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OMIG AUDIT PROTOCOL DURABLE MEDICAL EQUIPMENT (DME)

EFFECTIVE 06/14/2013

Audit protocols assist the Medicaid provider community in developing programs to evaluate compliance with Medicaid requirements under federal and state statutory and regulatory law. Audit protocols are intended solely as guidance in this effort. This guidance does not constitute rulemaking by the New York State Office of the Medicaid Inspector General (OMIG) and may not be relied on to create a substantive or procedural right or benefit enforceable, at law or in equity, by any person. Furthermore, nothing in the audit protocols alters any statutory or regulatory requirement and the absence of any statutory or regulatory requirement from a protocol does not preclude OMIG from enforcing the requirement. In the event of a conflict between statements in the protocols and either statutory or regulatory requirements, the requirements of the statutes and regulations govern.

A Medicaid provider's legal obligations are determined by the applicable federal and state statutory and regulatory law. Audit protocols do not encompass all the current requirements for payment of Medicaid claims for a particular category of service or provider type and, therefore, are not a substitute for a review of the statutory and regulatory law. OMIG cannot provide individual advice or counseling, whether medical, legal, or otherwise. If you are seeking specific advice or counseling, you should contact an attorney, a licensed practitioner or professional, a social services agency representative, or an organization in your local community.

Audit protocols are applied to a specific provider type or category of service in the course of an audit and involve OMIG's application of articulated Medicaid agency policy and the exercise of agency discretion. Audit protocols are used as a guide in the course of an audit to evaluate a provider's compliance with Medicaid requirements and to determine the propriety of Medicaid expended funds. In this effort, OMIG will review and consider any relevant contemporaneous documentation maintained and available in the provider's records to substantiate a claim.

OMIG, consistent with state and federal law, can pursue civil and administrative enforcement actions against any individual or entity that engages in fraud, abuse, or illegal or improper acts or unacceptable practices perpetrated within the medical assistance program. Furthermore, audit protocols do not limit or diminish OMIG's authority to recover improperly expended Medicaid funds and OMIG may amend audit protocols as necessary to address identified issues of non-compliance. Additional reasons for amending protocols include, but are not limited to, responding to a hearing decision, litigation decision, or statutory or regulatory change.

OMIG AUDIT PROTOCOL – DURABLE MEDICAL EQUIPMENT (DME)

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1.	No Written Order
OMIG Audit Criteria	If a written order is missing, the paid claim will be disallowed.
Regulatory References	18 NYCRR Section 505.5(b)(1) NYS Medicaid Program Durable Medical Equipment Manual, Policy Guidelines, Version 2004-1, Section III Version 2009-2, Section III
2.	No Documentation of Service
OMIG Audit Criteria	The provider must prepare and maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program. The records must be kept for a period of six years. If the service cannot be documented, the paid claim will be disallowed.
Regulatory References	18 NYCRR Section 505.5(c)(2) 18 NYCRR Section 504.3(a) 18 NYCRR Section 540.7(a)(8) 18 NYCRR Section 517.3 NYS Medicaid Program Provider Manual Information for all Providers, Version 2004-1, Section II Version 2008-2, Section II
3.	Durable Medical Equipment Billed in Excess of the Maximum Allowance
OMIG Audit Criteria	Reimbursement of durable medical equipment must not exceed the lower of: the price shown in the fee schedule for durable medical equipment; or the usual and customary price charged to the general public. If the paid claim exceeds the maximum allowance, the amount exceeding the maximum will be disallowed.
Regulatory References	18 NYCRR Section 505.5(d)(2)(i)(a) and (b) NYS Medicaid Program Durable Medical Equipment Manual, Policy Guidelines, Version 2004-1, Section III NYS Medicaid Program Durable Medical Equipment Manual, Procedure Codes, Version 2008-1, Section 4.0

