

Durable Medical Equipment Documentation

Purpose

The Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) Documentation policy provides guidance on required documentation practices for DMEPOS providers.

Applicability

Eligible Providers

To receive payment from ND Medicaid, the eligible servicing and billing providers must be enrolled with ND Medicaid on the date of service, and their National Provider Identifiers (NPIs) must be active in their Medicaid enrollment records. Servicing providers acting as a locum tenens provider must be enrolled with ND Medicaid, and services they provide must be billed with their NPI. Please refer to [provider enrollment](#) for additional details on enrollment eligibility and supporting documentation requirements.

Eligible Members

Providers are responsible for verifying a member's eligibility before providing services. Eligibility can be verified using the [ND Medicaid MMIS Portal](#) or through the Automated Voice Response System by dialing 1.877.328.7098.

Refer to the [Member Eligibility Manual](#) for additional information regarding eligibility including information regarding limited coverage categories.

Covered Services and Limits

General Provider Policies

The [General Provider Policies](#) detail basic coverage requirements for all services. Basic coverage requirements include:

- The provider must be enrolled in ND Medicaid;
- Services must be medically necessary;
- The member must be eligible on the date of service; and
- If applicable, the service has an approved service authorization.

The [Procedure Code Look-up Tool](#) can be used to identify if a procedure code is covered by ND Medicaid along with code-specific details such as [Ordering/Referring/Prescribing \(ORP\) Provider](#) requirements, Service Authorization requirements, and current rates.

Documentation Requirements

General DME Requirements

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to ND Medicaid. Records must be retained for at least 7 years after the last date the claim was paid or denied. Providers must follow the documentation requirements in the [Provider Requirements Policy](#).

The practitioner note must contain documentation of the member's medical condition to substantiate the necessity for the type, quantity, and frequency of use or replacement of items being ordered. Please see the specific policy for the item(s) being requested to determine the minimum required documentation for each item.

DMEPOS documentation requirements include:

- Detailed record of item(s) provided that includes brand name, model number, quantity, and proof of delivery.
- Documentation supporting the member or the member's caregiver was provided with manufacturer instructions, warranty information, service manual, and operating instructions.
- The provider must maintain documentation that clearly shows monthly contact with the member and/or caregiver regarding their rental equipment/supplies and/or recurring supplies no sooner than fourteen (14) calendar days before submitting for delivery or for payment.
- Throughout any rental period or continuous supply, there must be an active practitioner's order for ongoing use, the service authorization (if required), effective dates, and documentation of a continued medical need. The member or their representative must be contacted a minimum of (14) calendar days prior to delivery to verify ongoing necessity and ensure compliance with authorization requirements.

Prescriptions/Orders

All prescriptions/orders must be clear and obtained from the ordering provider before a DMEPOS provider fulfills the request. Orders must be electronic or an original “pen-and-ink” document.

Prescriptions/orders must be legible and include:

- Member’s name;
- Member’s date of birth;
- Start date of the order;
- Length of time equipment is needed;
- Valid diagnosis code(s). The diagnosis code(s) on the written order must match the diagnosis code(s) reported on the DMEPOS claim and the service authorization request, if applicable;
- Sufficient details, including all options or additional features that are needed to meet the member’s needs. The description must be either a narrative description (e.g., “lightweight wheelchair base”) or a brand name and/or model number;
- Direction of use; and
- Signed and dated by the prescribing practitioner. An acceptable signature form includes an electronic signature or an original “pen and ink” signature. Signature stamps are not allowed.

Some items require additional elements in the order/prescription such as:

- Laterality;
- If the prescription/order is for supplies that will be provided on a periodic basis, it must include appropriate information on the quantity used (not case or package quantity), frequency of change, and duration of need. “As needed” or PRN orders are not acceptable. For example: one 4x4 hydrocolloid dressing changed twice daily for one month.
- If the prescription/order is for a DMEPOS item, such as, but not limited to, enteral formula, oxygen, etc., the order must specify the name of the product, concentration (if applicable), dosage, frequency, route of administration, and duration of infusion (if applicable);
- Custom-fabricated items must be clearly indicated on the prescription/order that has been signed and dated by the prescribing practitioner;
- Prescription for equipment and/or medical supplies used on a continuous/recurring basis must be renewed by a prescribing practitioner every 12 months; and

- An employee of the ordering practitioner may complete the detailed description of the item(s); however, the prescribing practitioner must review the detailed description and personally indicate their agreement by signing and dating.

