

Durable Medical Equipment Guidance

Purpose

The Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Guidance policy provides general guidance for ND Medicaid 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 (AVRS) 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 and equipment must be medically necessary;
- The member must be eligible on the date of service; and
- If applicable, the service or equipment has an approved service authorization.

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

Purchase

ND Medicaid will purchase equipment when it is the most cost-effective option. Payment may be made even if the item was previously rented. In some cases, rental may be required first to confirm that the item meets the member's needs; ND Medicaid will determine this on a case-by-case basis. If the member's primary insurer agrees to purchase the item, Medicaid will cover any co-insurance or remaining costs, provided the item meets Medicaid's coverage criteria.

If ND Medicaid decides to purchase an item after a rental period, the full rental allowance will be applied toward the purchase allowance. When Medicaid is the primary insurer, covered equipment may be rented or purchased at ND Medicaid's discretion.

Rental

Rentals approved by ND Medicaid are limited to a maximum period of 12 months and require an approved service authorization. All necessary supplies and maintenance needed to operate the rental equipment must be included in the rental amount, and the total amount paid during the rental period for the item, supplies, and maintenance cannot exceed the purchase price.

Rental payments are made on a monthly basis and will be made for the entire monthly rental fee, even if the period is less than a full month. Maintenance and repair costs of rental equipment are included during the rental period. Members are responsible for the basic care of the equipment.

A change in suppliers during the 12-month period does not start a new 12-month cycle. However, rental interruptions of 90 days or more require a new service authorization and begin a new rental period.

At the point that total rent paid equals 100% of the purchase allowance, the member is considered the owner of the item. It is the DMEPOS provider's responsibility to track the number of rental payments and discontinue billing once the purchase price has been reached. At that time the DMEPOS provider must transfer ownership of the item to the member.

If the member has rental coverage through a primary insurer, ND Medicaid will cover any co-insurance or noncovered costs up to the approved ND Medicaid rate.

Claims submitted for rentals must use the RR modifier.

Delivery Methods

ND Medicaid utilizes Medicare's three methods of delivery including:

- Delivery directly to the member or authorized representative;
- Delivery via shipping or delivery service; or
- Delivery of items to a nursing facility on behalf of the member.

Regardless of the method of delivery, ND Medicaid must be able to determine that the items delivered are the same items submitted for reimbursement and were received by the member.

DMEPOS providers may deliver items directly to the member or the designee (a person authorized to sign and accept delivery on the member's behalf). The relationship of the designee to the member should be noted on the delivery slip obtained by the provider and the designee's signature must be legible.

DMEPOS providers may deliver items to a member in a hospital or nursing facility for fitting or training, but no payment is made for these fitting or training services in those settings.

Items may also be delivered to a member's home in preparation for discharge from a hospital or nursing facility. Deliveries must occur within two days before the anticipated discharge date. The date of service must be the discharge date, and the place of service must be listed as the member's home. Proof of delivery documentation is required for coverage and must be available to ND Medicaid and/or its vendor upon request and kept for seven years.

DMEPOS providers, their employees, or anyone who has a financial interest in the delivery of the items are prohibited from signing and accepting an item on behalf of a member.

Repairs

ND Medicaid covers repairs to medically necessary member-owned equipment if needed, to restore it to proper functioning. If the cost of repairs is expected to exceed 75% of the estimated replacement cost, the provider must submit a service authorization request to replace the item.

Repairs require the following:

- An approved service authorization;
- An itemized breakdown of each code and quantity requiring repair;
- The reason for the repairs; and
- The number of labor units and technician signature if labor is requested.

Repairs do not require:

- A new practitioner visit, or
- A new prescription.

Providers cannot bill members for repairs, parts, equipment, or supplies that are covered by an expressed or implied warranty. The provider must clearly inform the member of the warranty coverage.

ND Medicaid may rent a loaner for up to one month while the member's equipment is being repaired. This applies when the repairs will take more than one day to complete.

Payment for repairs is not covered when:

- The skill of a technician is not required;
- The equipment has been previously denied;
- Equipment is being rented, including separately itemized charges for repair; or
- Parts and labor are covered under a manufacturer's or supplier's warranty;

Payment will not be made for repairs to equipment used in a skilled nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or swing bed, unless that equipment was member owned prior to entering the facility.

Service authorizations submitted for repairs require the appropriate HCPCS codes for the item being repaired, along with the repair modifier RB, the purchase modifier NU, or the rental modifier RR, and the RT/LT modifier when applicable.

