

**NEW YORK STATE
MEDICAID PROGRAM**

**DURABLE MEDICAL EQUIPMENT
MANUAL**

POLICY GUIDELINES

Table of Contents

SECTION I - REQUIREMENTS FOR PARTICIPATION IN MEDICAID	3
STANDARDS OF QUALITY	3
TELEPHONE OR FAX ORDERS	3
MEDICAID CO-PAYMENTS	3
RECORD KEEPING REQUIREMENTS	4
APPLICATION OF FREE CHOICE	4
SECTION II - DME SERVICES	5
ENTERAL THERAPY SERVICES	5
ENTERAL FORMULA PRIOR AUTHORIZATION PROGRAM	7
<i>General Information for Prescribers: Physicians, Nurse Practitioners, Midwives, Dentists</i>	7
NEW YORK STATE MEDICAID PROGRAM ENTERAL FORMULA PRIOR AUTHORIZATION PRESCRIBER WORKSHEET	8
OXYGEN THERAPY SERVICES	10
CONTINUOUS SUBCUTANEOUS INSULIN INFUSION PUMP (CSII PUMP) THERAPY SERVICES	11
INFORMATION ON SPEECH GENERATING DEVICES	12
SECTION III - BASIS OF PAYMENT FOR SERVICES PROVIDED	14
FILLING ORDERS FOR MEDICAL/SURGICAL SUPPLIES	15
BASIS OF PAYMENT FOR DURABLE MEDICAL EQUIPMENT FOR MANAGED CARE RECIPIENTS	15
PRIOR APPROVAL, DISPENSING VALIDATION AND SERVICE LIMITS	16
RENTAL OF DURABLE MEDICAL EQUIPMENT	18
PURCHASE OF DURABLE MEDICAL EQUIPMENT	19
PURCHASE OF MEDICAL/SURGICAL SUPPLIES	20
PURCHASE OF ORTHOTIC AND PROSTHETIC APPLIANCES	20
REIMBURSEMENT OF ORTHOPEDIC FOOTWEAR	20
REFILLING MEDICAL-SURGICAL SUPPLIES	21
GUIDELINES FOR THE DELIVERY OF MEDICAL/SURGICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT	22
MEDICARE/MEDICAID CROSSOVER	22
EQUIPMENT, SUPPLIES AND APPLIANCES PROVIDED IN RESIDENTIAL HEALTH CARE FACILITIES	23
EQUIPMENT, SUPPLIES AND APPLIANCES PROVIDED IN NOT-FOR-PROFIT FACILITIES	23
RECIPIENT RESTRICTION PROGRAM	23
SECTION IV - DEFINITIONS	25
ACQUISITION COST	25
CUSTOM-FITTED	25
CUSTOM-MADE	25
DURABLE MEDICAL EQUIPMENT	25
FISCAL ORDER	26
MEDICAL/SURGICAL SUPPLIES	26
MINIMUM ORTHOPEDIC SHOE SPECIFICATIONS	26
PRACTITIONER	26
PROSTHETIC APPLIANCES AND DEVICES	27
PROVIDERS	27

Section I - Requirements for Participation in Medicaid

Orthopedic footwear must be dispensed by a provider who is certified or employs others that are certified, by the American Board for Certification in Orthotics and Prosthetics, the Board for Certification in Pedorthics or the Board for Orthotist Certification.

Medical/surgical supplies, durable medical equipment, orthopedic footwear, prosthetic and orthotic appliances and devices must be dispensed by a provider who is licensed/registered by the appropriate authority, if existing, in the state in which the provider is located.

Standards of Quality

Providers are expected to be knowledgeable about the items they dispense and are expected to provide information to the recipient about the use and care of the item along with information regarding warranty services. Providers are required to uphold the terms of warranty.

Providers are responsible for any needed replacements or repairs that are due to defects in quality or workmanship.

Telephone or Fax Orders

In the event an order for durable medical equipment, medical/surgical supplies or orthotic or prosthetic appliances has been telephoned or faxed to the provider, *it is the provider's responsibility to obtain the signed fiscal order from the ordering practitioner within 30 calendar days.*

Medicaid Co-Payments

The Medicaid Program in November 1993 implemented recipient co-payments for sickroom supplies including enteral formulae and hearing aid batteries when dispensed by DME providers. The co-payment amount is \$1.00 co-payment for each **sickroom supply** product (claim line) dispensed. These products are identified in the Procedure Code and Fee Schedule section.

DME providers cannot deny services to an eligible recipient based on the recipient's statement that he/she is unable to pay the co-payment amount. In addition, providers must not reduce the amount charged on their Medicaid claim forms by the co-payment amount which is collected from Medicaid recipients. Each claim billed to the MMIS which requires co-payment will have a co-payment deducted from the final payment amount calculated as due from Medicaid.

There are exemptions to the Medicaid co-payments. Emergency services and family planning items are exempt from co-payments. In addition, recipients under the age of

21, pregnant women for the duration of their pregnancy and for the two full months following the month in which the pregnancy ends, recipients enrolled in managed care programs and comprehensive case management programs, ICF/DD and nursing facility residents, residents of OMH and OMRDD certified community residences, recipients enrolled in an OMRDD Home and Community Based Waiver Program and recipients participating in the Traumatic Brain and Head Injury Waiver are exempt from co-payments.

