DMEPOS Policy Guidelines

New York State Medicaid, Durable Medical Equipment, Prosthetics, Orthotics and Supplies

New York State Medicaid
Office of Health Insurance
Department of Health

CONTACTS:

eMedNY URL
https://www.emedny.org/

ePACES Reference Guide

https://www.emedny.org/selfhelp/ePACES/PDFS/5010_ePACES_Professional_Real_Time_Claim_Reference_Guide.pdf

GDIT
(800) 343-9000
Billing Questions, Remittance Clarification, Request for Claim Forms, ePACES Enrollment, Electronic Claim Submission Support (eXchange, FTP), Provider Enrollment

Bureau of Medical Review
(800) 342-3005
OHIPMEDPA@health.ny.gov
Prior Approval; Policies and Procedures concerning Durable Medical Equipment, Prosthetics, Orthotics, and Medical Supplies

All eMedNY Contact Information
eMedNY Contacts PDF

NYRx Medicaid Helpline
(800) 541-2831

Pharmacy Benefits and Coverage website
https://member.emedny.org/pharmacy/benefits

Policy Guidelines

Durable Medical Equipment, Prosthetics, Orthotics and Supplies

NEW YORK STATE OF OPPORTUNITY. Department of Health

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1.0 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 DMEPOS provider. Acquisition cost as established by invoice detailing the line-item cost to the provider from a manufacturer or wholesaler net of any rebates, discounts or valuable consideration, mailing, shipping, handling, insurance or sales tax.

Acquisition Price

Acquisition price means that price determined and periodically adjusted by the State Health Department, which it deems a prudent Medicaid provider would pay for a reasonable quantity of generically equivalent enteral products.

Common Medical Marketing Area

The common medical marketing area is the geographic area from which a community customarily obtains its medical care and services.

Contiguous States of New York State

States contiguous to New York include New Jersey, Vermont, Massachusetts, Pennsylvania and Connecticut.

Custom-fitted

Custom-fitted (customized) is any componentry made on or added to an already existing model or device that is assembled, adjusted or modified to fit the member's body.

Custom-made

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

Custom-made requires that the MA member be measured and that the custom-made item be fabricated from these measurements.

Durable Medical Equipment

Durable medical equipment (DME) is defined as 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. Where equipment is intended for use by only one person, it may be either custom made or customized. (See definitions above.)

DMEPOS

Durable medical equipment, prosthetics, orthotics (including orthopedic footwear), and medical supplies.

Emergency Medical Condition

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

Fiscal Order

A fiscal order from a practitioner is 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. A fiscal order may be a signed written order, or electronically transmitted fiscal order.

Signed Written Fiscal Order

The following signed fiscal orders will be accepted:

- The original signed fiscal order; or
- A facsimile of the original signed fiscal order that is legible and can be validated. The DMEPOS provider must confirm, and keep on file, proof that the facsimile was generated from the ordering provider's place of business. The provider is responsible to make a good faith effort to verify the validity of the order and the practitioner's identity.

Electronically Transmitted Fiscal Order

An electronically transmitted fiscal order for DMEPOS will be considered a fiscal order when the following requirements are met:

- The order must originate from the practitioner's computer and must be directly transmitted to the Pharmacy or DME provider's computer or fax.
- The provider is responsible to make a good faith effort to verify the validity of the order and the practitioner's identity. An agent of the provider may not electronically sign the order.
- Providers are required to maintain and retrieve all electronically transmitted fiscal orders for a period of six (6) years from date of payment.
- Electronic Fiscal Orders are considered Electronic Protected Health Information (EPHI). Covered entities must develop and implement policies and procedures for authorizing EPHI access, storing and its transmission in accordance with the HIPAA Security Rule at §164.308(a)(4) and the HIPAA Privacy Rule at §164.508. It is important that only those workforce members who have been trained and have proper authorization are granted access to EPHI.

Telephone Orders

Telephone orders may be accepted but require DMEPOS and pharmacy providers to obtain follow up verification of the validity of the order. **When an order for DMEPOS is telephoned to a DME or pharmacy provider, the provider must obtain the signed written fiscal order or electronically transmitted fiscal order defined above from the ordering practitioner within 30 calendar days.** If a valid order is not obtained within 30 days, documentation of the attempts to validate the order must be kept in the provider's records. Additional telephone orders from practitioners who do not comply should be rejected until a signed written fiscal order or electronically transmitted fiscal order is provided.