Replacement

ND Medicaid may cover the replacement of an item if the current item can no longer be used because the member's physical or mental condition has changed, the item is damaged beyond repair, lost, or stolen.

If a member requires different equipment due to a change in their physical or medical condition, the provider must submit a service authorization with the following information:

- The reason why the member's current equipment cannot be modified to meet the member's needs;
- The member's medical records containing documentation of the member's medical condition to substantiate the need for the type, quantity, and frequency of the equipment requested;
- The member's diagnosis and other pertinent information including, but not limited to:
 - Duration of time the member has had the condition;
 - The clinical course of the member's condition (deteriorating or improving);
 - The member's prognosis;
 - The member's functional limitations; and
 - Other relevant supporting documentation.
- Medical records including practitioner's office notes, hospital records, nursing facility records, home health notes, or records from nurses, physical and occupational therapists, prosthetists, and orthotists;
- The medical necessity for the items requested; and
- If equipment repair costs exceed 75% of replacement cost, the provider must include an itemized list showing ND Medicaid's rates of either the purchase cost or the rental cost for the replacement. This list must clearly show why each item needs to be replaced or modified.

The Reasonable Useful Lifetime (RUL) of items may be listed on the item's specific policy, but this does not guarantee the items will be replaced if they are still functional, repairable, or able to be cost-effectively modified to meet the member's needs.

Medicaid will not replace equipment that is lost, destroyed, or damaged as a result of misuse, abuse, neglect, loss, or wrongful disposition of equipment by the member, the member's caregiver(s), or the DMEPOS provider. Examples include:

- Failure to clean and maintain the equipment as recommended by the equipment manufacturer;
- Failure to store the equipment in a secure and covered area when not in use; or
- Equipment being lost, damaged, or destroyed because of careless, intentional, or harmful actions by the member, the member's caregiver, or the provider.

If equipment or supplies are stolen or destroyed due to an accident or natural disaster, the provider must obtain a completed police or insurance report that describes the specific medical equipment that was stolen or destroyed. The police or insurance report must be submitted with the new service authorization request.

Service authorizations submitted for replacements require the appropriate HCPCS code(s) for the item being replaced, along with the replacement modifier RA, the purchase modifier NU or rental modifier RR, and the RT/LT modifier when applicable.

Quantity Limits

Quantities are limited to the lesser of the two – the practitioner's prescription or a reasonable monthly amount. Requests at or below this maximum may be dispensed without a service authorization if all coverage criteria are met. The [Look-up Tool](#) lists each code's maximum allowed quantity.

A provider may not dispense only the maximum allowable quantity, nor dispense the full quantity and bill the member for any amount above the limit, unless:

- The ordering practitioner verifies that the excess quantity is not medically necessary, or
- A service authorization is denied because the excess quantity is not medically necessary.

The supplying provider must document that items are being dispensed solely for the member's and/or caregiver's convenience before the member can be charged. In the instances described above, the provider must inform the member of their financial liability before dispensing the items.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

EPSDT is a comprehensive approach to healthcare for Medicaid members through the age of 20. The EPSDT program is designed to prevent, identify, and treat health problems before they become disabling. Children with needs identified during a screening may receive any covered medically necessary DMEPOS item(s). Refer to the [Procedure Code Look-Up Tool](#) for information on coverage for DME. All applicable service authorization coverage requirements apply.

Service Authorization Requirements

An approved service authorization from ND Medicaid confirms only medical necessity. It does not guarantee payment or ensure the member's eligibility. A provider's prescription or recommendation does not, by itself, make equipment, supplies, or services medically necessary or covered.

Some services require authorization only when they are provided in certain residential settings or when the requested quantity exceeds the allowed limits. Refer to the [Skilled Nursing Facilities](#), [ICF/IDD](#), and [Swing Bed Facilities](#) policies for more information on residential settings.

Service authorizations must be submitted on the [ND Medicaid MMIS Portal](#), and:

- Be completed by an ND Medicaid enrolled DMEPOS provider;
- Include supporting documentation from the prescribing practitioner, including:
 - A detailed care plan explaining why the item is medically necessary in this unusual or unique situation;
 - An explanation of why comparable covered equipment or supplies are not appropriate; and
 - A description of other methods or therapies that were considered but not used or were used but did not meet the member's needs.

Upon completion of the review, a service authorization notification letter will be mailed to the member and the requesting provider. The submitted claim must include the service authorization number of the service authorization approval.

Members may choose any ND Medicaid-enrolled provider and may change providers for rental items or ongoing supplies. Service authorizations do not automatically transfer. The new provider must submit a new authorization request, and ND Medicaid may require verification that the member elected to change providers. Payment will not be made for services provided before the authorization start date or after the authorization end date.

