

Manual for Durable Medical Equipment, Prosthetics, Orthotics, & Supplies (DMEPOS)

Published by:

**Division of Medical Services
North Dakota Department of Health and Human Services
600 E Boulevard Ave, Dept 325
Bismarck, ND 58505-0250**

October 2025

FORWARD

PURPOSE

This handbook has been prepared for the information and guidance of Durable Medical Equipment, Prosthetics, Orthotics, & Supplies (DMEPOS) providers who offer items or services to members in the North Dakota Medicaid program. This handbook addresses both policy and procedures for DMEPOS items and services. Additionally, this handbook provides information on which items require service authorization and the procedures required to obtain a service authorization.

DMEPOS providers will be held responsible for compliance with all policy and procedures contained herein.

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KEY CONTACTS

Hours for key contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Central Time)

Provider Enrollment

Noridian Call Center

(877) 328-7098

(701) 328-7098

Fax: (701) 433-5956

ATTN: NDM Provider Enrollment

Send written inquiries to:

Noridian Healthcare Solutions
ND Medicaid Provider Enrollment
PO Box 6055
Fargo, ND 58108-6055

or e-mail inquiries to:

NDMedicaidenrollment@noridian.com

Third Party Liability

For questions about private insurance, Medicare, or other third-party liability:

(701) 328-2347

(800) 755-2604

Send written inquiries to:

Third Party Liability Unit
Medical Services
ND Dept. of Human Services
600 E Boulevard Ave-Dept. 325
Bismarck, ND 58505-0250

or e-mail inquiries to:

medicaidtpl@nd.gov

North Dakota Medicaid Call Center

For questions about member eligibility, payments, denials, or general claims questions:

(877) 328-7098

(701) 328-7098

Send written inquiries to:

Provider Relations
Medical Services
ND Dept. of Human Services
600 E Boulevard Ave-Dept. 325
Bismarck, ND 58505-0250600

or e-mail inquiries to:

mmisinfo@nd.gov

Surveillance/Utilization Review

To report suspected ND Medicaid provider fraud and abuse:

(701) 328-4024

(800) 755-2604

Send written inquiries to:

Fraud and Abuse
Surveillance/Utilization Review
Medical Services
ND Dept. of Human Services
Dept 325
600 E Boulevard Ave
Bismarck, ND 58505-0250

Or e-mail inquiries to:

medicaidfraud@nd.gov

STATEMENT OF INTENTION

Supersedes: North Dakota Medicaid DMEPOS (Durable Medical Equipment, Orthotics & Prosthetics, and Medical Supplies) Manual, November 2019, and all changes that have occurred in memorandums.

References: Title XIX, Social Security Act; United States Code (USC) §§ 1396-1396v, Subchapter XIX, Chapter 7, Title 42; Code of Federal Regulations (CFR), Chapter IV, Title 42, Subtitle A, Title 45; Administrative Rules of North Dakota Title 37.75, Chapter 02

Updated: October 2025

Codes, References, Etc. Mentioned in This Manual are Excerpts From:

- American Medical Association Current Procedural Terminology (CPT)
- CMS Healthcare Common Procedure Coding System (HCPCS)

DEPARTMENT OF HUMAN SERVICES, MEDICAL SERVICES DIVISION

Department of Human Services is the designated State Agency that administers the Medicaid or Title XIX Program. The Department's legal authority is contained in Title 75, Article 02, Chapter 02 of the ND Administrative Code. At the federal level, the legal basis for the program is included in Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations (CFR).

The Medicaid Program is administered in accordance with the Administrative Rules of North Dakota, Title 75. These rules are developed within the authority granted under the state and federal statutes and federal regulations cited above.

INTRODUCTION

Thank you for your willingness to serve the members of the North Dakota Medicaid program administered by the Department of Health and Human Services

MANUAL ORGANIZATION

- This manual provides information specifically for providers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS).
- Other essential manuals are the [General Provider Policies](#) and other Medical Assistance program manuals.
- Each DMEPOS provider is asked to review both the [General Provider Policies](#) and the specific manual for their provider type.

PROVIDER RESPONSIBILITY FOR INFORMATION

All approved updates and changes to the DMEPOS provider manual will be made available on the Department's website via the [ND Medicaid Provider Updates](#).

The DMEPOS Provider Manual and notices serve as guides only and do not exempt the DMEPOS provider from the responsibility to stay informed about and comply with current laws and regulations.

DMEPOS providers are responsible for the following:

- Replace all applicable page(s), inserts, and bulletins to maintain a current DMEPOS provider manual.
- This manual and the [DMEPOS webpage](#) link should be made available to billing personnel.
- This manual and policies should be used as a reference source for questions regarding coverage, billing, as well as covered and non-covered items.
- Choosing the HCPCS code that matches the item/service provided or checking with their supplier for the appropriate codes.
- Determining whether another DMEPOS provider has an approved active service authorization and/or providing services to the member.

UTILIZATION MANAGEMENT

- The Utilization Management Team reserves the right to deny any service authorization/claim for equipment and supplies at any time during the service authorization/claim review process if the request does not meet the requirements for coverage.
- The Utilization Management Team can change a service authorization amount or approval if that allowance/approval was made in error.

CLAIMS REVIEW

The Department is committed to paying Medicaid provider claims as quickly as possible.

- Medicaid claims are electronically processed and usually are not reviewed by medical experts prior to payment to determine if the services provided were appropriately billed.
- Although the computerized system can detect and deny most erroneous claims, there may be some errors that the system may not detect. For this reason, payment of a claim does not mean that the service was correctly billed, or that the payment made was correct.
- Periodic retrospective reviews are performed, which may lead to the discovery of incorrect billing or incorrect payment.

