

# Florida Medicaid

## Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook

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Agency for Health Care Administration







CHARLIE CRIST  
GOVERNOR

HOLLY BENSON  
SECRETARY

October 10, 2008

Dear Medicaid Provider:

Florida Medicaid has issued the revised Florida Medicaid Durable Medical Equipment and Supply Services Coverage and Limitations Handbook, July 2008. The revised handbook is available on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-Florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks. If you are unable to access the Internet, you may request a paper copy by calling the Provider Contact Center at 800-289-7799 and selecting Option 7.

The revised handbook contains updated provider qualifications and enrollment policies including mandatory accreditation, which is effective January 1, 2009.

Please contact your area Medicaid office if you have any questions. The area Medicaid offices' phone numbers and addresses are available on the Agency's website at <http://ahca.myflorida.com>. Click on Medicaid, and then on Area Offices. They are also listed in Appendix C of the Florida Medicaid Provider General Handbook. All the Medicaid handbooks are available on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-Florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks.

We appreciate the services that you provide to Florida's Medicaid recipients.

Sincerely,

Beth Kidder  
Chief, Bureau of Medicaid Services





# UPDATE LOG

## DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLY SERVICES COVERAGE AND LIMITATIONS HANDBOOK

### ***How to Use the Update Log***

#### **Introduction**

The current Medicaid provider handbooks are posted on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Provider Support, and then on Provider Handbooks. Changes to a handbook are issued as handbook updates. An update can be a change, addition, or correction to policy. An update may be issued as either replacement pages in an existing handbook or a completely revised handbook.

It is very important that the provider read the updated material. It is the provider's responsibility to follow correct policy to obtain Medicaid reimbursement.

#### **Explanation of the Update Log**

Providers can use the update log to determine if they have received all the updates to the handbook.

Update No. is the month and year that the update was issued.

Effective Date is the date that the update is effective.

#### **Instructions**

When a handbook is updated, the provider will be notified by a postcard or notice. The notification instructs the provider to obtain the updated handbook from the Medicaid fiscal agent's Web Portal at <http://mymedicaid-Florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks.

Providers who are unable to obtain an updated handbook from the Web Portal may request a paper copy from the Medicaid fiscal agent's Provider Support Contact Center at 800-289-7799, select Option 7.

UPDATE NO.	EFFECTIVE DATE
Nov1999—Replacement Pages	October 1999
May2000—Replacement Pages	January 2000
May2000 Errata—Pen-and-Ink Correction	January 2000
April2001—Replacement Pages	April 2001
April2001—Errata	April 2001
Jan2002—Replacement Pages	January 2002
March 2003—Replacement Pages	March 2003
Jul2008—Revised Handbook	July 2008



# DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLY SERVICES COVERAGE AND LIMITATIONS HANDBOOK

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## INTRODUCTION TO THE HANDBOOK

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### Overview

#### Introduction

This chapter introduces the format used for the Florida Medicaid handbooks and tells 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 the fee schedules.
- Reimbursement Handbooks describe how to complete and file claims for reimbursement from Medicaid.

Exception: For Prescribed Drugs, the coverage and limitations handbook and the reimbursement handbook are combined into one.

#### Legal 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, and
- Chapter 59G, Florida Administrative Code.

The specific Federal Regulations, Florida Statutes, and the Florida Administrative Code, for each Medicaid service are cited for reference in each specific coverage and limitations handbook.

#### In This Chapter

This chapter contains:

TOPIC	PAGE
Handbook Use and Format	ii
Characteristics of the Handbook	iii
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***Handbook Use and Format***

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**Purpose** The purpose of the Medicaid handbooks is to furnish the Medicaid provider with the 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.

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**Provider** The term “provider” is used to describe any entity, facility, person or group who is enrolled in the Medicaid program and renders services to Medicaid recipients and bills Medicaid for services.

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**Recipient** The term “recipient” is used to describe an individual who is eligible for Medicaid.

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**General Handbook** General information for 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. This general handbook is distributed to all enrolled Medicaid providers and is updated as needed.

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**Coverage and Limitations Handbook** Each coverage and limitations handbook is named for the service it describes. A provider who furnishes more than one type of service will have more than one coverage and limitations handbook.

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**Reimbursement Handbook** Each reimbursement handbook is named for the claim form that it describes.

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**Chapter Numbers** The chapter number appears as the first digit before the page number at the bottom of each page.

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**Page Numbers** Pages are numbered consecutively throughout the handbook. Page numbers follow the chapter number at the bottom of each page.

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**White Space** The "white space" found throughout a handbook enhances readability and allows space for writing notes.

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***Characteristics of the Handbook***

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<b>Format</b>	The format styles used in the handbooks represent a concise and consistent way of displaying complex, technical material.
<b>Information Block</b>	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.
<b>Label</b>	Labels or names are located in the left margin of each information block. They identify the content of the block in order to facilitate scanning and locating information quickly.
<b>Note</b>	Note is used most frequently to refer the user to pertinent material located elsewhere in the handbook.  Note also refers the user to other documents or policies contained in other handbooks.
<b>Topic Roster</b>	Each chapter contains a topic roster 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.

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***Handbook Updates***

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<b>Update Log</b>	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 No." and the "Effective Date".
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**Handbook Updates**, continued

<b>How Changes Are Updated</b>	<p>The Medicaid handbooks will be updated as needed. Changes may consist of any one of the following:</p> <ol style="list-style-type: none"> <li>1. Pen and ink updates—Brief changes will be sent as pen and ink updates. The changes will be incorporated on replacement pages the next time replacement pages are produced.</li> <li>2. Replacement pages—Lengthy changes or multiple changes that occur at the same time will be sent on replacement pages. Replacement pages will contain an effective date that corresponds to the effective date of the update.</li> <li>3. Revised handbook—Major changes will result in the entire handbook being replaced with a new effective date throughout.</li> </ol>
<b>Numbering Update Pages</b>	<p>Replacement pages will have the same number as the page they are replacing. If additional pages are required, the new pages will carry the same number as the preceding replacement page with a numeric character in ascending order. (For example: page 1-3 may be followed by page 1-3.1 to avoid reprinting the entire chapter.)</p>
<b>Effective Date of New Material</b>	<p>The month and year that the new material is effective will appear in the inner corner of each page. The provider can check this date to ensure that the material being used is the most current and up to date.</p> <p>If an information block has an effective date that is different from the effective date on the bottom of the page, the effective date will be included in the label.</p>
<b>Identifying New Information</b>	<p>New material will be indicated by vertical lines. The following information blocks give examples of how new labels, new information blocks, and new or changed material within an information block will be indicated.</p>
<b>New Label</b>	<p>A new label for an existing information block will be indicated by a vertical line to the left and right of the label only.</p>
<b>New Label and New Information Block</b>	<p>A new label and a new information block will be identified by a vertical line to the left of the label and to the right of the information block.</p>
<b>New Material in an Existing Information Block</b>	<p>New or changed material within an existing information block will be indicated by a vertical line to the left and right of the information block.</p>
<b>New or Changed Paragraph</b>	<p>A paragraph within an information block that has new or changed material will be indicated by a vertical line to the left and right of the paragraph.</p> <p> Paragraph with new material.  </p>

# CHAPTER 1

## DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLY SERVICES PROVIDER QUALIFICATIONS AND ENROLLMENT

**Overview**

**Introduction**

This chapter describes the purpose of the Medicaid Durable Medical Equipment (DME) and Medical Supply Services Program; the legal authority regulating the program; and provider qualifications, enrollment, and requirements.

**Legal Authority**

The Medicaid DME and Medical Supply Services Program is authorized by Title XIX of the Social Security Act and Title 42, Code of Federal Regulations (C.F.R.). The program was implemented through Chapter 409, Florida Statutes (F.S.), and Chapter 59G, Florida Administrative Code (F.A.C.).

**In This Chapter**

This chapter contains:

TOPIC	PAGE
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Provider Qualifications and Enrollment	1-3
Provider Requirements	1-17

***Purpose and Definitions***

**Purpose**

The purpose of the DME and Medical Supply Services Program 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 suppliers who provide services to Medicaid recipients. It must be used in conjunction with the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which contains specific procedures for submitting claims for payment, and the Florida Medicaid Provider General Handbook, which describes the Florida Medicaid Program.

Note: The Medicaid Handbooks are available on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks. The Florida Medicaid Provider Reimbursement Handbook, CMS-1500, is incorporated by reference in 59G-4.001, F.A.C., and the Florida Medicaid Provider General Handbook, is incorporated by reference in 59G-5.020, F.A.C.

**Purpose and Definitions**, continued

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<b>Durable Medical Equipment (DME)</b>	Durable medical equipment (DME) is defined as medically-necessary equipment that can withstand repeated use, serves a medical purpose, and is appropriate for use in the recipient's home as determined by the Agency for Health Care Administration (AHCA).
<b>Enrolled DME and Medical Supply Provider</b>	To be eligible to enroll as a Medicaid DME and medical supply provider, a provider applicant must meet the eligibility requirements described in this handbook and the Florida Medicaid Provider General Handbook and agree to provide goods and services at the fees established by Florida Medicaid.
<b>Enrolled Medicaid Pharmacy Provider</b>	In accordance with Chapter 465, F.S. and Chapter 59G-4.250, F.A.C., an enrolled Medicaid Pharmacy Provider is defined as a pharmacy that has a Medicaid provider agreement in effect with AHCA and is in good standing with AHCA.
<b>Medical Supplies</b>	Medical supplies are defined as medically-necessary medical or surgical items that are consumable, expendable, disposable, or non-durable and appropriate for use in the recipient's home.
<b>Orthotic Devices</b>	Orthotic devices are defined as medically-necessary 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.
<b>Prosthetic Devices</b>	Prosthetic devices are defined as medically-necessary artificial devices or appliances that replace all or part of a permanently inoperative or missing body part.

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**Provider Qualifications and Enrollment**

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**Who Can Provide Services**

The following entities may enroll in the Medicaid DME and Medical Supply Services Program:

- Businesses that supply DME and medical supplies;
- Pharmacies that supply DME and medical supplies;
- Home health agencies;
- Orthopedic physician's groups who supply orthotic and prosthetic devices that are not otherwise included in the physician's office visit charge, and
- Optometrists and opticians who supply prosthetic eyes.

Businesses are defined as enterprises, commercial entities, or firms in either the private or public sector, that are concerned with providing products or services to satisfy customer requirements.

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**Cost-Effective Purchasing of Health Care**

According to Florida Statute 409.912, the Agency for Health Care Administration may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without limiting access to care. The agency may seek federal waivers necessary to administer these policies.

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**Provider Enrollment Applications and Information**

The Florida Medicaid Provider Enrollment Application, AHCA 2200-003, can be obtained from the Medicaid fiscal agent by calling 800-289-7799 and selecting Option 4 or from its Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Enrollment. The Florida Medicaid Provider Enrollment Application is incorporated by reference in 59G-5.010, F.A.C.

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**General Medicaid Provider Enrollment Requirements**

DME and medical supply providers must meet the general Medicaid provider enrollment requirements that are contained in Chapter 2 of the Florida Medicaid Provider General Handbook. In addition, DME and medical supply providers must meet the specific enrollment requirements listed in this chapter.

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**Provider Qualifications and Enrollment**, continued

**Qualification Requirements**

To enroll as a Medicaid provider, a DME and medical supply entity must meet the following criteria:

- Be licensed by the local government agency as a business or merchant or provide documentation from the city or county authority that no licensure is required;
- Be licensed by the Department of Health, Medical Quality Assurance, Board of Orthotics and Prosthetics, if providing orthotics and prosthetic devices;
- Be licensed by the Agency for Health Care Administration, Division of Health Quality Assurance, in possession of a Home Health Equipment license;
- Be in compliance with all applicable laws relating to qualifications or licensure; and
- Have an in-state business location or be located not more than fifty miles from the Florida state line.

**Business Location Eligibility Requirements for DME and Medical Supply Providers**

Eligibility for initial enrollment, continued enrollment, or re-enrollment as a Medicaid DME and medical supply provider requires the provider to meet one of the following physical location criteria:

- Must be a DME or medical supply business currently occupying and operating from a physical business site that is located within the state of Florida, and that is easily accessed by the Medicaid recipients and the general public it serves; or
- Must be a DME or medical supply business that provides sufficient proof that the business occupies and operates a DME and medical supply or medical supply business location within fifty 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 the Florida Medicaid recipients and the general public it serves; or
- If the DME business or medical supply is physically located more than fifty miles from the Florida state line, the business must supply durable medical equipment 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. The Bureau of Medicaid Services, DME and Medical Supply Services Program, approves the initial and continued enrollment of businesses that are located more than fifty miles from the Florida state line.

**Provider Qualifications and Enrollment**, continued

**DME and Medical Supply Provider Qualifications for Enrollment and Re-enrollment**

Eligibility for initial enrollment, continued enrollment, or re-enrollment as a Medicaid DME and medical supply provider requires that any applicant must, at a minimum, meet all of the following criteria:

- 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; and
- Be in compliance with all applicable laws relating to qualifications or licensure. All licenses must be current and valid, with an address on the license that is the same address as the physical location of the DME and medical supply business; and
- Effective January 1, 2009, not be located at the same street address as another Medicaid DME and medical supply provider or an enrolled Medicaid pharmacy that is also enrolled as a DME provider, unless it is a licensed orthotist or prosthetist that provides only orthotic or prosthetic devices as a Medicaid durable medical equipment provider; and
- Provide proof that the DME and medical supply business location is in compliance with local zoning laws; and
- Have physical DME and medical supply business location(s) in compliance with the American with Disabilities Act (ADA), regarding parking and public access requirements; and
- Effective January 1, 2009, be easily accessible to the local public served during its scheduled, posted business hours and must operate no less than 5 hours per day and no less than 5 days per week, with the exception of scheduled and posted holidays. Licensed orthotist or prosthetist that provides only orthotic or prosthetic devices as a Medicaid durable medical equipment provider and manufacturer businesses that are located more than fifty miles from the Florida state line are exempt from this requirement; and
- Effective January 1, 2009, have signage that can be easily read from a distance of twenty feet, that readily identifies the business location as a business that furnishes durable medical equipment and or medical supplies, unless it is a licensed orthotist or prosthetist that provides only orthotic or prosthetic devices as a Medicaid durable medical equipment provider; and
- Be operating primarily as a walk-in DME and medical supply business location; and
- Be accredited. Effective January 1, 2009, all applicants and currently enrolled DME and medical supply providers must submit proof of current accreditation as a prerequisite for enrollment, continued enrollment, or re-enrollment, unless exempt. (See Exemption from Accreditation Requirements in this section). The Medicaid Durable Medical Equipment and Medical Supply Services Program will accept proof of accreditation from one of the accrediting organizations listed on the next page:

**Provider Qualifications and Enrollment**, continued

**DME and Medical Supply Provider Qualifications for Enrollment and Re-enrollment**, continued

- ⇒ 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, Inc.
- ⇒ The Compliance Team

Any currently enrolled Medicaid DME and medical supply provider or pending applicant whose application has been received by Medicaid Provider Enrollment prior to January 1, 2009 must submit proof of accreditation by one of the accrediting organizations listed above by January 1, 2009. Any new DME and medical supply provider enrollment application received by Medicaid Provider Enrollment on or after January 1, 2009, must include proof of current accreditation; and

- The provider must have not been terminated by any state or federal agency for reasons of fraud or abuse; and
- The provider must unless otherwise exempt, meet the minimum standards for home medical equipment providers; and
- The provider must unless otherwise exempt, provide proof of current HME licensure; and
- If the DME and medical supply services location is exempt from HME license requirements, the DME location's current working owner or manager must provide a notarized affidavit stating he has:
  - ⇒ A minimum of one (1) year of experience as a DME and medical supply business owner or Medicare DME and medical supply provider, identifying the business(es), business address(es), and contact(s); or
  - ⇒ A minimum of one (1) year of managerial experience or billing experience as an employee of a DME and medical supply provider, identifying the business(es), business address(es), and contact(s); and
- The provider must submit proof of renewal of all required licenses, certifications, accreditations, surety bonds, required in this chapter for each individual DME and medical supply services business location at least thirty (30) days prior to that document's expiration date; or submit a letter from the appropriate licensing, certification, bonding or accrediting entity that explains the reason for delay is not due to any actions or inactions on the part of the provider; and

**Provider Qualifications and Enrollment**, continued

**DME and Medical Supply Provider Qualifications for Enrollment and Re-enrollment**, continued

- The provider must 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 (6) months; and
- The provider must have not been denied DME and medical supply provider enrollment within the past year; and
- The provider must have a current physical DME and medical supply services business location with substantial stock, as defined in this chapter; and
- The provider must meet any other specific enrollment requirements listed in this chapter.

Failure to comply with these general DME and medical supply provider qualifications 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.

If the provider's DME and medical supply services location's surety bond or accreditation exemption, HME licensure, oxygen retailer permit, accreditation status, address, ownership, or contact information changes or is proposed to change, the Medicaid fiscal agent must be notified immediately at the following address:

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

Note: See Chapter 2 in the Florida Medicaid Provider General Handbook for additional information on Medicaid provider qualifications.

**Exceptions from Accreditation Requirements**

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; or
- Operated by and within a pharmacy that is currently enrolled as a Medicaid pharmacy provider; or
- A Medicaid-enrolled orthopedic physician's group, primarily owned by physicians, that is providing only orthotic and prosthetic devices, and is enrolled and has an active enrollment status as a Medicaid provider.

**Provider Qualifications and Enrollment**, continued

**Home Medical Equipment (HME) Providers**

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

Title XXIX, Chapter 400, Part VII of the Florida Statutes contains regulations regarding home medical equipment. According to s.400.93 F.S., any person or entity that holds itself out to the public as providing home medical equipment and services or accepts physician orders for home medical equipment and services, or any person or entity that holds itself out to the public as providing home medical equipment that typically requires home medical services must be licensed by AHCA to operate or provide home medical equipment and services in Florida. A separate license is required for all home medical equipment providers operating on separate premises, even if the providers are operated under the same management.

**HME Providers Exempt from Licensure**

Providers exempt from holding a current, standard HME license are those operated by the federal government, nursing homes, assisted living facilities, home health agencies, hospices, intermediate care facilities, hospitals and ambulatory surgical centers, manufacturers, and suppliers of consumable and disposable items only, and 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 at the following address:

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

Note: Call AHCA's HME unit at (850) 414-6010 for questions relating to HME licensure.

**Home Health Services**

Home health services are defined in section 400.462, F.S. as health and medical services and medical supplies furnished by an organization to an individual in the individual's home or place of residence. The term includes organizations that provide one or more of the following:

- Nursing care.
- Physical, occupational, respiratory, or speech therapy.
- Home health aide services.
- Dietetics and nutrition practice and nutrition counseling.
- Medical supplies, restricted to drugs and biologicals prescribed by a physician.

***Provider Qualifications and Enrollment***, continued

**Orthotic and  
Prosthetic  
Providers**

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.

Orthotic and prosthetic device providers must be licensed by the Department of Health, Medical Quality Assurance, Board of Orthotics and Prosthetics.

Representatives of product manufacturers who are not licensed by the Department of Health, Medical Quality Assurance, Board of Orthotics and Prosthetics and are not employed by the enrolled provider are not qualified to provide Medicaid DME orthotic and prosthetic services, including the assessment, adjustment and the fitting of orthotic and prosthetic devices.

***Provider Qualifications and Enrollment***, continued

**Requirements for  
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 providers and providers of oxygen-related equipment and services must also have current and valid oxygen retailer permits issued by the Department of Health, Central Pharmacy.

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

Oxygen providers must have a licensed certified respiratory therapist (CRT), registered respiratory therapist (RRT), registered nurse (RN), or respiratory care practitioner (RCP) 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, as required in Chapter 59A-25.003, F.A.C.

DME oxygen providers and providers of oxygen-related equipment and services must establish and implement business policies and procedures. These policies and procedures must ensure all new and used oxygen-related or respiratory equipment, including the internal filters, purchased by the provider, are appropriately disinfected, sterilized, serviced, and properly stored according to manufacturer's specifications, HME licensure requirements and industry standards, prior to renting, delivering, or providing the equipment to any individual customer.

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.

Pick up and delivery documentation must be maintained for all equipment.

The provider of DME oxygen services and oxygen-related equipment and services must maintain records. The individual patient record must include clearly documented initial and quarterly home visits. Patient records must include equipment assessments, such as oxygen concentrator hour meter readings. If the equipment is equipped with a patient compliance hour meter, that reading must also be documented and maintained in the patient's record.

Note: See Chapter 2 in this handbook for additional information regarding oxygen and oxygen-related equipment.

***Provider Qualifications and Enrollment***, continued

**Enrollment  
Requirements for  
Providers of  
Oxygen and  
Oxygen-Related  
Equipment**

To be reimbursed for the provision of oxygen and oxygen-related equipment, the DME and medical supply provider 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 Department of Health, 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 the Department of Health.