For additional information regarding co-payments, contact the NYS Department of Health, Office of Health Insurance Programs at (518) 473-5983.

Record Keeping Requirements

In addition to meeting the general record-keeping requirements outlined in the General Information Section of this manual, the provider filling an order for durable medical equipment, medical/surgical supplies, orthotic and prosthetic appliances and orthopedic footwear must keep on file the fiscal order signed by the prescriber and the delivery statement signed by the recipient for any item for which Medicaid payment is claimed. For audit purposes, these signed, written orders, in addition to other supporting documentation such as invoices and delivery receipts, must be kept on file for six years from the date the service was furnished or billed, whichever is later.

Application of Free Choice

The choice of which provider will fill the prescription or order for durable medical equipment, medical/surgical supplies, orthopedic footwear, or orthotic or prosthetic appliances, rests with the recipient. The prescribing practitioner should give the written prescription or fiscal order to the recipient in order to allow the recipient to exercise his or her freedom of choice.

Section II - DME Services

The following services are reimbursable under the Medicaid Program in addition to durable medical equipment and medical surgical supplies.

Enteral Therapy Services

Enteral nutritional therapy is covered by the New York State Medicaid Program under the following conditions:

- The enteral nutritional therapy must be an integral component of a documented medical treatment plan and ordered in writing by an authorized prescriber.
- Enteral nutritional therapy is covered for nasogastric, jejunostomy or gastrostomy tube feeding or as liquid oral enteral nutritional therapy when there is a documented diagnostic condition where caloric and dietary nutrients from food cannot be absorbed or metabolized.
- Medical necessity for enteral nutritional therapy must be substantiated by documented physical findings or laboratory data (e.g., changes in skin or bones, significant loss of lean body mass, abnormal serum/urine albumin, protein, iron or calcium levels, or physiological disorders resulting from surgery, etc.).

The New York State Medicaid Program does not cover enteral nutritional therapy for supplementation of daily protein-caloric intake where there is not a documented medical necessity or as a convenient food substitute.

An MA patient will be eligible for an enteral nutritional supplement if the following conditions are met:

- There is an established diagnostic condition where the patient is unable to sustain himself/herself nutritionally by eating regular food and the condition is one where nutritional supplements are generally considered by the medical community as the treatment-of-choice to produce nutritional and medical benefit.
- A physician orders the nutritional supplement in writing.
- The physician or other appropriate health care provider has documented the patient's nutritional depletion or provided an explanation for why nutritional depletion is imminent and can be forestalled by providing a specific nutritional supplement. Documentation for selection of patients who are candidates for nutritional support must include: 1.) an established diagnostic condition and the pathological process causing malnutrition as specified below and 2.) one or more of the following items:

- ▶ Clinical findings related to the malnutrition such as recent involuntary weight loss (Adults less than 85% of ideal body weight or less than 90% of normal lean body mass; or a child with no weight or height increase for six months);
- ▶ Laboratory evidence of low serum proteins (i.e., serum albumin less than 3 gms/dl; anemia or lymphopenia less than 1200/cmm);
- ▶ Failure to increase or maintain body weight with usual solid or oral liquid food intake;
- ▶ Inability to sustain adequate nutrition as a result of one or more of the clinical conditions listed below.

Nutritional depletion can occur in a wide variety of medical conditions, particularly where the disease affects the gastrointestinal system. This depletion may result from inadequate food intake, impaired digestion or absorption of nutrients, defective nutrient utilization or enhanced nutrient requirements.

PATHOLOGICAL PROCESS	ASSOCIATED CLINICAL CONDITION
A.) Inadequate food intake	Nausea and vomiting, anorexia, early satiety, wired jaw, poor dentition, stomatitis, dysphagia, severe dyspnea, periodontitis
B.) Impaired digestion and absorption of nutrients	Vomiting/diarrhea, obstructed bowel, enteropathy, resected small bowel, bowel fistula, biliary obstruction
C.) Defective nutrient utilization	Inherited metabolic defect, lactose intolerance, hyperglycemia, proteinuria, protein losing enteropathy, altered lipid metabolism, chyluria
D.) Enhanced nutrient requirement	Increased metabolic rate, fever, dyspnea

The calculation for pricing Enteral Therapy formulae is as follows: Number of calories per can divided by 100 equals caloric units per can.

ENTERAL FORMULA PRIOR AUTHORIZATION PROGRAM

Enteral formula requires a prior authorization initiated by an authorized prescriber, in order to be covered by the Medicaid Program.

Only medically necessary enteral formulas are to be ordered, dispensed and reimbursed.

Enteral formula is covered for tube feeding or for oral liquid administration when there is a documented diagnostic condition where caloric and dietary nutrients from food cannot be absorbed or metabolized.

Enteral nutritional therapy is **not** covered for supplementation of daily protein-caloric intake where there is not a documented medical necessity or as a convenient food substitute.

