

Durable Medical Equipment 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)
- Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)

The following payment policy applies to Tufts Health Plan contracting durable medical equipment (DME) providers. For Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options, [click here](#).

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 DME when medically necessary, as described below. Tufts Health Plan will determine whether it is appropriate to purchase or rent equipment for members.

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

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 [website](#) or by contacting [Provider Services](#).

MEMBER RESPONSIBILITY

DME coverage is not subject to an annual or lifetime dollar limit. Members are responsible for up to 30 percent coinsurance responsibility on covered DME items and services.

Specialty care must be approved, arranged, or provided by the member's primary care provider (PCP).

AUTHORIZATION REQUIREMENTS

The DME provider is responsible for obtaining the provider's order/prescription for any requested item(s). Prescriptions/orders should include quantity and refill information, as applicable.

Prior authorization is required for facility and home-based sleep studies, sleep therapy and supplies (for members age 18 years and older).

Sleep Studies

Note: All sleep studies, sleep therapy and resupplies require individual prior authorizations. For complete listings and coverage criteria for DME items requiring prior authorization, refer to the [medical necessity guidelines](#).

To obtain and verify authorizations, providers should [register](#) and [log in](#) to the secure [eviCore healthcare](#) website. Refer to the [Sleep Studies and PAP Therapy Prior Authorization Program](#) for additional information.

For a list of procedures, services and items that require prior authorization, refer to the Sleep Management [Prior Authorization/Notification Procedure Code List](#) or the [eviCore healthcare](#) website.

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

Note: This program applies to Massachusetts and Rhode Island Commercial products. This program does not apply to Tufts Medicare Complement, USFHP, CareLinkSM, or Commercial PPO plans that use the Cigna PPO or PHCS network.

Medical Supplies

Required medical/dressing supplies can be obtained by the member from a Tufts Health Plan contracted DME provider with a provider’s prescription. If the member is receiving home health care services, the skilled nurse from the home health care agency can call and order the medical/dressing supplies from a Tufts Health Plan contracted DME provider directly. If the member is receiving services in a skilled nursing facility (SNF), the SNF may order DME supplies or equipment directly from a Tufts Health Plan contracted DME provider. The DME provider will then bill Tufts Health Plan directly. Tufts Health Plan requires provider documentation for medical supplies. For an item to be covered, a written, signed and dated order must be received by the supplier.

Oral Enteral Formula

Members must obtain oral enteral formula through a Tufts Health Plan network DME provider. Previously, oral enteral formula that Commercial members obtained at a Tufts Health Plan network pharmacy may have been covered under the pharmacy benefit.

Oral enteral formula may require prior authorization. Refer to the oral formula medical necessity guidelines for [Massachusetts](#) and [Rhode Island](#) for additional information.

BILLING INSTRUCTIONS

- Submit multiple same-day services on one line; the number of services/units should reflect all services rendered.
- When billing oral enteral formulas, submit the NDC number for the specific enteral formula product, product description, and the quantity on the claim

Modifiers

All claims should be submitted with the appropriate [modifiers](#). The following list includes, but is not limited to, modifiers, which can be billed to indicate purchase, rental or maintenance and service of equipment:

Modifier	Description	When to Submit
LL	Lease/rental	Indicate a rental price is applied to the purchase price
MS	Maintenance and servicing fee	Indicate maintenance and service of equipment
NU	New equipment	Indicate a purchase
RR	Rental equipment	Indicate a rental
SQ	Item ordered by home health	Indicate item ordered by a home health provider
BO	Orally administered nutrition, not by feeding tube	Submit with oral enteral formula claims
RA	Replacement of a DME, orthotic or prosthetic item	Indicate replacement
RB	Replacement of a part of DME, orthotic or prosthetic item furnished as a repair	Submit with DME procedure code to indicate replacement of a part as a repair

COMPENSATION/REIMBURSEMENT INFORMATION

Bundling

Tufts Health Plan does not routinely compensate for additions if billed with a prefabricated or custom fabricated base orthosis, as they are included in the primary procedure.