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

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

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

**Provider Qualifications and Enrollment**, continued

**Fully-Operational at Time of Enrollment**

Effective January 1, 2009, the DME and medical supply entity's fully-operational status must be verified by Medicaid staff or Medicaid's authorized representative.

Florida Medicaid defines a fully operational DME entity as a DME business location that is currently open for business and providing and receiving payment for DME equipment and medical supplies and services provided to the general public and meets all of the following criteria:

- Is clearly identified with signage that can be read from 20 feet away; and
- Is readily accessible to the public during scheduled, posted business hours; and
- Is operating no less than five (5) hours per day, and no less than five (5) days per week, with the exception of scheduled and posted holidays; and
- Has a physical DME business location with durable medical equipment and medical supplies on site and readily available to the general public.
- Has a functional land-line business phone.

**Exceptions to Fully-Operational at Time of Enrollment**

Effective January 1, 2009, a licensed orthotist or prosthetist that provides only orthotic or prosthetic devices as a Medicaid durable medical equipment provider is exempt from the following criteria:

- Is clearly identified with signage that can be read from 20 feet away; and
- Is operating no less than five (5) hours per day, and no less than five (5) days per week, with the exception of scheduled and posted holidays.

**Substantial Inventory of DME and Medical Supplies**

The Medicaid DME and Medical Supply Services Program defines a substantial inventory as medical equipment and medical supplies that are readily available and sufficient to meet the needs of the DME business location's customers.

Medicaid staff or Medicaid's authorized representatives 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, rental agreements, documented purchases, and current and accurate inventory of all medical supplies, rental equipment and equipment for purchase, including model, stock number, serial number, batch number, etc.

The Medicaid DME and medical supply provider must maintain current and accurate inventory records for the DME business location and, upon request, make records readily available for review by Medicaid staff or Medicaid's authorized representatives.

**Provider Qualifications and Enrollment**, continued

**One Medicaid DME and Medical Supply Provider Per Physical Location**

The Medicaid DME and Medical Supply Services Program's definition of a physical location is 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 U.S. Postal Service or the building's owner.

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

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 that has been consistently located at the current street address and actively providing Medicaid 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.

**Multiple DME and Medical Supply Physical Locations Operated by the Same DME 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 by the Medicaid fiscal agent.

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 (NPI) 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.

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

***Provider Qualifications and Enrollment***, continued

**Surety Bond  
Submission  
Requirements  
and Exemptions**

Providers must comply with the surety bond requirements in 409.907(7), F.S. Effective January 1, 2009, in accordance with 409.912(48)(b), one \$50,000 bond is required for each DME and medical supply provider location, up to a maximum of five (5) bonds statewide or an aggregate bond of \$250,000 statewide as identified per Federal Employer Identification Number (F.E.I.N.). Providers who qualify for a statewide or an aggregate bond must identify all their locations in any Medicaid DME and medical supply provider enrollment application or bond renewal.

A surety bond must be submitted as part of the Medicaid DME and medical supply 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.

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

- Owned and operated by a government entity; or
- Operated by and within a pharmacy that is currently enrolled as a Medicaid pharmacy provider; or
- Medicaid-enrolled orthopedic physician's groups that are more than 50 percent owned by physicians, providing only orthotic and prosthetic devices, and has been an active Medicaid provider in good standing.
- A licensed orthotist or prosthetist that provides only orthotic or prosthetic devices as a Medicaid durable medical equipment provider.

**Provider Qualifications and Enrollment**, continued

**Site Visit Requirement**

Medicaid may contract with a private entity to conduct DME and medical supply provider site visits, as an authorized agency representative.

Unless the applying DME and medical supply entity meets one of the exemptions listed below, the applicant's DME and medical supply services business must have an unannounced site visit conducted by Medicaid or its authorized representative, before the entity's DME and medical supply provider enrollment application is considered for enrollment.

Each of the additional DME and medical supply services location(s) operated by the DME entity must also have an unannounced site visit conducted by Medicaid staff, or its authorized representative, before the individual physical location(s) can be considered for enrollment.

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 services entities are exempt from a pre-enrollment site visit:

- Entities associated with rural health clinics; or
- Entities that are government operated; or
- Entities that are licensed, Medicaid-enrolled optometrists providing prosthetic eyes; or
- Entities that are licensed Medicaid-enrolled orthotists or prosthetists that provide only orthotic or prosthetic devices and who provide copies of their professional licenses from the Department of Health with their enrollment applications; or
- Entities that are licensed Medicaid-enrolled orthopedic physicians working within an orthopedic physician's group that are more than 50 percent owned by physicians, providing only orthotic and prosthetic devices not otherwise included in the physician's visit fee.

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.

**Provider Qualifications and Enrollment**, continued

**DME and Medical  
Supply 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 Federal Employer Identification Number (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 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.

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.

All DME and medical supply services claims must be submitted to the Medicaid fiscal agent electronically or on the CMS-1500 (08/05) claim form, using the DME provider number.

Note: Please see definition of an Enrolled Medicaid Pharmacy Provider under Purpose and Definitions in this chapter.

Note: The CMS-1500 (08/05) claim form is available from the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Select Public Information for Providers, then Provider Support, and then Forms. It is also available from the Medicaid fiscal agent's Contact Center by calling 800-289-7799 and selecting Option 7. It is incorporated by reference in 59G-4.001, F.A.C.

**Provider Requirements**

**General Requirements**

In addition to the general provider requirements and responsibilities that are contained in Chapter 2 of the Florida Medicaid Provider General Handbook, DME and medical supply providers are also responsible for the provisions contained in this chapter.

**Background Screening Requirement**

State and national criminal background checks must be performed for any officer, director, billing agent, managing employee and any affiliated person, partner, or shareholder having ownership interest of five percent or greater in the agency, in accordance with section 409.907, F.S.

Effective January 1, 2009, a Level Two background screening, as described in s. 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 time of employment and every ten (10) years thereafter. It is the responsibility of the provider to ensure the request for screening or re-screening is submitted for processing in a timely manner.

An application for a Level Two background screening must be submitted for all appropriate employees on or before January 1, 2009, and within forty-five (45) days of employment for employees hired after the effective date of this requirement. Screening must be updated every ten (10) years thereafter. Copies of background screening applications and results must be maintained in the employees' personnel record and made available for review upon request.

Note: See Chapter 2 in the Florida Medicaid Provider General Handbook for additional information on background screenings.

**Provider Requirements**, continued

**Time-Sensitive Reporting Requirement for Selling, Closing, or Changing the Ownership of DME 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

The provider's notification must be submitted on the provider's company letterhead and must include, at a minimum, the following information:

- Provider name and provider correspondent's name and contact phone number;
- Address of provider's DME location(s) affected by the change in information;
- Provider's DME Medicaid number(s) for the DME location(s) affected by the change;
- Explanation, signed by the authorized signee identified on the Medicaid Enrollment Application, regarding the type of change (i.e., selling DME business, closing DME business, changing ownership of DME business, or no longer wishes to accept Medicaid for DME services);
- Name and contact information of person(s) purchasing the DME business(es); and
- Prospective or effective date(s) of change.

Note: See Chapter 2 in the Florida Medicaid Provider General Handbook for additional information on reporting changes.

***Provider Requirements***, continued

**Time-Sensitive Requirement for Reporting Provider's Change of Address and Contact Information**

The provider must notify the Medicaid fiscal agent of any change of address, including change in zip code, telephone number including area code, and any other pertinent contact information. The notification must include the provider phone number, new business and new mailing address, the physical location address if different, the provider's previous address, and the prospective or effective date of the change. The DME provider must call the Medicaid Provider Enrollment Unit at 800-289-7799 and select Option 4, to report a change to address.

Medicaid payments are mailed to the billing address listed in the Medicaid computer system. To avoid delays in Medicaid payments, changes in addresses and contact information, including telephone numbers and area codes, must be appropriately and immediately reported to the Medicaid fiscal agent.

Note: See Chapter 2 in the Florida Medicaid Provider General Handbook for additional information regarding reporting a change of address.

**Provider Requirements**, continued

**Time-Sensitive Requirement for 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.

DME 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 covered 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

**Provider Requirements**, continued

**Time-Sensitive  
Renewal  
Requirements for  
Accreditation  
Certificates**

DME 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 provider of Medicaid DME and Medical Supply Services.

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 covered by Medicaid, and the individual DME location without a current accreditation certificate on file will be terminated as a provider of Medicaid DME and Medical Supply Services.

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 Federal Employer Identification Number (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

**Provider Requirements**, continued

**Time-Sensitive  
HME License  
Renewal  
Requirements**

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 of Medicaid DME and Medical Supply Services.

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 covered by the Medicaid, and the individual DME location without a current HME license on file will be terminated as a provider of Medicaid DME and Medical Supply Services.

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

**Provider Requirements**, continued

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

DME and medical supply providers must submit proof of updated licenses, certifications, permits, and accreditation certificates, 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 the 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

Note: See Provider Qualifications in this chapter for the licenses, permits, certifications, insurance, and accreditation requirements necessary for initial and ongoing enrollment as a Medicaid DME and medical supply provider.

**Illegal Remunerations**

DME and medical supply providers may not offer, pay, solicit, or receive any remuneration, in violation of 42 U.S.C., 1320a-7b.

**Provider Requirements**, continued

**Solicitation**

Providers are not permitted to knowingly solicit, offer, pay, or receive any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made, in whole or in part, under the Medicaid program, or in return for obtaining, purchasing, leasing, ordering, or arranging for or recommending, obtaining, purchasing, leasing, or ordering any goods, facility, item, or service, for which payment may be made, in whole or in part, under the Medicaid program. A person who violates this subsection commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s.775.084, F.S.

**Non-Transfer of DME and Medical Supply Provider Medicaid 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 their DME and medical supply services business; or
- Person or legal entity planning to purchase or person or legal entity that is coordinating the purchase of their DME and medical supply services business; or
- Another Medicaid provider; or
- Another business, person or entity not currently enrolled in Medicaid or not authorized to use the identification number.

**Provider Requirements**, continued

**DME and Medical Supply 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:

- Providers must provide the services or supplies directly to the Medicaid recipient or caregiver 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; and
- Honoring provider's and manufacturer warranties in a timely manner; and
- 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; and
- Maintaining and repairing equipment, per manufacturer recommendations; and
- Hiring, contracting and supervising appropriately educated, trained and credentialed staff; and
- Maintaining the appropriate and required business records; and
- Maintaining the required service and medical documentation for customers served by the DME business location, for a minimum of five (5) years from the date of service; and
- Maintaining individual maintenance and service records on all durable medical equipment, as required by the manufacturer's guidelines, which includes the description, model and serial number, and current location of the individual equipment; and
- 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 recipient; and
- Used for the purpose for which they were designed; and
- Reasonable and effective in meeting the medical needs of the recipient; and
- Of equal quality as those products and items furnished to non-Medicaid patients; and
- Non-duplicative or do not perform the same function as equipment or supplies already in the recipient's possession; and
- Compliant with program policy and service requirements.

Note: See Exception to Nebulizer Delivery and Set Up in chapter 2 for qualifying conditions to store nebulizers at a physician's office.

***Provider Requirements***, continued

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**Training  
Documentation  
Requirements  
for Provider's  
Employees**

DME and medical supply providers must maintain documentation of employee training sessions for the staff working at each DME business location that, at a minimum, includes:

- Topic of training session; and
- Date of training; and
- Name and title of trainer; and
- Professional license number of trainer, if applicable; and
- Legible signatures of attendees and the DME business location where they are employed or the individual's certification of completion of on-line training; and
- Copy of training handouts and presentations; and
- Copy of overhead presentation, if applicable.

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**Provider  
Employees'  
Driver License  
Requirement**

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

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**Employee  
Competence**

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

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**Provider Requirements**, continued

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**Provider Responsibility and HIPAA**

Florida Medicaid has implemented the requirements contained in the federal Health Insurance Portability and Accountability Act (HIPAA). As trading partners with Florida Medicaid, all Medicaid providers, including their staff, contracted staff and volunteers, must comply with HIPAA privacy requirements. Providers who meet the definition of a covered entity according to HIPAA must comply with HIPAA Electronic Data Interchange (EDI) requirements. The Coverage and Limitation Handbooks contain information regarding changes in codes mandated by HIPAA. The Medicaid Provider Reimbursement Handbooks contain the claims processing requirements for Florida Medicaid, including the changes necessary to comply with HIPAA.

Note: For more information regarding HIPAA privacy in Florida Medicaid see Chapter 2 in the Florida Medicaid Provider General Handbook.

Note: For more information regarding claims processing changes in Florida Medicaid because of HIPAA, see Chapter 1 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500.

Note: For information regarding changes in EDI requirements for Florida Medicaid because of HIPAA, call the fiscal agent EDI help desk at 800-289-7799 and select Option 3.

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**Record Keeping Requirements and Availability of DME and Medical Supply Business Records**

In addition to the specific documentation required for the covered items listed in this handbook, DME and medical supply providers must also follow the record keeping requirements listed in Chapter 2 of the Florida Medicaid Provider General Handbook.

DME business records, including customer records, must be maintained by the provider for a minimum of five (5) years from the date of service and made readily available, upon request, to Medicaid staff and Medicaid's authorized representatives.

Note: See DME and Medical Supply Provider Responsibilities located in this section and in Chapter 2 of the Florida Medicaid Provider General Handbook.

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**Non-Compliance**

DME and medical supply providers found non-compliant with the rules contained in this handbook are subject to the following actions:

- Recoupment of funds; and
- Termination as a provider of Medicaid DME and Medical Supply Services; and
- Sanctions or other penalties afforded by law.

Note: See Chapter 5 in the Florida Medicaid Provider General Handbook for information on Medicaid fraud and abuse.

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## CHAPTER 2

### DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLY SERVICES COVERED SERVICES, LIMITATIONS AND EXCLUSIONS

**Overview**

**Introduction**

This chapter describes durable medical equipment (DME), medical supplies, orthotic and prosthetic devices, the service requirements, and limitations.

**Medicaid  
Information  
Available Online**

All Medicaid handbooks, fee schedules, forms, provider notices, and other important Medicaid information are available on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then click on Provider Handbooks, Fee Schedules, Forms, or Provider Notices.

The available forms include the Florida Medicaid Authorization Request, PA01, and the Medicaid Custom Wheelchair Evaluation, AHCA-Med Serv Form 015, July 2007.

Additional information is also available on the Agency for Health Care Administration's website at <http://ahca.myflorida.com>.

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**General Service Requirements**

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**Services Limited to Recipients Under 21 Years of Age**

Many durable medical equipment (DME) items and services are limited to recipients under 21 years of age.

To determine whether a service is available to all recipients or limited to recipients under age 21 years of age, refer to the DME and Medical Supply Services Provider Fee Schedules and the service specific requirements described in this handbook.

Note: The DME and Medical Supply Services Provider Fee Schedules are available on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Fee Schedules. The fee schedules are incorporated by reference in 59G-4.071, Florida Administrative Code.

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**Authorized Prescribers of Durable Medical Equipment and Medical Supplies**

All durable medical equipment, medical supplies, and orthotic and prosthetic devices must be prescribed by the Medicaid recipient's:

- Treating physician, or
- Treating physician's physician assistant, or
- Treating physician's advanced registered nurse practitioner (ARNP), or
- Treating podiatrist.

The prescribing professional must include the date, his signature, and current professional license number or national provider identification number on each documentation of medical necessity when requesting DME and services or medical supplies.

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**Qualified Technician**

A qualified technician is a working provider or a provider's employee who is able to demonstrate the appropriate level of training and competency necessary to perform DME equipment repairs and maintenance, as specified by the product's manufacturer.

All certificates of training must be maintained in each hired and contracted service and repair technician's personnel file and upon request, must be made readily available for review by Medicaid staff or Medicaid's authorized representatives.

A qualified technician cannot substitute for a required licensed professional.

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**General Service Requirements**, continued

**Independent  
Therapist or  
Physiatrist**

A licensed occupational or physical therapist or physiatrist cannot be employed by, under contract with, or receiving financial remuneration from any enrolled DME and medical supply provider or manufacturer of the DME equipment (or components of the equipment) from which he is recommending equipment and supplies for purchase by Medicaid.

Note: See Provider Requirements, Illegal Remunerations, in Chapter 1 for additional information.

**Plan of Care**

A plan of care is required by home health agencies furnishing medical services, including the supply of consumable medical supplies, during a recipient's prescribed home regimen. The plan of care is 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 ARNP, physician assistant, therapist, or speech pathologist. The treatment program is designed to meet the medical, health, and rehabilitative needs of the individual recipient.

The plan of care is developed by health care professionals, including a physician, and is approved by the recipient's treating physician or the treating physician's ARNP or physician assistant with his signature. The plan of care must meet the plan of care requirements in the Florida Medicaid Home Health Services Coverage and Limitations Handbook.

A recipient's individual plan of care may also serve as a redetermination of medical necessity for continued monthly equipment rental or medical supply needs. This documentation that specifies the medical goods and services must be updated and signed and dated by the treating, authorized prescriber every six (6) months for continued monthly treatment requiring DME equipment or medical supplies. The need for a new prescription every twelve (12) months is still required.

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.

Note: The Florida Medicaid Home Health Services Coverage and Limitations Handbook is available on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks. The handbook is incorporated by reference in 59G-4.130. F.A.C.

**General Service Requirements**, continued

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<b>Definition of a Year</b>	<p>For the interpretation of the maximum limit, a “year” is defined as 366 days from the date of service (DOS).</p> <p><u>Note:</u> See Chapter 1, Claim Item 24, in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for additional information on the date of service.</p>
<b>Medical Event</b>	<p>Certain DME equipment items listed on the DME and Medical Supply Services Provider Fee Schedules have limits described as “PER MEDICAL EVENT.”</p> <p>A medical event is defined as an inpatient hospitalization or significant change in the recipient’s medical or physical condition that has been recently documented by the recipient’s treating practitioner.</p>
<b>Service Criteria</b>	<p>All DME, medical supplies, and orthotics and prosthetic devices must be:</p> <ul style="list-style-type: none"><li>• Medically necessary, and</li><li>• Functionally appropriate for the individual recipient, and</li><li>• Adequate for the intended medical purpose, and</li><li>• For conventional use, and</li><li>• For the exclusive use of the recipient.</li></ul> <p>DME items requested or supplied must not duplicate or perform the same function as other DME equipment or medical supplies currently in the recipient’s possession.</p> <p><u>Note:</u> See Medical Necessity Definition and Documentation Requirements in this chapter for information on medical necessity criteria and documentation requirements.</p>

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**General Service Requirements**, continued

**Additional Criteria  
for Medical  
Supplies**

To be reimbursed by Medicaid, in addition to the above criteria, medical supplies must be needed for use with one of the following:

- Colostomy, urostomy, ileostomy appliances; or
- Surgical, wound, and burn dressings; or
- Gastric feeding sets and supplies; or
- Urinary catheters, irrigation apparatus, and related items; or
- Tracheostomy and endotracheal care supplies; or
- Disposable items, which if not provided could reasonably cause the recipient to require emergency treatment, become hospitalized, or be placed in a long term care facility; or
- In support of Medicaid-covered DME equipment used by the recipient.

Medical necessity documentation must specify the type, quantity, and frequency of need for consumable medical supplies prescribed by the recipient's treating physician or the treating physician's prescribing ARNP or physician assistant.

**Auto-Refilling**

Recipients' individual medical supply needs vary from month to month. Medical supply quantities must not exceed the individual recipient's one month's usage.

The over-provision of medical supplies by DME and medical supply providers and the stockpiling of unnecessary medical supplies by recipients is discouraged.

Unless consumable medical supplies specifically prescribed for infusion, wound or nutritional therapy are furnished by the visiting home health agency staff, the automatic refilling of consumable supplies by a DME provider is prohibited.

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

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

**General Service Requirements**, continued

**Place of Service or Recipient's Place of Residence**

DME, medical supplies, and orthotics and prosthetic devices are reimbursed only for Medicaid recipients residing in non-institutional settings within the community that include:

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

**Exceptions to Place of Service or Place of Residence**

Medicaid recipients who are under 21 years of age and 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 the Medicaid DME and Medical Supply Services Program.

**MediPass Authorization**

If the recipient is enrolled in MediPass, the recipient's MediPass primary care provider must prior authorize all durable medical equipment and medical supplies, including those items submitted to Medicaid for authorization.

Note: See Chapter 1 in the Florida Medicaid Provider General Handbook for information on MediPass authorization.

Note: See Prior and Post Authorization and Exceptions to the Service Limits in this chapter for information on prior authorization.

**DME and Medical Supplies Provided through Home and Community-Based Waiver Programs**

Medicaid Home and Community-Based Waiver programs that offer DME and medical supplies are only to be used by waiver recipients to supplement DME and medical supply needs that are not fully satisfied by the DME program.

