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POLICIES AND PROCEDURES

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PROGRAM REQUIREMENTS

DME OVERVIEW

The Department of Durable Medical Equipment (DME) at the South Carolina Department of Health and Human Services (SCDHHS) oversees the provision of medical supplies and equipment to eligible Medicaid beneficiaries. If you have questions about policies and procedures and would like to speak with a DME program coordinator, please see Section 5 and the Forms section for contact information.

As defined by SCDHHS, Durable Medical Equipment is equipment that provides therapeutic benefits or enables beneficiaries to perform certain tasks that they are unable to undertake otherwise due to certain medical conditions and/or illness. **This equipment can withstand repeated use, is primarily and customarily used for medical purposes, and is appropriate and suitable for use in the home.** Durable Medical Equipment includes equipment such as wheelchairs, hospital beds, traction equipment, canes, crutches, walkers, ventilators, oxygen, prosthetic and orthotic devices, and other medically needed items.

Providers should be aware of policy regulating medical necessity for durable medical equipment. The SCDHHS policy below describes DME-covered supplies and equipment.

Medicaid will pay for a service or item when the service or item is covered under the South Carolina State Plan, is medically necessary, and is appropriate for use in an eligible beneficiary's home (Please refer to the Fee Schedule in Section 4 for covered services and items).

“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. Convenience and prevention items are not covered. A provider's medical records for each beneficiary must substantiate the need for services and must include all findings and information necessary to support medical necessity.

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PROGRAM REQUIREMENTS

DME PROVIDER ENROLLMENT

A provider must be in compliance with all applicable federal and state licensure and regulatory requirements. Providers must submit all information requested by enrollment including, but not limited to, the type of services provided including a list of equipment/supplies by purchase procedure code. Define the location(s) to be serviced.

In-State Providers

Providers who render services at a physical facility on an appropriate site in South Carolina or within 25 miles of the South Carolina border may enroll as a straight Medicaid provider. An in-state provider can render services for patients who are eligible under fee-for-service (FFS) Medicaid (with or without private pay insurance) and/or are dually eligible (Medicare and Medicaid).

Out-of-State Providers

Providers who render services at a physical facility on an appropriate site outside of the 25-mile radius of the South Carolina border may enroll in the SC Medicaid program as one of the following provider types:

- Crossover only — For patients with Medicare and Medicaid
- Emergency services only — Equipment provided for Medicaid-eligible patients outside of their normal service area. Prior approval is required. Requests are reviewed on a case-by-case basis.
- Sole source provider — Provide specialized equipment and/or supplies to patients that can not otherwise be obtained using an in-state provider. Prior approval is required. Requests are reviewed on a case-by-case basis.

The physical facility must contain adequate space for storing business records including the supplier's delivery, maintenance, and beneficiary communication records. For purposes of this policy, a post office box or a commercial mailbox is not considered a physical facility. In the case of a multi-site supplier, records may be maintained at a centralized location.

Please see the Prior Authorization (PA) section for additional information on obtaining prior approval.

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PROGRAM REQUIREMENTS

Operating Procedures

A provider must fill orders from its own inventory, or must contract with other companies for the purchase of items necessary to fill the order. A provider may not contract with any entity that is currently excluded from the Medicare program, any state health care programs, or from any other federal procurement or non-procurement programs.

A provider must notify beneficiaries of warranty coverage and honor all warranties under applicable state law, and repair or replace free of charge Medicaid-covered items that are under warranty.

A provider must agree not to initiate telephone contact with beneficiaries in order to solicit new business.

A provider is responsible for delivery and must instruct beneficiaries on use of Medicaid-covered items, and maintain proof of delivery.

A provider must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.

A provider must maintain and replace at no charge, or repair directly, or through a service contract with another company, Medicaid-covered items it has rented to beneficiaries. If complaints are filed with SCDHHS, the agency may perform an investigation and/or review of the provider. If the results of this investigation and/or review are unfavorable, SCDHHS will assign the appropriate agency to perform an additional investigation and/or review to establish continuing competency of the provider.

A provider must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.

A provider must disclose these provider standards to each beneficiary to whom it supplies a Medicaid-covered item.

A provider must disclose to the government any person having ownership, financial, or control interest in the provider.

A provider must not convey or reassign a provider number: *i.e.*, the provider may not sell or allow another entity to use its Medicaid billing number.

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PROGRAM REQUIREMENTS

Operating Procedures (Cont'd.)

A provider must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.

Providers must bill their usual and customary charges and not the Medicaid reimbursement rate. Providers may not charge Medicaid any more for services to a beneficiary than they would customarily charge the general public.

Providers must accept the Medicaid payment as payment in full for covered services to patients accepted as Medicaid beneficiaries. (See Section 1, page 17, for additional information.)

Providers must make home visits as necessary on equipment that cannot be brought into the business or regular follow-up on equipment for maintenance when the equipment is under warranty or being rented.

Providers must bill the code that most accurately describes the item or services actually provided.

Providers cannot deny services to any eligible Medicaid member because of the member's inability to pay the copayment amount imposed. (See "Schedule of Copayments" in Appendix 3.)

Providers must not bill for DME items prior to the date of delivery to a member. Keep delivery records including date and signature of delivery person and member or caregiver. (See page 2-15 for additional information on proof of delivery.)

Providers accept responsibility for providing the appropriate equipment/supplies, set-up, or necessary assembly of the equipment in the home and any teaching necessary for correct use of the equipment and/or the supplies according to the manufacturer's directions and SCDHHS's policies and procedures. Providers accept responsibility for any follow-up teaching or monitoring, maintenance, or repair.

For all DME products that are supplied as an ongoing order, the provider must maintain documentation in the

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PROGRAM REQUIREMENTS

Operating Procedures (Cont'd.)

beneficiary's medical record showing they are not automatically shipping supply orders without confirming the number of units needed with the beneficiary or the beneficiary's caregiver.

Provider Agreements – Most providers sign formal participation agreements with SCDHHS. These agreements contain general requirements for all providers as well as specific requirements for each service type. Each claim constitutes an agreement for services provided under the claim.

All providers are responsible for ensuring that information on file with the Medicaid program for their practice or facility remains up-to-date. Refer to “Reporting Changes in Provider Status” in this section.

Enrollment Procedure

The enrollment process takes approximately two to four weeks. However, the process can take longer if supporting documentation from other entities is required. Enrollment periods vary according to provider types. Some enrollment periods are end-dated and require the provider to initiate the re-enrollment process at a specified time by contacting SCDHHS Provider Enrollment.

A provider must provide complete and accurate information on the DME provider application. Any changes to this information must be reported to SCDHHS Provider Enrollment. A provider has 30 days to report a change. After 60 days the provider's number will be terminated.

An authorized individual (one whose signature is binding) must sign the application for billing privileges.

Providers are assigned a provider number and are notified of their provider status by mail once the enrollment process has been completed. Providers are referred to SCDHHS's Web site at <http://www.scdhhs.gov/> Medicaid service information.

Tax Information

To ensure that 1099 MISC forms are issued to providers correctly, proper tax information must be on file for all providers. This will also ensure that the correct tax information is provided to the IRS. The procedure for submitting corrected tax information to the Medicaid program is as follows:

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Tax Information (Cont'd.)

All providers must submit completed and signed W-9 forms along with a completed and signed **Medicaid Provider Change Form** to Medicaid at the address listed below:

Medicaid Provider Enrollment
Post Office Box 8809
Columbia, SC 29202-8809

Providers must also report changes of ownership and group practice changes.

Other Rules That Affect Participation

Civil Rights Act

Providers must comply with the Title VI of the Civil Rights Act of 1964, which states, “No person in the United States shall, on the grounds of race, color or national origin, be excluded from participation under any program or activity receiving federal financial assistance.”

Rehabilitation and Disabilities Act

Providers must comply with the following requirements in addition to the laws specifically pertaining to Medicaid:

- **Section 504 of the Rehabilitation Acts of 1973**, as amended, which states “No otherwise qualified handicapped individual in the United States shall solely by reason of his handicap, be excluded from the participation in, be denied the benefit of, or be subject to discrimination under any program or activity receiving federal financial assistance.”
- **The Age Discrimination Act of 1975**, as amended, which states, “No person in the United States shall, on the basis of age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity receiving federal financial assistance.”
- **The Americans with Disabilities Act of 1990**, which prohibits exclusion from participation in or denial of services because the agency’s facilities are not accessible to individuals with a disability.

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Disclosure of Medicaid Information

The provider must comply with the requirements of the Social Security Act and federal regulations concerning:

1. Disclosure by providers (other than an individual practitioner or group of practitioners) of ownership and control information; and
2. Disclosure of information on a provider's owners and other persons convicted of criminal offenses against Medicare, Medicaid or the Title XIX services program. (*Basic Medicaid Billing Guide, August 2005*)

Rules on Self-Referral

Physician Self Referral

The rules on physician referrals are at 1877 of the Social Security Act (42 USC 1395nn) and in Part 411 of Title 42 of the Code of Federal Regulations. The rules are quite complex, with numerous exceptions.

Other Acts Involving Federal Health Care Programs

The criminal penalties for certain fraudulent acts (including the anti-kickback provisions) involving federal health care programs (including Medicaid) are at §1128B of the Social Security Acts (42 USC §13220a-7b).

Rules of Advance Directives

Section 4751 of the OBRA 1990, otherwise known as the Patient Self-Determination Act, requires certain Medicaid providers to provide written information to all patients 18 years of age and older about their rights under state law to make decisions concerning their medical care, to accept or refuse medical or surgical treatment, and to execute an advance directive (*e.g.*, living will or health care power of attorney). Effective January 1, 1998, a new law entitled "An Act to Establish Advance Instruction for Mental Health Treatment" (NCGS §122C-71-§122C-77) became effective. The law provides a method for an individual to exercise the right to consent to or refuse mental health treatment if the individual later becomes "incapable" (*i.e.*, lacks the capacity or ability to make and communicate mental health treatment decisions). The advance instruction becomes effective when delivered to the individual's physician or mental health treatment provider, who then makes it part of the individual medical record.

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Reporting Changes in Provider Status

What Changes Must Be Reported

All providers are required to report all changes in status to Medicaid. This includes changes of ownership (within 30 days), name, address, tax identification number, licensure status, and the addition or deletion of group members.

Failure to report changes in provider status results in incorrect information in the provider's file. This may prevent or delay payments to the provider, or providers may be liable for taxes on income not received by their business.

How to Report a Change

Provider Enrollment can be reached at 803-788-7622, Extension 41650.

Voluntary Termination

All providers must notify Provider Enrollment in writing at the address listed below of their decision to terminate their participation in the SC Medicaid program. Notification must be on the provider's letterhead and signed by the provider, office manager, or administrator.

Medicaid Provider Enrollment
Post Office Box 8809
Columbia, SC 29202-8809

Termination of Inactive Providers

Medicaid provider numbers that do not reflect any billing activity within the previous 12 months will be terminated. Providers are notified by mail of SCDHHS's intent to terminate their inactive number and will have two weeks to respond if they wish to request that their number not be terminated. These notices are sent to the current mailing address listed in the provider's file. Once terminated, providers are subject to the full re-enrollment process and can experience a period of ineligibility as a Medicaid provider.

