POLICY AND PROCEDURE

POLICY NAME: LTC (Long Term Care) Durable Medical Equipment (DME)/ Supplies / Orthotics & Prosthetics (O&P) Criteria	**POLICY ID:** LT.UM.10
BUSINESS UNIT: Sunshine State Health Plan	**FUNCTIONAL AREA:** Utilization Management
EFFECTIVE DATE: 05/01/2014	**PRODUCT(S):** Medicaid and Long Term Care
REVIEWED/REVISED DATE: 10/2014, 12/2015, 5/2016; 5/2017, 3/2018, 7/2020, 10/2021, 10/2022, 10/2023	
REGULATOR MOST RECENT APPROVAL DATE(S): Please refer to system of record – Archer	

POLICY STATEMENT:
Sunshine Health's Durable Medical Equipment (DME) and Supplies and Orthotics and Prosthetics (O&P) clinical policy supports the utilization management review process for the LTC benefits described in the Florida Agency for Health Care Administration (AHCA) contract FP060.

PURPOSE:
To establish clinical criteria on which to review requests for Durable Medical Equipment (DME), consumable supplies, Orthotics and Prosthetics (O&P) for Sunshine Health's Long Term Care (LTC) line of business. This applies for members residing in a home and community based environment. The goal of the DME, Supplies, or O&P services is to provide these services in the home to address the member's functional deficits, which may be a result of their medical conditions. The services will assist in maintaining the member in their home and community environment, in a safe manner, to avoid the risk for nursing home placement.

SCOPE: Sunshine Health Medicaid and Long Term Care Utilization Departments and the Long Term Care Case Management Department.
applies to all directors, officers, and employees of Centene Corporation, its affiliates, health plans, and subsidiary companies (collectively, the "Company").

POLICY:
Sunshine Health's Durable Medical Equipment (DME) and Supplies and Orthotics and Prosthetics (O&P) clinical policy supports the utilization management review process for the LTC benefits described in the Florida Agency for Health Care Administration (AHCA) contract FP060.

Description of Covered Services:
The following describes the DME/Supplies and O&P covered services:

Medical Equipment and Supplies Referred to in this policy as DME – Medical equipment and supplies specified in the member's plan of are, include: a) devices, controls, or appliances that enable the member to increase the ability to perform activities of daily living; b) devices, controls or appliances that enable the member to perceive, control or communicate the environment in which he or she lives; c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; d) such other durable and non-durable medical equipment that is necessary to address member functional limitations; e) necessary medical supplies not available under the State Plan f) consumable medical supplies listed on the Florida Medicaid Fee Schedule such as adult disposable diapers and pull-ups. This service included the durable medical equipment under the state plan service as well as expanded medical equipment and supplies coverage under the ACHA contract and applicable waiver. All items shall meet applicable standards of manufacture, design and installation. The service also includes repair of such items as well as replacement parts.

- **Consumable Supplies** – Are absorbent products such as diapers or brief-like garments, underpads or liners used to contain incontinence. These supplies include wipes, gloves and emollients.

- **Orthotic devices** - Are rigid and semi-rigid devices used for the purpose of supporting a weak or deformed body part or restricting or eliminating motion in a disease or injured body part.

- **Prosthetic devices** - Are custom-made artificial limbs or other assistive devices for people who have lost limbs as a result of traumatic injuries, vascular disease, diabetes, cancer or congenital disorders.

Durable Medical Equipment (DME)/ Supplies / Orthotics & Prosthetics (O&P) benefits must be authorized by Sunshine Health and be appropriate for the member. These services are only covered for Sunshine Health members who are eligible or pending eligibility on the date the service is provided.

When the member's physician or case manager identifies which DME / Supplies or O&P items are appropriate for the member, the physician or case manager will follow the Sunshine Health prior authorization process to request a prior authorization as outlined in the Timeliness of UM Decisions and Notifications policy FL.UM.05.00

All requests will be prior authorized and reviewed for medical necessity, as outlined in the Medical Necessity Review and Continuity of Care policy FL.UM.02.01 and Use of Clinical Criteria policy FL.UM.02.

