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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, please contact the SCDHHS Provider Service Center (PSC) at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us.

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 on the SCDHHS Web site at http://www.scdhhs.gov 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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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:

- 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 — Provides specialized equipment and/or supplies to patients that cannot 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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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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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, "Medicaid as Payment in Full" 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. (Please refer to "Proof of Delivery" in this section for additional information.)

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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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:

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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 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 Act (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

Medicaid Provider Enrollment can be reached via the SCDHHS Provider Service Center at 1-888-289-0709.

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 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 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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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 licensed provider has his or her license/certification revoked or suspended, the provider will 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 will 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).

NOTE: At a minimum, the provider is required to obtain and maintain in the beneficiary's file a MCMN for any and all HCPCS codes billed. Section 4 further lists specific HCPCS codes that require MCMN submission with the claim and specific HCPCS codes that require prior

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

authorization. If the beneficiary has commercial third party liability (TPL) or is dual-eligible (is eligible for both Medicaid and Medicare), the provider must follow SC DME Medicaid guidelines.

There are six versions of the MCMN:

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

Medicaid prohibits DME providers from preparing the entire Medicaid Certificate of Medical Necessity (MCMN). DME providers are specifically prohibited from completing Section B of the MCMN.

Note: The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or a service does not, in itself, make such care, goods or services medically necessary or a covered service.

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.

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

All supplies and medical equipment must be specifically identified by a HCPCS procedure code on the MCMN. The provider should refer to Section 4 of the manual for a list of procedure codes requiring a MCMN or KEPRO review.

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 must 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.

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, bi-level 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

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Capped Rental Equipment (Cont'd.)

The fee schedule can be found on the SCDHHS Web site at www.scdhhs.gov.

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

E0193 Powered air floatation bed

E0194 Air fluidized bed

E2402 Negative pressure wound therapy electrical pump (Please refer to "Negative Pressure Wound VAC" in this section.)

E0747 Osteogenesis stimulator

These items cannot be approved for the purpose of prevention.

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

MEDICAID PRIOR APPROVAL (PA) FROM KEPRO

Keystone Peer Review Organization (KEPRO) is the Quality Improvement Organization (QIO) for South Carolina Medicaid. Effective June 1, 2012, all prior authorization (PA) requests for DME codes must be submitted to KEPRO. KEPRO will use nationally developed clinical rules and best practices for medical necessity determinations such as McKesson's InterQual for Durable Medical Equipment. Providers for these services will continue to submit the Certificate of Medical Necessity, physician's orders, and all pertinent medical documentation. DME services and equipment requiring prior approval are identified in Section 4 of this manual.

DME will reimburse for medically necessary items only. Items billed as convenience or prevention are not covered.

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MEDICAID PRIOR APPROVAL (PA) FROM KEPRO (CONT'D.)

DME Providers are responsible for submitting and billing the correct HCPCS procedure code(s).

Case Managers and Service Coordinators for Community Long Term Care (CLTC) and the South Carolina Department of Disabilities and Special Needs (SCDDSN) home and community-based waiver programs will continue to authorize services for their waiver participants.

The Community Supports waiver program no longer covers any medical supplies or equipment for waiver participants. These individuals will have to access equipment and medical supplies through the normal DME process. Please note that some equipment and supplies require prior authorization through the KEPRO QIO. Please read all sections of the manual for all policies and requirements.

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

For dually eligible beneficiaries, Medicare's guidelines are followed for procedure codes that are deemed not medically justified. Providers are prohibited from billing 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.

INSTRUCTIONS FOR OBTAINING PRIOR APPROVAL

Requests for prior authorizations for the above services can be submitted to KEPRO using one of the following methods:

KEPRO Customer Service Phone: 855-326-5219
KEPRO Fax: 855-300-0082
For Provider Issues email: atrezzoissues@Kepro.com

Additional information regarding prior authorization will be found by visiting the KEPRO website at http://scdhhs.kepro.com.

The QIO reviewer will screen the medical information provided, using appropriate QIO or InterQual criteria for

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INSTRUCTIONS FOR OBTAINING PRIOR APPROVAL (CONT'D.)

non-physician review. If criteria are met, the DME item will be approved and an authorization number assigned. Notification of the approval and authorization number will be given by written confirmation to the physician. Write this number in block 23 of the CMS-1500 claim form.

If criteria are not met or a case is otherwise questioned, the QIO reviewer will refer the procedure request to a physician reviewer. If the physician reviewer cannot approve the DME item based on the initial information provided, he or she will make a reasonable effort to contact the DME provider for additional supporting documentation of the need for the procedure.

The physician reviewer will document any additional information provided, as well as his or her decision regarding the medical necessity and appropriateness of the DME item.

Review personnel will assign an authorization number (if the procedure is approved), and a written copy of the authorization number will be sent to the DME provider.

If the physician reviewer cannot approve the procedure based on the additional information, he or she will document the reasons for the decision. QIO review personnel will attempt to notify the DME provider's office of the denial.

KEPRO will accept medical review documentation via facsimile, telephone, or via their website. Providers are responsible for verifying beneficiary eligibility prior to the PA request being submitted and again prior to performing a service. Eligibility and managed care enrollment status may change during the time a request is submitted and approved and the actual date the DME item is ready for delivery.

The DME provider may request a reconsideration of the initial denial decision by submitting a written request outlining the rationale for recommending the DME item. Requests for reconsiderations must be submitted within 30 calendar days of receipt of the denial. The reconsideration request must include a copy of the denial letter and any documentation not previously submitted that supports the medical necessity of the equipment requested. The request should be in writing to KEPRO. If the original denial is upheld, providers may exercise their right to an appeal as outlined in Section 1 of this manual.

