Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options
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 information on Commercial products, [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, up to the member's benefit maximum\(^2\). Tufts Health Plan will determine whether it is appropriate to purchase or rent equipment for members.

Tufts Health Plan SCO provides coverage for all medically necessary DME 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

**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 [Senior Products Provider Relations](#).

**Note:** There is no member responsibility for covered services for Tufts Health Plan SCO members.

Providers supplying noncovered items should note that members may not be held liable for noncovered items unless member agrees in writing to pay for the items after being informed by the supplying provider that the items are noncovered.

**AUTHORIZATION REQUIREMENTS**

Certain DME items require prior authorization through the Tufts Health Plan Precertification Operations Department, while others may require notification to Tufts Health Plan or other entity (e.g., eviCore healthcare, our sleep benefits manager). 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.

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.

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

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\(^1\) Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink\(^n\) when Tufts Health Plan is the primary administrator.

\(^2\) Tufts Medicare Preferred HMO members: Authorized medical supplies, respiratory equipment/supplies (excluding PAP therapy, nebulizers and related supplies), insulin pumps and related diabetic supplies are not applied to member's benefit maximum.
**Tufts Medicare Preferred HMO**
With the exception of PAP therapy and related supplies, providers should fax all requests for coverage of DME for Tufts Medicare Preferred HMO members to the Precertification Operations Department at 617.972.9409.

**Sleep Studies**
**Tufts Medicare Preferred HMO**
Prior notification is required through the secure eviCore healthcare website for PAP therapy and related supplies. Tufts Health Plan’s Precertification Operations Department does not handle prior authorization requests for this equipment and related supplies. Ordering providers can submit prior notification through the eviCore healthcare website or by contacting eviCore healthcare.

**Tufts Health Plan SCO**
Prior notification must be submitted to the Tufts Health Plan SCO care manager for sleep studies, sleep equipment and related supplies. Contact Senior Products Provider Relations at 800.279.9022 to identify the appropriate Tufts Health Plan SCO care manager.

All sleep studies, sleep therapy, and resupplies require individual prior notifications. For more information, refer to the following:
- [Sleep Studies and PAP Therapy Prior Authorization Program](#)
- [Sleep Management Program: Prior Authorization/Notification Procedure Code List](#)

**Oral Enteral Formula**
Tufts Medicare Preferred HMO and Tufts Health Plan SCO members must obtain oral enteral formula through a contracted DME supplier.

**Medical Supplies**
Required medical/dressing supplies can be obtained by the member from a Tufts Medicare Preferred HMO and Tufts Health Plan SCO contracting 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 or care manager can order the medical/dressing supplies from a Tufts Medicare Preferred HMO or Tufts Health Plan SCO contracting DME provider directly.

If the member is in a skilled nursing facility (SNF), the SNF may order DME supplies or equipment directly from the Tufts Medicare Preferred HMO or Tufts Health Plan SCO contracted DME provider. The DME provider must bill Tufts Health Plan directly for the supplies.

**BILLING INSTRUCTIONS**
Refer to the billing guidelines issued by your DME Medicare Administrative Contractor (DME MAC) for the most up-to-date industry standard guidelines and information regarding modifiers.

**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:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>When to Submit</th>
</tr>
</thead>
<tbody>
<tr>
<td>LL</td>
<td>Lease/rental</td>
<td>Indicate a rental price is applied to the purchase price</td>
</tr>
<tr>
<td>MS</td>
<td>Maintenance and servicing fee</td>
<td>Indicate maintenance and service of equipment</td>
</tr>
<tr>
<td>NU</td>
<td>New equipment</td>
<td>Indicate a purchase</td>
</tr>
<tr>
<td>RR</td>
<td>Rental equipment</td>
<td>Indicate a rental</td>
</tr>
<tr>
<td>SQ</td>
<td>Item ordered by home health</td>
<td>Indicate item ordered by a <a href="#">home health</a> provider</td>
</tr>
<tr>
<td>BO</td>
<td>Orally administered nutrition, not by feeding tube</td>
<td>Submit with oral enteral formula claims</td>
</tr>
<tr>
<td>RA</td>
<td>Replacement of a DME, orthotic or prosthetic item</td>
<td>Indicate replacement</td>
</tr>
<tr>
<td>RB</td>
<td>Replacement of a part of DME, orthotic or prosthetic item furnished as a repair</td>
<td>Submit with DME procedure code to indicate replacement of a part as a repair</td>
</tr>
</tbody>
</table>
### Oral Enteral Formula
Submit the following information on claims for oral enteral formula:
- NDC number for the specific enteral formula product
- Product description and quantity
- Modifier BO (orally administered nutrition, not by feeding tube)

