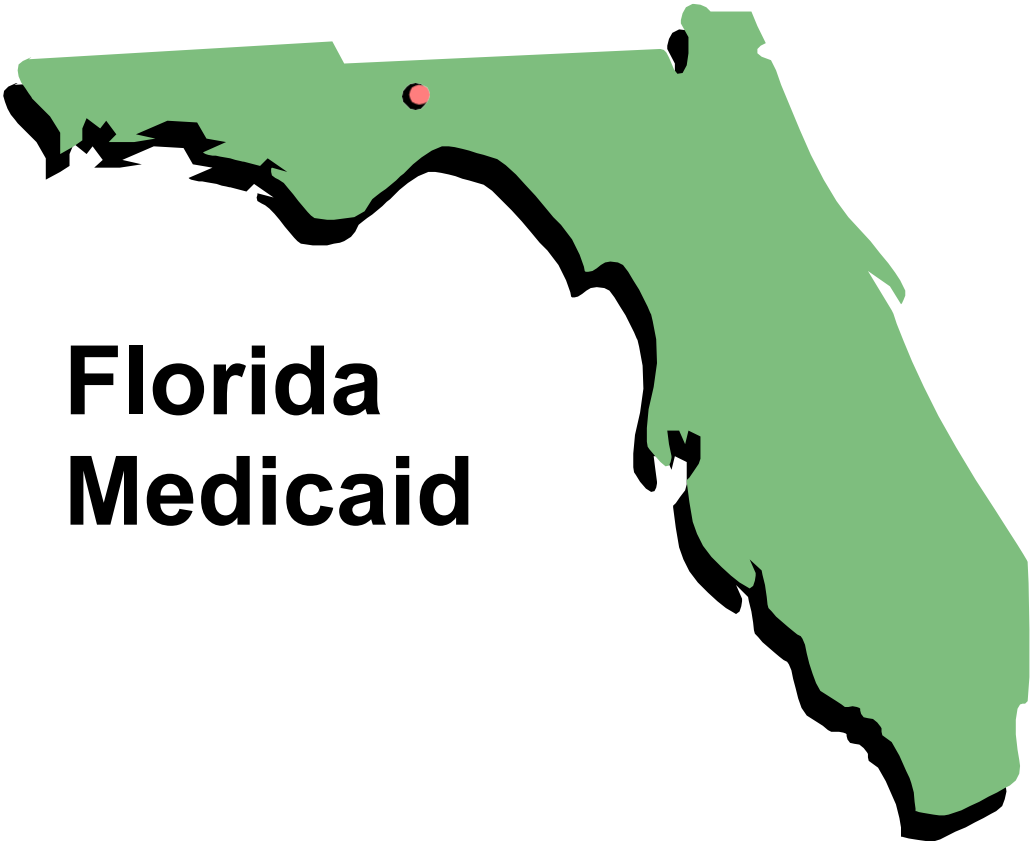

Florida Medicaid

Durable Medical Equipment and Medical Supply Services Coverage Policy: Specialized

Agency for Health Care Administration

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1.0 Introduction

Florida Medicaid specialized durable medical equipment and medical supply (DME) services provide medically necessary devices and items that are unique from other DME classifications.

1.1 Florida Medicaid Policies

This policy is intended for use by providers that render specialized DME services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid's General Policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency for Health Care Administration's (AHCA) website at http://ahca.myflorida.com/Medicaid/review/index.shtml.

1.2 Statewide Medicaid Managed Care Plans

Florida Medicaid managed care plans must comply with the service coverage requirements outlined in this policy, unless otherwise specified in the AHCA contract with the Florida Medicaid managed care plan. The provision of services to recipients enrolled in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies.

1.3 Legal Authority

Florida Medicaid specialized DME services are authorized by the following:

- Title XIX of the Social Security Act (SSA) Section 1902
- Title 42, Code of Federal Regulations (CFR) Part 440
- Section 409.906, Florida Statutes (F.S.)

1.4 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to Florida Medicaid's Definitions Policy.

1.4.1 Certificate of Medical Necessity (CMN)

Documentation signed by the ordering practitioner to establish a recipient's need for certain durable medical equipment. The CMN states the recipient's diagnosis, prognosis, reason for the equipment, and estimated duration of need.

1.4.2 Claim Reimbursement Policy

A policy document found in Rule Division 59G, F.A.C. that provides instructions on how to bill for services.

1.4.3 Coverage and Limitations Handbook or Coverage Policy

A policy document found in Rule Division 59G, F.A.C. that contains coverage information about a Florida Medicaid service.

