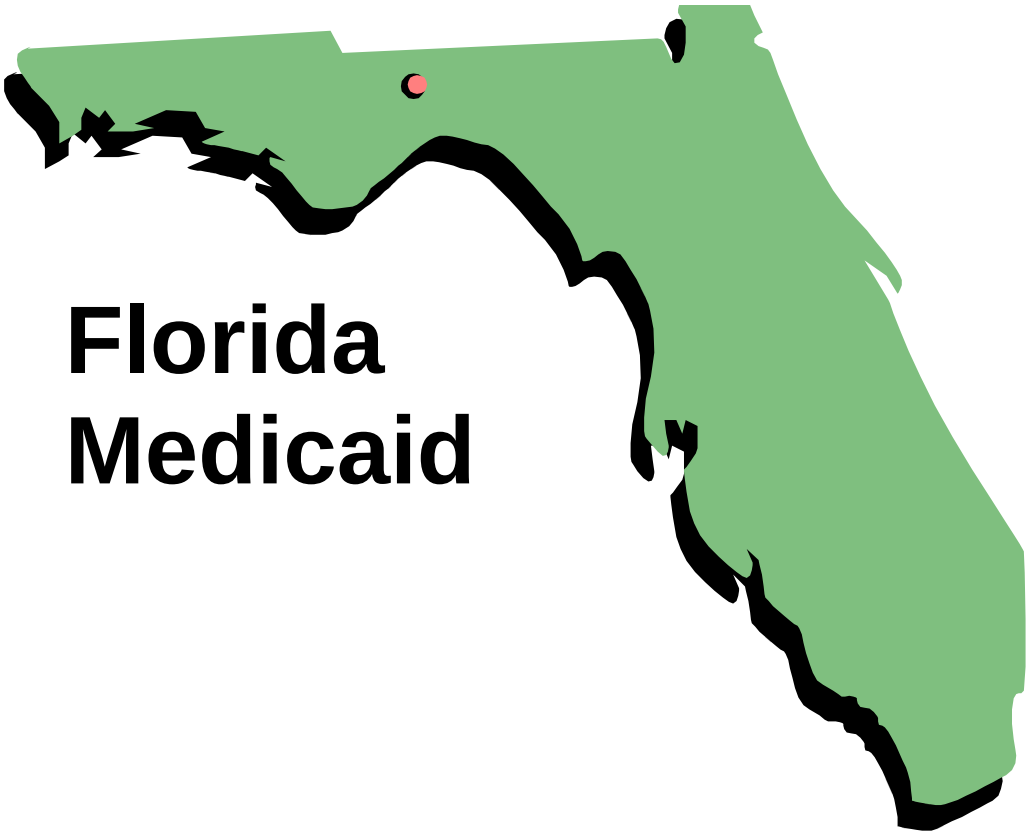


Florida Medicaid

DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLY SERVICES COVERAGE AND LIMITATIONS HANDBOOK

Agency for Health Care Administration

Draft Rule

DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLY SERVICES
COVERAGE AND LIMITATIONS HANDBOOK
UPDATE LOG

How to Use the Update Log

Introduction

The update log provides a history of the handbook updates. Each Florida Medicaid handbook contains an update log.

Obtaining the Handbook Update

When a handbook is updated, the Medicaid provider will be notified. The notification instructs the provider to obtain the updated handbook from the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Explanation of the Update Log

Providers can use the update log below to determine if updates to the handbook have been received.

Update describes the change that was made.

Effective Date is the date that the update is effective.

UPDATE	EFFECTIVE DATE
Replacement Pages	October 1999
Replacement Pages	January 2000
Errata - Pen-and-Ink Correction	January 2000
Replacement Pages	April 2001
Errata	April 2001
Replacement Pages	January 2002
Replacement Pages	March 2003
Revised Handbook	July 2008
Revised Handbook	July 2010
Replacement Handbook	_____

DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLY SERVICES
COVERAGE AND LIMITATIONS HANDBOOK
TABLE OF CONTENTS

Chapter and Topic **Page**

Chapter 2 – Covered, Limited, and Excluded Services, continued

Chapter 3 – Reimbursement and Fee Schedule

Appendices

INTRODUCTION TO THE HANDBOOK

Overview

Introduction

This chapter outlines the three types of Florida Medicaid policy handbooks that all enrolled providers must comply with in order to obtain reimbursement. This chapter also describes the format used for the handbooks and instructs the reader how to use the handbooks.

Background

There are three types of Florida Medicaid handbooks:

- Provider General Handbook describes the Florida Medicaid program.
- Coverage and limitations handbooks explain covered services, their limits, who is eligible to receive them, and any corresponding fee schedules. Fee schedules can be incorporated within the handbook or separately.
- Reimbursement handbooks describe how to complete and file claims for reimbursement from Medicaid.

The current Florida Medicaid provider handbooks are posted on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Federal and State Authority

The following federal and state laws govern Florida Medicaid:

- Title XIX of the Social Security Act
- Title 42 of the Code of Federal Regulations
- Chapter 409, Florida Statutes
- Rule Division 59G, Florida Administrative Code

In This Chapter

This chapter contains:

Handbook Use

Purpose	The purpose of the Medicaid handbooks is to educate the Medicaid provider about policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients. The handbooks provide descriptions and instructions on how and when to complete forms, letters, or other documentation.
Provider	Term used to describe any entity, facility, person, or group who is enrolled in the Medicaid program and provides services to Medicaid recipients and bills Medicaid for services.
Recipient	Term used to describe an individual enrolled in Florida Medicaid.
Provider General Handbook	Information that applies to all providers regarding the Florida Medicaid program, recipient eligibility, provider enrollment, fraud and abuse policy, and important resources are included in the Florida Medicaid Provider General Handbook.
Coverage and Limitations Handbook	Each coverage and limitations handbook is named for the service it describes. A provider who renders more than one type of Medicaid service will have more than one coverage and limitations handbook with which they must comply.
Reimbursement Handbook	Most reimbursement handbooks are named for the type of claim form submitted.

Characteristics of the Handbook

Format	The format of the handbook represents a reader-friendly way of displaying material.
Label	Labels are located in the left margin of each information block. They identify the content of the block in order to help scanning and locating information quickly.
Information Block	Information blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of the subject. Blocks are separated by horizontal lines. Each block is identified or named with a label.
Chapter Topics	Each chapter contains a list of topics on the first page, which serves as a table of contents for the chapter, listing the subjects and the page number where the subject can be found.
Note	Note is used to refer the reader to other important documents or policies contained outside of this handbook.
Page Numbers	Pages are numbered consecutively within each chapter throughout the handbook. The chapter number appears as the first digit before the page number at the bottom of each page.
White Space	The "white space" found throughout a handbook enhances readability and allows space for writing notes.

Handbook Updates

Update Log	The first page of each handbook will contain the update log. Every update will contain a new updated log page with the most recent update information added to the log. The provider can use the update log to determine if all updates to the current handbook have been received. Each update will be designated by an "Update" and "Effective Date."
Handbook Update Classifications	The Medicaid handbooks will be updated as needed. Updates are classified as either a: • Replacement Handbook – Major revisions resulting in a rewrite of the existing handbook, without any underlines and strikethroughs throughout the rulemaking process. • Revised Handbook – Minor revisions resulting in modification of the existing handbook identified during the rulemaking process by underlines and strikethroughs.
Handbook Effective Date	The effective date of a handbook is the month and year that will appear on the final published handbook. The provider can check this date to ensure that the material being used is the most current and up to date.
Identifying New Information	New information or information moved from one place to another within the handbook will be identified by an underline on draft versions of the handbook during the development and proposed stages of the rulemaking process (e.g., <u>new information</u>).
Identifying Deleted Information	Deleted information will be identified by a line through the middle of the selected text on draft versions of the handbook during the development and proposed stages of the rulemaking process (e.g., ~~deleted information~~).
Final Published Handbook	The adopted and published version of the handbook will not have underlines (indicating insertions) and text with strikethroughs (indicating deletions).

CHAPTER 1
QUALIFICATIONS AND ENROLLMENT

Overview

Introduction

This chapter describes Florida Medicaid's durable medical equipment (DME) and medical supply services, the specific authority regulating these services, and provider qualifications and enrollment.

Legal Authority

Durable medical equipment and medical supply services are authorized by section 409.906, Florida Statutes (F.S.), and Rule 59G-4.070, Florida Administrative Code (F.A.C.).

In This Chapter

This chapter contains:

Purpose

Introduction

The purpose of Florida Medicaid's DME and medical supply services is to promote, maintain, or restore health and minimize the effects of illness, disability, or a disabling condition.

Medicaid Provider Handbooks

This handbook is intended for use by DME and medical supply providers that render services to eligible Medicaid recipients. It must be used in conjunction with the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which contains information about specific procedures for submitting claims for payment, and the Florida Medicaid Provider General Handbook, which describes the Florida Medicaid program.

Note: The Florida Medicaid provider handbooks are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. All of the Florida Medicaid provider handbooks are incorporated by reference in Rule Division 59G, F.A.C.

Definitions

Apnea	A cessation of airflow for at least ten seconds.
Business	Enterprises, commercial entities, or firms in either the private or public sector that are concerned with providing products or services to satisfy customer requirements.
Disposable Incontinence Supplies	Supplies consisting of incontinence briefs, diapers, protective underwear, pull-ons, liners, shields, guards, pads, and undergarments.
Durable Medical Equipment	Equipment that can withstand repeated use, serves a medical purpose, and is appropriate for use in the recipient's home as determined by the AHCA.
Fully Operational	A DME entity, as a DME business location, that is currently open for business and providing services to the general public and receiving payment for DME and medical supplies and meeting the following criteria: • Is clearly identified with an outdoor business sign that can be read from 20 feet away • Is readily accessible to the public during scheduled, posted, business hours • Is operating no less than five hours per day, and no less than five days per week, with the exception of scheduled and posted holidays • Has a physical DME business location with durable medical equipment and medical supplies onsite and readily available to the general public • Has a functional landline business phone
Hypopnea	An abnormal respiratory event lasting at least ten seconds with at least a 30 percent reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a four percent oxygen desaturation.

Definitions, continued

Medical Event	An inpatient hospitalization or significant change in the recipient's medical or physical condition recently documented by the recipient's treating practitioner.
Medical Necessity/ Medically Necessary	In accordance with Rule 59G-1.010(166), Florida Administrative Code (F.A.C.), defines: "[T]he medical or allied care, goods, or services furnished or ordered must: (a) Meet the following conditions: 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain; 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs; 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program and not experimental or investigational; 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider." "(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service."
Medical Supplies	Medical or surgical items that are consumable, expendable, disposable, or non-durable and appropriate for use in the recipient's home.
Orthotic Devices	Devices or appliances that support or correct a weak or deformed body part, or restrict or eliminate motion in a diseased or injured body part.
Permanent Medical Condition	For the purposes of this handbook, a permanent medical condition is a medically determinable condition which has lasted, or is expected to last, for more than 12 months.

Definitions, continued

Plan of Care	An individualized written treatment program specifying the type, quantity, frequency and length of need of services and goods ordered by the recipient's treating physician or the treating physician's prescribing advanced registered nurse practitioner (ARNP), physician assistant, therapist, or speech pathologist.
Prosthetic Devices	Artificial devices or appliances that replace all or part of a permanently inoperative or missing body part.
Quality Improvement Organization	The Quality Improvement Organization (QIO) vendor contracted with AHCA to monitor the appropriateness, effectiveness, and quality of care provided to Medicaid recipients. The vendor performs authorization reviews of services based on medical necessity determinations.
Substantial Inventory	Medical equipment and supplies readily available and sufficient to meet the needs of the DME business location and customers in a timely manner.
Warranty	All purchased or rent-to-purchase equipment remaining in effect for one year, beginning with the first date of delivery.
Year	For the purpose of this service, a year is 366 days from the date of service.

Qualifications

Accreditation	Durable medical equipment and medical supply providers must be accredited by one of the following organizations: • Joint Commission on Accreditation of Healthcare Organizations • Community Health Accreditation Program • Healthcare Quality Association on Accreditation • National Board of Accreditation for Orthotic Suppliers • Board for Orthotist/Prosthetist Certification • Accreditation Commission for Healthcare • National Association of Boards of Pharmacy • Commission on Accreditation of Rehabilitation Facilities • American Board for Certification in Orthotics, Prosthetics, and Pedorthics, Incorporated • The Compliance Team

Qualifications, continued

Accreditation, continued

A DME and medical supply business is exempt from accreditation requirements if the DME and medical supply services' physical location is:

- Owned and operated by a government entity.
- Operated by and within a pharmacy that is currently enrolled as a Medicaid pharmacy provider.

Training Documentation for Provider's Employees

The provider must ensure all hired and contracted personnel are assigned duties that are commensurate with their education, training, and experience.

Durable medical equipment and medical supply providers must maintain documentation of employee training sessions for the staff working at each DME business location.

Provider Employees' Driver License

The DME and medical supply business must ensure and document that all hired and contracted delivery personnel possess a current, valid driver license.

Home Medical Equipment Providers Licensure and Exemption

All home medical equipment (HME) companies must hold a current, standard license issued by AHCA, Division of Health Quality Assurance, unless exempt, pursuant to section 400.93, F.S.

Exempt from providers are those operated by:

- The federal government
- Nursing homes
- Assisted living facilities
- Home health agencies
- Hospices
- Intermediate care facilities
- Hospitals and ambulatory surgical centers
- Pharmacies
- Manufacturers or wholesale distributors when not selling directly to consumers
- Licensed health care practitioners who utilize HME in the course of their practice, but do not sell or rent HME to their patients

If the provider's exemption status changes, the provider must immediately notify the Medicaid fiscal agent.

Note: For more information or questions about HME licensure, contact AHCA's Home Care Unit at 850-412-4403.

Qualifications, continued

Orthotic and Prosthetic Providers	Orthotic and prosthetic device providers must be licensed by the Department of Health (DOH), Medical Quality Assurance, Board of Orthotics and Prosthetics. The licensed orthotist and prosthetist must be a working owner or working employee of the orthotic and prosthetic company providing direct services to Medicaid recipients. Licensed orthotic fitters, fitter assistants, and pedorthists must provide services within the scope of their individual license as defined in section 468.80, F.S. A licensed orthotist, prosthetist, or pedorthist cannot delegate the following duties to support personnel: patient evaluation, treatment formulation, or the final fitting of a device prior to patient use. Other delegated duties must be performed under the supervision of a licensed orthotist, prosthetist, or pedorthist.
Medical Oxygen Providers and Retailers	In addition to meeting the general DME and medical supply provider requirements and the HME licensure requirements described in Chapter 59A-25, F.A.C., oxygen and oxygen-related equipment and services providers must also have current and valid oxygen retailer permits issued by the DOH, Central Pharmacy. Oxygen providers must have a licensed certified respiratory therapist, registered respiratory therapist, registered nurse, or respiratory care practitioner under contract or on staff to provide management and consumer instruction, at the provider's physical DME business location or in the recipient's home.

Enrollment and Re-Enrollment

Eligible Entities	The following entities may enroll as Florida Medicaid DME and medical supply providers: • Businesses that supply DME and medical supplies • Pharmacies that supply DME and medical supplies • Home health agencies • Optometrists and opticians who supply prosthetic eyes

Enrollment and Re-Enrollment, continued

Enrollment and Re-enrollment Requirements

Providers must meet the qualifications, enrollment, continued enrollment, or re-enrollment requirements set forth by the Medicaid Provider General Handbook and Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook. Additionally providers must:

- Be licensed by the local city and county government agency as a business or merchant or provide documentation from the city or county authority, where the individual DME and medical supply business is physically located, that no such licensure is required.
- Provide proof that the DME and medical supply business location is in compliance with local zoning laws.
- Have physical DME and medical supply business location(s) in compliance with the American with Disabilities Act (ADA), regarding parking and public access requirements.
- Have not been terminated by any state or federal agency for reasons of fraud or abuse.
- Be an active DME and medical supply provider location, furnishing reimbursable DME and medical supplies and services to the general public within the past six months.
- Have not been denied DME and medical supply provider enrollment within the past year.

Failure to comply with the enrollment requirements will result in denial of the DME and medical supply business location's application for enrollment or re-enrollment or will result in the DME and medical supply business location's termination as a provider of Medicaid DME and medical supply services.

Exceptions to Being Fully Operational at Time of Enrollment

An individual who is licensed as an orthotist or prosthetist providing only orthotic or prosthetic devices as a Medicaid DME provider is exempt from the following criteria:

- Maintaining clearly identified outdoor business sign that can be read from 20 feet away
- Operating no less than five hours per day, and no less than five days per week, with the exception of scheduled and posted holidays

Medicaid enrolled pharmacies with one or more active DME provider identification number are exempt from being identified with an outdoor business DME sign which can be read from 20 feet away. This exception does not include Medicaid enrolled pharmacies that also supply oxygen and oxygen related equipment. Pharmacies must still identify that they are a pharmacy.

Enrollment and Re-Enrollment, continued

Business Location Eligibility

The provider must meet one of the following physical location criteria:

- Be a DME or medical supply business currently occupying and operating from a physical business site located within the state of Florida and easily accessed by the Medicaid recipients and the general public it serves
- Be a DME or medical supply business that provides sufficient proof the business occupies and operates a DME and medical supply or medical supply business location within 50 miles of the Florida state line (The business must submit proof of all current city and state licenses, permits, and certifications required of DME and medical supply providers operating within the state where the DME business is physically located and provide proof that the business location can be easily accessed by Florida Medicaid recipients and the general public it serves)
- If the DME business or medical supply is physically located more than 50 miles from the Florida state line, the business must supply DME or supplies not otherwise available from other enrolled providers located within the state (the business must also provide proof of all current and applicable licenses, permits, and certifications required of a DME or medical supply business in the state where the applicant business is physically located)

One Provider Per Physical Location

Medicaid's DME and medical supply services will only approve enrollment or maintain enrollment for one DME and medical supply provider at a time, per street address.

A street address may include two or more business suites or individual store front locations that may be individually identified by an additional and unique suite or store front number by the United States Postal Service, or the building's owner.

If it becomes necessary to terminate all but one DME and medical supply provider operating at the same physical location to meet this requirement, Medicaid will maintain enrollment with the currently enrolled provider located at the current street address and actively providing DME and medical supply services for the longest period of time, without experiencing a change in ownership or a change in its Medicaid provider number.

Enrollment and Re-Enrollment, continued

Multiple Physical Locations Operated by the Same Business Entity

A business entity that owns and operates DME and medical supply businesses at more than one physical location must be assigned a separate Medicaid provider number for each physical location.

Furnishing and claiming Medicaid reimbursement for DME and medical supplies provided by any staff, entity, or location other than that of the legitimately enrolled DME provider is not permitted.

The provider must submit a new and complete Medicaid provider enrollment application to enroll each additional DME and medical supply business location. The individual DME and medical supply business location's Medicaid provider number and physical location address must be included on all initial provider enrollment and enrollment renewal documents, including surety bonds and accreditation certificates, when documented by the accreditation company.