Changes to Fiscal Orders

Changes that can be obtained verbally from the ordering provider:

- Name, address, and telephone number of the ordering practitioner
- Corrections to the name and Medicaid identification number of the member

- Valid diagnosis code. The diagnosis code on the fiscal order must match the diagnosis code reported on the DMEPOS claim. The practitioner's diagnosis supports the medical necessity for the DMEPOS item ordered.

Changes that require a new fiscal order from the ordering provider:

- Date ordered
- Original signature of the ordering practitioner
- Name of the item, specific quantity ordered (not case or package quantity), size, catalog number as necessary, directions for use, and number of refills

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 have been ordered by a practitioner in the treatment of a specific medical condition and which are usually consumable, nonreusable, disposable, for a specific purpose and generally have no salvageable value.

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.

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

Sneakers and athletic shoes are not considered orthopedic shoes by the Medicaid Program and therefore are not Medicaid reimbursable.

Practitioner

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

Prosthetic Appliances and Devices

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

Providers

Provider, for the purpose of this manual, means 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.

Standard

Standard refers to those components that are not made solely for one individual. They are prefabricated and readily available on the commercial market (off the shelf) and can be utilized by a variety of patients.

2.0 Requirements for Participation in Medicaid

Medicaid Enrollment

Medical/surgical supplies, durable medical equipment orthopedic footwear, prosthetic and orthotic appliances and devices must be dispensed by a DMEPOS provider with site-specific Medicare approval prior to submitting their application for enrollment. In addition, the provider must be licensed/registered by the appropriate authority, if existing, in the state in which the provider is located.

Enrollment with the intention of providing an item (or items) with a specific HCPCS code that is not currently active with NYS FFS Medicaid will be denied. Inquiries about activating a HCPCS code should be sent to the Bureau of Medical Review at ohipmedpa@health.ny.gov .

Enrollment applications and instructions are available at:
http://www.emedny.org/info/ProviderEnrollment/dme/index.aspx

In-state DMEPOS providers

New York State Medicaid policy requires that DMEPOS providers located within New York State (or the common medical marketing area of the contiguous states):

- Be a fully operational and independent, walk-in business that is open to the general public and is staffed with trained personnel capable of providing the proper fitting, demonstration, and service of the supplies available to Medicaid members;
- Have the means to provide services such as returns and adjustments for all supplies or equipment that is distributed;
- Be responsible for any needed replacements or repairs that are due to defect in quality or workmanship;
- Be open and conduct business prior to being enrolled in Medicaid;
- Have a storefront with a sign indicating the business is open to the public
- and the hours of operation;
- Operate during normal business hours;
- Clearly display items provided; and
- Have appropriate door width, ramped entrance, handicapped parking and/or other features allowing access for people with physical disabilities.

Out-of-state DMEPOS providers
NYS Medicaid will consider enrollment of providers outside of the common medical marketing area of the contiguous states of New York who are solely mail order DMEPOS providers on a case-by-case basis under the following requirements:

- The DMEPOS provider is dispensing standard DME/supplies that cannot be obtained from enrolled DMEPOS providers and cannot dispense equipment that is custom, customized or that requires fitting, adjustments, or training by a provider; or

- A manufacturer that also functions as a billing provider dispensing equipment and/or supplies directly to members who meet all the following requirements:
  - Can provide direct customer service to respond to all customer concerns or complaints;
  - Can provide 24-hour clinical support for troubleshooting equipment issues and failures;
  - Can provide backup equipment when required;
  - Attests to understanding all NYS Medicaid guidelines, criteria and regulations;
  - Agrees to following the established "Guidelines for the Delivery of Medical/Surgical Supplies and Durable Medical Equipment "

Orthopedic Footwear (specialty 711)

Orthopedic footwear must be dispensed by a provider who is certified or employs others who are certified by one of the following:

- The American Board for Certification in Orthotics, Prosthetics and Pedorthics

- The Board of Certification/Accreditation, International

Enrollment criteria for orthopedic footwear (specialty 711) includes evaluation of the number of active Medicaid footwear providers within the county where the applicant's storefront is located to determine if there is an unmet need for those services, pursuant to 18 NYCRR §504.5(a)(14).

If it is determined that an adequate number of enrolled providers are servicing the county, the applicant's enrollment application will be denied. Each such determination is made on a case-by-case basis.

