PAYMENT POLICY		
Durable Medical Equipment		
Original Date Approved	**Effective Date**	**Revision Date**
1/1/2018	2/1/2026	8/14/2025
☒ Senior Care Options (FIDE-SNP)	☒ One Care (FIDE-SNP)	

PAYMENT POLICY STATEMENT:

This payment policy outlines covered durable medical equipment in accordance with state and federal guidelines for all CCA products.

DEFINITIONS:

Durable Medical Equipment (DME): Medical equipment or appliances that are manufactured to withstand repeated use, ordered by a physician or allowed practitioner for use in the home, and required to correct or ameliorate a member's disability, condition, or illness.

DMEPOS supplier: Means an entity with a valid Medicare supplier number, including an entity that furnishes items through the mail.

Medical Supplies: Consumable or disposable supplies or devices for home use necessary for the treatment of a specific illness, injury, disease, or disability.

Orthotic Device: A custom-fabricated or custom-fitted medical device that is used to support, align, correct, or prevent deformities of the body, which may be used to eliminate, control, or assist motion at a joint or body part.

Prosthetic Device: A device used as an artificial replacement for a missing body part, such as an artificial limb or total joint replacement.

Individual Consideration (I.C.): Items for which there is no specified rate or when otherwise designated by EOHHS as individual consideration. I.C. items require the provider to keep adequate records, including a copy of the invoice to assist with pricing as outlined in 101 CMR 322.03(19).

Adjusted Acquisition Cost (AAC): The price paid by an eligible provider for durable medical equipment and related supplies excludes additional costs such as shipping, handling, sales tax, and insurance. The adjusted acquisition cost (AAC) must incorporate all applicable discounts, including those from manufacturers, dealers, trade, volume discounts, and rebates. The only discount that does not need to be passed on

to the governmental unit is for timely payments to the supplier, limited to 5% of the AAC. The pricing methodology is specified in 101 CMR 322.03(17).

Centers for Medicare & Medicaid Services (CMS): A federal agency that is part of the U.S. Department of Health and Human Services responsible for administering and managing the Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), HIPAA, and the Clinical Laboratory Improvement Amendments (CLIA) programs.

MassHealth: The medical assistance and benefit programs administered by the Massachusetts Executive Office of Health and Human Services pursuant to Title XIX of the Social Security Act (42 U.S.C. 1396), Title XXI of the Social Security Act (42 U.S.C. 1397), M.G.L. c.118E, and other applicable laws and waivers to provider and pay for medical services to eligible members.

Healthcare Common Procedure Coding System (HCPCS): (Also known as HCPCS Level II) An alphanumeric code starting with an alphabetical letter followed by 4 numeric digits; it is used to identify medical related products, supplies, and services not included in the CPTS codes for billing purposes.

Modifier: A two-digit alphabetic, numeric, or alphanumeric code used to indicate a specific circumstance that altered a procedure or service without changing its definition or code and provides more information about the procedure or service performed.

CMS-1500: (also known as HCFA) Claim form used for professional services.

AUTHORIZATION REQUIREMENTS (If applicable):

DME may require prior authorization. Prior authorization requests should be submitted with a form which can be found in the CCA Provider Manual and should be submitted using the CCA Standard Request Form or electronically via the Tomorrow Health platform. Please refer to the provider manual https://www.commonwealthcarealliance.org/ma/providers/. In addition to the prior authorization form, CCA requires providers to submit an invoice for the following medical supplies and/or surgical dressings:

- Miscellaneous medical supply codes;
- Not Otherwise Specified (NOS) medical supply codes;
- Therapeutic molded shoes and shoe inserts for diabetics only;
- Wig codes; and
- Procedure codes identified as individual consideration.

Orders for DME items that may exceed the benefit limit or are considered non-covered will require prior authorization based on medical necessity.

REIMBURSEMENT GUIDELINES:

CCA reimburses medically necessary DME (medical equipment, prosthetic devices, orthotic devices, and medical supplies) according to CMS and MassHealth guidelines,

including standard limits and MUEs. DME must be non-experimental, non-investigational, of proven quality and dependability, and must meet the following criteria:

- Item must be durable, meaning it can withstand repeated use;
- Item must be used for medical purposes only;
- Item must be necessary and reasonable for the treatment of an illness or to improve the functioning of a malformed body member that is established by a physician prescription; and
- Item must be appropriate for home use.

