South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Post Office Box 8206
Columbia, South Carolina 29202-8206
www.scdhhs.gov

November 19, 2008

MCO
MHRC

MEDICAID BULLETIN

To: **Local Education Agencies (LEAs)**
Managed Care Organizations and Medical Homes Network

Subject: **I. Clarification of Coverage for Speech Generating Devices (SGDs) – Augmentative Alternative Communication (AACs) Devises**

II. Reimbursement for Health Care Procedure Coding System (HCPCS) Procedure codes Associated with SGDs/AACs

I. Clarification of Coverage for Speech Generating Devices (SGDs) – Augmentative Alternative Communication (AACs) Devices

Effective on or after July 1, 2008, all requests for the purchase of Speech Generating Devices (SGDs) also known as Augmentative Alternative Communication (AAC) Devices for children under age 21 should be forwarded to:

South Carolina Department of Health and Human Services
Attention: Medical Director
Post Office Box 8206
Columbia, South Carolina 29202-8206

To be considered for coverage, the request must include:

1. A detailed description of the beneficiary's communication abilities, communication needs and purpose for an AAC device. This should include an assessment of speech and language abilities related to the beneficiary's speech production status, oral and non-oral language comprehension abilities, current opportunities for communication interactions, and prior intervention history, including specific information related to patient's prior use of an AAC.

2. A description of the beneficiary's cognitive abilities related to the use of augmentative communication components for functional purposes, i.e., beneficiary's alertness, attention span, persistence, orientation, learning ability as relevant to his or her meaningful use of AAC.

3. A description of the beneficiary's cognitive abilities related to the use of augmentative communication components for functional purposes, i.e., beneficiary's alertness, attention span, persistence, orientation, learning ability as relevant to his or her meaningful use of AAC.

4. An assessment of current AAC abilities and specific communication needs - describe the aided low and/or high technology AAC components currently being used in the beneficiary's environment. Also, describe the unaided AAC techniques.

5. A symbol assessment, including performance data per mode and symbol assessed.

6. Summary of beneficiary's physical status, motor capabilities, and specific access abilities.

7. Sensory functioning data regarding the beneficiary's visual and auditory status.

8. Medical justification for the specific communication system prescribed.

II. Reimbursement for Health Care Procedure Coding System (HCPCS) Procedure Codes Associated with SGDs/AACs

Effective on or after October 1, 2008, Local Education Agencies (LEAs) will receive the following reimbursement for the specified Health Care Procedure Coding System (HCPCS) Procedure Codes listed below:

Procedure Code	Procedure Code Description	Modifier	Reimbursement Rate	Units	Frequency
E2500	Speech generating device, digitized speech, using pre-recorded messages, less than or equal to 8 minutes recording time	NU	**340.22**	1	3 Yr
E2500	Speech generating device, digitized speech, using pre-recorded messages, less than or equal to 8 minutes recording time	LL	**34.03**	1	1 Mo

Procedure Code	Procedure Code Description	Modifier	Reimbursement Rate	Units	Frequency
E2500	Speech generating device, digitized speech, using pre-recorded messages, less than or equal to 8 minutes recording time	UE	**255.16**	1	2 Yr
E2502	Speech generating device, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time	NU	**1040.35**	1	3 Yr
E2502	Speech generating device, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time	LL	**104.04**	1	1 Mo
E2502	Speech generating device, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time	UE	**780.27**	1	2 Yr
E2504	Speech generating device, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time	NU	**1,372.36**	1	3 Yr
E2504	Speech generating device, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time	LL	**137.24**	1	1 Mo
E2504	Speech generating device, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time	UE	**1029.25**	1	1 Yr

Procedure Code	Procedure Code Description	Modifier	Reimbursement Rate	Units	Frequency
E2510	Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access	NU	**5,888.38**	1	3 Yr
E2510	Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access	LL	**588.84**	1	1 Mo
E2510	Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access	UE	**4,416.28**	1	3 Yr
E2512	Accessory for speech generating device, mounting system	NU	**M**		
E2599	Accessory for speech generating device, not otherwise classified	NU	**M**		

In the column entitled “Modifier,” the letters **NU** are used to indicate New Equipment, **LL** means Rental (equipment may be converted to purchase), and the letters **UE** mean Used Equipment. (Equipment that was issued on a rental basis and then returned to the provider by the beneficiary is considered used equipment. If the provider reissues this equipment, the **UE** modifier must be used on the MCMN and claim form.)