Multiple Operating Locations

DMEPOS providers must be enrolled in the Medicaid Program and have a separate national provider identification (NPI) number for each operating location. DMEPOS providers must enroll each location that furnishes care, services or supplies for which reimbursement is sought and obtain a separate provider identification number. An additional operating location cannot be added to an existing provider service address unless it is a result of an address change.

Relocation of Service Address

Enrolled DME providers that relocate their service address must ensure that the new address is a fully operational walk-in store that is open to the general public and meets all criteria listed in the Medicaid Enrollment section above. Any DME provider that changes its service address and does not meet the criteria listed above will be considered non-compliant and will be terminated from New York State Medicaid.

Standards of Quality

Standards of quality must be met at the time of enrollment by DMEPOS providers and continue to be met during Medicaid revalidation. Enrolled DMEPOS providers are expected to:

- Be knowledgeable about the items they dispense;
- Provide information to the member about the use and care of the item;
- Provide the necessary fittings and adjustments;
- Provide information regarding warranty services and to uphold the terms of the warranty;
- Be responsible for any needed replacements or repairs that are due to defects in quality or workmanship;
- Be knowledgeable about the Medicaid program's coverage criteria, frequency limits and application of correct billing codes.

Knowingly making a claim for same/similar, unfurnished, or inappropriate services or items are unacceptable practices and can be subject to system edits.

Certain **complex DME** requires evaluation, configuration, fitting, adjustment, and/or programming. Providers of this medically necessary, individually configured DME must:

- Employ at least one full-time Rehabilitation Engineering and Assistive Technology Society of North America (RESNA)-certified Assistive Technology Professional (ATP), who specializes in wheelchairs, participates in the selection of appropriate equipment in consultation with a qualified practitioner who has specific training and/or experience in wheelchair evaluation and recommendations for complex DME; and
- The ATP must analyze the needs and capacities of patients with complex needs, have direct, in-person involvement in the wheelchair selection for the patient and provide training in its proper usage; and
- Have the capability to provide service and repair of this equipment by qualified technicians; and
- Provide written information to the user, prior to ordering equipment, regarding how to access service and repairs, including after-hours repairs or emergencies; and
- Provide suitable loaner equipment while the primary device is under repair.

Medicaid Co-Payments

Medicaid member co-payments are applicable for medical/surgical supplies including enteral formulas and hearing aid batteries when dispensed by DME providers.

The co-payment amount is $1.00 for each medical/surgical supply product dispensed. These products are identified in the Medical Supply Procedure Code manual and DMEPOS Fee Schedule section, available online at:

https://www.emedny.org/ProviderManuals/DME/

For additional information regarding co-payments, contact the NYS Department of Health (DOH), Helpline at: 1-800-541-2831.

Record Keeping Requirements

In addition to meeting the general record keeping requirements outlined in the General Policy Section, the provider filling an order for DME, 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 member for any item for which Medicaid payment is claimed.

For audit purposes, these signed, fiscal orders, in addition to other supporting documentation such as invoices and delivery receipts, must be kept on file for six years from the date of payment. See Guidelines for the Delivery of Medical/Surgical Supplies and Durable Medical Equipment.

Application of Free Choice

The choice of which provider will fill the prescription or order for DME, medical/surgical supplies, orthopedic footwear, or orthotic or prosthetic appliances, rests with the member.

3.0 Basis of Payment for Services Provided General Guidelines

- For payment to be made by the Medicaid Program, a member must be eligible on the date of service. It is the provider's responsibility to confirm the member's eligibility on the date the order is received and on the date of service.
- Prior approval/prior authorization does not guarantee payment.
- The item of DME, 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 the need arises in the same quantity as the original order.
- Reimbursement amounts for DME, medical/surgical supplies, prosthetics, orthotics and orthopedic footwear include delivery, set-up and all necessary fittings and adjustments. Reimbursement amounts for the purchase of DME, medical/surgical supplies, orthotics, non-preparatory prosthetics and orthopedic footwear are for new, unused items.
- Reimbursement amounts are payment in full. Pricing is based on line-item invoices. 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, per Department regulation at Title 18 NYCRR 505.5 (d) (1) (iii). 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, DME, 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.
- For more information regarding the Medicaid Eligibility Verification System, DMEPOS providers can access the following link: MEVS and DVS Manual.

Changes in Eligibility and/or Enrollment in Managed Care

Under the following circumstances, Medicaid providers may use the order date to claim for a DME item if the member loses eligibility or enrolls in a Medicaid managed care plan after an item is ordered but before it is provided to the member:

- The item of durable medical equipment (DME), medical/surgical supply, prosthetic, orthotic or orthopedic footwear for a member 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;
- A custom made item of DME, orthopedic footwear, prosthetic or orthotic appliance was ordered for a member but was delivered to the individual after eligibility expired.

