



DURABLE MEDICAL EQUIPMENT

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Overview

Durable medical equipment (DME) is defined as equipment which:

- (a) can withstand repeated use,
- (b) is primarily and customarily used to serve a medical purpose,
- (c) generally is not useful to a person in the absence of an illness or injury, and
- (d) is appropriate for use in the home.

Although an item may meet the definition of DME above, it may not be covered in every instance. DME must also be medically necessary for the treatment of the plan member's illness or injury and the DME must be used in the plan member's home.

FCHP's Technology Assessment Committee will evaluate each DME item in accordance with FCHP's Technology Assessment Criteria and will publish a written policy containing medical necessity criteria for each covered DME item.¹ In situations where FCHP has not established a written policy for a particular DME item, FCHP will follow a written policy established by the National Heritage Insurance Company (NHIC). NHIC is the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) for Medicare Jurisdiction A which includes Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island and Vermont. NHIC's policies are available at the following website: http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml.

With respect to Fallon Senior Plan, MassHealth and NaviCare members:

- FCHP will follow written policies established by NHIC for Fallon Senior Plan members. NHIC's written policies are known as local coverage determinations (LCDs). NHIC's LCDs are available at the following website: http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml. In situations where NHIC has not established an LCD for a particular DME item, FCHP will follow a written policy established by FCHP for that DME item.
- *MassHealth Guidelines for Medical Necessity Determination* supersede FCHP's written policies for MassHealth members. *MassHealth Guidelines for Medical Necessity Determination* are available at the following website: www.mass.gov. In situations where MassHealth has not established guidelines for medical necessity determination for a particular DME item, FCHP will follow a written policy established by FCHP for that DME item.

¹ FDA approval of a medical device is relevant information that FCHP uses in determining whether a device may be covered. However, FDA approval alone does not necessarily mean that FCHP will decide that a device should be covered for any particular plan member or all plan members.



- For NaviCare members, FCHP will follow LCDs established by NHIC. In the event that there is no LCD established by NHIC for a particular DME item (or if the NaviCare member does not meet the medical necessity criteria in the NHIC LCD, FCHP will follow the *MassHealth Guideline for Medical Necessity Determination* for that item. In the event that there is neither an NHIC LCD nor *MassHealth Guideline for Medical Necessity Determination*, FCHP will follow a written policy established by FCHP for that DME item.

In the absence of a written policy containing medical criteria for a covered DME item, FCHP will make a determination of medical necessity in accordance with FCHP's Technology Assessment Criteria.

For the purposes of the purchase or rental of DME, a plan member's home may be his/her own home or apartment, a relative's home (if the plan member lives there), and certain institutions for example, a Medicaid-only nursing facility primarily engaged in furnishing custodial care, or a non-participating nursing home (i.e., neither Medicare or Medicaid) primarily engaged in providing custodial care, may be referred to as a 'rest home.'

An institution cannot be considered a plan member's home if it:

- A. Meets the basic definition of a hospital, i.e., it is primarily engaged in providing by or under the supervision of physicians to inpatients diagnostic and therapeutic services for the medical diagnosis, treatment, and care of injured, disabled, and sick persons or rehabilitation services for the rehabilitation of injured, disabled, or sick persons (Social Security Act, Section 1861(e)(1); or
- B. Meets at least the basic requirement in the definition of a skilled nursing facility (SNF), i.e., it is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care or rehabilitation services for the rehabilitation of injured, disabled, or sick persons (Social Security Act, Section 1819(a)(1). This applies not only to Medicare-participating SNFs, but also to institutions which, though not participating in Medicare, do provide the type of care described in Section 1819(a)(1) of the Act.

Thus, if a plan member is a patient in an institution or distinct part² of an institution which meets the definition of a hospital or SNF, the plan member is not entitled to coverage for the rental or purchase of DME. These institutions provide skilled care which includes the inherent responsibility to dispense DME when needed.