When writing a fiscal order for an enteral formula, the prescriber will need to call the toll free voice interactive Enteral Prior Authorization Call Line at (866) 211-1736. If approval is given, an authorization number will be provided that must be written on the fiscal order. Then, the fiscal order is presented to the dispenser who calls the voice interactive Enteral Prior Authorization Call Line to complete the prior authorization process.

General Information for Prescribers: Physicians, Nurse Practitioners, Midwives, Dentists

1. The prescriber must call the toll free voice interactive Enteral Prior Authorization Call Line at (866) 211-1736 to initiate the prior authorization process.
2. Once approval has been given and a prior authorization number is obtained, the prior authorization number must be written on the order and documented on the Prior Authorization Prescriber Worksheet. A prescription pad may be used for an order.
3. The patient's medical record must include documentation of the patient's medical need for enteral formula. In addition, the completed prior authorization worksheet must be included in the patient's medical chart.
4. Prior authorization is required for each generic category of enteral formula. It is effective for up to six months, or the initial fill and five refills.

5. Each time a new order is written for an enteral formula, a new prior authorization must be obtained, and the new prior authorization number written on the order.

An agent of the prescriber (an employee such as a medical assistant) may complete the prior authorization call and write the prior authorization number on the order.

6. Prescribers do not have to initiate the enteral prior authorization process for orders written prior to April 1, 2003.
7. If a prior authorization number is not on an order for an enteral formula, the dispenser will be prohibited from filling the order. The dispenser or patient will need to contact the prescriber to ask that the prior authorization process be completed, or if completed to ask for the necessary prior authorization number.

New York State Medicaid Program Enteral Formula Prior Authorization Prescriber Worksheet

To facilitate the process, be prepared to answer these questions when you call the toll free voice interactive Enteral Prior Authorization Call Line at **(866) 211-1736**. Documentation must be maintained in the patient's medical record.

PRESCRIBER IDENTIFIER	Complete one of the following prescriber identifiers: MMIS ID Number _____ 0 0 _____ F _____ 0 0 0 _____ _____ (state abbreviation in first two spaces)
Ordering Prescriber Medicaid ID #	
NYS Physician/PA/Resident	
NYS Nurse Practitioner/Midwife	
NYS Dentist	
Out of State Prescriber License	
1. Recipient CIN (Client ID number is 2 alpha/5 numeric/1 alpha)	_____
2. Recipient Date of Birth (MM/DD/YYYY)	___ / ___ / _____
3. Prescriber telephone number (where you can be reached)	(____) _____ - _____
4. Mode of administration	1 = Tube 2= Oral
5. If patient is less than one year of age, is there a permanent non-function or disease of the structures that normally permit food to reach or be absorbed from the small bowel?	1 = Yes 2 = No
6. Are you prescribing more than one enteral formula?	1 = Yes 2 = No
7. Total number of calories prescribed per day.	_____
8. Number of refills (up to 5)	_____

Answer the following questions for oral administration only:

9. Is the enteral formula prescribed for an inborn metabolic disease or an infant formula for lactose intolerance?	1 = Yes 2 = No
10. Patient height in inches	__ __ inches
11. Patient weight in pounds	__ __ __ lbs
12. Does this patient have a medical condition that prevents him/her from consuming normal table, and softened, mashed, pureed, or blenderized foods?	1 = Yes 2 = No
13. Have alternatives such as dietary changes, instant breakfast drinks, rice cereal, etc., been tried but were not successful?	1 = Yes 2 = No
14. Has the adult patient had a significant unintentional weight loss (>5%) over the past two months or the pediatric patient had no weight gain in six months?	1 = Yes 2 = No
15. Is there objective medical evidence in the medical record to support the need for enteral nutrition (e.g., malnutrition documented by serum protein levels, albumin levels or hemoglobin, changes in skin or bones, physiological disorders resulting from surgery)?	1 = Yes 2 = No
Record the prior authorization number here (for your records) <u>and</u> on top of the patient's enteral formula order/prescription	_____

Oxygen Therapy Services

Oxygen therapy is covered by the New York State Medicaid Program under the following conditions:

- The oxygen therapy must be an integral component of a documented medical treatment plan and ordered in writing by an authorized prescriber.
- The prescriber has determined that the patient suffers a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy, the patient's blood gas levels indicate the need for oxygen therapy, the alternative treatment measures have been tried or considered and been deemed clinically ineffective.
- Coverage is provided for patients with significant hypoxia evidenced by any of the following blood gas levels:
 - ▶ Arterial PO₂ at or below 55 mm Hg, or an arterial oxygen saturation at or below 88%, taken at rest.
 - ▶ Arterial PO₂ at or below 55 mm Hg, or an arterial oxygen saturation at or below 88% taken during sleep for a patient who demonstrates an arterial PO₂ at or above 56 mm Hg, or an arterial oxygen saturation at or above 89%, while awake, or a greater than normal fall in oxygen level during sleep (a decrease in arterial PO₂ more than 10 mm Hg, or a decrease in arterial oxygen saturation more than 5%) associated with symptoms or signs reasonably attributable to hypoxia (e.g., cor pulmonale, "P" pulmonale on EKG, documented pulmonary hypertension and erythrocytosis), coverage is limited to nocturnal use.
 - ▶ Arterial PO₂ at or below 55 mm Hg or an arterial oxygen saturation at or below 88%, taken during activity for a patient who demonstrates an arterial PO₂ at or above 56 mm Hg.
 - ▶ Hg or arterial oxygen saturation at or above 89%, during the day while at rest, coverage of supplemental oxygen is provided for during exercise when breathing room air.
- Coverage is available for PO₂ 56 to 59 mm Hg or arterial blood oxygen saturation is 89% if any of the following are documented:
 - ▶ Dependent edema suggesting congestive heart failure;

