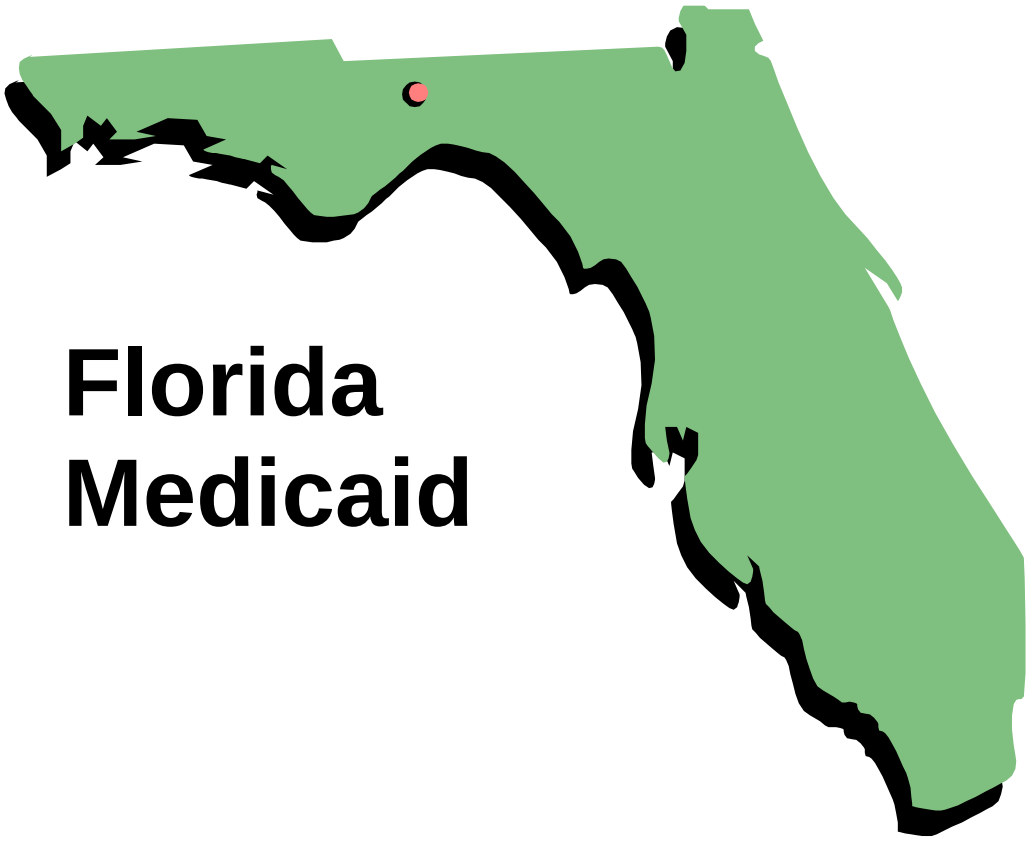

Florida Medicaid

Durable Medical Equipment and Medical Supply Services Coverage Policy: Orthotic and Prosthetic

Agency for Health Care Administration

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Incorporated by reference
in Rule 59G-4.073

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1.0 Introduction

Florida Medicaid orthotic and prosthetic durable medical equipment and medical supply (DME) services provide medically necessary orthotic and prosthetic devices to recipients by replacing a missing body part, preventing or correcting a deformity or malfunction, or supporting a weak or deformed body part.

1.1 Florida Medicaid Policies

This policy is intended for use by providers that render orthotic and prosthetic 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 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 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.

1.4.7 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 orthotic or prosthetic 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 orthotic or prosthetic 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.
- Orthotists, pedorthists, or prosthetists licensed in accordance with Part XIV of Chapter 468, F.S.
- Orthopedic physicians' groups primarily owned by physicians and fully licensed in accordance with Chapter 458 or 459, F.S.
- Optometrists fully licensed in accordance with Chapter 463, F.S. and working within the scope of their practice
  - Optometrists may only provide prosthetic eyes.
- Opticians fully licensed in accordance with Chapter 484, F.S. and working within the scope of their practice
  - Opticians may only provide prosthetic eyes.
- 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 orthotic and prosthetic durable medical equipment 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.