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4.	Medical/Surgical Supplies Billed in Excess of the Maximum Allowance
OMIG Audit Criteria	Payment for medical/surgical supplies listed in the Medicaid Durable Medical Equipment Manual must not exceed the lower of: the price shown in the New York State List of Medical/Surgical Supplies or the usual and customary price charged to the general public. Reimbursement of medical/surgical supplies listed in the Medicaid Durable Medical Equipment Manual must not exceed the lower of: the price shown in the New York State List of Medical/Surgical Supplies or the usual and customary price charged to the general public. Reimbursement of medical/surgical supplies not listed in the MMIS Manual must not exceed the lower of: the acquisition cost to the provider plus 50%, or the usual and customary charge to the general public. If the paid claim exceeds the maximum allowance, the amount exceeding the maximum will be disallowed.
Regulatory References	18 NYCRR Section 505.5(d)(3)(i) NYS Medicaid Program Durable Medical Equipment Manual, Procedure Codes, Version 2008-1, Section 4.0
5.	Oxygen Services Billed in Excess of the Maximum Allowance
OMIG Audit Criteria	Payment for oxygen must not exceed the lower of: the acquisition cost * to the provider plus 50%; or the usual and customary price charged to the general public. If the paid claim exceeds the maximum allowance, the amount exceeding the maximum will be disallowed. *Acquisition cost is established by invoice, detailing the line item cost to the provider from a manufacturer or wholesaler net of any rebates, discounts or valuable consideration as well as net of mailing, shipping, handling, insurance costs or any sales tax.
Regulatory References	18 NYCRR Section 505.5(d)(6)
6.	Item Billed in Excess of Quantity Ordered
OMIG Audit Criteria	The order must meet the requirements of a prescription under Section 6810 of the Education Law. When used in the context of a non-prescription item, the order must also contain the quantity ordered. If the paid claim is for a quantity exceeding what was ordered, the difference between the quantity on the claim and the quantity on the order will be disallowed.
Regulatory References	18 NYCRR Section 505.5(b)(3)

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7.	Item Billed Does Not Match Ordered Item
OMIG Audit Criteria	The order must meet the requirements of a prescription under Section 6810 of the Education Law. When used in the context of a non-prescription item, the order must also contain the name of the item. If the paid claim is for a different item than ordered, the paid claim will be disallowed.
Regulatory References	18 NYCRR Section 505.5(b)(3)
8.	No Signature on Written Order
OMIG Audit Criteria	<p>If the prescriber’s signature is missing on a written or fiscal order, the paid claim will be disallowed.</p> <p>Auditors will accept contemporaneous electronic signature equivalents; this can include a digitized signature, a verification/authentication number, or a printed name on the electronic order.</p>
Regulatory References	<p>18 NYCRR Section 505.5(a)(8)</p> <p>NYS Medicaid Program Durable Medical Equipment Manual, Policy Guidelines, Version 2004-1, Section III</p> <p>Version 2009-2, Section III</p>
9.	Missing Information on Written Order
OMIG Audit Criteria	The order must meet the requirements of a prescription under Section 6810 of the Education Law. When used in the context of a non-prescription item, the order must also contain the following information: patient name; name of the item; quantity ordered; size, if necessary; catalog number, if necessary; directions for use, if required, and number of refills, if any. If the written order is lacking this information, the paid claim will be disallowed.
Regulatory References	<p>18 NYCRR Section 505.5(b)(2)</p> <p>18 NYCRR Section 505.5(b)(3)</p>

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10.	Medical/Surgical Supplies Provided in Excess of the Allowable Number of Refills
OMIG Audit Criteria	The maximum number of refills permitted for medical/surgical supplies is found in the fee schedule for durable medical equipment, medical/surgical supplies, orthotic and prosthetic appliance and orthopedic footwear. The number of refills must not exceed the number that appears on the fiscal order. If the paid claim is not covered by the number of refills on the fiscal order, the paid claim will be disallowed.
Regulatory References	18 NYCRR Section 505.5(b)(4)(ii) NYS Medicaid Program Durable Medical Equipment Manual, Policy Guidelines, Version 2004-1, Section III Version 2009-2, Section III