The provider must cross reference its National Provider Identifier to its locations' Medicaid provider numbers by using taxonomy codes or zip code plus four as identifiers.

All initial provider enrollment and provider renewal documents, including surety bonds and accreditation certificates, when documented by the accreditation company, must include: the individual DME and medical supply business location's name; Medicaid provider number, if assigned; Federal Employer Identification Number (F.E.I.N); and physical location address.

Business Operated by a Medicaid Pharmacy

Pharmacy providers are automatically eligible to receive a DME provider number upon their initial Medicaid enrollment as a pharmacy, if the proposed DME business is located within the enrolled pharmacy, has the same F.E.I.N. as the pharmacy, and the physical location is not shared with another DME and medical supply provider that has been in operation at the same street address longer than the pharmacy provider without experiencing a change in ownership or change in Medicaid provider number. An exception is dispensing practitioners who enroll as pharmacy providers and are not eligible to enroll as a DME provider.

To be reimbursed for DME and medical supplies, the pharmacy provider must submit a letter to the Medicaid fiscal agent requesting activation of its DME provider number. The letter must be submitted on company letterhead and must contain an authorized original signature, per the Medicaid enrollment application instructions. Faxed letters will not be accepted.

Enrollment and Re-Enrollment, continued

Business Operated by a Medicaid Pharmacy, continued

The letter requesting DME provider number activation must be mailed to the following address:

Provider Enrollment
P.O. Box 7070
Tallahassee, Florida 32314-7070

When the DME provider number is activated, the fiscal agent will notify the pharmacy.

Pharmacy providers who also provide DME and bill Medicaid for oxygen must submit copies of their DOH pharmacy permits with their provider enrollment applications.

Background Screening

A Level II background screening, as described in section 435.04, F.S., is required as a condition of employment for provider staff in direct contact with and providing direct services to recipients of DME and medical supply services in their homes. This requirement includes repair and service technicians, fitters, and delivery staff.

Screening must be performed at the time of employment and every five years thereafter.

An application for a Level II background screening must be submitted for all appropriate employees and within forty-five days of employment for employees hired. Copies of background screening applications and results must be maintained in the employees' personnel record and made available for review upon request.

Note: For additional information and requirements on background screenings, see the Florida Medicaid Provider General Handbook.

Oxygen and Oxygen-Related Equipment

The DME and medical supply provider rendering oxygen and oxygen-related equipment services must add specialty code 69 (oxygen) to the provider enrollment application and submit a current and valid copy of its oxygen retail permit issued by the DOH, unless exempt. Providers filling their own oxygen tanks must maintain a current and valid copy of their oxygen compressed medical gases manufacturer permit issued by DOH.

The assigned Medicaid DME Medicaid provider number and current physical location address must be included on all correspondence for the DME and medical supply business location.

All providers of medical oxygen and oxygen-related equipment must have an updated contingency plan on file that ensures emergency oxygen, oxygen-related equipment and services will be provided to recipients on a 24-hour-a-day basis and will be available during emergency situations, which may include the aftermath of a natural or national disaster.

Enrollment and Re-Enrollment, continued

Site Visit

Before a DME and medical supply business is considered for enrollment, the business and each additional location will have an unannounced site visit conducted by its Medicaid or its authorized representative.

The completion of a site visit(s) does not guarantee DME and medical supply provider enrollment nor does it guarantee that all of the entity's DME and medical supply services physical locations will be approved for Medicaid participation.

The following DME and medical supply entities are exempt from a pre-enrollment site visit:

- Entities associated with rural health clinics
- Entities that are government operated
- Entities that are licensed (i.e. Medicaid-enrolled optometrists providing prosthetic eyes)
- Entities operated by and within a pharmacy (currently enrolled as a Medicaid pharmacy provider)
- Individuals who are licensed Medicaid-enrolled orthotists or prosthetists that provide only orthotic or prosthetic devices and who provide copies of their professional licenses from the DOH with their enrollment applications

Upon request, all business records, including patient records, equipment records, purchasing and sales documentation, business policies and procedures, and other pertinent business records for the DME and medical supply services location being visited must be made readily available to Medicaid staff or its representatives.

Surety Bond Submission and Exemptions

A surety bond must be submitted as part of the provider enrollment application. Each provider location's surety bond must be renewed annually and the provider must submit proof of renewal, even if the original bond is a continuous bond. Providers must comply with the surety bond requirements in section 409.907(7), F.S.

Enrollment and Re-Enrollment, continued

Time-Sensitive Renewal for Accreditation Certificates

Durable medical equipment and medical supply providers must renew their required accreditation certificates prior to the certificate's expiration date to avoid a lapse in coverage, a denial of Medicaid reimbursements, and termination as a Medicaid provider.

Accreditation certificate renewal documents must be submitted to the fiscal agent at least 30 days prior to the certificate's expiration date.

If the provider's renewal certificate will not be available for submission prior to expiration due to an untimely delay in the accrediting organization's monitoring schedule, the provider must submit a copy of correspondence from the accrediting organization. The documentation must clarify the reason for non-compliance. The provider must attach a written request for an extension, stating the amount of additional time needed to comply with renewal requirements. The provider's written request must be dated and signed by the owner named in the DME provider enrollment records that are currently on file with the Medicaid fiscal agent.

If there is a lapse in the certificate dates, the provider will be denied payments for services that may have been otherwise reimbursed by Medicaid, and the individual DME location without a current accreditation certificate on file will be terminated as a Medicaid provider.

The assigned Medicaid DME provider number and current physical location address must be included on the accreditation certificate renewal document for the individual DME and medical supply business location being accredited. If assigned is a new applicant, please include the applicant's F.E.I.N. If the information is not physically listed on the accreditation certificate, documentation from the accreditation organization must identify the specific Medicaid provider that has been accredited or renewed.

Renewal documentation must be submitted to the Medicaid fiscal agent at the following address:

Provider Enrollment
P.O. Box 7070
Tallahassee, FL 32314-7070

Enrollment and Re-Enrollment, continued

Time-Sensitive Home Medical Equipment License Renewal

Unless otherwise exempt from licensure, a copy of the current HME license is required for all DME and medical supply providers, regardless of the date the provider originally enrolled in Medicaid.

The DME and medical supply provider is responsible for maintaining current licensure and is also responsible for submitting required copies of current licensure to the Medicaid fiscal agent in a timely manner.

The DME and medical supply providers must renew required HME licenses and provide documented proof of renewal to the Medicaid fiscal agent to avoid a lapse in coverage, a denial of Medicaid reimbursements, and termination as a provider.

A copy of the renewed HME license must be submitted to the fiscal agent at least 30 days prior to the license expiration date or a letter from Health Quality Assurance, explaining the reason for the delay is not due to the actions or inactions of the provider.

If there is a lapse in HME licensure, the provider will be denied payments for services that may have been otherwise reimbursed by Medicaid, and the individual DME location without a current HME license on file will be terminated as a provider.

If the provider's renewed license will not be available for submission prior to expiration, due to an untimely delay in the licensing agency's monitoring schedule, the provider must submit a copy of correspondence from the licensing agency. The documentation must clarify the reason for non-compliance. The provider must attach a written request for an extension, stating the amount of additional time needed to comply with renewal requirements. The provider's written request must be dated and signed by the owner of the DME and medical supply services business location who is named in the DME and medical supply provider enrollment records that are currently on file with the Medicaid fiscal agent.

The assigned Medicaid DME and medical supply provider location number and current physical location address must be included on the HME license copy submitted for the individual DME and medical supply services business.

Copies of HME licenses must be submitted to the Medicaid fiscal agent at the following address:

Provider Enrollment
P.O. Box 7070
Tallahassee, FL 32314-7070

Enrollment and Re-Enrollment, continued

Time-Sensitive Oxygen Retail Permits

The provider must immediately report any changes or updates regarding the oxygen retail permit to the Medicaid fiscal agent at the following address:

Provider Enrollment
P.O. Box 7070
Tallahassee, Florida 32314-7070

Time-Sensitive Renewal of Surety Bond

Unless otherwise exempt, current surety bonds are required of all DME and medical supply providers, regardless of the date the provider originally enrolled in Medicaid.

The DME and medical supply provider is responsible for maintaining current surety bond coverage and is also responsible for submitting required surety bond documentation to the Medicaid fiscal agent in a timely manner.

Durable medical equipment and medical supply providers must renew their required surety bonds annually, before the day and month that the first bond was effective to avoid a lapse in coverage, a denial of Medicaid reimbursements, and termination as a provider of Medicaid DME and medical supply services.

Bond renewal documents must be submitted to the Medicaid fiscal agent at least 30 days prior to the individual bond's termination date.

If there is a lapse in the bond coverage dates, the provider will be denied payment for services that may have been otherwise reimbursed by Medicaid, and the individual DME location without a current surety bond on file will be terminated as a provider of Medicaid DME and medical supply services.

The assigned Medicaid DME provider location number and current physical location address must be included on the surety bond renewal document for the individual DME and medical supply business location being bonded.

Surety bond renewal documentation must be submitted to the Medicaid fiscal agent at the following address:

Provider Enrollment
P.O. Box 7070
Tallahassee, FL 32314-7070

Enrollment and Re-Enrollment, continued

Time-Sensitive Updates for Required Licenses, Certifications, and Permits

Durable medical equipment and medical supply providers must submit proof of updated licenses, certifications and, permits, required in this chapter, to the Medicaid fiscal agent in a timely manner.

All submitted documents must be current, valid, and must include the address of the current physical location of the DME business enrolled with Medicaid. These documents must be maintained on file and made readily available to Medicaid staff or the Medicaid's authorized representatives upon request.

Current and valid copies of the professional licenses and certifications of the provider's employees must be maintained on file and must be made easily available to Medicaid staff or Medicaid's authorized representatives upon request.

Renewal documentation must be submitted to the Medicaid fiscal agent at the following address:

Provider Enrollment
P.O. Box 7070
Tallahassee, FL 32314-7070

Reporting for Selling, Closing, or Changing the Ownership of Durable Medical Equipment Business, or No Longer Accepting Medicaid

The provider must notify the Medicaid fiscal agent if it is selling or closing the Medicaid DME business or no longer wishes to bill Medicaid for any reason.

Notification of the impending sale, change in ownership, business closure, or plans to no longer accept Medicaid, must be reported, prior to these changes, to the Medicaid fiscal agent at:

Provider Enrollment
P.O. Box 7070
Tallahassee, Florida 32314-7070

Note: For additional information on reporting changes, see the Florida Medicaid Provider General Handbook.

Enrollment and Re-Enrollment, continued

Non-Transfer of Medicaid Provider Identification Numbers

The DME and medical supply provider's assigned Medicaid provider identification is not transferable.

A Medicaid-enrolled provider will not permit the following persons or entities to use their assigned Medicaid provider identification number under any circumstances:

- The new owner of the DME and medical supply services business
- Person or legal entity planning to purchase or person or legal entity that is coordinating the purchase of the DME and medical supply services business
- Another Medicaid provider
- Another business, person, or entity not currently enrolled in Medicaid or not authorized to use the identification number

CHAPTER 2
COVERED, LIMITED, AND EXCLUDED SERVICES

Overview

Introduction

This chapter provides service coverage, limitations, and exclusions information. It also describes who can provide and receive services and any applicable service requirements.

In This Chapter

This chapter contains:

Overview, continued

In This Chapter, continued

This chapter contains:

General Information

Medical Necessity

Medicaid reimburses services that are determined medically necessary and do not duplicate another provider's service.

Acceptable Documentation of Medical Necessity

Medical necessity documentation must include the following information:

- Recipient's name
- Durable medical equipment item(s) or service(s) prescribed
- The prescribed quantity, frequency, and length of need (when equipment has been prescribed for less than 12 months)
- Authorized prescriber's dated original signature (the prescriber's stamped signature on medical office notes or documentation must be initialed by the prescriber)
- Complete evaluation by a professional therapist that includes a dated signature, professional license number, and National Provider Identifier (NPI) (if an evaluation for the item requested is appropriate)

General Information, continued

Acceptable Documentation of Medical Necessity, continued

Additionally, each service must be documented with at least one of the following:

- Written prescription less than 12 months old, with the printed name and the dated signature of the recipient's treating physician or the treating physician's advanced registered nurse practitioner (ARNP) or physician assistant. The prescription can be received by the durable medical equipment (DME) and medical supply provider before or after the DME service has been initiated, but the prescription cannot be dated more than 21 days after the date of service.
- Current hospital discharge plan with the dated signature of the recipient's treating physician or the treating physician's ARNP or physician assistant that clearly describes the type of DME item or service ordered.
- Certificate of Medical Necessity (CMN) less than 12 months old, which includes the printed name and the dated signature of the recipient's treating physician or the treating physician's ARNP or physician assistant. The CMN cannot be dated more than 21 days after the date of service. Medicaid prohibits vendors from preparing or creating sections of the CMN that are to be completed by the physician or authorized prescriber.
- Plan of care, if a home health agency.

Note: For more information regarding plan of care, see the Home Health Services Coverage and Limitations Handbook.

Who Can Receive

Unless otherwise specified in this handbook, DME, medical supplies, and orthotics and prosthetic devices are reimbursed only for Medicaid recipients residing in non-institutional settings within the community, including:

- The recipient's own home.
- The recipient's family home.
- A group home.
- A custodial care facility.
- An assisted living facility.

Medicaid recipients who are under the age of 21 years who reside in a skilled nursing facility are eligible to receive customized wheelchairs, customized orthotic and prosthetic devices, and augmentative and alternative communication (AAC) devices through Medicaid's DME and medical supply services.

General Information, continued

Exceptions to the Limits (Special Services) Process

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 Social Security Act, codified in Title 42 of the United States Code 1396d(a).

Services for recipients under the age of 21 years in excess of limitations described within this handbook or the associated fee schedule may be approved, if medically necessary, through the process described in this handbook.

Who Can Prescribe

All durable medical equipment, medical supplies, and orthotic and prosthetic devices for a Medicaid recipient must be prescribed by one of the following:

- Treating physician
- Treating physician's physician assistant
- Treating physician's ARNP
- Treating podiatrist

Each medical necessity document must include the date, the prescribing professional's signature, and current professional license number or national provider identification number.

Provider Responsibilities

A Medicaid DME and medical supply provider is responsible for furnishing and supervising all aspects of DME and medical supply service provisions, which includes all of the following:

- Providing the services or supplies directly to the Medicaid recipient or the recipient's legal guadian at the provider location, recipient's residence, recipient's school, or appropriate clinical location or send the supplies directly to the recipient's residence with receipt of mailed delivery (Subcontracting or consignment of the service or supply to a third party is prohibited, except for qualified DME providers who store nebulizers at a physician's office for the purpose of having the physician's staff issue the equipment.)
- Honoring provider and manufacturer warranties in a timely manner
- Appropriately cleaning, sanitizing, disinfecting, storing, and transporting medical equipment and supplies (in a manner recognized by the product manufacturer and accreditation standards to prevent cross-contamination and reduce health hazards)

General Information, continued

Provider Responsibilities, continued

- Maintaining and repairing equipment, per manufacturer recommendations
- Hiring, contracting, and supervising appropriately educated, trained and credentialed staff
- Maintaining the appropriate and required business records
- Maintaining the required service and medical documentation for customers served by the DME business location (for a minimum of five years from the date of service)
- Maintaining individual maintenance and service records on all durable medical equipment (as required by the manufacturer's guidelines, including the description, model and serial number, and current location of the individual equipment)
- Providing the appropriate tubing, hoses, masks, and accessories needed for the proper and safe use of rental equipment

A Medicaid DME and medical supply provider must also ensure that all products and items provided to eligible Medicaid recipients are:

- Appropriate for the functional ability and exclusive use of the individual recipient.
- Used for the purpose for which they were designed.
- Reasonable and effective in meeting the medical needs of the recipient.
- Of equal quality as those products and items furnished to non-Medicaid recipients.
- Non-duplicative or do not perform the same function as equipment or supplies already in the recipient's possession.
- Compliant with Medicaid policy and service requirements.

Providers Contracted with Medicaid Managed Care Plans

The service-specific Florida Medicaid coverage and limitations handbooks provide the minimum requirements for all providers. This includes providers who contract with Florida Medicaid managed care plans (e.g., provider service networks and health maintenance organizations). Providers must comply with all of the requirements outlined in this handbook, unless otherwise specified in their contract with the managed care plan. The provision of services to enrollees in a Medicaid managed care plan must not be subject to more stringent criteria or limits than specified in this handbook.

General Information, continued

Requirements for Consumable Medical Supplies	Consumable medical supplies must be redetermined at least every six months with a new a specific prescription and one additional, acceptable medical necessity documentation, as specified in this chapter. Recipients with a permanent medical condition are exempt from redetermination every six months. Redetermination must take place annually instead of every six months. Documentation of medical necessity must clearly state that the recipient will require consumable medical supplies due to a permanent medical condition and include the diagnosis code(s) pertinent to the recipient's need for the item or service requested.
Requirements for Oxygen Therapy, Oxygen-Related Equipment, and Apnea Monitors	The DME provider must request the necessary documentation of medical necessity and arterial blood gas or pulse oximetry testing laboratory results from the recipient's treating authorized prescriber or physician. Oxygen therapy and the use of apnea monitors must be redetermined at least every 12 months with an updated prescription for continuation of services and additional acceptable medical necessity documentation. Prescribed oxygen services must include rates of flow, concentration, level of frequency, duration of use, and circumstances under which oxygen is to be used. If this information is not included, a new prescription that clarifies the order is required.
Substantial Inventory	Medicaid staff, or authorized representative, may review business records to determine the DME location's ability to meet its customer's needs in a timely manner. A review of provider records may, at a minimum, include a same day or within 24-hour delivery agreement with a product manufacturer of non-custom DME equipment and medical supplies.

General Information, continued

Auto-Refills

Placing a recipient on automatic replenishment until the prescription is all used or the recipient voluntarily discontinues services is also prohibited.

Recipients' individual medical supply needs may change each month. Medical supply quantities must not exceed the recipient's one month's usage.

The refilled amount supplied may not exceed the amount and frequency ordered by the authorized prescriber. Documentation of each request for refill must be maintained in the recipient's record.

New Equipment

Medicaid requires all DME equipment be provided to an eligible recipient with at least a one-year DME provider warranty. Medicaid will not reimburse the provider for replacement parts or repairs to the equipment within the first year of service.

Medicaid reimbursement includes all of the following:

- All elements of the manufacturer's warranty
- All routine or special equipment servicing (to the extent the same servicing is provided to non-Medicaid persons)
- All adjustments and modifications needed to make the item safe, useful, and functional for the recipient during the entire first year (including customized wheelchairs)
- Delivery, set-up, and installation of the DME by trained and qualified provider staff (in the area of the home where the equipment will be used or the appropriate room within the home, if home delivery for the item is defined)
- Adequate training and instruction (provided to the recipient or the recipient's legal guardian by the provider's trained and qualified staff in a language understood by the recipient or legal guardian regarding the manufacturer's recommendations for the safe, sanitary, effective, and appropriate use of the item)
- Honoring the required one-year provider warranty for all requests or prescriptions requesting equipment repair made on or before the 366th day of service

Upon receiving recipient notification that a repair or modification is needed, the provider may not delay the repair(s) or modification(s) due to the equipment being under the one-year warranty period.