² In order to categorize a particular portion of an institution separately from the remainder of that institution, it is necessary for that portion to constitute a distinct part, i.e., a separate, physically identifiable unit consisting of all beds in a particular building, floor, wing or ward. In this situation, if the participating distinct part of an institution meets the basic SNF definition and the remainder of the institution does not, DME payment would be available in the portion of the institution that qualifies as a home for DME coverage by virtue of not meeting the basic SNF definition, regardless of the type of care that the patient is receiving there. (Medicare Claims Processing Manual (Publication 100-04) Chapter 10, Section 10.2)



In addition to a hospital, a SNF, or a distinct part SNF, the following facilities are not considered a plan member's home for purposes of receiving DME benefit:

- a nursing home³ that is dually-certified as both a Medicare SNF and a Medicaid nursing facility (NF)⁴; and
- a Medicaid-only NF primarily engaged in providing skilled nursing or rehabilitation services.

Definitions

Capped rental – Capped rental means that FCHP will pay 10 monthly rental payments (equal to the allowed amount for the purchase of that item) to a DME supplier while the equipment is in continuous use by a plan member. (A period of continuous use allows for temporary interruptions, such as when a plan member is admitted to a hospital or skilled nursing facility for inpatient care. Interruptions that 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) will start a new capped rental period.) 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 item is considered to have been purchased by the plan member and title for the equipment will be transferred to the plan member.

Continuous monthly rental – Items requiring frequent and substantial servicing are covered on a continuous monthly rental basis until medical necessity ends. No coverage is provided for the purchase of continuous rental equipment, maintenance and servicing, or for repair or replacement of equipment in this category. The monthly rental payment is inclusive of all costs necessary for the effective use of the equipment by the plan member including supplies and accessories needed to use the equipment.

Policy

DME requires prior authorization by FCHP.

DME is covered when all of the following criteria are met:

1. The equipment meets the definition of DME.
2. The equipment is medically necessary for the treatment of the plan member's illness or injury or to improve the functioning of a malformed body part
3. The equipment is used in the plan member's home.

Prior authorization is not a guarantee of payment from FCHP. For many members, coverage is subject to cost-sharing, including deductibles and coinsurance, and/or benefit maximums.

FCHP maintains a list of inexpensive routinely purchased that does not require prior authorization. The list of DME that does not require prior authorization is available in

³ Nursing homes serve as permanent residences for people who are too frail or sick to live at home or as temporary residences during a recovering period.

⁴ Medicaid nursing facilities (NFs) were created when the 1987 nursing home reform legislation combined the previously separate Medicaid categories of SNFs and intermediate care facilities (ICFs) into a single category.



the FCHP Provider Manual at: www.fchp.org. Although these items do not require prior authorization, they are subject to member cost-sharing, including deductibles and coinsurance, and/or benefit maximums.

Even though this policy may indicate that a particular item is covered (or is not covered), this conclusion is not based upon the terms of a particular benefit plan. Each benefit plan contains its own specific provisions for coverage and its own exclusions. If there is a discrepancy between this policy and a particular plan of benefits, the provisions of that benefit plan will apply.

The following provisions apply to all covered DME:

1. To obtain DME for a plan member the treating physician (who may be a nurse practitioner or physician assistant) should contact a contracted FCHP DME supplier directly. DME requires a written order signed by the treating physician. Written orders may be an original "pen-and-ink" document, or a photocopy, a facsimile image, or an electronic copy. At a minimum, the written order must specify:
 - a. The start date of the order.
 - b. Duration of need.
 - c. Description of the item being requested, sufficiently detailed (brand names, model numbers, etc.), including all accessories and options that will be separately billed.
 - d. HCPCS code(s) for each item being requested.
 - e. Documentation of medical necessity, i.e., description of patient's condition, abilities, limitations, etc. (refer to individual medical policies for specific requirements).

