based on the type of replacement device that is provided but will not exceed the rental allowance for the power mobility device that is being repaired.

MassHealth Mobility Systems

Backup Manual Wheelchair

A manual wheelchair, including any necessary repairs, is covered as a backup to a power Mobility System (see *Definitio*n below) for a MassHealth member who is not residing in a nursing facility, or the member is residing in a nursing facility and has a written discharge plan, and one of the following conditions applies:

1. the level of customization of the member's primary power Mobility System would preclude the use of substitute rental equipment if the primary power Mobility System were removed for repair;
2. the member requires frequent outings to a destination that is not accessible to a power Mobility System (for example, stairs without an elevator); or
3. it is not possible to fit the primary mobility system in any of the vehicles available to the member for transportation.

Definition: Mobility System - a manual or power wheelchair or other wheeled device, such as a scooter, including a base, a seating system, its components, accessories, and modifications.

Source: MassHealth DME Manual, 130 CMR 409.413(D).

Repairs of a Member's Serviceable Retired Power Wheelchair

Effective for dates of service on or after July 1, 2022, repairs of a MassHealth member's Serviceable Retired Power Wheelchair are covered in accordance with 130 CMR 409.420(G) in the following instances:

1. the DME provider must obtain prior authorization from the Plan as a prerequisite for any repair of a member's Serviceable Retired Backup Power Wheelchair;
2. the member's medical complexity prevents them from being able to use a manual wheelchair or loaner power wheelchair when the primary mobility system needs repair;
3. the total cost of the repair of the Serviceable Retired Backup Power Wheelchair does not exceed $1,000.00 per calendar year unless the Plan exercises discretion to approve the total cost of the repair. The Plan will review requests exceeding $1,000.00 on a case-by-case basis;
4. the Plan will only pay for the repair of one Serviceable Retired Backup Power Wheelchair per calendar year;
5. DME providers must document the serial number of the repaired Serviceable Retired Backup Power Wheelchair and submit the documentation listed at 130 CMR 409.420(D)(2)(c), (d), and (e); and all documentation regarding the repaired Serviceable Retired Backup Power Wheelchair must remain in the member's file.

A serviceable backup mobility system is defined in 130 CMR 409.402 as a manual wheelchair approved by the MassHealth agency as a backup to a power wheelchair as identified in 130 CMR 409.413(D) or a MassHealth member's serviceable retired power wheelchair, that can be safely used by the MassHealth member when a manual backup or suitable loaner chair cannot be provided to meet the member's medical needs pursuant to 130 CMR 409.420(G).

MassHealth added the definition for Serviceable Backup Mobility System to support the repair of a member's manual wheelchair approved as a backup to a power wheelchair or to a serviceable retired power wheelchair when a manual wheelchair or suitable loaner power wheelchair is not available. See 130 CMR 409.420(G).

Additional Provider Guidance

The DME mobility provider must assess the member's medical mobility and positioning needs to determine if a suitable power wheelchair is available as a loaner on an as-needed basis. If the mobility provider determines that the member's needs cannot be met using a loaner power wheelchair and the member's retired chair is serviceable then the mobility provider should submit a PA for repair of the serviceable backup.

All documentation regarding the repaired serviceable backup power wheelchair must remain in the member's file.

PA requests must include:

- all HCPCS and labor codes regardless of the designation of “No” or “Sometimes” listed in the prior approval column on the MassHealth Durable Medical Equipment and Oxygen Payment and Coverage Guideline Tool;
- the serial number of the serviceable backup power wheelchair system being repaired;
- the U6 modifier when submitting the labor code K0739 UB or RB as identified on the DME and Oxygen Payment and Coverage Tool;
- a manufacturer invoice or quote for the repaired or replaced wheelchair part as applicable;
- a work order log with the estimated number of labor units required; and
- a brief description of the need to repair the retired serviceable backup power wheelchair.

Source: MassHealth Transmittal Letter DME-39 July 2022

Repair of Retired Serviceable Power Wheelchairs

In accordance with 101 CMR 322.03(16)(a), MassHealth implemented the use of the modifier U6 as an informational modifier. The U6 modifier is to be utilized with the repair code K0739 for any repair of a MassHealth member’s serviceable retired backup power wheelchair in accordance with 130 CMR 409.420 (G). All repairs to a member’s serviceable retired power wheelchair will require a prior authorization (PA). Durable medical equipment (DME) providers are required to include all relevant procedure codes when submitting PA for the repair of a member’s serviceable retired backup power wheelchair.

