RON DESANTIS
GOVERNOR

SHEVAUN L. HARRIS
ACTING SECRETARY

February 8, 2021

Statewide Medicaid Managed Care (SMMC) Policy Transmittal: 2021-04

Applicable to the **2018-2023 SMMC contract benefits** for:
- ☒ Managed Medical Assistance (MMA) and MMA Specialty
- ☒ Long-Term Care (LTC)
- ☐ Dental

Re: Durable Medical Equipment and Medical Supplies Benefit

The managed care plan must provide the services identified in Attachment II, and its Exhibits in accordance with the Florida Medicaid State Plan, the applicable federal waivers, as well as the Florida Medicaid promulgated rules in Chapter 59G-4, F.A.C., that include the Florida Medicaid Coverage and Limitations Handbooks, Florida Medicaid Coverage Policies, and services listed in the associated Florida Medicaid fee schedules, except where the provisions of this Contract or the applicable federal waivers alter the requirements set forth in the Handbooks, Coverage Policies, and Medicaid fee schedules. (Attachment II, Section VI.A.1.e.) The purpose of this policy transmittal is to provide the managed care plan with requirements for posting of detailed information for the durable medical equipment and medical supplies (DME) benefit.

Posting Covered DME Services and Codes Online:

The managed care plan must make publicly available at the managed care plan's website a listing of each covered service provided by the plan under the DME benefit, along with the specific procedure code(s) accepted by the managed care plan for claims and provider payment. Additionally, the managed care plan must provide in the list of covered DME benefits all services covered under miscellaneous procedure codes that are not listed on the Florida Medicaid DME fee schedule.

The managed care plan providing both Managed Medical Assistance and Long-Term Care benefits must post separate lists of covered DME services and specific procedure code(s) accepted by the managed care plan. A direct link to the DME benefit information must be provided to your Agency contract manager by March 10, 2021. The managed care plan must provide thirty (30) days' advanced notice to DME providers of changes to its permissible DME procedure codes.

DME Services Pricing:

The managed care plan that bases reimbursement of DME services on the Agency's fee schedule must ensure rates are developed for procedure codes with a rate of 0.00 on the Agency's fee schedule. The managed care plan must cover and reimburse for all services listed on the DME fee schedule, including those that do not have an assigned rate. The Agency conducted manual pricing when no maximum fee ($0.00) was listed for items on the 2019 Medicaid DME and Medical Supply Services Provider Fee Schedule. The Agency revised the 2020 Medicaid DME and Medical Supply Services Provider Fee Schedule to replace $0.00 items with MP (manually priced), BC (bundled code), or BR (by report) to indicate manual pricing is required.

The managed care plan must have a process in place for determining the appropriate reimbursement for bundled codes listed in the Medicaid DME and Medical Supply Services

Provider Fee Schedule. In addition, the managed care plan must cover consumable supplies outside of the bundled rate when needed to operate the device (e.g., tubing and masks), even when not listed on the DME fee schedule.

Exceeding the DME Fee Schedule: Coding and Limits
The managed care plan has the flexibility to exceed posted procedure codes and limits detailed on the Agency's DME fee schedule. Correct coding, when available for a specific item, service, or device, may be used by the managed care plan instead of miscellaneous procedure codes (e.g., E1399 or A0990).

Medically Necessary Equipment & Supplies:
The managed care plan must cover medically necessary equipment and supplies required to maintain and use durable medical equipment (such as ventilators), including rental equipment and rent-to-purchase equipment. In addition, the managed care plan may opt to reimburse providers for the purchase of, rather than to rent, DME items listed as rental only on the Medicaid Fee Schedule.

Repair and Maintenance of Equipment:
The managed care plan must cover maintenance and repair services of rent-to-purchase equipment after the rent-to-purchase agreement and the one-year provider warranty have been satisfied. (DME and Medical Supply Services Coverage and Limitations Handbook, page 2-28 through 2-30.)

Customized Wheelchairs:
The managed care plan must cover customized wheelchairs for children and adults. Additionally, the managed care plan must cover customized wheelchairs for enrollees under 21 years of age who reside in a skilled nursing facility. In the fee-for-service delivery system, the Agency requires prior authorization of customized wheelchairs and all accompanying parts. The managed care plan must cover customized wheelchairs for children and adults as listed in the DME and Medical Supply Services Coverage and Limitations Handbook, pages 2-91 through 2-96, and the DME and Medical Supply Services Fee Schedule, including all accompanying parts needed to operate the equipment.

Provider Notice of Billing Changes:
The managed care plan must post DME provider billing instructions on the managed care plan's or billing agent's website by close of business on March 10, 2021. The managed care plan must send providers written notice at least thirty (30) days prior to any change in how DME claims are to be billed, and updated provider billing instructions posted on the managed care plan's or billing agent's website must be available at the time the written notice is sent to providers.

If you have any questions, please contact your Agency contract manager.

Sincerely,

Beth Kidder
Deputy Secretary for Medicaid

BK/dvp