Client needs DME (not including specialized equipment/supplies or bathroom equipment)

1. The client gets a Rx from their MD (with the family or CM assisting, as necessary).
2. The client provides the Rx to the DME vendor.

If client is covered by private insurance, Medicare or Medicaid:

- If the item is a covered benefit, DME vendor bills insurance or Medicare.
- If not covered by Medicare or denied:
  - If approved:
    - The vendor bills Medicaid (MCO or HCA).
    - If the item is covered, it may require a Limitation Extension or Prior Authorization.
    - Some items may require an ETR.
  - If denied:
    - The case worker verifies the denial in ProviderOne.

If item is never covered by Medicare/Medicaid or The client is not covered by Medicare/Medicaid:

- The vendor claims in P1.
- After verifying the client received the item, the case worker changes the authorization’s status to “Approved”.

Vendor provides the item to the client.

NOTE: The DME provider can submit a quote to the case worker along with a copy of the prescription from the client’s medical provider. A signature returned from the case worker is acknowledgement that a social services authorization will be created if all other payor sources deny. The item will be reimbursed at the Medicaid rate (which must be noted by the case worker).