

Durable Medical Equipment and Medical Supplies Payment Policy

Applies to the following Tufts Health Plan products:

- Tufts Health Plan Commercial (including Tufts Health Freedom Plan)¹
- Tufts Medicare Preferred HMO (a Medicare Advantage product)²
- Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)²

Applies to the following Tufts Health Public Plans products:

- Tufts Health Direct (a Massachusetts Qualified Health Plan [QHP]; a commercial product)
- Tufts Health Together (a MassHealth MCO Plan and Accountable Care Partnership Plans)
- Tufts Health RITogether (a Rhode Island Medicaid Plan)
- Tufts Health Unify (OneCare Plan; a dual-eligible product)

The following payment policy applies to Tufts Health Plan contracting durable medical equipment (DME) providers.

In addition to the specific information contained in this policy, providers must adhere to the information outlined in the [Professional Services and Facilities Payment Policy](#).

Note: Audit and disclaimer information is located at the end of this document.

POLICY

Tufts Health Plan covers medically necessary DME and medical supplies up to the benefit maximum³, in accordance with the member's benefits, CMS, MassHealth, and/or Rhode Island (RI) EOHHS guidelines, as applicable. Tufts Health Plan will determine whether it is appropriate to purchase or rent equipment for members.

Tufts Health Plan SCO and Tufts Health Unify provide coverage for all medically necessary DME and medical supplies covered by original Medicare and Medicaid (MassHealth).

DEFINITION

DME is equipment that meets all of the following criteria:

- 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 an illness or injury
- Is appropriate for use in the home

Medical supplies are disposable or nonreusable items that generally do not contain the mechanical components commonly found in DME.

GENERAL BENEFIT INFORMATION

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider [portal](#) or by contacting [Provider Services](#).

Continuous Glucose Monitors (CGMs) for Tufts Health Direct

Effective for dates of service on or after January 1, 2021, Tufts Health Plan will no longer cover CGMs and their accompanying supplies through DME suppliers for Tufts Health Direct. All CGMs and

¹ Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLinkSM when Tufts Health Plan is the primary administrator.

² Tufts Medicare Preferred and Tufts Health Plan SCO are collectively referred to in this payment policy as Senior Products.

³ Authorized medical supplies, respiratory equipment/supplies (excluding PAP therapy, nebulizers and related supplies), insulin pumps and related diabetic supplies are not applied to the benefit maximum.

accompanying supplies will be available through the pharmacy only with a prescription under the pharmacy benefit.

Note: There is no member responsibility for covered services for Tufts Health Plan SCO, Tufts Health Unify, Tufts Health Together or Tufts Health RItogether members.

REFERRAL/PRIOR AUTHORIZATION/NOTIFICATION REQUIREMENTS

Certain DME items require prior authorization through Tufts Health Plan's Precertification Operations Department; DME related to sleep therapy may require prior authorization or notification through an approved vendor. Refer to the [Sleep Studies Payment Policy](#) for more information.

The DME provider is responsible for obtaining the practitioner's order/prescription for any requested item(s). As a condition of payment, it is the responsibility of the **rendering** provider to obtain prior authorization or notification, as applicable. If notification is not obtained or approved, the claim will be denied. For more information, refer to the [Referral, Prior Authorization and Notification Policy](#).

Commercial and Tufts Health Public Plans: Refer to the [medical necessity guidelines](#) and other DME resources found in the Provider Resource Center for more information on DME items requiring prior authorization.

Senior Products: Refer to the [prior authorization and inpatient notification](#) list for Tufts Medicare Preferred HMO or the [prior authorization](#) and [notification](#) lists for Tufts Health Plan SCO to identify specific items, services, and supplies that have prior authorization and/or notification requirements.

Medical Supplies

Required medical/dressing supplies can be obtained by the member from a Tufts Health Plan contracted DME provider with a provider order.

Home health agencies providing services to members may order medical supplies directly from a Tufts Health Plan contracting DME provider, who will then submit a claim to Tufts Health Plan. Tufts Health Plan requires provider documentation for medical supplies. A written, signed and dated order must be received by the supplier for an item to be covered.

Oral Enteral Formula

Members must obtain covered oral enteral formula through a contracting DME provider.

Oral enteral formula may require prior authorization for Commercial and Tufts Health Public Plans members. Refer to the oral formula medical necessity guidelines for [Massachusetts](#), [New Hampshire](#) and [Rhode Island](#) for additional information.

