

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Healthy Connections
MEDICAID



DURABLE MEDICAL EQUIPMENT SERVICES PROVIDER MANUAL

APRIL 1, 2024

South Carolina Department of Health and Human Services

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PROGRAM OVERVIEW

The South Carolina Department of Health and Human Services (SCDHHS) oversees the provision of medical supplies and equipment to eligible Medicaid beneficiaries. As defined by SCDHHS, Durable Medical Equipment (DME) 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 in any setting in which normal life activities take place, other than a hospital, nursing facility; intermediate care facility for individuals with intellectual disabilities; or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board. The use of “home” in the manual does not restrict the location of DME use in any way except as defined here. DME includes equipment such as wheelchairs, hospital beds, traction equipment, canes, crutches, walkers, ventilators, oxygen, prosthetic and orthotic devices and other medically needed items.

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>.

Providers are responsible for compliance with policy regulating medical necessity for DME. 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 any setting in which normal life activities take place as defined above. (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 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.

NOTE: References to supporting documents and information are included throughout the manual. This information is found at the following locations:

- [Provider Administrative and Billing Manual](#)
- [Forms](#)
- [Section 4 - Procedure Codes](#)

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PROVIDER ENROLLMENT

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 eligible under fee-for-service (FFS) Medicaid (with or without private pay insurance) and/or 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.

FINGERPRINT-BASED CRIMINAL BACKGROUND CHECKS

Certain types of health care providers are considered “high risk” and are required to submit to fingerprint-based criminal background checks (FCBC). High-risk providers are defined as a provider, or a person with 5 percent or more direct or indirect ownership interest in the provider. Failure to comply with the fingerprinting requirement will lead to termination from the Medicaid program. Providers who are also enrolled as high-risk provider with Medicare and comply with Medicare’s FCBC requirements will be deemed in compliance with the Healthy Connections Medicaid requirements. Both newly-enrolling and revalidating high-risk providers will be required to meet the FCBC requirements during the initial enrollment and revalidation processes.

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COVERED SERVICES AND DEFINITIONS

SUPPLIES AND MEDICAL EQUIPMENT

Apnea Monitors

Apnea monitors are reimbursed according to the following criteria:

- The monitor is part of a written plan of care ordered and supervised by the treating/ordering provider. Apnea monitors are only covered after evaluation and exclusion of, or treatment for, other known causes of newborn and infant apnea.
- Monitor use is instituted after:
 - Pediatric pneumogram and electrocardiography (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.
 - 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.
- A sibling has been diagnosed as having sudden infant death syndrome.
- The beneficiary is an infant with neurological conditions that cause central hypoventilation.

Mild Obstructive Sleep Apnea

Treatment of mild obstructive sleep apnea (OSA) is covered via use of eXciteOSA, a Food and Drug Administration (FDA) approved prescription medical device. The device will be allowed without prior authorization for full-benefit Healthy Connections Medicaid members ages 18 years or older. Eligible members must have a diagnosis of mild OSA, indicated by a sleep study, with a score of apnea-hypopnea index of more than 5 and less than 15. Medical providers must follow the FDA guidelines for use, indications and contraindications when prescribing the device.

The device has the following two units:

- Power Source and Control Unit**
 One prescription per lifetime is allowed for the power source and control unit. During the first two years, repairs or replacement covered under the product manufacturer’s warranty are not billable to SCDHHS. If the power source unit is damaged or lost after two years of usage or ownership, SCDHHS may allow a replacement power source unit with prior authorization. Providers must file the prior authorization request to the SCDHHS Quality Improvement Organization (QIO).
- Oral Appliance Unit**
 The prescription for the oral appliance unit must be renewed annually. During the first two years, repairs or replacement covered under the product manufacturer’s warranty are not billable to SCDHHS. If additional units of oral appliance are needed during a 12-month period, the provider must file a prior authorization request to the SCDHHS QIO justifying the need for the additional unit. Only one additional unit may be allowed.

To be eligible for reimbursement for eXciteOSA, Healthy Connections Medicaid-enrolled DME providers must maintain a copy of the Medicaid Certificate of Medical Necessity (MCMN) in the patient’s record.