Frequency Limitations

Specific codes have been assigned a maximum number of units that may be covered within a specified time frame for a member by any provider. Refer to CMS and the [DME Regional Carrier](#) for additional information.

Category	Code(s)	Maximum Units	Timeframe
Blood glucose monitor	A9275	1	365 days
Breast prostheses (silicone)	L8030	1 (per side)	2 years
Compression gradient stockings	A6530 ² , A6531, A6533 ¹ , A6534, A6536 ¹ , A6539	6 single (or 3 pairs)	365 days
	A6545 ¹	4	365 days
Dressings	A6197	186	28 days
	A6209	36	
	A6210	72	
	A6212	96	
	A6223	90	
	A6252	60	
	A6253	240	
	A6257	12	
Enteral Nutrition	B4087, B4088	6	90 days
	B4185	150	28 days
Incontinence appliances and care supplies	A4326	6	84 days
	A4332	600	
	A4349	105	
	A4351-A4353	600	
Injection supplies	A4216	168	84 days
	A4230	90	
	A4231	36	
Knee orthotic	L1820	1	365 days
Miscellaneous supplies	A4452	100	28 days
	A4457	2	365 days
Ostomy pouches and supplies	A4385	20	28 days
	A4394	48	84 days
	A4407, A4432	20	28 days
	A4414, A5063	60	84 days
	A5054	60	28 days
Other supplies	A4253	6	84 days
Oxygen supplies and related equipment	A4624	279	84 days
	E0424, E0431-E0434, E0439, E1390-E1392, E1405, E1406, K0738	36	5 years
Prosthetic sheaths, socks, and shrinkers	L8400, L8410, L8415	12	6 months
	L8417, L8420, L8430, L8435, L8440, L8460, L8465, L8470, L8480, L8485	12	1 year
Respiratory supplies	A7001	1	84 days
	A7034, A7001	1	168 days
Speech generating devices ³	E2508, E2510	1	1095 days

² Effective for dates of service on or after April 1, 2018.

³ Effective for dates of service on or after October 1, 2018.

Blood Glucose Monitoring

Tufts Health Plan does not routinely compensate for supplies that are billed with glucose monitoring devices or accessories, as supplies are not required for the proper functioning of the device.

Canes, Crutches, and Walkers

Tufts Health Plan does not routinely compensate for the following:

- E0117 (underarm, articulating, spring-assisted crutch), as E0114 or E0116 (crutch, underarm, other than wood) are the less costly alternatives
- E0114 (enclosed walker), as a folding walker is the less costly alternative
- Wheel attachments if billed the same day or within one month of a new or used nonwheeled walker

Cold Therapy

Tufts Health Plan does not routinely compensate for cold therapy in the home.

Diabetic Shoes

Therapeutic shoes/inserts/modifications for diabetics only (A5500-A5513) must be billed with a diagnosis of diabetes mellitus and the appropriate RT/LT modifier(s).

In accordance with CMS, Tufts Health Plan does not routinely compensate for the following:

- Diabetic shoes/inserts/modifications if billed with orthopedic footwear
- Orthopedic shoes/inserts/modifications if billed with diabetic footwear

Dual Mode Battery Charger

Tufts Health Plan does not routinely compensate for a dual mode battery charger, as a single mode battery charger is the less costly alternative.

Orthotics and Prosthetics

Tufts Health Plan does not routinely compensate for an orthotic procedure if the same procedure has been paid within the previous five years by any provider.

Knee Orthoses

Tufts Health Plan does not routinely compensate for additions if billed without a paid prefabricated or custom fabricated base orthosis.

Orthopedic Footwear

Tufts Health Plan does not routinely compensate for L3250 (orthopedic footwear, custom molded shoe, removable inner mold, prosthetic shoe) if billed with leg prostheses that are attached to the residual limb by other mechanisms. According to CMS, the custom molded shoe may be used only for a shoe that is custom fabricated from a model of a patient and has a removable custom fabricated insert designed for toe or distal partial foot amputation.

