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RI Medicaid  
Provider Reference Manual  
Durable Medical Equipment, Prosthetics, Orthotics,  
and Supplies

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## Revision History

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<b>Version</b>	<b>Date</b>	<b>Reason for Revisions</b>	<b>Sections</b>
1.0	June, 2016	New manual format	All
1.1	May, 2017	Added definition of prescribing providers	Certificate of medical necessity
1.2	June 2017	Home Health Final Rule – face to face	Section IV
1.3	April 2019	Updated Proof of Delivery	Section IV
1.4	October 2019	Update Proof of Medical Necessity	Section III
1.5	December 2020	Update DXC to Gainwell Technologies	Introduction & Section III

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**RI Executive Office of Health and Human Services**

**Medicaid Program**

**DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES**

**PROVIDER MANUAL**

## **INTRODUCTION**

The Executive Office of Health, and Human Services (EOHHS) in conjunction with Gainwell Technologies has developed the Durable Medical Equipment ( DME) provider manual to establish the rules of payment for services provided to beneficiaries eligible for the RI Medicaid Program. The General Rules and Regulations for the RI Medicaid program and the rules in the DME coverage guidelines are to be used together to determine eligibility for services.

## **SECTION I – REQUIREMENTS FOR PARTICIPATION IN RI MEDICAID**

### **Provider Participation Guidelines**

To participate in the RI Medicaid Program, providers must be located and performing services in Rhode Island or in a border community and certified to participate in the Medicare program. Consideration will be given to out-of-state providers if the covered service is not available in Rhode Island, the beneficiary is currently residing in another state or if the covered service was performed as an emergency service while the beneficiary was traveling through another state.

DME providers must be certified to participate in the Medicare program. Providers supplying only non-Medicare products may enroll without Medicare certification, and are required to pay the CMS required enrollment fee at the time of enrollment or revalidation. If a provider paid this fee to another state’s Medicaid program, valid proof of this payment may be submitted, and the enrollment fee may be waived for that enrollment period. Providers not enrolled in Medicare are also required to have a site visit as well as a fingerprint-based background check performed by the EOHHS Program Integrity staff.

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## SECTION II - DEFINITIONS

### Definition of Durable Medical Equipment, Orthotics, Prosthetics and Supplies

Durable Medical Equipment and appliances are items that are primarily and customarily used to serve a medical purpose, generally are not useful to an individual in the absence of a disability, illness or injury, can withstand repeated use, and can be reusable or removable.

Orthotics are mechanical devices intended to support or correct a defect or deformity or to improve the function of movable parts of the body and are generally referred to as a "brace" or "orthosis."

Prosthetic devices are non-dental artificial substitutes for a missing body part.

Supplies are defined as health care related items that are consumable or disposable, or cannot withstand repeated use by more than one individual, and that are required to address an individual medical disability, illness, or injury.

## SECTION III - General Guidelines

The purpose of the DME provider manual is to assist RI Medicaid providers with claim reimbursement, assist with understanding of coverage guidelines and covered services for RI Medicaid Fee for Service (FFS) beneficiaries.

In addition, the Gainwell Technologies Customer Service Help Desk is available to answer questions.

Gainwell Technologies Help Desk can be reached by calling:

- 1-401-784-8100 for local and long distance calls
- 1-800-964-6211 for in state toll calls or border community calls

### Statutory Authority

The statutory foundations of the Rhode Island Medicaid program are Title XIX of the Social Security Act (42 U.S.C. § 1396a *et seq.*), Rhode Island General Laws 40-8, and Rhode Island General Laws 42-7.2. Statutory authority for health care coverage funded in whole or in part by the federal Children's Health Insurance Program (CHIP) is derived from 42 U.S.C. § 1397aa *et seq.*, of the U. S. Social Security Act which establishes that program and provides the legal basis for providing health coverage, services and supports to certain targeted low-income children and pregnant women through Medicaid.

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Title XIX authorizes Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for all Medicaid beneficiaries who are under age twenty-one (21) for the purposes of identifying and treating behavioral health illnesses and conditions. Medically necessary EPSDT services must be provided irrespective of whether they are within the scope of Medicaid State Plan covered services.