DME and medical supplies covered by the Medicaid state plan must be claimed for available reimbursement using the HCPCS procedure codes listed on the DME and Medical Supply Services Provider Fee Schedules, prior to submitting claims for the same DME or medical supply items, using a Home and Community-Based Waiver Program's HCPCS procedure code.

**General Service Requirements**, continued

**DME and Medical Supplies Provided through Home Health Agencies**

Medicaid reimburses home health agencies for DME and medical supplies furnished by qualified providers only in accordance with the treating physician's prescription and approved plan of care, which must specify the type, quantity, frequency, and length of need.

**Over Billing and Unbundling**

Providers may not furnish the recipient with, or bill Medicaid for, unnecessary or unapproved DME equipment or medical supplies.

Providers may not bill Medicaid:

- Separately for items that are listed or identified in a procedure code's description (unbundling); or
- Separately by unbundling items that are included in a product manufacturer's product description or kit; or
- 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 that is listed on the DME and Medical Supply Services Provider Fee Schedules.

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***Medical Necessity Definition and Documentation Requirements***

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**Medical Necessity**

Medicaid reimburses for services that do not duplicate another provider's service and are determined to be medically necessary. Per 59G-1.010, F.A.C., to be medically necessary, services must meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
- 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;
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program and not experimental or investigational;
- 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
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

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.

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**Medical Necessity Definition and Documentation Requirements**, continued

**Acceptable  
Documentation of  
Medical Necessity**

Medical necessity must be established for each service and documented, at a minimum, with the following:

- Written prescription not more than 12 months old, with the printed name and the dated signature of the recipient's treating physician or the treating physician's ARNP or physician assistant. The prescription can be received by the 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 initiation of service (date of service); or
- 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; or
- Certificate of Medical Necessity (CMN) not more 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. Medicaid prohibits vendors from preparing sections of the CMN that are to be completed by the physician or authorized prescriber. The CMN cannot be dated more than 21 days after the initiation of service (date of service); and
- Plan of care, if a home health agency.

All documentation of medical necessity must include the type of medical equipment, services or consumable goods ordered, including the type, quantity, frequency and length of need ordered or prescribed. 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.

Note: See Prior and Post Authorization, Exceptions to the Service Limits and the specific DME service sections in this chapter, which describe the medical necessity and the specific documentation required for such DME items as a custom wheelchair, power-operated vehicles, custom wheelchair repairs, augmentative alternative communication devices (AAC) and AAC repairs, and hospital beds, etc.

Note: See Plan of Care and Time-Sensitive Update Requirement in the General Service Requirements section in this chapter for additional information.

**Medical Necessity Definition and Documentation Requirements**, continued

**Required Information for Documentation of Medical Necessity**

Medical necessity documentation must include, at a minimum, the following information:

- Recipient's name; and
- DME item(s) or service(s) prescribed; and
- Consumable medical supply(ies) requested including the type, quantity, frequency and length of need; and
- Authorized prescriber's dated original signature (the prescriber's stamped signature on medical office notes or documentation must be initialed by the prescriber); and
- Complete evaluation by a professional therapist (if an evaluation for the item requested is appropriate) that includes a dated signature, professional license number and National Provider Identifier (NPI).

**Time-Sensitive Medical-Necessity Redetermination Requirements for Consumable Medical Supplies**

The medical necessity for consumable medical supplies must be redetermined every six (6) months or for the length of time prescribed if less than six (6) months with:

- A new and specific prescription; or
- A Certificate of Medical Necessity (CMN); or
- An established plan of care, if a home health agency, that meets the plan of care criteria in the Florida Medicaid Home Health Services Coverage and Limitations Handbook; or
- A recent hospital discharge plan that includes the dated signature of the recipient's treating physician or the treating physician's ARNP or physician assistant.

Note: See Definition of Year, Plan of Care, and Acceptable Documentation of Medical Necessity in the General Service Requirements section in this chapter.

**Medical Necessity Definition and Documentation Requirements**, continued

**Time-Sensitive Medical-Necessity Redetermination 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.

Medical necessity for oxygen therapy and the use of apnea monitors must be redetermined every twelve (12) months or for the length of time prescribed if less than twelve (12) months with:

- A new prescription; or
- Certificate of Medical Necessity (CMN); or
- An established plan of care, if a home health agency, that meets the plan of care criteria in the Florida Medicaid Home Health Services Coverage and Limitations Handbook; or
- A recent hospital discharge plan, which includes the dated signature of the recipient's treating physician or the treating physician's ARNP or physician assistant.

The new documentation of medical necessity must specify the type of equipment, goods, or services requested and the quantity, frequency, and the length of need. Length of need must be documented when equipment has been prescribed for less than twelve (12) months.

Note: See Definition of Year, Plan of Care, and Acceptable Documentation of Medical Necessity in the General Service Requirements section in this chapter.

Note: See the Oxygen and Oxygen-Related Equipment section in this chapter for service requirements.

**Length of Medical Necessity for Rental and Rent-to-Purchase Items**

Unless a medical necessity redetermination frequency is otherwise required in this handbook, the length of medical necessity for a rent-to-purchase or a rental DME item is based upon a length of need. The length of need must be clearly specified by the recipient's authorized prescriber on the recipient's acceptable documentation of medical necessity.

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**Service Delivery, Pick-Up, and Training Documentation Requirements**

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**Delivery Documentation Requirements**

Delivery documentation is a record of the recipient's or responsible caregiver's receipt of prescribed and medically-necessary medical supplies or durable medical equipment.

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

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

Note: See the Service Delivery, Pick-Up, and Training Documentation Requirements in this chapter for information on the training document requirements for recipients of services.

***Service Delivery, Pick-Up, and Training Documentation Requirements***, continued

**Pick-up and Return Documentation Requirements**

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

- Medical equipment being returned to the provider's DME business location by the recipient or responsible caregiver; or
- Equipment no longer medically necessary and is picked up from the recipient's residence by the provider; or
- Equipment no longer functioning properly and is picked up from the recipient's residence; or
- 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; and
- Medicaid identification number of the DME location; and
- Address of the DME physical location that originally rendered the service or equipment; and
- Recipient's full name and ten (10) digit Medicaid identification number; and
- Complete description of item(s) picked up; and
- Manufacturer name of item(s) picked up; and
- Model and serial or item number(s) of item(s) picked up; and
- Reason the equipment is being picked up; and
- Current hour meter reading(s); and
- 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, etc., including the recipient's pick-up address; and
- When medical equipment being returned to the provider's DME business location by the recipient or responsible caregiver, the reason for the return; and
- Date of pick up or return; and
- Dated signature of staff picking up the equipment and his professional license number, if applicable; and
- Dated signature of recipient or responsible caregiver releasing the medical equipment to the provider, if the information was captured by the deliverer.

***Service Delivery, Pick-Up, and Training Documentation Requirements***, continued

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**Training  
Documentation  
Requirements for  
Recipients of  
Services**

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

- Recipient's name; and
  - Complete description of medical equipment or item(s) received; and
  - Model and serial number of item received; and
  - Date of training; and
  - Printed name, signature, and title of trainer; and
  - Professional license number of trainer, if applicable; and
  - Dated signatures of recipient or responsible caregiver, attesting to his understanding of information and handouts provided; and
  - Description of training handouts or brochures.
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***Prior and Post Authorization and Exceptions to the Service Limits***

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**DME Items and Services Requiring Prior Authorization (PA)**

Durable medical equipment services or items that require prior authorization (PA) are indicated on the DME Fee and Medical Supply Services Provider Schedules with a "PA" designation. DME services or items that require PA include the following:

- All custom wheelchairs, specially sized and constructed for the individual recipient; and
- Repairs or modifications for custom wheelchairs; and
- All non-custom power or motorized wheelchairs, motorized scooters, and conversion kits used to convert a standard wheelchair into a motorized or power wheelchair; and
- DME items that do not have an assigned procedure code(s) listed on the fee schedules and are requested using the miscellaneous DME procedure code; and miscellaneous DME, which may include items such as external insulin pumps and custom cranial remolding devices; and
- Fixed height hospital beds; and
- Adjustable height hospital beds; and
- Heavy duty hospital beds; and
- Augmentative alternative communication devices (AAC) and AAC device accessories; and
- Repairs to AAC devices.

Assigned procedure codes are subject to change with yearly National Healthcare Common Procedure Coding System (HCPCS) code updates.

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**Prior and Post Authorization and Exceptions to the Service Limits**, continued**Prior Authorization (PA) Process**

Except for the items specified below, PA requests for durable medical equipment must be submitted to the Medicaid fiscal agent on a Florida Medicaid Authorization Request, PAO1, 04/2002. The Florida Medicaid Authorization Request, PAO1, is incorporated by reference in 59G-4.003, F.A.C. After initial processing, the Medicaid fiscal agent forwards the PA request packets to the appropriate office for review.

PA requests for the following items must be submitted directly to the recipient's area Medicaid office:

- Modifications and substantial repairs to custom wheelchairs;
- Fee-schedule replacement wheelchair components or accessories that require PA;
- Non-custom motorized/powering wheelchairs (K0010, K0011, K0012); and
- Power Operated Vehicles (E1230).

PA requests for custom manual and custom power-operated wheelchairs (K0009 and K0014) must be submitted on either the Custom Wheelchair Evaluation, AHCA-Med Serv Form 015, July 2007, or another document that contains the same information as the form. The Custom Wheelchair Evaluation, AHCA-Med Serv Form 015, July 2007, is incorporated by reference in 59G-4.070, F.A.C. Send the request directly to the following address for review:

Bureau of Medicaid Services  
DME Prior Authorization  
2727 Mahan Drive, Mail Stop 20  
Tallahassee, FL 32308

Note: See Prior Authorization Documentation in this section.

Note: See Chapter 2 in the Florida Medicaid Provider Reimbursement Handbook, CMS 1500, for additional information regarding submitting prior authorization requests and a copy of the Florida Medicaid Authorization Request form. The authorization request form is available on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Forms.

Note: See Appendix A for a copy of the Custom Wheelchair Evaluation, AHCA Med Serv Form 015. The form is also available from the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Forms.

Note: See Appendix C of the Florida Medicaid Provider General Handbook for the telephone numbers and addresses of the area Medicaid offices, and listing of counties that they serve. A map of area Medicaid offices, with phone numbers and addresses, is available on Medicaid's website at <http://ahca.myflorida.com>.

***Prior and Post Authorization and Exceptions to the Service Limits***, continued

**Prior Authorization Documentation**

For all DME services and DME items requiring prior authorization (PA), at a minimum, item specific documentation along with the following documentation must be submitted to the appropriate office with the authorization request form:

- A statement clarifying why the recipient's current equipment no longer meets his current needs; and
- Full description of the item(s) requested; and
- Manufacturer's name and address; and
- Model; and
- Serial number or item number for non-custom manufactured item(s); and
- A listing of all parts, components, attachments, or special features of the requested durable medical equipment; and
- A statement clarifying whether the requested equipment or component is new, used or refurbished; and
- A statement clarifying whether 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); and
- 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; and
- DME provider's sales invoice, which must include the following information:
  - (1) A list of custom and non-custom components that are described by HCPCS procedure codes that are listed on the current DME and Medical Supply Services Provider Fee Schedules and the scheduled fee for each component;
  - (2) The invoice subtotal;
  - (3) 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; and
  - (4) The invoice total, excluding all shipping and handling fees; and
- 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; and
- 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; and

***Prior and Post Authorization and Exceptions to the Service Limits***, continued

**Prior Authorization Documentation**, continued

- Evaluation documentation for all custom and prior-authorized mobility equipment must clearly justify each unique feature and the construction of the item requested as medically necessary; and
- If a more costly device or component is being recommended over a less costly alternative, the therapist evaluator and the provider must clearly justify why the less costly alternative will not appropriately meet the recipient's needs; and
- Requests 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; and
- Requests for all mobility devices (custom or non-custom) must include a description of the recipient's current mode of transportation within the community and how the recipient's current mobility equipment is transported; and
- Requests for all mobility devices (custom or non-custom) must include a description of the recipient's cognitive and functional ability to effectively and safely use any mobility equipment and component(s) requested; and
- Requests for all custom mobility equipment must include either the Custom Wheelchair Evaluation, AHCA Med Serv Form 015, July 2007 (Appendix A) or another document that contains the same information requested on the Medicaid form. 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; and
- Requests for all non-custom power mobility equipment must include a copy of a signed and dated medical documentation or treating physician's office notes, which describes the recipient's current medical condition, physical limitations, cognitive and functional abilities, and prognosis, clinical course (worsening or improvement, prognosis, nature and extent of functional limitations, or other therapeutic interventions and results, past experience with related items, etc.); and
- Diagnosis code(s), using the most current version of the International Classification of Diseases, Clinical Modification (ICD-9-CM), that is pertinent to the recipient's need for the item or service being requested; and
- 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; and
- Product information that is required for items purchased by Medicaid.

***Prior and Post Authorization and Exceptions to the Service Limits***, continued

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**Approved PA Documentation Requirements**

When prior authorization is approved and the equipment or device is provided to the recipient, the recipient's required record must also include a description of the item provided that, at a minimum, includes:

- Complete description of device provided, and
  - Manufacturer's name, and
  - Model, and
  - List of components billed, and
  - Serial number(s); and
  - Prescription for the device; and
  - Therapist's evaluation, if applicable.
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**Required Documentation for Post Authorization Requests**

PA requests submitted to the fiscal agent after the item has been provided to the recipient are referred to as post-authorization requests. 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, such as a hospital bed for which the HCPCS procedure code requires prior authorization, at his discretion the DME provider may deliver the hospital bed 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 for hospital beds must be submitted directly to the Medicaid fiscal agent.

All post authorization requests for hospital beds must, at a minimum, include the required prior authorization documentation listed in this section and the additional following documentation:

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

All inquiries regarding post authorization requests should be directed to the area Medicaid office nearest to the recipient's address location.

***Prior and Post Authorization and Exceptions to the Service Limits***, continued

**Required Documentation for Post Authorization Requests**, continued

Note: See Chapter 2 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for additional information on prior authorization and a copy of the Florida Medicaid Authorization Request form.

Note: See Hospital Beds in this chapter for additional documentation requirements, specific to hospital bed requests.

**Maximum Limit Exceptions**

Service limits indicated on the DME and Medical Supply Services Provider Fee Schedules may be exceeded only for eligible recipients under 21 years of age. An exception is that the service limit for temporary wheelchair rentals may be exceeded for recipients of all ages. See Temporary Wheelchair Rentals section in this chapter for additional information.

If it is medically necessary that the maximum limits must be exceeded, the additional services must:

- Be documented as medically necessary in the treating physician's progress notes; and
- Prescribed by an authorized prescriber; and
- Meet all DME service requirements; and
- Be authorized by the recipient's MediPass primary care provider, if the recipient is enrolled in MediPass.

Providers must consult with the staff at the recipient's area Medicaid office when submitting a request to exceed maximum limits.

Documentation of medical necessity, required to justify the recipient's need to exceed the maximum limits, must be submitted with a paper CMS-1500 claim and submitted directly to the recipient's area Medicaid office for processing.

Note: See Appendix C of the Florida Medicaid Provider General Handbook for the telephone numbers and addresses of the area Medicaid offices, and a listing of the counties that they serve. A map of the area Medicaid offices with phone numbers and addresses is also available on Medicaid's website at <http://ahca.myflorida.com>. Click on Medicaid, Area Offices.

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## ***Equipment Purchase, Trade, or Rental***

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### **Purchasing New Equipment**

Medicaid requires that all DME equipment be provided to an eligible recipient with a minimum of 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 elements of the manufacturer's warranty; and
- All routine or special equipment servicing, to the extent the same servicing is provided to non-Medicaid persons; and
- All adjustments and modifications needed to make the item safe, useful and functional for the recipient during the entire first year (including customized wheelchairs); and
- Delivery, set-up and installation of the durable medical equipment 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 as required in this chapter; and
- Adequate training and instruction provided to the recipient or the recipient's responsible caregiver by the provider's trained and qualified staff, in a language understood by the recipient or caregiver regarding the manufacturer's recommendations for the safe, sanitary, effective, and appropriate use of the item; and
- Honoring the required one-year provider warranty for all requests or prescriptions requesting equipment repair made on or before the 366<sup>th</sup> day of service.

Providers may not disregard a recipient's requests for warranty equipment repairs or modifications and may not delay needed repairs or modifications, otherwise permitted by DME policy, until the provider's or manufacturer's warranty has expired.

Note: See Training Documentation Requirements for Recipients of Services in the Service Delivery, Pick-Up, and Training Documentation Requirements section in this chapter for additional information.

Note: See the Definition of Year in the General Service Requirements Section of this Handbook.

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**Equipment Purchase, Trade, or Rental**, continued

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**Used Equipment**

When non-custom DME equipment, which has been previously used by one or more persons, is furnished to an eligible Medicaid recipient the provider must:

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

Note: See Used Equipment Billing in Chapter 3 for additional information.

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**Repairs to Equipment and Devices**

DME, orthotics, and prosthetics coverage includes general repairs and service of equipment that is owned and used by a recipient.

Unless otherwise specified in this handbook, Medicaid will not reimburse for repairs made to new or used equipment within the first year of service.

Note: See Purchasing New Equipment in this section for additional information.

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**Equipment Purchase, Trade, or Rental**, continued

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**Equipment Trade-Ins**

When equipment purchased by Medicaid is no longer suitable for the recipient because of growth, development, or changes in the recipient's medical or physical condition, the Medicaid prior authorization request reviewer and the DME provider may negotiate a good faith trade-in of the recipient's current equipment.

A full description of the trade-in item, including the age, model, serial number, and the pro-rated trade-in amount must be clearly indicated on the purchase invoice for the new equipment.

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**Rent-to-Purchase Equipment**

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

For rent-to-purchase equipment, Medicaid's total reimbursement may not exceed a total of ten (10) monthly claims. The provider may not submit a claim for more than one unit of service within the same calendar month.

When the tenth and final payment is made for a specific rent-to-purchase item, the equipment becomes the personal property of the Medicaid recipient.

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

Submitting claims for more than the maximum ten months of payments for the same rent-to-purchase item for the same recipient, or submitting claims for the repair, replacement, or modification to the equipment during the rent-to-purchase agreement period is not allowed.

Note: See Over Billing and Unbundling in the General Service Requirements section in this chapter for additional information.

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**Equipment Purchase, Trade, or Rental**, continued

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**Rental Agreement**

A rental or rent-to-purchase agreement between a provider and recipient may not be discontinued without the consent of the recipient or caregiver unless:

- The recipient becomes ineligible for Medicaid before the agreement ends, or
- The recipient's medical need for the equipment has ended, or
- During the rental agreement, the recipient is enrolled in a Provider Service Network (PSN) or Health Maintenance Organization (HMO) plan and the rental service has been or is being terminated.

Documentation that the recipient's medical need for the equipment ended must be dated and signed by the recipient's authorized prescriber and maintained in the recipient's file.

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**Temporary  
Wheelchair Rentals**

Medicaid reimburses temporary rentals while a recipient's personal wheelchair is being repaired. The temporary rental period must not exceed ten (10) days. The rental fee is calculated and billed at the prorated daily rental rate listed on the DME and Medical Supply Services Provider Fee Schedules.

Providers must consult with staff at the recipient's area Medicaid office when submitting a request to exceed maximum limits for a temporary 10 day wheelchair rental. Exception to the 10-day limit may be granted for recipients of all ages.

Note: See required procedures for Exceptions to the Service Limits section in this chapter for additional information.

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***Equipment Purchase, Trade, or Rental***, continued

**Provider  
Responsibilities**

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; and
- 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; and
- Substitute like equipment at no additional cost to Medicaid if the equipment becomes broken or damaged or while the original rental equipment is being repaired; and
- Replace equipment that is beyond repair at no additional charge and maintain documentation of the replacement; and
- Maintain documentation that is signed and dated by both the provider and the recipient or recipient's responsible caregiver at the time of delivery, which attests to the fact that instruction has been provided by trained and qualified provider staff to the recipient or caregiver regarding the recipient's or caregiver's responsibility for cleaning the equipment and performing the general maintenance on the equipment, as recommended by the manufacturer; and
- Maintain documentation that is signed and dated by both the provider and the recipient or recipient's responsible caregiver, which attests that the recipient or the caregiver 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.

Note: See Delivery Documentation in the General Service Requirements section in this chapter for additional information.

**Equipment Purchase, Trade, or Rental**, continued

**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 caregiver(s), or the provider.

At a minimum, examples of equipment misuse, abuse, neglect, loss or wrongful disposition by the recipient, the recipient's caregiver, or the provider include the following:

- Failure to clean and maintain the equipment as recommended by the equipment manufacturer; and
- 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. The police or insurance report must be submitted with the prior authorization request, if the item requires prior authorization, or to the recipient's area Medicaid office with the claim for reimbursement, if the item does not require prior authorization.

