Notice to all Providers dispensing Orthotics and Prosthetics

Please note the following changes will be effective for dates of service on or after April 1st, 2013:

- All Orthotic and Prosthetic codes listed in sections 4.5 and 4.7 of the DME manual will require either a Dispensing Validation System (DVS) authorization or paper prior approval. HCPCS codes requiring a DVS authorization are indicated by a "#" at the beginning of the code description. Please be sure to check your manual prior to dispensing an orthotic or prosthetic. DVS authorizations must be obtained on or prior to the date of service. Should the DVS authorization attempt return a rejected status due to exceeded service limitations, submit a DVS override request via a paper prior approval. The request must include all necessary supporting documentation. Fee for service Medicaid will not issue a paper prior approval for codes requiring a DVS authorization due to failure of the vendor to obtain the necessary DVS authorization.
- Please note that all valid and required modifiers must be used when obtaining the DVS authorization and must match those used on the claim submission. For additional information please refer to the MEVS/DVS provider manual at https://www.emedny.org/ProviderManuals/AllProviders/supplemental.aspx.
- Please note that the allowed frequencies on some HCPCS codes have changed. In order to ensure timely processing of frequency override requests related to growth or physical changes, please ensure that detailed measurements establishing the amount or degree of growth are provided in additional to any other required documentation.
- K0 to K4 modifiers, used to describe the functional classification levels of ambulation, must be used on all lower extremity prosthetic HCPCS codes. This is in addition to the currently required LT and RT modifiers for all side specific orthotics and prosthetics.
- Please refer to the December 29th, 2008 provider communication regarding prior approval and DVS requirementsfor beneficiaries who are eligible for both Medicare and Medicaid (dual eligibles),
- Approved periods of service for DVS authorizations are 180 days. Providers have 90 days to cancel any unused or incorrect DVS authorizations.

The above changes will be reflected in the 2013 DME manual which will be released prior to April 1st 2013.

For questions on billing, including the DVS authorization process, call Computer Sciences Corporation at (800) 343-9000

For questions on policy and coverage, call the Division of OHIP Operations at (800) 342-3005 option 1