Consumable Medical Supplies and Durable Medical Equipment

Ron DeSantis
Governor
Barbara Palmer
APD Director

This webinar will review the following:

- Medicaid State Plan (MSP) requirements for
  - Consumable Medical Supplies (CMS)
  - Durable Medical Equipment (DME)
- Medicare Coverage and DME

- iBudget Waiver Handbook requirements for
  - Consumable Medical Supplies (CMS)
  - Durable Medical Equipment (DME)
- Transitioning from Medicaid to Waiver

Durable Medical Equipment (DME): What is it?

- Can withstand repeated use
- Used to serve a medical purpose
- Not useful to a person w/out illness or injury
- Appropriate for use in home

Durable Medical Equipment: Medicaid Service criteria

- Medically necessary
- Functionally appropriate
- Adequate for the intended medical purpose
- For conventional use
- For the exclusive use of the client

Consumable Medical Supplies: What are they?

- Medically necessary
- Consumable
- Expendable
- Disposable or non-durable
- Appropriate for home use

Consumable Medical Supplies: Medicaid Service Criteria cont'd

- 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.

Consumable Medical Supplies: Medicaid Service Criteria cont'd

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  - 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.

Consumable Medical Supplies: Waiver criteria

- Supplies covered under the waiver must meet all of the following conditions:
  - Not covered by MSP
  - Meet the definition of medical necessity

Medical Necessity Definition and Documentation Requirements

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.

DME and CMS: Medical Necessity

- For a DME or CMS item to be medically necessary, it must meet the following criteria:
  - Be necessary to protect life, prevent significant illness or disability, or to alleviate severe pain;

DME and CMS: Medical Necessity

- 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;

DME and CMS: Medical Necessity

- Be consistent with generally accepted professional medical standards as determined by the Medicaid program and not experimental or investigational;

DME and CMS: Medical Necessity cont'd

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DME and CMS: Medical Necessity cont'd

- Be furnished in a manner not primarily intended for the convenience of the recipient, recipient's caretaker, or the provider.

DME and CMS: Medical Necessity cont'd

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DME & CMS
WHO PAYS FOR?

g-tubes, pumps, gauze, tape, suction catheters, ventilators, tracheostomy tubes, formula, wheelchairs, ramps, Q-tips, diapers, wipes

Required Documentation

What is needed?

Where to look?

DME and CMS: Medicaid Reimbursement

- Medicaid reimburses for services that
  - do not duplicate another provider's service
  - are determined to be medically necessary

- Documentation of medical necessity must include:
  - type of medical equipment, services or consumable goods ordered
  - including quantity, frequency and length of need ordered or prescribed

DME and CMS: Medicaid Reimbursement cont'd

- Medical necessity must be established for each service and documented, at a minimum, with the following:
  - Written prescription not more than 12 months old; or
  - Current hospital discharge plan; or
  - Certificate of Medical Necessity (CMN) not more than 12 months old; or
  - Plan of care, if home health agency
- All documentation of medical necessity must include the type of equipment, services or consumable goods ordered.

MEDICARE: Part A

- Part A covers DME in some cases.
  - However, this is only if the beneficiary is currently hospitalized or eligible for home health care.
  - If a patient requires home medical supplies based upon an injury or illness while hospitalized, they are then covered under their Medicare Part A insurance

MEDICARE: Part B (medical insurance)

- Part B is part of Original Medicare and covers:
  - Medical services and supplies that are medically necessary to treat your health condition.
  - This can include outpatient care, preventive services, ambulance services, and **durable medical equipment.**

MEDICARE and DME

- Medicare has certain criteria for DME to qualify for coverage:
  - It must be durable (repeatedly used).
  - It must be used for a medical reason in your own home, (okay to use outside your home, too).
  - DME also must be an item that is generally **NOT USEFUL** to someone who is NOT ILL OR INJURED.

MEDICARE and DME: common items

- Here are some common Medicare items:

  - Hospital beds, canes, walkers, crutches and commode chairs
  - Wheelchair and power mobility devices
  - Nebulizers and the medications used in them
  - Home Oxygen equipment and accessories
  - Sleep Apnea devices and accessories
  - Infusion pumps and supplies
  - Blood glucose monitors and test strips for diabetes self-testing
  - Some incontinence products, such as catheters
  - Braces such as Medicare back brace or Medicare knee brace

MEDICARE and DME: exclusions and limitations

- Medicare pays for the basic model of the DME equipment
- Expensive upgrades are the recipient's responsibility
- DME item must be useful/used inside the home
- Modifications to living quarters are not covered
- Medicare may not cover single use items unless the recipient is receiving home health care.