In the column entitled “Reimbursement Rate”, the letter “M” is used to indicate that the item is Manually Priced. Pricing information must be attached to all requests involving procedure codes that do not have an established Medicaid maximum reimbursement rate. These procedure codes require manual pricing and are identified in the Fee Schedule by the presence of an “M” in the “Payment Rate” column.

A current listing of the available SGDs shown above is also located in Section 4, pages 4-77 and 4-78 of the South Carolina Medicaid DME Provider Manual. The most current version of the DME provider manual is maintained on the SCDHHS web site at **www.scdhhs.gov**.

Prior approval is still necessary and school districts should be aware of the policy requiring medical necessity for durable medical equipment. "Medically necessary" means that the service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. An Individualized Educational Plan (IEP) and medical records of the student/beneficiary must substantiate the need for services and must include all findings and information necessary to support medical necessity.

Additional requests for similar/same equipment previously provided will not be approved under the following circumstances:

1. If previous equipment is operable.
2. If the item is repairable (Repair options should be obtained before item is replaced).
3. If only to obtain a "new" model.
4. If requested as a back-up or for convenience (i.e., because the beneficiary is eligible to receive another one due to the expiration of the time frequency limit of the previous equipment).

In cases where the beneficiary's medical need exceeds the authorized units for medical equipment as specified in the Fee Schedule (whether Medicaid is primary or secondary to other insurance), the documentation must justify the medical need for the additional unit on the MCMN before approval can be requested. This is not an automatic approval process.

A Prior Authorization (DHHS Form 214) for SGDs must be completed and forwarded along with all supporting documentation. The PA form can be found in the forms Section of the DME Provider Manual. Approved devices must be provided prior to the expiration date and billed within one year from the date of service. A copy of the PA and MCMN form is attached for reference.

It is important to note that there are several types of Medicaid and health care coverage; therefore, benefit levels may vary.

Children who are covered by Fee for Service Medicaid or enrolled in a Medical Homes Network (MHN) program will follow the procedure as outlined in this bulletin. For children enrolled with a Medicaid Managed Care Organization (MCO), the LEAs will need to contact the specific managed care company to request coverage for a Speech Generating Device.

Speech Generating Devices are not covered for children enrolled in the Healthy Connections Kids (HCK) program.

Questions regarding this bulletin should be directed to your School-Based Services Program Coordinator at (803) 898-2655. Your continued support and participation in the South Carolina Medicaid program is appreciated.

/s/

Emma Forkner
Director

EF/mhhw

Attachment

Note: To sign up for Electronic Funds Transfer of your Medicaid payment, please go to http://www.dhhs.state.sc.us/dhhsnew/hipaa/index.asp and select "Electronic Funds Transfer (EFT)" for instructions.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM
FOR EQUIPMENT/ SUPPLIES

CERTIFICATION TYPE/DATE: INITIAL / / REVISED / / RECERTIFICATION / /

SECTION A: MUST BE COMPLETED BY PROVIDER:

(1) **Recipient's name:** ______________________________ **Height:**__________**Weight:**____________________

(2) **Recipient's Medicaid # (10 digits):** ______________________**Sex:** __________**DOB:** ____________________

(3) **Date of (telephone/written/fax) order:** ____________________ **Date of service:**__________________________

(4) **Provider's name:** ______________________________ **Provider's DME # / NPI#**______________________

(5) **Provider's signature:** ____________________________**Date:** ______________________________

(6) **Street address:** ________________________________**City:** ______________________________

(7) **State:** ____________________________________ **Zip:** ___________**Local telephone #** ____________

(8) **Print treating/ordering physician's name:** ______________________________**NPI #**__________________

Is additional information attached on separate sheet? _____Yes ____ No (If "yes", enter recipient's name & I.D. Medicaid number on attachment)

(9) SPECIFICALLY LIST ALL PROCEDURE CODES THAT ARE ORDERED BY THE TREATING/ORDERING PHYSICIAN FOR EQUIPMENT ON THE BACK OF THIS FORM.

NOTE: ALL PROCEDURE CODES THAT ARE COVERED, BUT DO NOT HAVE AN ESTABLISHED PRICE, MUST INCLUDE MANUFACTURER PRICE LIST. RECERTIFICATION IS REQUIRED PRIOR TO EXPIRATION OF THE CURRENT CMN/AF FOR RENTAL ITEM (S).