Medicaid may replace equipment when the recipient's medical necessity changes. The provider must submit the documentation required to justify the purchase of the replacement equipment.

Providers must contact the appropriate area Medicaid office if uncertain how to submit a request for a replacement item.

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

Note: See Medical Necessity in the General Service Requirements section and the Prior and Post Authorization and Exceptions to the Service Limits section in this chapter for additional information.

Note: See Appendix C of the Florida Medicaid Provider General Handbook for the telephone numbers and addresses of the area Medicaid offices, and a listing of the counties that they serve. A map of the area Medicaid offices with phone numbers and addresses is also available on Medicaid's website at <http://ahca.myflorida.com>.

## ***Equipment Maintenance, Repair, and Renovation***

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### **Maintenance Requirements**

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

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

Please note that certain maintenance procedures are subject to prior authorization.

Note: See the definition of qualified technician in the General Service Requirements section in this chapter.

Note: See Chapter 3 and the DME and Medical Supply Services Provider Fee Schedules for the procedures that require prior authorization.

Note: See Chapter 2 in the Medicaid Provider Reimbursement Handbook, CMS-1500, and the Prior and Post Authorization and Exceptions to the Service Limits section in this chapter for instructions on how to request prior authorization.

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**Equipment Maintenance, Repair, and Renovation**, continued

**Routine Maintenance to be Performed by the Recipient or Responsible Caregiver**

The provider is required to inform the recipient or the recipient's responsible caregiver of his responsibility to perform routine maintenance, as described in the manufacturer's operating manual.

Activities of routine maintenance may include testing, cleaning, regulating, and lubricating the equipment as needed, per the manufacturer's recommendations.

The provider's qualified technician, licensed or certified staff, as appropriate, must inform the recipient and the recipient's responsible caregiver about the equipment's replacement limitations and provide instruction regarding the recipient's and caregiver's responsibilities for performing the routine general maintenance required to prolong the life of the equipment.

DME providers must provide the recipient or the recipient's responsible caregiver with the manufacturer's information regarding the routine care and maintenance of the equipment being purchased or rented and document that they have done so.

Note: See Training Documentation Requirements for Recipients of Services in the Service Delivery, Pick-Up, and Training Documentation Requirements Section of this handbook.

**Labor for Non-Routine Maintenance and Repair**

Medicaid reimburses a provider for labor when providing non-routine maintenance and repairs necessary to keep the durable medical equipment 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 AAC device or custom wheelchair.

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

Note: See the DME and Medical Supply Services Provider Fee Schedules for the procedure codes used for the repair and non-routine maintenance of custom wheelchairs and AAC device repair.

Note: See the Prior and Post Authorization and Exceptions to the Service Limits section in this chapter for information on DME services that require prior authorization.

**Equipment Maintenance, Repair, and Renovation**, continued

**Substantial Repair or Renovation**

Providers may be reimbursed for substantial non-routine maintenance repairs or renovation of durable medical equipment for equipment, other than augmentative alternative communication devices (AAC) devices, using procedure code E1340 for labor performed by qualified technicians.

HCPCS procedure code E1340 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 appropriate HCPCS procedure code(s).

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; and
- 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; and
- The make, model and serial number of the equipment needing repair.

Note: See Chapter 2 in the Medicaid Provider Reimbursement Handbook, CMS-1500, and the Prior and Post Authorization and Exceptions to the Service Limits section in this chapter for instructions on how to request prior authorization.

Note: Assigned procedure codes are subject to change with yearly National Healthcare Common Procedure Coding System (HCPCS) code updates.

**Reimbursement for Equipment Repairs and Renovation**

Reimbursement for DME equipment maintenance is limited to the amount necessary to make the item serviceable and safe, but not to exceed 75 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.

***Equipment Maintenance, Repair, and Renovation***, continued

**Warranty  
Information**

A DME provider warranty for all purchased or rent-to-purchase equipment remains in effect for one year, beginning with the first date of delivery.

Medicaid will not reimburse for any repairs, replacements or modifications for the purchased equipment within one year of date of delivery.

Medicaid will not reimburse for any labor costs associated with the repairs, modifications, or the replacement of all or part of the equipment covered under a DME provider's warranty.

Claiming reimbursement for labor, repairs, modifications, parts and equipment covered under a manufacturer's or a provider's warranty is not allowed.

Note: See the Definition of a Year in the General Service Requirements Section of this handbook.

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## ***Ambulatory Aids***

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### **Description**

An ambulatory aid is a medically necessary item that is required by a recipient with impaired ambulation. Ambulatory aids include canes, crutches, and walkers that are to be complete with tips, pads, and grips.

Note: Various types of walkers and walker accessories are listed on the DME and Medical Supply Services Provider Fee Schedules.

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### **Pediatric Gait Trainers**

Pediatric gait trainers may be reimbursed as an ambulating aid. This equipment requires prior authorization, using the HCPCS procedure code for miscellaneous DME.

Documentation must be included detailing the expected benefit of gait training.

Note: See Chapter 2 in the Medicaid Provider Reimbursement Handbook, CMS-1500, and the Prior and Post Authorization and Exceptions to the Service Limits section in this chapter for instructions on how to request prior authorization.

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### **Wheeled Walkers**

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

Note: Current limitations for wheeled walkers are listed on the DME and Medical Supply Services Provider Fee Schedule.

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## ***Apnea Monitors***

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### **Description**

An apnea monitor is a device that meets the Food and Drug Administration's 510 (k) guidelines and is equivalent to the device marketed in interstate commerce prior to May 28, 1976, or to a device that has been classified into Class I or Class II since the enactment of the medical device amendments of May 28, 1976.

Medicaid approved apnea monitors are:

- Apnea/Bradycardia/Tachycardia (Impedance Monitoring Technique); and
  - Apnea/Bradycardia (Impedance Monitoring Technique); and
  - Apnea/Bradycardia/Tachycardia (Piezoelectric Transducer Technique).
-

**Apnea Monitors**, continued

**Provider Responsibilities Regarding Apnea Monitors**

The treating physician may specifically 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; and
- Ensure that the type of apnea monitor prescribed and provided is a cardiorespiratory monitor; and
- Provide maintenance coverage 24 hours a day, seven days a week, which may include the aftermath of a national or natural disaster; and
- Respond to emergency repair requests within six hours or set up a “loaner” monitor within two hours; and
- Ensure that a home visit to provide training is completed by a qualified registered nurse (RN), certified respiratory therapist (CRT), or a registered respiratory therapist (RRT) within five days following a hospital discharge or significant change in recipient’s caregiver; and
- Ensure and maintain documentation that a home visit is completed by a qualified RN, CRT, or RRT every 30 days after the initial visit; and
- Maintain documentation of all training provided and visits made by qualified staff and therapists; and
- Obtain a redetermination of medical necessity from the recipient’s treating physician every twelve (12) months or for the length of time prescribed if less than twelve (12) months; and
- Maintain documentation on file of loaner monitors provided, the testing of, and the repairs and maintenance to the equipment.

Note: See Medical Necessity Redetermination Requirements for Oxygen Therapy and Oxygen-Related Equipment in the Medical Necessity Definition and Documentation Requirements section in this chapter for additional information.

**Apnea Monitors**, continued

**Home Visit  
Documentation  
Requirements**

When an RN, CRT, or RRT conducts a face-to-face home visit, the licensed professional must document the following information in the recipient's medical record:

- Recipient's current family situation; and
- Recipient's current home environment; and
- Recipient's diagnosis; and
- Recipient's current condition and recent changes in the recipient's condition based upon an interview with the recipient's family and caregiver; and
- Dates and reason for telephone contact(s) with Children's Medical Services, the recipient's treating physician or Health Maintenance Organization (HMO), and the names of the person(s) contacted; and
- Changes in the recipient's address, contact names and phone numbers; and
- Any non-compliance in the use of the monitor; and
- Equipment problems reported; and
- Face-to-face home visit schedule, agreed upon and signed by both parties; and
- Documentation of type of training provided to the recipient's caregiver(s) and the printed name(s) and dated signature(s) of the person(s) receiving and providing the training.

Documentation of an attempted home visit or a phone call does not satisfy the requirement for a face-to-face home visit.

Note: See Service Delivery, Pick-Up and Training Documentation Requirements in this chapter for additional information.

**Apnea Monitors**, continued

**Provider  
Equipment  
Responsibilities**

The provider is responsible for ensuring and maintaining documentation that the appropriate licensed or certified employees or contracted staff are supervising and that the following equipment is available at the time of delivery and set-up:

- Monitor with recording feature, prescribed by the treating physician or the treating physician's ARNP or physician assistant or monitor without a recording feature, if a recording monitor is not prescribed by the treating physician or the treating physician's ARNP or physician assistant; and
- The battery pack, case, and emergency battery; and
- Two sets of electrodes and, if requested, one extra set for replacement; and
- If disposable electrodes are necessary, at least ninety (90) per month; and
- Two sets of modified safety lead wires; and
- Two electrode belts; and
- Operator's manual; and
- Copy of the infant monitoring handbook; and
- Remote alarm, if prescribed by the treating physician or the treating physician's ARNP or physician assistant.

**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 that occur after the provider receives the treating physician's orders to discontinue monitoring services.

Note: See Medical Necessity Redetermination Requirements for Oxygen Therapy and Oxygen-Related Equipment in the Medical Necessity Definition and Documentation Requirements section in this chapter for additional information.

**Apnea Event  
Recording**

The provider is responsible for initiating an event recording within two weeks of receiving the treating physician's verbal order, unless otherwise specified in writing by the treating physician.

The provider must send the recording results to the treating physician within three (3) days and maintain documentation in the recipient's record of the recording event and submission of the recording to the physician.

**Apnea Monitors**, continued

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**Apnea Event  
Recording  
Documentation**

Event recording documentation must include:

- Name and age of the recipient; and
- Length of the recording; and
- Date of the recording event; and
- Date of the recording event was submitted to the physician; and
- Name of the physician receiving the recording.

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**Time-Sensitive  
Medical-Necessity  
Renewal for Apnea  
Monitors**

Medical necessity renewal time frame for apnea monitors is every twelve (12) months or for the length of time prescribed if less than twelve (12) months.

Note: See Medical-Necessity Redetermination Requirements for Oxygen Therapy and Oxygen-Related Equipment in the Medical Necessity Definition and Documentation Requirements section in this chapter.

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**Augmentative and Alternative Communication Systems**

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**Introduction**

Dedicated augmentative and alternative communication systems (AAC) devices are reimbursed through the Medicaid DME and medical supply services program.

Evaluations for the AAC device system, ongoing training, and therapy are reimbursed through the Medicaid Therapy Services program and the Medicaid Certified School Match program.

Note: See the Florida Medicaid Therapy Services and Certified School Match Coverage and Limitations Handbooks for information about therapy services. All Medicaid handbooks are available on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks.

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**Augmentative and Alternative Communication Systems**, continued

**Definition of Augmentative and Alternative Communication (AAC) Systems Devices**

AAC devices are designed to allow individuals to communicate.

As defined by the American Speech-Language Hearing Association (ASHA), an 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 impairments.

Dedicated AAC systems are designed specifically for a disabled population 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.

Note: See Chapter 2 in the Medicaid Provider Reimbursement Handbook, CMS-1500, and the Prior and Post Authorization and Exceptions to the Service Limits section in this chapter for instructions on how to request prior authorization.

**Who is Eligible to Receive an AAC Device**

For Medicaid to reimburse for an AAC device, the recipient must meet the following criteria:

- Demonstrate a severe, expressive communication disorder; and
- Have the physical, cognitive, and language abilities necessary to use the specific type of AAC device requested, as documented in an evaluation that was performed and dated by a licensed speech-language pathologist, within the past six (6) months.

**Exception to Place of Residence**

If all the AAC device service prior authorization requirements are met, recipients who are under 21 years of age and residing in a skilled nursing facility may be eligible to receive an AAC device.

Note: See Place of Service or Recipient's Place of Residence in the General Service Requirements section in this chapter.

**Augmentative and Alternative Communication Systems**, continued

**Interdisciplinary (ID) Team and Evaluation of Recipients Under 21 Years of Age and Enrolled in Public School**

For recipients under 21 years of age and enrolled in public school, an interdisciplinary team (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 must include 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. It is expected that most cases will require the need for an occupational therapist to be a part of the ID team. The recipient who will use the AAC device should be encouraged to participate on the ID team, as well as the recipient's caregivers, teachers, social workers, case managers, and any other members deemed necessary.

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 of concurrence. Documentation must include an evaluation and individual action 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.

An interdisciplinary team for recipients attending home school must consist of the evaluating speech-language pathologist, the home schoolteacher, and the recipient's parent or responsible caregiver. If the recipient is currently receiving occupational or physical therapy services, the occupational or physical therapist should be included on the team.

**Evaluation for Recipients 21 and Older or Recipients Not Enrolled in Public or Home School**

For recipients age 21 or older or recipients not enrolled in public school or not home schooled, 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 age 21 or older or for recipients not enrolled in public school or not being home schooled) 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); and
- Significant treatment information and current medications; and
- Medical prognosis; and
- Motor skills, i.e., posture and positioning, wheelchair use (if applicable), selection abilities, range and accuracy of movement, etc.; and
- Cognitive skills, i.e., alertness, attention span, vigilance, etc.; and
- Sensory and perceptual abilities, i.e., hearing, vision, etc.; and
- Language comprehension; and
- Expressive language capabilities; and
- Oral motor speech status; and
- Use of communication and present communication abilities; and
- Communication needs including the need to enhance conversation, writing, and signaling emergency, basic care and related needs; and
- Writing impairments, if any; and
- Environment, i.e., home, work, etc., with a description of communication barriers; and
- 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; and
- The evaluator's printed name, title, copy of current professional license or Department of Education (DOE) certification, and legible and dated signature; and
- The evaluator's telephone number for contact purposes.

**Augmentative and Alternative Communication Systems**, continued

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**AAC Device Evaluations**

All evaluations for AAC devices and AAC device accessories must be performed by a licensed or Department of Education-certified speech-language pathologist.

AAC device evaluations are valid for six (6) months from the date of completion.

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**Individualized Action Plan or Plan of Care**

The ID team, led by the speech-language pathologist (or the speech-language pathologist for recipients age 21 and older or for recipients not enrolled in public school or not being home schooled), is responsible for developing the recipient's individualized action plan or plan of care.

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**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; and
  - Current use of the system(s) and its limitations; and
  - Appropriate long and short-term therapy objectives; and
  - Recommended AAC device (based on cost-effectiveness and the recipient's needs); and
  - Recommended length of a trial period, if applicable; and
  - Description of any AAC devices that the recipient has previously tried; and
  - Specific benefits of the recommended AAC device over other possibilities; and
  - Established plan for mounting, if necessary, repairing, and maintaining the AAC device; and
  - Who is responsible to deliver and program the AAC device to operate at the level recommended by the ID team; and
  - Who will train the support staff, recipient, and primary caregiver in the proper use and programming of the AAC device; and
  - Documentation of medical necessity.
- 

**AAC Device Selection**

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 three (3) year period.

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**Augmentative and Alternative Communication Systems**, continued

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**Concurrence by Public School Personnel**

If the recipient is in the public school system, appropriate school personnel must be given the opportunity to comment and concur with the ID team's recommended device.

School personnel must agree that the recipient's teacher and school therapist are knowledgeable in the use of the AAC device or will be trained regarding its use.

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**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.

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**Approval of Recipient's Treating Physician**

If the recipient is enrolled in MediPass, the recipient's MediPass primary care provider must authorize the AAC device prior to the DME provider's submission of a prior authorization request to the Medicaid fiscal agent.

The recipient's treating physician, the treating physician's ARNP or physician assistant, or designated physician specialist must review the evaluation and the individualized action plan or plan of care; and if he concurs, affix a legible and dated signature on the evaluation and provide a written prescription for the appropriate AAC device.

The prescription must include the authorizing prescriber's legible and dated signature and professional license number. If the recipient is enrolled in MediPass, a MediPass authorization number is also required.

The treating physician, the treating physician's prescribing ARNP or physician assistant, or designated physician specialist must return the signed and dated evaluation, individualized action plan or plan of care, and prescription to the speech-language pathologist.

Note: See Chapter 3 in the Florida Medicaid Provider General Handbook for information on MediPass authorization.

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**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 statement of non-conflict must be included in the therapist's documentation and included with the prior authorization request packet.

Note: See Self-Referral and Conflict of Interest in the Provider Requirements section in Chapter 1.

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**Augmentative and Alternative Communication Systems**, continued

**Prior Authorization Requirement for AAC Devices**

Prior authorization (PA) requests for AAC devices, AAC device accessories, and repairs must be reviewed for medical necessity by Medicaid's professional consultant or designated staff member and authorized by the Medicaid DME and Medical Supply Services Program.

Current procedure codes used for AAC devices are listed on the DME and Medical Supply Services Provider Fee Schedule.

**Note:** See Chapter 2 in the Medicaid Provider Reimbursement Handbook, CMS-1500, and the Prior and Post Authorization and Exceptions to the Service Limits section in this chapter for information regarding the authorization process and where to submit prior authorization requests for AAC devices, accessories and repairs.

**Steps for Completion of a PA Package for Recipients Under 21 Years of Age Enrolled in Public or Home School**

The steps below must be followed to obtain Medicaid authorization for an AAC device for recipients who are under 21 years of age and enrolled in public school or attending home school.

Written documentation from each step must be included in the Medicaid prior authorization package:

1. An interdisciplinary team (ID team), led by the speech-language pathologist, evaluates the recipient, recommends an AAC device, and writes an individualized action plan or plan of care.
2. The speech-language pathologist sends the 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 to the recipient's physician, treating physician's ARNP or physician assistant, or designated physician specialist.
3. 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 if he concurs, sign and date the evaluation and prescribe the AAC device.
4. If the recipient is enrolled in MediPass, the recipient's MediPass primary care provider must authorize the AAC device. (The DME provider must obtain MediPass authorization in order to be reimbursed for the claim.)
5. The ID team forwards the prior authorization package to the DME provider.
6. The DME provider completes the prior authorization package by attaching an invoice, proof of manufacturer's cost, and a Florida Medicaid Authorization Request form and submits the package to the Medicaid fiscal agent.
7. The Medicaid professional consultant reviews the prior authorization package and recommends approval or denial of the authorization request.

***Augmentative and Alternative Communication Systems***, continued

**Steps for  
Completion of a  
PA Package for  
Recipients 21 or  
Older or for  
Recipients not  
Enrolled in  
Public or Home  
School**

The following steps must be followed to obtain Medicaid authorization for an AAC device for recipients who are age 21 or older or recipients who are not enrolled in public or home school.

The written documentation for each step must be included in the Medicaid prior authorization package:

1. The speech-language pathologist sends the 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 to the recipient's physician, treating physician's ARNP or physician assistant, or designated physician specialist.
2. 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 if he concurs, sign and date the evaluation and prescribe the AAC device.
3. If the recipient is in MediPass, the recipient's MediPass primary care provider must authorize the AAC device. (The DME provider must obtain MediPass authorization in order to be reimbursed for the claim.)
4. The speech-language pathologist forwards the prior authorization package to the DME provider.
5. The DME provider completes the prior authorization package by attaching an invoice, proof of manufacturer's cost, and a Florida Medicaid Authorization Request form and submits the package to the Medicaid fiscal agent.
6. The Medicaid professional consultant reviews the prior authorization package and recommends approval or denial of the authorization request.

**Augmentative and Alternative Communication Systems**, continued

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**Submitting Prior Authorization Request for AAC Devices**

For AAC devices, AAC device accessories or AAC device repairs, send prior authorization requests to the Medicaid fiscal agent:

Florida Medicaid  
P.O. Box 7090  
Tallahassee, Florida 32314-7090

Note: See Chapter 2 in the Medicaid Provider Reimbursement Handbook, CMS-1500, and the Prior and Post Authorization and Exceptions to the Service Limits section in this chapter for instructions on how to request prior authorization.

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**Medicaid Approval**

Medicaid's decision for coverage will be based on a 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 a medical need.

Medicaid will not deny an AAC device based solely on the fact that the recipient can communicate in writing.

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**Videotape Requests**

The Medicaid reviewer may request a videotape of the recipient in different functional communication settings, if needed, for the evaluation of the prior authorization request.

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**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.

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**Augmentative and Alternative Communication Systems**, continued

**Service Components**

Medicaid reimbursement for AAC device system procedure codes includes the following service components:

- AAC device; and
- Programming needed to custom fit the system to achieve the recipient's specific speech-language goals; and
- Modifications to adapt the system to the physical characteristics and limitations of the recipient, i.e., wheelchair use.