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PROOF OF DELIVERY: DME DELIVERY METHODS

General Set-up and Delivery Requirements

DME providers are responsible for the delivery and set-up of Medicaid covered items to beneficiaries, and for educating/training the beneficiary in the proper use of the item. Delivery of DME products must either be provided directly by the DME provider or via a shipping or delivery service. The utilization of a shipping or delivery service (*e.g.* FedEx, UPS, USPS) is limited. Please see the section of this policy below titled Restrictions to Product Delivery Via a Shipping or Delivery Service for additional detail on when direct delivery is required. Providers must not deliver an item requiring prior approval before approval for the product has been received. Providers who deliver DME products prior to receiving approval do so at their own risk. All DME products whether delivered directly by the provider or via a shipping or delivery service must be done in a timely manner as agreed upon by the beneficiary and/or their caregiver, supplier, and prescribing physician.

Proof of Delivery

Providers, their employees, or anyone else having 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). Designee is defined as a person who can accept the delivery of the durable medical equipment on behalf of the beneficiary. The relationship of the designee to the beneficiary should be noted on the delivery documentation obtained by the provider *(i.e.,* spouse or power of attorney, etc.). The signature of the designee should be legible. If the signature of the designee is not legible, the provider must note the name of the designee on the delivery documentation.

Documentation Requirements

Providers must retain all documentation of the provision of the product as well as the proof of delivery, in the beneficiary's file for five years. All documentation including the proof of delivery must be made available to SCDHHS upon request. SCDHHS will recoup payment for services found to have inadequate documentation including proof of delivery in a post-payment review. Additionally, DME providers must comply with all applicable Local,

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Documentation Requirements (Cont'd.)

State and Federal laws and regulations pertaining to licensure and any relevant health and safety guidelines.

Direct Delivery to the Beneficiary by the DME Provider

DME providers may elect to deliver products directly to the beneficiary or designee. In the case of lost, stolen, damaged or incomplete delivery of medical equipment and/or supplies, the provider is solely responsible for replacing the medical equipment and/or supplies and without cost to the beneficiary or SC Medicaid. If the provider elects to directly deliver all DME products the delivery documentation must have the following:

- Beneficiary's name
- Delivery address
- Quantity delivered
- Date Delivered
- Detailed description of the item being delivered, to include identifying the item as being new or used (if equipment)
- Brand name
- Serial number, if applicable
- Signature of the beneficiary or designee and date of signature
- Relationship of the designee to the beneficiary (if applicable)

Note: The date on the delivery documentation must be the date the item(s) was received by the beneficiary or designee. In instances where the equipment and/or supplies are delivered directly by the provider, the date the beneficiary received the equipment and/or supply is the date of service on the claim. Medicaid will allow an exception to deliver an item to a hospital patient for the purpose of fitting or training the patient on the item up to two days prior to discharge. In these instances, the provider will bill the date of discharge as the date of service on the claim. No billing may be made for the item for those days the patient was receiving training or fitting in the hospital.

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Delivery Via Shipping or Delivery Service to the Beneficiary

If the provider elects to use a shipping service or mail order process for products not requiring direct delivery, the provider must maintain proof of delivery documentation to include the following:

- Beneficiary's name
- Delivery address
- Delivery service's package identification number, or the corresponding package identification number given by the shipping service
- A detailed description of the products delivered in the package, to include brand name and serial number Detailed description of the item being delivered, to include identifying the item as being new or used (if equipment)
- Quantity delivered
- Date delivered

If the provider uses a shipping service or mail order process, the shipping date is used as the date of service on the claim.

Providers may also use a return postage-paid delivery invoice from the beneficiary or designee as a form of proof of delivery. The delivery invoice must contain the information specified above.

Note: Additional charges for freight, postage and/or delivery are prohibited since these services are considered to be all-inclusive in a provider's charge for the product. In the case of lost, stolen, damaged or incomplete delivery of medical equipment and/or supplies, the provider is solely responsible for replacing the medical equipment and/or supplies and without cost to the beneficiary or SC Medicaid.

Restrictions to Product Delivery Via Shipping or Delivery Service

SCDHHS allows equipment and supplies to be delivered via a shipping or delivery service; however, items that require an initial set-up and training in the use of the equipment **MUST NOT** be delivered via a shipping or delivery service, and **MUST** be delivered directly by the provider of record on the claim form.

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Restrictions to Product Delivery Via Shipping or Delivery Service (Cont'd.)

Examples of items that **MUST NOT** be delivered via shipping or delivery service include but are not limited to:

- Hospital Beds
- Wheelchairs (Manual, Power and Complex Rehabilitative Wheelchairs and Assistive Technology)
- Ventilators and Respiratory Equipment, Supplies and Services (The supplier shall provide respiratory services 24 hours a day, 7 days a week as needed by the beneficiary and/or caregiver.)

AUTO-REFILLING

The over-provision of medical supplies by durable medical equipment (DME) and medical supply providers and the stockpiling of medical supplies by beneficiaries are inappropriate and unnecessary. Beneficiaries' individual medical supply needs vary from month to month. Medical supply quantities must not exceed the individual beneficiary's one month's usage. Placing a beneficiary on automatic supplying or replenishment until the prescription or the active Medicaid Certificate of Medical Necessity (MCMN) expires, or the beneficiary voluntarily discontinues services is prohibited.

For products that are supplied as refills to an original order, providers must contact the beneficiary prior to dispensing the refill. This is done to ensure that the refilled item is necessary and to confirm any changes or modifications to the order. The provider will contact the beneficiary or designee regarding refills no sooner than seven days prior to the shipping date. This is regardless of which delivery method is used. The DME provider is expected to deliver refilled supplies no sooner than approximately five days prior to the end of usage for the current product. Documentation showing each request for refill must be maintained in the beneficiary's medical record.

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. The fee schedule can be found on the SCDHHS Web site at http://www.scdhhs.gov.

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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 on the SCDHHS Web site for pricing information.)

To ensure accurate payment of manually priced and Not Otherwise Classified (NOC) codes, the provider must submit an actual invoice or a manufacturer price quote. If submitting screen prints and web-page printouts, a signature is required certifying the date, quantity, cost, and description of items being billed. Medicaid will reimburse the invoice cost plus 25 percent. Providers will indicate in documentation if pricing is at cost or Manufacturer Suggested Retail Pricing (MSRP). Claims submitted with documents other than an invoice or a signed document as indicated above will be rejected.

