JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Provider Relations and Network Innovation Reimbursement Policy**	*Policy Number*	RPC.012
		Effective Date	07/05/2024
		Approval Date	04/10/2024
	Subject **Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)**	*Supersedes Date*	N/A
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This document applies to the following Participating Organizations:

EHP | Johns Hopkins Advantage MD | Priority Partners | US Family Health Plan

Keywords: Durable Medical Equipment (DME), Orthotics, Oxygen and Oxygen Supplies, Parenteral and Enteral Nutrition (PEN), Prosthetics, Supplies

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I. ABOUT OUR REIMBURSEMENT POLICIES

The most current version of the reimbursement policies can be found on www.hopkinsmedicine.org.

Johns Hopkins Health Plan LLC (JHHP) reimbursement policies serve as a guide to assist in accurate claim submissions and outline the basis for reimbursement of services covered by a member's JHHP benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a guarantee that you will be reimbursed. Services must meet prior authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence. Providers are expected to and must follow proper billing and submission guidelines. Providers are required to use industry standard, compliant codes on all claim submissions. Services must be billed with valid ICD-10 diagnosis codes, Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, place of service (POS) codes, and/or revenue codes as defined by the Centers for Medicare & Medicaid Services (CMS) and in the American Medical Association's (AMA's) "CPT Manual".

The codes billed should denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the patient's medical record and/or office notes and JHHP reserves the right to request the records. If a corrected claim is filed, it must comply with timely filing to be reprocessed through the claims system. Corrected claims are for administrative errors on the claim (i.e., misspelled name, CPT/HCPCS code transposed, wrong DOB, missing modifier, etc.). Intentionally changing the CPT/HCPCS or diagnosis code in order to get the claim paid, after the billed service was denied, is not a correction. The medical records must match the services billed. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

JHHP policies apply to all providers (e.g., practitioners, hospitals, suppliers, non-physician providers, etc.) eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. JHHP reimbursement policies are developed based on nationally accepted industry standards, coding principles, and follows the CMS guidelines, and the CMS developed National Correct Coding Initiative (NCCI) program to prevent inappropriate payment of services that should not be reported together. These policies may be superseded by regulatory mandates in provider or state contracts, or state, federal or CMS contracts and/or requirements. If appropriate, when coding/billing guidelines or current reimbursement policies are not followed, JHHP may:

- Reject or deny the claim
- Recover and/or recoup claim payment

JHHP reserves the right to modify policies at any time and publish new versions when necessary. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, JHHP strives to minimize these modifications. When there is an update, policies will be published on our website.

II. PURPOSE

To provide basic billing and reimbursement guidance for the reimbursement of covered Durable Medical Equipment (DME), Prosthetics, Orthotics and Supplies (DMEPOS) and Parenteral and Enteral Nutrition (PEN) items. For the purpose of this policy, the term “DMEPOS” will refer to DME, Prosthetics, Orthotics and Supplies, PEN items, as well as surgical dressings, and therapeutic shoes. Each line of business possesses its own unique contract and guidelines for benefit and payment purposes. As such, there could be various factors that may impact reimbursement, including but not limited to legislative mandates, provider contracts, and/or the member’s benefit coverage, including provisions addressing services rendered by non-participating providers, which may supplement, modify, or supersede this policy.

III. POLICY STATEMENT

This reimbursement policy applies to both network and non-network providers who are (including, but not limited to) Physicians or Other Qualified Health Care Professionals, DME/DMEPOS and PEN vendors and/or suppliers, who submit claims to JHHP for payment. A prior authorization/referral may be required for certain types of care, items and services, but it is not a guarantee of payment. Providers are responsible to verify the individual member’s contract for specific plan benefits and to obtain a prior authorization/reauthorization before an item, procedure or services rendered. Prior authorization is not a guarantee of payment.

*Providers are responsible for reviewing the **“EXCEPTIONS & EXCLUSIONS” Sections** below for specific plan guidance, as some guidelines in this policy may not be applicable to all health plans/products.*

IV. GENERAL BILLING GUIDELINES AND PAYMENT METHODOLOGY

1. A. JHHP will align with CMS billing guidance and reimbursement methodologies for DMEPOS, PEN items, surgical dressings, and therapeutic shoes.
   B. When billing JHHP for new or used equipment, rentals, purchases, replacements and repairs for DMEPOS and PEN, providers are required to use the appropriate modifier or the claim will be denied.
      i. The use of anatomic modifiers may be necessary when DMEPOS claims are submitted to JHHP for reimbursement. Refer to JHHP’s Anatomic Modifier policy for further guidance.
   C. In certain situations prior authorizations/referrals may be required for items or services provided by someone other than the member's primary care physician/provider (PCP). In such cases, claims may be pended for review and payments are subject to determination of a member’s eligibility, eligibility of charges as covered expenses, and the application of the exclusions and limitations and other provisions of the policy at the time services are rendered.