General Information, continued

Used Equipment

When previously used DME equipment is furnished to an eligible Medicaid recipient, the provider must:

- Obtain a written, signed, and dated agreement from the recipient or the recipient's legal guardian stating the recipient has been informed by the provider and understands that the equipment being furnished is used equipment and willingly accepts the used equipment.
- Maintain product service records to ensure the used equipment is functionally sound, has been properly cleaned and sanitized between each user, and has been fully serviced and attractively re-conditioned before releasing the equipment to the recipient.
- Ensure the used product or used item furnished includes the required "warranty" conditions listed under New Equipment in this section.
- Ensure the repaired or refurbished equipment with replaced parts is equivalent in quality and condition to the manufacturer's warranty on a similar new item.
- Ensure the used equipment provided is durable enough to meet Medicaid's maximum limit replacement requirements for that item.
- Furnish all routine or special equipment servicing to the extent that routine or special equipment servicing is provided to individuals who are not Medicaid recipients.
- Bill Medicaid the reduced amount required by the Medicaid DME policy for used equipment.

Repairs to Equipment and Devices

Durable medical equipment, orthotics, and prosthetics coverage includes general repairs and service of equipment owned and used by a recipient.

Rent-to-Purchase Equipment

For rent-to-purchase equipment, Medicaid reimburses up to ten monthly payments. The provider may not submit a claim for more than one unit of service within the same calendar month. During the rent-to-purchase agreement period, the equipment remains the property of the provider.

The length of time for the rent-to-purchase agreement will be determined at the time of prior or post authorization approval; therefore, redetermination of medical necessity or an updated plan of care is not required for these items.

General Information, continued

Rent-to-Purchase Equipment, continued

After the rent-to-purchase agreement has been satisfied, the equipment becomes the personal property of the recipient. The equipment is still covered under the one year provider warranty beginning with the date of service, whereby the provider is responsible for all repairs, replacements, and modifications.

If the recipient becomes ineligible for Medicaid before the ten-month contract expires or before a tenth installment payment is billed by the provider, the equipment remains the property of the provider.

Rental Agreement Requirements

When rental equipment is furnished to a recipient, as part of the rental agreement the provider must:

- Ensure and maintain documentation on file that the equipment is routinely serviced and maintained by qualified provider staff, as recommended by the product manufacturer.
- Repair or replace all expendable parts or items, such as masks, hoses, tubing and connectors, and accessory items necessary for the effective and safe operation of the equipment.
- Provide substitute equipment, at no additional charge to Medicaid or the recipient, if the equipment becomes broken or damaged or while the original rental equipment is being repaired.
- Replace equipment that is beyond repair at no additional charge and maintain documentation of the replacement.
- Maintain documentation signed and dated by both the provider and the recipient or legal guardian at the time of delivery, which attests that:
  - Instruction has been provided by trained and qualified provider staff to the recipient or legal guardian regarding the recipient's or legal guardian's responsibility for cleaning the equipment and performing the general maintenance on the equipment, as recommended by the manufacturer.
  - The recipient or the legal guardian was provided with the manufacturer instructions, servicing manuals, and operating guides needed for the routine service and operation of the specific type or model of equipment provided.

Discontinuation of a Rental Agreement

A rental or rent-to-purchase agreement between a provider and recipient may be discontinued with the recipient's or legal guardian's consent if:

- The recipient becomes ineligible for Medicaid before the agreement ends.
- The recipient's medical need for the equipment has ended, as dated and signed by the recipient's authorized prescriber.
- During the rental agreement, the recipient is enrolled in a managed care plan and the rental service has been or is being terminated following the continuity of care period.

General Information, continued

Temporary Wheelchair Rentals

Medicaid reimburses temporary rentals for up to ten days while a recipient's wheelchair is being repaired. The rental fee is calculated and billed at the prorated daily rental rate listed on the DME and medical supply services provider fee schedules.

Customized wheelchair rentals are not permitted.

Limitations for Replacement of Equipment

Medicaid will not replace equipment in cases of misuse, abuse, neglect, loss, or wrongful disposition of equipment by the recipient, the recipient's legal guardian or responsible caregiver, or the provider. This includes the following:

- Failure to clean and maintain the equipment as recommended by the equipment manufacturer
- Failure to store the equipment in a secure and covered area when not in use

If equipment is stolen or destroyed in a fire, the provider must obtain, in a timely manner, a completed police or insurance report that describes the specific medical equipment that was stolen or destroyed.

If damages are as a result of an automobile accident, documented effort to seek reimbursement from the automobile insurance plan must occur prior to submitting a request to Florida Medicaid.

If the item requires prior authorization or will exceed a service limit, the police or insurance report must be submitted with the request to Medicaid's QIO for review.

Providers are responsible for the repair or replacement of items damaged by the provider.

General Information, continued

Maintenance

Medicaid will reimburse for the maintenance and repair of equipment when all of the following conditions are met:

- Equipment is covered by Medicaid
- Equipment is the personal property of the recipient
- Item is still medically necessary
- The equipment is used exclusively by the recipient
- No other payment source is available to pay for the needed repairs
- Equipment damage is not due to equipment misuse, abuse, neglect, loss or wrongful disposition by the recipient, the recipient's family, the legal guardian, responsible caregiver, or the provider
- Equipment maintenance is performed by a qualified technician
- Maintenance is not currently covered under a manufacturer's or provider's warranty agreement
- Maintenance is not performed on a duplicate type of item already being maintained for the recipient during the maximum limit period

Labor for Non-Routine Maintenance and Repair

Medicaid reimburses a provider for labor when providing non-routine maintenance and repairs necessary to keep the DME safe and functional.

Labor for non-routine maintenance and repairs must be performed by qualified technicians and does not require prior authorization, unless the repairs are to be made to an augmentative and alternative communication (AAC) device or custom wheelchair. The reimbursement covers units of labor only and does not cover travel time, repair assessment time, or the cost of repair and replacement parts or components. Parts are billed separately with the appropriate procedure code(s).

Labor is not reimbursed for repairs and modifications made to equipment that is currently under a DME provider warranty.

Repair, Replacement, or Renovation

The provider's documentation must identify the item(s) requiring repair or replacement and include:

- A written and detailed explanation of how damage to the equipment was sustained or an explanation regarding the missing components or pieces of the equipment.
- A written explanation that clearly specifies that the repairs or non-routine maintenance needed requires the recipient's equipment to be temporarily replaced with rental equipment.
- The make, model, and serial number, as applicable, of the equipment needing repair.

General Information, continued

Repair, Replacement, or Renovation, continued

Reimbursement for DME repairs is limited to the amount necessary to make the item serviceable and safe, but not to exceed 66 percent of the original cost of the equipment plus the cost of subsequent modifications in need of repair or renovation.

Requests for substantial modifications or renovations to custom equipment should also include the provider's statement assuring the proposed modification or renovation will increase the lifetime of the device or equipment by a specified number of months or years.

Delivery Documentation Requirement

Delivery documentation must be maintained in the recipient's record and, at a minimum, include the following information:

- Name of the DME and medical supply provider
- Provider's identification number (for the DME physical location that rendered the service or equipment)
- Address of the DME physical location that rendered the service or equipment
- Recipient's full name and 10 digit Medicaid identification number
- Documentation of the service location (identifying whether medical equipment or supplies were received by the recipient or the recipient's legal guardian or responsible caregiver at the DME physical location or delivered directly to recipient's residence)
- Date of delivery
- Complete description of item(s) delivered
- Manufacturer name of equipment delivered
- Model number
- Serial or item number(s), where applicable
- Current hour meter reading(s), if applicable
- Oxygen tank or cylinder's contents, if applicable
- Clearly written statement identifying whether the equipment is new, used, or refurbished
- Signed and dated documentation of training provided to the recipient or recipient's legal guardian or responsible caregiver
- Dated signature and professional license number of the DME delivery person (when applicable)
- If a DME item is appropriate for shipment, the date of shipment, and proof of documented delivery and receipt (such as a UPS tracking document)
- Signature of recipient or recipient's legal guardian or responsible caregiver and date of delivery or receipt (if the information was captured by the deliverer)

General Information, continued

Pick Up and Return Documentation Requirement

Pick up and return documentation must be maintained in the recipient's record for the following circumstances:

- Medical equipment being returned to the provider's DME business location by the recipient or the recipient's legal guardian
- Equipment no longer medically necessary and is picked up from the recipient's residence by the provider
- Equipment no longer functioning properly and is picked up from the recipient's residence
- Equipment picked up from the recipient's residence for other clearly documented reasons

Pick up documentation must include, at a minimum, the following information:

- Name of DME and medical supply provider
- Medicaid identification number of the DME location
- Address of the DME physical location that originally rendered the service or equipment
- Recipient's full name and ten digit Medicaid identification number
- Complete description of item(s) picked up
- Manufacturer name of item(s) picked up
- Model and serial or item number(s) of item(s) picked up
- Reason the equipment is being picked up
- Current hour meter reading(s)
- A description of the pick up location that identifies whether medical equipment or supplies were returned to the DME business location or retrieved from the recipient's residence (including the recipient's pick up address)
- The reason for a return when medical equipment being returned to the provider's DME business location by the recipient or the recipient's legal guardian
- Date of pick up or return
- Dated signature of staff picking up the equipment and his professional license number (if applicable)
- Dated signature of the recipient or the recipient's legal guardian releasing the medical equipment to the provider (if the information was captured by the deliverer)

General Information, continued

Training Documentation Requirement

The recipient's record must contain documentation of the training that was provided to the recipient upon receiving prescribed medical equipment and supplies. Training documentation must, at a minimum, include the following information:

- Recipient's name
- Complete description of medical equipment or item(s) received
- Model and serial number of item received
- Date of training
- Printed name, signature, and title of trainer
- Professional license number of trainer (when applicable)
- Dated signatures of the recipient or the recipient's legal guardian (attesting to the understanding of information and handouts provided)
- Description of training handouts or brochures

Apnea Monitors

Who Can Receive

Infants under the age of 12 months with documented apnea or who have known risk factors for life threatening apnea, bradycardia, and hypoxemia after hospital discharge.

Who Can Provide

The treating physician may prescribe an apnea monitor with or without recording features.

The provider must, at a minimum:

- Maintain and update documentation that proves the recipient's family or current caregiver successfully completed infant Cardio Pulmonary Resuscitation training.
- Ensure the type of apnea monitor prescribed and provided is a cardiorespiratory monitor.
- Provide maintenance coverage 24 hours a day, seven days a week, which includes the aftermath of a national or natural disaster.
- Respond to emergency repair requests within six hours.
- Ensure a home visit to provide training is completed by an RN, CRT, or an RRT within five days following a hospital discharge or significant change in recipient's legal guardian.
- Ensure and maintain documentation that a home visit is completed by a qualified RN, CRT, or RRT every quarter after the initial visit.
- Maintain documentation of all training provided and visits made by qualified staff and therapists.
- Obtain a redetermination of medical necessity from the recipient's treating physician if the length of time prescribed is less than twelve months.

Apnea Monitors, continued

Service Requirement

The provider is responsible for ensuring and maintaining documentation that the appropriate licensed or certified employees or contracted staff set up the following:

- Monitor with or without recording feature (as prescribed)
- All ancillary (accessory) items necessary to safely operate the equipment to ensure the highest level of functionality and medical care including:
  - Battery pack
  - Case
  - Emergency battery
  - Electrodes (as many as required)
  - Safety lead wires
  - Electrode belt(s)
  - Remote alarm (if prescribed)

Home Visit Documentation

When a registered nurse (RN), certified respiratory therapist (CRT), or registered respiratory therapist (RRT) conducts a face-to-face home visit, the licensed professional must document the following information in the recipient's medical record:

- Recipient's diagnosis
- Recipient's current condition and recent changes in the recipient's condition based upon an interview with the recipient's family and legal guardian
- Any non-compliance in the use of the monitor
- Equipment problems reported
- Face-to-face home visit schedule (agreed upon and signed by both parties)
- Documentation of the type of training provided to the recipient's legal guardian(s), caregiver(s), and the printed name(s) and dated signature(s) of the person(s) receiving and providing the training

Attempted home visit or a phone call does not meet the requirement for a face-to-face home visit.

Apnea Monitors, continued

Discontinued Apnea Monitoring Service	Apnea monitors must be removed from the recipient's home within three days of the treating physician's order to discontinue the monitoring service. The provider must not submit Medicaid claims for dates of service occurring after the provider receives the treating physician's orders to discontinue monitoring services.

Augmentative and Alternative Communication Systems

Description	An augmentative and alternative communication systems (AAC) device attempts to compensate for the impairment and disability patterns of individuals with severe, expressive communication disorders (i.e., individuals with severe speech-language and writing impairment). Dedicated AAC systems are designed specifically for a recipient and must be prior authorized. Non-dedicated systems are commercially available devices such as laptop computers with special software and are not reimbursable by Medicaid.
Evaluations	All evaluations for AAC devices and AAC device accessories must be performed by a licensed or Department of Education-certified speech-language pathologist. Augmented and alternative communication device evaluations are valid for six months from the date of completion.
Medicaid Approval	Prior authorization (PA) requests for AAC devices, AAC device accessories, and repairs must be reviewed for medical necessity by Medicaid's QIO. The QIO decision for coverage will be based on medical necessity, including the medical rationale for the request of a particular system, a comparative analysis of equipment tested, and the individual recipient's ability to use the equipment as it relates to the medical need.
Repairs	Medicaid reimburses AAC device repairs. AAC device repairs must be prior authorized.

Augmentative and Alternative Communication Systems, continued

Interdisciplinary Team and Evaluation of Recipients Enrolled in Public School	An interdisciplinary (ID) team must evaluate the recipient, recommend an AAC device, and write an individualized action plan or plan of care. The ID team must consist of at least two members of different professional disciplines and a speech-language pathologist who will lead the team. The speech-language pathologist may request the assistance of an occupational therapist or a physical therapist. Most cases will require an occupational therapist to be a part of the ID team. For an individual who is wheelchair dependent for mobility, a physical or occupational therapist must be a member of the ID team. The ID team must include a treating speech-language pathologist, if different from the evaluating speech-language pathologist. It is the responsibility of the team leader to provide the team members and other appropriate individuals with the necessary documentation to review and make a determination. Documentation must include an evaluation and individual plan or plan of care.
Evaluation for Recipients Attending Home School	For recipients attending home school, a speech-language pathologist is responsible for performing an evaluation, recommending an AAC device and accessories, and for writing an individualized action plan or plan of care. The speech-language pathologist must consult the home schoolteacher, occupational or physical therapist (if receiving occupational or physical therapy services), and the recipient's legal guardian when writing the individualized action plan or plan of care.
Recipients Not Enrolled in Public or Home School	A speech-language pathologist is responsible for performing an evaluation, recommending an AAC device and accessories, and for writing an individualized action plan or plan of care.

Augmentative and Alternative Communication Systems, continued

Speech-Language Pathologist's Evaluation

Once the ID team (or the speech-language pathologist for recipients not enrolled in public school or home school) has evaluated the recipient and recommended an AAC device, the speech-language pathologist must document the following information in writing (the first three items are obtained from the recipient's medical record):

- Significant medical diagnosis(es)
- Significant treatment information and current medications
- Medical prognosis
- Motor skills (i.e., posture and positioning, wheelchair use if applicable include the make and model of the wheelchair, selection abilities, range, and accuracy of movement)
- Cognitive skills (i.e., alertness, attention span, vigilance)
- Sensory and perceptual abilities (i.e., hearing, vision)
- Language comprehension
- Expressive language capabilities
- Oral motor speech status
- Use of communication and present communication abilities
- Communication needs (including the need to enhance conversation, writing, and signaling emergency, basic care and related needs)
- Writing impairments, if any
- Environment (i.e., home, work, etc., with a description of communication barriers)
- AAC device recommendation (which may include symbol selection, encoding method, selection set (physical characteristics of display), type of display needed, selection technique, message output, literacy assessment, vocabulary selection, and participation patterns)
- If requested, a video (including audio) of the recipient demonstrating the ability to independently access the device when the access method is other than direct select such as eye gaze technology
- The evaluator's printed name, title, copy of current professional license or Department of Education (DOE) certification, and legible and dated signature
- The evaluator's telephone number for contact purposes

Components of the Individualized Action Plan or Plan of Care

The recommended individualized action plan or plan of care must include the following information:

- Explanation of any AAC device currently being used or owned by the recipient at home, work, or school
- Current use of the system(s) and its limitations
- Current speech-language therapy goals, status, and progress
- Appropriate long and short-term therapy objectives
- Recommended AAC device (based on cost-effectiveness and the recipient's needs)
- Recommended length of a trial period, if applicable
- Description of any AAC devices that the recipient has previously tried
- Specific benefits of the recommended AAC device over other possibilities

Augmentative and Alternative Communication Systems, continued

Components of the Individualized Action Plan or Plan of Care, continued	• Established plan for mounting, if necessary, repairing, and maintaining the AAC device • Who is responsible to deliver and program the AAC device to operate at the level recommended by the ID team • Who will train the support staff, recipient, and primary guardian in the proper use and programming of the AAC device • Documentation of medical necessity
Concurrence by Public School Personnel	If the recipient is in the public school system, appropriate school personnel must be given the opportunity to comment on the ID team's recommended device and acknowledges that the device may be used by the recipient while at school. School personnel must acknowledge that the recipient's teacher and school therapist are knowledgeable in the use of the AAC device or will be trained regarding its use. The public school is not responsible for the repair of AAC devices that were funded by Florida Medicaid.
Concurrence by Home School Teacher	The home school teacher must concur with the recommendation of the AAC device, by providing his printed name, title, and dated signature on the individualized action plan or plan of care. As appropriate, the speech-language pathologist must train the home school teacher regarding the AAC device and its use.
Conflict of Interest for AAC Device	The medical professionals who evaluate the recipient, serve on the ID team, or prescribe the AAC device must not have a financial relationship with or receive any financial gain from the AAC device manufacturer or the DME provider. A signed and dated conflict of interest statement must be included in the therapist's documentation and included with the prior authorization request packet.
Additional Evaluation Requested by Medicaid	Florida Medicaid reserves the right to request an evaluation of a recipient from another physician or an individual who is board-certified as a neurologist, physiatrist, otolaryngologist, audiologist, optometrist, or ophthalmologist for the purpose of establishing the appropriateness of the device being recommended.

Augmentative and Alternative Communication Systems, continued

Reimbursement	The ID team must select an AAC device that is based on the recipient's current medical needs and projected changes in the recipient's communication development over at least a five year period. Medicaid may reimburse for one dedicated AAC device system every five years per recipient and a software upgrade every two years, if needed and prior authorized. Medicaid will reimburse for replacement of AAC devices, components, or accessories when there is irreparable failure or damage, not caused by the willful misuse, abuse, neglect, loss, or wrongful disposition of equipment by the recipient, the recipient's legal guardian(s), responsible caregiver(s), or the provider.