If a claim is paid and the Department later discovers that the services were paid in error, the Department is required by federal regulations to recover any overpayment regardless of whether the incorrect payment was the result of the Department, provider error, or other cause.

GETTING QUESTIONS ANSWERED

- The provider manuals are designed to answer most questions; however, if a provider has coverage, service authorization, or claims questions, Provider Relations can be reached at (877) 328-7098 or via email at mmisinfo@nd.gov for further assistance.
- The [Provider Guidelines, Manuals and Policies](#) provide general provider and claims policy information.
- The DMEPOS manual, DMEPOS Quick Reference Policy section, Look-up Tool, provider education, and additional resources are available on the [DMEPOS Provider web page](#).
- Medicaid manuals, notices, inserts, updates, fee schedules, forms, and other provider resources are available on the [ND Medicaid Provider Information](#) website.

NATIONAL CORRECT CODING INITIATIVE (NCCI)

North Dakota Medicaid applies the following billing requirements for submitting claims for reimbursement:

- Procedure codes that are denied by NCCI procedure-to-procedure edits are not separately payable by Medicaid, as they are either included in the payment for the base equipment or included in the most comprehensive procedure/service. Procedure codes are also not covered when reported together if they are provided to the member on the same date of service. It is against Medicaid policy for any provider to resubmit claims for denied procedure codes on a different date of service in an attempt to avoid NCCI edits. If this is discovered at any time by the Department, all items paid on another date of service will be recouped, and the provider may be put on prepayment review and/or reported to the Medicaid Fraud Control Unit (MFCU).

All Services:

All items submitted on a service authorization for reimbursement must be billed using the same date of service they were actually provided.

- The date of service that the procedure is rendered/delivered is the date of service on the claim (excludes supplies with a grace period).
- All base procedures, along with ANY related services, options, or accessories, are to be billed with the date of service they are rendered or delivered.

For DMEPOS: replacement parts are the only items that may be reported on a date of service that is not the same as the delivery date of the base equipment.

The Department does not review NCCI edits during the Service Authorization process. Items approved by the Department on a service authorization that fail NCCI edits are not separately payable. The DMEPOS Provider is responsible for reviewing the files to determine if it is appropriate to request approval for the items.

FEDERALLY MANDATED MAXIMUM UNITS (MUE)

The MUE file is the maximum number of units expected to be reported on a single date of service for a single member for most situations.

ND Medicaid follows the [Medicaid Only NCCI and MUE methodology](#).

GENERAL DMEPOS COVERAGE PRINCIPLES

This section provides covered service information that applies specifically to services and supplies provided by DMEPOS providers. Like all healthcare services received by Medicaid members, services rendered by these providers must also meet all document and coverage requirements listed in this manual.

North Dakota Medicaid follows Medicare's coverage requirements for some items. A Medicare DMEPOS manual is available from the Durable Medical Equipment Regional Carrier (DMEPOSRC) website. North Dakota Medicaid considers Medicare, Region D DMEPOSRC medical review policies as the minimum standard for the DMEPOS industry. This manual outlines the criteria for items that are either in addition to Medicare requirements or are not covered by Medicare.

North Dakota Medicaid coverage determinations are a combination of Medicare, Region D DMEPOSRC policies; Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and Department-designated medical review decisions. DMEPOS providers are required to follow specific North Dakota Medicaid policy or applicable Medicare policy when North Dakota Medicaid policy does not exist.

SERVICES FOR CHILDREN

The Early and Periodic Screening, Diagnosis, and Treatment Program (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 medically necessary DMEPOS item/items described in this manual.
- All applicable service authorization coverage requirements apply.

PROVISION OF SERVICES

Federal regulations require that items covered by the Department be:

- Reasonable and necessary in amount, duration, and scope to achieve their purpose.
- The most economical and functional item(s) available to fulfill the basic medical need.
- Ordered by an approved prescribing practitioner.
- Coverage is limited to members living at home, which can include a house, apartment, relative's residence, or a group facility. Institutions like hospitals, nursing facilities, swing beds, and ICF/IID facilities are not considered homes. Some exceptions may apply. For more detailed information, refer to the Look-Up Tool or the related Facility Responsibility and Separate Payment policies.
- Dispensed as quickly as possible due to the medical necessity identified for an item. However, providers who deliver an item requiring prior approval before approval has been received do so with the possibility of the prior approval being denied and therefore the item not being covered.

- Members in institutions who plan to return to their own home may receive consideration for equipment received before discharge if the equipment will be used in the member's home. Members' wishes, preferences, and personal conveniences are not considered medical needs.

DURABLE MEDICAL EQUIPMENT (DMEPOS) REUSE

North Dakota Medicaid is not responsible for acquiring, storing, maintaining or distributing DMEPOS.

North Dakota Medicaid encourages members and families to donate DMEPOS when, and if, that equipment is no longer in use or medically necessary. This includes members and families who access Medicaid waived services.

Members should not donate items that they need, nor should they donate items with the intent of being provided new or updated equipment in return. North Dakota Medicaid cautions members and families to scrutinize the potential for future use of any item being considered for donation.

The following organizations can be contacted for additional information about equipment donations. Please note this list is not all-inclusive.

