Durable Medical Equipment (DME) and Medical Supplies Payment Policy

Policy

The Plan reimburses approved providers for durable medical equipment (DME) when medically necessary. In general, the Plan uses the Medicare capped rental fee schedule to determine whether an item will be rented or purchased. The Plan will defer to the Center for Medicare & Medicaid Services (CMS) for payment rules and medical necessary criteria for all Products unless other regulatory standards exist.

For rented items, the Plan will pay a provider the contractual allowable amount for the rental of the item, up to a maximum of ten months. After ten months, the member owns the equipment and reimbursement is limited to costs associated with replacement parts, repair, and labor.

Rental of DME is appropriate when the prescribing provider specifies that the item is medically necessary for a limited duration of time. Claims for DME rental must be for the time period the equipment is actually used by the member, but not to exceed the maximum allowed rental period for the equipment.

The rental period for oxygen system and equipment for Medicare Plan members is capped to 36 months. The Plan will follow Medicare guidelines relating to reimbursement for oxygen after the cap is reached. This rental period applies to all of the Plan products.

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.

A 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

DME:

The Plan will reimburse for:

- 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.
- Spare or back-up equipment.
- 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.

Power mobility devices:

Power mobility devices require Plan prior authorization. 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 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: Documentation and Coverage Requirements

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

DME:

Most DME items require prior authorization. Please refer to the Managing Patient Care section on Durable Medical Equipment and Orthotic/Prosthetic Devices in the Plan's Provider Manual for prior authorization requirements.

In the absence of Plan-specific medical policy, the Plan follows the Centers for Medicare and Medicaid Services (CMS) guidelines for medical necessity criteria.

Medical supplies:

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,
- Therapeutic molded shoes and shoe inserts for diabetics only, and

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.

Power mobility devices:
Power mobility devices require Plan prior authorization.

Fallon Health Weinberg and Navicare® models of care are based on patient care coordination; therefore, we encourage referring providers to contact the member's designated navigator if there are questions or concerns prior to prescribing tests, supplying equipment, or providing any other additional appointments or services that may not routinely be authorized or may require prior authorization.

Summit ElderCare® is based on member care coordination; therefore, the referring Summit ElderCare PACE site must be contacted for approval, prior to coordinating and/or rendering services.

Billing/coding guidelines

Professional charges must be submitted on a CMS-1500 form. 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.

Bill items with valid HCPCS codes and use one of the following modifiers:

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	Submit with HCPCS DME code to indicate six month maintenance and servicing fee for reasonable and necessary parts and labor which are not covered under any manufacturer or supplier warranty

Place of service

This policy applies to DME provided for use in the member's home and medical supplies/ surgical dressings provided in the home. Additionally when provided as part of a skilled home care service authorized by the Plan in an outpatient setting. For the purposes of the policy, a long term care facility is not considered a member's home

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.

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.