Bathroom and Toileting Aids

Description	Bathroom and toileting aids are to assist recipients who are incapable of using standard toilet facilities.
Reimbursement	A portable commode may be reimbursed if a recipient has limited or no access to toilet facilities. A detachable or drop arm commode may be reimbursed if a recipient cannot perform a pivot transfer without assistance.

Disposable Incontinence Supplies

Who Can Receive	Disposable incontinence supplies are reimbursed for recipients four years of age, when a child would normally be expected to achieve continence, through the age of 20 years.
Service Requirement	Disposable incontinence supplies are only for use by individuals with chronic incontinence caused by a permanent physical or mental condition, including cerebral palsy and developmental delay.

Disposable Incontinence Supplies, continued

Documentation Requirement

To receive incontinence supplies, the following documentation must be included in the recipient's record:

- Physician's prescription, including the specific diagnosis pertaining to the underlying condition(s) that lead to the need for incontinence products (The prescription must specify the type of incontinence (the secondary diagnosis code) for which the incontinence supplies were prescribed. The prescription must be written prior to the delivery of supplies.)
- Measurements (e.g., waist and hip size, weight) which support reimbursement for the specific size of product supplied
- Monthly record of specific type, brand, and size of product(s) supplied
- Quantity of disposable supplies needed per month (Documentation must reflect the number of units by which each product is measured. For example, diapers are measured as individual units. If one package of 200 diapers is delivered, the delivery slip or invoice and the claim must reflect that 200 diapers were delivered and not that one package was delivered.)

Reimbursement

Disposable incontinence supplies are reimbursed up to a combined total of 200 per calendar month.

Incontinence liners are not menstrual pads.

"Blanket" incontinence supply orders covering more than one recipient or orders not specific to a product type and quantity are not acceptable.

Enteral Nutrition

Description

Enteral nutrition is the delivery of nutrients by mouth or by nasogastric, jejunostomy, or gastrostomy feeding tube.

Note: A category listing of the enteral formula products that Medicaid reimburses is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Forms.

Enteral Nutrition, continued

Service Requirement for Enteral Formulas for Recipients Under the Age of 21 Years

Commercial enteral products are reimbursable if such products constitute 50 percent or more of total recipient caloric intake.

Products are not approved to augment normal dietary sources of nutrition.

The recipient must have a documented diagnosis of a barrier to ingestion, digestion, or absorption of regular food or renal failure, hepatic failure, or an inborn error of metabolism.

Recipients who do not need to meet the 50 percent of calories requirement, must have one of the following conditions:

- Inborn errors of metabolism
- Recipients on dialysis who meet two or more of the criteria listed below:
  - Albumin less than 3.5 mg/dl for two consecutive months
  - nPCR/nPNA less than .8 for two consecutive months
  - Unplanned or unintended weight loss for two consecutive months

The physician must submit a letter that documents that the recipient meets the criteria. Laboratory tests or weight measurements must be performed within 60 days of the date of service.

Service Requirement for Enteral Formulas for Recipients Age 21 Years and Older

Commercial enteral products are reimbursable if such products constitute 100 percent of total recipient caloric intake.

Products are reimbursable if the product is the recipient's sole source of nutrition. The recipient must have a documented diagnosis of a barrier to ingestion, digestion, or absorption of regular food or renal failure, hepatic failure, or inborn error of metabolism.

Elemental products (hydrolyzed proteins) are reimbursed only with a documented diagnosis of a malabsorption condition.

Recipients with the following conditions, but do not need to meet the sole source (100 percent) calorie requirement are eligible for enteral formulas:

- Inborn errors of metabolism
- Recipients on dialysis who meet at least two or more of the criteria listed below:
  - Albumin less than 3.5 mg/dl for two consecutive months
  - nPCR/nPNA less than .8 for two consecutive months
  - Unplanned or unintended weight loss of more than five percent in one month, seven percent in three months, or ten percent in six months

The physician must submit a letter that documents that the recipient meets the criteria. Laboratory tests or weight measurements must be performed within 60 days of the date of service.

Enteral Nutrition, continued

Women, Infant, and Children Programs	Pregnant, breast-feeding, postpartum women, and children under the age of five years must register with the Federal Special Supplemental Nutrition Program for Women, Infants and Children (WIC). The WIC program must be the primary provider of enteral products if the recipient is WIC eligible. Medicaid only approves covered enteral product in excess of WIC's maximum quantities as set by the United States Department of Agriculture. Recipients must meet all other Medicaid criteria as described in this handbook.

Gastric Suction Machines

Description	The gastric suction machine is versatile and can be used as both a stationary unit, using an electrical wall outlet, and as a portable unit for up to eight hours when the rechargeable battery has been fully charged.
Reimbursement	Tubing and accessories necessary to operate gastric suction equipment are reimbursable only for recipient owned equipment.

Glucose Monitors, Diabetic Testing Strips, Insulin Syringes, and Blood Lancets

Home Glucose Monitors and Diabetic Testing Strips	These items are reimbursed for recipients whose documented medical condition requires frequent monitoring of urine or blood glucose levels. Maximum monthly limits for blood glucose test reagent strips for home blood glucose monitoring are listed in the durable medical equipment and medical supply services provider fee schedules. The order for home blood glucose monitors or diabetic testing supplies must include the following elements: • All item(s) to be dispensed • Specific frequency of daily testing
Insulin Syringes	Insulin syringes are reimbursed for recipients whose documented medical condition requires insulin to be injected.

Glucose Monitors, Diabetic Testing Strips, Insulin Syringes, and Blood Lancets, continued

Blood Lancets	Blood lancets are used to pierce the skin for the purpose of obtaining a blood sample when monitoring blood glucose levels. Blood lancets are reimbursed for recipients whose documented medical condition requires frequent monitoring of blood glucose levels.

Heat Lamps and Pads

Description	Heat lamps and heating pads are appliances or equipment used to apply heat to areas of the body.
Heat Lamp and Pad Reimbursement	Medicaid reimburses heat lamps and heating pads when prescribed by a treating physician or the treating physician's prescribing ARNP or physician assistant to treat a condition or illness that requires the application of localized heat therapy to affected area(s) of the body.
Portable Paraffin Bath Reimbursement	Portable paraffin bath units are reimbursable for recipients under the age of 21 years who has undergone a successful trial period of paraffin therapy and is expected to receive relief through long-term use. The prescription for the paraffin bath use must describe area of the body requiring treatment and the frequency and duration of treatments. Medical necessity must be redetermined at least every six months with a new medical necessity document.

Hospital Beds, Mattresses, and Rails

Description	A standard hospital bed consists of a modified latch spring assembly mattress, bed ends with casters, and two manually operated foot end cranks. It is equipped with four sockets and is capable of accommodating a trapeze bar, side rails, an overhead frame, and other accessories.
Service Requirements for Manual Beds	Medicaid reimburses for a hospital bed when the recipient requires repositioning of the body in a way not feasible in an ordinary bed or attachments for the bed are required that cannot be used with an ordinary bed. Medicaid reimburses for a multi-height bed when it is medically necessary to permit the recipient to transfer from a bed into a chair or wheelchair or to permit ambulation.

Hospital Beds, Mattresses, and Rails, continued

Semi-Electric and Electric Beds	Medicaid reimburses for a semi-electric bed or an electric bed for a recipient who is cognitively and physically capable of safely adjusting the position of the bed by independently operating the bed controls. The authorized prescriber must determine that the recipient's condition requires frequent changes in body position and that the recipient cannot tolerate delays in repositioning. Recipients must be able to independently operate semi-electric or electric beds.
Heavy Duty Hospital Bed	Medicaid reimburses for a heavy duty bed for recipients weighing in excess of 350 pounds. The recipient's current height and weight must be included in the medical necessity documentation signed by the treating physician or the treating physician's prescribing ARNP or physician assistant.
Hospital Bed Documentation	The provider must submit, at a minimum, the following documentation with all required prior authorization requests and maintain copies in the recipient's record: • Recipient's name • Recipient's date of birth • Recipient's current height and weight • Place of service, including address • Copy of the recipient's most recent hospital discharge summary (if hospitalized or institutionalized within the past 30 days) • Recipient's diagnosis and current symptoms that justify the medical necessity for the type of hospital bed requested • Length of time the bed will be medically necessary • Severity and frequency of the symptoms that necessitate a hospital bed for positioning or transfer • Prescription and CMN (which includes the printed name and dated signature of the treating physician or the treating physician's ARNP or physician assistant and the prescriber's professional license number)
Mattress Replacement	Medicaid reimburses for the replacement of a hospital bed mattress every four years.

Hospital Beds, Mattresses, and Rails, continued

Hospital Bed or Hospital Bed Rails Replacement	Medicaid reimburses for the replacement of a hospital bed or the replacement of the hospital bed's rails every eight years.
Safety Enclosure Frame and Canopy	Medicaid reimburses for a safety enclosure frame and canopy for the recipients self-protection under the age of 21 years when prescribed by the treating physician or the treating physician's ARNP or physician assistant. Note: For the appropriate HCPCS code and scheduled fee, see the DME and medical supply services provider fee schedules.
Safety Enclosure Frame and Canopy Documentation	The following safety enclosure frame and canopy documentation, with the authorized prescriber's signature, must be included: • Diagnosis-related cognitive or communication impairment or a severe behavioral disorder (which may risk safety in the bed) • Evidence of mobility putting the recipient at risk for injury while in bed (more than standing at the side of the bed), or the recipient has had an injury relating to bed mobility • Less costly alternatives have been unsuccessful or contraindicated (e.g., putting a mattress on the floor, padding added to ordinary beds or hospital beds, transparent plastic shields, medications, helmets) • The ordering practitioner ruled out physical and environmental factors reasons for recipient behavior (such as hunger, thirst, restlessness, pain, need to toilet, fatigue due to sleep deprivation, acute physical illness, temperature, noise levels, lighting, medication side effects, over- or under-stimulation, or a change in caregivers or routine) • A behavior management plan (for recipient with a behavioral disorder) • A written monitoring plan approved by the ordering and treating practitioners (describing when the bed will be used, how the recipient will be monitored at specified time intervals, how all of the recipient's needs will be met while using the enclosed bed (including eating, hydration, skin care, toileting, and general safety, identification by relationship of all caregivers providing care to the recipient, and an explanation of how any medical conditions (e.g., seizures) will be managed while the recipient is in the enclosed bed)

Infusion Pumps (Parenteral, Drug, and Enteral Nutrition)

Description	Infusion pumps deliver fluids, including nutrients and medications, into a recipient's body in a controlled manner.
Infusion Pump Rental	An infusion pump rental includes all initial supplies for the initiation of home infusion therapy, including dressing kits, injection cap, betadine wipes, alcohol, wipes, two inch Dermiclear tape, one inch Dermiclear tape, one quart Sharps container, Destruclip box, and other miscellaneous supplies.
Enteral Nutrition Pump Reimbursement	Enteral nutrition pumps are reimbursed when documented gravity feedings or syringe feedings have caused repeated reflux and/or aspiration complications.

Intermittent Catheter with Insertion Supplies

Reimbursement	Medicaid reimburses a sterile, closed-system intermittent catheter kit, with or without an insertion or introducer tip used for self-catheterization. The catheter can be packaged together or separately from the insertion supply kit but both products must be sterile and provided. Contents of the insertion supply kit must remain in the original sterilized packaging from the insertion supply kit manufacturer. It is not acceptable to unbundle a sterile insertion supply kit.

Lymphedema Pump

Description	A non-segmental lymphedema pump is a device that has a single outflow port on the compressor that produces a set level of pressure. A segmental lymphedema pump is a device that has multiple outflow ports on the compressor that lead to distinct segments on the appliance that inflates sequentially.

Lymphedema Pump, continued

Documentation Requirement

The following information must be included in the recipient's record:

- Indication that the recipient or the recipient's legal guardian has been instructed on the operation of the equipment and the appropriate amount of pressure to be used
- Frequency and duration of use

Medical necessity documentation must include a diagnosis of intractable lymphedema of the extremities and that the recipient had one or more previous admissions to treat complications of the intractable lymphedema or evidence of ulceration due to lymphedema.

Reimbursement

Medicaid reimburses for lymphedema pumps if medical necessity indicates treatment is required for intractable lymphedema of the extremities.

Documented conservative treatments that should first be tried may include limb elevation, properly applied compression dressings (as with elastic bandage wrapping), and the use of custom-fabricated gradient-pressure compression dressings.

Osteogenesis Stimulator

Description

An osteogenesis stimulator is a device that provides electrical stimulation to augment bone repair.

Reimbursement

Medicaid reimburses for an osteogenesis stimulator when non-union long bone fractures exceed three months, when there is congenital pseudoarthrosis or failed fusion.

The treating physician's prescription must specify that less costly alternatives were tried and that the osteogenesis stimulator has been prescribed in lieu of surgery.

Passive Motion Device

Description	A passive motion device is a mechanical device that is used to extend and flex the knee.
Who Can Receive	Medicaid reimburses for a passive motion device for recipients under the age of 21 years who have undergone TKA or reconstruction (open or arthroscopic repair) of the ACL of the knee.
Service Requirement	The provider's appropriately trained staff must: • Deliver and assemble the passive motion device in the recipient's home. • Provide instruction to the recipient or the recipient's legal guardian, regarding the safe and proper use of the device. • Maintain documentation of the delivery, pick up, and the instructions provided in the recipient's record.
Documentation Requirement	The provider must have documentation in the recipient's record that supports the use of a CPM device as medically necessary, because the recipient has undergone total knee arthroplasty (TKA) or reconstruction (open or arthroscopic repair) of the anterior cruciate ligament (ACL) of the knee.
Reimbursement	The coverage must begin within two days following surgery and must not exceed 21 days. Sheepskin pads are included in the reimbursement.

Phototherapy (Bilirubin) Light with Photometer

Description	Phototherapy is the exposure to artificial light for treatment of neonatal jaundice.
Service Requirement	Medicaid reimburses for a phototherapy light with photometer if: • The treating physician's diagnosis is neonatal jaundice. • Treatment is limited to five consecutive days and occurs during the first 30 days of life. • Treatment includes a fiberoptics system with the fiberoptics blanket, covers, light sources, and related supplies.

Phototherapy (Bilirubin) Light with Photometer, continued

Documentation Requirement

The provider must maintain documentation of medical necessity that includes the following in the recipient's record:

- Duration of treatment
- Frequency of use per day
- Maximum number of days for use

Pressure Ulcer Care

Description

Medical equipment used to treat or prevent pressure ulcers.

Documentation Requirement

The following must be included in the recipient record:

- Documentation of medical necessity
- Documentation of reasons why less costly alternatives were found ineffective
- Documentation of the recipient's current course of treatment

Reimbursement

Medicaid reimburses for pressure ulcer care pads and wheelchair cushions when the recipient currently has pressure ulcers or is highly susceptible to pressure ulcers.

Medicaid reimburses for alternating pressure pads or mattresses and pumps for beds when a recipient is confined to a bed, has evidence of pressure ulcers, or provides evidence that the recipient is highly susceptible to pressure ulcers.

Traction Equipment

Description

Traction equipment is used to draw or pull sections of the body to improve skeletal alignment.

Reimbursement

Medicaid reimburses for traction equipment when prescribed by the recipient's treating physician, treating physician's prescribing ARNP, or physician assistant for an orthopedic impairment requiring traction equipment that prevents ambulation during the period of use.

Trapeze Equipment

Description

Trapeze equipment is a device that is freestanding or attached to a bed that enables the recipient to change his position in the bed or to transfer from the bed to a chair or wheelchair.

Reimbursement

Medicaid reimburses for trapeze equipment when a recipient is confined and needs help to get in or out of bed, change his body position, or sit up for a respiratory condition.

Medicaid also reimburses trapeze equipment for exercise to prevent muscular deterioration when prescribed by the recipient's treating physician, the treating physician's ARNP, or physician assistant.

Mobility Aids

Ambulatory Aids

An ambulatory aid is reimbursed for a recipient with impaired ambulation. Ambulatory aids include canes, crutches, and walkers that are to be complete with tips, pads, and grips.

Gait Trainers

Gait trainers are funded for use within the home. This equipment requires prior authorization, using the miscellaneous procedure code.

Documentation must detail the expected medical benefit of gait training.

Documentation of a trial for first time request must show the recipient's independent ability to:

- Come to an upright weight bearing position without the use of a seat or hip support.
- Take reciprocal steps to guide the device on a straight path.
- Independently change directions.

Patient Lifts

Reimbursement

Medicaid reimburses for portable patient lifts, for use in the recipient's home, when the assistance of more than one person is necessary to move the recipient from bed to chair or chair to toilet and the:

- Recipient's condition is such that periodic movement is necessary for effective treatment or care.
- Device is used to prevent deterioration of a condition where the alternative is bed confinement.

A portable patient lift device requires prior authorization through the Medicaid QIO.

Walkers

Reimbursement

Wheeled walkers with a seat and wheel locks are reimbursed, when prescribed, in lieu of a wheelchair.

A standard walker and related accessories are medically necessary when:

- The recipient has a medical condition impairing ambulation and there is a potential for ambulation.
- There is a need for greater stability and security than a cane or crutches provide.

Heavy duty walkers are for assisting recipients who weigh more than 300 pounds.

Wheelchairs

Description

A wheelchair is a seating device system mounted on wheels used to transport a non-ambulatory individual or an individual with severely limited mobility.

Wheelchairs, continued

Service Requirement	Medicaid reimburses and provides maintenance for only one wheelchair (regardless of type) or power operated vehicle (POV) procedure code per recipient, per maximum limit period, as stated in the DME and medical supply services provider fee schedules. For recipients under the age of 21 years, the wheelchair must accommodate a minimum of two inches of adjustments for anatomical growth, in the primary dimensions (seat depth, seat width, back height, and leg drop). The following types of wheelchairs and POV devices require prior authorization: • Customized manual wheelchairs • Customized power wheelchairs • Non-custom power wheelchairs • Motorized scooters (POV) • Power Conversion kits
Customized Wheelchair Documentation	Medicaid will not approve a customized wheelchair or wheelchair custom upgrade without the medical necessity documentation that establishes the recipient's inability to perform activities of daily living within the recipient's home. Activities of daily living include bathing, eating, toileting, dressing, transferring in and out of a bed or chair, and moving about within the home.
Motorized or Power Wheelchair and Power Operated Vehicle Documentation	Medicaid will not approve a power wheelchair (custom or non-custom), POV, or wheelchair power upgrade, without documentation from an independent licensed physical therapist or occupational therapist or physiatrist, which documents the recipient's inability to perform activities of daily living in the home and the medical consequences that will occur without the equipment requested. When a motorized wheelchair (custom or non-custom) or power-operated vehicle is prescribed, the documentation must state that the recipient has successfully demonstrated a consistent ability to safely and independently operate a powered mobility device or wheelchair. The recipient must meet all of the following conditions: • Has documented, severe abnormal upper extremity dysfunction or weakness • Has demonstrated sufficient eye and hand perceptual capabilities and the cognitive skills necessary to safely operate and guide the chair or POV independently, and is capable of evacuating a residence or building with minimal or no verbal prompting in case of an emergency • Currently resides in or will primarily use the equipment in an environment conducive to the use of a motorized wheelchair or POV based on the type and size requested

Wheelchairs, continued

Motorized or Power Wheelchair and POV Documentation, continued

The following additional criteria must be met for a POV:

- Recipient's medical necessity requires the use of a POV to independently move around the residence
- Recipient is physically unable to operate a manual wheelchair
- Recipient can transfer safely in and out of the POV and has adequate trunk stability to be able to safely ride in the POV
- An independent licensed physical therapist, occupational therapist, or physiatrist has determined and documented a recommendation of the most appropriate and medically necessary POV to meet the recipient's individual mobility needs

Clinical documentation of a power wheelchair trial, supervised by an independent licensed physical therapist or occupational therapist or physiatrist, must accompany any first request for a custom power wheelchair.