North Dakota Association for the Disabled, Inc. (NDAD)

1-800-532-6323 www.ndad.org

Healthcare Equipment Recycling Organization (HERO)

1-701-212-1921 www.herofargo.com

Life Skills and Transition Center

1-800-252-4911 <https://www.hhs.nd.gov/individuals-disabilities/LSTC>

Easter Seals Goodwill ND

1-701-663-6828 <https://www.esqwnd.org/>

PROVIDER DOCUMENTATION 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, orthotic or prosthetic.
 - **"RB"** for replacement of a part of a DMEPOS, orthotic or prosthetic item furnished as a repair.
 - **"RT"** to identify the right side of the body.
 - **"LT"** to identify the left side of the body.
- All records shall be maintained in hard copy for at least seven years after the date of service or as required by the North Dakota Administrative Code. Upon reasonable request, the Department, the U.S. Department of Health and Human Services (DHHS), or their agencies shall be given immediate access to, and permitted to review and copy, all records relied upon

by the DMEPOS provider in support of services billed to Medicaid. Copies will be furnished at the provider's expense. The provider agrees to comply with all applicable state and federal laws and regulations regarding the confidentiality of records.

- The medical record must be in its original or legally reproduced form, which may be electronic, so that the medical records may be reviewed and audited by authorized entities. For more information, refer to the [Media Formats policy](#).
- The provider agreement states that the provider agrees to document each item or service for which Medicaid reimbursement is claimed and is in compliance with the documentation requirements of the Department.
- In the absence of proper and complete records, no payment will be made, and payments previously made will be recouped.
- North Dakota Medicaid accepts a physician (MD/DO/DPM), certified nurse practitioner (NP), physician assistant (PA), or a Clinical Nurse Specialist (CNS) signature, within the scope of their practice as defined by state law. These providers will herein be referred to as "practitioners".
- All medical record entries must be legible and complete, dated and timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided. If there is no signature appended to the medical record documentation, the service authorization/claims will be denied for lack of a signature.
- The member's medical records retained by the provider must coincide and 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 refer to the policy specific to the requested item to determine the minimum required documentation for each item.
- A current prescribing practitioner's prescription/order. Coverage decisions are not based solely on the prescription.
- Copy of the service authorization notification letter, if applicable.
- 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 DMEPOS 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 are still applicable, and there is a continued medical need for the item. The DMEPOS provider must contact the member or their representative within fourteen (14) calendar days prior to the delivery/shipping date to verify the rented item is still medically necessary, in working condition, and being used by the member (contact does not include system-generated

correspondence). Verification must be documented and maintained in the DMEPOS provider's records, and it must be accessible for audits.

- Pick-up and return documentation must be maintained in the member's file. For example: *(not an all-inclusive list)*
 - Member requests equipment/supplies or recurring supplies to be picked up.
 - Medical equipment is being returned to the DMEPOS provider's DMEPOS business location by the member or responsible caregiver.
 - Equipment is no longer medically necessary and is picked up from the members' residence by the DMEPOS provider.
 - Equipment is no longer functioning properly and is picked up from the members' residence.
 - Equipment picked up from the member's residence for other clearly documented reasons.
- Pick-up or return documentation must include, at a minimum, the following information:
 - Name of DMEPOS item.
 - DMEPOS 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.
 - 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 DMEPOS business location by the member or responsible caregiver.
 - Date of pick up or return.
 - Dated signature of staff picking up the equipment.
 - Dated signature of member or responsible caregiver releasing the medical equipment to the DMEPOS provider.

PRACTITIONER NOTE

- For DMEPOS item(s) that **require** service authorization, the member must have been seen/examined within 90 days prior to the DMEPOS item(s) service authorization start date.
- For DMEPOS items that **do not** require a service authorization, the member must have been seen/examined within 90 days prior to the DMEPOS item(s) being initially delivered.
- 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.

PRESCRIPTION/ORDER

- General standards of care/practice mandate that if a prescription/order is not clear or is missing required elements, a clarification of the order must be obtained from the ordering practitioner prior to a DMEPOS provider acting on it.
- Prescriptions/orders must be obtained prior to submitting a service authorization or delivery of DMEPOS items. Orders may be electronic or an original “pen-and-ink” document.
- All prescriptions/orders must be legible and include at a minimum the following elements:
 - Member’s name.
 - Member’s date of birth.
 - Start date of the order.
 - Length of need.
 - 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.
 - Be sufficiently detailed, 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 is required for all items.
 - Be signed and dated by the prescribing practitioner. An acceptable signature form includes an electronic signature or an original “pen and ink”. Signature stamps are not allowed.
- Certain items require additional elements in the orders/prescriptions, as follows:
 - When applicable, must specify laterality. Such as left, right or bilateral.
 - 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.
- 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.
 - 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.

DELIVERY AND METHODS

Regardless of the method of delivery, the Department must be able to determine that the item(s) delivered are the same item(s) submitted for reimbursement and that the item(s) were received by a specific member. The Department will utilize Medicare's three methods of delivery:

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

DMEPOS Providers, their employees, or anyone else having a financial interest in the delivery of the item(s) are prohibited from signing and accepting an item on behalf of a member (i.e., acting as a designee on behalf of the member).

DMEPOS Providers may deliver item(s) directly to the member or the designee (person authorized to sign and accept delivery on behalf of the member). The relationship of the designee to the member should be noted on the delivery slip obtained by the provider (i.e., spouse, neighbor). The signature of the designee must be legible. If the signature of the designee is not legible, the provider/shipping service should note the name of the designee on the delivery slip.

Proof of delivery (POD) documentation, as well as claims documentation, must be maintained in the DMEPOS provider's files for 7 years (starting from the date of service).

Proof of delivery documentation must be available to the Department and/or its contractor on request. All services that do not have appropriate proof of delivery from the DMEPOS provider will be denied and overpayments will be requested.