1.4.4 General Policies

A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1, F.A.C. containing information that applies to all providers (unless otherwise specified) rendering services to recipients.

1.4.5 Provider

The term used to describe any entity, facility, person, or group enrolled with AHCA to furnish services under the Florida Medicaid program in accordance with the provider agreement.

1.4.6 Recipient
For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

2.0 Eligible Recipient

2.1 General Criteria
An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy.

Provider(s) must verify each recipient's eligibility each time a service is rendered.

2.2 Who Can Receive
Florida Medicaid recipients requiring medically necessary specialized DME services. Some services may be subject to additional coverage criteria as specified in section 4.0.

2.3 Coinsurance and Copayments
There is no coinsurance or copayment for this service in accordance with section 409.9081, F.S. For more information on copayment and coinsurance requirements and exemptions, please refer to Florida Medicaid's Copayments and Coinsurance Policy.

3.0 Eligible Provider

3.1 General Criteria
Providers must meet the qualifications specified in this policy in order to be reimbursed for Florida Medicaid specialized DME services.

3.2 Who Can Provide
Services must be rendered by one of the following:

- Durable medical equipment and supply services businesses fully licensed in accordance with Chapter 400, F.S.
- Inpatient and outpatient hospitals and ambulatory surgical centers
  - These facilities may only provide surgically implanted devices listed in section 4.2.6
- Orthopedic physicians' groups that supply orthotic and prosthetic devices not included in a physician's office visit
- Pharmacies fully licensed in accordance with Chapter 465, F.S.

4.0 Coverage Information

4.1 General Criteria
Florida Medicaid covers services that meet all the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria
Florida Medicaid covers specialized durable medical equipment and medical supply services in accordance with the American Medical Association's Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS), and the applicable Florida Medicaid fee schedule(s), or as specified in this policy.

Florida Medicaid covers custom and specialized equipment when a less costly alternative is not available to fulfill the recipient's need.

Florida Medicaid-covered DME must include a manufacturer's or one-year warranty, whichever is greater.

4.2.1 Augmentative and Alternative Communication Systems

Medicaid covers speech-generating devices and software that allow recipients with severe expressive communication disorders to communicate. The recipient must have the physical, cognitive, and language abilities necessary to operate the AAC device, as documented in an evaluative report and individualized action plan developed by a speech-language pathologist who is licensed in accordance with Chapter 468, Part I, F.S. and meets the requirements of 42 CFR 440.110.

Recipients residing in a skilled nursing facility are eligible to receive AAC devices through this benefit.

Florida Medicaid coverage of an AAC device includes the following service components:

- The AAC device or software
- Modifications to adapt the AAC device to the physical characteristics of the recipient
- The programming necessary to meet the recipient's functional communication needs

Prior to filing a claim for an AAC device, the DME provider must ensure the selected device and all components/accessories have been delivered to the recipient and are operational. Prior to the delivery of the AAC device, the provider must notify the recipient's speech-language pathologist of the delivery date.

4.2.2 Pneumatic Compressor and Appliances

Devices to compress air for use by air-driven equipment and include intermittent pneumatic pressure pumps with single or multiple outflow ports.

Appliances include sequential and non-sequential inflatable garments.

4.2.3 Phototherapy (Bilirubin) Lights with Photometers

Covered for up to 30 days after birth for up to 5 consecutive days of treatment.

Phototherapy (bilirubin) lights with photometers must include all of the following:

- Covers and related supplies
- Fiberoptics blanket
- Fiberoptics system
- Light sources

4.2.4 Suction Machines

In-home suction machines include devices designed for upper respiratory or gastric suction that may be used without technical or professional supervision.

4.2.5 Breast Pumps

Florida Medicaid covers electric breast pumps when a nursing mother experiences prolonged separation from her infant due to work, school, or medical reason.

Florida Medicaid covers hospital-grade electric breast pumps under one of the following circumstances:

- When a nursing mother is receiving treatment for an infection of the breast
- For nursing mothers of recipients born at less than 37 weeks gestation

4.2.6 Surgically Implantable Devices

Florida Medicaid covers the following, when services are rendered in accordance with Rules 59G-4.020, 59G-4.150, or 59G-4.160, F.A.C., as applicable:

- Intrathecal baclofen pumps and equipment
  - Complete device and partial replacement of the device
- Vagus nerve stimulators and equipment
  - Complete device and partial replacement of the device

4.2.7 Specific Specialized Durable Medical Equipment

Florida Medicaid covers the following:

