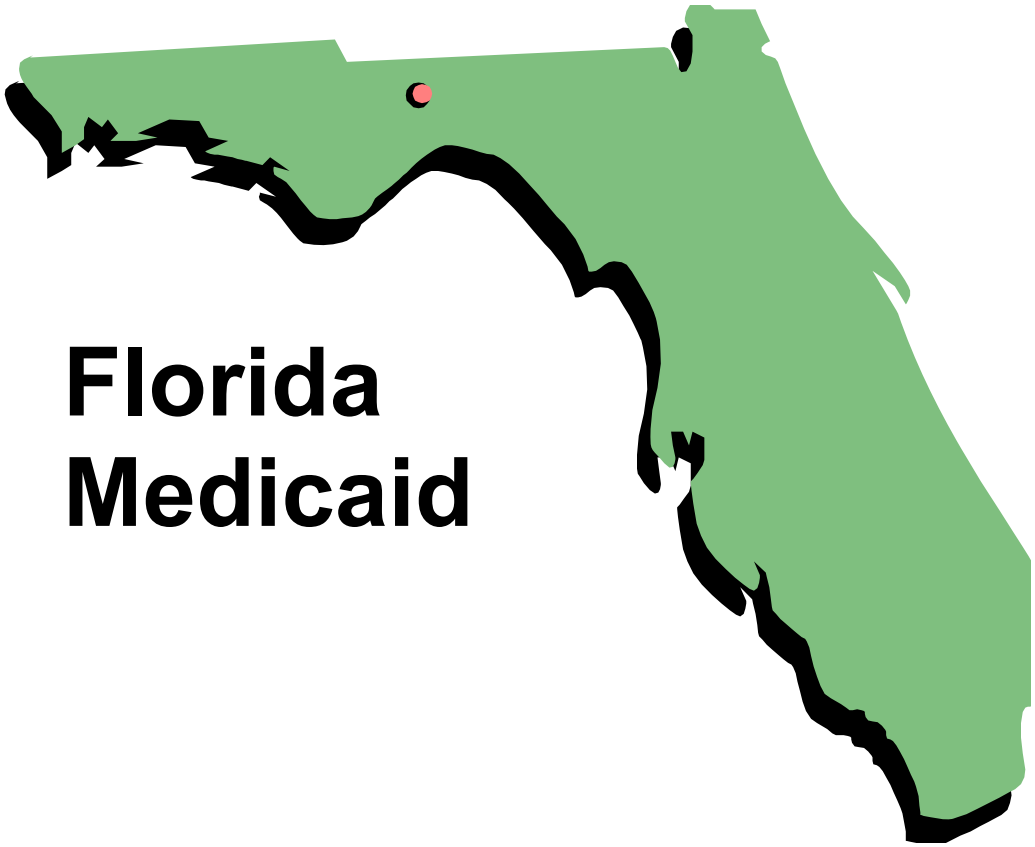

Florida Medicaid

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

Agency for Health Care Administration

Table of Contents

1.0 Introduction

Florida Medicaid enteral and parenteral nutrition durable medical equipment and medical supply (DME) services provide formulas, equipment, or supplies to recipients with digestive and metabolic conditions to sustain the recipient at home or in the community.

1.1 Florida Medicaid Policies

This policy is intended for use by providers that render enteral and parenteral nutrition 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) Web site 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)
- Title 42, Code of Federal Regulations (CFR)
- 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 Claim Reimbursement Policy

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

1.4.2 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.

1.4.3 Enteral

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

1.4.4 General Policies

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

1.4.5 Medically Necessary/Medical Necessity

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

1.4.6 Parenteral

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

1.4.7 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.

1.4.8 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 enteral and parenteral nutrition 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 enteral and parenteral nutrition 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 the following 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:

- Enteral formula and medical supplies:
  - For recipients of any age when using the product as a sole source of nutrition

  - For recipients under the age of 21 years when using the product as 50% or more of the recipient's caloric intake
- Enteral and parenteral pumps and infusion supplies
- Equipment maintenance and repair
- Rental and rent-to-purchase equipment
  - Up to the total of ten monthly claims for rent-to-purchase equipment

  Durable medical equipment and medical supplies provided under a rent-to-purchase agreement between the provider and a recipient becomes the personal property of the recipient at the end of the lease.

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:

- Food products, including food thickeners, baby food, and those used for food allergies (e.g., soy based or gluten free)
- 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, replacement, and maintenance of any equipment in cases of misuse, abuse, neglect, loss, or wrongful disposition of equipment by a recipient, a recipient's legal representative, responsible caregiver, or provider
- 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 Policy.

6.2 Specific Criteria

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

- Certificate of Medical Necessity that meets the following requirements:
  - Specifies the type of DME prescribed

  - Is less than 12 months old
  - Is dated within 21 days after the initiation of service
- Current hospital discharge plan that clearly describes the type of DME item or service ordered
- Written prescription

The documentation must be individualized and specify all of the following:

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

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

- Equipment and supply delivery, pick-up, and return documentation
- Recipient training documentation
- Rental equipment documentation
- Replacement of stolen or destroyed equipment documentation
- Used equipment documentation

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 as follows:

- When indicated on the applicable Florida Medicaid fee schedule(s)
- For non-classified procedure codes
- To exceed the coverage limits specified in section 4.0 for recipients age 21 years or older

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 Web site at http://ahca.myflorida.com/Medicaid/review/index.shtml.

8.5.1 By Report Claims

Providers must submit medical necessity and product or service documentation to AHCA for pricing.

8.5.2 Rental Equipment

Florida Medicaid reimburses for rental equipment at the prorated daily amount of the monthly rate, per day.

8.5.3 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.