PROCEDURE:

A. Identification of Member Potential Need for DME/Medical Supplies, consumable items or O&P services:

- Initial assessment:

The LTC Care Coordinators are responsible to develop a person-centered care plan and complete an assessment of new LTC members to determine the medical necessity of covered benefits which may meet the member's needs. Both the Department of Elder Affairs Comprehensive Assessment Form 701B and the LTC Supplemental Assessment are completed face to face at the orientation visit and following the timelines established by the Florida Agency for Health Care Administration. At the initial visit, the LTC Care Coordinator completes the 701B and LTC Supplemental Assessments and assists the member in establishing personal goals for community integration while developing the member's person-centered care plan. This information is utilized to identify the specific services and amount of services, which addresses the member's needs to maintain them in the least restrictive environment in a safe manner and to support their desired goals. The LTC Care Coordinator educates and assists member in obtaining the necessary prescription and medical records, which are faxed directly to the Utilization Management Prior Authorization department. If the member already has the documentation to give to the LTC Care Coordinator at the time of the visit, then the LTC Care Coordinator will upload the documents into the member's electronic record (chart) and forward the request to the Utilization Management Prior Authorization department. The LTC Care Coordinator refers the request to the LTC Utilization Management (UM) team. The Utilization Management reviewers access the member record including the member's person-centered care plan, the Department of Elder Affairs Comprehensive Assessment Form 701B, the LTC Supplemental Assessment, and the prescription and medical records to complete a thorough clinical review to make the appropriate determination for member's care that is in line with and supportive of the member's personal goals that are noted on the person centered care plan.

- Ongoing assessment:

The LTC Care Coordinators reassess the member's functional, cognitive, and social needs and informal supports at every contact. This information is used to identify changes in the member's status and if modifications to the member's goal and type of service(s) and/or amount of service(s) in place should be considered and evaluated based on medical necessity of the service(s).

- Annual assessment:

On an annual basis the LTC Care Coordinators will complete an updated Department of Elder Affairs Comprehensive Assessment Form 701B and the LTC Supplemental Assessment on an enrolled LTC member. This information is used to identify changes in the member's goals and in the member's status and if modifications to the type of service(s) and/or amount of service(s) in place should be considered and evaluated based on medical necessity of the service(s) and to be supportive of member's goal.

- Physician identification:

At any time, a physician or other health care professional who is treating the member may identify that the member may benefit from receiving DME/Supplies or O&P services. The treating physician or other health care professional can contact Sunshine Health to request a prior authorization of these services.

If the request for DME/Supplies or O&P services has not been initiated by the member's treating physician or other health care professional and the LTC Care Coordinators identifies the potential need, the LTC Care Coordinators will refer the member to their physician for evaluation and recommendation. The physician will ascertain the member's need based on medical necessity. For skilled DME requests the physician will submit their referral and supporting clinical documentation to an in-network DME provider, who will then submit their authorization request to the health plan. The health plan is available to assist if needed.

B. Medical Necessity Determination

Sunshine Health's utilization management department will respond to physician requests within the timelines as outlined in the policy Timeliness of UM Decisions and Notifications, FL.UM.05.00. Any decision to deny, reduce, suspend or terminate services must be made by a Sunshine Health Medical Director as outlined in the policy Use of Clinical Criteria FL.UM.02.00

1. Durable Medical Equipment (DME), Supplies, Orthotics and Prosthetics

Sunshine Health's Utilization Management Department will use the Interqual© criteria or other criteria in the DME and O&P Criteria policy CP.MP.107 If the DME/Supplies or O&P item requested is not covered by criteria in that policy, the following criteria will be used:

- Medical Necessity Review and Continuity of Care policy FL.UM.02.01
- Agency for Healthcare Administration, Durable Medical Equipment and Medical Supplies Coverage and Limitations Handbook
- Current AHCA Medicaid contract

To assist in determining the medical necessity of any DME/supply or O&P, the clinical criteria established in this policy will be applied.

2. Incontinence Supplies

Prior authorization is required for diapers, gloves, perineal wipes, emollients and absorbent products used to manage incontinence in individuals covered by Sunshine Health LTC product. Coverage determinations are based on an assessment of the individual's unique clinical needs as documented in the clinical information submitted by the requesting provider and/or the current 701B assessment completed by the LTC Care Coordinators. The 701B assessment is used to identify the member's level of incontinence, functional status as measured through Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL), and level of caregiver support.