Modifier U6 is an informational modifier to be used in conjunction with K0739 and modifier UB/RB when repair is performed to member’s serviceable retired backup power wheelchair.

The use of these modifiers (RB U6 or UB U6, as applicable) in the exact modifier position is required to ensure accurate payment.

HCPCS Code and Modifiers	Description
K0739 RB U6	Repair or nonroutine service for durable medical equipment other than oxygen requiring the skill of a technician, labor component, per 15 minutes (repair, excluding ATP providers)
K0739 UB U6	Repair or nonroutine service for durable medical equipment other than oxygen requiring the skill of a technician, labor component, per 15 minutes (repair, ATP providers only)

Source: EOHHS Administrative Bulletin 22-14

Definition: Assistive Technology Professional (ATP) - An individual with experience in assistive/rehabilitation technology and certification by the Rehabilitation Engineering and Assistive Technology Society of North America who analyzes the equipment needs of persons with disabilities, assists in the selection of equipment, and trains the person with a disability on how to use the specific equipment. This equipment may include manual and power wheelchairs, seating and alternative positioning, ambulation assistance, environmental control, alternate computer access, augmentative and alternative communication devices, and products of daily living. Source: 101 CMR 322.02: General Definitions.

Payment for Evaluation Time

Effective for dates of service on or after July 1, 2023, DME mobility providers may bill for evaluation time when performing repairs to a MassHealth members’ primary or backup mobility system as identified in 130 CMR 409.00.

HCPCS code/modifier combination K0739 U7 may be used in the following circumstances:

- Providers may request up to two units for a mobility system repair evaluation. One unit is equal to one hour.
- Providers may directly bill HCPCS code/modifier combination K0739 U7 using a separate line item on a claim associated with the repair of a mobility system.

All documentation regarding the evaluation of the mobility system repair must remain in the member’s file and should identify if the evaluation was performed remotely or in person.

Modifier U7 - Used in conjunction with K0739 for direct service components when an evaluation is performed for the repair of a mobility system RE-1 and RE-2.

HCPCS Code and Modifier	Description
K0739 U7	Direct Service Component (RE units) for evaluation of repair of a mobility system RE-1 and RE-2 when evaluation is performed. (One RE unit equals one hour.)

Definition: Direct Service Component (RE Units) - Payment to an eligible DME provider for the initial evaluation of customized seating, positioning, mobility systems, installation of customized movable and fixed patient lift systems, and assembly of at pre-approved levels of time and complexity as defined in 101 CMR 322.03(2).

Source: MassHealth Transmittal Letter DME-43 July 2023

Replacement of a Member's Primary Mobility System

The Plan covers replacement of a MassHealth member's primary Mobility System in accordance with 409.413(E) when the DME provider has obtained prior authorization and

(1) the existing primary mobility system exceeds five years of age or is no longer reliable as a primary mobility system in all settings in which normal life activities take place;
(2) the cost of repairing or modifying the existing primary mobility system would exceed the value of that system; or
(3) the member's physical condition has changed enough to render the existing mobility system ineffective.

Shipping Fee for MassHealth Members

Effective for dates of service on or after July 1, 2023, DME providers may bill a shipping fee on claims that require items to be shipped or delivered to a MassHealth member.

HCPCS code A9901 may be used in the following circumstances:

- Providers may submit a one-time claim for HCPCS code A9901 for items that require shipping and delivery.
- HCPCS code A9901 may not be submitted as an individual claim and must be included in the claim for the item being shipped/delivered.
- Providers may not bill HCPCS code A9901 for rental months for items beyond the initial date of delivery

Source: MassHealth Transmittal Letter DME-43 July 2023

Medical supplies and surgical dressings

Required medical/surgical supplies can be obtained by the member from a Plan-contracted DME provider with a provider's prescription. The Plan reimburses for medical supplies and surgical dressings when they are determined to be medically necessary, are appropriate for the treatment of the member's condition, are prescribed by a practitioner, and are used primarily for the practitioner's supervised treatment of a medical illness or injury.

Medical supplies and surgical dressings are not covered when they are items usually stocked in the home for general use, or when they are considered a routine part of the doctor's office visit. If a specialist applies a surgical dressing as part of a professional service, the surgical dressings are considered incidental to the professional service and are not reimbursed separately from the office visit.