Medicaid does not reimburse sales tax.

Medicare Information/ Pricing Updates

As pricing becomes available for manually priced procedure codes, and Medicare prices fluctuate, Medicaid will 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 without prior notification. Providers are encouraged to routinely check the Medicaid Web site at http://www.scdhhs.gov/ for updates.

Note: Consult the PSC, submit an online inquiry, or visit the SCDHHS agency Web site for codes and pricing updates.

Frequency Limitations

Providers must only bill Medicaid the actual number units of any supply or equipment that is medically necessary for the beneficiary. 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

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Frequency Limitations (Cont'd.)

allowed. SCDHHS will seek recoupment of payments made to providers when maximum frequencies for supplies and/or equipment were billed and paid and the beneficiary medical records maintained by the provider do not support 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 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 are to be utilized 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 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

Providers will only use miscellaneous procedure codes when there is not an available code that best describes the product or service being billed. Providers cannot use a miscellaneous code to "bypass" an established code because of pricing issues.

Procedure codes K0108 and E1399 must **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**.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Modifiers

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:

NU New Equipment

LL Rental (equipment may be converted to purchase)

RR Rental (equipment that will always remain on a rental basis)

00 Purchase (used for medical supplies)

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.)

RT Right

LT Left

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.)

National Correct Coding Initiative (NCCI)

The Centers for Medicare and Medicaid Services (CMS) implemented the National Correct Coding Initiative (NCCI) to control improper coding that leads to inappropriate increased payment for health care services. The South Carolina Medicaid program utilizes NCCI edits and its related coding policy to control improper coding and to evaluate billing of CPT codes and Healthcare Common Procedure Coding System (HCPCS) codes by Medicaid providers in post-payment review of providers' records. For assistance in billing, providers may access the NCCI Edit information online at the CMS Web site, http://www.medicaid.gov/Medicaid%CHIP%Program%Information/By%Topics/Data%and%Systems/National%Correct%Coding%Initiative.html

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

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SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

SPECIAL PROGRAMS

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 – Medically Complex Children's Waiver (WMCC) 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 WMCC participants are adjudicated by the Medicaid agency.

For detailed information concerning Medicaid Managed Care, please review the information contained in the Managed Care Supplement and the MCO Policy and Procedure Guide. The MCO Policy and Procedure Guide 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

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Hospice (Cont'd.)

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 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 are 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. Providers will contact the PSC at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us for additional information related to terminal illness.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

QUALIFIED MEDICARE BENEFICIARY (QMB)

Medicaid beneficiaries who are also eligible for Medicare benefits are commonly referred to as "dually eligible." Providers are allowed to 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 are allowed to 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 Web-Based Claims Submission Tool, in Section 1, for instructions on how to access beneficiary information, including QMB status.

COVERED SERVICES/ITEMS

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 nor reimburse for maintenance of rented equipment. Parts and supplies used in the maintenance of rented equipment are included in the rental payment of the equipment.

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 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

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Warranties (Cont'd.)

- 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 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 when the surface does not remain intact due to normal wear.

In the event a provider asks reimbursement 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 and/or Repairs

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.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Replacement and/or Repairs (Cont'd.)

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. For items with established procedure codes requiring prior authorization, the CRLC form and manufacturer's pricing must be submitted to KEPRO for prior authorization. For items with established procedure codes not requiring prior authorization, attach the CRLC form to the CMS-1500 claim form when billing.

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
- L4205 (orthotics)

Repair requests are not to 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 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

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Apnea Monitors (Cont'd.)

respiratory distress syndrome or aspiration, bacterial or viral pneumonia; sepsis, seizure disorder, intracranial hemorrhage, hypoglycemia, cardiac abnormalities due to congestive heart failure, patent ductus arteriosis, 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.

Incontinence Products

Incontinence supply providers are responsible for obtaining the Physician Certification of Incontinence, SCDHHS Form 168IS, prior to delivering incontinence supplies. All incontinence supplies needed by the waiver participant must be listed on the SCDHHS Form 168IS and signed by the primary physician.

For incontinence products policy and procedures, please refer to the Home Health Services Provider Manual located on the SCDHHS website at http://www.scdhhs.gov.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Augmentative Alternative Communication (AAC) Device

An augmentative alternative communication (AAC) device is a speech-generating device. The following medical justification is required and must be submitted with the prior authorization request:

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
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

Diabetic Supplies

Diabetic Supplies are reimbursed according to the following criteria:

- Eligible Medicaid beneficiaries under the age of 21 are allowed up to 300 diabetic strips per month as needed; those ages 21 and over are allowed up to 150 diabetic strips per month. If additional diabetic strips are

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Diabetic Supplies (Cont'd.)

medically necessary, then the treating and/or ordering physician, nurse practitioner, or physician assistant must justify the medical need for the specific number of additional diabetic strips on the MCMN form.

- 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

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

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 must 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 intermittent 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 must not 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). For initial certification, the provider must maintain the interpretation of the sleep study, signed by a physician, documenting medical necessity effectiveness of the device in the beneficiary's

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

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

medical record. The date of the physician's order, resulting from the sleep study interpretation, must be within 90 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.

   For dates of service on or before September 30, 2015, ICD-9-CM diagnosis codes for diabetic shoes are located on the SCDHHS website on the Durable Medical Equipment Provider Manual webpage.

   For dates of service on or after October, 1, 2015, providers must use ICD-10-CM diagnosis codes E10.10-E13.9. Please refer to Section 4 of this manual for a complete listing of ICD-10-CM codes.

   For dates of service on or after October, 1, 2017, providers must use ICD-10-CM diagnosis codes E10.10-E13.9. Please refer to Section 4 of this manual for a complete listing of ICD-10-CM codes.

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 ID/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-ID/RD Medicaid beneficiaries who are 21 or older.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Home Intravenous Hydration Therapy

Prior authorization is not required for hydration therapy; 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.

If a provider issues a single use disposable infusion device for the administration of a drug in intravenous therapy, the provider must not 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.