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 member loses Medicaid eligibility or disenrolls from Medicaid managed care after the item is ordered but before it is provided to the member.

Filling Orders for DMEPOS

Information Requirements on Fiscal Orders

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 member;
- Date ordered;
- Original signature of the ordering practitioner; and
- Name of the item, specific quantity ordered (not case or package quantity), size, catalog number as necessary, directions for use, date ordered and number of refills, if any.
- Valid diagnosis code. The diagnosis code on the fiscal order must match a diagnosis code reported on the DMEPOS claim. The practitioner's diagnosis supports the medical necessity for the DMEPOS item ordered.

An original fiscal order for DMEPOS may not be filled more than 60 days after it has been initiated by the ordering practitioner unless prior approval is required.

A fiscal order is not required for DMEPOS repairs, replacement parts, components, and labor under the following circumstances:

- When the DMEPOS provider has on record the original fiscal order for purchase of the equipment and its components; and
- When the DMEPOS item is less than five years old; and

- When the total estimated cost to make the DMEPOS item operative is less than 50% of the cost of replacement of the equipment and all of its components.

The **Length of Need** must be specified by the ordering practitioner on the fiscal order. If the order specifies a *Length of Need of less than 10 months,* the equipment must be rented initially. If *Length of Need is 10 months or greater,* the equipment may be initially rented or purchased.

A fiscal order for medical supplies may be refilled when the prescriber has indicated on the order the number of refills and the member has requested the refill.
All refills must be appropriately referenced to the original order by the dispenser.

The member 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 submitting a claim for unnecessary DMEPOS;
- Claiming for medical-surgical supplies and non-custom DME, Prosthetics and Orthotics appliances and devices when a member is hospitalized or moves into a skilled nursing facility, because medical-surgical supplies, and non-custom DME, Prosthetics and Orthotics appliances and devices are included in the Medicaid rate paid to the facility.
- Order being refilled more than 180 days from the original date ordered.

Prior Approval, Prior Authorization (DVS,), Direct Bill and Service Limits Prior Approval

Payment for those procedures where the code is underlined, in the Procedure Code Manual is dependent upon obtaining prior approval of the Department of Health (DOH) 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 Procedure code manual.

Prior approval is not required when claiming the Medicare co-insurance and deductible for items ordinarily requiring prior approval. Medicaid beneficiaries who are also enrolled in Medicare are referred to as dually eligible. For more information regarding the prior approval process for dually eligible beneficiaries see the following link: Prior Approval Process for Enrollees Eligible for Both Medicare and Medicaid

If a member has a third-party private insurance, the policy for DMEPOS requiring prior approval is that a medical review can be done concurrently with the third party's review.

Emergency Procedures for DME Requiring Prior Approval

An emergency is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

Only a qualified ordering practitioner may determine, using his or her professional judgment, whether a situation constitutes an emergency. The ordering practitioner's documentation of the specific need for emergency items/services must be maintained in the patient's records of the ordering practitioner and DME provider, along with the fiscal order.

In such emergency situations, prior approval is not required. DME Providers must indicate if a service is of an emergency nature by using the Emergency Indicator on the claim.

Dispensing Validation System

The Dispensing Validation System (DVS) is an automated approval process for selected items of medical/surgical supplies, DME, orthotics, prosthetics, and orthopedic footwear.

Pharmacy providers will receive authorizations for medical supplies that are given a 5-day period of service. DME, orthotics, prosthetics and orthopedic footwear are given a period of service of 180 days.

Payment for those items listed in the procedure code section of the manual, where the product description is preceded by a pound sign (#), is dependent upon obtaining a dispensing validation number through a Medicaid Eligibility Verification System (MEVS) transaction on the date the service.

DVS authorization is not required when claiming the Medicare co-insurance and deductible for items that ordinarily require dispensing validation.

DVS authorization is required when claiming balance due after third party private insurance claim payment.

The DVS authorization will verify whether the member 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.

The DVS authorization will inactivate if there has been no claim activity on the DVS authorization after 90 days. A roster notification will be sent to the equipment provider.

- Equipment Providers should check their authorization status prior to dispensing and if the original authorization was inactivated, a new DVS authorization must be obtained prior to dispensing.
- If a member has a primary insurance/third party payor, the system will not inactivate authorizations after 90 days. These authorizations will remain active for 180 days.
- If there has been claim activity on the authorization, the authorization will remain active for 180 days.