- Cranial helmets
- High frequency chest compression systems
- Osteogenesis stimulators
  - When prescribed (in lieu of surgery)
- Transcutaneous and neuromuscular electrical nerve stimulators

4.2.8 Maintenance and Repair

Florida Medicaid covers maintenance and repairs of specialized durable medical equipment that meets all of the following:

- Equipment damage is not due to misuse, neglect or wrongful disposition by the recipient, caregiver, or provider
- Equipment warranty is expired or does not cover the necessary maintenance or repairs
- Florida Medicaid provided the equipment

4.2.9 Used and Refurbished Equipment

Florida Medicaid covers used and refurbished specialized durable medical equipment that meets all of the following criteria:

- Equipment records indicate that the item is functional, sanitized, and serviced prior to delivery
- Equipment and replaced parts are equivalent in quality and condition to the manufacturer's warranty on new equipment
- Equipment must be durable enough to meet Florida Medicaid's maximum limit replacement requirements as stated on the DME fee schedule, incorporated by reference in Rule 59G-4.002, F.A.C.

4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's Authorization Requirements Policy.

5.0 Exclusion

5.1 General Non-Covered Criteria

Services related to this policy are not covered when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service

5.2 Specific Non-Covered Criteria

Florida Medicaid does not cover the following as part of this service benefit:

- AAC systems or devices that do not meet the definition of DME (e.g., no-tech or low-tech AAC, computers, tablets, smartphones, or other general computing devices)
- Automatic medication dispensers
- Blood pressure monitoring devices
- Specialized DME or medical supplies provided to recipients ages 21 and over residing

in institutional settings (e.g., skilled nursing facilities) AAC devices may be covered for recipients in a skilled nursing facility, as indicated in section 4.2.1
- First aid items
- Items or devices used or intended to be used for cosmetic purposes that are unrelated to a medical condition or illness
- Items listed or identified in a procedure code's description, separately
- Items unrelated or not necessary to operate an AAC device
- Medical alert monitoring systems
- Convenience, hygiene, or general sanitation items
- Repairs and maintenance of rental equipment, separately
- Shipping, handling, labor, measuring, fitting, or adjusting, separately
- Travel time and repair assessment time

6.0 Documentation

6.1 General Criteria

For information on general documentation requirements, please refer to Florida Medicaid's Recordkeeping and Documentation Policy.

6.2 Specific Criteria

Providers must maintain the following documentation in the recipient's file, as applicable:

- Documentation confirming the speech-language pathologist was notified prior to the delivery of an AAC device, including date and time of the notification
- Equipment and supply delivery, pick-up, and return documentation as specified in section 400.94, F.S.
- Florida Medicaid-covered DME must include manufacturer's or one-year warranty, whichever is greater
- Recipient training documentation
- Rental equipment maintenance and repairs
- Used equipment documentation, including:
  - Signed agreement with recipient, acknowledging receipt of used equipment

Providers must also maintain one of the following in the recipient's file:

- Certificate of Medical Necessity, prepared and signed by the authorizing practitioner, that meets all of the following requirements:
  - Is dated within 21 days after the initiation of service
  - Is less than 12 months old
  - Specifies a diagnosis as the basis for the services prescribed
- Current hospital discharge plan, when applicable, that clearly describes the type of DME item or service ordered
- Written prescription
  - Is less than 12 months old
  - Is dated within 21 days after the initiation of services
  - When applicable, documentation for redetermination of medical necessity or reauthorization of services

The plan of care, when applicable, must be individualized and specify all of the following:

- Frequency of use
- Length of time the recipient requires DME
- Quantity
- Type of DME

6.2.1 Augmentative and Alternative Communications Systems

Providers must maintain the following documentation in addition to the criteria specified in section 6.2:

- Speech-language pathologist's evaluation that reports the following:
  - Significant medical diagnosis(es), medical history, and prognosis (i.e., anticipated course of impairment)
  - Motor skills (e.g., accuracy of movement, writing impairments, etc.), including posture/position and mobility
  - Cognitive abilities
  - Sensory and perceptual processing (e.g., hearing, vision)
  - Oral motor speech status
  - Language comprehension and expression
  - Daily communication needs, based on environment and primary communication partners
  - AAC device recommendation, including a description of features and any necessary adaptive accessories (e.g., mounting system for wheelchair)
  - The printed name, signature, title, and date of the evaluating speech-language pathologist
- Individualized action plan or plan of care that includes the following:
  - Description of the AAC device
  - Specific benefits of the selected AAC device over other options, including trial data
  - Explanation of any AAC systems or devices previously used, including limitations/barriers
  - Long and short-term functional communication goals
  - Established plan for fitting, adjustments, and training
  - The lead SLP's printed name, signature, title, and date
  - Signatures, titles, and dates by all other contributing interdisciplinary team members (as applicable for children enrolled in school)
- The following information must be included with a request to repair an AAC device:
  - Model and serial number of the AAC device needing repair
  - The funding source of the AAC device needing repair
  - An outline of repairs needed
  - A detailed explanation regarding damage to an AAC device that requires substantial or frequent repairs

Individual action plans or plans of care require the signature of the recipient's treating physician.

