Priority Health	BILLING POLICY No. 087
DME REFILL REQUIREMENTS	
Date of origin: Apr. 15, 2025	**Review dates: None yet recorded**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise specified
- Medicaid follows MDHHS unless otherwise specified

DEFINITION

A provider may determine a patient's expected, ongoing medical need and write an order for DMEPOS for immediate use and refills for later dates. Before refilling orders for DMEPOS products, suppliers must contact the patient to make sure a refill is needed. Don't automatically ship a refill on a pre-determined basis.

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

For refills of enteral and parenteral nutrients and supplies, immunosuppressive drugs, intravenous immune globulin, oral anti-cancer drugs, oral antiemetic drugs and surgical dressings only a one-month quantity of supplies may be dispensed.

For all other refills that are provided on a recurring basis, suppliers may dispense no more than a three-month supply at any one time.

For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the expected end of the current supply, regardless of which delivery method is used.

Documentation requirements

Evidence that the patient or their representative has confirmed their need to refill the supplies within 30 calendar days from the expected end of the current supply. Patients don't have to count the remaining supply.

For shipped items, the following is required before shipping the product:

- Patient's name
- Date of contact
- Item requested
- Confirmation from the patient
- Explanation of the need for the refill

For items obtained in-person from a retail store, one of the following can be considered as sufficient documentation for a refill request:

- Delivery slip signed by the patient or their representative
- Copy of the itemized sales receipt

Resources

- Items Provided on a Recurring Basis and Request for Refill Requirements – Annual Reminder – January 2024
- MM13480 - Refillable DMEPOS Documentation Requirements

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made