

**NEW YORK STATE
MEDICAID PROGRAM**

**DURABLE MEDICAL EQUIPMENT
MANUAL**

POLICY GUIDELINES

Durable Medical Equipment, Orthotics, Prosthetics and Supplies Policy Guidelines

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Section I - 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.

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 body.

Custom-made

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

Custom-made requires that the MA beneficiary 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;

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- 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. (see definitions above)

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.

A fiscal order written for DMEPOS on an Official NYS Serialized Prescription Form and faxed to the DMEPOS provider will be considered an original order. When an order for DMEPOS not written on the serialized official prescription form has been telephoned or faxed to the provider, **it is the DME or Pharmacy provider's responsibility to obtain the original signed fiscal order from the ordering practitioner within 30 calendar days.**

An electronically transmitted fiscal order for DMEPOS will be considered an original 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.
- 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.

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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.

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.

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Practitioner

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

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.

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

Section II - Requirements for Participation in Medicaid

Providers

Provider, for the purpose of this section, 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.

DMEPOS, for the purpose of this section, means medical supplies, durable medical equipment, orthopedic footwear, prosthetic and orthotic appliances and devices.

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

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, Inc, or the Board for Certification/Accreditation, International.

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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.

Standards of Quality

DMEPOS providers are expected to be knowledgeable about the items they dispense and they are expected to provide information to the beneficiary about the use and care of the item. In addition they are expected to provide the necessary fittings and adjustments.

DMEPOS providers are required to provide information regarding warranty services and to uphold the terms of the warranty.

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

DMEPOS providers are expected to be knowledgeable about the Medicaid programs 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.

Medicaid Co-Payments

Medicaid recipient 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 Procedure Code and Fee Schedule section, available online at:

http://www.emedny.org/ProviderManuals/DME/PDFS/DME_Procedure_Codes.pdf

http://www.emedny.org/ProviderManuals/DME/PDFS/DME_Fee_Schedule.xls

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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 Information Section](#) of this manual, 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 beneficiary 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 [delivery guidelines](#).

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 beneficiary.

Section III - Basis of Payment for Services Provided

General Guidelines

- For payment to be made by the Medicaid Program, a beneficiary must be eligible on the date of service. It is the provider's responsibility to confirm the beneficiary'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.

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- 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 beneficiary loses eligibility or enrolls in a Medicaid managed care plan after an item is ordered but before it is provided to the beneficiary:

- The item of durable medical equipment (DME), medical/surgical supply, prosthetic, orthotic or orthopedic footwear for a beneficiary 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 beneficiary but was delivered to the individual after eligibility expired.

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

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 recipient;
- 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.

When filling an initial order, the DMEPOS 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.

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

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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 beneficiary has requested the refill.

All refills must be appropriately referenced to the original order by the dispenser.

The beneficiary 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 beneficiary 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, VIPS), 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.

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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 beneficiary 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 prior approval/dispensing validation.

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

The DVS authorization will verify whether the beneficiary 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.

Voice Interactive Telephone Prior Authorization

The Voice Interactive Telephone Prior Authorization System (VIPS) is an automated approval process for selected items of medical/surgical supplies, DME, orthotics, prosthetics, enteral products, and orthopedic footwear. This system is currently only used for enteral authorizations.

Payment for those items listed in the procedure code section of the manual, where the product description is preceded by an asterisk (*), is dependent upon obtaining prior authorization number through the automated telephone system.

The automated system will verify the medical necessity for the requested item. The ordering practitioner must call the prior authorization line (1-866-211-1736) to obtain the prior authorization number and then record this authorization number on the fiscal order. To activate the authorization, the dispensing provider must call the above listed telephone number, verify the information and apply the

correct billing code. The Prior authorization worksheets are available online. See [Prescriber Worksheet](#) or for DME/pharmacy [Dispenser Worksheet](#).

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 beneficiary. If a beneficiary 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:
http://www.emedny.org/ProviderManuals/DME/PDFS/DME_Fee_Schedule.xls

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Rental of Durable Medical Equipment

Equipment which is new to the beneficiary'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

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.

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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

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

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.

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Reimbursement includes delivery and all necessary fittings and adjustments.

Reimbursement is available for visits made in the beneficiary'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

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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 30%.

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 beneficiary or caregiver must request the refill. Confirmation of needed delivery shall be maintained in the patient’s record.
- The beneficiary 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 beneficiary 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.

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

Office of Mental Retardation and Developmental Disabilities (OMRDD) certified: Intermediate Care Facility for the Developmentally Disabled (ICF/DD), Supervised Individualized Residential Alternative (IRA), Supervised Community

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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 beneficiary'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 beneficiary 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.

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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 (Beneficiaries) 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. Beneficiaries who are restricted to a primary pharmacy must receive all pharmacy services, including medical/surgical supplies from that provider.

RRP: Ordered Services

When a beneficiary 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 beneficiary's restriction type.

The primary provider may refer the restricted beneficiary 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.