DMEPOS provider may deliver items to a member in a hospital or nursing facility for the purpose of fitting or training the member in its proper use. This may be done up to two (2) days prior to the member's anticipated discharge to home. On the service authorization request (if applicable) and

the claim, bill the date of service as the date of discharge and specify the place of service (POS) as the member's home. The item must be for subsequent use in the member's home.

A DMEPOS provider may deliver items to a member's home in anticipation of a discharge from a hospital or nursing facility A. The DMEPOS provider may arrange for actual delivery approximately two (2) days prior to the member's anticipated discharge to home. On the claim, bill the date of service as the date of discharge and specify the place of service (POS) as the member's home.

No payment is made on dates of service when the member receives training or fitting in the hospital or nursing facility for a particular DMEPOS item.

PURCHASE

- North Dakota Medicaid will purchase equipment when it is expected to be the most cost-effective option.
- Payment may be made for the purchase of an item even though rental payments may have been made for prior months. It may be necessary on a case-by-case basis to rent the item for a time to establish the item meets the identified need before the purchase.
- When a decision is made to purchase after renting an item, the full rental allowance is applied to the purchase allowance.
- Any Department approved piece of equipment that the member's primary insurer will purchase will also be purchased by Medicaid provided the Department has determined the equipment is a covered item and it meets established coverage criteria.
- Covered equipment may be rented or purchased at the discretion of the Department when the Department is the primary insurer.

RENTAL

- All rental items require a service authorization, except when stated in the policy or per the Look-up Tool.
- After the 12-month rental period, the Medicaid member will be deemed to own the item and the DMEPOS provider must transfer ownership of the item to the member. The DMEPOS supplier providing the item in the specified rental period is responsible for transferring ownership to the member. (Exception: If a member's primary insurer is Medicare and the member is dual eligible, North Dakota Medicaid will follow Medicare's Oxygen Equipment Rental period guidelines.)
- At the point that total rent paid equals 100 percent of the purchase allowance, the member is considered to own the item, and no further rental payments are made. It is the DMEPOS provider's responsibility to track the number of rental payments and discontinue billing beyond the 100 percent point.
- Any Department approved piece of equipment that the member's primary insurer will rent will also be rented by Medicaid provided the Department has determined the equipment is a covered item and it meets established coverage criteria.
- Rental approved by North Dakota Medicaid is limited to a maximum period of 12 months. All necessary supplies and maintenance needed to operate the rental equipment shall be

included in the rental amount. No additional allowances will be paid except those identified in the policy guidelines.

- All rentals are paid on a monthly basis (1 unit of service per month). Payment will be made for the entire monthly rental fee for the month, even if it is less than a full month.
- Maintenance and repair costs of rental equipment are included during the rental period. Members are responsible for caring for the equipment.
- A change in a DMEPOS supplier during the 12-month period will not result in the start of a new 12-month period.
- Only interruptions of 90 days or greater in the rental period will result in a new 12-month rental period and will require a new service authorization.
- Covered equipment may be rented or purchased at the discretion of the Department.

RECURRING RENTAL EQUIPMENT AND MONTHLY SUPPLIES REFILL DOCUMENTATION

The DMEPOS provider must maintain documentation that clearly shows monthly contact with the member and/or caregiver regarding their rental equipment/supplies, and/or recurring supplies prior to submitting to Medicaid for payment, to ensure that the member is continuing to use the equipment. DMEPOS providers must discontinue billing 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, the service authorization (if required), effective dates are still applicable, and there is a continued medical need for the item.

The DMEPOS provider must contact the member or their representative within fourteen (14) calendar days prior to the delivery/shipping date to verify that the rented item is still medically necessary, in working condition, and being used by the member (contact does not include system-generated correspondence).

The DMEPOS provider must contact the member prior to dispensing the monthly supply refill and not automatically ship on a pre-determined basis, even if authorized by the member. This shall be done to ensure that the refilled item remains reasonable and necessary, the existing supplies are approaching exhaustion, and to confirm any changes/modifications to the order.

General refill documentation requirements pertain to all DMEPOS policies. Refer to the applicable policy for specific refill requirements.

For items that 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 request for refill.

For items that are delivered to the member, documentation of a request for refill must be either a written document received from the member or a contemporaneous written record of a phone conversation/contact between the supplier and member. The refill request must occur and be documented before shipment. A retrospective attestation statement by the DMEPOS provider or member is not sufficient.

The refill record must include:

- 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 amount remaining 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., PAP and RAD supplies) the DMEPOS provider must assess whether the supplies remain functional, providing replacement (a refill) only when the supply item(s) is no longer able to function. The DMEPOS 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).

DMEPOS 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 DMEPOS provider's records and be accessible for audits.

Items delivered without a valid, documented refill request will be denied as not reasonable and necessary.

DMEPOS providers must not dispense a quantity of supplies exceeding a member's expected utilization.

DMEPOS providers must stay attuned to changed or atypical utilization patterns on the part of the member.

DMEPOS providers must verify with the ordering practitioners that any changed or atypical utilization is warranted.

RETURNED OR PICK-UP DMEPOS ITEM(S)

Pick-up and return documentation must be maintained in the member's file in all circumstances, such as: *note this is not an all-inclusive list*

- Medical equipment is being returned to the provider's DMEPOS business location by the member or responsible caregiver;
- Member has requested the DMEPOS provider to pick up DMEPOS item(s).
- DMEPOS item(s) is no longer medically necessary and is picked up from the member's residence by the DMEPOS provider;
- DMEPOS item(s) is no longer functioning properly and is picked up from the member's residence;
- DMEPOS item(s) picked up from the member's residence for other clearly documented reasons.