New prescriptions/orders are required when:

- There is a change in the order of a specific DMEPOS item;
- There is a change in the member's condition that warrants a change in the order;
- There is a change in the prescribing practitioner;
- There is a change in a DMEPOS provider;
- When a member's own equipment requires modification to make it functional due to a change in condition; or
- If a DMEPOS item is replaced for any reason.

Medical necessity information (narrative description of the member's condition, abilities, and limitations) is not in itself considered to be part of the order, although it may be put on the same document as the order.

Pick-Up and Return Documentation

Pick-up and return documentation must include, at a minimum, the following information:

- Name of the item;
- Provider name;
- Member's full name;
- Complete description of item(s) picked up;
- Manufacturer name of item(s) picked up;
- Model and serial number (s) or item number(s) of the item(s) picked up.
- The reason the equipment is being picked up or returned;
- A description of the pick-up location that identifies whether medical equipment or supplies were returned to the DMEPOS business location or retrieved from the member's residence, etc., including the member's pick-up address;
- The reason for returning medical equipment to the provider's business location by the member or the responsible caregiver;
- Date of pick up or return;
- Dated signature of staff picking up the equipment; and
- Dated signature of member or responsible caregiver releasing the medical equipment to the provider.

Pick-up and return documentation must be maintained in the member's file. Examples include but aren't limited to:

- Member requests equipment/supplies or recurring supplies to be picked up;
- Medical equipment is being returned to the provider or provider's business location by the member or responsible caregiver;
- Equipment is no longer medically necessary and is picked up from the member's residence by the provider;
- Equipment is no longer functioning properly and has been picked up from the member's residence; or
- Equipment picked up from the member's residence for other clearly documented reasons.

Recurring Rental Equipment and Monthly Supplies Refill Documentation

The DME provider must maintain documentation that clearly demonstrates monthly contact with the member and/or caregiver regarding their rental equipment/supplies and/or recurring supplies before submitting to Medicaid for payment, to ensure the member continues to use the equipment. Providers must discontinue billing ND Medicaid when the member is no longer using rental items or continuous supplies.

Throughout any rental period or continuous supply, there must be an active practitioner's order for ongoing use, a service authorization (if required), applicable effective dates, and documentation of a continued medical need for the item.

The provider must contact the member or their representative within fourteen (14) calendar days prior to the delivery/shipping date to verify that the member's medical condition has not changed, that the equipment is in working condition, and is being used by the member (contact does not include system-generated correspondence).

The provider must contact the member prior to dispensing the monthly supply refill and cannot ship automatically on a predetermined schedule, even if authorized by the member. This ensures the refilled item remains reasonable and necessary, that existing supplies are approaching exhaustion, and any changes or modifications to the order are confirmed. General refill documentation requirements pertain to all DMEPOS policies. Refer to the applicable DMEPOS equipment or supply policy for specific refill requirements.

For items the member obtains in person at a retail store, a signed delivery slip or a copy of the itemized sales receipt is sufficient documentation to support a refill request. For

items delivered to the member, documentation of a refill request must be either a written document received from the member or a contemporaneous written record of a phone conversation/contact between the supplier and the member. The refill request must be made and documented before shipment. A statement written after the fact by the provider or the member does not meet the requirements.

Refill records must include:

- The member's name or authorized representative if different from the member;
- A description of each item that is being requested;
- Date of refill request;
- For consumable supplies, i.e., those that are used up (e.g., ostomy or urological supplies, surgical dressings, etc.), the supplier must assess the quantity of each item that the member still has remaining to document that the remaining amount will be nearly exhausted on or about the supply anniversary date.
- For non-consumable supplies, i.e., those more durable items that are not used up but may need periodic replacement (e.g., CPAP and BiPAP supplies), the provider must assess whether the supplies remain functional, providing replacement (a refill) only when the supply item(s) are no longer able to function. The provider must document the functional condition of the item(s) being refilled in sufficient detail to demonstrate the cause of the dysfunction that necessitates replacement (refill).