**Trial Period for AAC Devices**

The ID team (or speech-language pathologist for recipients age 21 and older or for recipients not enrolled in public school or not attending home school) may recommend that the recipient have a trial period with the AAC device.

**Repair of AAC Devices**

Medicaid reimburses AAC device repairs.

AAC device repairs must be prior authorized.

Note: See Chapter 2 in the Medicaid Provider Reimbursement Handbook, CMS-1500, and the Prior and Post Authorization and Exceptions to the Service Limits section in this chapter for instructions on how to request prior authorization.

**Documentation Requirements for the Repair of AAC Devices**

The following information must be included with a request to repair an AAC device:

- Model and serial number of the AAC device needing repair; and
- The funding source of the AAC device needing repair; and
- An explanation of repairs needed; and
- A detailed explanation regarding damage to AAC device that requires substantial or frequent repairs.

***Augmentative and Alternative Communication Systems***, continued

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**Provider Responsibilities**

Prior to billing for an AAC device system, the DME provider is responsible for ensuring the properly selected system and all components have been delivered to the recipient and are operational in the recipient's home.

The provider must notify the recipient's speech-language pathologist of the proposed delivery date.

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**Reimbursement Limitations**

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.

Modifications, which may be in the form of replacing the AAC device or upgrading the AAC device's software, may be reimbursed only if the new technology will significantly improve the recipient's communication.

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 caregiver(s), or the provider.

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***Bathroom and Toileting Aids***

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**Description**

Bathroom and toileting aids are devices available to assist recipients who are incapable of using standard toilet facilities.

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**Reimbursement Limitations**

Bedpans and urinals may be reimbursed when a recipient is confined to a bed.

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.

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**Compressors**

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**Description**

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

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**Service Requirements**

Medicaid may reimburse for an air power source compressor when it is:

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

Medicaid reimburses for a pneumatic compressor.

The recipient or caregiver must receive instructions from the provider's licensed or certified CRT, RRT, RN, or RCP regarding the operations and use of the machinery, including frequency, duration, and pneumatic air pressure.

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

Note: See Service Delivery, Pick-Up, and Training Documentation Requirements for additional information on training requirements.

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<b><i>Custom Cranial Remolding Orthosis</i></b>	
<b>Description</b>	A custom cranial remolding orthosis is a non-invasive device used to correct the symmetry of an infant's skull.
<b>Eligibility and Reimbursement Requirements</b>	<p>Custom cranial remolding orthoses require prior authorization (PA). PA requests must be submitted using the appropriate DME procedure code, to ensure proper routing for physician review.</p> <p>Custom cranial remolding orthotic devices are covered by Medicaid when it is determined medically necessary to correct a moderate to severe craniofacial deformity. Supporting documentation, at a minimum, must include:</p> <ul style="list-style-type: none"> <li>• A prescription from an orthopedic or craniofacial surgeon; and</li> <li>• Clinical evidence, including measurements, indicating the infant's current cranial index of symmetry (CIS) is &lt;83; and</li> <li>• Current color photographs of the infant's head, taken from the following views: <ul style="list-style-type: none"> <li>⇒ Superior;</li> <li>⇒ Frontal;</li> <li>⇒ Posterior;</li> <li>⇒ Right and left lateral; and</li> </ul> </li> <li>• A statement from a treating orthopedic or craniofacial surgeon, stating that treatment using a cranial remolding orthosis is recommended due to poor improvement in the infant's CIS, after a documented six (6) months trial period of active counter positioning has been completed; and</li> <li>• Six (6) month's worth of documentation regarding daily counter positioning therapy.</li> </ul>

<b><i>Glucose Monitors, Diabetic Testing Strips, Insulin Syringes and Blood Lancets</i></b>	
<b>Home Glucose Monitors and Diabetic Testing Strips</b>	<p>Effective January 1, 2006, the Florida Medicaid DME and Medical Supply Services Program began reimbursing home glucose monitors, blood glucose, and urine keytone testing strips.</p> <p>These items are covered for recipients whose documented medical condition requires frequent monitoring of urine or blood glucose levels.</p> <p>Home glucose monitors are limited to five per recipient, per life time.</p> <p>Maximum monthly limits for blood glucose test reagent strips for home blood glucose monitoring are listed in the DME and Medical Supply Services Provider Fee Schedules.</p>
<b>Insulin Syringes</b>	<p>Effective January 1, 2006, the Florida Medicaid DME and Medical Supply Services Program began reimbursing insulin syringes. Insulin syringes are covered for recipients whose documented medical condition requires insulin to be injected.</p> <p>Maximum monthly limits for insulin syringes are listed in the DME and Medical Supply Services Provider Fee Schedules.</p>
<b>Blood Lancets</b>	<p>Blood lancets are used to pierce the skin for the purpose of obtaining a blood sample when monitoring blood glucose levels. Blood lancets are covered for recipients whose documented medical condition requires frequent monitoring of blood glucose levels.</p>

***Heat Lamps and Pads***

<b>Description</b>	<p>Heat lamps and heating pads are appliances or equipment used to apply heat to areas of the body.</p>
<b>Heat Lamps and Pads</b>	<p>Medicaid covers 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.</p>

**Heat Lamps and Pads**, continued

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<b>Portable Paraffin Bath and Time-Sensitive Redetermination Requirement</b>	<p>Portable paraffin bath units are covered for a recipient under 21 years of age who has undergone a successful trial period of paraffin therapy, and is expected to receive relief through long-term use.</p> <p>The prescription for the paraffin bath use must describe area of the body requiring treatment and the frequency and duration of treatments.</p> <p>A redetermination of medical necessity is required every six (6) months.</p>
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**Hospital Beds, Mattresses, and Rails**

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<b>Description</b>	<p>A standard hospital bed consists of a modified latch spring assembly mattress, bed ends with casters, and two manually operated foot end cranks.</p> <p>It is equipped with IV sockets and is capable of accommodating a trapeze bar, side rails, an overhead frame, and other accessories.</p>
<b>Service Requirements</b>	<p>Medicaid may reimburse 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.</p> <p>To be reimbursed for the hospital beds listed on the DME and Medical Supply Services Provider Fee Schedule, the provider must obtain authorization from Medicaid.</p> <p>To obtain authorization for hospital beds, the provider submits the Florida Medicaid Authorization form and required authorization documentation directly to the Medicaid fiscal agent, not to the area Medicaid office.</p> <p><u>Note:</u> See Chapter 2 in the Medicaid Provider Reimbursement Handbook, CMS-1500, and the Prior and Post Authorization and Exceptions to the Service Limits section in this chapter for instructions on how to request prior authorization.</p>
<b>Adjustable-Height or Multi-Height Hospital Bed</b>	<p>Medicaid may reimburse 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.</p> <p>Documentation of medical necessity, justifying the need for an adjustable-height hospital bed, must be included with the authorization request.</p>

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**Hospital Beds, Mattress, and Rails**, continued

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**Semi-Electric and Electric Beds**

Medicaid may reimburse for a semi-electric bed or an electric bed when it is medically necessary 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.

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**Heavy Duty Hospital Bed**

Medicaid may reimburse 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.

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**Hospital Bed Documentation**

The provider must submit, at a minimum, the following documentation with all required prior authorization requests for a bed and maintain copies in the recipient's record:

- Recipient's name; and
  - Recipient's date of birth; and
  - Recipient's current height and weight; and
  - Place of service, including address; and
  - Copy of the recipient's most recent hospital discharge summary if hospitalized or institutionalized within the past 30 days; and
  - Recipient's diagnosis and current symptoms that justify the medical necessity for the type of hospital bed requested; and
  - Length of time the bed will be medically necessary; and
  - Severity and frequency of the symptoms that necessitate a hospital bed for positioning or transfer; and
  - Prescription and Certificate of Medical Necessity (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.
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***Hospital Beds, Mattress, and Rails***, continued

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**Safety Enclosure  
Frame and Canopy  
Coverage and  
Billing**

Medicaid may reimburse for a safety enclosure frame and canopy for recipients under 21 years of age when prescribed by the treating physician or the treating physician's ARNP or physician assistant as medically necessary for the recipient's self-protection.

The frame and canopy do not need prior authorization, but must be billed with a hospital bed procedure code listed on the DME and Medical Supply Services Provider Schedules.

Note: See the DME and Medical Supply Services Provider Fee Schedules for the appropriate HCPCS procedure code and scheduled fee.

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**Safety Enclosure  
Frame and Canopy  
Documentation  
Requirements**

The following safety enclosure frame and canopy documentation, with the authorized prescriber's signature, must be included in the recipient record:

- A medical statement that the recipient is confined to bed and will be in the enclosed bed for at least 18 hours a day; and
  - Proof of medical necessity for continued care in the home; and
  - Supporting medical documentation that states the recipient would be institutionalized without the enclosed bed; and
  - Supporting information that the enclosed bed will provide effective treatment or prevent self-harm or self-injury when the recipient bites or chews.
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**Mattress  
Replacement**

Medicaid may reimburse for the replacement of a hospital bed mattress every four (4) years, when medically necessary.

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**Hospital Bed or  
Hospital Bed Rails  
Replacement**

Medicaid may reimburse for the replacement of a hospital bed or the replacement of the hospital bed's rails every eight (8) years, when medically necessary.

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***Intermittent Catheter with Insertion Supplies***

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**Description**

For DME purposes, Medicaid defines the item provided by procedure code A4353 as a sterile, closed-system intermittent catheter kit, with or without an insertion or introducer tip, which is used for self-catheterization. The sealed, sterile kit must be packaged by the product's manufacturer.

Note: Assigned procedure codes are subject to change with yearly National Healthcare Common Procedure Coding System (HCPCS) code updates.

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**Lymphedema Pump**

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**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.

The pump available under procedure code E0651 creates the same pressure in each segment. The pump available under procedure code E0652 has calibrated gradient pressure and is further characterized by a regulator on each outflow port that delivers a specified pressure to an individual segment.

Assigned procedure codes are subject to change with yearly National Healthcare Common Procedure Coding System (HCPCS) code updates.

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**Service Requirements**

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

Documented conservative treatments that should first be tried include, but are not limited to, limb elevation, properly applied compression dressings (as with elastic bandage wrapping), and the use of custom-fabricated gradient-pressure compression dressings.

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.

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**Documentation**

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

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

Note: See Service Delivery, Pick-Up, and Training Documentation Requirements for additional information on training documentation requirements for recipients receiving services.

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**Nebulizer**

**Description**

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

**Nebulizer**

Medicaid covers 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.

Nebulizers are not reimbursable as rental items.

Some nebulizer models come with an administration kit. Providers may not bill an additional charge for kits that come with the device.

Note: See the Acceptable Documentation of Medical Necessity section in this chapter for additional information.

**Self-contained, Ultrasonic**

When prescribed, Medicaid covers a self-contained ultrasonic nebulizer including a decontamination filter.

Medicaid will reimburse for only one type of nebulizer device per two year period.

**Compressor and Heater**

Medicaid may reimburse for a compressor and nebulizer with 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 manufacturer's nebulizer compressor models come equipped with an administration kit, some of which include a mask.

**Nebulizer Delivery and Set Up**

The provider is responsible for ensuring:

- The prescribed nebulizer is provided directly to the recipient or the recipient's 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; and
- Qualified staff or contracted licensed professionals provided the recipient or caregiver training and instruction regarding proper use and care of device and accessories; and
- Training documentation must be maintained in the recipient record.

Note: See the Service Delivery, Pick-Up, and Training Documentation Requirements section in this chapter for additional information.

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***Nebulizer***, continued

<b>Exception to Nebulizer Delivery and Set Up</b>	<p>Durable medical equipment 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:</p> <ul style="list-style-type: none"> <li>• The physician must document the medical necessity and need to prevent further deterioration of the patient's respiratory status by the timely delivery of the nebulizer in the physician's office.</li> <li>• The durable medical equipment provider must have written documentation of the competency and training by a Florida-licensed registered respiratory therapist of any durable medical equipment staff who participate in the training of physician office staff for the use of nebulizers, including cleaning, warranty, and special needs of patients.</li> <li>• The physician's office must have documented the training and competency of any staff member who initiates the delivery of nebulizers to patients. The durable medical equipment provider must maintain copies of all physician office training.</li> <li>• The physician's office must maintain inventory records of stored nebulizers, including documentation of the durable medical equipment provider source.</li> <li>• A physician contracted with a Medicaid durable medical equipment provider may not have a financial relationship with that provider or receive any financial gain from the delivery of nebulizers to patients.</li> </ul>
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***Orthopedic Footwear***

<b>Description</b>	<p>Orthopedic footwear refers to footwear used in the preservation, restoration, and development of the form and function of the feet.</p>
<b>Orthopedic Footwear Coverage</b>	<p>Orthopedic footwear includes orthopedic shoes, shoe modifications, wedges, heels, and miscellaneous shoe additions.</p> <p>Foot orthotics are for congenital forefoot deformities in children who are under 18 months of age, unless determined medically necessary for an older child who is not yet walking.</p>
<b>Fitting Orthopedic Footwear</b>	<p>The appropriately licensed professional must ensure prefabricated orthopedic footwear fits properly prior to releasing the footwear to the recipient.</p> <p>A licensed pedorthotist, orthotist or prosthetist-orthotist must ensure custom orthopedic footwear fits properly prior to releasing the footwear to the recipient.</p>

**Orthopedic Footwear**, continued

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<b>Orthopedic Footwear Coverage Exclusions</b>	<p>Medicaid does <b>not</b> reimburse for orthopedic shoes for:</p> <ul style="list-style-type: none"><li>• Flexible flat feet; or</li><li>• Toe-in or toe-out problems, except where there is specific foot deformity; or</li><li>• Torsional problems of the extremities, except when attached to a brace.</li></ul>
<b>Orthopedic Footwear Service Requirements</b>	<p>Medicaid may reimburse for orthopedic footwear when the following minimum requirements are met:</p> <p>The orthopedic footwear is prescribed by a licensed physician or podiatrist (D.P.M. or D.P.); and</p> <ul style="list-style-type: none"><li>• The recipient has congenital foot deformities, including clubfoot in children; or</li><li>• 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; or</li><li>• The recipient has a rigid foot deformity; or</li><li>• The recipient's foot or feet have severe structural deformities (e.g. rheumatoid arthritis, diabetic osteopathy or arthropathy, or following trauma); or</li><li>• 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; or</li><li>• The prescribed shoe is constructed by a licensed professional to provide support for a totally or partially missing foot; or</li><li>• The prescribed shoe is required in conjunction with an orthotic system.</li></ul>
<b>Required Orthopedic Footwear Components</b>	<p>Orthopedic footwear must have all the following components:</p> <ul style="list-style-type: none"><li>• Strap or lace closure; and</li><li>• Long medial counters; and</li><li>• Steel shanks; and</li><li>• Goodyear welt construction; and</li><li>• Bunion last; and</li><li>• High toe box; and</li><li>• Thomas heel.</li></ul>

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**Orthopedic Footwear**, continued

**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 pair 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" using procedure code L3257. Assigned procedure codes are subject to change with yearly National Healthcare Common Procedure Coding System (HCPCS) code updates.

Both pairs of orthopedic footwear must be billed on the same claim form.

Note: See Chapter 3 for information on By Report requirements.

**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 Requirements**

Orthotic devices furnished to Medicaid recipients must match the HCPCS procedure code description, and described illustrations included in the current edition of *The Illustrated Guide to Orthotics and Prosthetics* ©.

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.

Note: See Orthotic and Prosthetic Providers in the Provider Qualification and Enrollment section of Chapter 1 for additional information on provider qualifications.

**Orthotic Devices**, continued

**Documentation Requirements**

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; and
- Dated documentation of fitting(s) performed by the appropriately licensed fitter, pedorthotist, orthotist, or prosthetist, which includes the professional's printed name, signature, and professional license number; and
- Documentation, signed and dated by the recipient or the recipient's responsible caregiver attesting that written instructions for use and care of the device and written information was provided to the recipient; and
- Documentation of delivery, signed, and dated by recipient or recipient's caregiver; and
- Written progress notes.

A signed and dated prescription, which includes the printed name and address of the treating physician or the treating physician's ARNP or PA and the prescriber's professional license number is required documentation that must be maintained in the recipient's record.

**Provider Responsibilities Regarding Fitting, Adjustments, Modifications and Replacements**

The provider's facility must have the necessary equipment available on site for the repair, fabrication and adjustments of custom devices, if billing Medicaid for these services.

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

The provider is responsible for all needed adjustments, modifications, and replacements for the first six (6) months after the date of delivery.

Orthotic and prosthetic providers must have a physical location in Florida or a physical location within 50 miles of the Florida state line where the devices can be measured, fitted, dispensed and adjusted.

The provider must be staffed appropriately with licensed orthotists, prosthetists, and orthotic fitters to provide direct services to Medicaid recipients, within the scope of their professional licenses.

Note: See Orthotic and Prosthetic Providers in the Provider Qualifications and Enrollment section of Chapter 1 for additional information on the provider qualifications.

**Orthotic Devices**, continued

<b>Unit Limits for Single and Bilateral Devices</b>	The same units and limits specified on the DME and Medical Supply Services Provider Fee Schedule apply to both single and bilateral needs.
<b>Splints</b>	<p>Splints are orthotic devices.</p> <p>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 six (6) months after date of delivery.</p>
<b>Repairs for Artificial Larynx</b>	<p>Medicaid reimburses artificial larynx repairs, which require prior authorization.</p> <p><u>Note:</u> See Chapter 2 in the Medicaid Provider Reimbursement Handbook, CMS-1500, and the Prior and Post Authorization and Exceptions to the Service Limits section in this chapter for instructions on how to request prior authorization.</p>

**Osteogenesis Stimulator**

<b>Description</b>	An osteogenesis stimulator is a device that provides electrical stimulation to augment bone repair.
<b>Osteogenesis Stimulator</b>	<p>Medicaid may reimburse for an osteogenesis stimulator when non-union long bone fractures exceed three (3) months, when there is congenital pseudoarthrosis or failed fusion.</p> <p>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.</p>

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## ***Oxygen and Oxygen-Related Equipment***

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### **Description**

Medicaid may reimburse oxygen and oxygen-related equipment, such as continuous positive airway pressure (CPAP) and bi-level pressure capability (BIPAP) devices, oxygen concentrators, and ventilators for recipients with hypoxia.

Pulse oximeters are reimbursable for children who meet the eligibility criteria described under pulse oximeter in this section.

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### **Provider Service Requirements Regarding Oxygen and Oxygen-Related Equipment**

An oxygen provider must meet the following requirements:

- Have any and all valid permit(s) from the Department of Health necessary to manufacture, purchase, possess, and sell medical oxygen and oxygen concentrators, as applicable; and
- Provide all necessary supplies for the administration of oxygen and oxygen-related services, as part of the scheduled rental fee; and
- Provide all equipment and accessories, as prescribed; and
- Provide all contents for stationary and portable oxygen; and
- Supply and replace disposable items such as tubing, masks, cannulas, and filters; and
- Be able to adequately serve the geographic area where the recipient lives and readily provide emergency services; and
- Make provisions for emergency oxygen due to equipment failure, natural or national disaster; and
- Ensure accurate oxygen flow as low as 110 ml/minute for recipients under 21 years of age; and
- Ensure recipient home visits are performed by qualified individuals at the frequency required by policy for the service or device provided; and
- Ensure that oxygen and oxygen-related equipment is delivered by the appropriately trained staff in the recipient's home; and
- Ensure that oxygen and oxygen-related equipment set-up in the recipient's home is supervised by the licensed professional; and
- Recipient and caregiver training is provided by licensed professional at the time of set-up; and
- Maintain the required documentation of delivery and pick up and recipient training and instruction in the recipient's record; and
- 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.

Claiming separate reimbursement for the disposable tubing, masks, cannulas and filters considered part of the scheduled monthly rental fee is not allowed.

Note: See Provider Staff Responsibilities and Required Documentation for the Service Delivery, Pick-Up, and Training Documentation Requirements section in this chapter for additional information.

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***Oxygen and Oxygen-Related Equipment***, continued

**Emergency Service Requirements**

The oxygen provider must be able to provide recipients with emergency service.

Emergency service includes:

- Responding to an oxygen failure within two hours or less; and
- Having appropriate staff available twenty-four (24) hours a day, seven (7) days a week; and
- Providing an emergency supply that will last the duration of the emergency, including services provided during the aftermath of a natural or national disaster.

**Provider Staff Requirements**

When oxygen and oxygen-related equipment is set up in the recipient's home, a licensed certified respiratory therapy (CRT), registered respiratory therapist (RRT), registered nurse (RN), or respiratory care practitioner (RCP) who is employed by or under a current contract agreement with the DME provider must supervise the placement and set up of the equipment in the recipient's residence.

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, which meets the contract requirements described in this section.

A qualified technician cannot substitute for a licensed professional.

**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 72 hours prior to the recipient's anticipated discharge from a 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 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.