If an item is determined to be medically necessary, payment authorization will be based on the date the provider's request was received for review, not the date the item was delivered to the member.

Equipment purchased by ND Medicaid becomes the property of the member. ND Medicaid will not make separate payments to providers for equipment or medical supplies furnished in the member's home when the cost of those items is already included in a facilities or organization's capitated rate. Additional information is available in the [Quick Reference: Facility Responsibility and Separate Payment](#), the [Service Authorization policy](#), and [Service Authorization Submission Instructions](#).

ND Medicaid does not allow a service authorization request solely for a denial to receive payment from another source. Providers must provide the alternate payer with documentation supporting the non-coverage of the item such as a policy or verification in the [Look-Up Tool](#).

Service Authorization Request Status Codes

Updates on the status of the service authorization can be found in the [MMIS web portal](#). The following is a list of status codes:

- A1 – Certified in total: all items requested were approved as requested;
- A2 – Certified – Partial: no items were approved;
- A3 – Not Certified: SA denied;
- A4 – Pended: waiting to be reviewed; and
- A6 – Modified: items requested were approved but not approved as requested.
 - Example: labor units requested are 8, but only 6 were approved.

Miscellaneous or Not Otherwise Specified (NOS) HCPCS Codes

Providers may use miscellaneous HCPCS codes only when no specific HCPCS code exists. Any service authorization request containing a miscellaneous code must include:

- A statement from the DMEPOS provider confirming that no specific HCPCS code is available; and
- If the item is custom: an explanation of why an off-the-shelf or prefabricated item is not suitable and confirmation that no specific HCPCS code exists.

Invoice Requirements

- All miscellaneous/NOS codes require an invoice with the authorization request.
- The invoice can be a manufacturer invoice or a supplier quote.
- The invoice must be itemized and show the price of each item.
- If multiple items appear on the invoice, the provider must identify which item(s) correspond to the miscellaneous/NOS code(s).
- ND Medicaid must receive all discounts, rebates, or sales pricing listed on the invoice.
- The invoice must clearly show the miscellaneous/NOS code units and acquisition cost.
- The units and cost submitted on the service authorization or claim must match the invoice; failure to match will result in denial.
- If items are purchased in bulk, the invoice must clearly identify the unit-level cost corresponding to the miscellaneous/NOS code.

Claims Handling

- Claims submitted with miscellaneous/NOS codes are subject to prepayment review, which may delay processing.
- Prepayment review is not a prior authorization.
- All paid claims are subject to retrospective audit.

Non-Covered Services

General Non-Covered Services

The [Non-Covered Services Policy](#) contains a general list of services that are not covered by North Dakota Medicaid. To request coverage for a non-covered item, please complete and submit the Service, Technology, or Procedure Assessment form ([SFN 905](#)).

Reimbursement is limited to the most economical, medically necessary items provided in the most appropriate and cost-effective way. An item will not be reimbursed if another option is equally safe and effective but significantly less costly.

The following is a list of items generally considered not reimbursable by ND Medicaid through the DMEPOS program. The items may be covered under a [waiver program](#).

- Vehicle modifications;
- Environmental control items;
- Exercise/therapeutic items;
- Personal care items;
- Convenience/comfort items;
- Medical Alert Bracelets;
- Educational items;
- Institutional;
- Sensory or self-soothing items;
- Building modifications; and
- Items or services provided to a member in a skilled nursing facility setting.

All items must be suitable for use in the home or residence. Items primarily intended for leisure, recreation, or adaptive daily living activities are not reimbursable. Medicaid has no liability for these services, supplies, or equipment.

To verify coverage of a specific item, refer to the [Look-Up Tool Procedure Code Look-Up Tool](#).

Documentation Requirements

General 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](#) and the DME Documentation policy.

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 Form

DME Services must be billed using the CMS 1500 claim form or 837p. Detailed claim instructions are available on the [ND Medicaid Provider Guidelines, Policies & Manual webpage](#).

Definitions

Repair – to fix or mend an existing component and to put the equipment back in good condition after damage or wear. All repairs require the RB modifier.

Replacement – providing a new item when the member has already received the same or similar item before, and the current item can no longer be used because the member's physical or mental condition has changed, or the item is damaged beyond repair, lost or stolen. All replacement items require the RA modifier.

References

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

Contact

Medical Services
600 East Boulevard Ave.
Bismarck, ND 58505-0250
Phone: (701) 328-2310
Email: dhsmedicalservices@nd.gov

Policy Updates

October 2026

- Policy created