11.	Original Order Filled Beyond Acceptable Timeframe
OMIG Audit Criteria	Paid services will be disallowed if a fiscal order for medical-surgical supplies is filled more than 60 days after the date of the written order, unless prior approval is required. If the item is not dispensed within the time frame listed on the prior approval the paid claim will be disallowed.
Regulatory References	NYS Medicaid Program Durable Medical Equipment, Fee Schedule Version 2005-1, Section 4.0 NYS Medicaid Program Durable Medical Equipment Manual, Procedure Codes, Version 2008-1, Section 4.0

12.	Order Refilled More Than 180 Days After It Has Been Initiated by the Prescriber
OMIG Audit Criteria	Paid claims will be disallowed if a fiscal order is refilled more than 180 days after the date of the written order. (Except Oxygen. See Protocol #24, which states: “Oxygen therapy must be re-ordered once every 12 months or more frequently if the patient’s need for oxygen changes.”)
Regulatory References	18 NYCRR Section 505.5(b)(4)(iii)

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13.	Unqualified Ordering Practitioner
OMIG Audit Criteria	The ordering of durable medical equipment, medical/surgical supplies, orthotic and prosthetic appliances and devices and orthopedic footwear is limited to the practitioner’s scope of practice. Qualified practitioners are defined as physicians, dentists, podiatrists, physician assistants, and nurse practitioners. Ordering is limited to the practitioner’s scope of practice. If the practitioner signing the fiscal order is not qualified to order the items related to the paid claim, the claim will be disallowed.
Regulatory References	18 NYCRR Section 505.5(b)(1)(i) 18 NYCRR Section 505.5(a)(6)
14.	Missing Documentation Confirming Receipt/Delivery of Item
OMIG Audit Criteria	Written orders and supporting documentation such as invoices and delivery receipts must be kept on file for six years from the date the service was furnished or billed, whichever is later. If there is not sufficient documentation of delivery of the billed item, the paid claim will be disallowed.
Regulatory References	18 NYCRR Section 505.5(c)(2) 18 NYCRR Section 504.3(a) 18 NYCRR Section 540.7(a)(8) 18 NYCRR Section 517.3 NYS Medicaid Program Durable Medical Equipment Manual, Policy Guidelines, Version 2004-1, Section I Version 2009-2, Section I
15.	Billing of Item Prior to Delivery
OMIG Audit Criteria	A disallowance will be taken if an item/service (including refills) is billed prior to being furnished.
Regulatory References	NYS Medicaid Program Durable Medical Equipment Manual, Policy Guidelines, Version 2004-1, Section III Version 2009-2, Section III

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16.	No Explanation of Benefits (EOB)/Documentation for Medicare Covered Items
OMIG Audit Criteria	All charges must first be billed to Medicare. The provider must bill Medicare or any other insurance first for <i>covered</i> services <i>prior</i> to submitting a claim to Medicaid. Only after an EOB is received from the Medicare intermediary and payment made, where appropriate, may a claim be submitted for Medicaid reimbursement. The provider must maintain the EOB on file for six years following the date of payment for audit purposes. If the recipient is Medicare eligible and there is no EOB produced for an item covered by Medicare, the paid claim will be disallowed.
Regulatory References	NYS Medicaid Program Durable Medical Equipment Manual, Policy Guidelines, Version 2004-1, Section III Version 2009-2, Section III DOH <i>Medicaid Update</i> , December 2005, Vol 20, No. 13
17.	Other Insurance Payments Not Applied
OMIG Audit Criteria	Any insurance payments, including Medicare, must be applied against the total price of the item. If the amount paid by third party insurance is not applied, the difference between the paid claim and the appropriate claim amount, had the insurance payment been applied, will be disallowed.
Regulatory References	18 NYCRR Section 505.5(d)(1)(v) 18 NYCRR Section 360-7.2
18.	Incorrect Procedure Code Billed
OMIG Audit Criteria	An overpayment includes any amount not authorized to be paid under the medical assistance program, whether as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake. If the incorrect procedure code is billed, the difference between the paid claim amount and the amount related to the correct procedure code will be disallowed.
Regulatory References	18 NYCRR Section 505.5(d)(2)(i)(a) 18 NYCRR Section 518.1(c) NYS Medicaid Program Durable Medical Equipment Manual, Policy Guidelines, Version 2004-1, Section III Version 2009-2, Section III

