Home Health Final Rule
Non-covered DME and POS Items for Adults

As indicated in the July 2017 Medicaid Bulletin, Durable Medical Equipment and Orthotics/Prosthetics (DMEPOS) policies 5A-1, 5A-2, 5A-3 and 5B have been updated to comply with the Centers for Medicare & Medicaid Services (CMS) Home Health Final Rule, 42 CFR Part 440.70. Below are guidelines for providers when requesting medical necessity reviews for non-covered DMEPOS items for adults.

1. The general requirements and criteria set forth in clinical coverage policies 5A-1, 5A-2, 5A-3 or 5B must be met. This includes, but is not limited to:

    a. The item being requested must fit the definition of either Durable Medical Equipment (DME), medical supplies, orthotics or prosthetics; and,
    b. The beneficiary must be enrolled in the N.C. Medicaid program and be eligible for DMEPOS items; and,
    c. The provider must be enrolled in the N.C. Medicaid program with an appropriate taxonomy; and,
    d. The requested item must be safe, effective, economical and not intended for the convenience of the beneficiary, the beneficiary's caregiver, or the provider; and,
    e. The item must be medical in nature, generally recognized as an accepted method of treatment, and must not be experimental or investigational; and,
    f. The item must be ordered by a physician, physician assistant, or nurse practitioner; and,
    g. The item must be medically necessary to maintain or improve a beneficiary's medical, physical or functional level, and appropriate for use in any non-institutional setting in which normal life activities take place; and,
    h. A documented face-to-face encounter with the beneficiary and the ordering physician, physician assistant, or nurse practitioner related to the primary reason the beneficiary requires DME and supplies must have occurred no more than six months prior to the initiation of DME and supplies; and
    i. The beneficiary's need for DME and supplies must be reviewed by the ordering physician, physician assistant, or nurse practitioner at least annually.

2. If the provider determines that the applicable requirements and criteria set forth in the related DMEPOS clinical coverage policy have been met, then the provider may submit a completed Certificate of Medical Necessity/Prior Approval (CMN/PA) and the usual supportive prior authorization documentation, including the documentation required for manual pricing (see May 2017 Medicaid Bulletin for details), to the N.C. Division of Medical Assistance (DMA) for a medical necessity review.

3. The documentation should be **faxed to DMA at 919-715-1255** with a cover sheet to the attention of the **DME unit**. **Do not** submit these requests through NCTracks.

4. The same timelines for review used by CSRA may also apply to this medical necessity review process.

5. If approved, the provider will be notified and given instructions for submitting claims.

6. If denied, the provider and beneficiary will be notified, and normal beneficiary appeal rights will apply.

7. Providers will be notified if the item requested is covered by a different N.C. Medicaid policy area or waiver program.

Additional Resources

For additional information, link to the DMA Durable Medical Equipment web page, the DMA Medical Equipment Clinical Coverage Policies web page, and the CMS final rule at 42 CFR Part 440.70.