Please see the *Non-Covered Services* payment policy code report for further details regarding coverage of specific codes.

Practitioner orders and maximum quantity of supplies

To ensure alignment with industry standards, the Plan follows CMS guidelines regarding unit limits (for members enrolled through MassHealth, the Plan will follow MassHealth guidelines). Please refer to CMS or MassHealth guidelines for more details.

Order quantity must be based on medical necessity and not for the convenience of the member or home health agency staff.

Quantity Limits When Billing for MassHealth Members

It is important to be mindful of quantity limits in the MassHealth Payment and Coverage Guideline Tool as well as NCCI Medically Unlikely Edits (MUEs). Claims billed with units of service greater than either of these limits may result in payment denials, even if you have authorization that would otherwise allow coverage for the item. If the MUE limit is less that the quantity limit in the MassHealth Payment and Coverage Guideline Tool you will need to ship and bill on multiple dates so as not to exceed the MUE date of service limit.

Documentation Requirements for DME and Related Supplies and Accessories Provided on a Recurring Basis Secondary to Written Order/Prescription

For Fallon Medicare Plus, Fallon Medicare Plus Central, NaviCare, Summit Eldercare PACE, Fallon Health Weinberg PACE, and Community Care Plan members, DME and related accessories and supplies require a written order/prescription. In some cases a treating practitioner may determine a patient's expected, ongoing medical need, and write an order for a DMEPOS item for immediate use and refills for later dates. Before refilling orders for DMEPOS items, the supplier must contact the patient to make sure a refill is needed.

Refills mean DMEPOS products that are provided on a recurring basis secondary to a medically necessary DMEPOS order.

The DME supplier must document contact with the plan member or their representative to verify the refill is needed. This documentation must include both of the following:

Documentation **-**The DMEPOS supplier must document contact with the plan member or their representative to verify the refill is needed. This documentation must include both of the following:

(A) Evidence of the member or their representative's affirmative response of the need for supplies, which should be obtained as close to the expected end of the current supply as possible. Contact and affirmative response must be within 30 calendar days from the expected end of the current supply.

(B) (1) For shipped items, the member name, date of contact, the item requested, and an affirmative response from the member, indicative of the need for refill, prior to dispensing the product; or

(2) For items obtained in-person from a retail store, the delivery slip signed by the member or their representative or a copy of the itemized sales receipt is sufficient documentation of a request for refill.

Suppliers are permitted to use any mode of communication so long as the member affirmation is received, and documentation of the contact is captured and can be provided upon request. For example, automated text messaging or email may be used so long as the captured information demonstrates the beneficiary's name, item(s), date of contact, and affirmative response.

Delivery of DMEPOS items provided on a recurring basis **-** The date of service for DMEPOS items provided on a recurring basis must be no earlier than 10 calendar days before the expected end of the current supply. This is regardless of which delivery mthod is utilized.

Date of service (for refilled items) means either—
(1) The date of delivery for the DMEPOS item; or
(2) For items rendered via delivery or shipping service, the shipping date.

Shipping date means—
(1) The date the delivery/shipping service label is created; or
(2) The date that the item is retrieved for delivery. These dates must not demonstrate significant variation.

For MassHealth ACO members, all DME items require either a prescription or letter of medical necessity (LOMN), or a combination of a prescription and LOMN for the purchase or rental of DME and related supplies and accessories.

Refills of DME (130 CMR 409.416(F):
(1) The Plan may allow payment of refills of DME prescribed up to a maximum of 12 months.

(2) The absence of an indication to refill by the prescriber renders the prescription nonrefillable.
(3) The Plan does not pay for any refill without approval from a member or member's authorized representative, provided at the time the prescription is to be refilled. The possession by a provider of a prescription with remaining refills does not constitute approval from the member to refill the prescription.
(4) The DME provider must keep records of all member or authorized representative approval of refills in accordance with 130 CMR 409.430(L) (130 CMR 409.430(L): a written description or an electronically dated note of all contacts the provider has had with the member or the member's caregiver, including member or authorized representative approval for refills, signed and dated by the provider staff who had the contact).

The DME provider must keep a record, either paper or electronic, at the service facility for each member. The record must include all purchases, rentals, and repairs of DME provided for each member in accordance with 130 CMR 409.430. Payment for services is conditioned upon the complete documentation in the member's record. In addition to fulfilling the requirements of 130 CMR 450.205: Recordkeeping and Disclosure.