Payment Suspension

If RAs and checks cannot be delivered due to an incorrect billing address in the provider's file, all claims for the provider number are suspended and the subsequent RAs and/or checks are no longer printed. Automatic deposits are also discontinued. Once a suspension has been placed on the provider number, the provider has 60 days to submit an address change. After 60 days, if the address has not been

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PROGRAM REQUIREMENTS

*Payment Suspension
(Cont'd.)*

corrected, claims in suspension deny and the provider number is terminated.

*Licensure Revocation or
Suspension*

Any provider whose license(s)/certification is revoked or suspended is not eligible for participation in the SC Medicaid program. In the event that a provider who is licensed should have their license/certification revoked or suspended, the provider should notify Provider Enrollment.

Reactivation in the Medicaid program may occur when the license/certification is reinstated by the licensing authority. The provider must re-enroll and provide a copy of the reactivated license/certification. Reactivation is effective no earlier than the date on the reinstated license.

Sanctions

Providers who receive sanction(s) from CMS are ineligible for Medicaid participation and are responsible for refunding any Medicaid payments made to them while under a CMS sanction(s). CMS will notify SCDHHS of providers who are sanctioned. Individual providers who are sanctioned should notify SCDHHS immediately.

**MEDICAID CERTIFICATE OF
MEDICAL NECESSITY
(MCMN)**

A treating/ordering physician, nurse practitioner with prescribing authority, or physician assistant with prescribing authority has the authority to order the items needed in connection with his or her patient's plan of treatment and to determine the length of time the equipment or supplies will be needed.

The physician assistant should perform the services he or she is legally authorized to perform in the state in which he or she practices in accordance with state law (or the state regulatory mechanism provided by state law), and meet all training, education, and experience requirements.

In order for a provider to be reimbursed for equipment or supplies, a physician, nurse practitioner, or physician assistant must medically justify the need for the requested medical equipment and/or supplies on a Medicaid Certificate of Medical Necessity (MCMN).

There are six versions of the MCMN:

- Equipment/ Supplies (DME 001)
- Power/Manual Wheelchairs and/or Accessories (DME 003)

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MEDICAID CERTIFICATE OF MEDICAL NECESSITY (MCMN) (CONT'D.)

- Orthotics/Prosthetics/Diabetic Shoes (DME 004)
- Enteral Nutrition (DME 005)
- Parenteral Nutrition (DME 006)
- Oxygen (DME 007)

Please refer to the Forms section of this manual for a copy of these forms. Each MCMN has instructions attached.

All applicable fields on the MCMN must be completed and legible. MCMNs that are illegible will be returned to the provider. All corrections to the MCMN must be initialed and dated by the individual responsible for the corrections. Changes to Section A can be made only by the DME provider. Changes to Section B can be made only by the treating or ordering physician.

Any change in the beneficiary's condition, products, or quantities requires a new MCMN.

For equipment/supplies that require a prior authorization (PA), only the date of service field on the MCMN may be completed after the approval is obtained. However, it must be filled in once equipment and supplies are delivered.

All supplies and medical equipment must be specifically identified by procedure code on the MCMN. The provider should refer to the Fee Schedule (Section 4) for a list of procedure codes to enter on the form. All procedure codes listed in the Fee Schedule require a MCMN.

An MCMN can be valid up to a maximum of 12 months from the date the patient was seen for the equipment/supplies prescribed.

DME providers are encouraged to resolve any questions or concerns they have about DME coverage before dispensing the item. If any item ordered appears inappropriate or a potential source of problems, a provider should contact the treating/ordering physician, nurse practitioner, or physician assistant before dispensing for clarification.

All medical documentation supporting the provision of items must be kept on file by the provider. These records are subject to review during on-site visits by SCDHHS. Failure to maintain MCMNs and other appropriate records may subject the provider to recoupment of funds.

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Capped Rental Equipment

The items listed below are considered to be capped rental equipment. These items cannot initially be purchased. A capped rental item is only considered purchased when it has been rented for a maximum of ten months. Capped rental items will have the “LL” modifier in the fee schedule but will not have “NU” or “UE” options with the units/time span being “10 in 5 years.”

E0250 Manual hospital bed with mattress side rails

E0470 Respiratory assist device, bilevel pressure capability without backup rate feature

E0471 Respiratory assist device, noninvasive interface

E0472 Respiratory assist device, invasive interface

E0601 Continuous airway pressure (CPAP) device

E0784 Insulin pump

E0791 Parenteral infusion pump

E0940 Trapeze free stand complete with grab bar

E2000 Gastric suction pump

K0001 Standard manual wheelchair

K0195 Elevating leg rest, pair

The payment categories for codes E0471 and E0472 were revised to move Respiratory Assist Devices from the DME category for frequently serviced items to the DME payment category for capped rental items, effective on August 1, 2006.

Limited Rentals

The following equipment has a limited rental period. Each item will only be rented for four months and must be requested by a Prior Authorization form and accompanied by a Certificate of Medical Necessity. Any pertinent medical records or justification must also accompany this request. Requests for additional months must be resubmitted with a new Prior Authorization, recertified CMN, and progress notes, and will be reviewed on a case-by-case basis. None of these items can be rented over 10 months.

E0372 Powered air overlay mattress

E0277 Power pressure-reducing air mattress

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Limited Rentals (Cont'd.)

E0193 Powered air floatation bed

E0194 Air fluidized bed

E2402 Negative pressure wound therapy electrical pump (See additional criteria on page 34 of this section)

E0747 Osteogenesis stimulator

These items cannot be approved for the purpose of prevention.

The MCMN and Prior Authorization must be sent to the following address:

SC Department of Health and Human Services
Department of Durable Medical Equipment, 12th Fl.
Post Office Box 8206
Columbia, SC 29202-8206

For detailed instructions on completing the MCMN, please refer to Section 3 of this manual.

PRIOR APPROVAL (PA)

Certain services and equipment require prior approval from SCDHHS. For beneficiaries with private third party insurance, the provider must follow DME's guidelines for prior approval. For dually eligible beneficiaries, DME will follow Medicare's guidelines for procedure codes that are deemed not medically justified or not covered by Medicare.

Services and equipment requiring prior approval are identified by two asterisks (**) in the "MCMN" column of the Fee Schedule in Section 4 of this manual. When prior approval is indicated, a Prior Authorization (PA) (Form 214) must be completed by the provider and the treating/ordering physician and submitted along with the MCMN. Please refer to Section 3 of this manual for detailed instructions on completing the PA.

The MCMN and the PA must be sent to the address listed below:

SC Department of Health and Human Services
Department of Durable Medical Equipment, 12th Fl.
Post Office Box 8206
Columbia, SC 29202-8206

A DME program coordinator and/or a physician consultant

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PRIOR APPROVAL (PA) (CONT'D.)

review the PA and MCMN for completion, accuracy, medical justification, and correct procedure codes. (Providers are responsible for submitting and billing the correct procedure code(s). Program coordinators check the accuracy of the code vs. the description, NOC codes vs. established codes, etc.) Providers are responsible for submitting/billing accurate information and verifying eligibility. Please refer to Section 1 of this manual for further information regarding verification of eligibility. The request will be returned to the provider if any field is left uncompleted on the MCMN. The program coordinator may request additional documentation for medical review by the physician consultant.

Documentation

The following documentation must be submitted when requesting a prior authorization:

- Completed PA form (if faxed, must be legible)
- Completed MCMN form and original prescription (if faxed, must be legible)
- PT/OP evaluation for all mobility devices

DME will reimburse for medically necessary items only. Items billed as convenience or prevention will not be covered. Additional medical documentation may be requested by DME staff to ensure medical necessity is established. Documentation may be requested on a case-by-case basis.

Upon receipt and review of all necessary documents, SCDHHS will approve or deny the request. DME will process the PA and MCMN in the order in which they are received. (This includes general mail, certified mail, electronic mail, and faxes. Prior authorization requests cannot be made by telephone.) DME requires 30 days to review and return the Prior Authorization request. All requests returned to the provider for additional or corrected information start a new 30-day process. Each resubmission starts the 30-day review period over. The PA and MCMN must be received by DME within 60 days from the date the equipment/supplies were ordered and date physician, nurse practitioner or physician's assistant signed the MCMN.

All approved requests are assigned a seven-digit number and returned to the provider. This authorization number

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PRIOR APPROVAL (PA) (CONT'D.)

will appear in the right corner (field 9) of the PA and must be entered in field 23 on the CMS-1500 claim form when it is submitted for payment.

For beneficiaries with private third party insurance, the provider must follow DME's guidelines for prior approval.

For dually eligible beneficiaries, DME will follow Medicare's guidelines for procedure codes that are deemed not medically justified. Providers are prohibited from billing DME for reimbursement under this circumstance.

An approved authorization is not a guarantee that Medicaid will reimburse the service. Both the provider and beneficiary must be eligible on the date of service, the service must not have exceeded any applicable service limits, and a clean claim must be submitted within the time limit for submitting claims. Denied requests are returned to the provider with a letter of explanation. See Section 1 of this manual for information on eligibility verification.

PROOF OF DELIVERY

DME providers are responsible for delivering and setting up medical equipment, and for educating the beneficiary in how to use it. The provider may deliver directly to the beneficiary or a designee. The relationship of the designee to the beneficiary should be noted on the delivery slip and the signature should be legible. Providers, their employees, and others with a financial interest in the delivery of the item are prohibited from signing and accepting an item on behalf of a beneficiary (*i.e.*, acting as a designee on behalf of the beneficiary). Delivery to the beneficiary's home via the United States Postal Service, Federal Express, UPS, etc. is strictly prohibited for medical equipment. Confirmed cases of this type of delivery will have payments recouped.

Providers must maintain proof of the delivery of supplies and medical equipment (*i.e.*, return receipt to include beneficiary's name, quantity delivered, detailed description of delivered item, brand name, and serial number) in their place of business for a minimum of five years. Proof of delivery documentation must be made available to Medicaid upon request. Any claims for services that do not have a documented proof of delivery from the supplier shall be denied and payments recovered.

Note: Date of delivery must match date of service.

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BILLING

The cost of an item or service must not be disproportionate to its therapeutic benefits or more costly than a reasonable alternative. The item must not serve the same purpose as equipment already available to the beneficiary. Providers must bill their usual and customary charges up to the Medicaid allowable as indicated in the Fee Schedule.

Manual Pricing and Not Otherwise Classified (NOC) Codes

DME does not require enrolled providers to submit manufacturer pricing information with prior authorization requests for procedure codes that have an established allowable. However, 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 “Price” column. (Please refer to the Fee Schedule in Section 4 of this manual.)

For manually priced and Not Otherwise Classified (NOC) codes, Medicaid will reimburse in one of the following ways:

1. Wholesale cost plus 25% (25% includes fitting fee, freight, delivery, etc.)
2. 90% of Manufacturer’s Suggested Retail Price (MSRP)

Only actual invoices or manufacturer pricing lists will be accepted. If both the retail and wholesale pricing documentation are submitted, Medicaid will calculate reimbursement at the lesser of the two. For custom orthotics and prosthetics, providers should submit their usual and customary costs on company letterhead. **All other providers are prohibited from sending in their own quotes.**

Medicaid does not reimburse sales tax.

Medicare Information/ Pricing Updates

As pricing becomes available for manually priced procedure codes, and Medicare prices fluctuate, Medicaid may implement automatic pricing updates, written deletions, and changes without prior notification. Additionally, as Medicare updates codes, Medicaid will implement code updates and corresponding policy changes with out prior notification. Providers are encouraged to routinely check the Medicaid Web site at

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PROGRAM REQUIREMENTS

Medicare Information/ Pricing Updates (Cont'd.)