DME Providers must utilize the following procedure codes, criteria, and limitations when billing for the prescription of eXciteOSA:

Code	Descriptor	Limitations and Billing
E0490	Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, controlled by hardware remote	Allowed one (1) power source & control unit per patient per lifetime. This is a capped rental device. Procedure code may be billed monthly for up to 13 months KH- DMEPOS item, initial claim, purchase of first month rental. KI – DMEPOS item, the second or third month of the capped rental period. KJ- DMEPOS item, month four to thirteen of the capped rental period.
E0491	Oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, used in conjunction with the power source and control electronics unit, controlled by hardware remote, 90-day supply	Supply Purchase. Oral device allowed one (1) per day per patient and up to four (4) per 12 months. No modifier is required.

Augmentative Alternative Communication (AAC) Device

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

- Summary of beneficiary's communication abilities, communication needs and purpose for an AAC device.
- 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.
- 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.
- 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.
- Symbol level — complete a symbol assessment, including performance data per mode and symbol assessed.
- Summary of beneficiary's physical status, motor capabilities and specific access abilities.
- Sensory functioning—provide data regarding the beneficiary's visual and auditory status.
- Delineate features of communication system prescribed and submit medical justification.

Bath items

Medicaid covers the following bath items for the adult population (ages 21 and above):

- Raised Toilet Seat / Bariatric Raised Toilet Seats
- Shower Chair / Bariatric Shower Chair
- Transfer Shower Bench / Bariatric Shower Bench

Beds (Hospital)

Medicaid covers most hospital beds with each request handled on a case-by-case basis. A provider prescription, Medicaid Certificate of Medical Necessity (MCMN) and documentation, including medical records and provider reports, must establish medical need. In appropriately documented cases, a hospital bed may be 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/her to ambulate by enabling the patient to place his/her feet on the floor while sitting on the edge of the bed.
- Patients with severe cardiac conditions who can 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 can transfer from bed to a wheelchair, with or without help.
- Patients with other severely debilitating diseases and conditions, if the variable height feature is required to assist the patient to ambulate.

If the stated reason for a hospital bed is patient positioning, the prescription and other documentation must describe the medical condition and 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.

Beds (Bariatric)

Requests for bariatric beds for morbidly obese patients 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:

- Medicaid determines that the patient’s condition requires a frequent change in body position.
- There may be an immediate need for a change in body position.
- The patient can operate the controls and cause the adjustments. Exceptions may be made in cases of spinal cord or brain injury. The documentation must indicate that the patient and/or caregiver can perform these changes in body positioning only using electric controls.

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 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 Glucose Monitoring (CGM)

CGM measures glucose levels in real-time. An electrode called a sensor is inserted under the skin to measure glucose levels in interstitial fluid. The sensor is connected to a transmitter which sends the information wirelessly to a monitoring and display device. The monitoring system may be either a stand-alone system or it may be integrated into an external insulin pump.

Coverage Guidelines

Coverage of CGM is limited to beneficiaries with:

Type 1, no age limitations

Insulin-dependent pregnant women, any type of diabetes

Medical Criteria

The following criteria must be met:

Documents self-monitoring of blood glucose at least 4x/day AND

Requires insulin injections 3 or more times/day or requires insulin pump for maintenance of blood sugar control AND

Prescribed by board certified endocrinologist

At least one of the following criteria must be met in addition to ALL the above criteria:

Unexplained hypoglycemic episodes OR

Nocturnal hypoglycemic episodes OR

Hypoglycemic unawareness and/or frequent hypoglycemic episodes leading to impairment in activities of daily living (ADLs) OR

HbA1c 9% or greater with demonstrated compliance with insulin regimen and blood glucose monitoring at least 4x/day

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

Criteria for CPAP and BIPAP include obstructive sleep apnea and hypopnea. Criteria for Bi-Level Positive Airway Pressure Spontaneous/Timed Mode (BIPAPST) device includes, but is not limited to, chronic obstructive pulmonary disease, musculoskeletal disorders, muscular dystrophy, cystic fibrosis and multiple sclerosis. Related supplies are included in the rental of the BIPAPST. For initial certification, the provider must maintain the interpretation of the sleep study, signed by a provider, documenting medical necessity effectiveness of the device in the beneficiary's medical record. The date of the provider 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 the Billing Guidance section for more information.