Written Order/Prescription

- An order for each item billed must be signed and dated by the **treating practitioner** and kept on file by the supplier and made available upon request from the Plan.
- A written, signed, and dated order must be received by the supplier before a claim is submitted.

For Fallon Medicare Plus, Fallon Medicare Plus Central, NaviCare, Summit Eldercare PACE, Fallon Health Weinberg PACE, and Community Care members, the written order/prescription must include the following elements:

1. Beneficiary Name or Medicare Beneficiary Identifier (MBI).
2. General Description of the item.
    a. The description can be either a general description (e.g., wheelchair or hospital bed), a brand name/model number, a HCPCS code, or a HCPCS code narrative;
    b. For equipment – In addition to the description of the base item, the SWO may include all concurrently ordered options, accessories, or additional features that are separately billed or require an upgraded code (List each separately);
    c. For supplies – In addition to the description of the base item, the SWO may include all concurrently ordered supplies that are separately billed Note: If such items are not concurrently ordered, they nonetheless require an order for payment purposes.
3. Quantity to be dispensed, if applicable.
4. Order Date.
5. Treating Practitioner Name or National Provider Identifier (NPI).
6. Treating Practitioner Signature.

A new order/prescription is required:

- For all claims for purchases or initial rentals;
- If there is a change in the DMEPOS order/prescription (e.g., quantity);
- On a regular basis (even if there is no change in the order/prescription) only if it is so specified in the documentation section of a particular medical policy;
- When an item is replaced; and
- When there is a change in the supplier, and the new supplier is unable to obtain a copy of a valid order/prescription for the DMEPOS item from the transferring supplier.

For MassHealth ACO members, the written prescription or letter of medical necessity must include the following information, with the exception of item 5., which may be provided in additional supporting documentation**:**

1. The member's name
2. The date of the order/prescription
3. The name and quantity of the prescribed item and the number of refills (if appropriate).
4. The name, NPI number and signature of the ordering practitioner and the date signed.
5. Medical justification for the item(s) being ordered, including diagnosis or ICD-10-CM code.

6. The equipment settings, hours to be used per day, options, or additional features as they pertain to the equipment.
7. Length of need.
8. The expected outcome and therapeutic benefit of providing the requested item(s) or treatment, upon request, and
9. A summary of any previous treatment plan, including outcomes, that was used to treat the diagnosed condition for which the prescribed treatment is being requested, upon request.

Refer to 130 CMR 409.416: Requirements for Prescriptions or Letters of Medical Necessity Completed by the Ordering Practitioner for additional information.

Medical record documentation requires the following**:**
1. The type of supply or dressing, listed by code.
2. When applicable, the number of surgical/debrided wounds being treated with a dressing.
3. When applicable, the reason for dressing use (e.g., surgical wound, debrided wounds).
4. When applicable, whether the dressing is being used as primary or secondary.
5. The source of that information and date obtained must be documented in the supplier's records.
6. Current clinical information which supports the reasonableness and necessity of the type and quantity of supplies or surgical dressings provided must be easily inferred in the patient's medical records.
7. Evidence of monthly evaluation of patient status must be performed and documented, and if not, reasons why an evaluation could not occur.
8. The evaluation must include the type of wound, location, size and depth, the amount of drainage, and any other information.

This information must be made available upon request of the Plan.

New orders – every 3 months:
- A new order is needed if a new supply or dressing is added or if the quantity of an existing supply or dressing to be used is increased. A new order is not needed if the quantity of supplies or dressings is decreased.
- A new order is required at least every 3 months for each supply or dressing being used even if the quantity used has remained the same or decreased.
- Medical supplies (e.g., catheters) for chronic, permanent conditions may have a standing order issued that is valid for a maximum of one year.

Referral/notification/prior authorization requirements

Most DME items require prior authorization. Please refer to the Procedure code look-up tool on the Plan website for prior authorization requirements. The Procedure code look-up tool is available at: http://www.fchp.org/providertools/ProcedureCodeLookup/.

Effective July 1, 2025, prior authorization requests for DME for all members, excluding Summit ElderCare PACE and Fallon Health Weinberg PACE members, must be submitted to Integrated Home Care Services (IHCS) at FAX number: 844-215-4265. Prior authorization requests for PACE members will continue to be submitted to the PACE member's interdisciplinary care team.