<http://www.scdhhs.gov/> for updates.

Note: Consult the DME program coordinator and SCDHHS agency Web sites for codes and pricing updates.

Frequency Limitations

Frequency limitations are listed in the DME Fee Schedule located in Section 4. Providers may only bill Medicaid the actual number units of any supply or equipment that is medically necessary up to the allowed number of units allowed in the Fee Schedule. The provider may be requested to submit documentation secondary to the Medicaid Certificate of Medical Necessity (MCMN) to substantiate reimbursements paid for the maximum number of units allowed in the Fee Schedule. SCDHHS may seek recoupment of payments made to providers when maximum frequencies for supplies and equipment were billed and paid when beneficiary medical records maintained by the provider do not support the medical necessity of the number or units billed. Requests for reimbursement for items exceeding the frequency limitations will not automatically warrant reimbursement. If a physician requires that a beneficiary receive services beyond Medicaid's normal frequency limits, this must be noted on the MCMN and attached to the CMS-1500 claim form that, in turn, will be forwarded to the program area as a request for review. 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 "newer" 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 supplies or medical equipment as specified in the Fee Schedule (whether Medicaid is primary or secondary to other insurance), the treating/ordering physician, nurse practitioner, or physician assistant must

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PROGRAM REQUIREMENTS

Frequency Limitations (Cont'd.)	justify the medical need for the specific number of additional units on the MCMN before approval can be sought. This is not an automatic approval process.
Miscellaneous Procedure Codes	<p>Providers can only use miscellaneous procedure codes when there is not a code available that best describes the product or service being billed. Providers cannot use a miscellaneous code to “bypass” an established code because of pricing issues.</p> <p>The DME department staff should be consulted before entering Not Otherwise Classified (NOC) procedure codes on the prior authorization form. These procedure codes must be listed on the MCMN.</p> <p>Note: Procedure codes K0108 and E1399 should not be used in lieu of established (or similar) codes located in our manual. The use of these codes in lieu of established (or similar) codes located in our manual for greater reimbursement is not allowed.</p>
Modifiers	<p>The following modifiers are acceptable for durable medical equipment and must be listed on the Prior Authorization form. Once Medicare has been billed for reimbursement on dually eligible beneficiaries, the modifier must be changed to the appropriate Medicaid modifier and/or the modifier indicated in the Fee Schedule:</p> <p>NU New Equipment</p> <p>LL Rental (equipment may be converted to purchase)</p> <p>RR Rental (equipment that will always remain on a rental basis)</p> <p>00 Purchase (used for medical supplies)</p> <p>52 Reduced Rate (Reduced rental payments are made every 6 months beginning on the 16th month of use regardless of the type or life span of the equipment.)</p> <p>RT Right</p> <p>LT Left</p>

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Modifiers (Cont'd.)

- UE** 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, this modifier must be used on the MCMN and claim form.)
- SC** Medically necessary service or supply (This modifier is used only with certain home infusion codes when more than one home infusion therapy is being administered.)

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

SPECIAL PROGRAMS

Waivers

Waivers are programs that allow individuals who meet the waiver requirements to receive items that may or may not be covered through the South Carolina State Plan. In cases where a waiver recipient's needs differ from those outlined in the waiver policies, the provider must have a written order (MCMN) justifying the medical need. All waiver services/supplies only require a service authorization from the service coordinator or case manager prior to provision of the service and/or supply.

Waiver items should be billed using the waiver codes authorized on the waiver form. Providers must bill using the CMS-1500 claim form.

Special attention must be taken when verifying eligibility either by using the toll-free number at 1-888-809-3040 or by using point-of-sale devices. Callers must be sure to listen beyond general eligibility information to verify if the beneficiary is on any special waiver program or has other insurance.

Services provided under all waivers discussed here must be billed on a CMS-1500 claim form. The form is mailed to:

Medicaid Claims Receipts
Post Office Box 1412
Columbia, SC 29202-1412

Payment will be made in the usual manner and will be reported on the provider's SCDHHS remittance advice.

Mental Retardation/Related Disabilities (MR/RD) Waiver

The Department of Health and Human Services and the South Carolina Department of Disabilities and Special Needs (SCDDSN), in a joint cooperative effort, are serving individuals with mental retardation or related disabilities under a special waiver.

The SCDDSN service coordinators initiate a referral form to the provider for authorized equipment and/or supplies that the Medicaid program would not otherwise cover. The referral form must list the equipment or supplies being requested and include the dollar amount for the item(s).

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PROGRAM SERVICES

Mental Retardation/Related Disabilities (MR/RD) Waiver (Cont'd.)

Appropriate procedure codes for medical supplies and medical equipment must be used when billing MR/RD Waiver approved supplies and equipment.

When a provider bills procedure codes X1915 and X1916, all supplies or equipment purchased on the same date of service should be combined and billed as a single line item when it is filed as a claim to South Carolina Medicaid.

PERS: Individuals participating in the MR/RD Waiver may also be authorized to receive Personal Emergency Response (PERS) equipment. A durable medical equipment provider capable of providing this service will be contacted by the SCDDSN service coordinator and given authorization for this service. The procedure code for PERS installation is S5160, for monthly monitoring, S5161.

DIAPERS AND UNDERPADS: The MR/RD Waiver also reimburses diapers and underpads for clients enrolled in the MR/RD Waiver. Effective September 1, 1998, a case of medium-size (minimum size 22" x 23", total minimum area 506 sq inches) underpads must have a minimum count of 200, and a case of large-size (minimum size 22" x 35", total minimum area 770 sq inches) underpads must have a minimum count of 150.

The following table indicates procedure codes to be used when billing for diapers, along with reimbursement rates.

DDSN Incontinence Supplies

Diaper Size	Diaper Price	Maximum Frequency	Case Quantity Authorized	Procedure Code	Total Reimbursement
Small	\$0.73/diaper	3 cases Monthly	96	T4521	\$70.08
Medium	\$0.73/diaper	3 cases Monthly	96	T4522	\$70.08
Large	\$0.97/diaper	3 cases Monthly	72	T4523	\$69.84
Extra Large	\$1.26/diaper	3 cases Monthly	54	T4524	\$68.04
Child Small/Medium	\$0.73/diaper	3 cases Monthly	96	T4529	\$70.08
Child Large	\$0.73/diaper	3 cases Monthly	96	T4530	\$70.08
Youth Diaper	\$0.73/diaper	3 cases Monthly	96	T4533	\$70.08
Underpads	\$45.00/case	3 cases Monthly	1	A4554	\$43.65

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Mental Retardation/Related Disabilities (MR/RD) Waiver (Cont'd.)

HEARING AIDS: Eligible beneficiaries under 21 years of age and/or in the MR/RD Waiver may obtain hearing aids under contractual agreement with the Division of Children's Rehabilitative Services, Department of Health and Environmental Control.

Head and Spinal Cord (HASCI) Waiver

The Department of Health and Human Services and the South Carolina Department of Disabilities and Special Needs (SCDDSN), in a joint cooperative effort, are serving individuals with head and spinal cord injuries under a special waiver.

The SCDDSN service coordinators initiate a referral form to the provider for authorized equipment and/or supplies that the Medicaid program would not otherwise cover. The referral form must list the equipment or supplies being requested and include the dollar amount for the item(s).

Procedure code X1922, Medical Supplies and Equipment, must be used when billing HASCI Waiver approved supplies and equipment. When a provider bills procedure code X1922, all supplies or equipment purchased on the same date of service should be combined and billed as a single line item when it is filed as a claim to South Carolina Medicaid.

PERS: Individuals participating in the HASCI Waiver may also be authorized to receive Personal Emergency Response (PERS) equipment. A durable medical equipment provider capable of providing this service will be contacted by the SCDDSN service coordinator and given authorization for this service. The procedure code for PERS installation is S5160, for monthly monitoring, S5161.

DIAPERS AND UNDERPADS: The HASCI Waiver also reimburses diapers and underpads for clients enrolled in the HASCI Waiver. Effective September 1, 1998, a case of medium-size (minimum size 22" x 23" total minimum area 506 sq inches) underpads must have a minimum count of 200, and a case of large-size (minimum size 22" x 35", total minimum area 770 sq inches) underpads must have a minimum count of 150.

The following table indicates procedure codes to be used when billing for diapers, along with reimbursement rates:

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Head and Spinal Cord (HASCI) Waiver (Cont'd.)

DDSN Incontinence Supplies

Diaper Size	Diaper Price	Maximum Frequency	Case Quantity Authorized	Procedure Code	Total Reimbursement
Small	\$0.73/diaper	3 cases Monthly	96	T4521	\$70.08
Medium	\$0.73/diaper	3 cases Monthly	96	T4522	\$70.08
Large	\$0.97/diaper	3 cases Monthly	72	T4523	\$69.84
Extra Large	\$1.26/diaper	3 cases Monthly	54	T4524	\$68.04
Child Small/Medium	\$0.73/diaper	3 cases Monthly	96	T4529	\$70.08
Child Large	\$0.73/diaper	3 cases Monthly	96	T4530	\$70.08
Youth Diaper	\$0.73/diaper	3 cases Monthly	96	T4533	\$70.08
Underpads	\$45.00/case	3 cases Monthly	1	A4554	\$43.65

Mechanical Ventilator Dependent Waiver (VENT)

The Department of Health and Human Services serves ventilator-dependent individuals under a special waiver.

For an individual to receive these services, a case manager or nurse consultant working through the Community Long Term Care Division (CLTC) of SCDHHS must authorize medical equipment and supplies by means of the CLTC service authorization. The authorization form must list the equipment or supplies being requested, the starting date, and the dollar amount for the item(s). Procedure code X1917 for medical equipment and X1918 for medical supplies must be used when billing for individuals in the Mechanical Ventilator Dependent Waiver. These procedure codes must be used when billing for supplies and equipment other than incontinence supplies, PERS, and nutritional supplement by mouth.

NUTRITIONAL SUPPLEMENT: The reimbursement rate for nutritional supplement procedure code X9202, by mouth, is \$33.00 per case regardless of the type of nutritional supplement. Each can of nutrient must have a minimum of 225 cal/250 ml and come in a 24-count case in order to qualify for Medicaid reimbursement. Up to four cases of nutritional supplements will be allowed per mouth with a doctor's order.

PERS: Individuals participating in the VENT Waiver may also be authorized to receive Personal Emergency

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

*Mechanical Ventilator
Dependent Waiver (VENT)
(Cont'd.)*

Response (PERS) equipment. A durable medical equipment provider capable of providing this service will be contacted by the CLTC case manager and given a service authorization for this service. The procedure code for PERS installation is S5160, and for monthly monitoring, S5161.

