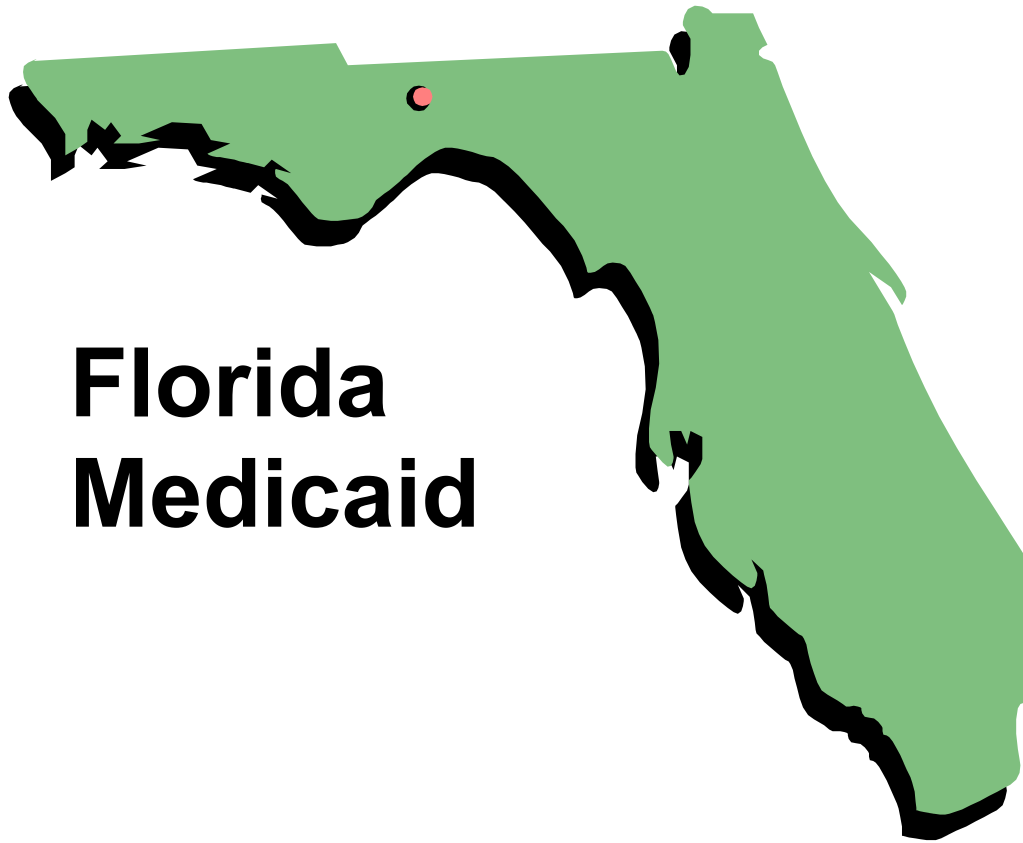

Durable Medical Equipment and Supply Services Coverage Policy: Enteral and Parenteral Nutrition

Agency for Health Care Administration
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Incorporated by reference in
Rule 59G-4.077

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1.0 Introduction

Florida Medicaid nutritional durable medical equipment and supply (DME) services provide medically necessary equipment, supplies, or nutrition for metabolic support of eligible recipients.

1.1 Florida Medicaid Policies

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

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

1.2 Statewide Medicaid Managed Care Plans

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

1.3 Legal Authority

Florida Medicaid DME services are authorized by the following:

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

1.4 Definitions

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

1.4.1 Certificate of Medical Necessity (CMN)

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

1.4.2 Claim Reimbursement Policy

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

1.4.3 Coverage and Limitations Handbook or Coverage Policy

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

1.4.4 Enteral

A way to provide nutrition through a tube placed in the nose, stomach, or small intestine.

1.4.5 General Policies

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

1.4.6 Medically Necessary/Medical Necessity

As defined in Rule 59G-1.010, F.A.C.

1.4.7 Parenteral
A way to provide nutrition other than through the mouth or alimentary canal, usually intravenously or by injection.