D. JHHP will cover medically necessary DMEPOS when:
   i. Ordered by a physician and certain types of non-physician practitioners who are eligible to order or refer items or services, only when acting within the scope of practice under state/federal law;
   ii. The item is not otherwise excluded from coverage; and
   iii. In accordance with the member's benefits and plan coverage.

E. All items of DME, related supplies and accessories, rentals, repairs, adjustments or replacement requests may be subject to medical review.

F. Requests for items that are custom-built for the patient to their physical specifications and/or a physician's prescription, are subject to medical review.

G. In alignment with industry standards, JHHP utilizes the gap-filling reimbursement methodology to establish fee schedule amounts for new DMEPOS items or services that do not have a fee schedule pricing history. Fee schedule amounts for new HCPCS codes for items and services without a fee schedule pricing history are established by JHHP using existing fee schedule amounts for comparable items when items with existing fee schedule amounts are determined to be comparable to the new items and services.
   - A comparison can be based on, but not limited to the following components: physical, mechanical, electrical, function and intended use, and additional attributes and features. When examining whether an item is comparable to another item, the analysis can be based on the items as a whole, its subcomponents, or a combination of items. A new product does not need to be comparable within each category, and there is no prioritization to the categories.
   - Refer to the billing and reimbursement guidance found in the JHHP Gap-Fill Fee Schedule policy for additional information.

H. When benefits are provided under the member's contract for Foot Orthotics, Prosthetic devices, and PEN, refer to the appropriate JHHP Medical Policies for additional information.

I. JHHP will deny services reported with not otherwise classified (NOC) codes if valid codes are available for an item.

J. For DME Rent to Own (RTO), refer to the authoritative guidance in JHHP's DME-Rent-to-Own Policy.

K. JHHP will cover oxygen services, equipment, supplies and accessories in alignment with CMS guidance.

L. Consistent with CMS guidance and JHHP's NCCI and MUE Edits policy, billed units of service/items are not to exceed the quantity, frequency limitations, PTP or MUE values defined by CMS, for a covered HCPCS/CPT code, or the claim will be denied.

M. JHHP may utilize the Master List of DMEPOS Items, maintained by CMS, which are subject to one or both of the following prior to delivery:
   - a face-to-face encounter and written order
   - prior authorization requirements

V. INAPPROPRIATE BILLING of DMEPOS

JHHP does not reimburse for the following unless there is a benefit or contract exception, or allowed by state/federal legislation:

A. Aesthetic appearance of DMEPOS for the preference of the member or caregiver
B. Clinically unproven equipment
C. Dentures
D. Disposable supplies customarily provided as part of a nursing or personal care service or a medical diagnostic or monitoring procedure
E. DMEPOS items considered to be experimental or investigational

F. Unless otherwise stated by a provider contract, DMEPOS items provided by a skilled nursing facility (SNF) when the equipment is part of the facility per diem and is not separately reimbursable.
G. Electric lifts
H. Emergency and nonemergency alert devices
I. Items of comfort and convenience
J. Exercise equipment
K. Furniture
L. Enhancements or upgraded of DMEPOS for the convenience of members or caregivers
M. Environmental modifications (e.g. home, bathroom, ramps, etc.) or environmental control equipment
N. Institutional equipment
O. Equipment designed for use by a physician or trained medical personnel
P. Additional items of DMEPOS used for the same purpose, but not at the same time (example: for home/work/school) are considered convenience (example: additional and/or "backup" glucometers, wheelchairs, etc.)
Q. Items of comfort and convenience
R. DMEPOS claims submitted without the appropriate anatomic modifier