DIAPERS AND UNDERPADS: The VENT Waiver also reimburses incontinence supplies for enrolled clients. Effective September 1, 1998, a case of medium-size (minimum size 22" x 23", total minimum area 506 sq inches) underpads must have a minimum count of 200, and a case of large-size (minimum size 22" x 35", total minimum area 770 sq inches) underpads must have a minimum count of 150. The following table indicates procedure codes to be used when billing for incontinence supplies, along with reimbursement rates:

CLTC Incontinence Supplies

Service	Rate	Maximum Frequency	Quantity Authorized	Procedure Code	Total Reimbursement
Adult Extra Large	\$1.26/diaper	Monthly	96	T4524	\$120.96
Adult Large	\$0.97/diaper	Monthly	96	T4523	\$93.12
Adult Medium	\$0.73/diaper	Monthly	96	T4522	\$70.08
Adult Small	\$0.73/diaper	Monthly	96	T4521	\$70.08
Youth Diaper	\$0.73/diaper	Monthly	96	T4533	\$70.08
Adult Brief Extra Large (protective underwear)	\$1.26/brief	Monthly	80	T4528	\$100.08
Adult Brief Large (protective underwear)	\$0.97/brief	Monthly	80	T4527	\$77.60
Adult Brief Medium (protective underwear)	\$0.87/brief	Monthly	80	T4526	\$69.60
Adult Brief Small (protective underwear)	\$0.87/brief	Monthly	80	T4525	\$69.60
Youth Brief (protective underwear)	\$0.87/brief	Monthly	80	T4534	\$69.60
Incontinence Pads	\$0.29/pad	Monthly	130	T4535	\$37.70
Underpads	\$43.65/case	Monthly	1	A4554	\$43.65
Wipes	\$7.76/box	Monthly	70	T5999	\$7.76

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

HIV/AIDS Waiver

The Department of Health and Human Services serves individuals with HIV/AIDS under a special waiver.

For an individual to receive these services, a case manager or nurse consultant working through the Community Long Term Care Division (CLTC) of SCDHHS must authorize incontinence supplies and nutritional supplementation by means of the CLTC service authorization. The authorization form must list the service authorized and the starting date for the service(s).

NUTRITIONAL SUPPLEMENT: The reimbursement rate for nutritional supplements may vary based on the type of nutritional supplement; the minimum reimbursement for procedure code X1939 is \$33.00. Each can of nutrient must have a minimum of 225cals/250ml and come in a 24-count case in order to qualify for Medicaid reimbursement. Two cases of nutritional supplements will be allowed per month with a doctor's order.

DIAPERS AND UNDERPADS: The HIV/AIDS Waiver also reimburses incontinence supplies for enrolled clients. Effective September 1, 1998, a case of medium-size (minimum size 22" x 23", total minimum area 506 sq inches) underpads must have a minimum count of 200, and a case of large-size (minimum size 22" x 35", total minimum area 770 sq inches) underpads must have a minimum count of 150. The following table indicates procedure codes to be used when billing for incontinence supplies, along with reimbursement rates:

CLTC Incontinence Supplies

Service	Rate	Maximum Frequency	Quantity Authorized	Procedure Code	Total Reimbursement
Adult Extra Large	\$1.26/diaper	Monthly	96	T4524	\$120.96
Adult Large	\$0.97/diaper	Monthly	96	T4523	\$93.12
Adult Medium	\$0.73/diaper	Monthly	96	T4522	\$70.08
Adult Small	\$0.73/diaper	Monthly	96	T4521	\$70.08
Youth Diaper	\$0.73/diaper	Monthly	96	T4533	\$70.08
Adult Brief Extra Large (protective underwear)	\$1.26/brief	Monthly	80	T4528	\$100.08
Adult Brief Large (protective underwear)	\$0.97/brief	Monthly	80	T4527	\$77.60

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

HIV/AIDS Waiver (Cont'd.)

CLTC Incontinence Supplies (Cont'd.)

Service	Rate	Maximum Frequency	Quantity Authorized	Procedure Code	Total Reimbursement
Adult Brief Medium (protective underwear)	\$0.87/brief	Monthly	80	T4526	\$69.60
Adult Brief Small (protective underwear)	\$0.87/brief	Monthly	80	T4525	\$69.60
Youth Brief (protective underwear)	\$0.87/brief	Monthly	80	T4534	\$69.60
Incontinence Pads	\$0.29/pad	Monthly	130	T4535	\$37.70
Underpads	\$43.65/case	Monthly	1	A4554	\$43.65
Wipes	\$7.76/box	Monthly	70	T5999	\$7.76

Community Choices Waiver

The Department of Health and Human Services serves individuals who are elderly and disabled and who otherwise would meet the criteria to enter nursing home care under a special waiver.

For an individual to receive these services, a case manager or nurse consultant working through the Community Long-Term Care Division (CLTC) of SCDHHS must authorize incontinence supplies, medical supplies, nutritional supplements, and PERS by means of the CLTC service authorization. The authorization form must list the service authorized and the starting date for the service(s).

The reimbursement rate for nutritional supplements may vary based on the type of nutritional supplement. The minimum reimbursement for procedure code X1939 is \$33.00. Each can of nutrient must have a minimum of 225 cal/250 ml and come in a 24-count case in order to qualify for Medicaid reimbursement. Two cases of nutritional supplements will be allowed per month with a doctor's order.

Individuals participating in the Community Choices waiver may be authorized to receive the following medical equipment and supplies. A durable medical equipment provider capable of providing this service will be contacted by the CLTC case manager and given authorization for services. The table below indicates reimbursement rates

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

*Community Choices Waiver
(Cont'd.)*

and procedure codes used when billing for medical supplies.

DME Supply/Service	Rate	Frequency	Quantity Authorized/Limit	Procedure Code	Total Reimbursement
Nutritional supplements	Min \$33.00/case	Monthly	2	X1939	\$33.00 min
Personal Emergency Response installation	\$36.00	One time		S5160	\$36.00
Ongoing monitoring	\$36.00	Monthly		S5161	\$36.00
Wipes	\$8.00/box	Monthly	70	T5999	\$8.00
Raised toilet seat	\$35	One per participant	1	E0244	\$35.00
Hand held shower	\$50	One per participant	1	T2028	\$50.00
Transfer shower bench	\$150	One per participant	1	E0247	\$150.00
Shower chair/seat	\$35.40	One per participant	1	E0240	\$35.40

The Community Choices waiver also reimburses incontinence supplies for clients enrolled in the Community Choices waiver. Effective September 1, 1998, a case of medium size underpads must have a minimum count of 200 (minimum size 22"-23", total minimum area 506 sq inches), and a case of large size underpads must have a minimum count of 150 (minimum size 22"-35", total minimum area 770 sq inches).

The table below indicates reimbursement rates and procedure codes used when billing for incontinence supplies.

CLTC Incontinence Supplies

Service	Rate	Maximum Frequency	Quantity Authorized	Procedure Code	Total Reimbursement
Adult Extra Large	\$1.26/diaper	Monthly	96	T4524	\$120.96
Adult Large	\$0.97/diaper	Monthly	96	T4523	\$93.12
Adult Medium	\$0.73/diaper	Monthly	96	T4522	\$70.08
Adult Small	\$0.73/diaper	Monthly	96	T4521	\$70.08

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Community Choices Waiver (Cont'd.)

CLTC Incontinence Supplies (Cont'd.)

Service	Rate	Maximum Frequency	Quantity Authorized	Procedure Code	Total Reimbursement
Youth Diaper	\$0.73/diaper	Monthly	96	T4533	\$70.08
Adult Brief Extra Large (protective underwear)	\$1.26/brief	Monthly	80	T4528	\$100.08
Adult Brief Large (protective underwear)	\$0.97/brief	Monthly	80	T4527	\$77.60
Adult Brief Medium (protective underwear)	\$0.87/brief	Monthly	80	T4526	\$69.60
Adult Brief Small (protective underwear)	\$0.87/brief	Monthly	80	T4525	\$69.60
Youth Brief (protective underwear)	\$0.87/brief	Monthly	80	T4534	\$69.60
Incontinence Pads	\$0.29/pad	Monthly	130	T4535	\$37.70
Underpads	\$43.65/case	Monthly	1	A4554	\$43.65
Wipes	\$7.76/box	Monthly	70	T5999	\$7.76

Medically Complex Children's Waiver

The South Carolina Department of Health and Human Services serves medically complex children under a special waiver.

For an individual to receive these services a care coordinator working through a Medical Home network must authorize incontinence supplies by means of a service authorization. The authorization form must list the supplies being requested, the starting date, and the dollar amount for the item(s).

DIAPERS AND UNDERPADS: The Community Choices waiver also reimburses incontinence supplies for enrolled clients. Effective September 1, 1998, a case of medium size underpads must have a minimum count of 200 (minimum size 22"-23", total minimum area 506 sq inches), and a case of large size underpads must have a minimum count of 150 (minimum size 22"-35", total minimum area 770 sq inches). The following table indicates procedure codes to be used when billing for incontinence supplies, along with reimbursement rates:

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PROGRAM SERVICES

*Medically Complex
Children's Waiver (Cont'd.)*

CLTC Incontinence Supplies

Service	Rate	Maximum Frequency	Quantity Authorized	Procedure Code	Total Reimbursement
Adult Extra Large	\$1.26/diaper	Monthly	96	T4524	\$120.96
Adult Large	\$0.97/diaper	Monthly	96	T4523	\$93.12
Adult Medium	\$0.73/diaper	Monthly	96	T4522	\$70.08
Adult Small	\$0.73/diaper	Monthly	96	T4521	\$70.08
Pediatric Diaper Small	\$0.73/diaper	Monthly	96	T4529	\$70.08
Pediatric Diaper Large	\$0.73/diaper	Monthly	96	T4530	\$70.08
Pediatric Brief Small	\$0.87/diaper	Monthly	80	T4531	\$69.60
Pediatric Brief Large	\$0.87/diaper	Monthly	80	T4532	\$69.60
Youth Diaper	\$0.73/diaper	Monthly	96	T4533	\$70.08
Adult Brief Extra Large (protective underwear)	\$1.26/brief	Monthly	80	T4528	\$100.08
Adult Brief Large (protective underwear)	\$0.97/brief	Monthly	80	T4527	\$77.60
Adult Brief Medium (protective underwear)	\$0.87/brief	Monthly	80	T4526	\$69.60
Adult Brief Small (protective underwear)	\$0.87/brief	Monthly	80	T4525	\$69.60
Youth Brief (protective underwear)	\$0.87/brief	Monthly	80	T4534	\$69.60
Incontinence Pads	\$0.29/pad	Monthly	130	T4535	\$37.70
Under Pads	\$43.65/case	Monthly	1	A4554	\$43.65
Wipes	\$7.76/box	Monthly	70	T5999	\$7.76

Medicaid Managed Care

DME services are considered a core benefit with respect to Medicaid Managed Care. As such, if a beneficiary is enrolled in a Managed Care Organization (MCO), the DME services rendered must be authorized by the MCO and provided by an in-network DME provider. Claims for DME services rendered to MCO members are adjudicated by the MCO.

DME services rendered to beneficiaries enrolled in the Medical Homes Network (MHN) program are to be handled the same as DME services rendered to beneficiaries enrolled in traditional fee-for-service (FFS) Medicaid. Claims for DME services provided to MHN members are adjudicated by the Medicaid agency.

For detailed information concerning Medicaid Managed Care, please review the information contained in the

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Medicaid Managed Care (Cont'd.)

Managed Care Supplement, and the MCO and MHN Policy and Procedure Guides. This information is located in the Managed Care section on the SCDHHS Web site:
<http://www.scdhhs.gov>.

Hospice

Hospice services are an additional benefit under the Medicaid State Plan. Hospice services provide palliative care (relief of pain and uncomfortable symptoms) as opposed to curative care for terminally ill individuals. In addition to meeting the patient's medical needs, hospice addresses the physical, psychosocial, and spiritual needs of the patient, as well as the psychosocial needs of the patient's family and caregiver.

Hospice services are available to Medicaid beneficiaries who choose to elect the benefit and who have been certified as terminally ill with a life expectancy of six months or less by their attending physician and/or the Medical Director of the hospice.