All DME items require a written order/prescription from the treating practitioner and must be provided by a supplier or provider that is enrolled in Medicare and, if Medicaid is the primary payor, enrolled as a MassHealth provider (any MassHealth category, i.e. fee-for-service, QMB, ORP, or MCE-only). The ordering/referring provider's name, National Provider Identifier (NPI), and qualifier DN or DK (for electronic claims) must be billed on the claim to receive reimbursement. For fulfillment, CCA recommends contracted/in-network providers use Tomorrow Health to order or request DME items and requires these providers to refer members to a contracted/in-network supplier.

CCA covers the following as outlined in CMS Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Medical Claims Processing Manual and MassHealth 130 CMR 409.000 DME Medical Equipment Manual:

- The purchase of inexpensive DME, other routinely purchased DME, and used equipment. Providers must bill with the correct modifiers to indicate purchased new and used DME.
- Items that require frequent and substantial servicing (i.e. continuous passive motion devices). These items are reimbursed on a rental basis only.
- Certain customized items.
- Other prosthetic and orthotic devices.
- Capped rental items. Providers must bill with the correct modifiers to indicate rented and capped rental DME.

Out of Network providers will be reimbursed in accordance with CCA's Out-Of-Network Provider Policy. All DME reimbursements are subject to applicable CMS and MassHealth Medicare-Medicaid cost-sharing regulations.

Capped Rental Items/Equipment:

For Capped Rental items, CCA will reimburse a period of 13 monthly payments for Continuous Use of DME item. Continuous Use is a period of time that allows for temporary interruptions in the use of equipment. Interruptions must exceed 60 consecutive days, plus the days remaining in the rental month in which the use ceases

(not calendar month, but the 30-day rental period) and a new capped rental period to begin.

The capped rental payment is inclusive of all costs for the effective use of the equipment by the CCA Member including maintenance and services, repairs or replacement, and supplies and accessories needed to use the equipment. At the end of the capped rental period, the plan member owns the equipment. The supplier will transfer ownership and any warranties to the plan member.

After 13 months of rental has been paid CCA pays for reasonable and necessary maintenance and servicing of the item, i.e., parts and labor not covered by a supplier's or manufacturer's warranty. The rental should not exceed the purchase price.

DME Provided to Members in Nursing Facilities: In accordance with the section 1861(n) of the Social Security Act, the CMS bundled billing requirements, CMS Medicare Claims Processing Manual Chapter 6 Section 10.1, and MassHealth requirements in 130 CMR 409 for members located in or residing in a nursing facility, CCA does not pay for DME rendered or used predominantly within the facility except as provided under MassHealth regulation **130 CMR 409.415 et al**.

Repairs, Maintenance, and Replacements: DME repairs, maintenance, and replacements are covered as follows:

- **Repairs** – Repairs are covered for DME equipment that has been purchased or is owned by the member and is not covered under the warranty except for oxygen equipment. The cost of repairs should not exceed the purchase rate of the item or the monthly rental rate of an identical/similar item. Any parts of the equipment that are replaced during repair should be billed with the appropriate modifier. If the equipment must be removed from the member, CCA will cover a temporary replacement. Additionally, CCA will cover a manual wheelchair as a back-up during the repair of a power mobility system (power wheelchair) as outlined in MassHealth 130 CMR 409 Durable Medical Equipment Manual. Payment for repairs of capped rental items is included in the monthly fee and will not be separately reimbursed.

  Corrective Mobility System Repair Add-on Payment

  - CCA will pay an eligible provider for a corrective mobility system repair add-on payment if all of the following requirements are met:
    - Corrective repair is performed within 12 calendar days (from intake to completion and delivery to the member).
    - The mobility system is thoroughly evaluated using a safety and performance evaluation, or industry equivalent evaluation.