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

(10) Diagnosis codes (ICD-9) __________ **Descriptions):**____

__________ ____

__________ ____

(11) Indicate patient's ambulatory status while performing activities of daily living: ___Non-ambulatory ___Ambulatory, without assistance ___Ambulatory with the aid of a walker or cane, ____Ambulatory, with other assistance as described

____

____

Does the patient have decubitus ulcers? ___Yes___ No. If yes, circle stage(s): I, II, III, or IV. Indicate the wound size(s): _____________

Please describe how this equipment / supply is medically necessary, the benefits to the recipient and how long will it take for the benefit to be evident:

____

____

____

(12) For supplies, please indicate the dressing change required per day, week, month, etc.

____

____

Is additional information attached on separate sheet? ______Yes ______No (If "yes", enter recipient's name & I.D. Medicaid number on attachment

(13) Please indicate the date that the patient was seen for the equipment/supplies ordered: ______________________

(14) Duration of need (maximum of 12 months): ______________________________

(Please indicate duration by months, not to exceed 12. If lifetime use required, enter 12)

I certify that I am the treating/ordering physician identified in Section B of this form. Any statement attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission or concealment of material fact may subject me to civil or criminal liability. Additionally, I certify that the requested equipment/supplies is appropriate for the patient.

(15) PHYSICIAN'S SIGNATURE ______________________________**DATE___/___/___ (SIGNATURE AND DATES STAMPS ARE NOT ACCEPTABLE)**

PHYSICIAN'S NPI # :_______________

PLEASE REFER TO THE MEDICAID CMN POLICY IN THE DME MEDICAID PROVIDER MANUAL.

(DME 001 - Dated 12/01/06) (Rev 01/01//09)

MAIL TO: DEPT. OF HEALTH AND HUMAN SERVICES, P. O. BOX 8206, COLUMBIA, S. C. 29202-8206

PRIOR AUTHORIZATION

1 CLAIM CONTROL NUMBER (DO NOT WRITE IN THIS SPACE)

TYPEWRITER ALIGNMENT
USE CAPITAL LETTERS ONLY

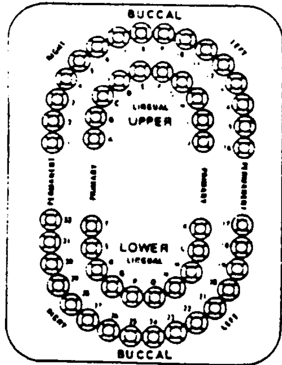
PROVIDER INFORMATION

2 PROVIDERS NAME
3 PROVIDER ID NUMBER
4 OWN REFERANCE #
5 DATE SUBMITTED
6 STREET ADRESS
7 CITY/ STATE/ZIP
8 NAME AND CITY OF MEDICAL PROVIDER
9 PRIOR AUTHORIZATION #

RECIPIENT INFORMATION

10 RECIPIENT NAME (FIRST, MIDDLE INITIAL, LAST)
11 RECIPIENT ID NUMBER
12 SEX
13 BIRTH DATE

Line	SERVICE INDICATOR	SERVICE CODE	MODIFIER	TYPE OF SALE	REQUESTED # BILLINGS	EPSDT REFERRAL	PROPOSED CHARGE	SERVICE NAME	TOOTH #	TOOTH SURFACES	AUTHORIZED	ALLOWED # BILLINGS	DELETE	AUTHORIZED CHARGE	EXPIRATION DATE
1	14	15	16	17	18	19	20	24	25	26	21	22	23	27	28
2	29	30	31	32	33	34	35	39	40	41	36	37	38	42	43
3	44	45	46	47	48	49	50	54	55	56	51	52	53	57	58
4	59	60	61	62	63	64	65	69	70	71	66	67	68	72	73
5	74	75	76	77	78	79	80	84	85	86	81	82	83	87	88



Cross (X) Missing Teeth

89 DOCUMENTATION ATTACHED
90 TOTAL LINES ENTERED
91 TOTAL PROPOSED CHARGES
92 TOTAL AUTHORIZED CHARGES

EXPLAIN MEDICAL NECESSITY FOR EACH PROCEDURE BELOW

X

93 REVIEWED BY (FOR DEPARTMENT USE ONLY)

X

94 PROVIDERS SIGNATURE

DHHS FORM 214 (4/97) Replaces DSS Form 3204 (1-79) which may be used until exhausted.