Documentation of the recipient's current activities of daily living capabilities, ambulation, and transfer skills must also be included in the physical therapist, occupational therapist, or the physiatrist's clinical documentation.

Detailed documentation of home accessibility is required in a prior authorization request for any extra-wide wheelchair or powered mobility device.

Alternative funding sources should be explored for power or motorized wheelchairs and power mobility devices needed specifically for community leisure, vocational, or school use.

Wheelchair Repairs

All repairs to wheelchairs that include the replacement of non-custom parts that are described on the DME and medical supply services provider fee schedules (such as armrests, seatbelt, adjustable angle footplate, tires, casters, caster forks, etc.) must be billed at the scheduled fee with the appropriate procedure code.

A physical assessment of the wheelchair must be performed before submitting a prior authorization repair request.

Using the procedure code that describes the technical labor units to claim travel time, repair assessment time, or the cost of the replacement and repair parts is not permitted.

Wheelchairs, continued

Reimbursement

Medicaid reimburses the following categories of wheelchairs:

- Narrow wheelchair required due to narrow doorways in the home
- Lightweight wheelchair required when the recipient cannot propel a standard wheelchair
- Ultra lightweight wheelchair (requires justification, from the prescriber, as to why the recipient cannot propel a standard or light weight wheelchair)
- Wide, heavy-duty wheelchair for recipients whose measurements and body weight exceeding 200 pounds require a wider and more durable wheelchair
- Amputee wheelchair (required for recipients with a missing limb(s)
- Motorized wheelchair (required when medical needs cannot be achieved by a manual wheelchair)
- Other model(s) if the features and accessories are medically necessary
- Customized wheelchair that is specially constructed for the individual recipient and not otherwise available from manufacturers

Medicaid reimburses for a wheelchair when the recipient is non-ambulatory or has severely limited mobility and it is medically documented that a wheelchair is medically necessary to accommodate the recipient's physical characteristics.

The scheduled monthly fee for rental and rent-to-purchase wheelchairs includes the standard components such as armrests, wheels, tires, backs, batteries, battery chargers, and leg and foot rests.

Claiming separate reimbursement for standard components, custom seating modifications, or repairs for a rental or rent-to-purchase wheelchair currently under a rental or a rent-to-purchase agreement is not allowed.

Custom Cranial Remolding Orthosis

Description

A custom cranial remolding orthosis is a non-invasive device used to correct the symmetry of an infant's skull.

Service Requirement

Custom cranial remolding orthoses require prior authorization. Requests must be submitted using the appropriate procedure code to ensure proper routing for Medicaid's QIO review.

Custom Cranial Remolding Orthosis, continued

Documentation Requirement

Custom cranial remolding orthotic devices are reimbursed by Medicaid when it is determined medically necessary to correct a moderate to severe craniofacial deformity. Supporting documentation must include:

- A prescription from a neurologist, neurosurgeon, craniomaxillofacial surgeon, craniofacial surgeon, or plastic surgeon.
- Clinical evidence, including measurements, indicating the infant's current cranial index of symmetry (CIS) has a cephalic index of two standard deviations below mean (head narrow for its length) or two standard deviations above mean (head wide for its length).
- A statement from a treating neurologist, neurosurgeon, craniomaxillofacial surgeon or craniofacial surgeon, indicating use of a cranial remolding orthosis is recommended due to poor improvement in the infant's CIS, after a documented three months trial period of active counter positioning has been completed.
- Three months' worth of documentation regarding daily counter positioning therapy and has failed to improve the deformity and is determined to be unlikely to do so.
- Upon QIO request, current color photographs of the infant's head, taken from the following views:
  - Superior
  - Frontal
  - Posterior
  - Right and left lateral

Orthopedic Footwear

Description

Orthopedic footwear refers to footwear used in the preservation, restoration, and development of the form and function of the feet.

Who Can Receive

Foot orthotics are for congenital forefoot deformities in children who are under the age of 18 months, unless determined medically necessary for an older child who is not yet walking.

Fitting

The appropriately licensed professional must ensure prefabricated orthopedic footwear fits properly prior to releasing the footwear to the recipient.

A licensed pedorthotist, orthotist, or prosthetist-orthotist must ensure custom orthopedic footwear fits properly prior to releasing the footwear to the recipient.

Orthopedic Footwear, continued

Service Requirement

Orthopedic footwear must have all the following components:

- Strap or lace closure
- Long medial counters
- Steel shanks
- Goodyear welt construction
- Bunion last
- High toe box
- Thomas heel

Reimbursement

Medicaid reimburses for prescribed orthopedic footwear when one the following requirements are met:

- The recipient has congenital foot deformities (including clubfoot in children)
- One of the recipient's feet is full size and the other foot is one and one half times in length or two full widths larger than the other and the recipient requires a lift of one inch or more
- The recipient has a rigid foot deformity
- The recipient's foot or feet have severe structural deformities (e.g. rheumatoid arthritis, diabetic osteopathy or arthropathy, or following trauma)
- There are persistent skin breakdowns or ulcerations (caused by such conditions as diabetic neuropathies or degenerative disorders when a total contact system on the sole is expected to promote healing and avoid hospital care and surgical intervention)
- The prescribed shoe is constructed by a licensed professional to provide support for a totally or partially missing foot
- The prescribed shoe is required in conjunction with an orthotic system

Orthotic Devices

Description

Orthotic devices are appliances that support or correct a weak or deformed body part or restrict or eliminate motion in a diseased or injured part of the body.

Service Requirement

Orthotic providers must be staffed appropriately with licensed orthotic fitters, pedorthotist, orthotists, or prosthetists who provide direct services to Medicaid recipients, within the scope of their professional licenses.

The licensed pedorthotist, orthotist, or prosthetist must ensure that a custom orthotic or prosthetic device fits properly before releasing the device to the recipient.

Orthotic Devices, continued

Service Requirement, continued	The licensed pedorthotist, licensed fitter, or licensed fitter assistant must ensure that a prefabricated orthotic device fits properly before releasing the device to the recipient. The provider's facility must have the necessary equipment available on site for the repair, fabrication, and adjustments of custom devices. The provider is responsible for all needed adjustments, modifications, and replacements for the first year after the date of delivery.
Splints	Splints are orthotic devices. The appropriately licensed professional must document measurement and fitting to ensure the splint fits properly prior to releasing the device to the recipient. The provider is responsible for all adjustments, modifications, and replacements for the first year after date of delivery.
Documentation Requirement	The following medical necessity documentation must be written, dated, and signed by an appropriately licensed orthotics or prosthetics professional and maintained in the recipient's record: • Documentation of measurements taken • Dated documentation of fitting(s) and professional's printed name, signature, and professional license number • Documentation signed and dated by the recipient or the recipient's legal guardian attesting that written instructions for use and care of the device and written information was provided to the recipient • Documentation of delivery (signed and dated by recipient or recipient's legal guardian) • Written progress notes A signed and dated prescription, which includes the printed name and address of the treating physician, the treating physician's ARNP, or physician's assistant and the prescriber's professional license number, is required documentation that must be maintained in the recipient's record.

Pediatric Dynamic Splinting Device

Description	A pediatric dynamic splinting device is used to allow independent leg, knee, and hip motion and incrementally limit rotation of the feet.
Service Requirement	A licensed orthotist must assess and measure the recipient for the initial device and for any adjustments or modifications made to the device thereafter. The licensed orthotist must ensure that the device fits properly before releasing it to the recipient. The provider is responsible for all adjustments, modifications, and replacements for the first year after the date of delivery.
Reimbursement	Medicaid reimburses for a pediatric dynamic splinting device for clubfoot and internal tibial torsion. Reimbursement for a pediatric dynamic splinting device includes the center bar, hinged and rotational joints, the shoe assembly, and the shoes.

Prosthetic Devices

Description	Prosthetic devices are artificial devices or appliances that replace all or part of a permanently inoperative or missing body part.
Service Requirement	The appropriately licensed professional must ensure that the prosthetic device fits properly prior to releasing the device to the recipient. The provider is responsible for all adjustments, modifications, and replacements for the first year after date of delivery.
Documentation Requirement	The following documentation must be recorded, signed, and dated by the appropriate professional providing the direct service and filed in the recipient's record: • Assessment notes • Measurements taken • Fitting of the device • Written instructions and written information given to the recipient • Written progress notes

Prosthetic Eyes

Service Requirement	The recipient record must contain an evaluation that was completed by a physician or optometrist no more than 90 days prior to the provision of the prosthetic eye.
Reimbursement	Medicaid reimburses for prosthetic eyes if prescribed by an attending physician or optometrist. When the provider bills Medicaid, the following requirements apply: • Prosthetic eye cannot be billed until it has been fitted • Date of service entered on the claim must be the date the provider ordered the eye • Fee includes all costs related to measuring, fitting, and dispensing of the eye

Respiratory Equipment and Supplies

Documentation Requirement	The following information must be documented in the recipient's record: • Diagnosis • Prescription, certificate of medical necessity and redetermination of medical necessity • Machine setting for inspiratory positive airway pressure • Setting for expiratory positive airway pressure • Liter flow of oxygen, if appropriate • Time of day and number of hours a day the device is to be used • Estimated number of months the equipment will be needed • Home care protocol • Oxygen requirements • Documentation that the recipient, recipient's legal guardian, or responsible caregiver received training from a licensed professional regarding the proper and effective use of the equipment at the time of the set up • Visit documentation • Equipment assessments, repair, maintenance, and replacement • Delivery and pick up documentation

Compressors

Description

Compressors are machines that compress air into storage tanks for use by air driven equipment.

Documentation Requirement

Documentation of instruction must be maintained in the recipient's record.

The recipient or the recipient's legal guardian must receive instructions from the provider's licensed or certified CRT, RRT, RN, or respiratory care practitioner (RCP) regarding the operations and use of the machinery, including frequency, duration, and pneumatic air pressure.

Reimbursement

Medicaid reimburses for an air power source compressor when it is:

- Used to support medically necessary DME that is not self-contained.
- Used with a nebulizer that provides at least 50 pounds per square inch (psi).

Cough Stimulating Device

Description

Mechanical insufflator-exsufflator or cough stimulating devices are machines that apply positive and then negative pressure to the recipient's airway. This device helps recipient's clear secretions from the lungs as to stimulate a cough.

Service Requirement

Cough stimulating devices will be considered medically necessary when all of the following criteria are met:

- Recipient has a neuromuscular disease or high spinal cord injury causing a significant impairment of chest wall or diaphragmatic movement.
- Recipient has a peak cough expiratory flow of less than 2-3L per second.
- Standard treatments (inhalers, intermittent positive pressure breathing (IPPB) machine, incentive spirometry, positive expiratory pressure (PEP) devices, flutter valve devices and manual techniques such as chest percussion and postural drainage, under the guidance of a skilled professional practitioner) have not been successful in adequately mobilizing retained secretions.
- Recipient is motivated to use the device as prescribed or has able caregivers who can be trained to use the device effectively.

High-Frequency Chest Compression Systems

Service Requirement

High-frequency chest compression systems are considered medically necessary, in lieu of chest physiotherapy, for the following conditions with a documented failure of standard treatments to adequately mobilize retained secretions:

- Bronchiectasis (confirmed by CT scan, characterized by daily productive cough for at least six continuous months or by frequent exacerbations (i.e., more than four times a year) requiring antibiotic therapy)
- Cystic fibrosis
- The recipient has one of the following neuromuscular disease diagnoses:
  - Acid maltase deficiency
  - Anterior horn cell diseases
  - Hereditary muscular dystrophy
  - Multiple sclerosis
  - Myotonic disorders
  - Other myopathies
  - Paralysis of the diaphragm
  - Post-polio
  - Quadriplegia

Nebulizer

Description

A device used to administer medication in the form of a mist into the respiratory system.

Service Requirement

Medicaid reimburses for a nebulizer if the recipient's ability to breathe is severely impaired. The authorized prescriber must document the name of the medication(s) to be used with the nebulizer on the prescription for the device.

Medicaid reimburses for a compressor and nebulizer with heater for recipients with tracheostomies.

Compressor and Heater

Medicaid reimburses for a nebulizer with a compressor and heater for recipients with tracheostomies.

Administration Kit for Nebulizer Compressor

The administration kit includes a lid, jar, baffles, tubing, T-piece, and hand-held mouthpiece, as indicated for use with filtered or non-filtered disposable or non-disposable nebulizers.

Some nebulizer models come with an administration kit. Billing for additional kits that come with the device is not allowed.

Some manufacturer's nebulizer compressor models come equipped with an administration kit, some of which include a mask.

Nebulizer, continued

Delivery and Set Up	The provider is responsible for ensuring: • The prescribed nebulizer is provided directly to the recipient or the recipient's legal guardian, or responsible caregiver at the provider's physical DME location or is delivered and set up in the recipient's home and that the delivery is appropriately supervised. • Qualified staff or contracted licensed professionals provided the recipient or the recipient's legal guardian or responsible caregiver training and instruction regarding proper use and care of device and accessories. • Training documentation must be maintained in the recipient record.
Exception to Nebulizer Delivery and Set Up	Providers may store nebulizers at a physician's office for the purpose of having the physician's staff issue the equipment if it meets all of the following conditions: • The physician must document the medical necessity and need to prevent further deterioration of the recipient's respiratory status by the timely delivery of the nebulizer in the physician's office. • The DME provider must have written documentation of the competency and training by a Florida-licensed registered respiratory therapist of any DME staff who participate in the training of physician office staff for the use of nebulizers, including cleaning, warranty, and special needs of recipients. • The physician's office must have documented the training and competency of any staff member who initiates the delivery of nebulizers to recipients. The DME provider must maintain copies of all physician office training. • The physician's office must maintain inventory records of stored nebulizers, including documentation of the DME provider source. • A physician contracted with a Medicaid DME provider may not have a financial relationship with that provider or receive any financial gain from the delivery of nebulizers to recipients.

Oxygen and Oxygen-Related Equipment

Who Can Receive

Medicaid reimburses for oxygen and oxygen-related equipment for recipients who have one of the following conditions:

- Emphysema, chronic bronchitis, and bronchiectasis
- Chronic interstitial pneumonia
- Chronic interstitial pulmonary infiltrate-type pulmonary disease (such as pulmonary fibrosis from extensive tuberculosis, eosinophilia, granuloma, idiopathic fibrosis, and pneumoconiosis)
- Pulmonary hypertension
- Secondary polycythemia
- Terminal lung cancer

Additionally, Medicaid will reimburse oxygen for recipients under the age of 21 years who have one of the following conditions:

- Bronchopulmonary dysplasia (BPD)
- Cystic fibrosis
- Pulmonary fibrosis
- Pulmonary insufficiency of prematurity (PIP)
- Tracheomalacia
- Chronic lung disease
- Agenesis, hypoplasia, dysplasia of the lung
- Chronic cardiopulmonary disease (cor pulmonale)
- “P” pulmonale on EKG
- Erythrocytosis
  - Familial polycythemia
  - Hereditary elliptocytosis
  - Polycythemia, secondary

Who Can Provide

An oxygen provider must meet all of the following requirements:

- Provide all necessary supplies for the administration of oxygen and oxygen-related services, as part of the scheduled rental fee
- Provide all equipment and accessories, as prescribed
- Provide all contents for stationary and portable oxygen
- Supply and replace disposable items such as tubing, masks, cannulas, and filters
- Ensure accurate oxygen flow as low as 110 ml/minute for recipients under the age of 21 years
- Ensure recipient home visits are performed by qualified individuals at the frequency required by policy for the service or device provided

Oxygen and Oxygen-Related Equipment, continued

Who Can Provide, continued

- Ensure that oxygen and oxygen-related equipment is delivered by the appropriately trained staff in the recipient's home
- Ensure that oxygen and oxygen-related equipment set up in the recipient's home is supervised by one of the following professionals:
  - A licensed CRT, RRT, RN, or RCP who is employed by or under a current contract agreement with the DME provider (a qualified technician cannot substitute for a licensed professional)
  - The provider's employment of the CRT, RRT, RN, or RCP must be verifiable by a signed and dated W-4 income tax form. A contractual relationship must be evidenced by a current and valid contract. The DME provider is responsible for payment for services rendered by the DME provider's contracted CRT, RRT, RN, or RCP
- Recipient and caregiver training is provided by licensed professional at the time of set up
- Maintain the required documentation of delivery and pick up and recipient training and instruction in the recipient's record
- Ensure that the oxygen and oxygen-related equipment is not delivered to or dropped off at the recipient's home by independent courier or contracted courier services
- Make provisions for emergency oxygen due to equipment failure, natural or national disaster. Emergency service includes:
  - Responding to an oxygen failure within two hours or less.
  - Having appropriate staff available 24 hours a day, seven days a week.
  - Providing an emergency supply that will last the duration of the emergency, including services provided during the aftermath of a natural or national disaster.

Service Requirement

For Medicaid recipients of all ages, a physician-ordered test for blood oxygen levels must be conducted, and the oxygen provider must obtain a copy of the blood oxygen levels and the treating physician's orders related to the recipient's diagnosis.

Initial testing required for the medical necessity determination for oxygen must be performed only by the treating physician, staff employed by the physician and in the treating physician's medical office, or by a licensed laboratory.

The following components of the oxygen concentration must also be documented:

- The pO2 levels that equal or exceed 65mm Hg
- Oxygen saturation level at or under 90 percent

Oxygen and Oxygen-Related Equipment, continued

Service Requirement, continued

The provider may supply oxygen to recipients age 21 years and older if the recipient meets Medicare's criteria for laboratory results, arterial blood gases, or oximetry.

An oxygen evaluation is required for recipients under 21 years of age to determine the amount of oxygen necessary to prevent hypoxia. The evaluation is made over an extended period of time to measure different needs with different activities.