Hospice services are provided to the beneficiary according to a plan of care developed by an interdisciplinary staff of the hospice. Medical appliances and supplies, including drugs, which are used for the relief of pain and symptom control related to the terminal illness, are covered services through hospice.

A beneficiary who elects the hospice benefit must waive all rights to other Medicaid benefits for services related to treatment of the terminal condition for the duration of hospice care. Specific services that must be waived include:

1. Hospice care provided by a hospice other than the hospice designated by the individual (unless provided under arrangements made by the designated hospice)
2. Any Medicaid services related to the treatment of the terminal condition for which hospice care was elected, or related condition
3. Any services equivalent to hospice care except for services:
 - a) Provided (either directly or under arrangement) by the designated hospice
 - b) Provided by the individual's attending physician if that physician is not an employee of the

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Hospice (Cont'd.)

designated hospice or is not receiving compensation from the hospice for those services

- c) Provided as room and board by a nursing facility, if the individual is a resident

Services for illnesses or conditions not related to the terminal illness of the patient may be provided and billed by the appropriate service provider. However, prior authorization is required from the hospice provider before delivery of durable medical equipment and supplies to verify that the services being provided are for a condition not related to the terminal illness. Prior authorization must be obtained by calling the hospice provider (as indicated by the Medicaid beneficiary) to receive the authorization number. The authorization number must be entered in field 19 on the CMS-1500 claim form. Claims submitted without the required hospice authorization will be rejected. All services delivered to hospice beneficiaries will be subject to payment review. For additional information, the Medicaid hospice program can be reached at (803) 898-2590.

QUALIFIED MEDICARE BENEFICIARY (QMB)

Medicaid beneficiaries who are also eligible for Medicare benefits are commonly referred to as “dually eligible.” Providers may bill SC Medicaid for Medicare cost sharing for Medicaid-covered services for dually eligible beneficiaries. Some dual eligibles are also Qualified Medicare Beneficiaries (QMB). If the dually eligible beneficiary is also a QMB, providers may bill SC Medicaid for the Medicare cost sharing for services that are covered by Medicare without regard to whether the service is covered by SC Medicaid. Reimbursement for these services will be consistent with the SC State Medicaid Plan. Please refer to Section 3 of this manual for instructions regarding billing procedures for dually eligible beneficiaries. Please refer to the Medicaid Interactive Voice Response System (IVRS) and the Medicaid Web-Based Claims Submission Tool, in Section 1, for instructions on how to access beneficiary information, including QMB status.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

COVERED SERVICES/ITEMS

Rental Services

The beneficiary's prognosis is a deciding factor in approving equipment rental. In order to continue the rental, the treating/ordering physician, nurse practitioner, or physician assistant must submit a recertified MCMN request before the initial rental period has expired. At that point, a DME program coordinator makes the determination to either continue renting or convert to purchase. If purchase is decided, the approved dollar amount will reflect the allowable purchase price less the amount already paid in rental. **The provider must then bill the approved amount.**

Maintenance of Rented Equipment

Maintenance of rented equipment is not reimbursable by Medicaid. Parts and supplies used in the maintenance of rented equipment are included in the rental payment of the equipment.

Rent to Purchase

For dually eligible and Medicaid-only beneficiaries, Medicaid will rent most equipment for a maximum of ten months and the item is considered purchased thereafter. Medicaid does not reimburse for maintenance fees.

Warranties

The provider is required to honor all manufacturers' warranties for all new equipment, supplies, parts, and accessories that are issued to beneficiaries. This includes rentals that have been paid for ten months and that are therefore considered purchased. Used equipment is issued with an implied 60-day warranty guaranteed by the selling provider. Used parts, supplies, and accessories will have no warranties. Any warranty period will commence with the date of delivery to the beneficiary.

- Warranties pertaining to mobility equipment (*e.g.*, Custom Seating and Powered Mobility) – Providers must stand behind a two-year warranty of the major components for custom wheelchairs
- Manual wheeled mobility base – A wheelchair with a manual wheeled mobility base must have a lifetime warranty on the frame of the wheelchair against defects in material and workmanship.
- Powered mobility base – A unit with a powered mobility base must have a lifetime warranty on the

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Warranties (Cont'd.)

frame against defects in materials and workmanship for the lifetime of the member.

Additional Warranty

- The main electronic controller must have a two-year warranty from the date of delivery.
- Motors, gearboxes, and the remote joystick must have a two-year warranty from the date of delivery.
- Cushions and seating systems must have a two-year warranty or full replacement for manufacturer defects or the surface that does not remain intact due to normal wear.

In the event a provider asks the Medicaid DME program to approve payment for a repair to any new medical equipment within the first year of its use by the beneficiary, the provider must provide a copy of said warranty demonstrating a warranty period of less than one year. DME will reimburse any warranty labor not reimbursed by the manufacturer. The Medicaid Program may reimburse loaner equipment needed by the beneficiary during an extended repair only for the time that would be reasonable for the repair to be completed.

Prior authorization must be obtained if the loaner equipment procedure code requires prior approval.

Replacement

The DME Program covers replacement medical equipment as needed due to wear, theft, or irreparable damage or loss by disasters if the medical equipment is still medically needed by the beneficiary. Documentation must accompany the MCMN for reimbursement in these instances (*i.e.*, police report, fire report). Cases suggesting malicious damage, neglect, or wrongful misuse will be denied. Contact the Fraud and Abuse Hotline at 1-888-364-3224 if you have questions or suspect abuse.

Repairs

Repairs to Medicaid-covered durable medical equipment owned by the beneficiary are reimbursable by Medicaid. The Certificate of Repair and Labor Cost (CRLC) is used for labor and/or repairs. These repairs must be pre-authorized by DME staff. Providers are to use the Prior Authorization (Form 214) and attach the manufacturer's pricing with the request.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Repairs (Cont'd.)

For items with established procedure codes that do not require a PA, attach the CRLC form to the CMS-1500 form when billing.

Note: Replacement or repair of equipment is covered in cases of occurrences (*e.g.*, from fire) or when the member's condition changes. Equipment will NOT be replaced due to the member's negligence and/or abuse (*e.g.*, a wheelchair left outside). Equipment will NOT be replaced before its normal life expectancy has been attained unless supporting medical documentation of a change in the physical condition of the member is submitted for prior approval. In addition, a purchase estimate and supporting documentation must be submitted as to the reason for replacement of purchased equipment (*e.g.*, fire report).

Note: Labor codes listed below must be billed with all repairs on the same form.

- K0739 (replaces E1340 effective for dates of services on and after April 1, 2009)
- L4205 (orthotics)

Repair requests should not be combined with any other equipment request. If a repair exceeds the limitation on labor, a written justification must be attached to the request. These requests will be reviewed and considered for payment on a case-by-case basis.

Supplies and Medical Equipment

Apnea Monitors

Apnea monitors are reimbursed according to the following criteria:

1. The monitor is a part of a written plan of care ordered and supervised by the treating/ordering physician.
2. Monitor use is instituted after evaluation and treatment of other causes of prolonged sleep apnea to include but not limited to: arterial hypoxemia due to respiratory distress syndrome or aspiration, bacterial or viral pneumonia; sepsis, seizure disorder,

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Apnea Monitors (Cont'd.)

intracranial hemorrhage, hypoglycemia, cardiac abnormalities due to congestive heart failure, patent ductus arteriosus, and arrhythmias aspiration reflex; endocrine abnormalities; and child abuse.

3. Monitor use is instituted after pediatric pneumogram and ECG monitoring to determine the frequency and duration of sleep apnea and cardiac rate changes have recorded respirations and heart rate for at least several sleep cycles to confirm prolonged sleep apnea.
4. Monitor use is instituted after parents are provided with training and a plan of support to include use of the infant monitor; theory of operation; review of all controls, wires, leads, and electrodes; recording procedures; securing monitor and lead wires to prevent damage; use of event log; methods of responding to alarms (tactile stimulation and cardio-pulmonary resuscitation); 24-hour availability of appropriate personnel for monitoring of child and equipment; and a monitor anxiety and dependency reduction plan to include an explanation that the presence of a monitor does not guarantee there will be no complications.
5. A sibling has been diagnosed as having Sudden Infant Death Syndrome.
6. The beneficiary is an infant with neurological conditions that cause central hypoventilation.

Speech Generating Devices

An augmentative alternative communication (AAC) device is a speech-generating device. The following medical justification is needed and should be attached to the prior authorization and MCMN for medical review:

1. Summary of beneficiary's communication abilities, communication needs, and purpose for an AAC device
2. Speech and language abilities — provide assessment data related to 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 AAC

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PROGRAM SERVICES

Speech Generating Devices (Cont'd.)

3. Cognitive status — describe 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. 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. Symbol level — complete 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 — provide data regarding the beneficiary's visual and auditory status
8. Delineate features of communication system prescribed and submit medical justification

Special Features Blood Glucose Monitors

A special features blood glucose monitor (E2100) is a device that accurately measures the blood glucose levels for individuals diagnosed with insulin-dependent diabetes. The special features of the monitor include an integrated system with audio output for visually impaired diabetics and/or the ability of the device to store data and interface with a computer in order for a medical professional to evaluate the condition of an individual using the monitor.

In order for a special features blood glucose monitor to be approved, the beneficiary must be diagnosed as legally blind (20/200).

Diabetic Supplies

Diabetic Supplies are reimbursed according to the following criteria:

- Eligible Medicaid beneficiaries under the age of 21 can receive up to 300 diabetic strips per month as needed; those ages 21 and over can receive up to 150 diabetic strips per month. If additional diabetic strips are needed, then the treating and/or ordering

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PROGRAM SERVICES

Diabetic Supplies (Cont'd.)

physician, nurse practitioner, or physician assistant must justify the medical need for the specific number of additional diabetic strips on the MCMN form.

- Effective May 1, 2009, SC Medicaid allows diabetic meters and strips to be billed under the DME POS, the CMS-1500 claim form, or the SC Medicaid Web-based Claims Submission Tool.

External Insulin Infusion Pump

Criteria for External Insulin Pump (E0784) and related supplies

Continuous subcutaneous insulin infusion and related supplies are covered as medically necessary for the treatment of gestational diabetes or for insulin-dependent diabetes mellitus.

To receive an **initial approval** for beneficiaries who are diagnosed with insulin-dependent diabetes mellitus, providers must submit the following information on the MCMN form or attached documentation:

1. The beneficiary has a diagnosis of insulin-dependent diabetes mellitus or gestational diabetes.
2. An endocrinologist, physician, physician assistant, or nurse practitioner experienced in pump therapy orders the insulin pump and monitors the beneficiary's status at least every three months during the period of time that the beneficiary uses the pump.
3. The physician, physician assistant, or nurse practitioner documents a history of poor glycemic control on multiple daily injections of insulin, including a persistently elevated glycosylated hemoglobin level (HbA1C > 7.0%).
4. The physician, physician assistant, or nurse practitioner documents additional history of poor control, such as:
 - Widely fluctuating blood glucose levels before bedtime or mealtime
 - History of severe hypoglycemia (<60 mg/dl) or hyperglycemia (>300 mg/dl); or fasting blood glucose levels frequently above 200 mg/dl

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External Insulin Infusion Pump (Cont'd.)