Sunshine Health does not require a physician's prescription to review, approve or deny a request for standard incontinence supplies found on the Florida Medicaid Fee Schedule. Sunshine Health covers items for LTC members listed on the fee schedules for Medicaid Recipients "Under the Age of 21 Years" and "All Medicaid Recipients", even when the member is over the age of 21. Diapers, gloves, perineal wipes, emollients and absorbent products may be considered medically necessary in the management of incontinence associated with a broad range of medical conditions including, but not limited to neurological conditions, congenital anomalies, injuries to the pelvic region, injuries to the spinal cord, fistula, bowel prolapse and infections. Consideration is always given to the unique needs of a given individual.

Criteria to support need for incontinence products

Upon review of the 701B assessment, Sunshine Health will consider but is not limited to the following:

- Member must have current incontinence of the bladder and/or bowel; and/or
- Member must have one of the following limitations in their Activities of Daily living:
  Using the bathroom (toileting, hygiene, cleaning) and/or Walking/Mobility and/or Transferring:
  - Needs supervision or prompt
  - Needs assistance without a caregiver
  - Needs assistance with a caregiver
  - Needs total assistance without a caregiver
  - Needs total assistance with a caregiver

Sunshine Health may approve up to the amount allowed on the Medicaid fee schedule depending on the member's level of incontinence.

The clinical reviewer takes into consideration the individual needs of the member, which includes assessment and identification of the individual's specific medical, mobility and psychosocial needs. The assessment includes the frequency in which a member may need an incontinence diaper/brief changed and considers the health and lifestyle of the member wearing them. An independent individual with limited functional deficits may be able wear an incontinence

diaper/brief longer than someone who is frail and bedridden. Most adults with incontinence need to change their diaper between 5-8 times a day.

Diapers/briefs should be changed as soon as they become soiled or wet. If a bedbound individual does not wet diapers or briefs often, or has small leakage, consideration may be given to alternating between pads and diapers. The frequency and volume of urinary and bowel incontinence should be identified in order to select the appropriate type and amount of incontinence supplies. The goal is promote skin integrity. The impact of a brief allowing good air circulation, must be considered as this can lead to skin irritation and rashes.

Pull on briefs are appropriate when there is the presence of a medical condition causing bowel/bladder incontinence and the member is able to care for his/her toileting needs independently or with minimal assistance from a caregiver. Factors such as cognitive impairment, dementia and high fall risk are also taken into consideration. The criteria for Pull on briefs includes:

- Presence of a medical condition causing bowel/bladder incontinence, and one of the following:
    - The member would not benefit from a bowel/bladder program but has the cognitive ability to independently care for his/her toileting needs, or
    - The member is actively participating and demonstrating definitive progress in a bowel/bladder program.

Limitations:

Brand name supplies generally are not covered. Requests for brand name supplies must be accompanied by a prescription and supporting clinical information from the ordering provider.

- Diapers and pull-up briefs — for the member using both diapers and pull-on briefs, the combined total quantity of these items cannot exceed the benefit limit under the Florida Medicaid Fee Schedule.
- Diapers of different sizes — for a beneficiary using a combination of different sized diapers, the total quantity must not exceed the benefit limit under the Florida Medicaid Fee Schedule.
- Incontinence wipes — only covered for times when member is away from home. This supply is limited to the benefit limit under the Florida Medicaid Fee Schedule.

B. Referral and Authorization Process

Sunshine Health has timeframes in place for practitioners and providers to notify Sunshine Health of a service request and for Sunshine Health to make utilization management (UM) decisions and notifications to the enrollee, practitioner, and provider in a timely manner. See policy Timeliness of UM Decisions and Notifications Policy FL.UM 05.00

The Sunshine Health Utilization Management staff will process requests for authorizations regarding the DME/Supplies or O&P services for LTC members and make decisions following a standardized process and time period. (See Timeliness of UM Decisions and Notifications Policy)

All requests for LTC DME/Supplies or O&P services will be reviewed against criteria as indicated in this policy. If the requested DME/Supplies or O&P service(s) meet the criteria the service(s) will be approved, and an authorization communicated back to the requesting provider and member. If the request does not meet the established criteria, the request will be sent to a Sunshine Health Medical Director for review. If services are reduced, denied, terminated, or suspended by the Medical Director, communication of the denial will be sent to the requesting provider and member. See Processing Utilization Management Requests and Documentation policy FL.UM.06.00

- The time and date of receipt for any request for review of a service is documented in the Sunshine Health clinical management system. For fax requests, if the request was sent via fax, the date/time of the request field must be reconciled to the date/time stamp on the fax.
- If the request was received via Filenet/ CDMS, the date/ time of the line item request field must be reconciled to match the “Received by Centene” date/ time stamp on the document.