The evaluation must be completed by one of the following:

- Qualified pediatrician with a specialty in pulmonology or cardiology
- Neonatologist
- Intensivist pediatrician

The medical necessity for oxygen must be redetermined every 12 months, or for the length of time prescribed when less than12 months, with retesting performed by the treating physician's medical office, or by a licensed laboratory.

Service Requirement for Delivery Prior to Recipient's Discharge

Unless otherwise prohibited, oxygen and oxygen-related equipment may be delivered to the recipient's home by the provider's trained delivery staff within 48 hours prior to the recipient's anticipated discharge from a hospital or skilled nursing facility. The provider will coordinate the time and date for set up and the training with the family, the hospital or skilled nursing facility's discharge planner, and the licensed or certified professional.

Oxygen and oxygen-related equipment cannot be claimed for reimbursement until the recipient has been discharged home from the hospital or skilled nursing facility.

The provider must ensure that the recipient or his family has been properly instructed not to use the equipment until the required training and instruction has been provided by a CRT, RRT, RN or RCP.

The delivery person will provide the recipient or the recipient's legal guardian with the appropriate "Oxygen in Use" and "No Smoking" signage at the time of delivery, to be appropriately displayed at the recipient's residence.

Oxygen and Oxygen-Related Equipment, continued

Service Requirement for Initial and Quarterly Home Visit

When the CRT, RRT, RCP, or RN conducts the initial visit and qualified technicians conduct quarterly home visits, the provider must ensure the following:

- The display of required signage
- The quarterly checks of the operation and safety of the equipment
- Changing of filters
- Determination of oxygen output
- Oxygen concentrator meter reading (when a concentrator was delivered)
- Proper functioning of any oxygen back-up system
- Signed and dated acknowledgement from the recipient or the recipient's legal guardian (indicating that home visit services have been rendered and concentrator usage has been documented, when a concentrator was delivered)
- Information about the recipient's condition and the condition of the equipment documented in the recipient's record

Documentation Requirement

The following information must be filed in the recipient's record:

- Documentation of medical necessity for oxygen services that specifies:
  - Prescribed rate of flow.
  - Concentration level.
  - Frequency and duration of usage.
  - Circumstances under which oxygen is to be used.
  - Specific exercise or activity program that requires portable oxygen.
- Certified respiratory therapist, RRT, RN, or RCP staff members' names and titles
- Positive oxygen test results the treating physician is responsible for either performing the tests for medical necessity or ordering a licensed laboratory to perform the tests. (The treating physician must prescribe the oxygen within 30 days of the test results. If a prescription for oxygen is not provided within 30 days after the dated test results, the recipient must be re-examined and a new prescription obtained.)
- Type of system being used, portable or stationary
- Manufacturer's name, model, and serial number
- Set up and quarterly visit documentation
- Delivery and pick up documentation
- If a concentrator is in use, the number of hours used each quarter

Oxygen and Oxygen-Related Equipment, continued

Portable Oxygen Documentation Requirement

The oxygen provider must maintain the following documentation in the recipient's record:

- Documentation of medical necessity for oxygen service
- The recipient's treating physician has ordered a specifically-prescribed program of exercise or an activity program for therapeutic purposes
- Recommended exercises or activities cannot be accomplished by the use of stationary oxygen service
- Use of a portable oxygen system during the activity or exercise results in an improvement in the recipient's ability to perform the activities and exercises

Documentation for the Delivery and Set Up

Documentation of the installation must include the all of following information:

- The printed name and signature of the CRT, RRT, RCP or RN supervising the delivery and set up of the oxygen and oxygen-related equipment or supervising the set up after delivery but on the same day of recipient's scheduled discharge from a hospital or skilled nursing facility.
- A statement that the equipment delivered was clean, sanitary, functioning correctly, and proper signage was available and displayed.
- All the appropriate and necessary accessories were provided.
- The recipient or the recipient's legal guardian or responsible caregiver is provided with the necessary instruction and training regarding the manufacturer's recommended use and care of the equipment. The documentation of equipment delivery and training must be signed and dated by the supervising, licensed professional in attendance and the recipient or the recipient's legal guardian or responsible caregiver receiving the equipment and instruction.
- The scheduled frequency for the provider's trained staff to test and service the equipment.
- A statement signed by the recipient or the recipient's legal guardian verifying that they were provided with the DME provider's emergency contact information.

Reimbursement

Medicaid will reimburse for only one form of gaseous, liquid, or concentrated oxygen at a time.

Medicaid reimburses an all-inclusive rental fee for oxygen services, which includes:

- Supplies necessary for the administration of oxygen.
- All equipment and accessories, including tubing, masks, and back-up cylinders, etc.
- Signage for the recipient's residence, indicating oxygen is in use.
- Oxygen contents.
- Quarterly home visits and equipment monitoring.
- Equipment service and maintenance as required.
- Pick up, delivery, set up, and training.

Oxygen and Oxygen-Related Equipment, continued

Stationary Oxygen Services with Portable Equipment Reimbursement	Medicaid reimburses additional costs for portable equipment when both portable and stationary services are medically necessary. Medicaid will not reimburse for oxygen contents. The cost of oxygen contents for both portable and stationary services is included in the fee for the stationary oxygen code. If both stationary and portable services are medically necessary, Medicaid may reimburse: • One stationary oxygen type. • One portable equipment code.
Portable Oxygen Services Only Reimbursement	Medicaid reimburses for portable oxygen only when it is medically necessary and when the provider documents delivery, replacement, or refill of portable tanks and accessories each month.

Peak Flow Meter

Description	A peak flow meter measures how air flows from the lungs and is used in the medical management of asthma.
Service Requirement	The provider's appropriately trained and qualified staff is responsible for training the recipient and the recipient's legal guardain in the proper and effective use of the device and for documenting the training in the recipient's record.
Documentation Requirement	The following information must be included in the recipient's record: • Prescription for the item is dated and signed by the recipient's treating physician, the treating physician's ARNP, or physician assistant (including the prescriber's professional license number) • Diagnosis of moderate to severe asthma • Item is used as part of a continuing asthma treatment plan
Reimbursement	A peak flow meter is reimbursed for Medicaid recipients of all ages. Peak flow meters should not be used to diagnose chronic obstructive pulmonary disease.

Pulse Oximeter

Description	A pulse oximeter is a non-invasive device used to measure blood oxygen levels.
Service Requirement	The DME provider's licensed CRT, RRT, RN, or RCP must provide training to the recipient's legal guardain regarding the appropriate use of the device and accurate documentation of blood oxygen level readings.
Documentation Requirement	The caregiver is responsible for documenting daily pulse oximetry results to be provided to the child's treating physician.
Time-Sensitive Medical Necessity Redetermination	Medical necessity for the pulse oximeter must be redetermined every 12 months or for the length of time prescribed when less than 12 months, by the treating physician, the treating physician's assistant, or the treating physician's ARNP. The DME provider is not authorized to conduct any medical necessity testing or to provide any testing results to be used for the determination or the redetermination of medical necessity for pulse oximetry services. The DME provider may not pay for or offer remunerations to the prescribing practitioner or lab for the required testing services or results.
Reimbursement	Medicaid reimburses for the monthly rental of a medically necessary pulse oximeter to be used for the daily surveillance of recipients under the age of 21 years and not receiving oxygen therapy services. At least one of the following conditions must be met: • Chronic lung disease, chronic respiratory insufficiency or failure, pulmonary vascular hypertension, single ventricle defects, or cyanotic heart disease • Neurologically impaired with a tracheostomy who critically depends on maintaining an adequate oxygen saturation • Ventilator dependent • Being weaned from oxygen (Approval for rental of pulse oximeter to determine the advisability of discontinuation of oxygen for children who are being weaned from oxygen will be allowed for one month.)

Resuscitator Bag

Description	A resuscitator bag is a hand-held device used to temporarily provide artificial breathes for recipients who cannot breathe unaided. When used, the attached bag filled with air is manually squeezed to force air into the recipient's lungs.
Reimbursement	Medicaid reimburses for a resuscitator bag when prescribed for a recipient who is ventilator dependent and using a ventilator owned by the recipient or non-ventilator dependent recipients with a tracheostomy. A resuscitator bag is a necessary ventilator accessory included in the monthly scheduled rental fee for the ventilator equipment. Claiming separate reimbursement for a resuscitator bag for a recipient using a ventilator rented by Medicaid is not allowed.

Respiratory Suction Machine

Suction Machine Description	An electric aspirator designed for either upper respiratory and tracheal suction or gastric suction.
Tubing and Accessories	Tubing and accessories necessary to operate respiratory suction equipment are reimbursable only for recipient owned equipment.
Stationary Machine Reimbursement	Medicaid reimburses for a stationary respiratory suction machine when the medical necessity documentation indicates in-home use is appropriate and use of the machine does not require technical or professional supervision.
Mobile Machine Reimbursement	Medicaid reimburses for a mobile respiratory suction machine in conjunction with a stationary model, if the following conditions are met: • Prescribed because the recipient is subject to secretions that require suctioning during travel • Recipient is being transported for prescribed medical treatment, therapy, or rehabilitation services • The recipient is not being transported in an ambulance A mobile suction machine includes a vacuum regulator and is battery operated. The device must include a rechargeable battery and charger device, vehicle direct current (DC) adapter cable, canister or bottle, connector, and carrying case.

Continuous Positive Airway and Bi-Level Pressure Capability Devices

Description

A continuous positive airway pressure (CPAP) device is use as a noninvasive technique that provides a single level of air pressure from a flow generator, via a nose mask, through the nares. The purpose is to prevent the collapse of the oropharyngeal walls and the obstruction of airflow during sleep, which occurs in obstructive sleep apnea (OSA).

The bi-level pressure capability (BIPAP) device used as is a noninvasive technique that provides variable levels of air pressure instead of continuous pressure.

Service Requirement

A diagnosis of OSA requires at least 30 episodes of apnea, with each episode lasting a minimum of 10 seconds, during six to seven hours of recorded sleep. The use of CPAP is reimbursed under Medicaid when used in recipients diagnosed with a moderate or severe OSA where surgery is a likely alternative to the use of the CPAP device, as determined by a polysomnogram. The use of CPAP devices are also reimbursed when prescribed for recipient diagnosed with OSA, if either of the following criteria using the Apnea-Hypopnea Index (AHI) are met:

- AHI > 15 events per hour
- AHI > 5 and < 14 events per hour (with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, or documented hypertension, ischemic heart disease or history of stroke)

Polysomnographic studies must be performed at a facility-based sleep laboratory that is affiliated with a hospital or a licensed freestanding facility under the direction and control of a physician(s). The polysomnographic studies must not be performed by a DME provider or any entity with a financial relationship with the DME provider furnishing CPAP or a BIPAP device to Medicaid recipients.

The sleep study and titration report must be signed and dated by a physician qualified as a sleep specialist. The report must be dated no more than 60 days from the date of the initial documentation of medical necessity, or prescription, for the CPAP device.

The AHI is equal to the average number of episodes of apnea and hypopnea per hour and must be based on a minimum of two hours of sleep recorded by polysomnography using actual recorded hours of sleep (i.e., the AHI may not be extrapolated or projected).

Only after a documented trial period using a CPAP device has been completed, and a written and dated statement is issued from the recipient's treating physician stating the reason(s) why the recipient cannot or is unable to tolerate the CPAP device, will Medicaid reimburse a BIPAP device. This statement must be maintained in the recipient's records.

Continuous Positive Airway and Bi-Level Pressure Capability Devices, continued

Documentation Requirement

The provider must maintain the following documentation in the recipient's record:

- Prescription, certification and redetermination, medical documentation
- Diagnosis
- Laboratory results from qualified licensed facility
- Equipment delivery and pick up documentation
- Recipient and caregiver training at the time of the set up
- Hour meter reading for equipment usage
- Equipment testing and calibration testing results and maintenance or equipment replacement
- Delivery and replacement of necessary ancillary items
- Data reading to assess recipient's compliance

Documentation for Obstructive Sleep Apnea Syndrome

When intermittent respiratory service is prescribed for obstructive sleep apnea syndrome (OSAS) and an alternating positive airway pressure system is used, the provider must maintain documentation of the following information in the recipient's record:

- Obstructive sleep apnea syndrome was diagnosed based on a polysomnographic sleep study
- An ongoing plan of care has been ordered.
- Notification from treating physician if CPAP or BIPAP device has been tried and proven unsuccessful in relieving a member's symptoms, this indicates that apnea is not due to obstruction or the recipient is unable to tolerate a standard nasal/face mask due to facial discomfort, sinus pain, or claustrophobia from masks.

Time Sensitive Redetermination Documentation

Redetermination of medical necessity for a CPAP or BIPAP device is required every 12 months or for the length of time prescribed if less than 12 months by the treating physician, who also certifies that CPAP or BIPAP use is effective and that the recipient is compliant with prescribed treatment.

If redetermination of medical necessity is not obtained, the provider must discontinue claims for payment.

Respiratory Assist Devices Reimbursement

Medicaid reimburses for only one respiratory assist device per recipient, per month.

Medicaid will only reimburse for CPAP or BIPAP supplies for recipient-owned devices billed through the miscellaneous supply procedure code.

Continuous Positive Airway and Bi-Level Pressure Capability Devices, continued

Reimbursement for Respiratory Assist Devices, continued

All supplies needed to safely and effectively operate rented CPAP or BIPAP devices, including tubing and masks, are included in the provider's scheduled monthly rental fee. Claiming separate reimbursement for supplies used with a rented CPAP or BIPAP device rented by Medicaid is not permitted.

Heated or non-heated humidifiers prescribed for use with the covered CPAP or BIPAP device are not included in the device's monthly rental fee and may be reimbursed separately, if not integral to the CPAP or BIPAP device itself.

Intermittent Positive Pressure Breathing Machine

Documentation Requirement

The following information must be documented in the recipient's record for intermittent positive pressure breathing (IPPB) machine:

- Prescription, certificate of medical necessity, and redetermination of medical necessity (including the name of prescribed medication(s) to be used with device)
- Diagnosis
- Prescribed pressure settings for the machine
- Frequency and duration of treatment
- Documentation that the recipient or the recipient's legal guardain received training from a licensed professional regarding the proper and effective use of the machine at the time of the set up
- Quarterly IPPB equipment assessments
- Repair, maintenance, and replacement (as required)
- Delivery and pick up documentation

Reimbursement

Medicaid reimburses for an IPPB machine, if the recipient's ability to inhale is severely impaired.

Tubing and accessories necessary to operate the IPPB machine are included in the scheduled monthly rental fee.

Claiming separate reimbursement for accessory items included in the equipment's scheduled monthly rental fee is not permitted.

Ventilators

Description	Ventilators mechanically move breathable air into and out of the lungs, to provide the mechanism of breathing for a patient who is physically unable to breathe or breathing insufficiently.
Who Can Receive	Medicaid reimburses for a ventilator when prescribed for a recipient that has one of the following conditions: • Neuromuscular disorder • Thoracic restrictive disease • Congenital pulmonary disorder • Respiratory paralysis • Chronic respiratory failure, consequent to chronic obstructive pulmonary disease (COPD) • Neurological disorder, as with spinal cord injury • Bronchial pulmonary disease
Service Requirement	Medicaid reimburses for ventilators when prescribed as medically necessary by the recipient's treating physician, the treating physician's prescribing ARNP, or physician assistant.
Documentation Requirement	The following information must be documented in the recipient's record: • Prescription and certificate or redetermination of medical necessity • Diagnosis • Home care protocol • Airway stability • Oxygen requirement • Documentation that the recipient or the recipient's legal guardain received training from a licensed professional (regarding the proper and effective use of the equipment at the time of the set up) • Quarterly visit documentation • Equipment assessments, repair, maintenance, and replacement • Delivery and pick up documentation

Ventilators, continued

Documentation Requirements for Intermittent Positive Ventilator Support	When intermittent respiratory service is prescribed for OSAS and intermittent positive ventilator support is used, the provider must maintain documentation of the following information in the recipient's record: • The recipient's total ventilatory requirements cannot be met by the intermittent assist device with CPAP or BIPAP. • The medical purpose specifies that the device is prescribed for purposes other than nocturnal ventilatory assistance. • If the device is used in spontaneous timed or timed mode, the control settings are specified in writing by the treating physician.
Alternating Positive Airway Pressure and Intermittent Positive Ventilation System	Medicaid reimburses for an alternating positive airway pressure and intermittent positive ventilation system for intermittent respiratory service. For a child with a tracheotomy, an intermittent assist device with continuous positive airway pressure must be used with a CPAP or BIPAP system. Reimbursement includes all connectors, pressure measuring and alarm devices, breathing circuits, in-line thermometers, water traps, connectors, adapters, and training by licensed professionals.
Ventilator Reimbursement	The different types of reimbursable ventilators are listed in the durable medical equipment and medical supply services fee schedules. Claiming separate reimbursement for accessory items is not allowed. Tubing and accessories necessary to safely and effectively operate the ventilator are included in the scheduled monthly rental fee. A back-up ventilator is also included in the monthly Medicaid reimbursement.

Excluded Coverage

Exclusions

The following list of items and services are not reimbursed as a part of DME and medical supply services:

- Audiology services
- Automatic medication dispenser
- Blood pressure monitoring devices
- Car seats or car beds
- Computers and computer-related equipment
- Dentures
- Diapers and incontinence briefs of any kind for recipients age 21 years and older
- Disposable supplies customarily provided as part of a nursing or personal care service or a medical diagnostic or monitoring procedure
- Emergency and non-emergency alert devices
- Environmental control equipment (air conditioners, dehumidifiers, air filters, or air purifiers)
- Equipment or devices used primarily for transport
- Equipment or devices which require home modification (ceiling lifts)
- Equipment designed for use by a physician or trained medical personnel
- Facilitated communications
- Furniture and other items which do not serve a medical purpose
- Hearing and vision systems
- Institutional type equipment
- Items or devices used or intended to be used for cosmetic purposes
- Medical alert monitoring systems
- Non-sterile cotton tip applicators
- Personal comfort, convenience, or general sanitation items
- Physical fitness equipment
- Powered wheelchair component for standing
- Precautionary-type equipment (e.g., power generators)
- Printers, unless the printer is a built-in component of a dedicated AAC system
- Routine and first aid items
- Services or items provided to recipients out-of-state
- Supplies or equipment covered by Medicaid per diem rates
- Televisions, telephones, VCR machines
- Training equipment or adaptive self-help equipment or devices
- Transit tie downs
- Wheelchair electronics upgrades to control or have interface with other non-covered services and exclusions
- Wheelchair power attendant control
- Wheelchair lifts
- Wheelchair ramps and home modifications

Eligible home and community-based waiver recipients may by-pass the state plan's exception process and directly request these non-covered services through their respective home and community-based waiver for medical necessity review.