Recipients under the age of 21 years residing in a skilled nursing facility may receive customized orthotic and prosthetic devices through this benefit.

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

Florida Medicaid providers are responsible for all needed adjustments, modifications, and replacements for the first six months after the date of delivery.

4.2.1 Dynamic Splinting Devices

Must include all of the following components:

- Center bar
- Hinged and rotational joints
- Shoes and shoe assembly

4.2.2 Orthopedic Footwear

Florida Medicaid covers foot orthotics for congenital forefoot deformities in recipients under the age of 18 months, unless the orthotics are determined medically necessary for an older recipient who is not yet walking.

Includes the following:

- Heels
- Miscellaneous
- Orthopedic shoes
- Shoe modifications
- Wedges

Florida Medicaid covers prefabricated and custom orthopedic footwear when the recipient meets one of the following criteria:

- Congenital or rigid foot deformities
- One foot is not full size
- Totally or partially missing foot
- Shoe is required in conjunction with an orthotic system
- The recipient's foot or feet have severe structural deformities (e.g., rheumatoid arthritis, diabetic osteopathy or arthropathy, or following trauma)
- There are persistent skin breakdowns or ulcerations caused by such conditions as diabetic neuropathies or degenerative disorders when a total contact system on the sole is expected to promote healing and avoid hospital care and surgical interventions

Orthopedic footwear must have at least one of the following components:

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

- Thomas heel

4.2.3 Orthotic and Prosthetic Devices

Florida Medicaid covers splints and passive motion devices, which includes sheepskin pads.

4.2.4 Orthotic and Prosthetic Equipment

Includes the following:

- Breast prostheses
- Diabetic shoes and modifications
- Prosthetic eyes (including measuring and fitting)
  - Florida Medicaid covers prosthetic eyes when replaced as a result of no longer fitting or damage.

4.2.5 Maintenance and Repair

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

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

Florida Medicaid covers repairs for artificial larynxes.

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:

- Adjustments, modifications, and replacements of orthotic and prosthetic devices during the first six months following delivery, reimbursed separately
- Orthotic and prosthetic DME or medical supplies provided to recipients ages 21 and over residing in institutional settings (e.g., skilled nursing facilities)
- Items included in a procedure code's description that are billed separately
- Non-prescription shoe inserts
- Orthotic footwear or orthotic or prosthetic devices that do not fit
- Orthopedic footwear for recipients with the following conditions:
  - Flexible flat feet
  - Toe-in or toe-out problems if no specific foot deformity is present
  - Torsional problems of the extremities without the presence of a brace

- Personal comfort, convenience, hygiene, or sanitation items
- Shipping, handling, labor, measuring, fitting, or adjusting, separately
- Travel time and repair assessment time

6.0 Documentation

6.1 General Criteria

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

6.2 Specific Criteria

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

- 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

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

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

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

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

6.2.1 Orthotic and Prosthetic Device Criteria

Providers must maintain records of measurements taken and device fittings for the recipient in addition to the criteria specified above.

6.2.2 Orthopedic Footwear

Providers must maintain records of measurements taken and device fittings for the recipient in addition to the criteria specified above.

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 artificial larynx repairs
- 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 Orthopedic Footwear
Florida Medicaid reimburses for a second, smaller pair of orthotic shoes at up to 75% of the maximum fee of the larger pair for recipients with substantial size differences between feet. The claim for the smaller pair must be billed using the appropriate procedure code, and both pairs of orthopedic footwear must be billed on the same claim form.

8.5.3 Orthotic and Prosthetic Devices
Unit limits as specified on the applicable fee schedule apply to both single and bilateral needs.

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