- ▶ Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale of EKG (P wave greater than 3mm in Standard Leads II, III, or AVF); or
- ▶ Erythrocythemia with a hematocrit greater than 56%
- Liquid oxygen therapy requires prior approval by the department, and is limited to the following conditions:
 - ▶ Patient requires constant (24 hours per day) liter flow greater than 5LPM; or
 - ▶ Patient must be away from the home for long periods of time on a daily basis (e.g., school);
 - ▶ Patients who qualify for coverage of liquid oxygen will not receive coverage for any other delivery system during the same time period.

The provider must maintain the prescriber's documentation of medical necessity on file with the written order. Oxygen therapy must be re-ordered once every 12 months or more frequently if the patient's need for oxygen changes. All home oxygen therapy services are reimbursed on an all-inclusive rate that may be billed once per month.

Continuous Subcutaneous Insulin Infusion Pump (CSII Pump) Therapy Services

An MA patient is eligible for a CSII Pump if the following criteria are met:

- The request for prior approval is submitted in compliance with instructions found in Section 3.7.;
- The medical order is issued by an endocrinologist specialized in the diagnosis, evaluation, and treatment of diabetes mellitus;
- The CSII Pump is a component of a comprehensive treatment plan that includes intensive insulin therapy;
- The patient has accurately and regularly self-monitored blood glucose levels;
- The patient is at least 10 years old and has experienced suboptimal glycemic control with at least twice daily insulin therapy, or is a woman who plans to become pregnant;
- The endocrinologist expresses confidence that the patient will receive comprehensive education regarding insulin pump therapy, will learn and execute

the procedures necessary for successful operation and interruption of the insulin pump, and will diligently monitor outcomes. For patients between the ages of 10-18 years old, the endocrinologist must document his/her opinion that the patient is mature and that a supportive and responsible adult will also be educated and involved in the pump therapy.

Information on Speech Generating Devices

1. What is a speech-generating device?

Speech generating devices are speech aids that provide an individual who has severe speech impairment with the ability to meet functional speaking needs. Speech generating devices:

- Are dedicated speech generating devices, used solely by the individual who has a severe speech impairment;
- May have digitized speech output using pre-recorded messages with defined recording times;
- May have synthesized speech output, which requires message formulation by spelling and device access by physical contact with the device-direct selection technique, or multiple methods of device access.

2. What types of products are not dedicated devices?

Devices that are not dedicated, and thus not covered by Medicaid, are:

- Capable (locked or unlocked) of running software for purposes other than for speech generation, e.g., devices that can also run a word processing package, an accounting program, or perform other non-medical functions;
- Laptop computers, desktop computers, tablet computers or personal digital assistants, which may be programmed to perform the same function as a speech generating device, are non-covered since they are not primarily medical in nature and do not meet the definition of durable medical equipment;
- Not useful to someone without a severe speech impairment.

3. What are the prescriber's responsibilities?

Dedicated speech generating devices require prior approval and are covered when medically necessary. Documentation of medical necessity must be included with the prior approval request. The request must include:

- The physician prescription (includes specifications for the device and the necessary therapy and training to allow the individual to meet his/her communication potential);

- The evaluation worksheet and report completed by a NYS licensed Speech Language Pathologist (SLP).

4. What are the provider's responsibilities?

Providers of dedicated speech generating devices are expected to:

- Be knowledgeable about the items they dispense and provide information to the individual about the use and care of the item;
- Assist physician and SLP in coordinating training on the device;
- Provide information regarding warranty services, uphold the terms of the warranty and be responsible for any needed replacements or repairs that are due to defects in quality or workmanship.

Section III - Basis of Payment for Services Provided

For payment to be made under the Medical Assistance Program, a recipient must be eligible on the date items are provided to the recipient. It is the provider's responsibility to confirm the recipient's eligibility on the date the order is received and on the date of service. Should a recipient lose eligibility after an item is ordered but before it is provided and the former recipient does not purchase the ordered item, Medicaid reimbursement will only be made under the following circumstances:

- The item of durable medical equipment, medical/surgical supply, prosthetic, orthotic or orthopedic footwear for a recipient under age 21 has received prior approval by an official of the Physically Handicapped Children's Program and is provided within the time period specified in the prior approval determination but not in excess of six months from the date of loss of eligibility for all other services; or
- A custom made item of durable medical equipment, orthopedic footwear, prosthetic or orthotic appliance was ordered for a recipient but was delivered to the individual after eligibility expired.