Lower Limb Prostheses

Tufts Health Plan does not routinely compensate for the following, in accordance with CMS guidelines:

- Suction valve if billed with a below-knee or above-knee locking mechanism
- Test socket with an immediate prosthesis
- Sockets, ultra-light material, outer covering system and flex foot system if billed with a preparatory prosthesis
- Replacement sockets if billed with a lower limb prosthesis or preparatory lower limb prosthesis
- L5940-L5960 (ultra-light material endoskeletal system additions) if billed without a qualifying endoskeletal system or socket HCPCS code⁴
- L5647 or L5652 (addition to lower extremity, suction suspension) if billed with L5671 (addition to lower extremity, locking mechanism)⁶
- L7520 (prosthetic repair, labor per 15 minutes) if billed within 3 months of lower limb prostheses, preparatory lower limb, upper limb prostheses or preparatory upper limb prostheses

DME Modifiers

Tufts Health Plan does not routinely compensate for the following:

- Capped rentals, oxygen delivery system rentals or oxygen accessories billed without modifier RR

⁴ Effective for dates of service on or after April 1, 2018.

- HCPCS codes identified as “pair” codes billed with modifier RT or LT
- Refractive lenses billed without modifier RT or LT
- Any piece of DME if billed with RR, NU or UE if the same equipment has been paid with either UE or NU modifier(s) within the previous five years by any provider

Tufts Health Plan does not routinely compensate for the following:

- E1825 (Finger extension/flexion device) if billed without a finger modifier (FA-F9)
- E1830 or E1831 (toe extension/flexion device) if billed without a toe modifier (TA-T9)
- A5120 (skin barrier, wipes or swabs) if billed without modifier AU or AV by a DME provider
- Any HCPCS code other than A4450, A4452, A6457, A6531, A6532 or A6545 (medical surgical supplies/dressings) if billed with modifier AW by a DME provider
- Any HCPCS code billed inappropriately with modifier BA, based on CMS guidelines

Noncontact Normothermic Wound Warming Devices

Tufts Health Plan does not routinely compensate for noncontact normothermic wound warming devices, as they are considered noncovered due to lack of scientific and clinical evidence indicating the services are reasonable and necessary.

Oral Enteral Formula

Brand name and generic enteral formula are compensated in accordance with the contract. The average wholesale price will be determined by the provider based on the latest published pricing for enteral product in First Data Bank Pricing Guide or in the Red Book. The DME provider is responsible for submitting the AWP rate to the plan for compensation.

Ostomy Supplies

Tufts Health Plan does not routinely compensate for sleeves, bags or a cone/catheter with brush if billed with an ostomy irrigation kit, as these are included in the ostomy irrigation kit.

Oxygen and Oxygen Equipment

Tufts Health Plan does not routinely compensate for oxygen contents if billed more than once every month.

Topical Oxygen Delivery System

Tufts Health Plan does not routinely compensate for E0446 (topical oxygen delivery system), as it is not a covered benefit.

Tufts Health Plan does not routinely compensate oxygen equipment (E1390, E1391, E0433, K0738) if billed with modifier MS more than once every six months in any combination by any provider.

Intrapulmonary Percussive Ventilation System

Tufts Health Plan does not routinely compensate for intrapulmonary percussive ventilation system if billed in place of service 12 (home), 13 (assisted living facility), 14 (group home) or 33 (custodial care).

Pneumatic Compression Devices

Tufts Health Plan does not routinely compensate E0650-E0651 or E0655-E0673 (pneumatic compressor/appliance device) if billed with a diagnosis of venous insufficiency unless a diagnosis of chronic ulcer is also on the claim.

Respiratory Assist Devices (RAD)

Tufts Health Plan does not routinely compensate mutually exclusive RADs if billed on the same date of service or within a month.

Tufts Health Plan does not routinely compensate for E0471 (respiratory assist device) if billed without a diagnosis of obstructive sleep apnea.

Refer to the [Sleep Studies Payment Policy](#) for more information regarding sleep studies and related supplies.

Speech Generating Devices and Accessories

Tufts Health Plan does not routinely compensate for devices, accessories or software programs that are considered to be not the least intensive level of services (E2508, E2510, E2511, E2512).

