Medical Necessity Guidelines: Durable Medical Equipment (DME) and Supplies Costing Over $1,000 for Tufts Health Unify

Effective: January 8, 2021

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	**Yes ☒ No ☐**

Applies to:

COMMERCIAL Products

☐ Tufts Health Plan Commercial products; Fax: 617.972.9409

☐ Tufts Health Freedom Plan products; Fax: 617.972.9409

- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

TUFTS HEALTH PUBLIC PLANS Products

☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax:888.415.9055

☐ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055

☐ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404

☒ Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304

*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

SENIOR Products

- Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the Tufts Health Plan SCO Prior Authorization List
- Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

OVERVIEW

According to Commonwealth of Massachusetts MassHealth regulations (130 CMR 409.000), durable medical equipment (DME) is defined as equipment that:

(1) is fabricated primarily and customarily to fulfill a medical purpose;
(2) is generally not useful in the absence of illness or injury;
(3) can withstand repeated use over an extended period; and
(4) is appropriate for use in the Member's home.

All durable medical equipment and supplies (DME) must be of proven quality and dependability, and must conform to all applicable federal and state product standards.

Note: Prior authorization is **not** required for HCPCS codes L0112-L1940, L1950-L2750, L2760-L3901, L3905-L4631, and S1040.

CLINICAL COVERAGE CRITERIA

In order to qualify for coverage, DME items must meet all aspects of the definition of DME as stated above. There are certain items which require prior authorization for which there are specific posted medical necessity guidelines applicable to Tufts Health Unify. In addition, some DME items which cost over $1,000 also require prior authorization, but there may be no specific Tufts Health Unify medical necessity guidelines. For these items, the guidelines used to determine medical necessity will be as follows, according to this hierarchy:

- An applicable CMS National Coverage Determination (NCD) for the item, available at cms.gov/medicare-coverage-database/indexes/ncd-by-chapter-and-section-index.aspx?NCDId=317&ncdver=1&bc=AAAAQAAAAAAA&
- An applicable CMS Noridian Local Coverage Determination (LCD) for the item, available at med.noridianmedicare.com/web/jadme/policies/lcd/active

- Specific MassHealth guidelines for the item, if available, at mass.gov/lists/masshealth-guidelines-for-medical-necessity-determination
- InterQual® Criteria, Version 2018.2

For items which are not addressed by any of the above guidelines, current scientific medical literature, MassHealth provider manuals, and language in the member handbook/benefit document will be reviewed along with submitted clinical documentation to render a medical necessity coverage determination.

LIMITATIONS

Tufts Health Plan will not cover:

- Items which do not meet the definition of DME as described above
- Items specifically listed as non-covered on the Tufts Health Plan Medical Necessity Guideline: Noncovered Investigational Services tuftshealthplan.com/documents/providers/guidelines/medical-necessity-guidelines/noncovered-investigational-services-me
- Items which are determined to be investigational/experimental
- Items which address a need that can be met with a less costly, less intensive alternative

REFERENCES

1. Commonwealth of Massachusetts, Executive Office of Health and Human Services, MassHealth Provider Manual Series, Provider Regulations for Durable Medical Equipment. Available at mass.gov/regulations/130-CMR-409000-durable-medical-equipment-services. Last accessed May 6, 2019.
2. Commonwealth of Massachusetts, Executive Office of Health and Human Services, MassHealth Guidelines for Medical Necessity Determination. Available at mass.gov/service-details/guidelines-for-medical-necessity-determination. Last accessed May 3, 2019.
3. Noridian Health Care Solutions, LLC. Jurisdiction A Active LCDs. Available at med.noridianmedicare.com/web/jadme/policies/lcd/active. Last accessed May 3, 2019.
4. U.S. Centers for Medicare and Medicaid Services. Early and Periodic Screening, Diagnostic, and Treatment. Available at medicaid.gov/medicaid/benefits/epsdt/index.html. Last accessed May 7, 2019.

APPROVAL HISTORY

June 19, 2019: Reviewed by the Integrated Medical Policy Advisory Committee (IMPAC)

Subsequent endorsement date(s) and changes made:

- October 16, 2019: Reviewed by IMPAC, note added in "Overview" section listing HCPCS code ranges which do not require PA, effective January 1, 2020
- November 18, 2020: Reviewed by IMPAC, The Medical Necessity Guidelines for DME and Supplies Costing Over $1,000 has been divided into two policies: *Durable Medical Equipment (DME) and Supplies Costing Over $1,000* for Unify products and *High Cost Durable Medical Equipment (DME), Adaptive Strollers and Speech Generating Devices* for MA Together and RITogether products; applicable lines of business have been updated with an effective date of January 8, 2021.

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.

Provider Services