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

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 is 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 must document any request that exceeds the frequency limit. Those requests, along with all justification, must be submitted as claim(s) support documentation

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

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

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

2. Multiple gestation (three or more fetuses) that has required or will require hospitalization for IV tocolytic therapy
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.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Orthotic Appliances (Cont'd.)

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

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 (PaO_2) must be below 60mm Hg. If a PaO_2 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 PaO_2 is 56-59mm or an arterial blood oxygen saturation of 89 percent 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 percent

    Exceptions to these PaO_2 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 a 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.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Oxygen (Cont'd.)

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 is limited to 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.

On the first day after the month for which the 36th monthly payment amount is made, monthly payments will begin to be made for oxygen contents.

Ventilators

Invasive (tracheostomy tube) and non-invasive (mask, chest shell) ventilators are considered for rental only with prior authorization and documentation of medical necessity indicating a clinical need for mechanical ventilation. Consideration of reimbursement is based on meeting the following criteria:

- The beneficiary is medically dependent on a ventilator for at least six (6) hours per day
- The beneficiary has a diagnosis of at least one of the following as supported by medical records:
    - Chronic respiratory failure
    - Spinal cord injury
    - Neuromuscular disorder/disease
    - Thoracic restrictive disorder/disease
- The beneficiary has adequate support services or caregiver which would allow for safe use of the ventilator

A ventilator for the treatment of obstructive sleep apnea will only be considered for reimbursement upon a case-by-case review. Requests for a ventilator must be submitted to KEPRO for prior authorization (Medicaid Prior Approval).

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Ventilators (Cont'd.)

Reimbursement is based on the allowance for the least costly medically appropriate alternative. Reimbursement for a more costly alternative than medically appropriate will subject the DME provider to recoupment of funds.

Transportation of Self-Administered Oxygen Dependent Beneficiaries

The policy applies to beneficiaries who are admitted, as an inpatient of a Hospital or Hospital Emergency Room, are oxygen dependent and currently do not have their portable oxygen system in their possession, and do not require transportation via ambulance for their return trip to their residence for any other reason. The hospital is responsible for arranging and acquiring a portable oxygen system complete with all medically necessary accessories, upon discharge. **Hospitals and Ambulance providers will no longer receive reimbursement for non-essential, non-medically necessary ambulance transportation for self-administered oxygen dependent beneficiaries.** All provider types and services are subject to post payment review by the Division of Program Integrity.

It is the responsibility of both the Hospital and DME provider to coordinate and dispense oxygen to the Medicaid beneficiary who is currently admitted to the Hospital or Hospital Emergency Room in order for the appropriate mode of non-emergent transportation to be arranged with the transportation broker upon discharge. The dispensing DME provider will be responsible for arranging the return of the portable oxygen system dispensed by their company at the time of discharge from the admitting hospital facility.

It is the responsibility of EMS providers whenever possible to transport oxygen dependent beneficiaries with the beneficiary's personal portable oxygen system in anticipation of the beneficiary's medical/health needs.

Parenteral and Enteral Nutrition (PEN)

Parenteral Nutrition

Parenteral nutrition is the delivery of macronutrients (*i.e.*, proteins, fats and carbohydrates) and micronutrients (*i.e.*, vitamins, minerals and trace elements) intravenously. Parenteral nutrition is indicated in situations for which the gastrointestinal tract is incapable of digesting nutrients through enteral nutrition. Documentation maintained in the beneficiary's medical record must substantiate the beneficiary's medical need for parenteral nutrition and be made available to SCDHHS upon request.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

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

Supplies

A parenteral nutrition supply kit (premix or home mix), per day, may be used in conjunction with a parenteral administration kit, per day. However, at no time may more than one parenteral nutrition supply kit be billed with another parenteral nutrition supply kit on the same date of service with a parenteral administration kit.

Infusion pumps are reimbursable for beneficiaries for whom parenteral nutrition is medically necessary. Only one pump is covered at any one time. Additional pumps are considered neither reasonable nor necessary.

Enteral Nutrition

Enteral nutrition is the delivery of nutrients through a feeding tube to a normally functioning gastrointestinal tract. A feeding tube must be in place for the provision of nutrients. The formula in enteral feeding must provide nutrition that will maintain the beneficiary's body weight and/or provide nutrition for weight gain or healing. Special nutrient formulas are produced to meet unique nutrient needs for specific disease conditions. Documentation maintained in the beneficiary's medical record must document the specific condition and substantiate the need for the special nutrient. This information must be made available to SCDHHS upon request.

Enteral feedings are reimbursed based on 100-calorie units. The number of units reimbursed per diem must not exceed the quantity prescribed. When billing for enteral nutrition, providers must use the formula listed below. Please note that enteral nutrients are 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

[1500 calories per day, divided by 100 (1 unit) = 15 units, 15 units x 30 days = 450 units]

Supplies

The codes for feeding supply kits include all supplies, other than the feeding tube itself, required for the administration of

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

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

enteral nutrients to the beneficiary for one day. Supplies include but are not limited to bags, tubing, syringes, irrigation solution, dressing (any type), tape, etc. Payment for a catheter/tube anchoring device is included in the allowance for enteral feeding supply kits and is not billable separately. Reimbursement for buttons implanted in the physician's office is included in the surgical reimbursement.

Individual items may differ from beneficiary to beneficiary and from day to day. Only one unit of service is to be billed for any one day. Units of service in excess of one per day will be denied as not separately payable.

Hospital Beds

Medicaid covers most hospital beds and 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, 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 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.

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Hospital Beds (Cont'd.)

If the stated reason for a hospital bed is the patient's positioning, the prescription and 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 may 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 caregiver can perform these changes in body positioning only by the use of electric controls.

Wheelchairs

To qualify for Medicaid reimbursement for a wheelchair, the physician must prescribe the equipment which is medically necessary for the beneficiary. The attending physician is responsible for ordering the items in connection with his or her plan of treatment. The attending physician must be a licensed, active, South Carolina Medicaid provider. The DME provider is responsible for delivering and setting up the equipment as well as educating the beneficiary and/or caretaker as appropriate in the use of the equipment.