Supplies

Does not compensate for A5120 (skin barrier, wipes or swabs, each) or A4369 (ostomy skin barrier, liquid) if billed within the same month by any provider.

Suction Pumps

Tufts Health Plan does not routinely compensate A9272 (wound suction, disposable).

Tracheostomy Care Supplies

Tufts Health Plan does not routinely compensate for supplies when billed with a tracheostomy care kit, as the tracheostomy care kit includes gloves, tape, tracheostomy tube/collar/holder and other supplies.

Transcutaneous Electrical Nerve Stimulation (TENS) Supplies

Tufts Health Plan does not routinely compensate for the following codes if billed by any provider on the same date or during the same month as E0720, E0730 (TENS device):

- A4450, A4452 (adhesive tape)
- A4455 (adhesive remover)
- A4556 (electrodes, per pair)
- A4557 (lead wires, per pair)
- A4558 (conductive paste or gel)
- A4630 (replacement batteries for medically necessary TENS owned by member)

Ultrasonic/Electronic Aerosol Generator with Small Volume Nebulizer

Tufts Health Plan does not routinely compensate E0574 (aerosol generator with small-volume nebulizer), as E0570 (nebulizer with compressor) is the less costly alternative.

Urological Supplies

Tufts Health Plan does not routinely compensate for A5200 (catheter/tube anchoring device) if billed the same day or within a month of an indwelling catheter (A4311-A4316, A4338-A4346) and enteral nutrition (B4081-B4088, B4149-B4162) has not also been billed.

Wheelchair Options and Accessories

Tufts Health Plan does not routinely compensate for power wheelchair options/accessories unless a power wheelchair has also been billed on the same date of service.

In accordance with CMS, Tufts Health Plan does not routinely compensate for any of the following:

- Nonsealed lead acid batteries
- Manual wheelchair accessories if billed with a power wheelchair
- Power wheelchair accessories if billed with a manual wheelchair

ADDITIONAL RESOURCES

[Orthotic and Prosthetic Professional Payment Policy](#)

DOCUMENT HISTORY

- 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.
- December 2014: Moved information about unlisted procedure codes to the Claims Submission payment policy, template updates
- May 2014: Template updates
- March 2014: Added replacement modifiers RA and RB to the modifier section, updated language for orthotic procedures, template updates
- January 2014: Updated information about the Sleep Management Program Overview, and added links to overview and the Sleep Management Prior Authorization/Notification Code List, template updates
- August 2013: Added policies effective for dates of services on or after October 1, 2013, template conversion and updates
- January 2013: Template updates, clarified portable oxygen policy
- August 2012: Removed language regarding Suction Pumps, External Infusion Pumps & Laser Skin Piercing Devices as plan policies are consistent with CMS guidelines, minor clarification changes.
- June 2012: Added information regarding speech generated devices and topical oxygen delivery system that was previously documented in the Noncovered Services Medical Necessity Guidelines.
- May 2012: Added effective for claims adjudicated on or after July 1, 2012, Tufts Health Plan will not reimburse for hospital beds when billed without modifier KX.
- March 2012: Updated CareLink disclaimer language
- October 2011: Policy reviewed, templates updates, formatting changes for clarity, and added information regarding paper SOAs and the Summary of Account on Tufts Health Plan's secure Provider website effective January 1, 2012.
- October 2010: Added Effective January 1, 2011, DME suppliers dispensing CPAP and BiPAP machines will be required to obtain authorization from CareCore National. The Tufts Health Plan Precertification Department will no longer handle prior authorization requests for this equipment and related supplies. DME suppliers will also need to request authorization for supplies and new equipment for existing CPAP and BiPAP machines.
- August 2010: Added changes regarding annual or lifetime dollar limit, coinsurance responsibility, effective October 1, 2010 and removed all references to benefit, annual, or lifetime maximums. Also added prior authorization requirements effective for service dates on and after November 1, 2010.
- June 2009: Added new commercial coding methodologies effective for claims adjudicated on or after August 31, 2009
- November 2008: Added information about Rhode Island based employer groups and modifier BO for oral enteral formulas
- April 2008: Revised general benefit information with self-service channels information
- April 2000: Policy originated

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.