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

- Name of DMEPOS item(s);
- DMEPOS provider name;
- Member's full name;

- Member's Medicaid identification number;
- Complete description of item(s) picked up;
- Manufacturer name of item(s) picked up;
- Model and serial or item number(s) of item(s) picked up;
- Current hour meter reading(s), if applicable;
- A description of the pick-up location that identifies whether the DMEPOS item(s) 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 the return of the DMEPOS item(s) to the DMEPOS provider's DMEPOS business location by the member or responsible caregiver, the reason for the return;
- Date of pick up or return;
- Dated signature of staff picking up the DMEPOS item(s);
- Dated signature of member or responsible caregiver releasing the DMEPOS item(s) to the DMEPOS provider.

REPAIRS

To repair means to fix or mend an existing component and to put the equipment back in good condition after damage or wear.

Repairs include any modifications to make member's existing owned equipment functional.

- Repairs/modifications will be considered only for covered items based on related policy.
- If the expense for the equipment repair(s) exceeds 75% of the estimated expense of the replacement cost, the DMEPOS provider will need to submit a service authorization request for replacement of the item(s). See replacement section for more details.
- DMEPOS Providers cannot bill members for repairs, parts, or other equipment or supplies covered by an expressed or implied warranty and the DMEPOS provider must identify the extent of a warranty for any item they supply and inform the member of such.
- Payment for repairs is not covered when:
 - The skill of a technician is not required; **or**
 - The equipment has been previously denied; **or**
 - Equipment is being rented, including separately itemized charges for repair; **or**
 - Parts and labor are covered under a manufacturer's or supplier's warranty; **or**
 - Payment will not be made for repairs to equipment used in a skilled nursing facility, ICF/IID, or swing bed, unless that equipment was member owned prior to entering such facility.
- Service authorizations submitted for repairs require the use the appropriate HCPCS code(s) for the item to be repaired along with the repair modifier RB, the purchase modifier NU and the RT/LT modifier when applicable.
- An itemized labor breakdown which lists each code and quantity requiring repair charges must be submitted with the service authorization. Itemized breakdown needs to include why

the HCPCS code(s) needs to be repaired and if labor units requested, the specific number of units required to complete the repair.

REPLACEMENT

Replacement refers to the provision of an identical or nearly identical item that was previously approved.

- Temporary Replacement:
 - A maximum of one month rental of a temporary replacement for the member-owned equipment while it is being repaired.
 - The equipment in need of repair must be unavailable for use for more than one day. For example: the repair takes more than one day, or a part has to be ordered and the wheelchair is non-functional.
- Permanent Replacement:
 - Situations involving the provision of a different item because of a change in medical condition the DMEPOS provider must supply:
 - ❖ The reason why current equipment cannot be modified to meet member's needs.
 - ❖ The member's medical records containing sufficient documentation of the member's medical condition to substantiate the necessity for the type and quantity of items ordered and the frequency of the use or replacement.
 - ❖ The member's diagnosis and other pertinent information including, but not limited to, duration of member's condition, clinical course (deteriorating or improving), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc.
 - ❖ The records may include practitioner's office records, hospital, nursing home or home health records, records from other professionals including but not limited to nursing, physical and occupational therapists, prosthetists and orthotist, although medical necessity for item(s) requested must be stated by the prescribing practitioner.
 - ❖ When equipment repair costs exceed 75% of replacement cost, the DMEPOS provider needs to include an itemized list using the Department's rates of either the purchase cost or the rental cost for a replacement. This list must clearly show why each item needs repair/replacement for consideration.
- Reasonable Useful Lifetime (RUL) of DMEPOS item(s) may be listed on the item's specific policy, but this does not guarantee the item(s) will be replaced if it is still functional, repairable, or able to be cost-effectively modified to meet the member's needs.
- Service authorization (SA) for replacement item(s) requires the additional modifier "RA" or the SA will be denied.
- 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 of equipment misuse, abuse, neglect, loss, or wrongful disposition could include:

- Failure to clean and maintain the equipment as recommended by the equipment manufacturer; **or**
 - Failure to store the equipment in a secure and covered area when not in use; **and/or**
 - Loss, destruction, or damage to the equipment caused by the malicious, intentional, or negligent acts of the member, the member's caregiver, or the DMEPOS provider.
- If equipment/supplies are stolen or destroyed in a fire, the DMEPOS 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.

QUANTITY ALLOWABLE LIMITATIONS

Whether a service authorization is required or not, the quantity of medical supplies will be limited to the amount indicated by the prescribing practitioner or to a reasonable quantity per month, whichever is less. The [Look-up Tool](#) can be used to find a code's allowed quantity. Maximum quantities can be dispensed without a service authorization approval if all other requirements in this manual have been met.

If the prescribing practitioner has ordered a quantity that exceeds the designated maximum, the supplying DMEPOS provider must presume the higher quantity is medically necessary and must obtain a service authorization approval for the entire order. It is not permissible for the supplying DMEPOS provider to dispense only the maximum allowable quantity, or to dispense the full quantity and bill the member for the items in excess of the maximum allowable quantity, unless:

- The ordering practitioner confirms that the excess quantity is not medically necessary, **or**
- The service authorization request is denied because the excess quantity is not medically necessary, **or**
- The supplying DMEPOS provider can clearly document that items are being dispensed solely for members and/or caregiver's convenience before the member can be charged.

In the instances described above, the DMEPOS provider must inform the member of his or her financial liability before dispensing the items.

NON-COVERED EQUIPMENT AND SUPPLIES

Reimbursement is limited to only the most economical and medically necessary DMEPOS delivered in the most appropriate and cost-effective manner. An item is not reimbursable if there is another item that is equally safe, effective, and costs substantially less.