The delivery person will provide the recipient or responsible caregiver 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

**Delivery Prior to Recipient's Discharge,**  
continued

The person receiving the equipment will attest in writing to the type of equipment delivered, instructions received, signage provided, provider coordinated a date and time for the set up, and required recipient and caregiver training by the licensed professional, upon the recipient's arrival home.

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

**CRT, RRT, RN or RCP Contract Requirements**

The contract between a DME and medical supply services provider and a CRT, RRT, RN, or RCP must meet the following criteria:

- Be a written document; and
- Be dated, including the dates the contract is signed by both parties and one witness; and
- Specify the terms of the contract agreement with sufficient detail; and
- Indicate the exact date the contract begins and the exact date the contract terminates (open ended contracts are not accepted); and
- Specify the amount of payment that will be paid to the contractor by the DME company; and
- Specify that the licensed CRT, RRT, RN, or RCP providing direct services will comply with the requirements of oxygen providers, as described by Home Medical Equipment licensure requirements and Medicaid DME policy; and
- Be accompanied by evidence of current and updated copy of professional licensure of the CRT, RRT, RN, or RCP who will be providing oxygen services.
- Specify that all documentation must be legible, and include a signature, date, and license number.
- Specify that DME provider, not the Medicaid DME and Medical Supply Services Program, is responsible for payment for services rendered by the DME provider's contracted CRT, RRT, RN, or RCP.

**Provider Staff Responsibilities**

Medicaid requires a licensed CRT, RRT, RN, or RCP provide recipient or caregiver training and be present at the time of oxygen and oxygen-related equipment set up.

***Oxygen and Oxygen-Related Equipment***, continued

**Required Documentation for the Delivery and Set Up of Oxygen and Oxygen-Related Equipment**

Documentation of the installation must include the 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; and
- A statement that the equipment delivered was clean, sanitary, functioning correctly, and proper signage was available and displayed; and
- That all the appropriate and necessary accessories were provided; and
- The recipient or responsible caregiver were provided with the necessary instruction and training regarding the manufacturer's recommended use and care of the equipment; and
- The scheduled frequency for the provider's trained staff to test and service the equipment; and
- A statement signed by the recipient or responsible caregiver verifying that he was provided with the DME provider's emergency contact information; and
- The documentation of equipment delivery, and recipient and caregiver training must be signed and dated by the supervising, licensed professional in attendance and the recipient or responsible caregiver receiving the equipment and instruction.

**Unsupervised Delivery and Set Up of Oxygen and Oxygen-Related Services**

Providing oxygen and oxygen-related services without the required supervision of the employed or contracted, licensed professional is a violation of Florida Medicaid DME and Medical Supply Services Program policy.

Claiming Medicaid reimbursement for the unsupervised set up of oxygen and oxygen-related supplies, per the Medicaid DME and Medical Supply Services Program policy, is not allowed.

Providers in violation of this requirement are subject to being reported to the Department of Health and the Agency for Health Care Administration, Division of Health Quality Assurance.

Note: See Chapter 5 in the Florida Medicaid Provider General Handbook for information on Medicaid fraud and abuse.

***Oxygen and Oxygen-Related Equipment***, continued

**General Diagnostic Requirements**

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

- Emphysema, chronic bronchitis, and bronchiectasis; or
- Chronic interstitial pneumonia; or
- Chronic interstitial pulmonary infiltrate-type pulmonary disease such as pulmonary fibrosis from extensive tuberculosis, eosinophilia, granuloma, idiopathic fibrosis, and pneumoconiosis; or
- Pulmonary hypertension; or
- Secondary polycythemia; or
- Terminal lung cancer; or
- Other diagnoses that are approved by Medicaid, based on medical necessity.

**Initial and Quarterly Home Visit Requirements**

When the CRT, RRT or RN conducts the initial visit and qualified technicians conduct quarterly home visits, the following information about the recipient's condition and the condition of the equipment must be documented in the recipient's record:

- The display of required signage; and
- The quarterly checks of the operation and safety of the equipment; and
- Changing of filters; and
- Determination of oxygen output; and
- Oxygen concentrator meter reading, when a concentrator was delivered; and
- Proper functioning of any oxygen back-up system.

***Oxygen and Oxygen-Related Equipment***, continued

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**Diagnostic Requirements for Recipients Under 21 Years of Age**

In addition to the general requirements, Medicaid will reimburse oxygen for recipients under 21 years of age who have one of the following conditions:

- Bronchopulmonary dysplasia (BPD); or
  - Cystic fibrosis; or
  - Pulmonary fibrosis; or
  - Pulmonary insufficiency of prematurity (PIP); or
  - Tracheomalacia; or
  - Chronic lung disease; or
  - Agenesis, hypoplasia, dysplasia of the lung; or
  - Chronic cardiopulmonary disease (cor pulmonale); or
  - “P” pulmonale on EKG; or
  - Erythrocytosis;
    - ⇒ Familial polycythemia; or
    - ⇒ Hereditary elliptocytosis; or
    - ⇒ Polycythemia, secondary; or
  - Other diagnoses, based upon medical necessity.
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**Additional Service Criteria for Recipients Under 21 Years of Age**

For Medicaid reimbursement of oxygen and oxygen-related equipment for recipients under 21 years of age, laboratory results of oximetry or arterial blood gases must show:

- The pO<sub>2</sub> levels at or below 65mm Hg; or
- Oxygen saturation at or below 90 percent.

The Medicare criteria for arterial blood gases or oximetry do not apply for recipients under 21 years of age.

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***Oxygen and Oxygen-Related Equipment***, continued

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**Evaluation  
Requirements  
for Recipients  
Under 21 Years of  
Age**

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:

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

In cases of prevention of hypoxemia, recipients may demonstrate readings at or above 65mm Hg or oxygen saturation at or above 90 percent depending upon whether they are asleep, awake or exercising.

Oxygen services may be covered under these circumstances if associated with symptoms or signs reasonably attributable to hypoxemia, e.g., cor pulmonale, “P” pulmonale on EKG, documented pulmonary hypertension, and erythrocytosis.

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**Practitioner  
Requirements**

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.

The Department of Health and Human Services, Centers for Medicare and Medicaid Services, Certificate of Medical Necessity, CMS-484—Oxygen, Form CMS-484, (09/05) Ef 08/2206, may be used to document medical necessity for oxygen.

Note: Certificate of Medical Necessity, CMS-484—Oxygen, Form CMS-484, is available on the federal Centers for Medicare and Medicaid Services website at <http://www.cms.hhs.gov/cmsforms/>.

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**Oxygen and Oxygen-Related Equipment**, continued

<p><b>Practitioner Documentation Requirements</b></p>	<p>The treating physician's documentation of medical necessity must include:</p> <ul style="list-style-type: none"> <li>• Prescribed rate of flow; and</li> <li>• Concentration level; and</li> <li>• Frequency and duration of usage; and</li> <li>• Circumstances under which oxygen is to be used; and</li> <li>• Medical necessity, documented by arterial blood gas testing and the laboratory evidence of pO<sub>2</sub> or oxygen saturation by ear or pulse oximetry levels, that precedes the prescription for oxygen by no more than thirty (30) days; and</li> <li>• Specific exercise or activity program that requires portable oxygen.</li> </ul>
<p><b>Provider Documentation Requirements</b></p>	<p>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.</p> <p>The following components of the oxygen concentration must <b>also</b> be documented:</p> <ul style="list-style-type: none"> <li>• The pO<sub>2</sub> levels that equal or exceed 65mm Hg, or</li> <li>• Oxygen saturation level that equals or exceeds 90 percent.</li> </ul> <p>The provider may supply oxygen to recipients 21 and over if the recipient meets Medicare's criteria for laboratory results, arterial blood gases or oximetry.</p> <p>The provider must maintain all required documentation for oxygen therapy, including the redetermination of medical necessity every twelve (12) months, in the recipient's medical records.</p>
<p><b>Medical Necessity Testing for Oxygen and Oxygen-related Services</b></p>	<p>Initial testing required for the medical necessity determination for oxygen therapy must be performed by the treating physician, staff employed by the physician and in the treating physician's medical office, or by a licensed laboratory.</p> <p>The medical necessity for oxygen must be redetermined every twelve (12) months, or for the length of time prescribed when less than twelve (12) months, with retesting performed by the treating physician's medical office, or by a licensed laboratory.</p> <p>The DME provider is not authorized to conduct the testing or to provide the testing results to be used for the determination or the redetermination of medical necessity for oxygen and oxygen-related services.</p> <p>The DME provider may not pay for or offer any remunerations to the prescribing practitioner or lab for the required testing services or results.</p>

**Oxygen and Oxygen-Related Equipment**, continued

**Time-Sensitive  
Medical Necessity  
Renewal**

For Medicaid recipients of all ages, the medical necessity renewal time frame for oxygen therapy is every twelve (12) months or for the length of time prescribed when less than twelve (12) months.

The Department of Health and Human Services, Centers for Medicare and Medicaid Services, Certificate of Medical Necessity, CMS-484—Oxygen, Form CMS-484, (09/05) Ef 08/2206, may be used to document redetermination of medical necessity for oxygen.

Note: Certificate of Medical Necessity, CMS-484—Oxygen, Form CMS-484, is available on the federal Centers for Medicare and Medicaid Services website at <http://www.cms.hhs.gov/cmsforms/> may be used to document redetermination of medical necessity for oxygen therapy.

**Renewal Exception**

For Medicaid recipients of all ages, when an oxygen service test shows a pO<sub>2</sub> level at or above 55mm Hg or oxygen saturation at or above 89 percent, a second arterial blood gas or arterial oxygen saturation test must be performed within three (3) months of initiation of oxygen service.

**Documentation  
Requirements**

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

- Documentation of medical necessity for oxygen services that includes the rate of flow, concentration, level of frequency, duration of use, and circumstances under which oxygen is to be used; and
- CRT, RRT, RN or RCP staff members names and titles; and
- Positive oxygen test results; and
- Type of system being used, portable or stationary; and
- Manufacturer's name, model and serial number; and
- Set up and quarterly visit documentation; and
- Delivery and pick up documentation; and
- If a concentrator is in use, the number of hours used each quarter.

**Stationary Oxygen  
Service**

Medicaid reimburses for the following types of stationary oxygen services:

- Compressed oxygen system; and
- Liquid oxygen system; and
- Concentrators; and
- Oxygen and water vapor enriching system.

***Oxygen and Oxygen-Related Equipment***, continued

**Reimbursement for Stationary Services Only**

Each stationary oxygen service is reimbursed as an all-inclusive rental fee.

The rental fee for oxygen services includes the following:

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

**Portable Oxygen Service Criteria**

Medicaid reimburses for portable oxygen when a treating physician or a treating physician's ARNP or physician assistant prescribes activities requiring portable oxygen.

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

- Documentation of medical necessity for oxygen service; and
- The recipient's treating physician has ordered a specifically-prescribed program of exercise or an activity program for therapeutic purposes; and
- Recommended exercises or activities cannot be accomplished by the use of stationary oxygen service; and
- 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.

**Reimbursement for Stationary Oxygen Services with Portable Equipment**

Medicaid may reimburse additional costs for portable equipment when both portable and stationary services are medically necessary; however, 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, and
- One portable equipment code.

***Oxygen and Oxygen-Related Equipment***, continued

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**Reimbursement for Portable Oxygen Services Only**

Medicaid may reimburse for portable oxygen only when it is medically necessary.

The oxygen and oxygen-related equipment procedure codes identified on the DME and Medical Supply Services Provider Fee Schedule as RO (rental only) are reimbursed as an all inclusive fee for portable services, which includes such items as tubing, masks, and back-up cylinders, etc. that are necessary for the service.

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**Reimbursement**

Rental services may be reimbursed in the form of gaseous, liquid, or concentrated oxygen; however, Medicaid will reimburse for only one form of oxygen at a time.

For reimbursement of a concentrator service, the provider must use the procedure code appropriate to the prescribed flow rate.

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**Recipient Owned Equipment**

Medicaid may reimburse for the servicing of recipient owned oxygen equipment, when oxygen has been appropriately documented as medically necessary.

When billing Medicaid, the provider must use appropriate procedure codes for the type of oxygen provided (gaseous or liquid).

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<b><i>Parenteral and Drug Infusion Pumps</i></b>	
<b>Infusion Pumps</b>	Medicaid will reimburse for the infusion pumps listed on the DME and Medical Supply Provider and Medical Supply Services Provider Fee Schedule for Recipients Under 21 years of age.
<b>Description of Drug Infusion Pump</b>	A drug infusion pump is a device that is used to deliver solutions containing medication into the body at a regulated flow.
<b>Description of Enteral Nutrition Infusion Pump</b>	An enteral feeding pump is a device that is used to deliver solutions containing enteral nutritional supplements into the recipient's stomach or small intestine at a regulated flow.
<b>Infusion Pump Supplies</b>	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, Destructclip box, and other miscellaneous supplies.

***Passive Motion Device***

<b>Description</b>	A passive motion device is a mechanical device that is used to extend and flex the knee.
<b>Diagnostic Requirements</b>	<p>Medicaid may reimburse for a passive motion device for recipients under 21 years of age who have undergone total knee arthroplasty (TKA) or reconstruction (open or arthroscopic repair) of the anterior cruciate ligament (ACL) of the knee.</p> <p>The coverage must begin within two days following surgery and must not exceed 21 days. Sheepskin pads are included in the reimbursement.</p>

**Passive Motion Device**, continued

**Service Requirements**

The provider's appropriately trained staff must:

- Deliver and assemble the passive motion device in the recipient's home; and
- Provide instruction to the recipient or caregiver, regarding the safe and proper use of the device; and
- Maintain documentation of the delivery, pick up, and the instructions provided in the recipient's file.

Note: See the Service Delivery, Pick-Up, and Training Documentation Requirements section in this chapter for additional information on documentation.

**Documentation Requirements**

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.

**Patient Lifts**

**Description**

A patient lift is a portable device used to lift and transfer a recipient between a bed, a chair, wheelchair, or toilet with minimal personal assistance.

**Patient Lifts**

Medicaid may reimburse for portable patient lifts for recipients under 21 years of age, 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, etc.; and

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

Only one portable patient lift device may be reimbursed during the maximum limits period.

Note: See the DME and Medical Supply Services Provider Fee Schedules for information on the maximum limits.

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**Peak Flow Meter**

**Description**

A peak flow meter measures how air flows from the lungs and is used in the medical management of asthma.

**Peak Flow Meter Reimbursement**

A peak flow meter may be reimbursed for Medicaid recipients of all ages.

**Service Requirements**

The provider's appropriately trained and qualified staff is responsible for training the recipient and the recipient's caregiver in the proper and effective use of the device and for documenting the training in the recipient's record.

**Documentation Requirements**

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

- Prescription for the item that is dated and signed by the recipient's treating physician or the treating physician's ARNP or physician assistant, including the prescriber's professional license number; and
  - Diagnosis of moderate to severe asthma; and
  - Item is used as part of a continuing asthma treatment plan.
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### ***Pediatric Dynamic Splinting Device***

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#### **Description**

A pediatric dynamic splinting device is a device used to allow independent leg, knee and hip motion and incrementally limit rotation of the feet.

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#### **Service Requirements**

Medicaid may reimburse for a pediatric dynamic splinting device for clubfoot and internal tibial torsion.

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.

Orthotic and prosthetic providers must have a physical location in Florida or physical location within 50 miles of the Florida state line where devices can be measured, fitted, dispensed and adjusted. The provider must be staffed with appropriately licensed orthotists, pedorthotists, prosthetists, and fitters to provide direct services to Medicaid recipients.

Note: See Orthotic and Prosthetic Providers in the Provider Qualifications and Enrollment section in Chapter 1 of this handbook for additional information on the provider qualifications. See Orthotic Devices in this chapter for the documentation requirements.

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#### **Reimbursement Coverage**

Reimbursement for a pediatric dynamic splinting device includes the center bar, hinged and rotational joints, the shoe assembly, and the shoes.

The provider is responsible for all adjustments, modifications and replacements for the first six (6) months after the date of delivery.

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***Phototherapy (Bilirubin) Light with Photometer***

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**Description**

Phototherapy is the exposure to artificial light for treatment of neonatal jaundice.

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**Service Requirements**

Medicaid may reimburse for a phototherapy light with photometer if:

- The treating physician's diagnosis is neonatal jaundice; and
  - Treatment is limited to five consecutive days and occurs during the first 30 days of life; and
  - Treatment includes a fiberoptics system with the fiberoptics blanket, covers, light sources and related supplies.
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**Documentation Requirements**

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

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

Note: See Service Limit Exceptions, in the Prior and Post Authorization and Exceptions to Service Limits section of this Chapter.

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***Pressure Ulcer Care***

<b>Description</b>	Medical equipment used to treat or prevent pressure ulcers.
<b>Pads and Wheelchair Cushions</b>	Medicaid may reimburse for pressure ulcer care pads and wheelchair cushions if the recipient currently has pressure ulcers or is highly susceptible to pressure ulcers.
<b>Alternating Pressure Pads, Mattresses, Pumps</b>	Medicaid may reimburse for alternating pressure pads or mattresses and pumps for beds if a recipient is confined to a bed, has evidence of pressure ulcers, or provides evidence that the recipient is highly susceptible to pressure ulcers.
<b>Pressure Ulcer Care Documentation</b>	<p>The following must be included in the recipient record:</p> <ul style="list-style-type: none"> <li>• Documentation of medical necessity; and</li> <li>• Documentation of reasons why less costly alternatives were found ineffective; and</li> <li>• Documentation of the recipient's current course of treatment.</li> </ul>

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***Prosthetic Devices***

<b>Description</b>	Prosthetic devices are artificial devices or appliances that replace all or part of a permanently inoperative or missing body part.
<b>Service Requirements</b>	Reimbursement for prosthetic supplies is limited to supplies related to the medically-necessary prosthetic device.
	Prosthetic devices furnished to Medicaid recipients must match the HCPCS procedure code description and described illustrations included in the current edition of <i>The Illustrated Guide to Orthotics and Prosthetics</i> ©.
<b>Unit Limits for Single and Bilateral Devices</b>	The same units and limits specified for devices on the DME and Medical Supply Services Provider Fee Schedules apply to both single and bilateral needs.

**Prosthetic Devices**, continued

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**Provider Responsibilities**

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 six (6) months after date of delivery.

Orthotic and prosthetic providers must have a physical location in Florida or physical location within 50 miles of the Florida state line where devices can be measured, fitted, dispensed and adjusted. The provider must be staffed with the appropriately licensed orthotists, pedorthotists, prosthetists, and fitters to provide direct services to Medicaid recipients.

Note: See Orthotic and Prosthetic Providers in the Provider Qualifications and Enrollment section in Chapter 1 of this handbook for additional information on the provider qualifications.

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**Documentation Requirements**

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, and
  - Measurements taken, and
  - Fitting of the device, and
  - Written instructions and written information given to the recipient; and
  - Written progress notes.
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***Prosthetic Eyes***

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**Description**

Prosthetic eyes are artificial replacements for eyes.

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**Service Requirements**

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; and
  - Date of service entered on the claim must be the date the provider ordered the eye; and
  - Fee includes all costs related to measuring, fitting, and dispensing of the eye.
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**Prosthetic Eye Replacements**

Medicaid may replace an artificial eye that is damaged or no longer the appropriate size.

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**Documentation Requirements**

The recipient record must contain an evaluation that was completed by a physician or optometrist no more than ninety (90) days prior to the provision of the prosthetic eye.

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<b>Pulse Oximeter</b>	
<b>Description</b>	A pulse oximeter is a non-invasive device used to measure blood oxygen levels.
<b>Specific Diagnostic Requirements for Reimbursement</b>	<p>Medicaid may reimburse for the monthly rental of a medically-necessary pulse oximeter to be used for the daily surveillance of complex newborns and children under the age of six between multiple scheduled surgical procedures to treat the recipient's hypoplastic left heart syndrome (HLHS) condition, and who are <i>not</i> receiving oxygen therapy services.</p> <p>The caregiver is responsible for documenting daily pulse oximetry results to be provided to the child's treating physician.</p> <p>The DME provider's licensed CRT, RRT, RN, or RCP must provide training to the recipient's caregiver regarding the appropriate use of the device and accurate documentation of blood oxygen level readings.</p> <p>A quarterly visit must be made by a qualified technician to ensure the device is functioning properly and being used appropriately.</p>
<b>Time-Sensitive Medical Necessity Redetermination for Pulse Oximetry Services</b>	<p>Medical necessity for the pulse oximeter must be redetermined every twelve (12) months, or for the length of time prescribed when less than twelve (12) months, by the treating physician, the treating physician's assistant, or the treating physician's ARNP.</p> <p>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.</p> <p>The DME provider may not pay for or offer remunerations to the prescribing practitioner or lab for the required testing services or results.</p>
<b>Documentation Requirements</b>	Equipment delivery and caregiver training must be provided by qualified staff; and documentation of delivery, pick up, visits and caregiver training must be maintained in the recipient's record.

