

April 28, 2006

**DME**

**06-03**

## **MEDICAID BULLETIN**

**TO:** Durable Medical Equipment (DME) Providers

**SUBJECT:** Invitation to provide DME services and supplies for recipients of Community Long Term Care (CLTC) Home and Community Based Waiver Programs

CLTC authorizes incontinence supplies, nutritional supplements, personal emergency response systems (PERS) and other equipment to qualifying Medicaid waiver recipients. The purpose of this Medicaid Bulletin is to give all DME providers the opportunity to be listed by CLTC as a provider of these services and supplies.

**Effective immediately**, recipients in the CLTC Elderly/Disabled Waiver will be able to receive either 96 diapers, 80 briefs or 130 incontinence pads and one case of under pads as frequently as once per month as authorized by CLTC. This is an increase from previous limits on incontinence supplies. Limits are unchanged for recipients in the HIV/AIDS and Mechanical Ventilation Waivers. These services are prior authorized by CLTC based upon identified need and recipient choice of provider. PERS services will continue to be authorized at present levels.

In addition, pending federal approval, **effective July 1, 2006**, CLTC will also authorize raised toilet seats, transfer shower benches, shower chairs, hand held showers, nutritional supplements and disposable adult wipes. The chart below shows the Community Long Term Care services for Medicaid home and community based waiver recipients, the maximum frequency of authorization, the unit for each of these items and the unit price. Diapers and briefs are to be billed individually.

If you would like to be listed as a provider of any of these services, please complete the attached form and either mail or fax to the Division of Community Long Term Care. You will be added to the list of available providers for the counties you indicate on the enclosed form and will receive authorizations for services as recipients select your company.

### INCONTINENCE SUPPLIES

Service	Rate	Maximum Frequency	Quantity Authorized	Procedure Code	Total Reimbursement
Adult Extra Large	\$1.30/diaper	Monthly	96 diapers	T4524	\$124.80
Adult Large	\$1.00/diaper	Monthly	96 diapers	T4523	\$96.00
Adult Medium	\$0.75/diaper	Monthly	96 diapers	T4522	\$72.00
Adult Small	\$0.75/diaper	Monthly	96 diapers	T4521	\$72.00
Youth Diaper	\$0.75/diaper	Monthly	96 diapers	T4533	\$72.00
Adult Brief Extra Large (protective underwear)	\$1.30/brief	Monthly	80 briefs	T4528	\$104.00
Adult Brief Large (protective underwear)	\$1.00/brief	Monthly	80 briefs	T4527	\$80.00
Adult Brief Medium (protective underwear)	\$0.90/brief	Monthly	80 briefs	T4526	\$72.00
Adult Brief Small (protective underwear)	\$0.90/brief	Monthly	80 briefs	T4525	\$72.00
Youth Brief (protective underwear)	\$0.90/brief	Monthly	80 briefs	T4534	\$72.00
Incontinence Pads	\$0.25/pad	Monthly	130 pads	T4535	\$32.50
Under Pads	\$45.00/case (150 large or 200 medium per case)	Monthly	1 case	A4554	\$45.00
Wipes	\$8.00/box (70 wipes per box)	Monthly	1 box	T5999	\$8.00

### Other Waiver DME Products

Service	Rate	Maximum Frequency	Quantity Authorized	Procedure Code	Total Reimbursement
Nutritional supplements	\$27.00/case (may vary in special circumstances)	Monthly	1-2 cases of 24 cans	X1939	\$27.00
Personal Emergency Response Installation	\$35.00	One time		S5160	\$35.00
Ongoing monitoring	\$35.00	Monthly		S5161	\$35.00
Raised toilet seat	\$35.00	One time	1	E0244	\$35.00
Hand held shower	\$50.00	One time	1	T2028	\$50.00
Transfer shower bench	\$150.00	One time	1	E0247	\$150.00
Shower chair	\$35.40	One time	1	E0240	\$35.40

If you have questions, please contact George Howk or Tony Matthews at (803) 898-2590.

Thank you for your continued support and participation in the South Carolina Medicaid program.

/s/

Robert M. Kerr  
 Director

RMK

Attachment

**NOTE: To receive Medicaid bulletins by email or to sign up for Electronic Funds Transfer of your Medicaid payment, please go to the following link for instructions:**  
<http://www.dhhs.state.sc.us/dhhsnew/QLbulletins.asp>

# DME SERVICE AND COVERAGE FORM

Provider Name: \_\_\_\_\_

Medicaid Provider Number: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Contact Person: \_\_\_\_\_

**Please indicate below the products/services you would be interested in providing to CLTC clients. Please circle "Y" if you plan on providing the service/product statewide or "N" if you do not plan to provide the service/product statewide. If you circle N please indicate the counties you will serve in the county section of this form:**

Product/Service	Statewide		Product/Service	Statewide	
Incontinence Products	<input type="checkbox"/>	Y   N	Hand Held Shower	<input type="checkbox"/>	Y   N
Nutritional Supplements	<input type="checkbox"/>	Y   N	Transfer Shower Bench	<input type="checkbox"/>	Y   N
Bath/Shower Chair	<input type="checkbox"/>	Y   N	Raised Toilet Seat	<input type="checkbox"/>	Y   N
Emergency Response Systems (including installation and monitoring)	<input type="checkbox"/>	Y   N		<input type="checkbox"/>	Y   N

**Please check each county in which you intend to provide services or if you will provide services statewide please check the statewide box.**

<input type="checkbox"/> Abbeville <input type="checkbox"/> Aiken <input type="checkbox"/> Allendale <input type="checkbox"/> Anderson <input type="checkbox"/> Bamberg <input type="checkbox"/> Barnwell <input type="checkbox"/> Beaufort <input type="checkbox"/> Berkeley <input type="checkbox"/> Calhoun <input type="checkbox"/> Charleston <input type="checkbox"/> Cherokee <input type="checkbox"/> Chester <input type="checkbox"/> Chesterfield <input type="checkbox"/> Clarendon <input type="checkbox"/> Colleton	<input type="checkbox"/> Darlington <input type="checkbox"/> Dillon <input type="checkbox"/> Dorchester <input type="checkbox"/> Edgefield <input type="checkbox"/> Fairfield <input type="checkbox"/> Florence <input type="checkbox"/> Georgetown <input type="checkbox"/> Greenville <input type="checkbox"/> Greenwood <input type="checkbox"/> Hampton <input type="checkbox"/> Horry <input type="checkbox"/> Jasper <input type="checkbox"/> Kershaw <input type="checkbox"/> Lancaster <input type="checkbox"/> Laurens	<input type="checkbox"/> Lee <input type="checkbox"/> Lexington <input type="checkbox"/> McCormick <input type="checkbox"/> Marion <input type="checkbox"/> Marlboro <input type="checkbox"/> Newberry <input type="checkbox"/> Oconee <input type="checkbox"/> Orangeburg <input type="checkbox"/> Pickens <input type="checkbox"/> Richland <input type="checkbox"/> Saluda <input type="checkbox"/> Spartanburg <input type="checkbox"/> Sumter <input type="checkbox"/> Union <input type="checkbox"/> Williamsburg <input type="checkbox"/> York
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Please fax this form to the attention of Tony Matthews and/or George Howk at (803) 255-8209. If you have questions you may contact George Howk or Tony Matthews at (803) 898-2590.