Certain benefits covered by the Medicaid State Plan or the State's Section 1115 waiver are subject to limits under Federal and/or State law. Program-wide benefit limits are set forth in section 0300.10(D) of this rule (0300 Overview of the Rhode Island Medicaid and Children's Health Insurance Programs). Limits and restrictions applicable to specific coverage groups are located in the rules describing the coverage group and service delivery.

### Medical Necessity

The RI Medicaid program provides payment for covered services only when the services are determined to be medically necessary.

The term "medical necessity" or "medically necessary service" means medical, surgical, or other services required for the prevention, diagnosis, cure or treatment of a health related condition including such services necessary to prevent a decremental change in either medical or mental health status.

Medically necessary services must be provided in the most cost effective and appropriate setting and shall not be provided solely for the convenience of the beneficiary, caretaker or service provider.

### Determinations of Medical Necessity

Determinations that a service or procedure is medically necessary are made by EOHHS staff, consultants, and designees of EOHHS, and also by individuals and organizations under contract to the EOHHS. Services that are denied by another primary insurance or Medicare because they are not medically necessary are not reimbursable under the RI Medicaid program.

### Proof of Medical Necessity

Proof of Medical Necessity is required for all services covered under this program. All prescriptions for DME, regardless of format used (e.g., CMN, Prescription pad, or letter) shall, at a minimum contain the following elements:

1. Member name, and DOB;

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2. Diagnosis code for which the DME is required;
  3. Description of the DME, including quantities and any special options or add-ons;
  4. Length of need for the DME use;
  5. Name, address and NPI of the prescribing provider; and
  6. Prescribing provider's signature and date of signature. (Prescribing providers are enrolled physicians, clinical nurse specialists, certified nurse practitioner or physician assistants, within the scope of their practice as defined by state law).

All requests for purchase of DME to replace an item shall be fully explained, documenting the continuing medical necessity and including reasons for the replacement and the reason that repairs are not feasible or are more costly than replacement. Proof of medical necessity should be kept on file by the supplier and made available upon request.

Some services require a specific Certificate of Medical Necessity. The complete list is available at <http://www.eohhs.ri.gov/ProvidersPartners/FormsApplications.aspx>, in the Prior Authorization section.

Proof of Medical Necessity is valid for 12 months from the date of issue.

### Approval of Medical Necessity

The RI Medicaid program and its designees determine which services are medically necessary on a case-by-case basis, both in pre-payment and post-payment reviews, and via prior authorizations. Such determinations are the judgment of the RI Medicaid program. The prescription or recommendation of a physician or other service provider of medical services is required for a determination of medical necessity to be made, but such prescription or recommendation does not mean that the RI Medicaid program will determine the provider's recommendation to be medically necessary. The RI Medicaid program is the final arbiter of determination of medical necessity.

### Denial of Medical Necessity

When the RI Medicaid Program is requested to pay directly (fee-for-service) for a particular service for a beneficiary who has other third party coverage (such as Medicare or Blue Cross), for that particular service, if the third party denies payment for services based on medical necessity, this determination is adopted by the RI Medicaid Program. An independent determination of medical necessity is not made in such circumstances.



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For example, if Medicare determines that a home health service or DME item is not medically necessary, then that determination is binding on the RI Medicaid Program and payment for the service cannot be made.

### Appeal of Denial of Medical Necessity

Determinations made by the RI Medicaid program are subject to appeal by the beneficiary only. Providers may not appeal denials of medical necessity.

Procedures are available for individuals who are aggrieved because of an agency decision or delay in making a decision of medical necessity. Please refer to the RI Medicaid Code of Administrative Rules, Section 0110: Complaints and Hearings.

## SECTION IV – DURABLE MEDICAL EQUIPMENT REIMBURSEMENT

### Claims Billing Guidelines

Durable Medical Equipment (DME) may be rented or purchased based upon the patient's condition and the period of time the equipment will be required. Durable Medical Equipment that is rented on a monthly basis will be specified as to the length of time to be rented. In no instance may the total cost of the rental exceed the total value of the item. In such cases, no further payment of deductible or co-insurance payment will be made by the EOHHS.