BILLING INSTRUCTIONS

Unless otherwise stated, Tufts Health Plan follows industry standard coding guidelines. Refer to current industry standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules. For more information, refer to the [Professional Services and Facilities Payment Policy](#).

- Submit multiple same-day services on one line; the number of services/units should reflect all services rendered
- Append modifier SQ to indicate item ordered by a [home health](#) provider
- When billing oral enteral formulas, submit the NDC number for the specific enteral formula product, product description, quantity and modifier BO (orally administered nutrition, not by feeding tube), and the quantity on the claim

Modifiers

Tufts Health Plan requires all industry standard [modifiers](#) on DME, respiratory and medical supply claims. Claims submitted without complete and appropriate modifiers will be denied. Refer to the [DME Medicare Administrative Contractor \(MAC\)](#) for a list of modifiers appropriate for DME and medical supply claims.

Individual Consideration (Tufts Health Together)

DME and medical supplies designated as individual consideration (IC) or adjusted acquisition cost (AAC) are reimbursed with an invoice. Refer to the [Individual Consideration Services Payment Policy](#) for more information on claim submission.

COMPENSATION/REIMBURSEMENT INFORMATION

Providers are compensated according to the applicable contracted rates and applicable fee schedules, regardless of the address where the service is rendered. For more information, refer to the [Professional Services and Facilities Payment Policy](#).

Note: DME rental costs are reimbursed only up to the purchase cost.

Click [here](#) for a list of DME and medical supplies edits that may impact claims compensation.

ADDITIONAL RESOURCES

- [Orthotic and Prosthetic Payment Policy](#)
- [Sleep Studies and PAP Therapy Prior Authorization Program](#)

DOCUMENT HISTORY

- February 2021: Updated Resource Center link for Prior Authorization information for Commercial and Tufts Health Public Plans
- December 2020: Policy reviewed by committee; moved claim edits into separate document for clarity; clarified definitions for DME and medical supplies
- October 2020: Updated to include the following benefit information for Tufts Health Direct: lightbox coverage for SAD, effective for dates of service on or after November 1, 2020 and CGMs and accompanying supplies will be available through the pharmacy with a prescription under the pharmacy benefit, effective January 1, 2021
- March 2020: Removed frequency limitations for medical supplies
- June 2019: Removed speech generating devices edit, as it is no longer applicable
- April 2019: Removed frequency limitations for B4088, A4352, A4452, A4385, A4394, A4407, A4432, A4414, A4624, A5063, A5054
- February 2019: Clarified existing oral enteral formula coverage under the member's medical benefit
- August 2018: Added speech-generating device frequency limitation edit, effective for dates of service on or after October 1, 2018
- June 2018: Template updates
- March 2018: Policy reviewed by committee; condensed frequency limitations edits to table for clarity
- February 2018: Added claim edits for gradient compression stockings, enteral nutrition, lower limb prostheses, modifiers for DME, oxygen and oxygen equipment, pneumatic compression devices, suction pumps and supplies, and transcutaneous electrical nerve stimulation (TENS), effective for dates of service on or after April 1, 2018
- July 2017: Added edits for breast prostheses and mastectomy bras, diabetic shoes, knee orthoses, respiratory assist devices, and urological supplies effective for dates of service on or after October 1, 2017
- June 2017: Process clarified for DME supplies ordered by SNFs
- January 2017: Template updates
- November 2016: Added prosthetic frequency edits effective for dates of service on or after January 1, 2017
- September 2015: Template conversion, template updates
- July 2015: Added knee orthoses polices effective for dates of service on or after October 1, 2015, template updates
- May 2015: Added frequency policies based on maximum number of units that may be covered within a specified time frame, effective for dates of service on or after July 1, 2015
- March 2015: Policy reviewed, formatting changes and template updates
- February 2015: Removed electric lift mechanism policy, as it is no longer applies.

AUDIT AND DISCLAIMER INFORMATION

Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, Tufts Health Plan will expect the provider/facility to refund all payments related to noncompliance. For more information about Tufts Health Plan's [audit policies](#), refer to the Provider website.

This policy provides information on Tufts Health Plan claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will

be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the Tufts Health Plan products, as identified in the checkboxes on the first page, and to CareLinkSM for providers in Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna's provider agreements with respect to CareLink members. This policy does not apply to the Private Health Care Systems (PHCS) network (also known as Multiplan). Tufts Health Plan reserves the right to amend a payment policy at its discretion.