Under the above circumstances, the order date is to be used for the service date when billing.

The item of durable medical equipment, medical/surgical supply, prosthetics, orthotics or orthopedic footwear must be provided prior to being billed to the Medicaid Program. No item/service (including refills) may be billed prior to being furnished. Refills should be dispensed as need arises in the same quantity as the original order.

Reimbursement amounts for durable medical equipment, medical/surgical supplies, prosthetics, orthotics and orthopedic footwear include delivery, set-up and all necessary fittings and adjustments. Reimbursement amounts for the purchase of durable medical equipment, medical/surgical supplies, orthotics, non-preparatory prosthetics and orthopedic footwear are for new, unused items.

Reimbursement amounts are payment in full. No separate or additional payments will be made for shipping, handling, delivery, or necessary fittings and adjustments.

Any insurance payments including Medicare must be collected prior to billing Medicaid and must be applied against the total price of the item.

Payment will not be made for items provided by a facility or organization when the cost of these items is included in the facility's Medicaid rate. It is the dispensing provider's responsibility to verify with the facility whether the item is included in the facility's Medicaid rate.

All medical/surgical supplies, durable medical equipment, prosthetic and orthotic appliances and orthopedic footwear must be supported by the original, signed written order of a licensed physician, dentist, podiatrist, physician assistant or nurse practitioner.

The minimum information required on a fiscal order is:

- Name, address and telephone number of the ordering practitioner;
- Name and Medicaid identification number of the recipient;
- Date ordered;
- Original signature of the ordering practitioner; and
- Name of the item, quantity ordered, size, catalog number as necessary, directions for use, date ordered and number of refills, if any.

When filling an initial order, the provider must assign a unique fiscal order number. The same number must be used by the provider when billing for refills of the initial order.

Filling Orders for Medical/Surgical Supplies

An original fiscal order for medical/surgical supplies may not be filled more than fourteen days after it has been initiated by the ordering practitioner unless prior approval is required.

All refills must be appropriately referenced to the original order by the dispenser. The maximum quantity of refills is noted in Section 4.1 of this manual. If a fiscal order exceeds this amount, then prior approval is required.

No order may be refilled more than 180 days from the original date ordered.

Basis of Payment for Durable Medical Equipment for Managed Care Recipients

Durable Medical Equipment (DME) providers may bill for certain DME items *based on the order date, rather than the delivery date*, when the recipient loses Medicaid eligibility, or enrolls in, or disenrolls from, a Medicaid managed care plan.

In most circumstances, the Medicaid Program will pay for DME items only if the recipient was eligible on the date items are provided to the recipient. Under the following circumstances, Medicaid providers may use the order date to claim for a DME item if the recipient loses eligibility or enrolls in a Medicaid managed care plan *after an item is ordered but before it is provided to the recipient*.

1. The item of DME, medical/surgical supply, prosthetic, orthotic or orthopedic footwear is for a recipient under age 21, has been prior approved by an official of the Physically Handicapped Children's Program and was provided within the time period specified in the prior approval determination, but not in excess of six months from the date of loss of eligibility or enrollment in a Medicaid managed care plan; or
2. A custom-made item of DME, orthopedic footwear, prosthetic or orthotic appliance was ordered for a recipient but was delivered to the individual after eligibility expired or after the recipient enrolled in a Medicaid managed care plan.

Likewise, under the above circumstances, DME vendors participating in the Medicaid managed care program should bill the managed care plan using the order date if the enrollee loses Medicaid eligibility or disenrolls from Medicaid managed care after the item is ordered but before it is provided to the enrollee.

Prior Approval, Dispensing Validation and Service Limits

Please note that the request for prior approval of durable medical equipment, medical/surgical supplies, orthotic or prosthetic appliances or orthopedic footwear items must be accompanied by the invoice with all discounts clearly noted. The invoice must be retained with the patient record.

Prior Approval

Payment for those procedures where the MMIS code is **underlined** is dependent upon obtaining prior approval of the Department of Health Area Office Medical Director or their designee. Prior approval is also required for payment of medical/surgical supplies, durable medical equipment, prosthetics and orthotics and orthopedic footwear not specifically listed in the MMIS provider manual. For instructions concerning how to obtain prior approval, refer to the Prior Approval Section of this manual.

No prior approval is required when claiming the Medicare co-insurance and deductible for items ordinarily requiring prior approval.

No prior approval is required for apnea monitors (including accessories) for **children less than one year of age** when ordered through an Infant Apnea Center approved by the Physically Handicapped Children's Program.

Dispensing Validation

The Dispensing Validation System (DVS) is an automated approval process for selected items of medical/surgical supplies, durable medical equipment, orthotics, prosthetics, enteral products, and orthopedic footwear. Payment for those items listed in the procedure code section of the manual, where the product description is preceded by a

"#", is dependent upon obtaining a dispensing validation number through a MEVS transaction on the dispense date. The MEVS DVS will verify whether the patient has already received, or is currently eligible to receive, the particular product being ordered, based upon limits in the amount and frequency that can be dispensed to an eligible recipient.