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***Resuscitator Bag***

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**Description**

A resuscitator bag is a hand-held device used to temporarily provide artificial breathes for recipients who can not breathe unaided. When used, the attached bag filled with air is manually squeezed to force air into the recipient's lungs.

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**Service Requirements**

Medicaid may reimburse 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.

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**Reimbursement Limitations**

Resuscitator bags may be reimbursed using the miscellaneous DME procedure code for a ventilator dependent recipients using privately-owned ventilators or non-ventilator dependent recipient 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.

Note: See the Ventilators and Respiratory Equipment section in this chapter for additional information.

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**Suction Machines**

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**Description**

A suction machine is an electric aspirator designed for either upper respiratory and tracheal suction or gastric suction.

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**Stationary Model Respiratory Suction Machine**

Medicaid may reimburse 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.

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**Mobile Model Respiratory Suction Machine**

Medicaid may reimburse 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; and
- Recipient is being transported for prescribed medical treatment, therapy, or rehabilitation services; and
- 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 DC adapter cable, canister or bottle, connector, and carrying case.

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**Gastric Suction Machine**

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 (8) hours, when the rechargeable battery has been fully charged.

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**Reimbursement**

Tubing and accessories necessary to operate respiratory and gastric suction equipment are reimbursable only for recipient owned equipment.

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***Traction Equipment***

<b>Description</b>	Traction equipment is used to draw or pull sections of the body to improve skeletal alignment.
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<b>Traction Equipment</b>	Medicaid may reimburse for traction equipment when prescribed by the recipient's treating physician, or the treating physician's prescribing ARNP or physician assistant, for an orthopedic impairment requiring traction equipment that prevents ambulation during the period of use.
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***Trapeze Equipment***

<b>Description</b>	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.
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<b>Trapeze Equipment</b>	Medicaid may reimburse 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.
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<b>Trapeze Equipment</b>	Medicaid may also reimburse trapeze equipment for exercise to prevent muscular deterioration when prescribed by the recipient's treating physician or the treating physician's ARNP or physician assistant.
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***Ventilator and Respiratory Equipment***

<b>Description</b>	Ventilator and respiratory equipment is used to support the respiratory system.
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<b>Ventilators and Respiratory Equipment</b>	<p>Medicaid reimburses for the following ventilators and respiratory assist devices:</p> <ul style="list-style-type: none"> <li>• Continuous positive airway pressure device (CPAP); and</li> <li>• Respiratory assist device, bi-level pressure capability, without back-up rate feature, used with noninvasive interface (BIPAP); and</li> <li>• Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface (BIPAP); and</li> <li>• Intermittent positive pressure breathing machine (IPPB); and</li> <li>• Volume ventilator; and</li> <li>• Negative pressure ventilator; and</li> <li>• Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with invasive interface.</li> </ul>
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**Ventilator and Respiratory Equipment**, continued**Continuous Positive Airway Pressure Device (CPAP) and BIPAP Definitions and Criteria**

The CPAP is a noninvasive technique for providing 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).

Apnea is defined as a cessation of airflow for at least 10 seconds.

A diagnosis of OSA requires at least thirty (30) episodes of apnea, each episode lasting a minimum of 10 seconds, during six to seven hours of recorded sleep. The use of CPAP is covered under Medicaid when used in adult recipients with a moderate or severe OSA for whom surgery is a likely alternative to CPAP, as determined by a polysomnogram.

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 result or report must be signed and dated by a physician qualified as a sleep specialist. The report must be dated no more than 30 days prior to the date of the initial documentation of medical necessity, or prescription, for the CPAP device.

Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds with at least a 30 percent reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4 percent oxygen desaturation.

CPAP reimbursement must be supported by documentation of medical necessity written by the recipient's attending practitioner that specifies:

- The recipient has a diagnosis of moderate or severe obstructive sleep apnea; and
- Surgery is a likely alternative to the use of the CPAP device;

The documentation of medical necessity must be supported by a recent sleep study report dated no more than 30 days prior to the date of the order or prescription for the device.

The use of prescribed CPAP devices are also covered when prescribed for an adult recipient diagnosed with OSA if either of the following criteria using the Apnea-Hypopnea Index (AHI) are met:

- AHI > 15 events per hour; or
- 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.

***Ventilator and Respiratory Equipment***, continued

<p><b>Continuous Positive Airway Pressure Device (CPAP) and BIPAP Definitions and Criteria</b>, continued</p>	<p>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).</p> <p>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 bi-level positive airway pressure (BIPAP) device. This statement must be maintained in the recipient's records.</p> <p>Providers are prohibiting from billing Medicaid for a CPAP or BIPAP device if the recipient does not meet the criteria described above.</p>
<p><b>Documentation Requirements for CPAP and BIPAP</b></p>	<p>The provider must, at a minimum, maintain the following documentation in the recipient's record:</p> <ul style="list-style-type: none"><li>• Prescription, certification and redetermination, medical documentation; and</li><li>• Diagnosis; and</li><li>• Laboratory results from qualified licensed facility; and</li><li>• Equipment delivery and pick-up documentation; and</li><li>• Recipient and caregiver training at the time of the set up; and</li><li>• Hour meter reading for equipment usage; and</li><li>• Equipment testing and calibration testing results and maintenance or equipment replacement; and</li><li>• Delivery and replacement of necessary tubing, masks, etc.; and</li><li>• Data reading to assess recipient's compliance.</li></ul>
<p><b>Time-Sensitive Redetermination Documentation Requirements</b></p>	<p>Redetermination of medical necessity for a CPAP or BIPAP device is required every twelve (12) months or for the length of time prescribed if less than twelve (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.</p> <p>If redetermination of medical necessity is not obtained, the provider must discontinue claims for payment.</p>

**Ventilator and Respiratory Equipment**, continued

**Reimbursement for Respiratory Assist Devices**

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

Medicaid will only reimburse for CPAP or BIPAP supplies for recipient-owned devices.

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 (IPPB)**

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

**IPPB Documentation**

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

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

**Ventilator and Respiratory Equipment**, continued

<b>Reimbursement for IPPB Machines</b>	<p>Tubing and accessories necessary to operate the IPPB machine are included in the scheduled monthly rental fee.</p> <p>Claiming separate reimbursement for accessory items included in the equipment's scheduled monthly rental fee is not permitted.</p>
<b>Volume Ventilator</b>	<p>Medicaid may reimburse for a positive or negative pressure volume ventilator when prescribed as medically necessary by the recipient's treating physician or the treating physician's prescribing ARNP or physician assistant.</p>
<b>Service Requirements</b>	<p>Medicaid may reimburse for a volume ventilator when the recipient has one of the following diagnoses:</p> <ul style="list-style-type: none"> <li>• Neuromuscular disorder; or</li> <li>• Thoracic restrictive disease; or</li> <li>• Congenital pulmonary disorder; or</li> <li>• Respiratory paralysis; or</li> <li>• Chronic respiratory failure, consequent to chronic obstructive pulmonary disease (COPD); or</li> <li>• Neurological disorder, as with spinal cord injury; or</li> <li>• Bronchial pulmonary disease.</li> </ul>
<b>Volume Ventilator Documentation</b>	<p>The following information must be documented in the recipient's record:</p> <ul style="list-style-type: none"> <li>• Prescription, certificate of medical necessity, and redetermination of medical necessity; and</li> <li>• Diagnosis; and</li> <li>• Home care protocol; and</li> <li>• Airway stability; and</li> <li>• Oxygen requirement; and</li> <li>• Documentation that the recipient or the recipient's responsible caregiver received training from a licensed professional regarding the proper and effective use of the equipment at the time of the set up; and</li> <li>• Quarterly visit documentation; and</li> <li>• Equipment assessments, repair, maintenance and replacement; and</li> <li>• Delivery and pick up documentation.</li> </ul>

***Ventilator and Respiratory Equipment***, continued

<p><b>Reimbursement for Volume Ventilators</b></p>	<p>Tubing and accessories necessary to operate a volume ventilator are included in the scheduled monthly rental fee.</p> <p>Claiming separate reimbursement for accessory items included in the equipment's scheduled monthly rental fee is not allowed.</p>
<p><b>Negative Pressure Ventilator</b></p>	<p>Medicaid reimburses for a negative pressure ventilator, stationary or portable, when prescribed as medically necessary by the recipient's treating physician or the treating physician's prescribing ARNP or physician assistant.</p>
<p><b>Alternating Positive Airway Pressure and Intermittent Positive Ventilation System</b></p>	<p>Medicaid reimburses for an alternating positive airway pressure and intermittent positive ventilation system for intermittent respiratory service.</p> <p>For a child with a tracheotomy, an intermittent assist device with continuous positive airway pressure must be used with a CPAP or BIPAP system.</p> <p>Reimbursement for a therapeutic ventilator is limited to 12 hours or less per day.</p> <p>Reimbursement includes all connectors, pressure measuring and alarm devices, breathing circuits, in-line thermometers, water traps, connectors, adapters, and training by licensed professionals.</p>
<p><b>General Documentation Requirements</b></p>	<p>The following information must be documented in the recipient's record:</p> <ul style="list-style-type: none"> <li>• Diagnosis; and</li> <li>• Prescription, certificate of medical necessity and redetermination of medical necessity; and</li> <li>• Machine setting for inspiratory positive airway pressure; and</li> <li>• Setting for expiratory positive airway pressure; and</li> <li>• Liter flow of oxygen, if appropriate; and</li> <li>• Time of day and number of hours a day the device is to be used; and</li> <li>• Estimated number of months the equipment will be needed; and</li> <li>• Home care protocol; and</li> <li>• Oxygen requirements; and</li> <li>• Documentation that the recipient or the recipient's responsible caregiver received training from a licensed professional regarding the proper and effective use of the equipment at the time of the set up; and</li> <li>• Visit documentation; and</li> <li>• Equipment assessments, repair, maintenance and replacement; and</li> <li>• Delivery and pick up documentation.</li> </ul>

***Ventilator and Respiratory Equipment***, continued

---

**Documentation for Obstructive Sleep Apnea Syndrome (OSAS)**

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:

- OSAS was diagnosed based on a polysomnographic sleep study; and
  - An ongoing plan of therapy has been ordered; and
  - CPAP or BIPAP therapy was tried, but was proven unsuccessful; or the recipient was not able to tolerate the CPAP or BIPAP; and
  - Notification of treating physician if CPAP or BIPAP therapy has proven unsuccessful or is not tolerated by recipient.
- 

**Documentation 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 continuous positive airway pressure device (CPAP) or bi-level positive airway pressure device (BIPAP); and
  - The medical purpose specifies that the device is prescribed for purposes other than nocturnal ventilatory assistance; and
  - If the device is used in spontaneous timed or timed mode, the control settings are specified in writing by the treating physician.
- 

**Recipient Owned Ventilator**

When a recipient owns a ventilator, the provider may use procedure code A4618 to bill for a daily amount of accessories, supplies, and a quarterly home visit.

Assigned procedure codes are subject to change with yearly National Healthcare Common Procedure Coding System (HCPCS) code updates.

---

**Back-up Ventilator**

A back-up ventilator is included in the monthly Medicaid reimbursement.

---

**Documentation Requirements**

When service of a recipient owned ventilator is provided, the following information must also be documented in the recipient's record:

- Manufacturer's name, and
  - Model and serial number of the recipient's ventilator.
-

***Ventilator and Respiratory Equipment***, continued

**Reimbursement  
for Negative  
Pressure  
Ventilators and  
Alternating  
Positive Airway  
Pressure and  
Intermittent  
Positive Pressure  
Ventilators**

Tubing and accessories necessary to safely and effectively operate a negative pressure ventilator and an alternating positive airway pressure and intermittent positive ventilation system 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.

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## **Wheelchairs**

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### **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.

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### **Service Requirements**

Medicaid will reimburse 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.

Medicaid will reimburse and provide 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 Schedule.

The following types of wheelchairs and POVs devices require prior authorization:

- Customized manual wheelchairs,
- Customized power wheelchairs,
- Non-custom power wheelchairs,
- Motorized scooters (POV), and
- Power Conversion kits.

Note: See the DME and Medical Supply Services Provider Fee Schedules for the maximum limits.

---

### **Categories of Wheelchairs**

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;
  - Wide, heavy-duty wheelchair for recipients whose measurements or body weight 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 met by a less costly alternative;
  - Other model(s) if the features and accessories are medically necessary; and
  - Customized wheelchair that is specially constructed for the individual recipient and not otherwise available from manufacturers.
-

**Wheelchairs**, continued

**Customized Wheelchair Documentation**

Medicaid will reimburse for a medically-necessary, customized wheelchair that is specially constructed for the individual recipient.

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.

Prior authorization is required for all custom wheelchairs, power wheelchairs, power operated vehicles (POV), and modifications and custom upgrades. The following information must be submitted with the prior authorization request:

- Either the Medicaid Custom Wheelchair Evaluation form (Appendix A) or another document that contains the same information that is requested on the form; and
- Medical necessity documentation; and
- 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; and
- Wheelchair evaluations must be performed by and the evaluation information completed by or dictated by a registered physical or occupational therapist or a certified physiatrist and documented on either the Custom Wheelchair Evaluation, AHCA Med Serv Form 015, July 2007 (Appendix A) or another document that contains the same information that is requested on the form. The documentation must list a date of completion that is not more than six (6) months old and include the therapist's or physiatrist's signature and license number; and
- Discussion of the recipient's current mobility equipment and why the current equipment is no longer appropriate; and
- What physical improvement(s) can be anticipated; and
- What physical deterioration may be prevented with the type of wheelchair and specific features requested; and
- Listing of each customized feature required for unique physical status; and
- Specification of the medical benefit of each customized feature requested; and
- Identification of the principle place(s) the wheelchair will be used; and
- Itemized provider invoice, listing the provider's price requested for parts and labor (labor is included in the cost of the initial fabrication of a custom wheelchair or custom components); and
- List the source(s) for the accessories and modifications requested and the manufacturer's suggested retail price for each item that is not described by a procedure code with a scheduled fee on the DME and Medical Supply Services Provider Fee Schedule; and

**Wheelchairs**, continued

**Customized  
Wheelchair  
Documentation,**  
continued

- Itemized invoice listing provider's source of accessory and modification parts and manufacturers 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 Schedule; and
- Documentation of the recipient's home accessibility for the customized manual or motorized wheelchair requested; and
- Measurements of the recipient; and
- Weight of recipient; and
- Measurements of all exterior doorways of the recipient's residence; and
- Measurements of all interior doorways of the recipient's residence to be used by the recipient; and
- Documentation that the requested equipment is the least costly alternative to meet the recipient's needs must be available upon request.

Note: See Prior and Post Authorizations and Exceptions to the Service Limits in this chapter regarding the DME provider's sales invoice.

Note: See Chapter 2 in the Medicaid Provider Reimbursement Handbook, CMS-1500, and the Prior and Post Authorization and Exceptions to the Service Limits section in this chapter for instructions on how to request prior authorization.

Note: See Appendix A for a copy of the Custom Wheelchair Evaluation, AHCA Med Serv Form 015. The form is available by photocopying it from Appendix A or from the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Select Public Information for Providers, then Provider Support, and then Forms.

**Wheelchairs**, continued**Documentation  
Required for  
Motorized or Power  
Wheelchair and  
Power-Operated  
Vehicle (POV)**

Medicaid will not approve a power wheelchair (custom or non-custom), power-operated vehicle (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 his 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; and
- Has demonstrated that he possesses 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; and
- Currently resides in or will primarily use the equipment in an environment conducive to the use of a motorized wheelchair of the type and size wheelchair requested.

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's, occupational therapist's, 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.

**Note:** See Chapter 2 in the Medicaid Provider Reimbursement Handbook, CMS-1500, and the Prior and Post Authorization and Exceptions to the Service Limits section in this chapter for instructions on how to request prior authorization.

**Wheelchairs**, continued

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**Service Limitations  
Power Operated  
Vehicles (POVs)**

Medicaid will reimburse a powered mobility device, such as the vehicle described in HCPCS procedure code for a POV.

Since Medicaid may fund and maintain only one mobility device within the maximum limit period, the recipient is not eligible for more than one power-operated vehicle (POV) or wheelchair (standard or customized) within the same five-year maximum limit period.

Note: See the DME and Medical Supply Services Provider Fee Schedules for the maximum limits. The fee schedules are available on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Fee Schedules.

---

**Service  
Requirements**

A power-operated vehicle (POV) requires prior authorization.

The following criteria must be met for a POV:

- Recipient's medical necessity requires the use of a POV to independently move around his residence; and
- Recipient is physically unable to operate a manual wheelchair; and
- Recipient is capable of safely and independently operating the controls for the POV requested; and
- Recipient can transfer safely in and out of the POV and has adequate trunk stability to be able to safely ride in the POV; and
- An independent licensed physical therapist, occupational therapist or physiatrist has determined and documented his recommendation of the most appropriate and medically-necessary POV to meet the recipient's individual mobility needs; and
- The recipient does not have a wheelchair that was purchased by Medicaid within the past five years.

Note: See Chapter 2 in the Medicaid Provider Reimbursement Handbook, CMS-1500, and the Prior and Post Authorization and Exceptions to the Service Limits section in this chapter for instructions on how to request prior authorization.

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**Wheelchairs**, continued

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**Custom Wheelchair Repairs**

All repairs to custom 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 HCPCS procedure code.

Prior authorization requests for repair and modification are reserved for custom replacement and modification, such as custom seating, and adjustable skin protection and positioning cushions, not otherwise listed on the DME and Medical Supply Services Provider Schedules.

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.

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**Wheelchair Evaluation**

All wheelchair evaluations for custom manual and power wheelchairs must be completed by a licensed physical therapist, occupational therapist, or physiatrist using either the Custom Wheelchair Evaluation, AHCA Med Serv Form 015, (Appendix A) or another document that contains the same information that is requested on the form.

All wheelchair evaluations are valid for up to six months from the date the evaluation is signed and dated by the evaluator.

Documentation of home accessibility is required in a prior authorization request for an extra-wide wheelchair, custom or non-custom power wheelchair or POV.

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**Reimbursement for Wheelchairs**

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

If a non-standard component(s) must be provided on the rental or rent-to-purchase wheelchair during the agreement period, documentation of medical necessity for the upgrade is required. The provider must clarify that only the difference between the scheduled fee for the standard component and non-standard component will be claimed. The calculated reduced fee will be claimed for reimbursement, using the HCPCS procedure code that describes the non-standard component provided.

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.

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***Non-Covered Services and Exclusions***

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**Non-Covered Items**

The following list of items and services are not reimbursed through the Medicaid DME and Medical Supply Services Program; however some of these items may be reimbursed through other Medicaid programs, such as the Medicaid State Plan, Home and Community-Based Waiver Programs, or other state-operated programs:

- Audiology services
- Blood pressure monitoring devices
- Car seats or car beds
- Clinically unproven equipment
- Computers and computer-related equipment
- Dentures
- Diapers and incontinence briefs of any kind
- 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
- Experimental or investigational equipment of any type
- Facilitated communications (FC)
- 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
- Personal comfort, convenience or general sanitation items
- Physical fitness equipment
- Powered wheelchair component for standing
- Precautionary-type equipment (e.g., power generators, backup oxygen equipment unless specifically determined as medically necessary to assure life support)
- Printers, unless the printer is a built-in component of a dedicated AAC system
- Printer paper or cables
- Routine and first aid items
- Services or items provided to recipients out of state

***Non-Covered Services and Exclusions***, continued

**Non-Covered  
Items,**  
continued

- Supplies or equipment covered by Medicaid per diem rates
  - Televisions, telephones, VCR machines and devices designed to produce music or provide entertainment
  - 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 lifts
  - Wheelchair ramps and home modifications
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## CHAPTER 3

### DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLY SERVICES PROCEDURE CODES AND FEES

**Overview**

**Introduction**

This chapter describes the procedure codes for Medicaid reimbursable durable medical equipment (DME) and medical supply services, special billing requirements, and the requirements for By Report (BR) authorizations.

**In This Chapter**

This chapter contains:

TOPIC	PAGE
Reimbursement Information	3-1
How to Read the Fee Schedules	3-4
Non-Classified Procedure Codes	3-7
By Report Claims	3-8
Procedure Code Modifiers	3-8

**Reimbursement Information**

**Maximum Fee**

The Medicaid fee reimbursed for durable medical equipment (DME) and medical supplies includes labor, travel, delivery, shipping, handling, fees for measuring, casting, fitting, adjusting or dispensing items or products. It includes all costs associated with a back-up cylinder or oxygen concentrator, ventilator, continuous positive airway pressure (CPAP) device, and bi-level pressure capability (BIPAP) device.

The rental fee for oxygen and oxygen-related equipment includes the hoses, tubing and masks required for using the equipment. The rental fee for ventilators also includes the provision of a resuscitator bag.