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. PA for this equipment is obtained through the Quality Improvement Organization (QIO) contractor and requests may be submitted using one of the following methods:

QIO Customer Service Phone: 855-326-5219

QIO Fax: 855-300-0082

For Provider Issues email: atrezzoissues@Kepro.com

Diabetic Shoes

Criteria for diabetic shoes are as follows:

- The patient has diabetes mellitus.
- The patient has one or more of the following conditions:
 - Previous amputation of the other foot, or part of either foot.
 - History of previous foot ulceration of either foot.
 - History of pre-ulcerative calluses of either foot.
 - Peripheral neuropathy with evidence of callus formation of either foot.
 - Foot deformity of either foot.
 - Poor circulation in either foot.
- The certifying provider managing the patient's systemic diabetes condition has certified that indications (1) and (2) are met.

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 medically necessary, the treating and/or ordering provider must justify the medical need for the specific number of additional diabetic strips on the MCMN form.
- South Carolina 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 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 diagnosed with insulin-dependent diabetes mellitus, providers must submit the following information on the MCMN form or attach documentation:

- The beneficiary has a diagnosis of insulin-dependent diabetes mellitus or gestational diabetes.
 - A provider experienced in pump therapy orders the insulin pump and monitors the beneficiary's status at least every three months during the period the beneficiary uses the pump.
- The provider documents a history of poor glycemic control on multiple daily injections of insulin, including a persistently elevated glycosylated hemoglobin level (HbA1c > 7.0%).
- The provider 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.
 - Treatment of secondary diabetic complications requiring tighter blood glucose control.
- The provider documents the beneficiary and/or caregiver has demonstrated the ability and commitment to comply with the regimen of pump care, frequent self-monitoring of blood glucose and careful attention to diet and exercise. For pediatric beneficiaries, documentation must also address 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.
- 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.

Hearing Aids

Eligible beneficiaries under 21 years of age and/or enrolled in the Intellectual Disability and Related Disabilities (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 21 or older.

Home Infusion Therapy

The DME program will reimburse supplies used in the administration of parenteral medications 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 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 Intravenous Hydration Therapy

PA is not required for hydration therapy; however, a MCMN is required.

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

For the provider to be reimbursed, the treating/ordering physician provider must complete a Justification for HUAM/Supplies and Subcutaneous Tocolytic Therapy form, provided by the enrolled DME provider. 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 provider 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:

- Idiopathic pre-term labor that required or will require hospitalization for IV tocolytic therapy.
- Multiple gestation (three or more fetuses) that required or will require hospitalization for IV tocolytic therapy.
- Uterine anomalies or placenta previa that required or will require hospitalization for IV tocolytic therapy.

Additionally, the patient must meet all the following criteria:

- The patient has been diagnosed with pre-term labor based on uterine activity and/or cervical changes.
- The patient has been stabilized by tocolytic medication.

- There are no contraindications to the continuation of this pregnancy.
- There is no fetal distress.
- The patient's membranes are intact.
- The patient is on homebound status and is agreeable to bed-rest activities.
- The patient has a telephone and is agreeable to daily phone contact and frequent physician provider follow-up.
- The patient would have to be hospitalized for uterine activity monitoring and/or subcutaneous tocolytic therapy if this service were not offered.
- If the patient is hospitalized, this service will allow her to be discharged.
- The patient is assigned to a delivering physician who has back-up coverage in his or her absence.

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

Negative Pressure Wound Vacuum-Assisted Closure (VAC)

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 device and supplies, when medically necessary. 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 (present for at least 30 days) ulcer of mixed etiology.
- The therapy must be administered with the involvement of a home health nurse and the prescribing licensed medical professional in any setting in which normal life activities take place.
- 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:
 - Test and/or rule out all other wound therapies prior to application of Wound VAC therapy.