6.2.2 Cranial Helmets

Providers must maintain the following documentation in addition to the criteria specified in section 6.2:

- Documentation of a six-month trial period of active counter positioning
- Photographs of the infant's head taken from the superior, frontal, posterior, and right and left lateral perspectives

6.2.3 Pneumatic Compressors and Appliances

Providers must maintain records of previous hospital admission(s) to treat complications related to lymphedema or another condition that requires intermittent pneumatic compression in addition to the criteria specified in section 6.2.

7.0 Authorization

7.1 General Criteria

The authorization information described below is applicable to the fee-for-service delivery

system. For more information on general authorization requirements, please refer to Florida Medicaid's Authorization Requirements Policy.

7.2 Specific Criteria

Providers must obtain authorization from the quality improvement organization (QIO) as follows:

- For miscellaneous procedure codes
- When indicated on the applicable Florida Medicaid fee schedule(s)

8.0 Reimbursement

8.1 General Criteria

The reimbursement information below is applicable to the fee-for-service delivery system.

8.2 Claim Type

Professional (837P/CMS-1500)

8.3 Billing Code, Modifier, and Billing Unit

Providers must report the most current and appropriate billing code(s), modifier(s), and billing unit(s) for the service rendered, incorporated by reference in Rule 59G-4.002, F.A.C.

Providers must include a non-classified procedure code for customized equipment on the claim form.

8.4 Diagnosis Code

Providers must report the most current and appropriate diagnosis code to the highest level of specificity that supports medical necessity, as appropriate for this service.

8.5 Rate

For a schedule of rates, incorporated by reference in Rule 59G-4.002, F.A.C., visit AHCA's website at http://ahca.myflorida.com/Medicaid/review/index.shtml.

8.5.1 By-Report Claims

By-report claims involve non-classified procedure codes as indicated on the DME fee schedule incorporated by reference in Rule 59G-4.002, F.A.C., and require medical reviews by the QIO to approve and price the DME service.

Providers must submit the following to the Florida Medicaid QIO:

- Description of the items or services provided, including manufacturer's information
- Documentation of medical necessity
- Documentation of the provider's costs incurred, including invoices
- Documentation of the warranty and before and after descriptions of the item repairs

8.5.2 Maintenance and Repair

Repair costs must not exceed 75% of the equipment's original cost.

8.5.3 Rental Equipment

Florida Medicaid reimburses for rental equipment at the prorated daily amount of the monthly rate, per day, when the item is returned to the provider before the end of a 30-day period.

Florida Medicaid reimburses for up to the total of ten monthly claims for rent-to-purchase items; the item(s) then becomes the personal property of the recipient at the end of the lease.

8.5.2.1 Hospital Grade Breast Pumps

Florida Medicaid's rental amount includes all components necessary to use the breast pumps.

8.5.4 Pneumatic Compressor and Appliances

Florida Medicaid reimburses for pumps and garments separately.

8.5.5 Suction Machines

Florida Medicaid reimburses for tubing and accessories necessary for operating the device separately if the suction machine is owned by the recipient.

8.5.6 Surgically Implantable Devices and Implantation

Florida Medicaid reimburses for device implantation services separately, in accordance with Florida Medicaid's inpatient and outpatient hospital reimbursement methodologies.

8.5.6.1 Intrathecal Baclofen Therapy Pump

Florida Medicaid reimburses providers as indicated on the fee schedule, incorporated by reference in Rule 59G-4.002, F.A.C., in addition to the surgical rate for the practitioner and facility.

8.5.6.2 Vagus Nerve Stimulator

Florida Medicaid reimburses providers as indicated on the fee schedule, incorporated by reference in Rule 59G-4.002, F.A.C., in addition to the surgical rate for the practitioner and facility.

8.5.7 Used and Refurbished Equipment

Florida Medicaid reimburses for used equipment at the lesser of 66% of:

- The provider's usual and customary fee for new equipment
- The maximum rate on the applicable fee schedule

Florida Medicaid reimburses for refurbished equipment at 100% of the maximum rental fee on the applicable fee schedule.