Enteral Prior Authorization: Enteral Web Portal and Interactive Voice Response (IVR) System

The Enteral Web Portal and IVR System are two parts of the enteral product prior authorization system. Payment for those items listed in the procedure code manual marked with an asterisk (*) is dependent upon prior authorization through the automated system. The ordering practitioner must access the portal at https://medicaidenteralportal.health.ny.gov/portal/ or www.emedny.org home screen or alternatively, use the telephonic IVR system (1-866-211-1736) for the prior authorization number. The fiscal order, including the authorization number, is sent to the dispensing provider. The dispensing provider uses the portal or IVR to verify the information and submit the correct billing code. See the DME Procedure Code Manual for additional information and links to worksheets to assist with enteral authorization.

Direct Bill Items

Payment for those items listed in the procedure code section of the manual, where the product description is **neither** preceded by "#" nor is the item code underlined, is dependent on a claim form being submitted by an enrolled provider for payment. All other record keeping requirements apply.

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 member. If a member exceeds the limit on an item, prior approval must be requested with accompanying medical documentation as to why the limits need to be exceeded.

For more information, please refer to the Fee Schedule at:
https://www.emedny.org/ProviderManuals/DME/

Rental of Durable Medical Equipment

Equipment which is new to the member's treatment plan must be rented initially if a trial period is required per DME Procedure Code manual.
The monthly rental charge includes:

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

For DME items that have been assigned a Maximum Reimbursement Amount (MRA), the rental fee is 10% of the listed MRA.

For DME items that do not have a MRA, the rental fee is calculated at 10% of the equipment provider's acquisition cost.

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 payments and other third party payments, will be applied to the total purchase price of the item.

Where there is a prolonged need for a piece of DME and purchase is either undesirable or unavailable, rental terms will be set by the DOH Medical Director.

Purchase of Durable Medical Equipment

As of April 2022, a 1% increase was added to the DMEPOS fee schedule in response to a budget amendment. In addition, items that have no fee on file are manually priced at cost + 51% (the below payment methodology policy wording is unchanged due to cost+50% being in regulation, however, pricing will reflect the 1% change).

Reimbursement of DME must not exceed the lower of:

- The price as shown in the NYS Medicaid DME Services Fee Schedule; or
- The usual and customary price charged to the general public.

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

Reimbursement of Labor

Labor will be reimbursed as described in Section 4.0 General information and Instructions of the DME Procedure Code manual located under **'-RB' Replacement and Repair.**

For more information, please refer to Section 4.0 General Information and Instructions in the DME procedure code manual at:
http://www.emedny.org/ProviderManuals/DME/PDFS/DME_Procedure_Codes.pdf

Purchase of Medical/Surgical Supplies

As of April 2022, a 1% increase was added to the DMEPOS fee schedule in response to a budget amendment. In addition, items that have no fee on file are manually priced at cost + 51% (the below payment methodology wording is unchanged due to cost+50% being in regulation, however, pricing will reflect the 1% change).

Reimbursement of medical/surgical supplies listed in the Medicaid fee schedule must not exceed the lower of:

- The price shown in the NYS Medicaid DME Services Fee Schedule; or
- The usual and customary price charged to the general public.

Reimbursement of medical/surgical supplies not listed in the Medicaid 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.

Purchase of Orthotic and Prosthetic Appliances

As of April 2022, a 1% increase was added to the DMEPOS fee schedule in response to a budget amendment. In addition, items that have no fee on file are manually priced at cost + 51% (the below payment methodology wording is unchanged due to cost+50% being in regulation, however, pricing will reflect the 1% change).

Reimbursement of orthotic and prosthetic appliances listed in the Medicaid fee schedule must not exceed the lower of:

- The price shown in the NYS Medicaid DME Services Fee Schedule; or
- The usual and customary price charged to the general public.

Reimbursement of orthotic and prosthetic appliances not listed in the Medicaid fee schedule must not exceed the lower of:

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

Reimbursement includes delivery and all necessary fittings and adjustments.

Reimbursement is available for visits made in the member'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 NYS List of Prosthetic and Orthotic Appliances.

Reimbursement of Orthopedic Footwear

Reimbursement of orthopedic footwear must not exceed the lower of:

- The price shown in the NYS Medicaid DME Services Fee Schedule; 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 who possess certification from:

- The American Board for Certification in Orthotics and Prosthetics, Inc.
- The Board for Certification/Accreditation, International.