For a South Carolina Medicaid beneficiary to qualify for a manual or power wheelchair, a functional needs assessment must be completed and documented in the beneficiary's file at the DME provider's place of business.

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Wheelchairs (Cont'd.)

Functional Needs Assessment Criteria

The functional needs assessment is used to assess the presence of a mobility deficit to determine if a wheelchair or power wheelchair is medically necessary for an individual. This assessment must be documented and kept on file and be available upon request.

The beneficiary must meet the following functional needs assessment criteria:

1) The beneficiary has a mobility limitation that significantly impairs his and/or 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, that would be alleviated by the mobility device. A mobility limitation is one that:
    a) Prevents the beneficiary from accomplishing a MRADL entirely
    b) Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL,
    c) Prevents the beneficiary from completing an MRADL within a reasonable time frame
2) The absence of other conditions that limit the beneficiary's ability to perform MRADL at home is considered medically necessary if the other condition prevents completion of tasks even with a wheelchair.
    a) Some examples are the significant impairment of cognition or judgment and/or vision.
    b) For these beneficiaries, the provision of a wheelchair might not enable them to perform MRADL if the co-morbidity prevents effective use of the wheelchair or reasonable completion of the tasks even with a wheelchair.
3) If other limitations exist, the beneficiary must be ameliorated or compensated sufficiently such that the additional provision of mobility equipment will be reasonably expected to materially improve the individual's ability to perform MRADL in the home.

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Wheelchairs (Cont'd.)

a) A caretaker, for example a family member, may be compensatory, if consistently available in the beneficiary's home and willing and able to safely operate and transfer him or her to and from the wheelchair and to transport the beneficiary using the wheelchair. The caretaker's need to use a wheelchair to assist the beneficiary in the MRADL is to be considered in this determination.

b) If the amelioration or compensation requires the beneficiary's compliance with treatment, for example medications or therapy, substantive non-compliance, whether willing or involuntary, may be grounds for determination that a wheelchair does not meet medical necessity criteria if the non-compliance results in the beneficiary continuing to have a significant limitation. It may be determined that partial compliance results in adequate amelioration or compensation for the appropriate use of mobility assistive equipment.

4) The beneficiary must demonstrate the capability and the willingness to consistently operate the device safely.

   a) Safety considerations include personal risk to the beneficiary as well as risk to others. The determination of safety may need to occur several times during the process as the consideration focuses on a specific device.

   b) A history of unsafe behavior in other venues may be considered.

5) The beneficiary's mobility limitation cannot be sufficiently resolved by the use of an appropriately-fitted cane or walker.

   a) The cane or walker must be appropriately fitted to the beneficiary for this evaluation.

   b) The beneficiary's ability to safely use a cane or walker must be assessed.

Manual Wheelchairs

Medicaid considers the rental or purchase of one manual wheelchair (including any medically necessary accessories

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Wheelchairs (Cont'd.)

and attachments) medically necessary when the beneficiary's condition is such that, without the use of a wheelchair, he or she would otherwise be unable to ambulate about the home *(e.g.,* from bedroom to bathroom, bedroom to kitchen, etc.).

The following criteria **must** be met:

1. The beneficiary must meet the functional needs assessment criteria 1 through 5 listed above.
2. The beneficiary's typical environment (home) must support the use of manual wheelchairs.
    a) The beneficiary's environment must support the use of this type of mobility equipment;
    b) Factors such as temperature, physical layout, surfaces, and obstacles must be considered, as these may render mobility equipment unusable in the beneficiary's home; *and*
3. The beneficiary must have sufficient upper extremity function to propel a manual wheelchair in the home through the course of the performance of MRADL during a typical day. The manual wheelchair must be optimally configured (seating options, wheelbase, device weight and other appropriate accessories) for this determination.
    a) Limitations of strength, endurance, range of motion, coordination and absence or deformity in one or both upper extremities are relevant.
    b) An individual with sufficient upper extremity function may qualify for a manual wheelchair. The appropriate type of manual wheelchair, *i.e.*, light weight, heavy duty, etc. must be determined based on the beneficiary's physical characteristics and anticipated intensity of use.
    c) The beneficiary's home must provide adequate access, maneuvering space and surfaces for the operation of a manual wheelchair.
    d) The beneficiary's ability to safely use a manual wheelchair must be assessed.
4. The beneficiary's condition is such that the requirement for a wheelchair is long term (at least

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Wheelchairs (Cont'd.)

three months). The purchase of a wheelchair is considered not medically necessary if the underlying condition is reversible and the length of need is less than three months (*e.g.*, following lower extremity surgery which limits ambulation); and

5. Use of a wheelchair will significantly improve the beneficiary's ability to participate in MRADLs and the beneficiary will use it on a regular basis in the home.

A standard wheelchair must be requested unless documentation supports the need for any variation from the standard wheelchair. An example of this variation is an obese beneficiary who requires the wide heavy-duty wheelchair. Medicaid reimburses DME providers for extra heavy duty wheelchairs. These wheelchairs accommodate weight capacities up to 600 lbs. and greater. Medicaid will require weight, width, and depth specification for these items. (This information must be listed on the Medicaid Certificate of Medical Necessity.) The DME provider must ensure that the wheelchair is adequate to meet the beneficiary's need. For instance, providers must obtain measurements of obese beneficiaries to ascertain body width for issuance of a properly fitted wheelchair.

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.

Note: It is important to keep in mind that because of the way that the Social Security Act (section 1861(n)) defines durable medical equipment, a power wheelchair device is covered by Medicaid only if the beneficiary has a mobility limitation that significantly impairs his and/or her ability to perform activities of daily living within the home. Your evaluation must clearly distinguish the beneficiary's mobility needs within the home environment as defined in the Social Security Act only.

In order for Medicaid to provide reimbursement for a power wheelchair, there are several statutory requirements that must be met:

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Wheelchairs (Cont'd.)

1) There must be an in-person visit with a physician specifically addressing the patient's mobility needs.

