



## DATABASE INSTRUCTIONS

### Medical Supplier/DME/Prosthetics and Orthotics (DMEPOS)

This document contains information for interpreting this Michigan Medicaid database. Providers are instructed to refer to the Michigan Medicaid Provider Manual and/or MSA Bulletins for specific coverage, reimbursement policies, and required forms. To access this information via the MDCH website, click hyperlink: [Medicaid Policy & Forms](#).

The database is available in two formats:

- PDF excel file for viewing and/or printing a page
- An Excel file for downloading data onto your computer

Data elements and descriptions for this database are as follows:

Data Element	Description
HCPCS Code	The HCPCS Level I (CPT) or Level II code used to denote a service.
Modifier (R-Mod)	<p>Completed when a modifier identifies a set fee screen. A blank will appear for services, other than those identified below, and designates a purchase.</p> <p>BO = orally administered nutrition, not by feeding tube</p> <p>KH = DMEPOS item, initial claim, purchase or first month rental (Use with HCPCS code E0604 only if kit is provided)</p> <p>MS = six-month maintenance and servicing fee (report for HCPCS codes E0193 or E0194 only)</p> <p>RA = replacement of a DME item - RA modifier was removed from the database as information is duplicative to the purchase. RA must still be reported on the claim when applicable.</p> <p>RB = replacement of a part of DME furnished as part of a repair</p> <p>RR = rental (use when DME is to be rented)</p> <p>SH = second concurrently administered infusion therapy</p> <p>SJ = third concurrently administered infusion therapy</p> <p>U3 = Used with B4087 for low profile ext.</p> <p>U4 = Pediatric Supply Item/select procedure codes</p>
Modifier (I-Mod)	<p>Completed when a modifier is required for payment.</p> <p>A1 = dressing for one wound</p> <p>A2 = dressing for two wounds</p> <p>A3 = dressing for three wounds</p> <p>A4 = dressing for four wounds</p> <p>A5 = dressing for five wounds</p> <p>A6 = dressing for six wounds</p> <p>A7 = dressing for seven wounds</p> <p>A8 = dressing for eight wounds</p> <p>A9 = dressing for nine or more wounds</p> <p>K0 = Lower extremity prosthesis functional level 0 – does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility.</p> <p>K1 = Lower extremity prosthesis functional level 1 – has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.</p> <p>K2 = Lower extremity prosthesis functional level 2 – has the ability or potential for</p>



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	<p>ambulation with the ability to traverse low level environmental barriers such as curbs stairs or uneven surfaces. Typical of the limited community ambulator.</p> <p>K3 = Lower extremity prosthesis functional level 3 – has the ability or potential for ambulation with variable cadence. Typical of the community ambulatory who has the ability to transverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.</p> <p>LT = left side RT = right side</p>
Short Description	<p>The short description of the service associated with the HCPCS code.</p> <p><b>(RO)</b>=This is a replacement only procedure code.</p>
HCPCS Action Code	<p>Action code indicates the new action taken since last published database, if applicable. If cell is blank, no change has occurred.</p> <p>A = Add procedure or modifier code D = Discontinue procedure, or modifier code P = Payment change R = Re-activate discontinued/deleted procedure or modifier code</p>
Maximum Fee	<p>Represents the maximum fee screen Medicaid will pay for the service. If there is an "M" in the fee field, the code is manually priced and requires additional information. For items that do not have established fee screens or are custom fabricated, the reimbursement will be acquisition cost plus 17% over cost.</p>
Age	<p>Age range in which coverage of the item is considered. A blank cell is indicative that all ages apply.</p>
Limits	<p>Indicates the maximum quantity of a service that may be reimbursed within the time frame indicated unless an additional quantity has been prior authorized. This field may also indicate the maximum dollar amount that may be reimbursed within the time frame designated. Established limits for procedure codes with required Left (LT) and Right (RT) modifiers are based on the maximum services allowed for each side of the body.</p>
Nursing Facility Per Diem (NF)	<p>Indicates "Y" or "N" as to whether the item is considered as part of the nursing facility per diem rate. If "Y" is indicated, the medical supplier should not bill the item.</p>
ABC Certification (ABC)	<p>Indicates "Y" or "N" if ABC Certification is required to provide service.</p>
Prior Authorization (PA)	<p>Indicates "Y" or "N" if code requires Prior Authorization.</p>
PA MPRO	<p>Indicates "Y***" or "N" if item requires PA through MPRO <b>only</b> if a medical reason requires services greater than the allotted quantity/frequency limit. Contact MPRO for authorization.</p>
PA AGE	<p>Age range in which PA is required. A blank cell is indicative that all ages apply.</p>
Diagnosis	<p>Indicates the diagnoses codes representing medical conditions that bypass the PA requirement.</p>



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Comments	Indicates if additional pertinent data and/or documentation is required for claim submission (or) provides clarification of HCPCS code revisions.  Revised = denotes revisions to HCPCS codes other than reflected by an action code since last published database, if applicable.

Questions on the database should be directed to Provider Inquiry by phone at 1-800-292-2550 or e-mail to [ProviderSupport@michigan.gov](mailto:ProviderSupport@michigan.gov). Include your name, affiliation and phone number for contact information.