Shipping, freight, and delivery travel time are not reimbursable.

DME and Hearing Aid claims should be submitted electronically. If a paper claim must be submitted, it must be billed on a CMS 1500 claim form. Instructions for completing the CMS 1500 form are found on the Claims Processing page at <http://www.eohhs.ri.gov/ProvidersPartners/BillingampClaims/ClaimsProcessing.aspx>.

### Custom Made Equipment and Manually Priced Items

For custom made equipment and manually priced items, RI Medicaid reimburses at the lower of: 75 percent of the retail price; or 120 percent of the actual acquisition cost; or the provider's usual and customary charge (UCR) charged to the general public, including all group, sale, and quantity discounts, whichever is lower.

### Face-to-Face Requirement

Effective 7/1/17, in accordance with the CMS Home Health Final Rule (2348-F), physicians or authorized non physician practitioners (NPP) must document the occurrence of a face-to-face (F2F) encounter with the Medicaid eligible beneficiary. The face-to-face encounter must be related to the primary reason the beneficiary requires

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the medical equipment and the visit must occur no more than 6 months prior to delivery. The documentation must be maintained in the patient's file for a minimum of ten years.

DME providers must have the documentation of both the F2F encounter and the written order on file prior to delivery of these items. The list of DME items subject to the F2F encounter requirement may be viewed at:

[http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/MA%20Providers/MA%20Reference%20Guides/DME/dme\\_face\\_to\\_face\\_list.pdf](http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/MA%20Providers/MA%20Reference%20Guides/DME/dme_face_to_face_list.pdf)

### Investigational/Experimental Services

RI Medicaid does not cover experimental or investigational medical and surgical procedures, equipment, medications, or cosmetic procedures.

RI Medicaid does not cover FDA Category A or B devices or equipment.

Medical devices not approved by the FDA are considered investigational and are not covered by RI Medicaid.

The RI Medicaid Program determines whether a treatment, procedure, facility, equipment, drug, or supply is experimental or investigational.

### Maximum Allowable

The maximum allowable amount for Durable Medical Equipment will be based on the current RI DME Fee Schedule or usual and customary charge (UCR), whichever is lower.

This policy is predicated upon the prudent buyer concept; i.e., not paying more for an item when it can generally be obtained at a lesser cost.

Reimbursement of DME must not exceed the RI Medicaid allowed amount and will pay the lesser of:

- the price as shown in the RI fee schedule for durable medical equipment; or
- the usual and customary price charged to the general public, including all group, sale, and quantity discounts.

Reimbursement of DME with no price listed in the RI fee schedule will pay the lesser of:

- the actual acquisition cost by invoice to the provider after all discounts are applied plus 20%; or 75% of MSRP;

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- the usual and customary price charged to the general public, including all group, sale, and quantity discounts.

### Personal Needs in Nursing Facility or Intermediate Care Facility (ICF)

DME (i.e., wheelchairs, hospital beds, walkers) and supplies other than personal needs (hearing aids, prosthetics/orthotics, braces, stockings, etc.) are not covered in a Nursing Facility or ICF. These services are included in the per diem rate paid to nursing home providers.

### Prior Authorization

When prior authorization is required for a service, the provider of the service is to submit a completed Prior Authorization Request form. This form must be signed and dated by the provider as to the accuracy of the service requested. Attached to this form will be the Proof of Medical Necessity signed by the prescribing provider. When necessary, further documentation should be attached to the Prior Authorization Request form to justify the request.

Prior authorization does not guarantee payment. Payment is subject to all general conditions of RI Medicaid, including beneficiary eligibility, other insurance, and program restrictions.

An approved prior authorization cannot be transferred from one vendor to another. If the beneficiary wishes to change vendors once the prior authorization has been approved, the new vendor will submit another Prior Authorization Request form with a letter from the beneficiary requesting the previous prior authorization be canceled.