- Treatment of secondary diabetic complications requiring tighter blood glucose control
5. The physician, physician assistant, or nurse practitioner documents that the beneficiary and/or caregiver has demonstrated the ability and commitment to comply with the regiment of pump care, frequent self-monitoring of blood glucose, and careful attention to diet and exercise. For pediatric beneficiaries, the documentation should also address that the caregiver and/or parent is motivated and committed to use the insulin pump, test the child's blood glucose, and return for follow-up appointments as ordered. The beneficiary has been receiving at least three subcutaneous insulin injections per day for a minimum of six months prior to initiation of the insulin pump.
 6. The beneficiary has been self-monitoring blood glucose averaging four times per day for a minimum of one month prior to initiation of the insulin pump.

Catheter Care Supplies

The supplies used for the maintenance of an intravenous infusion catheter are reimbursable during periods when a drug is not infused, but future therapy is anticipated. The provider must submit a CMS-1500 claim form using procedure codes specified in the Fee Schedule for all supplies required to maintain the intravenous infusion catheter. The provider cannot bill a supply procedure code for any drug therapy supplies during the same dates of service that the catheter care supply procedure code is submitted.

Continuous Positive Airway Pressure (CPAP) and Bi-Level Positive Airway Pressure (BIPAP) Devices

Criteria for the CPAP and BIPAP include obstructive sleep apnea and hypopnea. Criteria for the Bi-Level Positive Airway Pressure Spontaneous/Timed Mode (BIPAPST) device include but are not limited to chronic obstructive pulmonary disease, musculoskeletal disorders, muscular dystrophy, cystic fibrosis, and multiple sclerosis. Documentation sufficient to establish the need for ventilatory support must be present on the MCMN. Related supplies are included in the rental of the BIPAPST (E0471). The provider must maintain in his or her files the

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Continuous Positive Airway Pressure (CPAP) and Bi-Level Positive Airway Pressure (BIPAP) Devices (Cont'd.)

interpretation of a sleep study, signed by a physician, that documents the beneficiary's medical need and the effectiveness of the device. The sleep study must be within the 60 days prior to the date of service on the MCMN. See "Capped Rental Equipment" in this section for more information.

Diabetic Shoes

Criteria for diabetic shoes are as follows:

1. The patient has diabetes mellitus (ICD-9 diagnosis codes 250.00-250.93).
2. The patient has one or more of the following conditions:
 - a) Previous amputation of the other foot, or part of either foot
 - b) History of previous foot ulceration of either foot
 - c) History of pre-ulcerative calluses of either foot
 - d) Peripheral neuropathy with evidence of callus formation of either foot
 - e) Foot deformity of either foot
 - f) Poor circulation in either foot
3. The certifying physician who is managing the patient's systemic diabetes condition has certified that indications (1) and (2) are met.

Hearing Aids

Eligible beneficiaries under 21 years of age and/or enrolled in the MR/RD waiver program may only obtain hearing aids under an agreement with the Division of Children's Rehabilitative Services, Department of Health and Environmental Control. Medicaid does not cover hearing aids for non-MR/RD Medicaid beneficiaries who are 21 or older.

Home Intravenous Hydration Therapy

Prior authorization is not required for hydration therapy (S9373-S9376); however, an MCMN is required.

Home Infusion Therapy

The DME program will reimburse supplies used in the administration of parenteral medications that are given in a home environment. The medication is classified as a pharmaceutical product and its usage must meet the guidelines of the Medicaid Pharmacy Services program for reimbursement.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Home Infusion Therapy (Cont'd.)

If a provider issues a single use disposable infusion device for the administration of a drug in intravenous therapy, the provider cannot bill separately for a durable infusion pump. Providers are permitted to bill two separate home infusion therapies that are administered at the same time. Modifier “SC” must be used to bill the second therapy. The device must be included as part of the supply kit for the particular therapy being administered. For example, if a provider is supplying antibiotic therapy to a beneficiary and using the manufacturer’s disposable infusion device to administer the drug, the provider must bill this device as part of other supplies using the antibiotic therapy supply procedure codes S9494, S9497, and S9500 thru S9504.

Home Uterine Activity Monitoring (HUAM)/Supplies and Subcutaneous Tocolytic Therapy

Reimbursement for HUAM (S9001 or S9349), in conjunction with Subcutaneous Tocolytic Therapy services, is covered through the Department of DME. In order for the provider to be reimbursed, the treating/ordering physician must complete a Justification for Home Uterine Activity Monitoring/Supplies and Subcutaneous Tocolytic Therapy form, which is provided to the physician by the enrolled DME provider. (A copy of this form can be found in the Forms section of this manual). This form must be attached to the CMS-1500 claim form for reimbursement. For auditing purposes, the DME provider must keep on file proof of daily monitoring. The physician should document any request that exceeds the frequency limit. Those requests, along with all justification, should be submitted to the program representative for review and approval before the service is rendered. Such cases will be considered for reimbursement on a case-by-case basis.

Clinical Criteria For HUAM Therapy: The patient must have a gestational age of at least 24 weeks, but not more than 35 weeks, and meet **at least one** of the following criteria which necessitates a home uterine activity monitor and/or subcutaneous tocolytic therapy:

1. Idiopathic pre-term labor that has required or will require hospitalization for IV tocolytic therapy
2. Multiple gestation (three or more fetuses) that has required or will require hospitalization for IV tocolytic therapy

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Home Uterine Activity Monitoring (HUAM)/Supplies and Subcutaneous Tocolytic Therapy (Cont'd.)

3. Uterine anomalies or placenta previa that has required or will require hospitalization for IV tocolytic therapy

Additionally, the patient must meet **all** of the following criteria:

1. The patient has been diagnosed with pre-term labor based on uterine activity and/or cervical changes.
2. The patient has been stabilized by tocolytic medication.
3. There are no contraindications to the continuation of this pregnancy.
4. There is no fetal distress.
5. The patient's membranes are intact.
6. The patient is on homebound status and is agreeable to bed-rest activities.
7. The patient has a telephone and is agreeable to daily phone contact and frequent physician follow-up.
8. The patient would have to be hospitalized for uterine activity monitoring and/or subcutaneous tocolytic therapy if this service were not offered.
9. If the patient is hospitalized, this service will allow her to be discharged.
10. The patient is assigned to a delivering physician who has back-up coverage in his or her absence.

Ongoing Supplies

Ongoing supplies for use in the home, such as ostomy supplies, catheters, and sterile gloves, are reimbursable by DME. The specific code for each supply must be listed on the MCMN. Recertification is required prior to the expiration of the current MCMN.

Orthotic Appliances

Orthotic appliances are those items employed for the correction or prevention of skeletal deformities. These include braces, splints, etc. Braces include rigid and semi-rigid devices that are used for the purpose of supporting weak or deformed extremities.

Providers who make custom equipment should submit quotes on company letterhead.

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Oxygen

Guidelines for oxygen therapy are as follows (specify portable or stationary):

1. The diagnosis must indicate a chronic debilitating medical condition.
2. The beneficiary's arterial oxygen partial pressure (PaO₂) must be below 60mm Hg. If a PaO₂ cannot be obtained, arterial oxygen saturation of the beneficiary must be provided. The arterial oxygen saturation must be below 89mm Hg. For nocturnal oxygen, the beneficiary must have at least five minutes of desaturations less than 89mm Hg to qualify for the oxygen. If the PaO₂ is 56-59mm or an arterial blood oxygen saturation of 89% at rest (awake), during sleep for at least five minutes, or during exercise, then any one of the following must apply:
 - a. Dependent edema suggesting congestive heart failure
 - b. Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale on EKG (P wave greater than 3mm in standard leads II, III, or AVF)
 - c. Erythrocythemia with a hematocrit greater than 56%

Exceptions to these PaO₂ and oxygen saturation levels will be based on the age of the beneficiary, diagnosis, and the severity of the disease.

3. The provider must maintain an MCMN in the beneficiary's file for audit purposes.
4. Portable oxygen systems are reimbursed if the physician has ordered an exercise program requiring the patient to be away from his or her stationary oxygen system or when a patient must receive oxygen while en route to a doctor's office, hospital, etc.
5. Associated equipment or supplies such as regulators, oxygen tubing, and cannulas are included in the rental of the system.
6. The use of the portable systems should be limited to

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PROGRAM SERVICES

Oxygen (Cont'd.)

periods of time in which a beneficiary must be separated from his or her stationary system.

7. The treating/ordering physician must have seen the beneficiary and obtained the arterial blood gas (ABG) and/or the arterial oxygen saturation within 30 days of prescribing oxygen therapy.

DME has established a 36-month (three-year) limit or cap on monthly payments for stationary and portable oxygen equipment. This cap applies to oxygen equipment furnished on or after January 1, 2006.

On the first day after the month for which the 36th monthly payment amount is made, monthly payments can begin to be made for oxygen contents using procedure codes E0441, E0442, E0443 and/or E0444 effective January 1, 2009.

Parenteral and Enteral Nutrition (PEN)

Parenteral nutrition is reimbursed for those beneficiaries who cannot absorb nutrients by the gastrointestinal tract. Enteral nutrition is reimbursed for beneficiaries with conditions that do not permit nutrients to reach a normally functional gastrointestinal tract.

These formulae must provide nutrition that will maintain the beneficiary's body weight and/or provide nutrition for weight gain or healing. A feeding tube must be in place for the provision of the nutrient. Feeding tubes are not included in the procedure code reimbursement and may be billed separately.

Enteral feedings will be reimbursed based on 100-calorie units. The number of units reimbursed per diem may not exceed the quantity prescribed.

When billing for parenteral and enteral nutrition for both dually eligible and straight Medicaid beneficiaries, providers must use the formula listed below. Please note that enteral nutrients should be billed in units (100 calories = 1 unit).

Formula:

Number of calories per day, divided by 100,
multiplied by days' usage

Example:

Delivery of 1500 calories per day for 30 days = 450
units

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Parenteral and Enteral Nutrition (PEN) (Cont'd.)

[1500 calories per day, divided by 100 (1 unit) = 15 units]

15 units x 30 days = 450 units]

If a pump (B9000-B9002) is ordered, there must be documentation in the patient's medical record to justify its use (*e.g.*, gravity feeding is not satisfactory due to reflux and/or aspiration, severe diarrhea, dumping syndrome, administration rate less than 100 ml/hr, blood glucose fluctuations, circulatory overload, gastrostomy/jejunostomy tube used for feeding). If the medical necessity of the pump is not documented, the pump will be denied as not medically necessary.

Special nutrient formulas, HCPCS codes B4149, B4153-B4157, B4161, and B4162, are produced to meet unique nutrient needs for specific disease conditions. The patient's medical records must adequately document the specific condition and the need for the special nutrient. This information shall be available to SCDHHS on request.

Supplies

Payment for a catheter/tube anchoring device is considered included in the allowance for enteral feeding supply kits (B4034-B4036). Code A5200 should not be billed separately and is not paid in addition to the supplies for enteral nutrition.

The codes for feeding supply kits (B4034-B4036) include all supplies, other than the feeding tube itself, required for the administration of enteral nutrients to the patient for one day. Supplies include but are not limited to bags, tubing, syringes, irrigation solution, dressings (any type), tape, etc. Individual items may differ from patient to patient and from day to day. Only one unit of service may be billed for any one day. Units of service in excess of one per day will be denied as not separately payable.

Coding Guidelines

When enteral nutrition is covered, dressings used in conjunction with a gastrostomy or enterostomy tube are included in the supply kit code (B4034-B4036) and should not be billed separately using dressing codes.

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Parenteral and Enteral Nutrition (PEN) (Cont'd.)