VI. DOCUMENTATION GUIDELINES

1. All claims billed to JHHP for DMEPOS items require a written order/prescription from the treating practitioner to be communicated to the supplier before submitting a claim for payment.
   - "All claims" refers to all claims submitted for payment of purchases, repairs, replacements or rentals to JHHP.
   - JHHP may review the information submitted by the ordering provider and make a determination if the item meets medical necessity criteria or not.
2. In accordance with Section 6407 of the Affordable Care Act requires a physician to document that the physician, PA, NP or CNS has had a face-to-face encounter examination with a patient in the six (6) months prior to the written order for items on the Master List of DMEPOS Items.
3. If a prior authorization is not required, JHHP may review the information submitted by the ordering provider and make a determination if the item(s) meet medical necessity criteria or not.
4. The name and National Provider Identifier (NPI) of the treating practitioner on the order/prescription for the item or service shall be reported on the claim submitted to JHHP. The order/prescription shall be kept on file and made available upon request.
5. Items billed with any HCPCS code with a narrative description that indicates miscellaneous, NOC, unlisted, or non-specified, must also include as much information as possible on the claim to ensure prompt processing. Examples of information to be added to claim (including, but not limited to):
   - Description of the item or service
   - Manufacturer name
   - Product name, model name and number
   - Supplier Price List (PL) amount (this is the same amount billed on the claim line)
   - HCPCS code of related item (if applicable)
   - If repair or replacement part, HCPCS code of item being repaired or replaced
   - Refer to the JHHP Medical Record Documentation Standards for further guidance

VII. ORDERING, REFERING and PRESCRBING PROVIDERS

1. A. Ordering, Referring, and Prescribing (ORP) providers must comply with federal and state rules, regulations and laws regarding enrollment and billing to receive payment for services.

B. Only physicians and certain types of non-physician practitioners are eligible to order or refer items or services for JHHP members.
C. Chiropractors are not permitted to prescribe DMEPOS items. All services or items ordered or referred by a chiropractor will be denied.
D. The name and National Provider Identifier (NPI) of the treating practitioner on the order/prescription for the item or service shall be reported on the claim submitted to JHHP.
   i. Refer to JHHP's National Provider Identifier (NPI) policy for additional guidance.
E. The order/prescription for the DMEPOS service/item shall be kept on file and made available upon request.
F. Providers who order, refer, or prescribe or submit claims to JHHP for DMEPOS items and services, are required to follow JHHP's Scope of Practice policy.
G. It is expected that patient's medical records reflect the need for care/services provided. Providers must ensure all necessary records are on file to support services rendered.
H. Medical necessity requirements must be met for ORP providers to order, prescribe or refer items or services for JHHP members.

VIII. EXCEPTIONS and EXCLUSIONS

1. **AdvantageMD and EHP:** JHHP aligns with CMS billing and reimbursement methodologies. Please consult the authoritative guidance found in the online CMS Manuals to obtain specific information on policy, benefits, and coverage, for DMEPOS, not addressed in this policy.
2. **PPMCO:** Please consult the authoritative guidance found in the Maryland Medicaid Manuals to obtain specific information on policy, benefits, and coverage, as JHHP will reimburse DMEPOS in accordance with MDH guidance, not addressed in this policy.
   - In alignment with the Maryland Department of Health (MDH), JHHP requires all providers (i.e., ordering, referring, rendering, servicing, billing) delivering services to Maryland Medicaid members to have an active enrollment status in the electronic Provider Revalidation and Enrollment Portal (ePREP) on the date of service.
   - Claims submitted by individual providers, provider groups and facilities who are inactive or unregistered in ePREP will not be reimbursed.
   - Providers are solely responsible for ensuring their information in the ePREP portal is valid and active.
3. **USFHP**: JHHP aligns with TRICARE billing and reimbursement methodologies. Please consult the authoritative guidance found in the TRICARE Manuals to obtain specific information on policy, benefits, and coverage for DMEPOS not addressed in this policy.
   - JHHP may use the reimbursement rates established by CMS for certain items and services of DMEPOS and Parenteral and Enteral Nutrition, for USFHP claims.
     - Inclusion or exclusion of a reimbursement rate does not imply coverage.
   - Refer to the following TRICARE Reimbursement Manual references:
     - Chapter 1, Section II
     - Chapter 3, Section I
     - Chapter 5, Section I