CMS:
Waiver Reimbursement

- Services must not be authorized via Waiver if available from another source.
- WSC's responsibility: check other funding sources like
  - Natural and community supports
  - Third party payer (private insurance)
  - Medicare
  - Other Medicaid programs (State Plan, Managed care)

DME : Waiver Reimbursement

- All equipment must
  - Have direct medical or remedial benefit to the recipient
  - Be necessary to prevent the recipient's institutionalization
- Assessment and prescription required

Aging out from Medicaid State Plan Services to Waiver Services at 21

Age

- Turning 21 years old
- **At least 6 months prior**

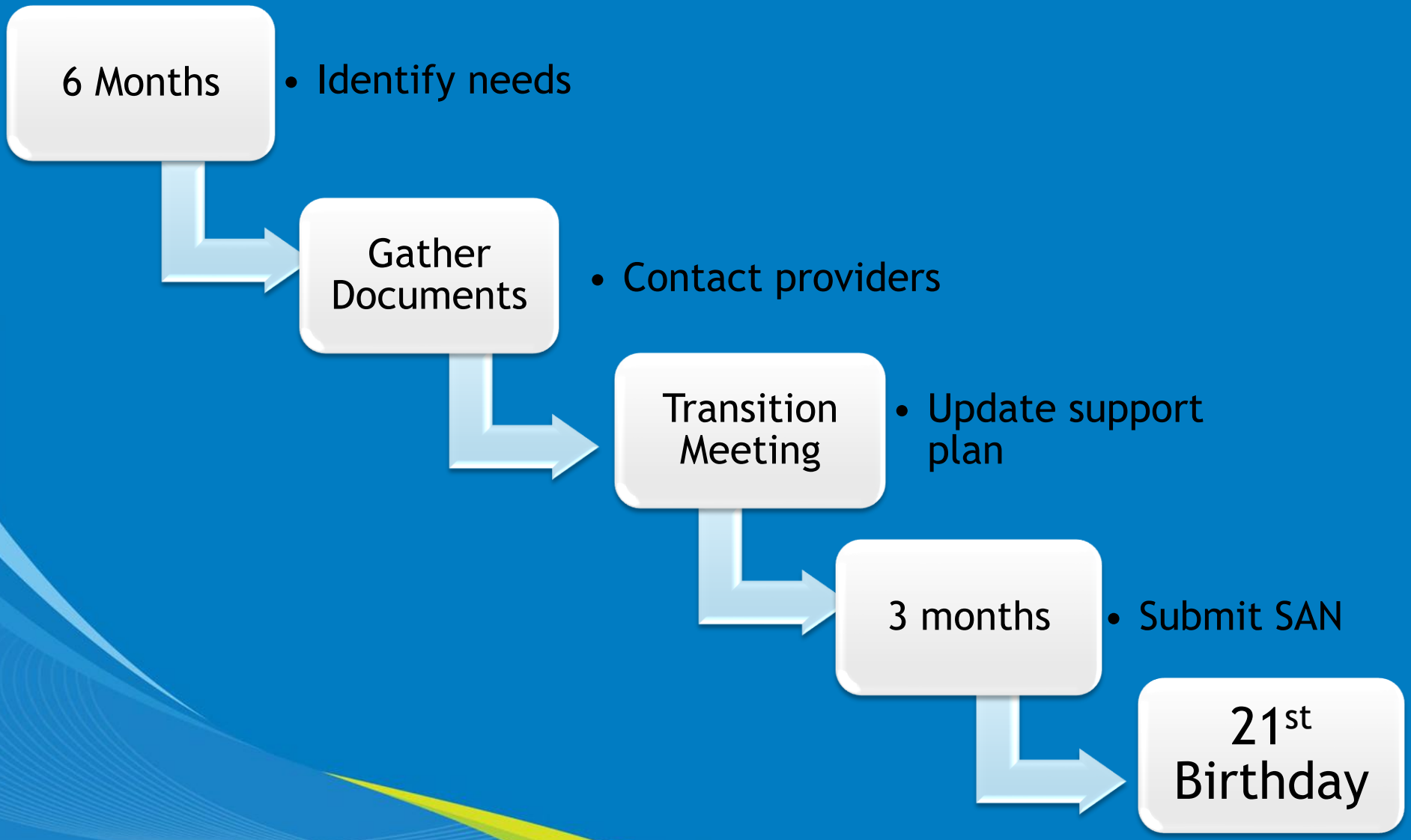
Services

- DME/CMS

What to Know About Transitioning to APD Waiver Services

- Plans and eQHealth Solutions prepare for transition.
- Transition planning occurs every 3 months if an individual resides in a NF.
- DME and CMS should be included in the discussion for transition planning.
  - This includes:
    - What Medicaid will continue to pay for
    - What Waiver and other funding sources will pay for