Service authorization requests submitted for items included in the Non-Covered policy will be voided. A denial will not be issued as the Department will not allow a service authorization request solely for the purpose of receiving a denial in order to receive payment from another source. Instead, the DMEPOS provider should supply the alternative payer with documentation supporting the non-coverage of the item (Provider manuals, Department notices and/or bulletins).

The following is a list of some generic categories/items specifically determined not reimbursable by Medicaid through the DMEPOS program. All coverage decisions are based on federal and state mandates for program funding by the U.S. Department of Health and Human Services, and the Medicare Program or the Department's designated review organization. This categorical list may not be all-inclusive.

- Automobile modifications
- Exercise/therapeutic items
- Convenience/comfort items
- Educational items
- Sensory or Self Soothing
- Building modifications
- Environmental control items
- Personal care items
- Medical Alert Bracelets
- Institutional
- Items/services provided to a member in a skilled nursing facility setting

The simplest way to verify coverage of a specific item is to utilize the Look-Up Tool.

DMEPOS item(s) are not useful to a person in the absence of illness or injury. The item must be appropriate for use in the home or residence. Items that are beneficial primarily in allowing leisure, recreation, or adaptive daily living activities are not reimbursable. Medicaid has no liability for such services, supplies, or equipment.

EXCEPTION REQUESTS

In order to request an exception, the following is required:

- Completed service authorization request by an ND Medicaid enrolled DMEPOS provider; **and**
- Substantiating documentation, which **must** be prepared by the prescribing practitioner and **cannot** be from a DMEPOS provider, therapist, or representative of the member or the DMEPOS provider facility; **and**
- Documentation must include a detailed care plan from the practitioner describing how the requested item is medically necessary in this unusual, unique, rare situation; **and**
- Documentation must support why a comparable covered equipment/supply would not be suitable; **and**
- Documentation indicating what other methods or therapies were considered and why they could not be used or have been tried and failed.

MISCELLANEOUS / NOT OTHERWISE SPECIFIED HCPCS CODES

Most HCPCS Level II coding categories have miscellaneous/not otherwise specified codes (e.g., equipment, orthotics, prosthetics, supplies, etc.). DMEPOS providers must determine if an alternative HCPCS Level II code better describes the item being requested. Miscellaneous codes should only be used if a more specific code is not available. Service authorization requests submitted containing a miscellaneous/not otherwise specified HCPCS code **must** have one of the following:

- All miscellaneous codes must receive prior approval. The service authorization request must contain a statement from the DMEPOS provider that a specific HCPCS code(s) is not available.
- If the miscellaneous item is a custom item, the service authorization must contain a statement from the DMEPOS provider that the item is a custom item and explain why an off-the-shelf or prefabricated is not suitable, if applicable and a specific HCPCS code(s) is not available.

Claims containing miscellaneous/not otherwise specified HCPCS code(s) are subject to prepayment review which may result in processing delays.

Prepayment review is not a prior authorization process before delivery of the item and the payment of a claim does indicate that the item/service was reviewed for its necessity and/or appropriateness. Paid claims are always subject to retrospective review auditing.

Any miscellaneous code(s) requires a cost invoice to be submitted with the service authorization request. A cost/manufacture invoice is an itemized bill issued directly from the supplier/manufacture to the DMEPOS provider, listing the item(s) supplied and stating the amount of money due to the supplier. If the cost invoice contains more than one item, the DMEPOS provider must clearly indicate the corresponding item(s) to the corresponding miscellaneous code(s) and its cost. The Department reminds DMEPOS providers that North Dakota Medicaid is to receive all discounts, rebates or sales on the cost invoice.

- The miscellaneous code's unit(s) and acquisition cost must be clearly indicated on the supplier/manufacture invoice(s) to prevent a service authorization/claim denial.
- The miscellaneous code's requested unit(s) and the requested acquisition cost amount submitted on the service authorization/claim must match the unit(s) and the acquisition cost amount on the supplier/manufacture cost invoice(s) or it will be denied.
- If supplies/items are purchased by the DMEPOS provider in bulk, the units and acquisition cost that apply to the corresponding miscellaneous code(s) must be clearly indicated on the cost/manufacture invoice to prevent a service authorization/claim denial.

SERVICE AUTHORIZATION

Under the North Dakota Medicaid program, as a condition of reimbursement, certain covered services and equipment requires prior approval via a service authorization submitted on the MMIS web portal. Service Authorization (SA) reviews are conducted to evaluate the SA and additional supporting documentation for medical necessity, appropriateness, location of service, cost-effectiveness, and compliance with the Department's DMEPOS manual policy coverage criteria, prior to delivery of service.

To ensure federal funding requirements are met, certain items are reviewed before delivery to a Medicaid member. These items are reviewed for appropriateness based on the member's medical need. In determining medical appropriateness of an item, the Department Utilization Management Team applies six criteria when granting prior approval.

The equipment must:

- Be medically necessary; and
- Be appropriate and effective to the medical needs of the members; and

- Be timely, considering the nature and present state of the members medical condition; and
- Be furnished by a DMEPOS provider with appropriate credentials; and
- Be the least expensive appropriate alternative health service available; and
- Represent an effective and appropriate use of program funds.

Prior approval from the Department pertains to medical necessity **only**. It does ***not*** guarantee payment of submitted charges nor does it guarantee member eligibility.

NOTE: The fact that a DMEPOS provider has prescribed or recommended equipment, supplies or services does not, in itself, make it medically necessary or a medical necessity or a covered service.