**Reimbursement Information**, continued

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<b>Procedure Codes</b>	<p>The procedure codes referenced in this handbook are Level II Healthcare Common Procedure Coding System (HCPCS) codes. The codes are part of the standard code set described in HCPCS Level II Expert code book. 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.</p>
<b>Purchased Equipment Credits</b>	<p>Providers are required to credit any parts or accessories that are removed from the amount charged for the equipment before delivery.</p> <p>Credit must be deducted prior to submitting the claim to Medicaid.</p>
<b>Billing Requirements for Used DME Equipment</b>	<p>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.</p> <p>When the amount billed is less than the fee identified in the DME and Medical Supply Services Provider Fee Schedules, the Medicaid claims system will pay the lesser amount.</p> <p>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.</p> <p><u>Note:</u> See the DME and Medical Supply Services Provider Fee Schedules for a list of Medicaid fees. The fee schedules are available on the Medicaid fiscal agent's Web Portal at <a href="http://mymedicaid-florida.com">http://mymedicaid-florida.com</a>. Click on Public Information for Providers, then on Provider Support, then on Fee Schedules.</p>
<b>Refurbished Equipment</b>	<p>Refurbished equipment is used equipment that primarily displays 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.</p> <p>The provider must document the new components and parts used to update the used equipment in his records. Upon request, the provider's records must be made readily available for review by Medicaid staff or Medicaid's representatives.</p>

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**Reimbursement Information**, continued

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**Rent-to-Purchase**

For rent-to-purchase equipment, Medicaid's total reimbursement may not exceed a total of ten (10) monthly claims. The provider may not submit a claim for more than one unit of service within the same calendar month.

When the tenth and final payment is made for a specific rent-to-purchase item, the equipment becomes the personal property of the Medicaid recipient.

Authority for rental payments terminates when the equipment is no longer medically necessary or the recipient is no longer eligible for Medicaid.

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

---

**Rental-Only  
Items  
(RO)**

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, and
- Any monthly home visits or services by the provider's staff, as recommended by the manufacturer or required by Medicaid policy.

Home visits and services must be conducted and clearly documented to ensure that the recipient and caregiver are adequately trained in the use and care of the equipment, that the equipment is operating optimally, that the settings are correctly maintained, and that the recipient is using the equipment appropriately as ordered by his treating physician.

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

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.

It is the DME provider's responsibility to bill the appropriate amount for the rental equipment.

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## **How To Read The Fee Schedules**

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### **Introduction**

The DME and Medical Supply Services Provider Fee Schedules are tables of columns listing the Medicaid reimbursable Healthcare Common Procedure Coding System (HCPCS) Level II procedure codes, their descriptors, and other information pertinent to each code.

The procedure codes are listed in alpha-numeric order.

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### **Fee Schedules**

The DME and Medical Supply Services Provider Fee Schedule for All Medicaid Recipients lists the DME and medical supplies covered for all Medicaid recipients, regardless of age.

The DME and Medical Supply Services Provider Fee Schedule for Recipients Under Age 21 lists the DME and medical supplies covered only for Medicaid recipients under 21 years of age.

The format for both fee schedules is the same.

Note: The DME and Medical Supply Services Provider Fee Schedules are available on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Fee Schedules. The fee schedules are incorporated by reference in 59G-4.071, Florida Administrative Code.

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### **Code**

This column identifies the procedure code.

The Medicaid DME and Medical Supply Services Program uses the following sections from the HCPCS coding system:

- A codes - Medical and Surgical Supplies, Diabetic Footwear and Miscellaneous Orthotic Devices
  - B codes - Enteral Formulas and Parenteral Infusion Therapy Supplies
  - E codes - Durable Medical Equipment, including select Wheelchairs
  - J Codes – Pre-filled Flush Syringes
  - K codes – Wheelchairs and select Orthotic Devices
  - L codes – Orthotic and Prosthetic devices
  - S codes- Insulin syringes, Solid Food Supplements
  - V codes – Vision
- 

### **Procedure Code Modifier**

Certain procedure codes have modifiers that are used with the HCPCS procedure codes to more fully describe the procedure performed.

If a code modifier is listed on the DME and Medical Supply Services Provider Fee Schedules, the modifier must be used with the HCPCS procedure code on authorization requests and claim forms.

Note: See Procedure Code Modifiers in this chapter for additional information.

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**How To Read The Fee Schedules**, continued

**Code Description**

This column 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.

**Max 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 maximum fee for ostomy supplies is per stoma or per fistula, unless otherwise specified.

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.

Note: See Chapter 2 in the Medicaid Provider Reimbursement Handbook, CMS-1500, and the Prior and Post Authorization and Exceptions to the Service Limits section in Chapter 2 of this handbook for instructions on how to request prior authorization.

Note: See By Report Claims in this chapter for additional information.

**Rental Only (RO)**

This column means the equipment will remain the property of the provider and a monthly fee will be reimbursed during the authorized medically necessary time frame.

**Rent to Purchase**

This column represents items that total reimbursement may not exceed a total of ten (10) monthly claims. The provider may not submit a claim for more than one unit of service within the same calendar month.

When the tenth and final payment is made for a specific rent-to-purchase item, the equipment becomes the personal property of the Medicaid recipient.

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

**Units**

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

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**By Report  
(BR)**

This column identifies a “non-classified” procedure code that requires a medical review to approve and price the procedure correctly.

Submit the medical-necessity documentation, the provider’s attainment cost and wholesale price information, the provider invoice, and documentation proving the item is the least costly alternative to meet the needs of the recipient with the claim and send it directly to the Medicaid fiscal agent.

Note: See By Report Claims and Medical Supplies with non-classified codes in this chapter for additional information.

---

**PA**

This column identifies the procedure codes that require prior authorization before the service is performed.

Note: See Chapter 2 in the Medicaid Provider Reimbursement Handbook, CMS-1500, and the Prior and Post Authorization and Exceptions to the Service Limits section in Chapter 2 of this handbook for instructions on how to request prior authorization.

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**Limits**

The number in this column shows the maximum limits allowed for a procedure code.

Reimbursement of procedure codes is limited to the number in the “Limits” column.

Note: See the Prior and Post Authorization and Exceptions to the Service Limits section in Chapter 2 for instructions on how to request prior authorization for services that exceed the limitations for recipients under 21 years of age.

Note: See the Exceptions to the Service Limits section in Chapter 2 for instructions on how to request authorization for services that exceed the limitations for providers requesting temporary wheelchair rentals. This exception is for recipients of all ages.

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**Per Medical  
Event**

A medical event is defined as an in-patient hospitalization or a recently documented and significant change in the recipient’s medical condition.

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## **Non-Classified Procedure Codes**

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### **Introduction**

The DME and Medical Supply Services Provider Fee Schedules have "non-classified" procedure codes. Non-classified procedure codes allow the provider to request reimbursement from Medicaid when a reimbursable item does not have an established fee identified. Pricing non-classified procedure codes is established either by prior authorization or a By Report claim.

Note: See Chapter 2 in the Medicaid Provider Reimbursement Handbook, CMS-1500, and the Prior and Post Authorization and Exceptions to the Service Limits section in Chapter 2 of this handbook for instructions on how to request prior authorization.

Note: See Submitting By Report Claims in this chapter for information and the documentation requirements for By Report claims.

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### **When to Use Non-Classified Procedure Codes**

Providers must use a non-classified procedure code when the item is reimbursable, but:

- The equipment requested needs to be customized to the physical condition of the recipient, and
  - There is no less expensive treatment modality, equipment, or measures available to meet the recipient's medical needs.
- 

### **Reimbursement for Non-Classified Codes**

A provider may be reimbursed for a non-classified procedure code after the claim is approved and priced by AHCA.

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### **Medical Supplies with Non-Classified Codes**

When approved, AHCA will price a medical supply with a non-classified procedure code using the following methodology:

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

Medicaid will reimburse the lesser of the above three (3) methodologies.

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**By Report Claims**

**Description**

For a By Report claim, the provider must submit, with the claim, a detailed and formal account that enables Medicaid to review and price the procedure.

**Submitting By Report Claims**

A By Report claim is submitted directly to the fiscal agent and must include the necessary documentation for Medicaid staff or professional medical consultants to complete a medical review and to price the procedure.

The following written documentation must be submitted with the claim:

- Documentation of medical necessity; and
- Description of the items or services provided; and
- Name of the manufacturer’s model, serial number, style, features, attachments, modifications, and accessories; and
- Description of the time, skill, and equipment used; and
- Documentation of any cost incurred, including the provider’s billing invoices from the manufacturer; and
- Manufacturer catalog information, which lists manufacturer’s suggested retail price; and
- The provider’s invoice; and
- If for a non-routine service, a description of the item before and after repair; and
- If for a repair for service, the manufacturer, duration of the warranty, model, and serial number; and
- Date the item was made available to the recipient.

Note: See Medical Necessity Definition and Documentation Requirements in Chapter 2 of this handbook additional information.

**Procedure Code Modifiers**

**Description of Modifiers**

Some of the procedures that Florida Medicaid covers are not adequately defined by HCPCS procedure codes, so Florida Medicaid adds modifiers to the HCPCS procedure code to better define the procedure.

DME and medical supply providers use procedure code modifiers with certain procedure codes for enteral supplies. The modifier must be used with the HCPCS procedure code on authorization requests and claim forms.

Local-code modifiers can only be used with the procedure codes listed. Use of local-code modifiers with any other procedure codes will cause the claim to deny or pay incorrectly.

***Procedure Code Modifiers***, continued

**Entering Modifiers  
on the Claim Form**

The modifier is entered in the field next to the procedure code field in item 24D, Modifier, on the CMS-1500 claim form.

Note: See Chapter 1 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for additional information on entering modifiers on the claim form.



APPENDIX A

FLORIDA MEDICAID WHEELCHAIR EVALUATION FORM



## 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: _____
Funding: _____	Age: _____	Sex: _____
Referred By: _____	Date of Birth: _____	OT: _____
	Height: _____	PT: _____
	Weight: _____	
Medicaid ID # _____		

Reason for Referral: _____
Patient Goals: _____
Caregiver Goals: _____

### MEDICAL HISTORY:

Dx: _____	ICD-9: _____	ICD-9: _____
	ICD-9: _____	ICD-9: _____
Date of injury/onset: _____		
Prognosis/ Hx: _____		
Recent / Planned Surgeries: _____		
Cardio-Respiratory Status: _____	Comments: _____	
<input type="checkbox"/> Intact <input type="checkbox"/> Impaired		

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

Chair: _____	Age: _____
Serial # _____	
w/c Cushion: _____	Age: _____
w/c Back: _____	Age: _____
Other Positioning Components: _____	
Reason for <input type="checkbox"/> Replacement / <input type="checkbox"/> Repair / <input type="checkbox"/> Update: _____	
Funding Source: _____	

### HOME ENVIRONMENT:

<input type="checkbox"/> House <input type="checkbox"/> Apt <input type="checkbox"/> Asst Living <input type="checkbox"/> LTCF <input type="checkbox"/> Alone <input type="checkbox"/> w/ Family-Caregivers:	
Length of time at residence: _____	
Entrance: <input type="checkbox"/> Level <input type="checkbox"/> Ramp <input type="checkbox"/> Lift <input type="checkbox"/> Stairs	Entrance Width: _____
w/c Accessible Rooms: <input type="checkbox"/> Yes <input type="checkbox"/> No	Narrowest Doorway Required to Access: _____
Is a caregiver available 24 hours a day: <input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Intact:	<input type="checkbox"/> Impaired:	Comments:
Problem Solving	<input type="checkbox"/> Intact:	<input type="checkbox"/> Impaired:	Comments:
Judgment	<input type="checkbox"/> Intact:	<input type="checkbox"/> Impaired:	Comments:
Attn / Concentration	<input type="checkbox"/> Intact:	<input type="checkbox"/> Impaired:	Comments:
Vision	<input type="checkbox"/> Intact:	<input type="checkbox"/> Impaired:	Comments:
Hearing	<input type="checkbox"/> Intact:	<input type="checkbox"/> Impaired:	Comments:
Other	<input type="checkbox"/> Intact:	<input type="checkbox"/> Impaired:	Comments:

**ADL STATUS:** Indep Assist Unable Comments / Other AT Equipment Required

Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grooming/Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meal Prep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Bowel Management: Continent Incontinent

Bladder Management: Continent Incontinent

**MOBILITY SKILLS:** Indep Assist Unable N/A Comments

Bed ↔ w/c Transfers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
w/c ↔ Commode Transfers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ambulation:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Device:
Manual w/c Propulsion:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Operate Power w/c w/ Std. Joystick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Operate Power w/c w/ Alternative Controls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ability to Stand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Able to Perform Weight Shifts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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? Explain: Yes No

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? Explain: Yes No

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

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

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

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

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:

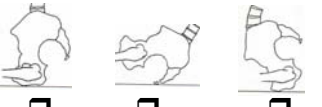


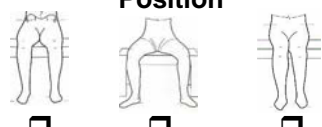


**RECOMMENDATION / GOALS:**

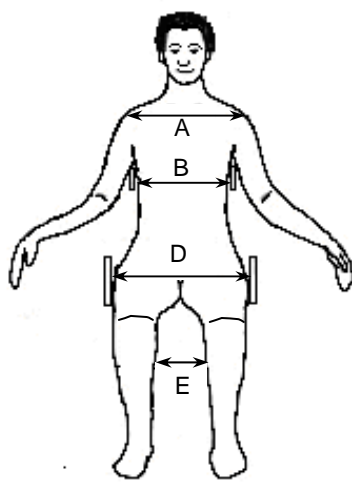
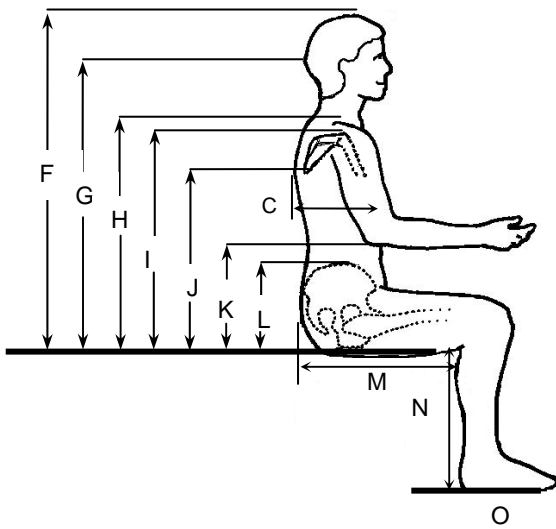
MANUAL WHEELCHAIR  POV  POWER WHEELCHAIR:  POSITIONING SYSTEM(TILT/RECLINE)  SEATING

**Mat Evaluation: (NOTE IF ASSESSED SITTING OR SUPINE)**

	POSTURE:	FUNCTION:	COMMENTS:	SUPPORT NEEDED
<b>HEAD &amp; NECK</b>	<input type="checkbox"/> Functional <input type="checkbox"/> Flexed <input type="checkbox"/> Extended <input type="checkbox"/> Rotated <input type="checkbox"/> Laterally Flexed <input type="checkbox"/> Cervical Hyperextension	<input type="checkbox"/> Good Head Control <input type="checkbox"/> Adequate Head Control <input type="checkbox"/> Limited Head Control <input type="checkbox"/> Absent Head Control <input type="checkbox"/> Tone/ Reflex		
<b>U P P E R E X T R E M I T Y</b>	<b>SHOULDERS</b> <b>Left</b> <b>Right</b> <input type="checkbox"/> WFL <input type="checkbox"/> WFL <input type="checkbox"/> elev / dep <input type="checkbox"/> elev / dep <input type="checkbox"/> pro / retract <input type="checkbox"/> pro / retract <input type="checkbox"/> subluxed <input type="checkbox"/> subluxed	<b>R.O.M.</b>  <b>Strength:</b>  <b>Tone/Reflex:</b>		
	<b>ELBOWS</b> <b>Left</b> <b>Right</b> <input type="checkbox"/> Impaired <input type="checkbox"/> Impaired <input type="checkbox"/> WFL <input type="checkbox"/> WFL	<b>R.O.M.</b>  <b>Strength:</b>  <b>Tone/Reflex:</b>		
<b>WRIST &amp; HAND</b>	<b>Left</b> <b>Right</b> <input type="checkbox"/> Impaired <input type="checkbox"/> Impaired <input type="checkbox"/> WFL <input type="checkbox"/> WFL	<b>Strength / Dexterity:</b>		
<b>T R U N K</b>	<b>Anterior / Posterior</b>  <input type="checkbox"/> WFL <input type="checkbox"/> ↑ Thoracic Kyphosis <input type="checkbox"/> ↑ Lumbar Lordosis  <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other	<b>Left Right</b>  <input type="checkbox"/> WFL <input type="checkbox"/> Convex Left <input type="checkbox"/> Convex Right  <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other	<b>Rotation</b>  <input type="checkbox"/> Neutral <input type="checkbox"/> Left Forward <input type="checkbox"/> Right Forward  <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other	

	<b>Anterior / Posterior</b>	<b>Obliquity</b>	<b>Rotation</b>	
--	-----------------------------	------------------	-----------------	--

<b>P E L V I S</b>	 <input type="checkbox"/> Neutral <input type="checkbox"/> Posterior <input type="checkbox"/> Anterior	 <input type="checkbox"/> WFL <input type="checkbox"/> Left Lower <input type="checkbox"/> Rt. Lower	 <input type="checkbox"/> WFL <input type="checkbox"/> Right <input type="checkbox"/> Left		
	<input type="checkbox"/> Fixed <input type="checkbox"/> Other <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Flexible	<input type="checkbox"/> Fixed <input type="checkbox"/> Other <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Flexible	<input type="checkbox"/> Fixed <input type="checkbox"/> Other <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Flexible		
<b>H I P S</b>	<b>Position</b>  <input type="checkbox"/> Neutral <input type="checkbox"/> ABduct <input type="checkbox"/> ADduct	<b>Windswept</b>  <input type="checkbox"/> Neutral <input type="checkbox"/> Right <input type="checkbox"/> Left	<b>Range of Motion</b>  <b>Left</b> Flex: _____° Ext: _____° Int R: _____° Ext R: _____°	<b>Right</b> Flex: _____° Ext: _____° Int R: _____° Ext R: _____°	
	<input type="checkbox"/> Fixed <input type="checkbox"/> Subluxed <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Dislocated <input type="checkbox"/> Flexible	<input type="checkbox"/> Fixed <input type="checkbox"/> Other <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Flexible			
<b>K N E E S &amp; F E E T</b>	<b>Knee R.O.M.</b> <u>Left</u> <u>Right</u> <input type="checkbox"/> WFL <input type="checkbox"/> WFL <input type="checkbox"/> Flex _____° <input type="checkbox"/> Flex _____° <input type="checkbox"/> Ext _____° <input type="checkbox"/> Ext _____°	Strength:  Hamstring ROM Limitations: (Measured at _____° Hip Flex) Left _____    Right _____  Orthosis? Prosthetic?	<b>Foot Positioning</b> <input type="checkbox"/> WFL <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Dorsi-Flexed <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Plantar Flexed <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Inversion <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Eversion <input type="checkbox"/> L <input type="checkbox"/> R	Foot Positioning Needs:	
<b>M O B I L I T Y</b>	<b>Balance</b> Sitting Balance:    Standing Balance <input type="checkbox"/> WFL <input type="checkbox"/> WFL <input type="checkbox"/> Min Support <input type="checkbox"/> Min Support <input type="checkbox"/> Mod Support <input type="checkbox"/> Mod Support <input type="checkbox"/> Unable <input type="checkbox"/> Unable	<b>Transfers</b> <input type="checkbox"/> Independent <input type="checkbox"/> Min Assist <input type="checkbox"/> Max Asst <input type="checkbox"/> Sliding Board <input type="checkbox"/> Lift / Sling Required	<b>Ambulation</b> <input type="checkbox"/> Unable to Ambulate <input type="checkbox"/> Ambulates with Assistance <input type="checkbox"/> Ambulates with Device <input type="checkbox"/> Independent without Device <input type="checkbox"/> Indep. Short Distance Only		



**Neuro-Muscular Status:**

Tone:

Reflexive Responses:

Effect on Function:

**Measurements in Sitting:                      Left    Right**

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

Additional Comments and please add Trunk and Pelvic width with brace/ Orthosis, when applicable.

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**\*\*** 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):

<input type="checkbox"/> Physical Therapy license	License #	<input type="text"/>
<input type="checkbox"/> Occupational Therapy license		<input type="text"/>
<input type="checkbox"/> Psychiatrist board certification		<input type="text"/>

\_\_\_\_\_  
**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:** \_\_\_\_\_





Charlie Crist  
Governor

Holly Benson  
Secretary

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