For those beneficiary's dually enrolled in the RI Medicaid Program and Medicare, prior authorization is not required for Medicare covered DME services. Providers are required to accept Medicare assignment for all covered DME services. RI Medicaid will reimburse the copay and/or deductible as determined by Medicare up to the RI maximum allowable amount using the lesser of logic, defined under the Maximum Allowable section of this guide.

### Proof of Delivery

#### **Direct from Provider**

RI Medicaid providers may deliver directly to the beneficiary. In this case, proof of delivery (POD) to a beneficiary must include a signed and dated delivery slip.

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The POD record must include:

- Beneficiary name
- Delivery address
- Quantity delivered
- Date delivered and;

A detailed description of the item/s delivered including the brand name.

- Beneficiary (or designee) signature and date of signature. The date of signature on the delivery slip and the date of service on the claim must be the date that the DME item was received by the beneficiary or designee.

For the delivery method noted: a designee is defined as any person who can sign and accept the delivery of DME on behalf of the beneficiary.

RI Medicaid will accept the member's mark or a signature stamp as proof of delivery on behalf of a member whose disability inhibits the member's ability to write.

Suppliers, their employees, or anyone else having a financial interest in the delivery of the item are prohibited from signing and accepting an item on behalf of a beneficiary. The signature of the designee should be legible. If the signature of the designee is not legible, the supplier/shipping service should note the name of the designee on the delivery slip.

#### **Delivery via Shipping service**

For durable medical equipment that is delivered to a beneficiary by a shipping service, the DME provider is responsible for maintaining in the beneficiary's record a copy of the delivery services tracking slip attached to the provider's shipping invoice. The shipping invoice must include:

- Beneficiary name
- Delivery Address
- Quantity delivered
- Date delivered

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- A detailed description of the items delivered including the brand name and if applicable, the serial number; and
  - The delivery service's package identification number.

If the provider utilizes a shipping service or mail order, provider have two options for the DOS to use on the claim.

1. Providers may use shipping date as DOS
2. Providers may use date of delivery as DOS on claim.

Please refer to the RI Medicaid General Guidelines Manual for record retention guidelines located on the EOHHS website at:

<http://www.eohhs.ri.gov/ProvidersPartners/ProviderManualsGuidelines/MedicaidProviderManual.aspx>

### Refill Requirements

For DME products that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill and not automatically ship on a pre-determined basis, even if authorized by the beneficiary. This shall be done to ensure that the refilled item remains reasonable and necessary, existing supplies are approaching exhaustion, and to confirm any changes/modifications to the order. Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery /shipping date or delivery of refills.

### Service and Repair

Service and repair charges are included in the equipment rental fee. If the equipment is patient-owned and it is not under warranty, RI Medicaid will cover the charge for service and repair.

### Service Limits

Selected items of medical/surgical supplies, durable medical equipment, orthotics, prosthetics and orthopedic footwear may have limits in the amount and frequency that they can be dispensed to an eligible beneficiary. If a beneficiary exceeds the limit on an item, prior approval must be requested with accompanying medical documentation as to why the limits need to be exceeded.

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## SECTION V- SCREENING LIST AND COVERED SERVICES

### Screening List

A screening list can be found on the EOHHS website at:

[http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/screening\\_list\\_DME.pdf](http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/screening_list_DME.pdf) or in the Appendix.

### Covered Services

Coverage Guidelines for the covered DME items is also found on the website at:

<http://www.eohhs.ri.gov/ProvidersPartners/ProviderManualsGuidelines/MedicaidProviderManual/DME/CoverageGuidelinesforDurableMedicalEquipment.aspx> or in the Appendix.

## APPENDIX

[DME and Hearing Aids – CMS 1500 Claim form](#)

[CMS1500 Claim Form Instructions](#)

[Prior Authorization Forms](#)

[ESC Code List \(English\)](#)

[EOB Codes and Messages List \(English\)](#)

[EOB Codes and Messages List \(Spanish\)](#)

[Third Party Liability \(TPL\) Carrier Codes](#)

[Third Party Liability Coverage Codes](#)