Certain services require service authorization only when provided in a specific place of residence or when the quantity exceeds quantity allowed limits. These specific residences are explained in detail in each residence's related Facility Responsibility and Separate Payment policy that can be reviewed under the [Quick Reference: DMEPOS policies](#) section on the DMEPOS webpage.

NOTE: The Department will not allow a service authorization request solely for a denial in order to receive payment from another source. Instead, provide the alternate payer with documentation supporting the non-coverage of the item (Provider manuals, Department notices and/or bulletins).

SERVICE AUTHORIZATION (SA) GUIDELINES

The following general guidelines pertain to all authorized DMEPOS services:

- Only North Dakota Medicaid enrolled DMEPOS providers may request service authorization.
- The service must be ordered by a physician (MD/DO/DPM), certified nurse practitioner (NP), physician assistant (PA), or a Clinical Nurse Specialist (CNS) signatures, within the scope of their practice as defined by state law.
- Members must be eligible for Medicaid.
- Use member's current place of residence.
- List member's primary insurance in the service authorization notes section.
- Upon completion of the review, a service authorization notification letter will be mailed to the member and the requesting DMEPOS provider. The claim must contain the service authorization number and match the service authorization approval **exactly**.
- Members are entitled to choose any North Dakota enrolled DMEPOS providers and may choose to change DMEPOS providers for rental items or ongoing supply needs. The service authorization ***will not*** automatically transfer to a new DMEPOS provider. The new DMEPOS provider will need to submit for a new service authorization. The Department may request verification that the member chose to make the change.
- Correct Coding Initiative (NCCI/MUE) edits will deny items billed in excess of what CMS allows or items that are not appropriately reported together (unbundled).
- Reference the specific DMEPOS policy for required documents and documentation that needs to be submitted to the Department for review.
- Required documents ***must*** be submitted when the SA is entered via the web portal. If no documentation is submitted, the SA will be denied as information not received.

- Payment will not be made for services initiated prior to the approval date of the SA or after the authorization end date.
- If an item is considered medically necessary, payment authorization is based on when the request was **received** for review from the DMEPOS provider, not the **delivery** of the item to the member.
- Equipment purchased by the Department for a member is the property of the member.
- Separate payment will not be made to DMEPOS providers for equipment and medical supplies provided to a member in their home when the cost of such items is already included in the capitated (per diem) rate paid to a facility or organization. Review the related [Quick Reference: Facility Responsibility and Separate Payment policy](#) for items that may be submitted to the Department for separate payment.

SERVICE AUTHORIZATION SUBMISSION

- A Service Authorization (SA) request **must** be submitted via the web portal by Medicaid enrolled DMEPOS servicing providers.
- The servicing DMEPOS provider is required to submit the SA via the MMIS web portal prior to delivery.
- Use the [Service Authorization Instructions](#) when submitting requests as it is a detailed step by step entry instructions. The handout has screenshots of the DMEPOS MMIS provider screens along with instructions on how to submit required information.
- DMEPOS providers must submit a service authorization with the most appropriate HCPCS code(s) available and may not unbundle items included in the HCPCS code description. If an item has a designated code available, the miscellaneous code cannot be used. DMEPOS providers may contact the Medicare Pricing, Data Analysis and Coding (PDAC) contractor, or the DMEPOS MAC for guidance on correct coding.
- Sufficient documentation or information **must** be linked to the SA request to determine the medical necessity of the service. Reference the specific policy for required documents and documentation needed to be submitted to the Department.
- Documentation submitted for consideration of the SA request **must** include the prescribing practitioner's order and all required supporting documents that clearly support coverage qualifications and member's medical need for the supply/equipment. Failure to provide all of the required supporting medical documentation in its entirety, and within the required timeframe, will result in a denial of the service authorization request.
- All required documents **must** be linked the date the SA is entered via the web portal. If no documentation is received the SA will be denied as information not received.
- Unless otherwise stated in the DMEPOS policy, a service authorization may be submitted to request authorization to exceed established quantity limitations when the medical documentation supports medical necessity for the increased quantity or frequency.

SERVICE AUTHORIZATION REQUEST STATUS CODES

DMEPOS providers can check the status of the SA submitted on the MMIS web portal at any time. Below is a list of codes/reasons used:

- **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
- **A6** – Modified – all items requested approved but not approved as requested.
Example: labor units requested is 8 but only 6 were approved.

RECONSIDERATION OF DENIED SERVICE AUTHORIZATIONS

Service Authorization requests are denied for two reasons:

1. Technical - incomplete or missing forms and documentation, etc.
 - Technical denials require the submitting DMEPOS provider to resubmit a new SA with corrections as instructed in denied SA denial notes along with all required supporting documents.
2. The member does not meet established coverage criteria.
 - If a DMEPOS provider or prescribing practitioner feels the denial was incorrect the DMEPOS provider can resubmit the SA. Additional new information must be included along with all other required supporting documents to aid the Department in the reconsideration.

DEFINITIONS AND ACRONYMS

This section provides definitions, abbreviations, and acronyms commonly used throughout this manual.

Accessory

A medically necessary device or supply, which augments or complements the functions of the equipment to which it is connected.

Acquisition Cost

The price that a DMEPOS provider pays for an item, which would include group rates, discounts, or sales.

Allowed Amount

The maximum amount reimbursed to a DMEPOS provider for a health care service, as determined by Medicaid or another payer. Other cost factors, such as TPL are often deducted from the allowed amount before final payment. Medicaid's allowed amount for each covered service is listed on the Department fee schedule.

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.

Capped Rental

Rentals classified by North Dakota Medicaid as capped rental items are limited to a specified rental period. All necessary supplies needed to operate the rented equipment item are included in the rental amount. No additional allowances are made, unless specified otherwise in the guidelines.