Service Limits

Selected items of medical/surgical supplies, durable medical equipment, orthotics, prosthetics and orthopedic footwear have limits in the amount and frequency that can be dispensed to an eligible recipient. If a recipient exceeds the limit on an item, prior approval must be requested with accompanying documentation as to why the limits need to be exceeded. The following items are limited in amount and frequency:

Item:	Description/Limit:
Prescription	
Orthopedic	
Footwear	2 pair per yr.
Z5781	Flare heels (each) 2 pair per yr.
L3320	Cork lifts 2 pair per yr.
Z5784	Steindler heel corrections 2 pair per yr.
L3001	Spenco Insert 2 pair per yr. per child
L3350	Heel wedge 2 pair per yr.
L3010	Foot, insert, removable, molded to patient model, longitudinal arch support, each 1 pair per yr. per adult
L3020	Foot, insert, removable, molded to patient model, longitudinal/ metatarsal support, each 1 pair per yr. per adult
L3040	Foot, arch support, removable, premolded, longitudinal, each 1 pair per yr. per adult
L3060	Foot, arch support, removable, premolded, longitudinal/ metatarsal, each 1 pair per yr. per adult
L3070	Longitudinal arch support 1 pair per yr. per adult
L3080	Foot, arch support 2 pair per yr. per adult
Z5835	Removable mold/Levi mold 1 pair per yr. per adult
L8100	Elastic stocking/below knee medium wt. 4 pair per yr.
L8110	Elastic stocking/below knee heavy wt. 4 pair per yr.
L8130	Elastic stocking/above knee medium wt. 4 pair per yr.
L8140	Elastic stocking/above knee heavy wt. 4 pair per yr.

L8160	Elastic stocking/full length medium wt. 4 pair per yr.
L8170	Elastic stocking/full length heavy wt. 4 pair per yr.
L8190	Elastic stocking/leotards 4 pair per yr.
L8230	Elastic stocking/garter belt 4 pair per yr.
A4500	Surgical stocking/below knee 4 pair per yr.
A4495	Surgical stocking/thigh length 4 pair per yr.
A4510	Surgical stocking/full length 4 pair per yr.
Z4713	Handheld shower head 1 every 3 yrs.
Z2623	Humidifier, cold air 1 every 3 yrs.
E1130	Standard adult wheelchair 1 every 3 yrs.
E0176	Air pressure pad or cushion, nonpositioning 1 per year.
E0177	Water, pressure pad or cushion, nonpositioning 1 per year.
E0178	Gel pressure pad or cushion, nonpositioning 1 per year.
E0179	Dry pressure pad or cushion, nonpositioning 1 per year.
E0100	Cane 1 every 3 yrs.
E0105	Cane, Quad or three prong 1 every 3 yrs.
E0210	Electric heating pad 1 every 3 yrs.
E0276	Bed pan 1 every 3 yrs.
Z2304	Hot fomentation heating pads 1 every 3 yrs.
A4359	Urinary suspensory 1 every 5 yrs.
E0160	Sitz bath 1 every 5 yrs.
E0167	Commode pail 1 every 5 yrs.
E0325	Urinal, male 1 every 5 yrs.
E0326	Urinal, female 1 every 5 yrs.
Z2142	Emesis basin 1 every 5 yrs.
L0500	Corset, Lumbar 2 per year
L0600	Corset Sacroiliac 2 per year

Rental of Durable Medical Equipment

Most rentals, except those involving Medicare crossover, must be prior approved by the Department of Health Area Office Medical Director. The Director will determine, based on the submitted medical documentation including estimated length of use, whether the item will be rented or purchased. If rented, the Director will also determine the length of rental time for which payment will be made. Monthly rental of a standard wheelchair for a period up to 3 months does not require prior approval.

The monthly rental charge includes all necessary equipment, delivery, maintenance and repair costs, parts, supplies and services for equipment set-up, maintenance and replacement of worn essential accessories or parts (tubes, mouthpieces, hoses, etc.)

The rental payment must not exceed the lower of the monthly rental charge to the general public or the price determined by the Department of Health Area Office.

The total accumulated monthly rental charges may not exceed the actual purchase price of the item. If the item is eventually purchased, all accumulated monthly rental payments including Medicare and other third-party payments, will be applied against the total purchase price of the item.

Where there is prolonged need for a piece of durable medical equipment, and purchase is either undesirable or unavailable, rental terms will be set by the Department of Health Area Office Medical Director.

Purchase of Durable Medical Equipment

Reimbursement of durable medical equipment must not exceed the lower of:

- The price as shown in the fee schedule for durable medical equipment; or
- The usual and customary price charged to the general public.

Reimbursement of durable medical equipment with no price listed in the fee schedule must not exceed the lower of:

- The acquisition cost (by invoice to the provider) plus 50%; or
- The usual and customary price charged to the general public.

Reimbursement for items of durable medical equipment provided by a not-for-profit facility will be made at the facility's acquisition cost.

Purchase of Medical/Surgical Supplies

Reimbursement of medical/surgical supplies listed in the MMIS provider manual must not exceed the lower of:

- The price shown in the New York State List of Medical/Surgical Supplies; or
- The usual and customary price charged to the general public.