To obtain prior authorization for DME, the treating physician (who may be a nurse practitioner, clilnical nurse specialist or physician assistant) must submit the prior authorization request to IHCS directly.

The Plan may request medical records for determination of medical necessity.

Prior authorization is not required for medical supplies and/or surgical dressings with the exception of the following:
- Miscellaneous medical supply codes,
- Not Otherwise Specified (NOS) medical supply codes, and
- Therapeutic molded shoes and shoe inserts for diabetics.

The DME supplier must obtain orders, maintain medical record documentation, and produce this documentation upon the request of the Plan.

If the member is self-pay, a copy of the member's waiver letter must be available upon request of the Plan.

Each PACE plan member is assigned to an Interdisciplinary Team. PACE provides participants with all the care and services covered by Medicare and Medicaid, as approved by the interdisciplinary team, as well as additional medically necessary care and services not covered by Medicare and Medicaid. With the exception of emergency care and out-of-area urgently needed care, all care and services provided to PACE plan members must be approved by the interdisciplinary team.

Billing/coding guidelines

Professional charges must be submitted on a CMS-1500 claim form or electronic equivalent. Hospital charges must be submitted on a UB-04 or in HIPAA standard electronic formats, per industry standard guidelines.

Pricing Modifiers
Pricing modifiers should be in the first modifier position.

Bill DME items with a valid HCPCS code and one of the following pricing modifiers as indicated on the Medicare DMEPOS Fee Schedule or MassHealth DME & Oxygen Payment and Coverage Guidelines Tool, as applicable

NU	Submit with HCPCS DME code to indicate new durable medical equipment
UE	Submit with HCPCS DME code to indicate used durable medical equipment
RR	Submit with HCPCS DME code to indicate a rental

MS Modifier – Medicare Six Month Maintenance and Servicing Fee
The 6-month maintenance and servicing fee is only payable for certain oxygen concentrators and transfilling equipment (E1390, E1391, E0433, or K0738) and enteral and parenteral nutrition pumps (B9002, B9004, B9006) which the member owns. See Oxygen and Oxygen Equipment Payment Policy for maintenance and servicing for oxygen equipment.

The 6-month maintenance and servicing fee is not payable for capped rental items furnished on or after January 1, 2006. Effective January 1, 2006, the supplier must transfer title of the item to the member on the first day that begins after the last continuous month in which capped rental payments are made. Payment for maintenance and servicing of member owned equipment is made on the basis of reasonable and necessary charges for parts and labor not otherwise covered under a manufacturer's or supplier's warranty.

Necessary maintenance and servicing of parenteral/enteral pumps after the 15-month rental limit is reached may include repairs and extensive maintenance that involve the breaking down of sealed components, or performing tests that require specialized testing equipment not available to the beneficiary or nursing home. Payment will only be made for actual incidents of maintenance, servicing or replacement. The Plan may request written proof from the supplier of maintenance and servicing of the pump.

For enteral nutrition pumps (B9002), no more than one M & S payment may be paid every six months, beginning six months after the last rental payment.

For parenteral nutrition pumps (B9004, B9006), no more than one M & S payment may be paid every three months, beginning three months after the last rental payment for the pump.

MS	Six month maintenance and servicing fee for reasonable and necessary parts and labor which are not covered under any manufacturer or supplier warranty

Capped Rental Modifiers

For Medicare and Community Care members, use the RR modifier and one of the capped rental modifiers to indicate the capped rental period.

For MassHealth ACO plan members use one of the following modifiers to indicate the capped rental period (do not use the RR modifier).

KH	First rental month
KI	Second and third rental months
KJ	Fourth to thirteenth rental months

For ACO members, please refer to the MassHealth DME Payment and Guideline Tool at: **https://www.mass.gov/info-details/masshealth-payment-and-coverage-guideline-tools**.

Ordering/Referring Provider NPI
Effective December 1, 2020, all claims for items and services that are the result of an order or referral must include the ordering/referring provider's name, qualifier (DN/DK), and valid NPI.