Additionally, the following should occur when billing for the gastrostomy button:

1. DME should not be billed for buttons that are implanted at the doctor's office. The reimbursement is included in the surgical price. Additionally, a statement should be added to all future MCMNs to indicate if the button is being implanted in the doctor's office or at home.
2. The button kits are to be billed with the B9998 code. The frequency limitations will be four per year instead of the one per month.
3. The following frequency changes are effective with dates of services beginning July 1, 2009, in accordance with Medicare's frequency limitations:
 - B4081 are limited to 24 per year
 - B4082 are limited to 24 per year
 - B4083 are limited to 24 per year
 - B4087 are limited to 24 per year
 - B4088 are limited to 24 per year

Hospital Beds

Medicaid covers most hospital beds. As is customary, each request is handled on a case-by-case basis. In order for a patient to be eligible to receive a hospital bed, the patient's condition must make such an item medically necessary. A physician's prescription, MCMN and additional prescription, documentation, including medical records and physician's reports, must establish medical need. In appropriately documented cases, Medicaid may determine that a hospital bed is medically necessary and, therefore, covered for the following situations:

- Patients, who require positioning of the body to alleviate pain, promote good body alignment, prevent contractures, avoid respiratory infections, etc., in ways not feasible in an ordinary bed
- Patients with severe arthritis and other injuries to lower extremities, *e.g.*, fractured hip such that the patient requires the variable height feature to assist him or her to ambulate by enabling the patient to place his or her feet on the floor while sitting on the

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PROGRAM SERVICES

Hospital Beds (Cont'd.)

edge of the bed

- Patients with severe cardiac conditions who are able to leave bed, but who must avoid the strain of “jumping” up or down
- Patients with spinal cord injuries, including quadriplegic and paraplegic patients and multiple limb amputees and for those patients who are able to transfer from bed to a wheelchair, with or without help
- Patients with other severely debilitating diseases and conditions, if the variable height feature is required to assist the patient to ambulate.

If the stated reason for a hospital bed is the patient’s positioning, the prescription or other documentation must describe the medical condition and also the severity and the frequency of the symptoms of the condition that necessitate a hospital bed for positioning.

If the stated reason for a hospital bed is that the patient’s condition requires special attachments, the prescription must describe the patient’s condition and specify the attachments that require a hospital bed. Special attachments will only be considered if they cannot be fixed or used on an ordinary bed. Bedside rails can be covered as an integral part of, or as an accessory to a hospital bed.

Bariatric Beds

Request for bariatric beds for patients who are morbidly obese must include information regarding weight management. A hospital bed will not be approved for morbid obesity alone.

Electrically powered adjustments to lower and raise the head and foot of the bed may be covered when:

1. Medicaid determines that the patient’s condition requires a frequent change in body position; and/or
2. There may be an immediate need for a change in body position; and
3. The patient can operate the controls and cause the adjustments. Exceptions may be made in cases of spinal cord injury and brain damaged patients. The documentation must indicate that the patient and/or

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PROGRAM SERVICES

Bariatric Beds (Cont'd.)

caregiver can perform these changes in body positioning only by the use of electric controls.

Power Wheelchairs

Medicaid covers most power (motorized) wheelchairs. As is customary, each request will be handled on a case-by-case basis. Medicaid will not provide power chairs for leisure or recreation. In order for a beneficiary to be eligible to receive a power wheelchair, the beneficiary's condition must make such an item medically necessary. All the conditions below must be met.

The beneficiary must be:

1. Non-ambulatory, with severe weakness in the upper extremities due to a neurological or muscular condition
2. Bed- or chair-confined when not using a wheelchair
3. Unable to operate a manual wheelchair
4. Able to safely operate the controls of a power wheelchair

The following documentation must be on file:

1. A written physician's order to include:
 - a) The beneficiary's name and full address
 - b) A physician prescription
 - c) The physician's signature and date
 - d) The date the prescription or order was signed
 - e) A description of the item needed
 - f) Date and length of face-to-face examination for equipment ordered
 - g) A diagnosis supporting the medical necessity of the equipment
 - h) A realistic estimate of the total length of time the equipment will be needed
2. Specialty evaluation

The following documentation should be submitted with power wheelchair requests and a copy kept on file:

1. A completed MCMN, signed and dated by a physician, nurse practitioner, or physician assistant,

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PROGRAM SERVICES

Power Wheelchairs (Cont'd.)

with a detailed summary of the patient's medical condition. (The MCMN should be legible and include the physician, nurse practitioner, or physician assistant's license information.)

2. A physician's prescription (if faxed, must be legible)
3. A copy of the delivery slip and manufacturer information to include manufacturer, make, model, etc.
4. Relevant portions of the patient's medical record containing PT or OT evaluations. Physicians can complete the PT/OT evaluation for patients. Patients who are attending public school also have the option of getting a PT evaluation from the school's physical therapist. All PT/OT evaluations should include but not be limited to the following information:
 - a. Range of motion and semi-quantitative assessment of strength in the extremities
 - b. Quantitative limitations to passive range of motion in the extremities
 - c. The presence or absence of increased muscle tone or spasms
 - d. Detailed description of patient's condition including related diagnoses and history
 - e. Describe how the equipment benefits the patient in performing Activities of Daily Living (ADLs)
 - f. Detailed list, description, and justification of wheelchair base and accessories
 - g. Detailed description of patient's long-term prognosis
 - h. Size, weight, and measurements of the patient
 - i. Patient's medical condition necessitating use of a power chair
 - j. Progression of the condition and prognosis
 - k. MAT Exam
 - l. The extent of the patient's ability to ambulate. If the patient can ambulate, what are the limits to this ambulation and does it require an assistive

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Power Wheelchairs (Cont'd.)

- device? If a device is currently being used, indicate what device is currently being used.
- m. Past use of walker, cane, and/or wheelchair that have been tried and the results
 - n. Previous equipment tried and the results
5. Attestation statement. There must be a signed and dated attestation by the provider that the PT/OT therapist has no financial relationship with the provider.
 6. Manufacturer information to include price, make, models, and serial numbers.
 7. Home assessment

Basic Coverage Criteria

In addition to the patient condition and documentation requirement that should be submitted and kept on file (see pages 2-40 through 2-42), all of the following basic criteria (A-C) must be met for a power mobility device (K0800-K0898) to be covered. Additional coverage criteria for specific devices are listed below.

- A) The patient has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. A mobility limitation is one that:
 - Prevents the patient from accomplishing an MRADL entirely, or
 - Places the patient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or
 - Prevents the patient from completing an MRADL within a reasonable time frame.
- B) The patient's mobility limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker.
- C) The patient does not have sufficient upper extremity function to self-propel an optimally-configured manual

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PROGRAM SERVICES

Power Wheelchairs (Cont'd.)

wheelchair in the home to perform MRADLs during a typical day.

- Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.
- An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate nonpowered accessories.

Specific Types of Power Wheelchairs

I. A Group 1 PWC or a Group 2 PWC is covered if the patient condition and documentation requirements are submitted and kept on file, all of the coverage criteria (a)-(e) for a PWC are met, and the wheelchair is appropriate for the patient's weight.

II. A Group 2 Single Power Option PWC is covered if the patient condition and documentation requirements are submitted and kept on file, all of the coverage criteria (a)-(e) for a PWC are met, and if:

- A) Criterion 1 or 2 is met; and
- B) Criterion 3 is met.
 1. The patient requires a drive control interface other than a hand or chin-operated standard proportional joystick (examples include but are not limited to head control, sip and puff, switch control).
 2. The patient meets coverage criteria for a power tilt or a power recline seating system (see Wheelchair Options and Accessories policy for coverage criteria) and the system is being used on the wheelchair.
 3. The patient has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Power Wheelchairs (Cont'd.)

medical necessity for the wheelchair and its special features. The PT, OT, or physician may have no financial relationship with the provider.

If a Group 2 Single Power Option PWC is provided and if II(A) or II(B) is not met (including but not limited to situations in which it is only provided to accommodate a power seat elevation feature, a power standing feature, or only power elevating legrests) but the coverage criteria for a PWC are met, payment will be based on the allowance for the least costly medically appropriate alternative Group 2 PWC.

III. A Group 2 Multiple Power Option PWC) is covered if the patient condition and documentation requirements are submitted and kept on file, all of the coverage criteria (a)-(e) for a PWC are met, and if:

A) Criterion 1 or 2 is met; and

B) Criterion 3 is met.

1. The patient meets coverage criteria for a power tilt and recline seating system (see Wheelchair Options and Accessories policy) and the system is being used on the wheelchair.

2. The patient uses a ventilator which is mounted on the wheelchair.

3. The patient has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features (see Documentation Requirements section). The PT, OT, or physician may have no financial relationship with the supplier.

If a Group 2 Multiple Power Option PWC is provided, the patient condition and documentation requirements are submitted and kept on file, and if III(A) or III(B) is not met but the criteria for another PWC are met, payment will be based on the allowance for the least costly medically appropriate alternative Group 2 PWC.

IV. A Group 3 PWC with no power options is covered if:

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Power Wheelchairs (Cont'd.)

A) All of the coverage criteria (a)-(e) for a PWC are met; and

B) The patient's mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity; and

C) The patient has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features (see Documentation Requirements section). The PT, OT, or physician may have no financial relationship with the supplier.

If a Group 3 PWC is provided and criterion A is met but either criterion B or C is not met, payment will be based on the allowance for the least costly medically appropriate alternative Group 2 PWC.

V. A Group 3 PWC with Single Power Option or with Multiple Power Options is covered if the patient condition and documentation requirements are submitted and kept on file, and if:

A) The Group 3 criteria IV(A) and IV(B) are met; and

B) The Group 2 Single Power Option (criteria II[A] and II[B]) or Multiple Power Options (criteria III[A] and III[B]) (respectively) are met.

If a Group 3 Single Power Option or Multiple Power Options PWC is provided and Criterion IV(A) is met but all of the other coverage criteria are not met, payment will be based on the allowance for the least costly medically appropriate alternative Group 2 or Group 3 PWC.

VI. Group 4 PWCs have added capabilities that are not needed for use in the home. Therefore, if these wheelchairs are provided and coverage criteria for a Group 2 or Group 3 PWC are met, payment will be based on the allowance for the least costly medically appropriate alternative.

VII. A Group 5 (Pediatric) PWC with Single Power Option or with Multiple Power Options is covered if the patient condition and documentation requirements are submitted and

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PROGRAM SERVICES

Power Wheelchairs (Cont'd.)

kept on file, and if:

- A) All the coverage criteria (a)-(e) for a PWC are met; and
- B) The patient is expected to grow in height; and
- C) The Group 2 Single Power Option (criteria II[A] and II[B]) or Multiple Power Options (criteria III[A] and III[B]) (respectively) are met.

If a Group 5 PWC is provided but all the coverage criteria are not met, payment will be based on the allowance for the least costly medically appropriate alternative.

Least Costly Alternative

Coverage criteria for power mobility devices are based on a stepwise progression of medical necessity. If coverage criteria for the device that is provided are not met and if there is another device that meets the patient's medical needs (as defined in this policy), payment will be based on the allowance for the least costly medically appropriate alternative.

Determinations of least costly alternative will take into account the patient's weight, seating needs, and needs for other special features (*i.e.*, power seating systems, alternative drive controls, ventilators).

Miscellaneous

A power wheelchair with Captain's Chair is not appropriate for a patient who needs a separate wheelchair seat and/or back cushion. If a skin protection and/or positioning seat or back cushion that meets coverage criteria is provided with a power wheelchair with Captain's Chair, the PWC will be denied as not medically necessary.

