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
☒ Fallon Health Weinberg Managed Long-Term Care
☒ Community Care (Commercial/Exchange)

Policy

The Plan reimburses contracted suppliers for medically necessary covered durable medical equipment (DME).

For Medicare (Fallon Medicare Plus, Fallon Medicare Plus Central, NaviCare HMO SNP, NaviCare SCO, Summit Eldercare PACE, Fallon Health Weinberg PACE) members, Medicare statutes, regulations (42 CFR 414.200 – 414.238), National Coverage Determinations (NCDs), and Local Coverage Determinations (LCDs) are used to determine whether a DME item is covered and whether the item is purchased or rented.

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

- Inexpensive or routinely purchased items
- Items requiring 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.)
- Certain customized items
- Oxygen and oxygen equipment
- Capped rental items

Supplies and accessories that are necessary for the effective use of medically necessary DME are covered.

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 LCDs and LCAs can be by searching the Medicare Coverage Database at: https://www.cms.gov/medicare-coverage-database/search.aspx.

For Community Care members, in the absence of Plan-specific policy, Medicare guidelines are used to determine whether a DME item is covered and whether the item is purchased or rented.

For MassHealth ACO members, the MassHealth Durable Medical Equipment Program Regulations at 130 CMR 409.000, Durable Medical Equipment Subchapter 6, and the MassHealth DME and Oxygen Payment and Coverage Guidelines Tool are used to determine whether a DME item is covered and whether the item is purchased or rented.

For NaviCare members, Medicare statutes, regulations (42 CFR 414.200 – 414.238), National Coverage Determinations (NCDs), and Local Coverage Determinations (LCDs) are used to determine whether a DME item will be covered and whether the item is purchased or rented. In the event that there is no Medicare guidance for a particular DME item or if the member does not meet the coverage criteria in the Medicare guidance, Fallon Health will then follow MassHealth guidance to determine whether the DME item is covered and whether the item is purchased or rented.

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 vendor. 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 reimburse maintenance and servicing.

Upgrades that are beneficial primarily in allowing the plan 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 **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.
Reference: 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.

Providers submitting a prior authorization request for a repair of a member's Serviceable Retired Backup Power Wheelchair must include all applicable HCPCS codes that are involved in the repair — whether or not the code, or codes, requires PA. This includes HCPCS codes K0739 (labor) and K0108 (miscellaneous components) (MassHealth Transmittal Letter DME-34).

Definition: Serviceable Backup Mobility System – 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). *Reference*: MassHealth Durable Medical Equipment Manual, 130 CMR 409.413(D).

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.

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)

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. *Reference* 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).

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

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.

Written orders

- 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.

The order must specify the following:

1. Type of supply or dressing (e.g., catheter, hydrocolloid wound cover, hydrogel wound filler).
2. Size of the dressing (if appropriate).
3. The number/amount to be used at one time (if more than one).
4. The frequency of dressing changes expected (if appropriate).
5. The date of the order.
6. The expected duration of need.
7. The signature of the ordering, treating practitioner.

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/.

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 vendor 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.

The Plan may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

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

Per Noridian Healthcare Solutions, LLC, the MS modifier can only be used for maintenance and servicing (M & S) of certain oxygen concentrators and transfilling equipment (E1390, E1391, E0433, or K0738) and with enteral and parenteral nutrition pumps (B9002, B9004, B9006) which the member owns: https://med.noridianmedicare.com/web/jddme/topics/modifiers/ms.

See Oxygen and Oxygen Equipment Payment Policy for M & S for Oxygen Equipment.

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

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.

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.