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

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

2.0 Eligible Recipient

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

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

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

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

3.0 Eligible Provider

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

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

- Durable medical equipment and supply services businesses fully licensed in accordance with Chapter 400, F.S.
- Home health agencies fully licensed in accordance with Chapter 400, F.S.
- Pharmacies fully licensed in accordance with Chapter 465, F.S.

4.0 Coverage Information

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

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

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

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

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

4.2.1 Nutrition

Florida Medicaid covers the following nutritional services for recipients with a medical condition(s) that prevents adequate nutrition from being obtained through regular food and beverage.

- Orally ingested formulas
- Enteral and parenteral formulas

4.2.2 Enteral and Parenteral Infusion Pumps

Florida Medicaid covers enteral and parenteral pumps and infusion supplies.

- Infusion and feeding supply kits must include a one-month supply of all items needed for initiation of use. The infusion and feeding supply kit include, but are not limited to:
  - Alcohol and betadine wipes
  - Destruclip box
  - Dressing Kits
  - Injection cap
  - Miscellaneous supplies necessary to operate the device
  - One and two inch dermiclear tape
  - One quart sharps container

4.2.3 Maintenance and Repair

Florida Medicaid covers maintenance and repairs of DME that meets all of the following criteria:

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

4.2.4 Used and Refurbished Equipment

Florida Medicaid reimburses for used and refurbished DME that meets all of the following:

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

4.3 Early and Periodic Screening, Diagnosis, and Treatment

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

5.0 Exclusion

5.1 General Non-Covered Criteria

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

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

5.2 Specific Non-Covered Criteria

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

- Commercially available food products, including food thickeners, baby food, and those used for food allergies (e.g., lactose or gluten intolerance) or metabolic disorders
- Enteral and parenteral nutritional DME or medical supplies provided to recipients ages 21 and over residing in institutional settings (e.g., skilled nursing facilities)
- Items listed or identified in a procedure code's description that are billed separately
- Products that are used for the following:
  - Replacing fluids and electrolytes
  - Bodybuilding, athletic performance enhancement, or weight reduction
- Repairs and maintenance of rental equipment, separately
- Shipping, handling, labor, measuring, fitting, or adjusting, separately
- Specially modified medical foods
- Travel time and repair assessment time

6.0 Documentation

6.1 General Criteria

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

6.2 Specific Criteria

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

- Equipment and supply delivery, pick-up, and return documentation
- Florida Medicaid-covered DME must include manufacturer's or one-year warranty, whichever is greater
- Recipient training documentation
- Rental equipment maintenance and repairs
- Used equipment documentation, including:
  - Signed agreement with recipient, acknowledging receipt of used equipment
  - Documentation of redetermination of medical necessity or services or reauthorization
  - Requests for reorder of supplies and enteral formulas by recipient or caregiver

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

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

- When applicable, documentation for redetermination of medical necessity or reauthorization of services

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

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

7.0 Authorization

7.1 General Criteria

The authorization information described below is applicable to the fee-for-service delivery system. For more information on general authorization requirements, please refer to Florida Medicaid's Authorization Requirements Policy.

7.2 Specific Criteria

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

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

8.0 Reimbursement

8.1 General Criteria

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

8.2 Claim Type

Professional (837P/CMS-1500)

8.3 Billing Code, Modifier, and Billing Unit

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

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

8.4 Diagnosis Code

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

8.5 Rate

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

8.5.1 By-Report Claims

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

Providers must submit all of the following to the Florida Medicaid QIO:

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

8.5.2 Maintenance and Repair

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

8.5.3 Rental Equipment

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

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

8.5.3.1 Enteral and Parenteral Infusion Pumps

Florida Medicaid bundles payment for all supplies necessary to operate enteral and parenteral infusion pumps into the rental amount, which include the following:

- Alcohol and betadine wipes
- Destruclip box
- Dressing Kits
- Injection cap
- Miscellaneous supplies necessary to operate the device
- One and two inch dermiclear tape
- One quart sharps container

8.5.4 Used and Refurbished Equipment

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

- The provider's usual and customary fee for new equipment
- The maximum rate on the applicable fee schedule
- Florida Medicaid reimburses for refurbished equipment at 100% of the maximum rental fee on the applicable fee schedule.