- Describe in detail why more conservative treatment has not been or would not be appropriate.
- Provide an estimate of the length of time Wound VAC therapy is required.
- Provide documentation in the patient's medical record of evaluation, care and wound measurements by a licensed health care professional to include, if applicable:
 - › Evaluation of and provision for adequate nutritional status.
 - › Application of dressings to maintain a moist wound environment.
 - › Debridement of necrotic tissue if present.
- Evidence that:
 - › The patient has been appropriately turned and positioned.
 - › The patient has used a group two or three support surface for pressure ulcers on the posterior trunk.
 - › The patient's moisture and incontinence have been appropriately managed.
 - › For neuropathic ulcers (for example, diabetic):
 - » The patient has been on a comprehensive diabetic management program.
 - » Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities.
 - › 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 as not medically necessary if one or more of the following is present:

- The presence 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 provider 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. Requests must be submitted to SCDHHS along with a new MCMN and PA for approval consideration prior to administering:

- There must be monthly documented evidence that the Wound VAC therapy has decreased the size or improved the condition of the wound or wounds.
 - The anticipated extended use of the Wound VAC therapy will be based on a month-to-month evaluation.
 - The provider must explain the anticipated benefit of continued use of the Wound VAC.
 - On a regular basis the provider must:
 - › Directly assess the wound(s) treated with the Wound VAC.
 - › Supervise or directly perform the Wound VAC dressing changes.
 - › On at least a monthly basis, document changes in ulcer dimension 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:

- In the judgment of the treating provider adequate wound healing has occurred to the degree that Wound VAC therapy may be discontinued.
- 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.
- Four months. Coverage beyond four months will be given individual consideration based upon required additional documentation (See “Continued Wound VAC Coverage”).
- Once equipment or supplies are no longer needed.

Wound VAC Supplies

- Coverage is provided up to a maximum of 15 dressing kits per wound per month unless there is documentation 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 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 exceptions to coverage criteria and exclusions after a written request is received from the treating physician-provider. Please send requests for exceptions to:

SCDHHS
Medical Director
Post Office Box 8206
Columbia, SC 29202-8206

Ongoing Supplies

Ongoing supplies for use in any setting in which normal life activities take place, such as ostomy supplies, catheters and sterile gloves, are reimbursable as 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 items employed for the correction or prevention of skeletal deformities (braces, splints, etc.). Braces include rigid and semi-rigid devices used for the purpose of supporting weak or deformed extremities.

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

Oxygen

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

- The diagnosis must indicate a chronic debilitating medical condition.
- The beneficiary's arterial oxygen partial pressure (PaO₂) must be below 60mm Hg. If a PaO₂ cannot be obtained, arterial oxygen saturation of the beneficiary must be provided. The arterial oxygen saturation must be below 89mm Hg. For nocturnal oxygen, the beneficiary must have at least five minutes of desaturation less than 89mm Hg to qualify for oxygen. If the PaO₂ is 56–59mm or an arterial blood oxygen saturation of 89% at rest (awake), during sleep for at least five minutes or during exercise, then any one of the following must apply:
 - Dependent edema suggesting congestive heart failure.

- 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).
- Erythrocythemia with a hematocrit greater than 56%.

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

- The provider must maintain a MCMN in the beneficiary’s file for audit purposes.
- Portable oxygen systems are reimbursed if the provider 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 in route to a doctor’s office, hospital, etc.
- Associated equipment or supplies such as regulators, oxygen tubing and cannulas are included in the rental of the system.
- The use of a portable system is limited to periods of time in which a beneficiary must be separated from a stationary system.
- The treating/ordering provider 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 thirty-sixth monthly payment amount is made, monthly payments will begin for oxygen contents.

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 medical need for parenteral nutrition and be made available to SCDHHS upon request.

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 indicate 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

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

provider'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 more than one per day will be denied as not separately payable.

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.

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 sixteenth month of use, regardless of the type or life span of the 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 necessary as prescribed by a provider.

Transportation of Self-Administered Oxygen Dependent Beneficiaries

The policy applies to beneficiaries admitted, as an inpatient of a hospital or hospital emergency room (ER), 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 currently admitted to the hospital or hospital ER 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.

Ventilators

Invasive (tracheostomy tube) and non-invasive (mask, chest shell) ventilators are considered for rental only with PA 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 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 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 QIO for PA (Medicaid Prior Approval). Reimbursement is based on the allowance for the least costly medically appropriate alternative. Reimbursement for a costlier alternative than medically appropriate will subject the DME provider to recoupment of funds.