On a CMS-1500 claim form (02-12) or electronic equivalent:

- Report the name of the ordering provider in Item 17 and the appropriate qualifier to the left of the dotted line on the CMS-1500 (Version 02/12) claim form: DK (ordering provider); report the name of the ordering provider in 2420E Ordering Provider Loop, segment NM1 Ordering Provider Name (Segment NM101 (Qualifier), Segment NM103-NM105 (Name)).
- No information should appear in Item 17a. Item 17a was formerly used to report the Unique Physician Identification Number (UPIN), which is no longer used -- leave this item blank.
- Report the National Provider Identifier (NPI) of the ordering provider in Item 17b or the 837P 2420E Ordering Provider Loop, segment NM109 [NPI].

Qualifier	Provider Role
DN	Referring Provider
DK	Ordering Provider

Place of service

This policy applies to DME provided for use in the member's home.

For Medicare members, in addition to a hospital, a SNF or a distinct part SNF, the following LTC facilities cannot be considered a home for purposes of receiving the Medicare Part B DME benefit:

- A nursing home that is dually-certified as both a Medicare SNF and a Medicaid nursing facility (NF)
- A Medicaid-only NF that primarily furnishes skilled care;
- A non-participating nursing home (i.e. neither Medicare nor Medicaid) that provides primarily skilled care; and
- An institution which has a distinct part SNF and which also primarily furnishes skilled care.

Providers are reminded that the place of service is where the product is used (e.g., member's home, nursing facility, or rest home).

For MassHealth members, unless otherwise specified for purposes of rental and purchase of DME, a member's home may be a dwelling owned or rented by the member, a relative's or other person's home in which the member resides, a rest home, assisted living, or another type of group residence or community setting in which normal life activities take place. A home does not include an institutional setting including but not limited to a hospital, nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or any setting in which payment is or could be made under Medicaid inpatient services that includes room and board, except for items that are allowable pursuant to 130 CMR 409.415.

Policy history

Origination date: 11/06/2002

Previous revision date(s):	11/06/2002, 10/25/07 01/01/2011 - Moved to new payment policy format; expanded scope to address more than a capped period for rental of DME; added 36 month rental period cap for oxygen system and equipment for Senior Plan members; changed name from Durable Medical Equipment (DME) Capped Rental Payment Policy. 03/01/2013 – Updated discussion about prior authorization for rented DME. 09/01/2015 - Moved to Plan template and clarified capped language. 03/01/2016 - Updated policy section and clarified language regarding reasonable useful lifetime. 07/01/2016 - Added clarifying language regarding rental periods and reasonable useful lifetimes and added additional modifiers. 01/01/2017 - Updated the policy section. 07/01/2017 - Added requirements for power mobility device reimbursement. 09/01/2017 - Added medical supply language and updated title.
Connection date & details:	November 2017 – Updated the reimbursement section. April 2018 – Updated place of service section April 2019 – Updated policy section to clarify we defer to CMS rules. Removed authorization requirement for DME repair. July 2019 – Removed Wigs from requiring authorization section. October 2020 – Clarified payment for capped rental DME; added requirement for ordering/referring provider's name, qualifier, and valid NPI. January 2021 – Added clarification that the 13-month rental period shall apply to capped rental DME for MassHealth ACO members unless otherwise specified in the supplier's contract. January 2022 – Added information and link for the MassHealth DME and payment guidline tool which will be applied to MassHealth ACO members unless otherwise specified in supplier's contract. July 2022 – Under Reimbursement, added two new sections: Backup Manual Wheelchair and Repairs of a member's Serviceable Retired Backup Power Wheelchair October 2023 – Under Reimbursement, updated MassHealth Mobility Systems section to include instructions for billing for evaluation time when performing repairs to a MassHealth members' primary or backup mobility system and instructions for billing for shipping fee (A9901); under Billing/coding guidelines, clarified use of pricing modifiers. April 2024 – Under Reimbursement added new paragraph Quantity Limits When Billing for MassHealth Members. July 2024 – Under Reimbursement, Medicare Power Mobility Devices, added new section Wheelchair Replacements When the Manufacturer Exits Wheelchair Business; under Reimbursement, added new section Documentation Requirements for DME and Related Supplies and Accessories Provided on a Recurring Basis Secondary to Written Order/Prescription; under Reimbursement, updated information under Written Orders/Prescriptions. July 2025 – Under Referral/notification/prior authorization requirements, added new information about how to obtain prior authorizations for durable medical equipment effective July 1, 2025, under Billing/coding guidelines, clarified that the 6-month

maintenance and servicing fee billed with the MS modifier is not payable for capped rental items.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.