IX. CODES, TERMS and DEFINITIONS

Back-Up Equipment	Back-up medical equipment is defined by CMS as an identical or similar device that is used to meet the same medical need for a patient but is provided for precautionary reasons to deal with an emergency when the primary piece of equipment malfunction.
Durable Medical Equipment (DME)	Medical equipment that is all of the following: • Prescribed by a licensed physician/practitioner. • Suitable for use in any setting in which normal life activities take place. • Can withstand repeated use. • Generally not useful to a person without a disability, illness, or injury. • Can be reusable or removable. • Is not implantable within the body. • Primarily and customarily used to serve a medical purpose rather than convenience or comfort. Meets the federal and/or state definition of DME and/or Prosthetic Orthotic and related Supplies.
Face-To-Face Encounter	Section 6407 of the Affordable Care Act established a face-to-face encounter requirement for certain items of DME. The law requires that a physician must document that a physician, nurse practitioner, physician assistant or clinical nurse specialist has had a face-to-face encounter with the patient. The encounter must occur within the 6 months before the order is written for the DME. *Note that the date of the written order must not be prior to the date of the face-to-face encounter.
Physician or Other Qualified Health Care Professional (OQHCP)	A Physician or Other Qualified Health Care Professional is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privilege (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.
Ordering Provider	The Ordering Provider is the individual who requested the services, non-physician services, or items for their patient. Examples include, but are not limited to, provider ordering diagnostic tests and medical equipment or supplies, within their legal scope of practice.

Other Routinely Purchased DME	This category is defined as equipment that is acquired at least 75 percent of the time by purchase and includes equipment that is an accessory used in conjunction with a nebulizer, aspirator, or ventilators that are either continuous airway pressure devices or intermittent assist devices with continuous airway pressure devices, this also includes speech generating devices and accessories necessary for the effective use of speech generating devices.
Referring Provider	The Referring Provider is the individual who directed the patient for care to the provider rendering the services being reported. Examples include, but are not limited to, primary care provider referring to a specialist; physician referring to a physical therapist; provider referring to a home health agency.
Rendering Provider	The Rendering Provider is the person or company (laboratory or other facility) who rendered the care. In the case where a substitute provider (locum tenens) was used, enter that provider's information on the claim. The Rendering Provider does not include individuals performing services in support roles, such as lab technicians or radiology technicians.
Same Group Physician and/or Other Qualified Health Care Professional	All physicians and/or other qualified health care professionals of the same group who report with the same Federal Tax Identification Number (TIN). Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician.
Transcutaneous Electrical Nerve Stimulator (TENS)	TENS is a type of electrical nerve stimulator that is used to treat chronic lower back pain (CLBP). This stimulator is attached to the surface of the patient's skin over the peripheral nerve to be stimulated. It may be applied in a variety of settings (in the patient's home, a physician's office, or in an outpatient clinic). Refer to CMS' NCD 160.27- Transcutaneous Electrical Nerve Stimulation (TENS) for Chronic Low Back Pain for further guidance.

Used Equipment	Used equipment is considered routinely purchased equipment and is any equipment that has been purchased or rented by someone before the current purchase transaction. Used equipment also includes equipment that has been used under circumstances where there has been no commercial transaction (e.g., equipment used for trial periods or as a demonstrator). If a JHHP member rented a piece of brand new equipment and subsequently purchased it, the payment amount for the purchase should be high enough so that the total combined rental and purchase amounts at least equal the fee schedule for the purchase of comparable new equipment.

X. REFERENCES

This policy has been developed through consideration of the following:

- CMS Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
- CMS Transmittal 12183
- CMS Master List of DMEPOS Items Subject to Conditions of Payment
- CMS MLN SE20007 - Standard Elements for DMEPOS Order, and Master List of DMEPOS Items Potentially Subject to a Face-to-Face Encounter and Written Orders Prior to Delivery and, or Prior Authorization Requirements
- COMAR- Maryland Department of Health- Maryland Medicaid Administration
- CPT Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association
- Maryland Medicaid DME/DMS/Oxygen Approved List of Items
- Maryland Medicaid Ordering, Referring, and Prescribing (ORP) Providers
- Medicare Benefit Policy Manual CH.15– Covered Medical and Other Health Services
- Medicare Claims Processing Manual CH. 23 - Fee Schedule Administration and Coding Requirements
- Medicare Claims Processing Manual CH. 26- Completing and Processing Form CMS-1500 Data Set
- Medicare National Coverage Determinations (NCD) Manuals
- Medicare NCD 280.1- Durable Medical Equipment Reference List
- TRICARE Reimbursement Manual

XI. APPROVALS

Date	Review/Revision	Reason for Modification	Approved By
4/10/2024	N/A	New Policy	Reimbursement, Authorization and Coding Committee (RAC)