Wheelchairs

To qualify for Medicaid reimbursement for a wheelchair, the provider must prescribe the equipment, which is medically necessary for the beneficiary. The provider is responsible for ordering the items in connection with the plan of treatment. The provider must be a licensed, active, SC 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 SC 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.

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. This assessment must be documented, kept on file and available upon request.

The beneficiary must meet the following functional needs assessment criteria:

1. The beneficiary has a mobility limitation that significantly impairs the 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 any setting in which normal life activities take place, that would be alleviated by the mobility device. A mobility limitation is one that:
 - Prevents the beneficiary from accomplishing a MRADL entirely.
 - Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL.
 - 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 any setting in which normal life activities take place is considered medically necessary if the other condition prevents completion of tasks even with a wheelchair:
 - Some examples are significant impairment of cognition or judgment and/or vision.
 - 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 any setting in which normal life activities take place:
 - A caretaker, for example a family member, may be compensatory, if consistently available in any setting in which normal life activities take place and willing and able to safely operate and transfer 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.
 - 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:

- 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.
 - A history of unsafe behavior in other venues may be considered.
5. The beneficiary's mobility limitation cannot be sufficiently resolved using an appropriately fitted cane or walker:
- The cane or walker must be appropriately fitted to the beneficiary for this evaluation.
 - 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 and attachments) medically necessary when the beneficiary's condition is such that, without the use of a wheelchair, would otherwise be unable to ambulate in any setting in which normal life activities take place (e.g., from bedroom to bathroom, bedroom to kitchen, etc.).

The following criteria **must** be met:

- The beneficiary must meet the functional needs assessment criteria 1 through 5 listed above.
- The beneficiary's typical environment (any setting in which normal life activities take place) must support the use of manual wheelchairs:
 - The beneficiary's environment must support the use of this type of mobility equipment.
 - Factors such as temperature, physical layout, surfaces and obstacles must be considered, as these may render mobility equipment unusable in the beneficiary's environment.
- The beneficiary must have sufficient upper extremity function to propel a manual wheelchair in any setting in which normal life activities take place 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:
 - Limitations of strength, endurance, range of motion, coordination and absence or deformity in one or both upper extremities is relevant.
 - An individual with sufficient upper extremity function may qualify for a manual wheelchair. The appropriate type of manual wheelchair, (light weight, heavy duty, etc.) must be determined based on the beneficiary's physical characteristics and anticipated intensity of use.

- The beneficiary's home (defined as any setting in which normal life activities take place) must provide adequate access, maneuvering space and surfaces for the operation of a manual wheelchair.
- The beneficiary's ability to safely use a manual wheelchair must be assessed.
- The beneficiary's condition is such that the requirement for a wheelchair is long term (at least 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).
- 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 (defined as any setting in which normal life activities take place).

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 MCMN). 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. 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 DME, 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. The evaluation must clearly distinguish the beneficiary's mobility needs within the home environment as defined in the Social Security Act only.

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

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

- There must be a history and physical examination by the provider 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.
- A prescription must be written after the in-person visit has occurred and the medical evaluation is completed.
- 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:

- Non-ambulatory, with severe weakness in the upper extremities due to a neurological or muscular condition.
- Bed or chair-confined when not using a wheelchair.
- Unable to operate a manual wheelchair.
- 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, SC Medicaid will follow Medicare or primary insurance guidelines for frequency limitations. The provider will need to attach a copy of the primary insurance explanation of benefits 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.

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 or damaged due to weather because it was left out of doors, 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 relevant to the beneficiary's mobility needs.
- Symptoms that limit ambulation.

- Diagnoses responsible for symptoms.
- Medications or other treatment for 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 is not sufficient.
- Ambulatory assistance (cane, walker, wheelchair) currently used and why it is not sufficient.
- What has changed to now require use of a power wheelchair.
- Ability to use a manual wheelchair.
- Description of the environment and the ability to perform activities of daily living in the space.
- Physical examination relevant to the patient's mobility needs.
- Weight and height.
- 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 responsible for ambulatory difficulty or impact ambulatory ability.