Providers must not deliver refills without a refill request from a member and must document the number of items the member has left at that time of contact.

Verification must be documented and maintained in the provider's records and be accessible for audits. Items delivered without a valid, documented refill request will be denied as not reasonable and necessary.

Providers must not dispense a quantity of supplies exceeding a member's expected utilization and must be aware of changes or atypical utilization patterns on the part of the member.

Providers must verify with the ordering practitioners that any changes or atypical utilization are warranted.

Service Authorizations

For DMEPOS items that require service authorization, the member must have been seen or examined within the past 90 days, or within the timeframe specified in the applicable policy, prior to the start date of the DMEPOS service authorization. Refer to the Service Authorization Requirements section on the DME Guidance policy.

Please refer to the [Durable Medical Equipment Provider page](#) for instructions on submitting a service authorization.

Reimbursement Methodology and Claim Instructions

Timely Filing

ND Medicaid must receive an original Medicaid primary claim within one hundred eighty (180) days from the date of service. The time limit may be waived or extended by ND Medicaid in certain circumstances. The [Timely Filing Policy](#) contains additional information.

Third-Party Liability

Medicaid members may have one or more additional sources of coverage for health services. ND Medicaid is generally the payer of last resort. Providers must pursue the availability of third-party payment sources. The [Third Party Liability Policy](#) contains additional information.

Client Share (Recipient Liability)

Client share (recipient liability) is the monthly amount a member must pay toward the cost of medical services before the Medicaid program will pay for services received. The [Client Share Policy](#) contains additional information.

Reimbursement

A claim for services must be submitted at the provider's usual and customary charge. Payment for services is limited to the lesser of the provider's usual and customary charge or the ND Medicaid calculated reimbursement.

Claim Requirements

The following is a list of approved modifiers to be used when submitting service authorizations and claims.

- RR – for rental items.
- NU – for purchasing DMEPOS items.
- RA – for replacement of a DMEPOS item.
- RB – for replacement of a part of a DMEPOS item furnished as a repair.
- RT – to identify the right side of the body.
- LT – to identify the left side of the body.

Definitions

Authorization – an official approval for action taken for, or on behalf of, a Medicaid member. This approval is only valid if the member is eligible on the date of service.

Claim or Electronic Billing – the health insurance billing form or the electronic transmission of billings.

Date of delivery – the date on which the member took physical possession of an item or piece of equipment.

Code of Federal Regulations (CFR) – executive departments and agencies of the federal government publish rules.

DMEPOS – Durable Medical Equipment, Prosthetics, Orthotics, and Supplies.

Durable Medical Equipment – Items that are used primarily and customarily for a medical purpose are suitable for use in the home, can withstand repeated use, and would not ordinarily be of use in the absence of illness, injury, or disability. Items in this class include but are not limited to orthotics, prosthetics, hearing aids, oxygen concentrators, apnea monitors, wheelchairs, and walkers. Eyeglasses and dentures are covered under the program but are listed in other chapters of the manual.

Provider or Provider of Service – an institution, agency, or person: Having a signed agreement with Health and Human Services (HHS) to furnish medical care and goods and/or services to members; and eligible to receive payment from HHS.

Service Authorization (SA) – a written approval by HHS for appropriate medical services, equipment, or supplies before such items are ordered or purchased. A practitioner visit/examination note, and a prescription must be attached to the SA request.

Supplies – medically necessary expendable items that are ordinarily used and replenished on a regular basis. Supplies include, but are not limited to, ostomy appliances, catheters, and oxygen.

System Generated Correspondence – an automated update letter or email where there is no active interaction with the member or their representative.

References

- [North Dakota Administrative Code](#)
- [North Dakota Century Code](#)
- [Code of Federal Regulations](#)

Contact

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Policy Updates

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- Policy created