Orthopedic footwear must be dispensed only by those providers holding one of the above certifications.

For more information see Prescription Footwear Form

Reimbursement of Enteral Formula

Reimbursement of enteral therapy is limited to the lower of:

- The price shown in the NYS Medicaid DME Services Fee Schedule; or
- The usual and customary price charged to the general public.

Screen Prices

The Medicaid Program does not establish maximum reimbursable fees for certain specialized enteral formulas as noted in the Fee Schedule section of the DME manual. The prices for certain specialized enteral formulas are screen prices as indicated by "BRSC" in the Fee Schedule. 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. The claim will be pended for manual review and priced at acquisition cost (by invoice to the provider) plus 31%.

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

Enrolled durable medical equipment, prosthetics, orthotics and supply (DMEPOS) providers may ship certain items to members directly under the following guidelines:

- 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, including dispensing fees and delivery charges.
- The member or caregiver must request the refill. Confirmation of request shall be maintained in the member's record.
- DMEPOS providers cannot use a shipping or delivery service for customized items or any items that require fitting and adjustments from a provider.

- The DMEPOS provider must guarantee appropriate delivery of intact, usable product.
- If a DMEPOS provider uses a delivery service, the DMEPOS provider retains responsibility for delivery of the product to the intended member or caregiver.
- The DMEPOS provider must maintain proof of delivery of supplies for at least 6 years after the date of service.
- The following are considered proof of delivery for DMEPOS supplies:
  - The member or caregiver signature accepting the delivery. Electronic signatures for receipt of product is permitted only if retrievable and kept on file by the DME provider.
  - If the provider uses a shipping service or direct from distributor shipping, proof of delivery documentation must include a complete record of tracking the item(s) from the DMEPOS provider/distributor to the member. This would include both the provider's own detailed description of the items being delivered AND the delivery service's tracking information, including date and time of delivery.

The provider's record must be linked to the delivery service record by a clear method, such as an invoice number or unique package identifying number. This information must be presented upon request.

- Replacement of lost, stolen or misdirected supplies and DME is the sole financial responsibility of the DMEPOS provider. The Medicaid program does not provide reimbursement for replacement supplies of lost, stolen or misdirected DMEPOS deliveries.
- The Department reserves the right to require member or caregiver signatures in situations where there is high probability of lost or stolen items, or an increase in complaints from members concerning lost or stolen items.

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 formulas provided to a member in a residential health care facility whose Medicaid rate includes the cost of such items, will be denied.

Office for People with Developmental Disabilities (OPWDD) certified:
Intermediate Care Facility for the Developmentally Disabled (ICF/DD),
Supervised Individualized Residential Alternative (IRA), Supervised Community Residence (CR), and Specialty Hospital are fiscally responsible for the following medical supplies listed below:

- Medical gloves;
- Underpads and diapers; and
- Over-the-counter drugs (except insulin).

The residential provider is also responsible for purchasing these supplies for the member's use at a day program or summer camp.

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

Hospitals enrolled in Medicaid with a specialty code of 969 and category of service 0287 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 item is dispensed within 3 days of discharge.

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.

DME 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 are billed at the lowest of: acquisition cost of the components, the fee in the fee schedule or the usual and customary price charged to the general public.

Equipment, Supplies and Appliances Provided in Assisted Living Programs (ALP)

For each Medicaid member participating in the ALP, a daily rate is paid to the ALP for the provision of nine home care services, including the provision of medical supplies and DME not requiring prior approval. ALP payment regulation at Title 18 NYCRR 505.35 (h) states that the Medicaid capitated daily rate is payment in full for the nine covered services.
Items in the manual that require a DVS authorization or are available via Direct Bill are considered part of Medicaid capitated daily rate paid to Assisted Living Programs. Consequently, DME providers are reimbursed only for DME items requiring prior approval.

Recipient Restriction Program

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

RRP: Ordered Services

When a member is restricted to an ordering provider (physician, clinic, podiatrist and/or dentist), all items of DME, medical/surgical supplies prosthetic and orthotic appliances and orthopedic footwear must be ordered by the primary provider within the member's restriction type.

The primary provider may refer the restricted member to another provider and the servicing provider may also order services. In either case, the primary provider's Medicaid identification number must be written on the order/prescription form and should be used by the dispensing DME dealer when accessing the MEVS system as well as when submitting claims.