- Any qualifying repair must include any additional items that may not have been identified by the member at the time of the intake for the repair.
- The completed evaluation must be kept in the member file.
- A delivery ticket or additional documentation upon delivery must include all of the following (see 130 CMR 409.430(F)(4)):
  - the date the member or member's designee contacted the DME provider to report the need for the repair;
  - the number of calendar days required to complete the repair (intake to completion and delivery to the member);
  - a statement from the DME provider attesting the timeline provided on the delivery ticket or additional documentation is accurate; and
  - an option on the delivery ticket or additional documentation for the member or member's designee to confirm that the repair was completed and the mobility system returned in the time frame identified on the delivery ticket.
- The submitted claim includes HCPCS code/modifier combination K0739 U3.
- The corrective mobility system repair add-on payment can be applied to repairs performed for dual eligible members and members with other primary insurance if the requirements above are met. Providers must follow MassHealth Third Pary Liability (TPL) billing guidelines to obtain reimbursement (see 130 CMR 450. 316 through 318).

- Filing and Reporting Requirements (101 CMR 322.04(1)) Providers must comply with reporting and other requirements specified in EOHHS guidance regarding add-on payments or supplemental payments under 101 CMR 322.05.

- Recordkeeping Requirements: 130 CMR 409.430(F) For mobility system repairs, providers must include the following additional information on the delivery ticket, or on a separate document, provided at the time of the delivery.
  - The date the member or member's designee contacted the DME provider to report the need for the repair;
  - The number of calendar days required to complete the repair (intake to completion, including delivery to the member);
  - A statement from the DME provider attesting the timeline provided on the delivery ticket, or an option on the delivery ticket, or additional documentation, for the member or member's designee to confirm the repair was completed and the mobility system returned in the identified time frame. additional documentation, is accurate; and

- **Maintenance and repairs** – Maintenance for DME equipment is covered only when it is being purchased or already owned by the member, and the maintenance is considered extensive in that it requires a skilled technician for servicing or repairs. The maintenance must be deemed reasonable and necessary, and it cannot be covered under the manufacturer's or supplier's warranty. Covered DME maintenance includes lower-cost or frequently purchased DME, customized items, other prosthetic/orthotic devices, and capped rental items that have been purchased as specified in the CMS DMEPOS Medical Claims Processing Manual. Maintenance that does not require skilled labor is not covered.
- **Replacement** – Replacement due to loss, irreparable damage/wear, or change in a member's condition is covered for DME equipment that is being purchased, is already owned by the member, or is a capped rental item. This includes the replacement of essential accessories (i.e. hoses, tubes, mouthpieces, etc.) for owned or purchased equipment. The replacement of items that require frequent and substantial servicing is not covered.

DME that requires I.C. and AAC: I.C. codes are procedure codes (HCPCS or CPT) that do not have an established fee schedule rate. This may include new, unlisted, and miscellaneous procedure codes. Codes that require I.C. may be priced using AAC plus the standard markup as defined in MassHealth 101 CMR 322.02. When submitting claims for I.C. or AAC, providers must include documentation and a copy of the invoice for reimbursement. Claims submitted without documentation will be denied.

Invoices: When submitting invoices with claims, providers should ensure the following:

- The invoice is within six months prior to the date of service;
- The invoice reflects all discounts applied to determine the AAC;
- The invoice is not a printed invoice, quote, or order from a manufacturer's website or servicing DME provider;
- For orthotics and prosthetics, the invoice must include the cost of the materials (if the provider is not the manufacturer of the materials); and
- For medical supplies, the shipping invoice must include:
    - The member's name;
    - The quantity of the supply delivered;
    - A detailed description of the items delivered including brand name and serial number (if applicable); and
    - The delivery service's package identification number.

Providers should keep a copy of the invoice on file for reference.

Lift Chairs: CCA will cover the mechanism (code E0627) and the chair (code A9900) separately. To ensure the lift chair is reimbursed accurately, the amount for the mechanism will be subtracted from the invoice amount for the chair.