2) There must be a history and physical examination by the physician or other medical professional (see below) focusing on an assessment of the beneficiary's mobility limitation and needs. The results of this evaluation must be recorded in the beneficiary's medical record.

3) A prescription must be written **after** the in-person visit has occurred and the medical evaluation is completed.

4) The prescription and medical records documenting the in-person visit and evaluation must be sent to the equipment supplier within 45 days after the completion of the evaluation.

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

Power wheelchair replacement is limited to one per seven years. For dually eligible beneficiaries or beneficiaries with primary insurance coverage, South Carolina Medicaid will follow Medicare or the primary insurance's guidelines for frequency limitations. The provider will need to attach a copy of the primary insurance EOB to the claim as proof that the primary approved and paid for the requested services.

If a wheelchair is stolen or destroyed due to a house fire or natural disaster a replacement is authorized. Providers must submit documentation along with requests such as fire department or police department reports as proof of incident. Normal wear and all items no longer under manufacturer warranty will also be considered. All requests for repair or replacement must be fully documented by the provider and submitted for review.

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Wheelchairs (Cont'd.)

Medicaid will not repair or replace equipment, within the seven year period, if during the review request, it is determined that the need for repair or replacement is patient neglect. Patient neglect such as loss of equipment, selling/loaning of equipment, equipment stolen because left outdoors, damage due to weather, or use outside of the home will not be covered.

Face-To-Face Examination Criteria

The in-person visit and mobility evaluation together are often referred to as the face-to-face examination. The complete history and physical examination typically includes:

- History of the present condition(s) and past medical history that is relevant to the beneficiary's mobility needs in the home
- Symptoms that limit ambulation
- Diagnoses that are responsible for these symptoms
- Medications or other treatment for these symptoms
- Progression of ambulation difficulty over time
- Other diagnoses that may relate to ambulatory problems
- How far the patient can walk without stopping and with what assistive device, such as a cane or walker
- Pace of ambulation
- History of falls, including frequency, circumstances leading to falls, and why a walker isn't sufficient
- What ambulatory assistance (cane, walker, wheelchair) is currently used and why it isn't sufficient
- What has changed to now require use of a power wheelchair
- Ability to use a manual wheelchair
- Description of the home setting and the ability to perform activities of daily living in the home
- Physical examination that is relevant to the patient's mobility needs
- Weight and height

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Wheelchairs (Cont'd.)

- Cardiopulmonary examination
- Musculoskeletal examination
  - Arm and leg strength and range of motion
- Neurological examination
  - Gait
  - Balance and coordination

If the beneficiary is capable of walking, the report must include documented observation of ambulation (with use of a cane or walker, if appropriate)

Examples of vague or subjective descriptions of the beneficiary's mobility limitations include:

- Upper extremity weakness
- Poor endurance
- Gait instability
- Weakness
- Abnormality of gait
- Difficulty walking
- SOB on exertion
- Pain
- Fatigue
- Deconditioned

These types of statements are insufficient and do not objectively address the mobility limitation or provide a clear picture of the beneficiary's mobility deficits. Objective measurements must be provided.

The evaluation must be tailored to the beneficiary's conditions. **The history must detail a complete picture of the beneficiary's functional abilities and limitations on a typical day.** It must contain as much objective data as possible.

The physical examination must be focused on the body systems that are responsible for the beneficiary's ambulatory difficulty or impact on the beneficiary's ambulatory ability.

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Wheelchairs (Cont'd.)

The physician or supplier may elect to refer the beneficiary to another medical professional, such as a physical therapist or occupational therapist, to perform part of the evaluation as long as that beneficiary has no financial relationship with the wheelchair supplier. However, the physician does have to personally see the beneficiary before or after the PT/OT evaluation. The physician must review the report, indicate their agreement in writing on the report, and sign and date the report. If the physician does not see the beneficiary after the PT/OT evaluation, the date that they sign the report is considered to be the date of completion of the face-to-face examination.

Mobility evaluations that contain check-off boxes or space for only brief answers and thus do not provide enough detailed information about the beneficiary's ambulatory abilities and limitations to allow the Medicaid coordinator to determine if a coverage criterion has been met are not allowed. What is required is a thorough narrative description of the beneficiary's current condition, past history, and pertinent physical examination that clearly describes his/or her mobility needs in the home and why a cane, walker, or optimally configured manual wheelchair is not sufficient to meet those needs. Physicians must record the visit and mobility evaluation in their usual medical record-keeping format.

The physician must write a prescription for a power wheelchair ONLY after the visit and examination are complete. This prescription must contain the following seven elements:

1. Beneficiary's name
2. Description of the item that is ordered. This may be general (*e.g.*, power wheelchair) device or may be more specific.
3. Date of completion of the face-to-face examination
4. Pertinent diagnoses and/or conditions that relate to the need for the power wheelchair
5. Length of need
6. Physician's signature
7. Date of physician signature

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Wheelchairs (Cont'd.)

The physician must send a copy of the face-to-face evaluation (received from the supplier or PT/OT) and seven-element prescription to the supplier within 45 days from the completion of the face-to-face mobility exam. The physician must also include copies of previous notes, consultations with other physicians, and reports of pertinent laboratory, x-ray, or other diagnostic tests when helpful in documenting the severity of the patient's ambulatory problems.

Once this information is received, the supplier will prepare a detailed product description that describes the item(s) being provided including all options and accessories. After gathering this information the physician must review it and if in agreement with what is being provided, sign, date and return it to the supplier. If the physician does not agree with any part of the detailed product description, he or she must contact the supplier to clarify what the beneficiary is to receive.

Power Wheelchair Home Assessment

The power wheelchair home assessment must 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
5. A copy of the home assessment must be kept on file and be available on request.