### COMPENSATION/REIMBURSEMENT INFORMATION

#### 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.

<table>
<thead>
<tr>
<th>Category</th>
<th>Code(s)</th>
<th>Maximum Units</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastrostomy/jejunostomy tube(^3)</td>
<td>B4087, B4088</td>
<td>6</td>
<td>90 days</td>
</tr>
<tr>
<td>Gradient compression stockings</td>
<td>A6545, A6530, A6533 or A6536</td>
<td>4 pairs</td>
<td>Calendar year</td>
</tr>
<tr>
<td>Oxygen supplies and related equipment(^3)</td>
<td>E0424, E0439, E1405, E1406, E1390, E1391, E0431, E0433, E0434, E1392, K0738, K0741</td>
<td>36</td>
<td>5 years from first date of service</td>
</tr>
<tr>
<td>Prosthetic sheaths</td>
<td>L8400, L8410, L8415</td>
<td>12</td>
<td>6 months</td>
</tr>
<tr>
<td></td>
<td>L8417</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prosthetic socks</td>
<td>L8420, L8430, L8435, L8470, L8480, L8485</td>
<td>12</td>
<td>Calendar year</td>
</tr>
<tr>
<td>Prosthetic shrinker</td>
<td>L8440, L8460, L8465</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wound care supplies(^4)</td>
<td>A4253</td>
<td>6</td>
<td>90 days</td>
</tr>
<tr>
<td></td>
<td>A4311</td>
<td>3</td>
<td>90 days</td>
</tr>
<tr>
<td></td>
<td>A4362, A4425, A5063</td>
<td>60</td>
<td>90 days</td>
</tr>
<tr>
<td></td>
<td>A6212</td>
<td>12</td>
<td>1 month</td>
</tr>
<tr>
<td></td>
<td>A6550</td>
<td>15</td>
<td>1 month</td>
</tr>
</tbody>
</table>

#### Lower Limb Prostheses
Effective for dates of service on or after April 1, 2018, Tufts Health Plan will not routinely compensate for the following:
- L5940-L5960 (ultra-light material endoskeletal system additions) if billed without a qualifying endoskeletal system or socket HCPCS code, based on CMS guidelines
- L5647 or L5652 (addition to lower extremity, suction suspension) if billed with L5671 (addition to lower extremity, locking mechanism)

#### Modifiers
Tufts Health Plan requires all industry standard modifiers on DME, respiratory, medical supplies, orthotics and prosthetic claims. Claims submitted without complete and appropriate modifiers will be denied. This includes modifier EY (no physician or other licensed health care provider order for this item of service) and KX (specific required documentation on file) when appropriate, per CMS guidelines.

#### Required DME Modifiers
Tufts Health Plan does not routinely compensate for power mobility devices billed without modifier KX.

Effective for dates of service on or after April 1, 2018, Tufts Health Plan does not routinely compensate for the following:
- E1825 ( Finger extension/flexion device) when billed without a finger modifier (FA-F9)
- E1830 or E1831 (toe extension/flexion device) when billed without a toe modifier (TA-T9)

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\(^3\) Effective for dates of service on or after April 1, 2018.