Excluded Coverage, continued

Disposable Incontinence Supplies	Personal hygiene products such as menstrual pads are not reimbursed.
Enteral Services	Medicaid does not reimburse for the following: • Enteral products for recipients with a diagnosis of failure to thrive, anorexia, or bulimia • Banked human breast milk • Enteral products designed to primarily to replace fluids and electrolytes • Standard milk • Soy based infant formulas • Products for recipients who are institutionalized • Products used for bodybuilding, athletic performance enhancement, or weight reduction • Regular food products including food thickeners and baby food.
Orthopedic Footwear	Medicaid does not reimburse for orthopedic shoes for: • Flexible flat feet. • Toe-in or toe-out problems, except where there is specific foot deformity. • Torsional problems of the extremities, except when attached to a brace.
Nebulizer	Medicaid will not reimburse for nebulizers used to administer compounded inhalation solutions.

CHAPTER 3
REIMBURSEMENT AND FEE SCHEDULE

Overview

Introduction

This chapter describes reimbursement and fee schedule information for durable medical equipment (DME) and medical supply services.

In This Chapter

This chapter contains:

Reimbursement Information

Procedure Codes

The procedure codes listed in the Durable Medical Equipment and Medical Supply Services Provider Fee Schedules are Healthcare Common Procedure Coding System (HCPCS) Level II, which is a part of a nationally standardized code set. Level II of the HCPCS is a standardized coding system used primarily to identify products, supplies, and services not included in the CPT codes. HCPCS Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter (A – V) followed by four numeric digits. Please refer to the current HCPCS Level II Expert code book for complete descriptions of the standard codes. The HCPCS Level II Expert© code book is copyrighted by Ingenix, Inc. All rights reserved.

Billing Restrictions and Unbundling

Providers may not bill Medicaid:

- Separately for items listed or identified in a procedure code's description (unbundling).
- Separately by unbundling items included in a product manufacturer's product description or kit.
- Using a miscellaneous procedure code to bill for a higher reimbursement for the same item or service currently covered by a HCPCS procedure code with a scheduled fee listed on the DME and medical supply services provider fee schedules.

Note: The DME and medical supply services provider fee schedules are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, Provider Support, and then Fee Schedules.

Reimbursement Information, continued

Billing Modifiers for Orthopedic Footwear	Providers must include modifier(s) to identify which side of the body the footwear is to be applied. "LT" (Left side) and "RT" (Right side) modifiers must be used when the footwear code is side-specific. Code descriptions that specify 'pair' do not require the LT or RT modifier(s).
Billing for Orthopedic Footwear for Different Foot Sizes	When there is a substantial difference in size between the left and right foot and the recipient needs two pairs of orthopedic footwear, the provider may be reimbursed for both pairs. Reimbursement for the smaller pair will not exceed 75 percent of the maximum fee of the larger pair. The claim for the smaller pair must be billed By-Report (BR) using procedure code L3257. Both pairs of orthopedic footwear must be billed on the same claim form.
Unit Limits for Single and Bilateral Devices	The same units and limits specified on the DME and medical supply services provider fee schedules apply to either single or bilateral needs.
Billing Modifiers for Orthotic Devices	Providers must include modifier(s) to identify which side of the body the orthotic is to be applied. LT and RT modifiers must be used when the orthotic code is side-specific. Code descriptions that specify 'pair' do not require the LT or RT modifier(s).
Billing Modifiers for Prosthetic Devices	Providers must include modifier(s) to identify which side of the body the orthotic is to be applied. LT and RT modifiers must be used when the prosthetic code is side-specific. Code descriptions that specify 'pair' do not require the LT or RT modifier(s).

Reimbursement Information, continued

Medical Supplies with Non-Classified Codes

Non-classified procedure codes allow the provider to request reimbursement when a reimbursable item does not have an established fee identified in the fee schedules.

Pricing and review of non-classified procedure codes is established either by submitting a prior authorization request or a BR claim.

Reimbursement for Non-Classified Codes

When approved, the Agency for Health Care Administration (AHCA) will price BR claims with a non-classified procedure code using the following methodology:

- Manufacturer's wholesale price plus 15 percent (includes fitting fee, freight, delivery, etc.)
- Provider's attainment cost (less manufacturer discounts, shipping and handling) plus 15 percent
- Provider's usual and customary fee

Medicaid will reimburse the lesser of the above three methodologies.

Billing Requirements for Used Equipment

The provider's request for reimbursement for the purchase, including rent-to-own purchases, of used non-custom equipment is calculated at 66 percent of the maximum fee shown on the DME and medical supply services provider fee schedules or 66 percent of the provider's usual and customary fee for new equipment, whichever is less.

It is the DME and medical supply services provider's responsibility to bill Medicaid for the reduced amount required for all used equipment, whether rented or purchased.

Refurbished Equipment

Refurbished rental-only equipment is used equipment that is comprised of new parts. Reimbursement for providing refurbished equipment is 100 percent of the maximum rental fee listed on the DME and medical supply services provider fee schedules.

Reimbursement Information, continued

Rental-Only

Rental reimbursement continues until there is a documented change in the medical necessity, the period of authorization terminates, or the recipient is no longer Medicaid eligible.

Rental-only (RO) items remain the property of the provider, regardless of the number of months the item is rented.

Reimbursement fees for rental-only items include:

- All ancillary (accessory) items necessary to safely operate the equipment to ensure the highest level of functionality and medical care.
- Any monthly home visits or services by the provider's staff, as recommended by the manufacturer or required by Medicaid policy.

When a rental period is less than 14 days, the provider must prorate the fee to not more than 50 percent of the monthly rental amount.

Rent-to-Purchase

The provider may not submit a claim for more than one unit of service within the same calendar month.

The rent-to-purchase item immediately becomes the personal property of the Medicaid recipient when the tenth payment is made.

Reimbursement fees include all the ancillary items necessary to safely operate the equipment and to ensure the highest level of functionality and medical care.

By-Report

By-Report claims are submitted directly to the fiscal agent and must include the necessary documentation to complete a medical review and to price the procedure.

The following written documentation must be submitted with the claim:

- Documentation of medical necessity
- Description of the items or services provided
- Documentation of any cost incurred, including the provider's billing invoices from the manufacturer or distributor
- Manufacturer catalog information (which lists manufacturer's suggested retail price)
  The provider's invoice
- Date the item was made available to the recipient

Reimbursement Information, continued

Exceeding Maximum Limit Set by Fee Schedules

Service limits indicated on the DME and medical supply services provider fee schedules may be exceeded only for eligible recipients under the age of 21 years.

Service limits for temporary wheelchair rentals and respiratory suction machines may be exceeded for recipients of all ages.

If it is medically necessary to exceed the service maximum limits, the request for additional services must:

- Be prescribed by an authorized prescriber with a medical explanation of why the recipient's current medical condition requires the service limit to be exceeded.
- Meet all DME service requirements.
- Confirm the recipient's maximum limit has been reached in the fiscal agent's claim system.

Providers must bill and be reimbursed for the fee schedule maximum limit prior to submitting a request to exceed the maximum limit.

Documentation required to justify the recipient's need to exceed the maximum limits, must be submitted directly using the Medicaid QIO Web-based system at http://fl.eqhs.org/.

Prior and Post Authorization

Durable Medical Equipment Items and Services

Equipment requiring prior or post authorization will be reviewed by Medicaid's contracted Quality Improvement Organization (QIO) for medical necessity. Medicaid will not reimburse for these services without authorization. Providers must adhere to the requirements outlined in this section in order to receive reimbursement for services.

The following DME services or items require prior authorization:

- All custom wheelchairs (specially sized and constructed for the individual recipient)
- Repairs or modifications for custom wheelchairs
- All non-custom power or motorized wheelchairs, motorized scooters, and conversion kits used to convert a standard wheelchair into a motorized or power wheelchair

Prior and Post Authorization, continued

Durable Medical Equipment Items and Services, continued	• Durable medical equipment items that do not have an assigned procedure code(s) listed on the fee schedules and are requested using the miscellaneous DME procedure code • Fixed height hospital beds • Adjustable height hospital beds • Heavy duty hospital beds • Patient lifts • AAC devises and accessories • Repairs to AAC devices Assigned procedure codes are subject to change with yearly HCPCS updates.
Submitting a Prior Authorization	Requests must be submitted using the Medicaid QIO Web-based system at http://fl.eqhs.org/. All required documentation supporting the request must be included at the time of the submission.
Quality Improvement Organization Review Criteria	In addition to using Agency established policy, the QIO may use a national standardized set of criteria, as approved by AHCA, as a guide to establish medical necessity for prior authorization requests at the first review level. If services cannot be approved by the first level nurse reviewer, the QIO's physician peer reviewer will determine medical necessity using his clinical judgment, acceptable standards of care, state and federal laws, and Medicaid's medical necessity definition. Medicaid may modify these criteria based upon policy or the clinical judgment or recommendation of the QIO physician reviewer.
Approval Process	The Medicaid QIO will review each prior authorization request to make a determination or request additional information to support the request. Prior authorization requests may include a telephonic or face-to-face contact with the Medicaid recipient in their place of residence, interviews with the ordering physician, or a review of the recipient's medical record. Providers must check the Medicaid QIO Web-based system for the status of submitted prior authorization requests.

Prior and Post Authorization, continued

Approved Request	If the request is approved, the approval will contain a prior authorization (PA) number for billing and reference. An approved request does not guarantee Medicaid reimbursement for the service. The provider and recipient must be eligible on the date of service and the service must not exceed any applicable service limits.
Content of Approved Requests	The approval of services, accessed via the Web-based system, specifies the: • 10-digit prior authorization number. • Procedure code. • Units of service. • Service authorized. • Authorized dates of service. • Discipline authorized to provide the service. • Number of days for which the prior authorization is valid.
Changes to Approved Requests	To change an approved request, the provider must submit new supporting documentation clarifying the need for change. When requesting additional units of service within a certification period, the provider should indicate the request is for a change to an already requested certification period and includes the attending physician's approved plan of care, new orders, and a reason for adjustment.
Denied Requests or Partial Denials	In a partial denial, a portion of the requested units of service may be denied due to lack of medical necessity. If the QIO denies a request or issues a partial denial, the QIO will post the decision on its Web-based system. If the QIO physician determines that services are not medically necessary, the recipient, ordering provider and DME provider will be notified in writing of the denial or reduction in services. The notification letter will include information regarding the recipient's appeal rights.
Reauthorization Requests	Reauthorization requests should be submitted within the timeframe specified by the QIO.

Prior and Post Authorization, continued

Reconsideration Review

A provider or recipient who receives a denial may request reconsideration. If reconsideration is requested, the provider must submit additional information to be considered during the review process.

Requests for reconsideration of the denial decision must be submitted within ten business days of the date of the denial determination using the Medicaid QIO's Web-based system.

Prior Authorization Documentation

For all DME services and items requiring prior authorization, specific documentation along with the following must be submitted to the Medicaid QIO:

- Recipient's name, address, date of birth, and Medicaid ID number
- Requesting provider's name, address, and Medicaid provider number
- Ordering provider's National Provider Identifier or Florida Medical License number, name, address, and Medicaid provider number
- Procedure code(s), with modifier(s) if applicable, matching the services
- A statement clarifying why the current equipment no longer meets the recipient's, current needs for replacement equipment
- Full description of the item(s) requested
- Manufacturer's name and address
- Device and equipment model name and number
- Serial number or item number for non-custom manufactured item(s)
- A listing of all parts, components, attachments, or special features of the requested DME
- A statement indicating if the requested equipment or component is new, used, or refurbished
- A statement indicating if the requested equipment is to be purchased, rented, or purchased as a rent-to-purchase item (if the requested equipment is a rental or rent-to-purchase item, the total quantity of monthly rental units must be identified on the authorization request form)
- Documentation regarding the length of time (number of months or years) the requested item will be medically necessary to meet the recipient's current needs
- DME provider's sales invoice, including the following information:
  - A list of custom and non-custom components described by HCPCS procedure codes listed on the current DME and medical supply services provider fee schedules and the scheduled fee for each component.
  - The invoice subtotal.
  - A list of the remaining components not listed on the DME and medical supply services provider fee schedules and the provider's requested price for each individual component.
  - The invoice total, excluding all shipping and handling fees.
- Description of the current items or equipment being used or currently owned by the recipient of the same or similar type requested (indicating whether the equipment is rented or was purchased specifically for the recipient, the age of the equipment and whether and when the recipient's equipment was purchased by Medicaid)

Prior and Post Authorization, continued

Prior Authorization Documentation, continued

- A signed and dated prescription or Certificate of Medical Necessity (CMN) specifying the type of durable medical equipment prescribed from the recipient's treating physician or the treating physician's prescribing ARNP or physician assistant, with the Florida professional license number
- Evaluation documentation for all custom and prior authorized mobility equipment (clearly justifying each unique feature and the construction of the item requested as medically necessary)
- Justification if a more costly device or component is being recommended over a less costly alternative (the therapist evaluator and the provider must clearly state why the less costly alternative will not appropriately meet the recipient's needs)
- A video of the recipient (at the request of the QIO if necessary, for the evaluation of the PA request)
- For all mobility devices (custom or non-custom) must include:
  - Documentation of measurements that ensure the type and size of equipment requested can be safely and effectively used by the individual recipient during ingress and egress in all areas of the recipient's home and areas where the equipment or device is intended to be used by the recipient.
  - A description of the recipient's current mode of transportation within the community and how the recipient's current mobility equipment is transported.
  - A description of the recipient's cognitive and functional ability to effectively and safely use any mobility equipment and component(s) requested.
- For all custom mobility equipment, either the Custom Wheelchair Evaluation, found in the appendices, or another document that contains the same information (The form must be completed by an independent occupational or physical therapist or physiatrist with a dated signature and the evaluator's professional license number.)
- For all non-custom power mobility equipment must include a copy of a signed and dated medical documentation or treating physician's office notes, describing the recipient's current medical condition, physical limitations, cognitive and functional abilities, prognosis, and clinical course (worsening or improvement, prognosis, nature and extent of functional limitations, or other therapeutic interventions and results, past experience with related items, etc.)
- Diagnosis code(s) (using the most current version of the International Classification of Diseases, Clinical Modification (ICD-CM) that is pertinent to the recipient's need for the item or service being requested)
- Documentation that a sufficient amount of space is available in the recipient's home to ensure safe and effective use and storage of the equipment
- Product information that is required for items purchased by Medicaid

Prior and Post Authorization, continued

Prior Authorization Package for Recipients Enrolled in Public or Home School	The DME provider must obtain Medicaid authorization for an AAC device for recipients who are under the age of 21 years of age and enrolled in public school or attending home school. The following written documentation must be included in the prior authorization request: • The interdisciplinary team's led by the speech-language pathologist, individualized action plan or plan of care including the recommended AAC device, the speech-language pathologist's plans for management of the recipient's communication disorder, and the non-conflict of interest statement. – The treating physician, treating physician's prescribing ARNP or physician assistant, or designated physician specialist must review the evaluation and individualized action plan or plan of care; and sign and date the evaluation and prescribe the AAC device. • An invoice and proof of manufacturer's cost.
Prior Authorization Package for Recipients for Recipients not Enrolled in Public or Home School	The DME provider must obtain Medicaid authorization for an AAC device for recipients who are age 21or older or recipients who are not enrolled in public or home school. The following written documentation must be included in the prior authorization request: • The speech-language pathologist evaluation, which includes the recommended AAC device, the individualized action plan or plan of care, the speech-language pathologist's plans for management of the recipient's communication disorder, and the non-conflict of interest statement. – The treating physician, treating physician's prescribing ARNP or physician assistant, or designated physician specialist must review the evaluation and individualized action plan or plan of care; and sign and date the evaluation and prescribe the AAC device. • An invoice and proof of manufacturer's cost.

Prior and Post Authorization, continued

Wheelchair and Power Operated Vehicle Devices

The following information must be submitted with the prior authorization request:

- Either the Custom Wheelchair Evaluation, found in the appendices, or another document that contains the same information that is requested on the evaluation
  - Wheelchair evaluations must be completed and performed or dictated by a registered physical or occupational therapist or a certified physiatrist
  - The documentation must list a date of completion that is not more than six months old and include the therapist's or physiatrist's signature and license number
- Medical necessity documentation
- Written documentation (describing the physical status of the recipient with regard to mobility, self-care status, strength, cognitive and physical abilities, coordination, and activity limitations)
- Documentation of the recipient's current mobility equipment and why the current equipment is no longer appropriate
- Listing of each customized feature required for unique physical status
- Specification of the medical benefit of each customized feature requested
- Identification of the principle place(s) the wheelchair will be used
- Itemized provider invoice, listing the assigned procedure code and provider's price requested for each part and labor (labor is included in the cost of the initial fabrication of a custom wheelchair or custom components)
- List the source(s) for the accessories and modifications requested and the manufacturer's procedure code and suggested retail price for each item that is not found on the DME and medical supply services provider fee schedules
- Itemized invoice listing provider's source of accessory and modification parts and manufacturer's suggested retail pricing (MSRP) for the parts, and listing the procedure codes and scheduled fees for the components that are described on the DME and medical supply services provider fee schedules
- Documentation of the recipient's home accessibility for the customized manual or motorized wheelchair requested
- Measurements of the recipient
- Weight of recipient
- Measurements of all exterior doorways of the recipient's residence
- Measurements of all interior doorways of the recipient's residence to be used by the recipient
- Documentation that the requested equipment is the least costly alternative to meet the recipient's needs must be available upon request
- For initial requests for a power wheelchair with alternative controls, a brief video demonstrating the recipient's independence in safely operating the wheelchair may be requested by Medicaid's QIO

Prior and Post Authorization, continued

Required Documentation for Post Authorization Requests

Post authorization requests may be submitted to the QIO after the item has been provided to the recipient.

Post authorizations are generally used for rent-to-purchase hospital bed requests.

Custom medical equipment and devices cannot be post authorized.

If an eligible recipient has an urgent need for an item for which the HCPCS procedure code requires prior authorization, at the DME provider's discretion, the item may be delivered to the recipient's place of residence prior to submitting the authorization request to Medicaid.

The provider must obtain a prescription or CMN that is signed and dated by the recipient's treating physician or the treating physician's ARNP or physician assistant within 21 days after the date of service (the date the item was delivered to the recipient's home).

Post authorization requests must include the required prior authorization documentation listed in this section and the following information:

- Manufacturer's name and address
- Model number of the bed provided
- Serial number of the bed provided
- The date of service or date of delivery
- The delivery address
- Copy of the hospital discharge summary

All inquiries regarding post authorization requests should be directed to the QIO.

How to Read the Fee Schedules

Fee Schedules

The DME and medical supply services provider fee schedules are tables of columns listing the Medicaid reimbursable procedure codes, their descriptors, and other information pertinent to each code.

The procedure codes are listed in alpha-numeric order.

Code

This column describes the procedure code.