Basic Coverage Criteria

In addition to the beneficiary's condition and documentation requirements that must be submitted and kept on file, all of the following basic criteria (1-9) must be met for a power wheelchair to be covered:

1. The beneficiary has a mobility limitation that significantly impairs his or her ability to participate in one or more MRADLs such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. A mobility limitation is one that:

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Wheelchairs (Cont'd.)

a) Prevents the beneficiary from accomplishing an MRADL entirely, or

b) Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or

c) **Prevents the beneficiary from completing an MRADL within a reasonable time frame.**

2. The beneficiary's mobility limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker.
3. The beneficiary does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADLs during a typical day.
4. The beneficiary has the mental and physical capabilities to safely operate the power wheelchair provided.
5. If the beneficiary is unable to safely operate the power wheelchair, the beneficiary has a caregiver who is unable to adequately propel an optimally configured manual wheelchair, but is available, willing, and able to safely operate the power wheelchair that is provided.
6. The beneficiary's weight is less than or equal to the weight capacity of the power wheelchair that is provided.
7. The beneficiary's home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the power wheelchair that is provided.
8. Use of a power wheelchair will significantly improve the beneficiary's ability to participate in MRADLs and the beneficiary will use it in the home. For beneficiaries with severe cognitive and/or physical impairments, participation in MRADLs may require the assistance of a caregiver.
9. The beneficiary has not expressed an unwillingness to use a power wheelchair in the home.

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Wheelchairs (Cont'd.)

a) 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.

b) An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate non-powered accessories.

Specific Types of Power Wheelchairs

I. A Group 1 power wheelchair or a Group 2 power wheelchair is covered if the beneficiary's condition and documentation requirements are submitted and kept on file, all of the coverage criteria (1)-(9) for a PWC are met, and the wheelchair is appropriate for the patient's weight.

II. A Group 2 Single Power Option power wheelchair is covered if the beneficiary's condition and documentation requirements are submitted and kept on file, all of the coverage criteria (1)-(9) for a power wheelchair are met, and if:

A. Criterion 1 or 2 is met; and

B. Criterion 3 is met.

The criterion is as follows:

1. The beneficiary 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 beneficiary 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 beneficiary has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT),

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Wheelchairs (Cont'd.)

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. The PT, OT, or physician may have no financial relationship with the DME provider.

If a Group 2 Single Power Option power wheelchair 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 leg rests) but the coverage criteria for a power wheelchair are met, payment will be based on the allowance for the least costly medically appropriate alternative Group 2 power wheelchair.

III. A Group 2 Multiple Power Option power wheelchair is covered if the patient's condition and documentation requirements are submitted and kept on file, all of the coverage criteria (1)-(9) for a power wheelchair are met, and if:

A) Criterion 1 or 2 is met; and

B) Criterion 3 is met.

The criterion is as follows:

1. The beneficiary 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 beneficiary uses a ventilator which is mounted on the wheelchair.

3. The beneficiary 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.

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Wheelchairs (Cont'd.)

If a Group 2 Multiple Power Option power wheelchair is provided, the beneficiary 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 power wheelchair are met, payment will be based on the allowance for the least costly medically appropriate alternative Group 2 power wheelchair.

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

A) All of the coverage criteria (1)-(3) for a power wheelchair are met;

and

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

C) The beneficiary 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 power wheelchair 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 power wheelchair.

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.

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Wheelchairs (Cont'd.)

If a Group 3 Single Power Option or Multiple Power Options power wheelchair 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 power wheelchair.

VI. A Group 4 power wheelchair is covered when all criteria for a Group 3 power wheelchair are met and medical necessity is determined and documented for any additional capabilities specific to a Group 4 power wheelchair. If the additional capabilities are deemed not medically necessary, then payment will be based on the allowance for the least costly medically appropriate alternative.

VII. A Group 5 (Pediatric) power wheelchair 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) All the coverage criteria (1)-(9) for a power wheelchair are met;

and

B) The beneficiary 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 power wheelchair 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 wheelchairs 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 beneficiary's medical needs (as defined in this policy), payment will be based on the allowance for the least costly medically appropriate alternative.

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Wheelchairs (Cont'd.)

Determinations of least costly alternative will take into account the beneficiary's weight, seating needs, and needs for other special features (*i.e.*, power seating systems, alternative drive controls, and 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 power wheelchair will be denied as not medically necessary.

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

If a beneficiary's weight can be accommodated by a power wheelchair 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 power wheelchair is provided and if all of the criteria (1-9) for a power wheelchair are met, payment will be based on the allowance for the least costly medically appropriate alternative Group 2 power wheelchair without seat elevator.

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

Backup wheelchairs, either manual or motorized, are not considered as medically necessary and are non-covered.

One month's rental of a power wheelchair 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

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exceed the rental allowance for the power mobility device that is being repaired.

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

Code K0108 (Wheelchair component or accessory, not otherwise specified) is the only reimbursable miscellaneous code billable to manual and power wheelchairs. Billing miscellaneous wheelchair items with code E1399 is not permissible.

When billing for equipment not given an established code by PDAC (*e.g.,* K0108) providers must submit an invoice that contains Manufacturer Suggested Retail Pricing (MSRP) for the items billed. If submitting an internet "screen print", a signature is required certifying the date, quantity, cost, and description of items being billed. If submitting billing cost instead of MSRP, Medicaid will reimburse cost plus 25 percent. Claims submitted with documents other than an invoice or a signed document as indicated above will be rejected.

Covered Wheelchair Options and Accessories

Medicaid considers certain wheelchair accessories medically necessary if the wheelchair is considered medically necessary and the options or accessories are necessary for the beneficiary to function in the home and perform the activities of daily living.

The following wheelchair options and accessories may be considered medically necessary when the beneficiary meets the medical necessity criteria for a wheelchair.*

- Amputee adapter
- General use back cushion
- General use seat cushion
- Heel loops
- IV rod
- Narrowing device
- Oxygen carrier

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Wheelchairs (Cont'd.)

- Speech generating device (SGD) table
- Step tube
- Suspension fork
- Ventilator tray
- Wide stance arm bracket

* This list is not all-inclusive.

Non-Covered Wheelchair Accessory/Attachment

Generally a wheelchair accessory/attachment or wheelchair upgrade is considered a convenience item when used to adapt to the outside environment, for work, or to perform leisure or recreational activities.