The receipt date and time of authorization request is located in the clinical management system.

C. Coordination of Benefits

Determination of who is responsible to pay for services for a comprehensive member which is a member enrolled in the Long Term Care (LTC) product and also in a Managed Medical Assistance (MMA) product is made by identifying the type of service requested. For any service identified as a mixed service, the LTC product is responsible for payment of those services, regardless of if the MMA plan is Sunshine Health. Mixed services include:

- Skilled nursing services
- Durable Medical Equipment (DME)
- Therapies in the home (physical therapy, speech therapy, respiratory therapy, occupation therapy, and respiratory therapy)
- Hospice
- Transportation (only for LTC benefits)

The LTC Care Coordinator in collaboration with the LTC UM Team will coordinate all LTC covered mixed services with the applicable vendor(s) collaboration with the applicable MMA plan. The LTC UM Team will follow up with member to verify that services are received and to address any issues with the delivery and or vendor.

REFERENCES:

Medicare Benefit Policy Manual, Chapter 7 -Coverage Home Health Services, (Rev. 265, 01-10-20). https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf. Accessed 07-17-20

Centers for Medicare and Medicaid Services. Medicare Benefit Policy Manual. Chapter 16. General exclusions from coverage. (Rev. 198, 11-06-14). https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c16.pdf. Accessed 07-17-20

Centers for Medicare and Medicaid Services. Medicare Benefit Policy Manual. Chapter 8. Coverage of Extended Care (SNF) Services under Hospital Insurance. (Rev. 261, 10-04-19).https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08pdf.pdf. Accessed 07-17-20

Agency for Healthcare Administration, Standard Contract FPO026, Available at: http://ahca.myflorida.com/medicaid/statewide_mc/model_health_FY18-23.shtml

Agency for Healthcare Administration, Provider General Handbook, Version 1.4, July 2012, http://portal.flmmis.com/FLPublic/Provider_ProviderSupport/Provider_ProviderSupport_ProviderHandbooks/tabId/42/Default.aspx. Accessed 07-17-20.

Agency for Healthcare Administration, Assistive Care Services Coverage and Limitations Handbook, Version 1, July 2010, http://portal.flmmis.com/FLPublic/Provider_ProviderSupport/Provider_ProviderSupport_ProviderHandbooks/tabId/42/Default.aspx. Accessed 07-17-20.

Agency for Healthcare Administration, Durable Medical Equipment and Medical Supplies Coverage and Limitations Handbook, Version 1, July 2010, http://portal.flmmis.com/FLPublic/Provider_ProviderSupport/Provider_ProviderSupport_ProviderHandbooks/tabId/42/Default.aspx. Accessed 07-17-20.

Florida Medicaid Durable Medical Equipment and Medical Supply Services Provider Fee Schedule for Medicaid Recipient's for All Medicaid Recipient's 2022, Accessed 10-6-22 https://ahca.myflorida.com/medicaid/review/fee_schedules.shtml

US Department of Commerce, United States Census Bureau, Florida Quick Facts, Accessed 07-17-20, https://www.census.gov/quickfacts/FL. Accessed 7-20-20

FL.UM.02.01 – Medical Necessity Reviews and Continuity of Care
FL UM.05.00 - Timeliness of UM Decisions and Notifications
FL.UM.02 – Use of Clinical Criteria
CP– CP.MP.107 DME and O&P Criteria
FL.UM.06.00 - Processing Utilization Management Requests and Documentation

ATTACHMENTS: N/A

ROLES & RESPONSIBILITIES: Utilization Management

REGULATORY REPORTING REQUIREMENTS: State review and approval required for any substantial changes and upon request.

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
New Policy	Policy Created	10/26/2014
Annual Review	Update of policy numbers	12/08/2015
Annual Review	Added criteria for incontinence supplies	05/24/2016
Annual Review	Updated LTC case managers to care coordinators; included reference to Use of Clinical Criteria FL.UM.02.	09/22/2017
Annual Review	Revised to add reference to current contract language requirements	03/01/2018
Annual Review	Updated AHCA contract information; updated reference links and policy names and numbers.	07/01/2020
Annual Review	No changes needed	10/13/2021
Annual Review	Grammatical edits, Updated the reference links in the bottom to the most up-to-date ones, and updated the way that providers submit skilled DME requests.	10/20/2022
Annual Review	Updated Footer with policy ID and name Made minor grammatical changes	10/2023

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.