CCA does not cover the following:

- DME that is experimental or investigational in nature;
- DME that is more costly than medically appropriate/feasible equipment;
- DME that serves the same purpose as already owned or rented DME;
- Repairs that are not identified as covered by CMS or MassHealth;
- Repairs where the cost is equal to or more than the cost of purchasing a replacement;
- Routine testing, cleaning, regulating, and checking of DME that is owned by the member;
- Repairs or replacements where a member repeatedly fails to use the equipment safely and properly;
- Spare or back-up equipment with the exception of a manual wheelchair as a backup to a power mobility system as outlined in MassHealth 130 CMR 409;
- Sales tax, shipping and handling, or restocking charges associated with obtaining DME;
- Replacement during the reasonable useful lifetime of the equipment as outlined in CMS Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Medicare Claims Processing Manual; and
- Standard “off the shelf” batteries including but not limited to battery sizes AAA, AA, A, C, D, etc. except when specifically used for insulin pumps and/or continuous glucose monitors.

Please note: All in-network providers and suppliers must be enrolled with MassHealth. All DME suppliers must be enrolled in Medicare to provision Medicare covered supplies.

Below are the modifiers allowed for DME (this is not an inclusive list):

Modifier	Description
NU	New equipment
UE	Used durable medical equipment
RR	Rental of durable medical equipment and oxygen/respiratory therapy equipment
KR	Rental item for a partial month
KH	Capped rental; Initial claim, either rent (first month) or purchase
KI	Capped rental; Second or third month rental
KJ	Capped rental; Rental months four to 13
LT	Left side (used to identify procedures performed on the left side of the body)
RT	Right side (used to identify procedures performed on the right side of the body)

KC	Replacement of special power wheelchair interface
MS	Six-month maintenance and servicing fee for reasonable and necessary parts and labor which are not covered under any manufacturer or supplier warranty
RA	Replacement of a DME item
RB	Replacement of a part of a DME furnished as part of a repair
U3	Corrective Mobility Repair add-on payment when used in conjunction with HCPCS code K0739

RELATED SERVICE POLICIES:

General Coding and Billing

Oxygen

Repairs and Modifications of Durable Medical Equipment (DME) Medical Necessity Guidelines

Provider Manual

AUDIT and DISCLAIMER:

As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction 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, state and federal cost sharing rules, referral/authorization, utilization management guidelines, adherence to plan policies and procedures, and claims editing logic. CCA has the right to conduct audits on any provider and/or facility to ensure accuracy and 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, CCA has the right to recover refunds from the provider/facility for all payments related to non-compliance. CCA reserves the right to amend this payment policy at its discretion. CPT and HCPCS codes are updated as applicable; provider/facility shall adhere to the most current CPT and HCPCS coding guidelines.

REFERENCES:

CCA Repairs and Modifications of Durable Medical Equipment (DME) Medical Necessity Guidelines
https://www.commonwealthcarealliance.org/ma/wp-content/uploads/2025/03/Repairs-and-Modifications-of-Durable-Medical-Equipment_DME_096_03.31.25.pdf

CMS Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services
https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c15.pdf

CMS Medicare Claims Processing Manual, Chapter 20 – Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c20.pdf

CMS Medicare Claims Processing Manual, Chapter 6 – SNF Inpatient Part A Billing and SNF Consolidated Billing
https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c06.pdf

MassHealth 130 CMR 409.000 Durable Medical Equipment Manual
https://www.mass.gov/doc/durable-medical-equipment-regulations/download

MassHealth 101 CMR 322.00 Rates for Durable Medical Equipment, Oxygen and Respiratory Therapy Equipment
https://www.mass.gov/doc/rates-for-durable-medical-equipment-oxygen-and-respiratory-therapy-equipment-effective-july-7-2023-0/download

Out of Network Payment Policy

https://www.commonwealthcarealliance.org/ma/wp-content/uploads/sites/1/2022/03/CCA-Payment-Policy_Individual-Consideration-Codes.pdf

Capped Rental Requirements – Noridian DME Regional MAC for DME Jurisdiction A:
https://med.noridianmedicare.com/web/jddme/article-detail/-/view/2230715/reasonable-useful-lifetime…

POLICY TIMELINE DETAILS:

1. Approved: January 2018
2. Revision: October 2021; added Medicare Advantage Part D
3. Revision: June 2022, updated formatting
4. Revision: June 2025, updated template, updated definitions, updated authorization requirements by adding repair and non-covered language, updated Medicare and Medicaid requirements, added I.C./AAC language, added invoice language, added lift chairs requirements, updated non-covered services, updated modifier list