\(^4\) Effective for dates of service on or after October 1, 2018.
• A5120 (skin barrier, wipes or swabs) when billed by a DME provider without modifier AU or AV
• Any HCPCS code other than A4450, A4452, A6457, A6531, A6532 or A6545 (medical surgical supplies/dressings) if billed by a DME provider with modifier AW
• Any HCPCS code billed inappropriately with modifier BA, based on CMS guidelines

Tufts Health Plan does not routinely compensate for the following if billed without modifier(s) KX, GA or GZ:

• Wearable defibrillators or nonwearable automatic defibrillators
• Form-fitting conductive garment for delivery of transcutaneous electrical nerve stimulation (TENS)
• E0784 (ambulatory infusion pump, insulin) or J1817 (insulin for administration through DME)
• A7025, A7026, or E0483 (high frequency chest wall oscillation devices)
• A4310-A4328, A4332-A4360, or A5102-A5114 (urological supplies)

Nebulizers
Tufts Health Plan does not routinely compensate for a noncompounded inhalation solution when billed without modifier KX.

Oral Enteral Formula
Brand name and generic enteral formula is compensated in accordance with the contract. The average wholesale price is 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.

Osteogenic Stimulators
Effective for dates of service on or after January 1, 2018, Tufts Health Plan does not routinely compensate E0748 (electrical osteogenesis stimulator) if billed without a diagnosis of post-surgical arthrodesis status.

Oxygen and Oxygen Equipment
Effective for dates of service on or after April 1, 2018, Tufts Health Plan will not routinely compensate oxygen equipment (E1390, E1391, E0433, K0738) when billed with modifier MS more than once every six months in any combination by any provider.

Pneumatic Compression Devices
Effective for dates of service on or after April 1, 2018, 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 present.

Prefabricated Knee Orthoses
Tufts Health Plan limits coverage of useful lifetime for prefabricated knee orthoses to one every two years for members 18 years and older.

Suction Pumps and Supplies
Effective for dates of service on or after April 1, 2018, Tufts Health Plan will not routinely compensate A9272 (wound suction, disposable).

Transcutaneous Electrical Nerve Stimulation (TENS)
Effective for dates of service on or after April 1, 2018, Tufts Health Plan will not routinely compensate for the following if billed by any provider on the same date or during the same month as E0720 or 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)

Wheelchair Options/Accessories
Tufts Health Plan does not routinely compensate for a wheelchair option or accessory when billed without modifier KX on the same date of service as a power wheelchair base.

ADDITIONAL RESOURCES
Orthotic and Prosthetic Professional Payment Policy
DOCUMENT HISTORY

- August 2018: Added frequency limitation edits for wound care supplies, 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, external infusion pumps, high-frequency chest wall oscillation devices, lower limb prostheses, modifiers for DME, oxygen and oxygen equipment, suction pumps and supplies, transcutaneous electrical nerve stimulation (TENS), and urological supplies, effective for dates of service on or after April 1, 2018
- November 2017: Added edits for osteogenic stimulators effective for dates of service on or after January 1, 2018.
- June 2017: Process clarified for DME supplies ordered by SNFs
- January 2017: Template updates
- November 2016: Added prosthetic frequency limitations effective for dates of service on or after
- September 2015: Template conversion
- July 2015: Added useful lifetime for prefabricated knee orthoses policy effective for dates of service on or after October 1, 2015; template updates
- March 2015: Policy reviewed; added DME definition; formatting changes; template updates
- November 2014: Added policies regarding automatic external defibrillators, nebulizers, power mobility devices, TENS and wheelchair options/accessories, effective for dates of service on or after January 1, 2015; template updates
- May 2014: Incorporated information for SCO members; template updates
- January 2014: Added link to the Sleep Management Program Overview; added information about prior notification template updates
- September 2013: Template conversion
- December 2012: Sleep Program clinical criteria updated; template updates.
- April 2012: Template updates made
- October 2011: Policy reviewed; no content changes; template updates made
- March 2011: Reviewed document for clarity; no content changes made.
- October 2010: Added information regarding prior authorization of CPAP/BiPAP
- January 2010: Removed references to the Tufts Medicare Preferred PPO document
- March 2009: Policy originated; moved Tufts Medicare Preferred information to its own document
- November 2008: Added information about modifier BO for oral enteral formulations
- April 2008: Clarified that all requests for coverage of DME for Tufts Medicare Preferred members should be sent the Precertification Department
- November 2007: Added Tufts Medicare Preferred modifier information

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 an office/facility did not comply with this payment policy, Tufts Health Plan will expect the office/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.