Upgraded and specialty wheels (*e.g.*, Spinergy) are considered not medically necessary because they are not required for performance of instrumental activities of daily living.

The following wheelchair items are non-covered as they are considered personal convenience items*:

- Articulating (telescoping) elevating leg rests
- Back support systems: Back support systems have a plastic frame which is padded and covered with cloth or other material; they are designed to be attached to a wheelchair base, but do not completely replace the wheelchair back. These back support systems are considered convenience items, because they are not generally necessary to provide trunk support in members in wheelchairs. An adequate seating system would allow the beneficiary to function appropriately in the wheelchair.
- Power Assist Devices
- Battery charger: A battery charger for a power wheelchair is included in the allowance for a power wheelchair base. A dual mode battery charger for a power wheelchair is considered a convenience item and is non-covered.
- Canopies
- Clothing guards to protect clothing from dirt, mud, or water thrown up by the wheels (similar to mud flaps for cars)

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Non-Covered Wheelchair Accessory/Attachment (Cont'd.)

- Crutch or cane holder
- Flat-free inserts (zero pressure tubes): Flat free inserts have a removable ring of firm material that is placed inside of a pneumatic tire. Flat free inserts are intended to allow the wheelchair to continue to move if the pneumatic tire is punctured.
- Gloves
- Home modifications: Modifications to the structure of the home to accommodate wheelchairs are not considered treatment of disease and are non-covered. Examples of home modifications and installations that are non-covered include wheelchair ramps, wheelchair accessible showers, elevators, and lowered bath or kitchen counters and sinks.
- Identification devices (such as labels, license plates, name plates)
- Lighting systems
- Power add-ons to manual wheelchairs: A power add-on is used to convert a manual wheelchair to a motorized wheelchair (*e.g.*, an add-on to convert a manual wheelchair to a joystick-controlled power mobility device or to a tiller-controlled power mobility device).
- Powered seat elevator attachments for electric, powered, or motorized wheelchairs
- Shock absorbers
- Snow tires for wheelchair
- Speed conversion kits
- Transit Options (tie downs)
- Warning devices, such as horns and backup signals
- Wheelchair baskets, bags, or pouches - used to hold personal belongings
- Wheelchair lifts (*e.g.*, Wheel-O-Vator, trunk loader) - devices to assist in lifting wheelchair up stairways, into car trunks, or in vans
- Wheelchair rack for automobile (auto carrier) - car attachment to carry wheelchair

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Non-Covered Wheelchair Accessory/Attachment (Cont'd.)

- Wheelchair ramp - provides access to stairways or vans
- Wheelchair tie downs
- Any type of computer or electronic device to operate electric, powered, or motorized wheelchair while person is not physically sitting in equipment.

*Note: This list is not all inclusive.

Documentation Requirements for Prior Authorization Review

The following documentation must 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, with a detailed summary of the beneficiary's medical condition. (The MCMN must 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 beneficiary's medical record containing PT or OT evaluations. Physicians can complete the PT/OT evaluation for beneficiaries. Beneficiaries who are attending public school also have the option of getting a PT evaluation from the school's physical therapist. All PT/OT evaluations must 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

    a) The presence or absence of increased muscle tone or spasms

    b) Detailed description of patient's condition including related diagnoses and history

    c) Describe how the equipment benefits the patient in performing Activities of Daily Living (ADLs)

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Documentation Requirements for Prior Authorization Review (Cont'd.)

d) Detailed list, description, and justification of wheelchair base and accessories

e) Detailed description of patient's long-term prognosis

f) Size, weight, and measurements of the patient

g) Patient's medical condition necessitating use of a power chair

h) Progression of the condition and prognosis

i) MAT Exam

j) 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 device? If a device is currently being used, indicate what device is currently being used.

k) Past use of walker, cane, and/or wheelchair that have been tried and the results

l) 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

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 Wound VAC (vacuum assisted closure device) and supplies , 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.

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Negative Pressure Wound VAC (Cont'd.)

- 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 must either be addressed, applied or considered and ruled out prior to the application the Wound VAC:

1. Test and/or rule out all other wound therapies prior to application of Wound VAC therapy.
2. 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.
3. Provide an estimate of the length of time that Wound VAC therapy will be required.
4. Provide documentation in the patient's medical record of evaluation, care, and wound measurements by a licensed health care professional to 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:

    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 ulcers (for example, diabetic) :

    - The patient has been on a comprehensive diabetic management program.

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Negative Pressure Wound VAC (Cont'd.)

- Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities.

e. For venous insufficiency ulcers:

- Compression bandages and/or garments have been consistently applied.
- 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
- The presence of cancer in the wound
- The presence of a fistula to an organ or body cavity within the vicinity of the wound

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 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 will 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 must:
   a. Directly assess the wound(s) being treated with the Wound VAC

Negative Pressure Wound VAC (Cont'd.)

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.

Wound VAC Supplies

- Coverage is provided up to a maximum of 15 dressing kits 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 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

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Negative Pressure Wound VAC (Cont'd.)

approved prior to administration. If this documentation is not present, excess quantities will be denied for lack of medical necessity.

The SCDHHS Medical Director(s) 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
Medical Director, 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 must submit quotes on company letterhead.

Cranial Remolding Orthotic Devices

Coverage for Cranial Remolding Orthotic Devices is only considered as an adjunct to surgical therapy for craniosynostosis and not for treating positional or non-synostotic plagiocephaly or brachycephaly.

Approval of a cranial remolding orthotic device is only considered when requested by a Pediatric Neurosurgeon, Pediatric Neurologist, Pediatric Ear Nose and Throat (ENT) Physician, or a Cranial Facial Surgeon.

Requests for prior authorization for this equipment is obtained through KEPRO and it may be submitted using one of the following methods:

KEPRO Customer Service Phone: 855-326-5219
KEPRO Fax: 855-300-0082
For Provider Issues email: atrezzoissues@Kepro.com

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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.

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 does not 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 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.

Medications

Medications used in connection with supplies and medical equipment are not covered for payment as 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.

SECTION 2 POLICIES AND PROCEDURES

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Stand-By Oxygen

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.

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