How to Read the Fee Schedules, continued

Description	This column specifically describes the service or procedure associated with the procedure code. The provider is responsible for providing specific items when the description shows plural nomenclature, such as bilateral or pair.
Maximum Fee	This column is the maximum amount that Medicaid will pay for the DME, medical supply, or orthotic or prosthetic device. The fee listed is the unilateral, single item or each unit, unless otherwise specified in the description. The provider's charges for services billed to Medicaid must be less than the provider's lowest charge to any other third party source for the same or equivalent medical and allied care, goods, or services provided to individuals who are not Medicaid recipients. The Medicaid fee reimbursed for DME and medical supplies includes labor, travel, delivery, shipping, handling, fees for measuring, casting, fitting, adjusting, or dispensing items or products. When there is no maximum fee listed (0.00), the procedure code is considered "non-classified" and the provider must request prior authorization or submit a By-Report claim as identified on the fee schedules.
Rental-Only	This column indicates the equipment will remain the property of the provider and a monthly fee will be reimbursed during the authorized medically necessary time frame. Rental-only items will be identified by an RO.
Rent-to-Purchase	This column represents items that do not exceed a total of ten monthly claims.
Unit(s)	This column indicates the number of units that may be billed for dates of service within the same month. The provider may bill for up to a one-month's supply for a single billing date, based on the recipient's medical need.

How to Read the Fee Schedules, continued

By-Report	This column identifies a procedure code that requires a medical review of the claim and manual pricing. By-Report items are identified by a BR.
Prior Authorization	This column identifies the procedure codes that require prior authorization before the service is performed. Prior authorized items are identified by a PA.
Limit	This column identifies the maximum limit allowed for a procedure code.

APPENDIX A

CUSTOM WHEELCHAIR EVALUATION

Custom Wheelchair Evaluation

The intent of this form is to secure sufficient information to determine the medical necessity for a custom wheelchair request submitted for prior approval to Florida Medicaid.
This form must be completed by the licensed therapist or the certified physiatrist performing the evaluation.
The evaluator may choose to include additional information that substantiates medical necessity for the equipment requested.

Recipient Name: _____ Date Referred: _____ Date of Evaluation: _____
Address: _____ Phone: _____ Physician: _____
_____ Age: _____ Sex: _____ OT: _____
Funding: _____ Date of Birth: _____ PT: _____
Referred By: _____ Height: _____
_____ Weight: _____
Medicaid ID #

Reason for Referral:

Patient Goals:

Caregiver Goals:

MEDICAL HISTORY:

Dx: ICD:_____ ICD:_____ ICD:_____ ICD:_____

Date of injury/onset:

Prognosis/ Hx:

Recent / Planned Surgeries:

Cardio-Respiratory Status: ❒Intact ❒Impaired

Comments:

CURRENT SEATING / MOBILITY: (Type – Manufacturer – Model)

Chair: Age:

Serial #

w/c Cushion: Age: **w/c Back**: Age:

Other Positioning Components:

Reason for ❒Replacement / ❒Repair / ❒Update:

Funding Source:

HOME ENVIRONMENT:

❒House ❒Apt	❒Asst Living	❒LTCF	❒Alone ❒w/ Family-Caregivers:		
Length of time at residence:					
Entrance: ❒Level	❒Ramp	❒Lift	❒Stairs	Entrance Width:	
w/c Accessible Rooms: ❒Yes ❒No	Narrowest Doorway Required to Access:				
Is a caregiver available 24 hours a day: ❒Yes ❒No	If no, how many hours a day is a caregiver available?				
Comments:					
TRANSPORTATION: ❒Car ❒Van ❒Bus ❒Adapted w/c Lift ❒Ramp ❒ Ambulance ❒Other:					

COGNITIVE / VISUAL STATUS:

Memory Skills	❒Intact:	❒Impaired:	Comments:
Problem Solving	❒Intact:	❒Impaired:	Comments:
Judgment	❒Intact:	❒Impaired:	Comments:
Attn / Concentration	❒Intact:	❒Impaired:	Comments:
Vision	❒Intact:	❒Impaired:	Comments:
Hearing	❒Intact:	❒Impaired:	Comments:
Other	❒Intact:	❒Impaired:	Comments:

ADL STATUS:	Indep	Assist	Unable	Comments / Other AT Equipment Required
Dressing	❒	❒	❒	
Bathing	❒	❒	❒	
Feeding	❒	❒	❒	
Grooming/Hygiene	❒	❒	❒	
Toileting	❒	❒	❒	
Meal Prep	❒	❒	❒	
Home Management	❒	❒	❒	
Bowel Management: ❒Continent ❒Incontinent				
Bladder Management: ❒Continent ❒Incontinent				

MOBILITY SKILLS:	Indep	Assist	Unable	N/A	Comments
Bed ↔ w/c Transfers	❒	❒	❒	❒	
w/c ↔ Commode Transfers	❒	❒	❒	❒	
Ambulation:	❒	❒	❒	❒	Device:
Manual w/c Propulsion:	❒	❒	❒	❒	
Operate Power w/c w/ Std. Joystick	❒	❒	❒	❒	
Operate Power w/c w/ Alternative Controls	❒	❒	❒	❒	
Ability to Stand	❒	❒	❒	❒	
Able to Perform Weight Shifts	❒	❒	❒	❒	Type:
Hours Spent Sitting in w/c Each Day:			Comments:		

SENSATION:

❒Intact ❒Impaired ❒Absent	Hx of Pressure Sores ❒Yes ❒No
Current Pressure Sores ❒Yes ❒No Location/Stage	
Comments:	

CLINICAL CRITERIA / ALGORITHM SUMMARY

Is there a mobility limitation causing an inability to safely participate in one or more Mobility Related Activities of Daily Living in a reasonable time frame? ❒Yes ❒No

Explain:

Are there cognitive or sensory deficits (awareness / judgment / vision / etc) that limit the users' ability to safely participate in one or more MRADL's or ADL's? ❒Yes ❒No

If yes, can they be accommodated / compensated for to allow use of a mobility assistive device to participate in MRADL's? ❒Yes ❒No

Explain:

Does the user demonstrate the ability or potential ability and willingness to safely use the mobility assistive device? ❒Yes ❒No

Explain:

Can the mobility deficit be sufficiently resolved with only the use of a cane or walker? ❒Yes ❒No

Explain:

Does the user's environment support the use of a ❒ MANUAL WHEELCHAIR ❒ POV ❒POWER WHEELCHAIR: ❒Yes ❒No

Explain:

If a manual wheelchair is recommended, does the user have sufficient function/abilities to use the recommended equipment? ❒Yes ❒No ❒N/A

Explain:

If a POV is recommended, does the user have sufficient stability and upper extremity function to operate it? ❒Yes ❒No ❒N/A

Explain:

If a power wheelchair is recommended, does the user have sufficient function/abilities to use the recommended equipment? ❒Yes ❒No ❒N/A

Explain:

RECOMMENDATION / GOALS:

❒ **MANUAL** WHEELCHAIR ❒ **POV** ❒**POWER WHEELCHAIR:** ❒**POSITIONING SYSTEM**(TILT/RECLINE) ❒**SEATING**

MAT EVALUATION: (NOTE IF ASSESSED SITTING OR SUPINE)

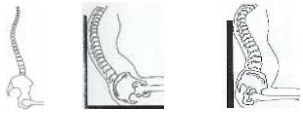
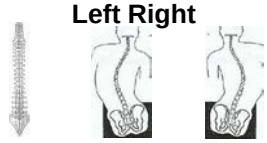
	POSTURE:	FUNCTION:	COMMENTS:	SUPPORT NEEDED
HEAD & NECK	❒ Functional ❒ Flexed ❒ Extended ❒ Rotated ❒ Laterally Flexed ❒ Cervical Hyperextension	❒ Good Head Control ❒ Adequate Head Control ❒ Limited Head Control ❒ Absent Head Control ❒ Tone/ Reflex		

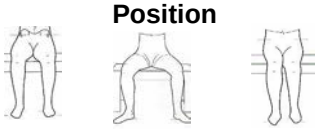
<table>
<tr><td rowspan="2">UPPER EXTREMITY</td><td>SHOULDERS
Left Right
❒WFL ❒WFL
❒elev / dep ❒elev / dep
❒pro / retract ❒pro / retract
❒subluxed ❒subluxed</td><td>R.O.M.

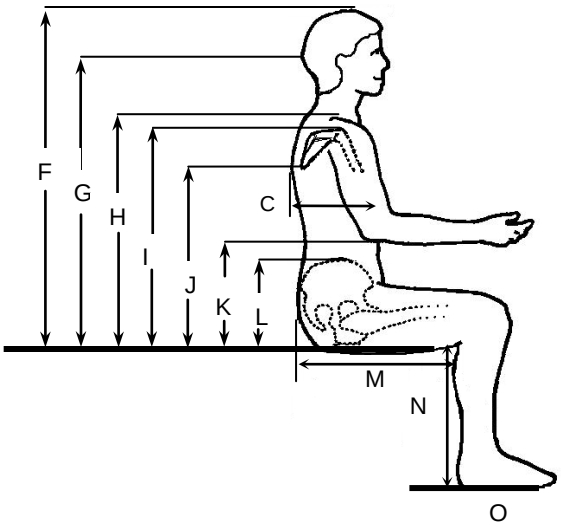
Strength:

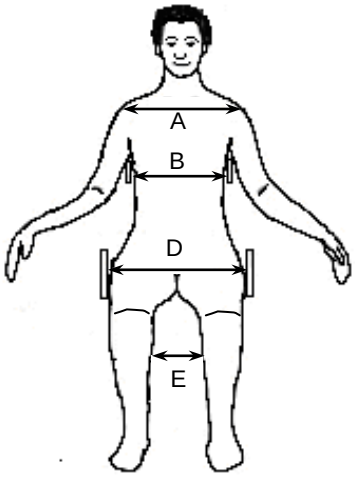
Tone/Reflex:</td><td></td><td></td></tr>
<tr><td>ELBOWS
Left Right
❒Impaired ❒ Impaired
❒WFL ❒ WFL</td><td>R.O.M.

Strength:

Tone/Reflex:</td><td></td><td></td></tr>
<tr><td>WRIST & HAND</td><td>Left Right
❒Impaired ❒Impaired
❒WFL ❒WFL</td><td>Strength / Dexterity:</td><td></td><td></td></tr>
<tr><td>TRUNK</td><td>Anterior / Posterior
 
❒ WFL ❒ ↑ Thoracic Kyphosis ❒ ↑ Lumbar Lordosis
❒ Fixed ❒ Flexible
❒ Partly Flexible ❒ Other</td><td>Left Right
 
❒ WFL ❒ Convex Left ❒ Convex Right
❒ Fixed ❒ Flexible
❒ Partly Flexible ❒ Other</td><td>Rotation
 
❒ Neutral
❒ Left Forward
❒ Right Forward
❒ Fixed ❒ Flexible
❒ Partly Flexible ❒Other</td><td></td></tr>
<tr><td>PELVIS</td><td>Anterior / Posterior
 
❒ Neutral ❒ Posterior ❒ Anterior
❒ Fixed ❒ Other
❒ Partly Flexible
❒ Flexible</td><td>Obliquity
 
❒ WFL ❒ Left Lower ❒ Rt. Lower
❒ Fixed ❒ Other
❒ Partly Flexible
❒ Flexible</td><td>Rotation
 
❒ WFL ❒ Right ❒ Left
❒ Fixed ❒ Other
❒ Partly Flexible
❒ Flexible</td><td></td></tr>
</table>

HIPS	**Position**  ❒ Neutral ❒ ABduct ❒ ADduct ❒ Fixed ❒ Subluxed ❒ Partly Flexible ❒ Dislocated ❒ Flexible	**Windswept**  ❒ Neutral ❒ Right ❒ Left ❒ Fixed ❒ Other ❒ Partly Flexible ❒ Flexible	**Range of Motion**  **Left** **Right** Flex: ____ o ____ o Ext: ____ o ____ o Int R: ____ o ____ o Ext R: ____ o ____ o	
KNEES & FEET	**Knee R.O.M.** Left Right ❒ WFL ❒ WFL ❒ Flex____ o ❒ Flex____ o ❒ Ext ____ o ❒ Ext ____ o	Strength: Hamstring ROM Limitations: (Measured at ___ o Hip Flex) Left_____ Right_____ Orthosis? Prosthetic?	**Foot Positioning** ❒ WFL ❒L ❒R ❒ Dorsi-Flexed ❒L ❒R ❒ Plantar Flexed ❒L ❒R ❒ Inversion ❒L ❒R ❒ Eversion ❒L ❒R	Foot Positioning Needs:
MOBILITY	**Balance** Sitting Balance: / Standing Balance ❒ WFL ❒ WFL ❒ Min Support ❒ Min Support ❒ Mod Support ❒ Mod Support ❒ Unable ❒ Unable	**Transfers** ❒ Independent ❒ Min Assist ❒ Max Asst ❒ Sliding Board ❒ Lift / Sling Required	**Ambulation** ❒ Unable to Ambulate ❒ Ambulates with Assistance ❒ Ambulates with Device ❒ Independent without Device ❒ Indep. Short Distance Only	





Neuro-Muscular Status:

Tone:

Reflexive Responses:

Effect on Function:

	Measurements in Sitting:	Left	Right		
	A: Shoulder Width				
	B: Chest Width			**H:**	Top of Shoulder
	C: Chest Depth (Front – Back)			**I:**	Acromium Process (Tip of Shoulder)
	D: Hip Width			**J:**	Inferior Angle of Scapula
	****** Asymmetrical Width			**K:**	Elbow
	E: Between Knees			**L:**	Iliac Crest
	F: Top of Head			**M:**	Sacrum to Popliteal Fossa
	G: Occiput			**N:**	Knee to Heel
				O:	Foot Length

Additional Comments and please add Trunk and Pelvic width with brace/ Orthosis, when applicable.
****** Asymmetrical Width: i.e., windswept or scoliotic posture; measure widest point to widest point

REQUESTED EQUIPMENT:

Requested Frame (make and model):
Dimensions:
Amount of growth available:

SIGNATURE:

As the evaluating therapist, I hereby attest that I have personally completed this five page evaluation form and that I am not an employee of or working under contract to the manufacturer(s) or the provider(s) of the durable medical equipment recommended in my evaluation. I further attest that I have not and will not receive remunerations of any kind from the manufacturer(s) or the Medicaid Durable Medical Equipment provider(s) for the equipment I have recommended with this evaluation. I accept the responsibility of performing a follow-up evaluation at the time of the initial fitting and delivery of the recommended equipment and will be available for a follow-up evaluation six months after the equipment was delivered to recommend any additional adjustments, if a six-month follow up evaluation is needed.

I am currently enrolled as a Medicaid provider and my provider number is: _____

or, I am not currently enrolled as a Medicaid Provider and have attached a copy of my current (double click on appropriate box and select: Checked):

	License #
☐ Physical Therapy license	
☐ Occupational Therapy license	
☐ Physiatrist board certification	

_____ _____ _____

Signature, as it appears on license or certification ***Date*** ***Daytime contact number(s)***

_____ _____ _____

Fax Number ***Email Address*** ***Cell phone number (optional)***

Optional:

Physician: I have read & concur with the above assessment _____ **Date:** _____ **Phone:** _____

APPENDIX B

QUALITY STANDARDS FOR DISPOSABLE INCONTINENCE SUPPLIES

Quality Standards for Disposable Incontinence Supplies (Brief, Diaper, Protective Underwear, Pull-On, Liner, Shield, Guard, Pad, Undergarments)

Minimum Quality Standards for Briefs and Diapers

				Product Performance[2]		
Size	**Minimum Length[1]**	**Minimum Width[1]**	**Waist Range[1]**	**Rate Of Absorbency (ROA)**	**Rewet**	**Capacity**
				≤	≤	≥
	inches	inches	inches	seconds	grams	grams
Youth	21.0	15.0	15 - 22"	65.0	4.0	900
Small	26.0	17.5	20 - 31"	65.0	4.0	1,100
Medium	31.0	24.0	32 - 44"	65.0	6.0	1,400
Regular	33.0	27.0	40 - 48"	65.0	6.0	1,400
Large	36.5	29.5	45 - 58"	65.0	6.0	1,700
Extra Large	38.0	31.0	56 - 66"	65.0	6.0	1,700
Extra Extra Large	38.0	36	>66”	65.0	6.0	2,100

Notes: Briefs and diapers must be classified and assigned to a specific HCPCS code (as defined by the Centers for Medicare and Medicaid Services).

(1) If the briefs and diapers have been assigned into a specific HCPCS code, the Minimum Length and Width and Waist Range can be used as a guide.
- Measured by cutting leg elastic and stretching flat.
- Measured at non-tape end.

(2) To qualify for reimbursement, products need to meet or exceed two of the three performance standards and be within 15% of the third standard. The qualifying product performance standards are as follows:
- Rate of Absorbency (ROA)
- Rewet
- Capacity

Universal Requirements

1. Designed with wetness indicator visible on the outside of the brief.
2. Designed with a side closure system (if tape tab, minimum of 2 per size and width ≥ 5/8").
3. Designed with multi-elastic leg gathers.
4. Backing is waterproof.

Minimum Quality Standards for Pads, Inserts, Shields

Product Performance		
ROA	**Rewet**	**Capacity**
≤	≤	≥
- na -	- na -	250

The products must have one of the following attributes:
1. Embossed or channeled absorbent mat
2. Elastic gathers
3. Super absorbent polymer
4. Waterproof backing

This is the Minimum Quality Standards for Pads, Inserts, and Shields: providers must supply products that meet the medical needs of the recipient, including moderate and heavy needs.

Minimum Quality Standards for Underpads

Total Capacity (grams) (1)	ROA (seconds) (1)	Rewet (grams) (1)
700	300	15

Notes
(1) To qualify for reimbursement, products need to meet or exceed two standards and be within 15% of the third standard.

Minimum Quality Standards for Protective Underwear

			Product Performance(1)		
Size	**Minimum Inside Width(2)**	**Minimum Length(2)**	**ROA**	**Rewet**	**Capacity**
			≤	**≤**	**≥**
	inches	**inches**	**seconds**	**grams**	**grams**
Small	**18**	**23**	**60.0**	**2.0**	**900**
Medium	**22**	**28**	**60.0**	**2.0**	**1,000**
Large	**27**	**31**	**60.0**	**2.0**	**1,100**
Extra Large	**31**	**32**	**60.0**	**2.0**	**1,200**

Universal Requirements
1. Designed with a continuous elasticized waistband and side panels.
2. Designed with multi-elastic leg gathers.
3. Backing is waterproof.

Notes
(1) To qualify for inclusion on the formulary, products need to meet or exceed two of the three performance standards and be within 15% of the third standard.
(2) Measured by cutting leg elastic and stretching flat.

Minimum Quality Standards for Undergarments

			Product Performance[1]		
			ROA	Rewet	Capacity
Size	**Minimum Length[2]**	**Minimum Width[2]**	**≤**	**≤**	**≥**
	inches	**inches**	**seconds**	**grams**	**grams**
Unisize	**25**	**8**	**60.0**	**2.0**	**950**

Universal Requirements

1. Designed with a closure system consisting of either reusable belts with buttons or velcro (minimum of one set per package), or continuous elasticized waistband.
2. Designed with multi-elastic leg gathers
3. Backing is waterproof

Notes

[1] To qualify for inclusion on the formulary, products need to meet or exceed two of the three performance standards and be within 15% of the third standard.

[2] Measured by cutting leg elastic and stretching flat.