Reimbursement of medical/surgical supplies not listed in the MMIS provider manual must not exceed the lower of:

- The acquisition cost to the provider plus 50%; or
- The usual and customary price charged to the general public.

Purchase of Orthotic and Prosthetic Appliances

Reimbursement of orthotic and prosthetic appliances listed in the MMIS provider manual must not exceed the lower of:

- The price shown in the New York State List of Prosthetic and Orthotic Appliances; or
- The usual and customary price charged to the general public.

Reimbursement includes delivery and all necessary fittings and adjustments.

Reimbursement is available for visits made in the recipient's home for the purpose of fitting, repairing and adjusting prosthetic and orthotic appliances and devices. Since visit fees are to be billed once per trip rather than once per patient fitted, the fees must be pro-rated if more than one patient is seen per trip.

Reimbursement for orthotic and prosthetic appliances provided by not-for-profit facilities will be made at the lower of the actual cost of components or the price shown in the New York State List of Prosthetic and Orthotic Appliances.

Reimbursement of Orthopedic Footwear

The Medicaid Program does not establish maximum reimbursable fees for orthopedic footwear. The prices listed in the fee schedule, are screen prices. A screen price is a guideline to determine when an invoice must be attached to the Medicaid claim for payment. An invoice is required when the amount charged to Medicaid for the item exceeds the screen price.

Reimbursement of Orthopedic Footwear must not exceed the lower of:

- The acquisition cost to the provider plus 50%; or
- The usual and customary price charged to the general public.

Reimbursement for orthopedic footwear is only available to providers who possess, or employ others that possess certification from the American Board for Certification in Orthotics and Prosthetics, the Board for Certification in Pedorthics, or the Board for Orthotist Certification. Orthopedic footwear must be dispensed by those holding the certification.

It is the provider's responsibility to provide the New York State Department of Health with a current copy of their certificate. Copies should be sent to the Department at P.O. Box 1935, Albany, New York 12201-1935 and must include the provider's business name, address and MMIS I.D. number.

Refilling Medical-Surgical Supplies

A fiscal order for medical-surgical supplies may be refilled when the prescriber has indicated on the order the number of refills and the recipient has requested the refill.

The recipient or representative must request each refill because their medical condition and/or living situation may change over the course of the fiscal order. Examples of medical-surgical supplies include: diabetic supplies, enteral formulas, incontinence products and wound dressings.

The following are unacceptable practices:

- Automatic refilling and claiming for medical-surgical supplies;
- Refilling in excess of the number of refills indicated on the fiscal order;
- Knowingly making a claim for unnecessary medical-surgical supplies;
- Claiming for medical-surgical supplies when a recipient is hospitalized or moves into a skilled nursing facility, because medical-surgical supplies are included in the Medicaid rate paid to the facility.

Guidelines for the Delivery of Medical/Surgical Supplies and Durable Medical Equipment

Medical/surgical supplies or durable medical equipment (DME) must be prepared in accordance with instructions provided on the prescription or fiscal order.

- All shipping and/or delivery costs are the responsibility of the provider of service. Dispensing fees include routine delivery charges.
- The DME provider must first contact the recipient or caregiver to ensure that a delivery is needed. Confirmation of needed delivery shall be maintained in the patient's record.
- The recipient or caregiver must receive delivery. Electronic signatures for receipt of product are permitted only if retrievable and kept on file by the DME provider.
- If a DME provider uses a delivery service, the DME provider is responsible for delivery of the product to the intended recipient or caregiver. Replacement of lost, stolen or misdirected supplies and DME is the sole financial responsibility of the DME provider. The Medicaid Program does not provide reimbursement for replacement supplies of lost, stolen or misdirected DME deliveries.
- The DME provider must guarantee appropriate delivery of intact, usable product

Medicare/Medicaid Crossover

Medicaid is required to pay the Medicare co-insurance and deductible for Medicare covered supplies, equipment and appliances provided to Medicaid recipients who are also Medicare beneficiaries. Medicaid will pay the difference between the Medicare approved amount and the Medicare paid amount.

All charges must first be billed to Medicare. Only after an Explanation of Medical Benefits (EOB) is received from the Medicare intermediary and payment made, where appropriate, may a claim be submitted for Medicaid reimbursement. The provider must maintain the EOB on file for six years following the date of payment for audit purposes.

Prior approval/dispensing validation is not required when claiming the Medicare co-insurance and deductible for items that ordinarily require prior approval/dispensing validation. However, when claiming the Medicare co-insurance and deductible for unlisted or not otherwise specified item codes, such claims must be submitted on paper with the Medicare EOB attached.

Equipment, Supplies and Appliances Provided in Residential Health Care Facilities

Claims for durable medical equipment, medical/surgical supplies, prosthetic and orthotic appliances and devices, oxygen and enteral formulae provided to a recipient in a residential health care facility whose Medicaid rate includes the cost of such items, will be denied.