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19.	Billed Item Included in a Facility’s Rate
OMIG Audit Criteria	Payment will not be made for items provided by a facility or organization when the cost of these items is included in the rate. It is the dispensing provider’s responsibility to verify with the facility whether the item is included in the facility’s Medicaid rate. If the item is included in the facility’s Medicaid rate then the dispensing provider should bill the facility.
Regulatory References	18 NYCRR Section 505.5(d)(1)(iii) NYS Medicaid Program Durable Medical Equipment Manual, Policy Guidelines, Version 2004-1, Section III Version 2009-2, Section III
20.	Rental Amount Exceeded Purchase Price of Item
OMIG Audit Criteria	The total accumulated monthly rental charges may not exceed the actual purchase price of the item. Rental payment includes all necessary equipment, delivery, maintenance and repair costs, parts, supplies and services for equipment set-up, maintenance of worn essential accessories or parts. If the paid claim results in the accumulated rental charges exceeding the purchase price, the excess amount will be disallowed. This finding does not apply to oxygen rentals.
Regulatory References	18 NYCRR Section 505.5(d)(2)(iv) NYS Medicaid Program Durable Medical Equipment Manual, Policy Guidelines, Version 2004-1, Section III Version 2009-2, Section III
21.	Quantity Dispensed Exceeded Maximum Monthly Allowance
OMIG Audit Criteria	The quantity dispensed should not exceed the maximum allowed per month. If the fiscal order quantity exceeds the maximum allowable monthly amount, the provider must obtain prior approval. If there is no prior approval for the quantity exceeding the maximum allowable per month the excess quantity will be disallowed.
Regulatory References	NYS Medicaid Program Durable Medical Equipment Manual, Procedure Codes, Version 2008-1, Section 4.0 Version 2011-1, Section 4.0

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22.	Duplicate Payment
OMIG Audit Criteria	An overpayment includes any amount not authorized to be paid under the medical assistance program, whether as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake. If the paid claim is a duplicate payment it will be disallowed.
Regulatory References	18 NYCRR Section 518.1(c) NYS Medicaid Program Provider Manual Information for all Providers, Version 2004-1, Section II Version-2008-2, Section II
23.	Unqualified Dispenser
OMIG Audit Criteria	<p>Medical/surgical supplies, durable medical equipment, orthopedic footwear, prosthetic and orthotic appliances and devices must be dispensed by a provider who is licensed / registered by the appropriate authority, if existing, in the state in which the provider is located. If the item related to the paid claim was dispensed by an unqualified dispenser, the claim will be disallowed.</p> <p>Orthopedic footwear must be dispensed by an employee who has certification from one of the following:</p> <ul style="list-style-type: none"> • the American Board of Certification in Orthotics, and Prosthetics; • the Board for Certification in Pedorthics, or • the Board for Orthotist Certification.
Regulatory References	18 NYCRR Section 505.5(d)(5)(ii) NYS Medicaid Program Durable Medical Equipment Manual, Policy Guidelines, Version 2004-1, Section I Version 2009-2, Section I
24.	Oxygen Therapy Order Refilled Beyond 12 Months of Issuance
OMIG Audit Criteria	Oxygen therapy must be re-ordered once every 12 months or more frequently if the patient's need for oxygen changes. If the paid claim relates to a refill of an item related to oxygen therapy beyond the 12 month from order date limit, it will be disallowed.
Regulatory References	NYS Medicaid Program Durable Medical Equipment Manual, Policy Guidelines, Version 2004-1, Section II NYS Medicaid Program Durable Medical Equipment Manual, Procedure Codes Version 2009-4, Section 4.4