Best Practice Plan for Transition



General character items vs Waiver

- A prescription for supplies that is generally available to the general public without a prescription does not change the character of the item for purposes of coverage via the Waiver
- Items of general use like deodorant, lotions, cream rinses, creams, ointments are not covered by the Waiver, regardless of whether it was prescribed by the physician

Overages vs Waiver

Key point to remember:

Waiver is the payor of last resort

Overages vs Waiver

- Supplies available under Medicaid state plan cannot be purchased with Waiver funds
- Waiver funds cannot be used to purchase additional quantities of CMS that are above the Medicaid state plan limitation amount except:
  - It is determined that the recipient's health cannot be met within the limits of **INCONTINENCE SUPPLIES** set by Medicaid state plan

Overages vs Waiver

- To request an exception for additional incontinence supplies:
  - A physician, APRN, or physician assistant must prescribe or provide a statement of why the items are medically necessary for the recipient's health and how they are directly related to the recipient's developmental disability.
  - The regional medical case manager must concur before the additional item(s) can be approved.

Suelyn and Duke

Meet Suelyn, she is aging out of Medicaid State Plan

She has a tracheostomy and a g-tube. She is incontinent of bowel and bladder.

She has been receiving the items below from Medicaid state plan (MSP):

- Tracheostomy supplies (ties, collar, and inner cannula)
- Suction cannister and suction catheters
- Sterile water 500ml
- Diapers, wipes, and bed pads
- Formula
- Feeding pump, IV pole, feeding bags, and g-tube extensions

What will Suelyn get from MSP when she ages out?

MSP

- Tracheostomy supplies (ties, collar, and inner cannula)
- Suction cannister and suction catheters
- Formula

What will Suelyn get from APD when she ages out?

APD Waiver

- Diapers, wipes, and bed pads
- Feeding pump
- IV pole
- Feeding bags
- Sterile water

Meet Duke, he's 35 and has been on the APD Waiver for years

He received a colostomy and g-tube 2 years ago. He's due for an annual support plan review and has been receiving the items below from the waiver:

- colostomy supplies
- G-tube extensions
- Diapers, wipes, pads
- Feeding bags, pump, and pole

Meet Duke, he's 35 and has been on the APD Waiver for years

The review will be a partial approval for only those items reimbursed by the Waiver which are:

- Diapers, wipes, pads
- Feeding bags, pump, and pole

The rest:

- colostomy supplies
- G-tube extensions

will need to go through Medicaid

Service Summary

Service Code	4446	Service Level	None
Procedure Code	S5199UC	Service Ratio	None
Unit Type	Each	Provider Type	Agency
		Service Rate	357.00
Current Units	0	Current Allocation	0.00
Annualized Units	0	Current Annualized Amount	0.00
Recommendation	New Request	Stage	WSC
Total # Units Current FY(current + new)	5	New Amount	1785.00
New Annualized Units	12	New Annualized Amount	4284.00

Comments: 6 packs wipes; 4 feeding sets; 30 syringes; 200 sponges; 200 Gauze; Washable Bed Pads

Service Summary

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Unit Type	Each	Provider Type	Agency
		Service Rate	357.00
Current Units	0	Current Allocation	0.00
Annualized Units	0	Current Annualized Amount	0.00
Recommendation	New Request	Stage	WSC
Total # Units Current FY(current + new)	5	New Amount	1785.00
New Annualized Units	12	New Annualized Amount	4284.00

Comments

6 packs wipes per month @ $7.50 each = $45 monthly
4 feeding sets per month @ $28 each = $112 monthly
30 syringes per month @ $2.00 each = $60 monthly
200 drain sponges @ $.10 each = $20 monthly
200 Gauze, sterile 4x4 @ $.50 each = $100 monthly
Washable Bed Pads – 1 per month @ $20 = $20 monthly

AHCA Coverage Policy (Handbooks)

- http://apd.myflorida.com/ibudget/docs/iBudget%20Waiver%20Handbook%20June%202018.pdf
- http://ahca.myflorida.com/medicaid/review/Specific/CL_10_100601_DME_ver1_0.pdf
- https://www.medicare.gov/Pubs/pdf/11045-Medicare-Coverage-of-DME.PDF

Still Need Help?

Local staff assistance can be found through the APD Regional Staff Lists:
http://apdcares.org/region/

- Regional Medical Case Manager
- Regional Clinical Workstream Lead
- Regional Waiver Workstream Lead

Questions?

For more information, contact:

Cheryl Smith
cheryl.smith@apdcares.org

Lori Gephart, RN
lori.gephart@apdcares.org

Sabah Bissainthe, RN
sabah.bissainthe@apdcares.org

Elizabeth Keating
elizabeth.keating@apdcares.org