Someone other than the treating physician may provide the details of the written order; however, the treating physician must review and *personally* sign and date the order to indicate agreement. The supplier must have a written order from the treating physician before dispensing any DME to a plan member.

2. The DME supplier will obtain prior authorization from FCHP when prior authorization is required.
3. FCHP will authorize DME that is not more costly than an alternative service, sequence of services, device or equipment that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.
4. An upgrade is a feature or component of a DME item which is beyond what is medically necessary as determined by FCHP. DME suppliers may furnish an upgraded DME item to a plan member as long as the cost to FCHP is the same as the cost for the non-upgraded item and the payment by FCHP to the supplier is payment in full. DME suppliers may not bill FCHP plan members for non-covered features or components of a covered item even if the plan member agrees to pay extra for the upgrade.
5. The reasonable useful lifetime of DME is 5 years. Computation of useful lifetime is based on when the equipment is delivered to the plan member, not the age of the equipment at the time of delivery to the plan member.
6. DME can be replaced in less than 5 years under certain situations, such as when the item is irreparably damaged, lost or stolen, or because of a change in the patient's



condition. FCHP will cover replacement an item as long as the item continues to be medically necessary for the plan member. Proof of loss or damage through documentation such as a police report, picture, or corroborating statement will be required. In situations where misuse, malicious damage, culpable neglect, or wrongful disposition of equipment has occurred, FCHP will not cover replacement of the item.

7. DME items carry a manufacturer's warranty. Manufacturer's warranties range in duration from one year to lifetime, depending on the item and the manufacturer's policy. The cost of the manufacturer's warranty is included in the cost of the item and is not separately reimbursable. Extended warranties are not covered or reimbursed. Repair or replacement of DME that is covered under a manufacturer's warranty is not covered by FCHP.
8. DME will be purchased or rented from a contracted supplier. FCHP, at its discretion, will determine whether an item is purchased or rented.
9. When a DME item is rented (including capped rental), the supplier retains title for the item and is responsible for repair, maintenance and servicing during the capped rental period. FCHP will not cover repair, maintenance and servicing for capped rental items for which the first rental month occurred on or after January 1, 2006.⁵ At the end of a capped rental period, the supplier will transfer title of the equipment to the plan member.
10. FCHP will cover the reasonable and necessary repair, performed by authorized technicians, of DME owned by a plan member and not covered by manufacturer's warranty. Travel time or equipment pick-up and delivery charges are not separately reimbursable. Use HCPCS code K0739 (Repair or non-routine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes) to report repair of DME.
11. Replacement parts must be billed with the appropriate HCPCS code that represents the item or part being replaced, along with a pricing modifier (NU, UE, RR) and replacement modifier (RP). If the part that is being replaced has not been assigned a specific HCPCS code, use a miscellaneous HCPCS code (E1399 or K0108 for wheelchair parts) to bill each part. Itemization must accompany each claim that contains miscellaneous codes for replacement parts.
12. FCHP will cover temporary replacement for equipment that is being repaired that is owned by a plan member for up to one month (HCPCS code K0462 (Temporary replacement for patient-owned equipment being repaired, any type) is used when a supplier provides a replacement item to a plan member on a temporary basis when his/her equipment requires major repair (i.e., taking more than one day). Reimbursement for replacement equipment is based on the rental rate for the equipment being repaired.
13. Sales tax is included in the reimbursement for the purchase of all items.

⁵ For capped rental items for which the first rental month occurred prior to January 1, 2006, plan members had the option to either take ownership of the equipment at the end of the capped rental period or continue to rent the equipment from the supplier. If the plan member chose to continue to rent the equipment, FCHP will cover semi-annual maintenance and servicing, even if no services are furnished, until the plan member returns the equipment to the supplier.