Equipment, Supplies and Appliances Provided in Not-For-Profit Facilities

Hospitals enrolled in Medicaid with a specialty code of 969 representing hospital durable medical equipment, orthotic and prosthetic appliance vendor, as well as any other Medicaid enrolled durable medical equipment provider, may bill Medicaid for durable medical equipment and prosthetic and orthotic appliances provided to hospital inpatients when the cost of the items is not included in the facility's rate.

Clinics enrolled in Medicaid with a specialty code of 969 as noted above may bill Medicaid for these items when they are provided to registered clinic patients or to ordered ambulatory patients when the cost of such items is not included in the facility's rate or fee.

Hospitals and clinics may not bill separately for medical/surgical supplies since these items are included in the facility's rate.

Durable medical equipment and orthopedic footwear provided by not-for-profit facilities is billed at the lower of acquisition cost or the usual and customary price charged to the general public.

Prosthetic or orthotic appliances provided by not-for-profit facilities is billed at the lowest of acquisition cost of the components, the fee in the MMIS manual or the usual and customary price charged to the general public.

Recipient Restriction Program

Recipients who have been assigned to a designated durable medical equipment dealer are required to receive all durable medical equipment and prosthetic and orthotic appliances from the selected provider as a condition of the recipient restriction program (RRP). All claims from other durable medical equipment dealers will be denied. Recipients who are restricted to a primary pharmacy must receive all pharmacy services, including medical/surgical supplies from that provider.

RRP: Ordered Services

When a recipient is restricted to an ordering provider (physician, clinic, podiatrist and/or dentist), all items of durable medical equipment, medical/surgical supplies prosthetic and orthotic appliances and orthopedic footwear must be ordered by the primary provider within the recipient's restriction type. The primary provider may refer the restricted recipient to another provider and the servicing provider may also order services. In either case, the primary provider's MMIS identification number must be written on the order/prescription form and should be used by the dispensing durable medical equipment dealer when accessing the MEVS system as well as when submitting claims.

Section IV - Definitions

For the purposes of the Medicaid Program and as used in this Manual, the following terms are defined to mean:

Acquisition Cost

Acquisition cost is the line item cost to the provider. Acquisition cost is net of any discounts and does not include mailing, shipping, handling, insurance costs or any sales tax.

Custom-fitted

Custom-fitted is a componentry made on or added to an already existing model or device that is assembled, adjusted or modified to fit the body.

Custom-made

Custom-made is any durable medical equipment, orthopedic footwear, orthotics, or prosthetics fabricated solely for a particular Medicaid recipient from mainly raw materials which cannot be readily changed to conform to another recipient's needs. These materials are used to create the item from patient measurements, tracings and patterns. Custom-made requires that the MA recipient be measured and that the custom-made item be fabricated from these measurements.

Durable Medical Equipment

Durable medical equipment are devices and equipment, other than prosthetic or orthotic appliances, which have been ordered by a practitioner in the treatment of a specific medical condition and which have all the following characteristics:

- Can withstand repeated use for a protracted period of time;
- Are primarily and customarily used for medical purposes;
- Are generally not useful in the absence of an illness or injury;
- Are not usually fitted, designed or fashioned for a particular individual's use; and
- Where equipment is intended for use by only one patient, it may be either custom-made or customized.

Fiscal Order

A fiscal order is an original, signed written direction required by Medicaid to provide supplies, durable medical equipment, prosthetic and orthotic appliances and orthopedic footwear for which prescriptions may not be required by law or regulation. The ordering practitioner may use his/her prescription blanks or the Medicaid Order/Prior Approval/Authorization Form to write fiscal orders. FAX orders are not acceptable fiscal orders.

Medical/Surgical Supplies

Medical/surgical supplies are items for medical use other than drugs, prosthetic or orthotic appliances, durable medical equipment or orthopedic footwear which treat a specific medical condition and which are usually consumable, non-reusable, disposable, for a specific purpose and generally have no salvageable value.

Minimum Orthopedic Shoe Specifications

Minimum orthopedic shoe specifications consist of Blucher or Bal construction, leather construction or synthetic material of equal quality, welt construction with a cement attached outsole or sewn on outsole, upper portion properly fitted as to length and width, no unit sole, bottom sized to the last, closure appropriate to foot condition (Velcro strap or lace closure preferred), full range of width; not just narrow, medium, wide; extended medial counter and firm heel counter. Please note that sneakers and athletic shoes are not considered orthopedic shoes by the Medicaid Program and therefore are not Medicaid reimbursable.

Orthotic Appliances and Devices

Orthotic appliances and devices are appliances and devices used to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body.

Orthopedic Footwear

Orthopedic footwear are shoes, shoe modifications or shoe additions which are used to correct, accommodate or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot; to support a weak or deformed structure of the ankle or foot or to form an integral part of a brace.

Practitioner

A practitioner is a physician, dentist, podiatrist, physician assistant or nurse practitioner.

Prosthetic Appliances and Devices

Prosthetic appliances and devices are appliances and devices (other than artificial eyes and dentures), which replace any, missing part of the body.

Providers

Providers are a pharmacy, certified home health agency, medical equipment and supply dealer, hospital, residential health facility or clinic enrolled in the medical assistance program as a medical equipment dealer.