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25.	Billed Service Date After Patient’s Death
OMIG Audit Criteria	The provider must submit claims for payment only for services actually furnished and which were medically necessary. If work was initiated on custom equipment before a change in eligibility (including death), the claim is payable and the order date should be reported as the date of service. If the paid claim was for a date of service after the patient’s death and does not relate to the custom equipment exception, it will be disallowed.
Regulatory References	18 NYCRR Section 504.3(e)
26.	Improper Medicaid Billings for Medicare Crossover Patients
OMIG Audit Criteria	All charges must first be billed to Medicare. Medicaid will pay, on behalf of qualified Medicare beneficiaries, the full amount of any deductible, and coinsurance. Medicaid will pay the difference between the Medicare approved amount and the Medicare paid amount. The provider must include the same information on the Medicaid claim as is represented on the EOB, including Medicare approved and paid amounts as well as procedure codes and modifiers. If the paid claim amount is incorrect due to the incorrect Medicare payment information being submitted on the claim, the difference between the paid claim amount and the correct claim amount will be disallowed.
Regulatory References	18 NYCRR Section 360-7.2 18 NYCRR Section 360-7.7(a) NYS Medicaid Program Durable Medical Equipment Manual Policy Guidelines, Version 2004-1, Section III Version 2009-2, Section III

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27.	Ordering Prescriber Conflicts with Claim Prescriber
OMIG Audit Criteria	<p>A claim identifies the prescriber by either: a Medicaid Provider ID number, a license number with profession code, or an NPI number</p> <p><u>Prior to October 1, 2009:</u> The ordering provider’s Medicaid ID number should be used; if the ordering provider is not enrolled in Medicaid, the provider’s license number is used. When the order originates from a hospital or clinic, and is written by an intern or resident, the supervising physician’s Medicaid ID number is used. If the supervising physician is not enrolled in the Medicaid program, then his/her state license number may be used instead. When the order is originated in an Article 28 facility and these numbers are unavailable, it is permissible to use the facility’s Medicaid ID number.</p> <p><u>For October 1, 2009 and Forward:</u> The ordering and the referring provider’s National Provider Identifier (NPI) must be used. A facility ID cannot be used for the Ordering/Referring Provider. In those instances where a service was ordered by a facility, the NPI of a practitioner at the facility ordering the service must be used.</p>
Regulatory References	<p>18 NYCRR Section 505.5(c)(1) NYS Medicaid Program Durable Medical Equipment Manual, Billing Guidelines, Version 2004-1, Section II Version 2009-1, Section II Version 2009-2, Section II</p>

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28.	Telephone or Fax Order Lacks Signed Follow Up Order
OMIG Audit Criteria	<p>In the event an order for durable medical equipment, medical-surgical supplies, or orthotic or prosthetic supply has been telephoned or faxed to the provider, it is the provider’s responsibility to obtain the signed fiscal order from the ordering practitioner within 30 calendar days. A fiscal order written for DMEPOS on an Official NYS Serialized Prescription Form and faxed to the DMEPOS provider will be considered an original order. When an order for DMEPOS not written on the serialized official prescription form has been telephoned or faxed to the provider, it is the DME or Pharmacy provider’s responsibility to obtain the original signed fiscal order from the ordering practitioner within 30 calendar days. If the telephone or faxed fiscal order was not on the Official NYS Prescription Form and the original signed order has not been obtained within 30 days, the paid claim will be disallowed.</p> <p>Effective October 1, 2009, an electronically transmitted fiscal order for DMEPOS will be considered an original fiscal order when the following requirements are met:</p> <ul style="list-style-type: none"> • The order must originate from the practitioner’s computer and must be directly transmitted to the DME provider’s computer or fax.
Regulatory References	NYS Medicaid Program Durable Medical Equipment Manual Policy Guidelines, Version 2004-1, Section I Version 2009-2, Section I

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