14. Delivery, set-up and installation of equipment are included in the cost of the equipment and are not separately reimbursable.
15. Some items are designated in policy as requiring a trial period. The purpose of a trial period is to assess effectiveness and compliance. In some instances, at the discretion of FCHP, the trial period may be waived. Any monthly rental payment made by FCHP during a trial period will apply toward the 10-month capped rental or reimbursement for the purchase of the item.
16. This policy does not apply to surgically implanted DME, such as implantable infusion pumps (E0782, E0783, E0785, and E0786) used for long-term drug therapy.
17. This policy does not apply to oxygen, oxygen equipment or oxygen supplies.

Exclusions

The following exclusions apply to all products and plans except where a product or employer group plan has added coverage for a specific item and coverage is documented in the plan member's Evidence of Coverage.

1. Custom DME (DME that has been uniquely constructed or substantially modified for a specific person) is not covered.
1. Convenience items are not covered, including but not limited to total electric hospital beds (HCPCS codes E0265, E0266, E0297, and E0297)
2. Back-up equipment is not covered.
3. Disposable equipment is not covered.
4. Personal comfort items are not covered.
5. Equipment that is not primarily medical in nature (i.e., not useful in the absence of illness or injury), such as air conditioners, dehumidifiers, white noise machines, whirlpools (HCPCS code E1300), incontinence products, ear plugs, exercise equipment (HCPCS code A9300), etc., is not covered
6. Safety equipment, such as harnesses (HCPCS code E0700), restraints (HCPCS code E0710), protective helmets, mouth guards, car seats, safety glasses, telephone alert systems, such as Lifeline® Medical Alert System, etc. are not covered.
7. Adaptive aids, such as toilet seat lift mechanisms (HCPCS code E0172) bath/shower chairs (HCPCS code E0240), bath tub/toilet rails (HCPCS codes E0241, E0242, and E0243) raised toilet seats (HCPCS code E0244), over-bed-tables (HCPCS code E0274), patient lifts (HCPCS code E0625), standing frames (HCPCS codes E0637, E0638, E0641, and E0642), stair lifts or elevators, etc. are not covered.
8. Wheelchair ramps, including portable ramps are not covered.
9. Modifications to a plan member's home that may be necessary to accommodate DME (including but limited to enlarging doorways, electricity or plumbing) are not covered.

Products to Which This Policy Applies

- ⊕ FCHP Direct & Select Care
- ⊕ Fallon Preferred Care (PPO)
- ⊕ Major Medical
- ⊕ MassHealth
- ⊕ Companion Care
- ⊕ Commonwealth Care
- ⊕ NaviCare



- ⊕ Fallon Senior Plan™
- ∅ Summit Elder Care® PACE (Note: With the exception of emergency care, all services for Summit ElderCare® PACE participants must be authorized and arranged by the Summit ElderCare (SE) Interdisciplinary Team (IDT) overseeing the care for that participant. The applicable IDT can be determined by the HCO code on the participant ID card. The site codes and corresponding telephone numbers are: SW1-SE East Mtn St. Worcester-508-852-2026, SW2-SE Grafton St. Worcester-508-373-7400, SC1-SE Charlton-508-434-3200, SL1-SE Leominster-978-401-3100.)

Committee review date(s):

Technology Assessment Committee: 11/20/2003, 08/23/2011

Benefit Oversight Committee: 09/14/2011

IMPORTANT NOTE: Not all services are covered for all Commercial products or employer groups. Even though this policy may indicate that a particular service or supply is considered covered, this conclusion is not based upon the terms of your particular benefit plan. Each benefit plan contains its own specific provisions for coverage and exclusions. Not all benefits that are determined to be medically necessary will be covered benefits under the terms of your benefit plan. You need to consult the Evidence of Coverage to determine if there are any exclusions or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and your plan of benefits, the provisions of your benefits plan will govern. However, applicable state mandates will take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, Federal mandates will apply to all plans. With respect to Medicare and Medicaid members, this policy will apply unless Medicare and Medicaid policies extend coverage beyond this Medical Policy.