If a patient needs a seat and/or back cushion but does not meet coverage criteria for a skin protection and/or positioning cushion, it is appropriate to provide a Captain's Chair seat (if the code exists) rather than a sling/solid seat/back and a separate general use seat and/or back cushion. If a general use seat and/or back cushion is provided with a power wheelchair with a sling/solid seat/back, total payment for those items will be based on the allowance for the least costly medically appropriate

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PROGRAM SERVICES

Power Wheelchairs (Cont'd.)

alternative – e.g., the code for the comparable power wheelchair with Captain's Chair, if that code exists.

If a patient's weight can be accommodated by a PWC with a lower weight capacity than the wheelchair that is provided, payment will be based on the allowance for the least costly medically appropriate alternative.

A seat elevator is a non-covered option on a power wheelchair. Therefore, if a Group 2 Seat Elevator PWC is provided and if all of the criteria (a)-(e) for a PWC are met, payment will be based on the allowance for the least costly medically appropriate alternative Group 2 PWC without seat elevator.

An add-on to convert a manual wheelchair to a joystick-controlled power mobility device will be allowed if medical necessity is met.

Payment is made for only one wheelchair at a time. Backup chairs are denied as not medically necessary.

One month's rental of a PWC is covered if a patient-owned wheelchair is being repaired. Payment is based on the type of replacement device that is provided but will not exceed the rental allowance for the power mobility device that is being repaired.

A power mobility device will be denied as not medically necessary if the underlying condition is reversible and the length of need is less than 3 months (e.g., following lower extremity surgery which limits ambulation).

A PWC which has not been reviewed by the SADMERC or which has been reviewed by the SADMERC and found not to meet the definition of a specific PWC listed in the Durable Medical Equipment Fee Schedule will be denied as not medically necessary.

Wheelchair Options/Accessories

Separate billing/payment at the time of initial issue is not allowed. See list below for items and exceptions:

1. Lap belt or safety belt
2. Battery charger single mode
3. Complete set of tires and casters any type
4. Leg rests. There is no separate billing payment if fixed or swing away detachable non-elevating leg

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PROGRAM SERVICES

Wheelchair Options/Accessories (Cont'd.)

rests with/without calf pad are provided. Elevating leg rests may be billed separately.

5. Fixed/swing away detachable footrests with/without angle adjustment footplate/platform
6. Armrests. There is no separate billing/payment if fixed/swing away detachable non-adjustable armrests with arm pad are provided. Adjustable height armrests may be billed separately.
7. Upholstery for seat and back of proper strength and type for patient weight capacity of the power wheelchair
8. Weight specific components per patient weight capacity
9. Controller and Input device. There is no separate billing/payment if a non-expandable controller and proportional input device (integrated or remote) is provided. If a code specifies an expandable controller as an option (but not a requirement) at the time of initial issue, it may be billed separately.

Effective for dates of service beginning February 1, 2006, claims for two units of wheels zero-pressure tire tube billed along with a standard motorized power wheelchair and two units of rear wheel pressure tire tube insert will be denied as not separately payable at initial issue.

Power Wheelchair Home Assessment

The power wheelchair home assessment should include the following:

1. On-site evaluation of the beneficiary's home
2. Beneficiary's ability to adequately maneuver the equipment in the existing physical space
3. Measure doorway width
4. Inspect doorway thresholds and surfaces

A copy of the home assessment should be kept on file and be available on request.

Negative Pressure Wound VAC

South Carolina Department of Health and Human Services (SCDHHS) may reimburse for up to a maximum of four months of therapy with the negative pressure wound therapy electrical pump, stationary or portable (E2402) Wound VAC

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Negative Pressure Wound VAC (Cont'd.)

(vacuum assisted closure device) and supplies A6550 and A6551, when medically necessary. In order for SCDHHS to process the initial order for this product and related supplies, the patient must meet the following conditions:

- The patient has a chronic Stage III or IV pressure ulcer, neuropathic (for example, diabetic) ulcer, venous or arterial insufficiency ulcer, or a chronic (being present for at least 30 days) ulcer of mixed etiology.
- The therapy must be administered in a home setting with the involvement of a home health nurse and the prescribing licensed medical professional.
- For all ulcers or wounds, the following components of a wound therapy program must include a minimum of all the following general measures, which should either be addressed, applied or considered and ruled out prior to the application the Wound VAC:
 4. Have tested and/or rule out all other wound therapies prior to application of Wound VAC therapy.
 5. Describe in detail why more conservative treatment has not been or would not be appropriate for the specific patient who will receive the Wound VAC.
 6. Provide an estimate of the length of time that Wound VAC therapy will be required.
 7. Provide documentation in the patient's medical record of evaluation, care, and wound measurements by a licensed health care professional.

The documentation must include, if applicable:

- a. Evaluation of and provision for adequate nutritional status.
- b. Application of dressings to maintain a moist wound environment.
- c. Debridement of necrotic tissue if present
- d. Evidence that:

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Negative Pressure Wound VAC (Cont'd.)

- a. The patient has been appropriately turned and positioned
- b. The patient has used a group 2 or 3 support surface for pressure ulcers on the posterior trunk.
- c. The patient's moisture and incontinence have been appropriately managed.
- d. For neuropathic (for example, diabetic ulcers):
 - o The patient has been on a comprehensive diabetic management program.
 - o Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities.
- e. For venous insufficiency ulcers:
 - o Compression bandages and/or garments have been consistently applied.
 - o Leg elevation and ambulation have been encouraged.

Exclusions From Coverage

Wound VACs and supplies will be denied at any time as not medically necessary if one or more of the following is present:

- The presence in the wound of necrotic tissue with eschar, if debridement is not attempted
- Untreated osteomyelitis within the vicinity of the wound
- Cancer present in the wound
- The presence of a fistula to an organ or body cavity within the vicinity of the wound

Wound VACs and their supplies that have not been specifically designated as qualified for use of HCPCS codes E2402, A6550, and A7000 for billing to Medicaid will be denied as not medically necessary.

Continued Wound VAC Coverage

The attending physician must initiate any requests for continued use of this product and supplies after four months. Requests must include responses from the above listed

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Negative Pressure Wound VAC (Cont'd.)

concerns in addition to the following items listed below. They must be submitted to SCDHHS along with a new Medicaid Certificate of Medical Necessity and Prior Authorization for approval consideration prior to administering:

1. There must be monthly documented evidence that the Wound VAC therapy has decreased the size or improved the condition of the wound or wounds.
2. The anticipated extended use of the Wound VAC therapy would be based on a month-to-month evaluation.
3. The attending physician must explain the anticipated benefit of continued use of the Wound VAC.
4. On a regular basis the attending physician should:
 - a. Directly assess the wound(s) being treated with the Wound VAC
 - b. Supervise or directly perform the Wound VAC dressing changes
 - c. On at least a monthly basis, document changes in the ulcer's dimensions and characteristics

When Wound VAC Coverage Ends

Wound VAC coverage and supplies will be denied as not medically necessary with any of the following, whichever occurs earliest:

1. In the judgment of the treating physician, adequate wound healing has occurred to the degree that Wound VAC therapy may be discontinued.
2. Any measurable degree of wound healing has failed to occur over the prior month. Wound healing is defined as improvement occurring in either surface area (length times width) or depth of the wound.
3. Four months. Coverage beyond four months will be given individual consideration based upon required additional documentation (See "Continued Wound VAC Coverage")
4. Once equipment or supplies are no longer being used for the patient, whether or not by the physician's order.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Negative Pressure Wound VAC (Cont'd.)

Wound VAC Supplies

- Coverage is provided up to a maximum of 15 dressing kits (A6550) per wound per month unless there is documentation that the wound size requires more than one dressing kit for each dressing change.
- Coverage is provided up to a maximum of 15 canister sets (A7000) per month unless there is documentation evidencing a large volume of drainage (greater than 90 ml of exudate per day). For high volume exudative wounds, a stationary pump with the largest capacity canister must be used. Excess utilization of canisters related to equipment failure (as opposed to excessive volume drainage) will be denied as not medically necessary.

The medical necessity for use of a greater quantity of supplies than the amounts listed must be clearly documented in the patient's medical record and requests for such must be approved by Medicaid prior to administration. If this documentation is not present, excess quantities will be denied for lack of medical necessity.

The SCDHHS Medical Director must approve any exceptions to these coverage criteria and exclusions after a written request is received from the treating physician. Please send requests for exceptions to:

SCDHHS
Dept. of Durable Medical Equipment, 12th floor
Post Office Box 8206
Columbia, SC 29202-8206

Prosthetic Appliances

Prosthetic appliances replace all or part of the function of a permanently inoperative or malfunctioning body organ. Related supplies are covered when the appliances are essential to the effective use of the artificial limb.

Coverage of prosthetic appliances includes repair or replacement of Medicaid-covered prosthetic devices (other than dental and eyeglasses).

Providers who make custom equipment should submit quotes on company letterhead.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Reduced Pump Rental for Parenteral, Enteral, and Intravenous Drug Nutrition

Not all parenteral and enteral pumps are considered purchased for the beneficiary after the tenth month of rental. Providers will continue to use the standard procedure codes for pump rentals. These procedure codes are:

B9000 Enteral nutrition infusion pump without alarm

B9002 Enteral nutrition infusion pump with alarm

B9004 Parenteral nutrition infusion pump, portable

B9006 Parenteral nutrition infusion pump, stationary

E0781 Ambulatory infusion pump

E0791 Parenteral infusion pump, stationary

Reduced rental payments will be made every six months starting on the 16th month of use, regardless of the type or life span of the particular pump. Providers will continue to use the same procedure code but will use the “52” (reduced rental rate) modifier. Medical documentation must be sufficient to support the continued need by the beneficiary when using these reduced rental pump procedure codes.

The provider retains ownership of the pump and is responsible for its maintenance. Medicaid reimbursement is not available for the cost of maintenance.

Supplies

Supplies are those items that are necessary as prescribed by a licensed doctor of medicine.

NON-COVERED ITEMS

Bath Items

Medicaid will no longer cover bath items for the adult population (ages 21 and above).

Deluxe or Luxury Models

Although an item may be classified as durable medical equipment, its provision is not necessarily covered in every instance. Coverage is determined on a case-by-case basis and is subject to the requirement that the equipment is reasonable and necessary for treatment of an illness or injury. DME will deny payment for “deluxe” or “luxury” models if a standard model is adequate.

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PROGRAM SERVICES

Medications

Medications used in connection with supplies and medical equipment are not covered for payment by the Department of DME, but may be covered by Medicaid as a pharmaceutical service.

Nursing Home Use

Medicaid will not make direct reimbursement to a DME provider for supplies and medical equipment rendered to a patient residing in a nursing home. Medicaid will reimburse the coinsurance and deductible up to the Medicaid allowed amount for the dually eligible Medicare/Medicaid beneficiary in a Skilled Nursing Facility.

Stand-By Oxygen and Contents

Medicaid does not cover oxygen systems that function only as stand-by or precautionary devices and portable oxygen systems prescribed for patients who do not otherwise qualify for home oxygen therapy.

Oxygen contents are not reimbursable by Medicaid.

Wheelchair Accessories

Medicaid does not cover the following wheelchair accessories:

- Auto carrier
- Transport tie-down
- Baskets, bags, and pouches
- Gloves
- Wheelchair ramps
- Car trunk lifts/individual lifts
- Lowered seat elevator attachments for powered or motorized wheelchairs