Centers for Medicare and Medicaid Services (CMS)

Administers the Medicare program and oversees the state Medicaid

programs. Formerly the Health Care Financing Administration (HCFA).

Certificate of Medical Need (CMN)

CMN form contains information needed for the Utilization Review personnel to determine if an item is medically necessary for the Medicaid member.

Claim Form or Electronic Billing

The health insurance billing form or the electronic transmission of billings.

Date of delivery

The date the member took physical possession of an item or equipment.

DMEPOS

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

Code of Federal Regulations (CFR)

Rules published by executive departments and agencies of the federal government.

Durable Medical Equipment

Items that are used primarily and customarily for a medical purpose, are suitable for use in the home, are able to 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.

Eligible Member

An individual who meets all eligibility requirements for the North Dakota Medicaid Program.

HCPCS

The Health Care Common Procedure Coding System. These codes are required for service authorization of and billing for durable medical equipment or supplies.

Hearing aid

An apparatus or instrument that amplifies sound for persons with impaired hearing.

Individual Adjustment

A request for a correction to a specific paid claim.

Cost/Manufacturer Invoice

Document that provides proof of purchase and actual cost(s) for equipment and/or supplies to the servicing DMEPOS provider. The lowest price on the invoice, including all DMEPOS provider discounts, will be used to price all miscellaneous codes manually.

Maximum Allowable

The maximum dollar amount for which a DMEPOS provider may be reimbursed, as established by North Dakota Medicaid, for specific services, supplies, and/or equipment.

Medicaid

A program that provides health care coverage to specific populations, especially low-income families with children, pregnant women, disabled people and the elderly. State governments administer Medicaid under broad federal guidelines.

Medically Necessary

A term describing a requested service which is reasonably calculated to

prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the member. These conditions must be classified as one of the following: endanger life, cause suffering or pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There must be no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the member requesting the service. For the purpose of this definition, "course of treatment" may include mere observation or, when appropriate, no treatment at all.

Medicare

The federal health insurance program for specific individuals aged 65 or older or those with disabilities.

Neurologist

A physician specializing in diseases of the nervous system.

Orthopedic surgeon

A physician specializing in surgery for the prevention and correction of deformities involving the limbs.

Orthopedist

A physician specializing in orthopedics.

Orthosis

An orthopedic appliance, brace, or splint used to support, align, prevent or correct deformities or improve the function of movable parts of the body.

Physiatrist

A physician specializing in physical medicine.

Physician

A person licensed to practice medicine.

Podiatrist or chiropodist

A licensed individual who specializes in the diagnosis, treatment, and prevention of conditions of the foot.

Primary Care Provider (PCP)

Per North Dakota Medicaid policy – A physician, rural health clinic, Indian Health Service facility, or other practitioner named by a member as his or her primary health care provider.

Prosthesis

An artificial substitute to replace or augment a body part, including, but not limited to, eyes, arms, hands, legs, feet, or breasts. Service authorizations are required for these items.

Prosthetist

A person who is certified in making artificial limbs and other body parts.

Private-pay

When a member has on insurance/health care coverage and pays for medical services out of his or her own pocket.

Provider or Provider of Service

An institution, agency, or person: Having a signed agreement with the Department to furnish medical care and goods and/or services to members; and eligible to receive payment from the Department.

Purchase Price Rental

A medical term that limits rental payments to no more than the amount paid by the department to purchase the item. All supplies needed to operate the equipment are included in the rental fee.

Retroactive Eligibility

When a member is determined to be eligible for Medicaid effective prior to the current date.

Rheumatologist

A physician specializing in disorders marked by inflammation, degeneration, or metabolic derangement of the connective tissues especially joints and related structures.

Service Authorization (SA)

A written approval by the Department for appropriate medical services, equipment, or supplies before such items are ordered or purchased. A CMN and a physician's order or prescription must be attached to the SA request.

Specialist

A physician, preferably board-certified, whose practice is limited to a specific type of medicine or surgery by advanced training.

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 not active interaction with the member or their representative.

DURABLE MEDICAL EQUIPMENT AND SUPPLIES POLICY GUIDELINES

The [DMEPOS policy guidelines](#) are to help DMEPOS providers access North Dakota Medicaid coverage guidelines for DMEPOS items. Every effort will be made to maintain the accuracy of these guidelines. North Dakota Medicaid reserves the right to add, change, or delete guidelines as warranted. Additions or deletions to the policy guidelines will be posted to the Department's provider website via the update link. It is the DMEPOS provider's responsibility to periodically check the DMEPOS website to stay informed about all changes.

If North Dakota Medicaid is the primary insurer, the Department will determine if rental or purchase of the DMEPOS item(s) ordered is appropriate and the most cost-effective. The Department reserves the right to request additional documentation when necessary.

MANUAL REVISIONS LIST

- 11-01-2019 Due to the extensive revisions made to the March 2013 North Dakota Durable Medical Equipment, Prosthetics & Orthotics, and Medical Supplies (DMEPOS) Manual, there will be no individual changes listed. Instead, providers are reminded that the November 1, 2019 manual supersedes the March 2013 version, as well as all changes that have occurred in memorandums, provider updates, and provider bulletins.
- 12-20-2019 Inserted new paragraph with Medicare Dual Eligible information as second paragraph to the Service Authorization section on page 26.
- 1-15-2020 Service Authorization section on page 26 added to the second paragraph - (which include prior authorizations, additional documentation not required by Medicare, or additional prescription requirements of durable medical equipment and supplies).
- 10-10-2025 Reviewed and updated links. Remove DMEPOS policy list and add a link to the DMEPOS webpage.