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

Mobility evaluations that contain check-off boxes or space for only brief answers and therefore 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 and why a cane, walker or optimally configured manual wheelchair is not sufficient to meet those needs.

~~Physicians~~ Providers must record the visit and mobility evaluation in their usual medical record-keeping format.

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

- Beneficiary's name.
- Description of the item ordered. This may be general (e.g., power wheelchair) device or may be more specific.
- Date of completion of the face-to-face examination.
- Pertinent diagnoses and/or conditions that relate to the need for the power wheelchair.
- Length of need.
- Provider signature.
- Date of provider signature.

The provider 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 provider must also include copies of previous notes, consultations with other providers 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) provided including all options and accessories. After gathering this information, the provider must review it and if in agreement with what is provided, sign, date and return it to the supplier. If the provider 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:

- On-site evaluation of the beneficiary's home, or any setting in which normal life activities take place.
- Beneficiary's ability to adequately maneuver the equipment in the existing physical space.
- Doorway width.
- Inspect doorway thresholds and surfaces.
- A copy of the home (any setting in which normal life activities take place) assessment must be kept on file and available upon request.

Basic Coverage Criteria

In addition to the beneficiary's condition and documentation requirements that must be submitted and kept on file, all 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 the ability to participate in one or more MRADLs such as toileting, feeding, dressing, grooming, and bathing in customary locations. A mobility limitation is one that:
 - A. Prevents the beneficiary from accomplishing an 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 beneficiary's mobility limitation cannot be sufficiently and safely resolved using an appropriately fitted cane or walker.
3. The beneficiary does not have sufficient upper extremity function to self-propel an optimally configured manual wheelchair 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 provided.
6. The beneficiary's weight is less than or equal to the weight capacity of the power wheelchair provided.
7. The beneficiary's home living environment provides adequate access between rooms, maneuvering space and surfaces for the operation of the power wheelchair provided.
8. Use of a power wheelchair will significantly improve the beneficiary's ability to participate in MRADLs. 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:
 - 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

- 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 coverage criteria 1–9 for a PWC are met and the wheelchair is appropriate for the patient's weight.
- 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 coverage criteria 1–9 for a power wheelchair are met, and if:
 - Criterion 1 or 2 is met.
 - Criterion 3 is met.

The criterion is as follows:

- 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).
- 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 used on the wheelchair.
- The beneficiary has a specialty evaluation performed by a licensed/certified medical professional, such as a PT or OT, or physician with 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.

- 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 the coverage criteria 1–9 for a power wheelchair are met, and if:
 - Criterion 1 or 2 is met.
 - Criterion 3 is met.

The criterion is as follows:

- The beneficiary meets coverage criteria for a power tilt and recline seating system (see Wheelchair Options and Accessories policy) and the system is used on the wheelchair.
- The beneficiary uses a ventilator mounted on the wheelchair.
- The beneficiary has a specialty evaluation performed by a licensed/certified medical professional, such as a PT or OT or physician with specific training and experience in rehabilitation wheelchair evaluations and that documents medical necessity for the wheelchair and its special features (see Documentation Requirements section). The PT, OT or physician may have no financial relationship with the supplier.

If a Group 2 Multiple Power Options 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.

- A Group 3 power wheelchair with no power options is covered if:
 - All the coverage criteria 1–3 for a power wheelchair is met.
 - The beneficiary's mobility limitation is due to a neurological condition, myopathy or congenital skeletal deformity.
 - The beneficiary has had a specialty evaluation performed by a licensed/certified medical professional, such as a PT, OT or physician with specific training and experience in rehabilitation wheelchair evaluations and that documents 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.

- 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.
- The Group 3 criteria IV(A) and IV(B) are met.
- The Group 2 Single Power Option (criteria II[A] and II[B]) or Multiple Power Options (criteria III[A] and III[B]) (respectively) are met.
- If a Group 3 Single Power Option or Multiple Power Options power wheelchair is provided and Criterion IV(A) is met but all 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.

- 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.
- 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:
 - All the coverage criteria 1–9 for a power wheelchair is met.
 - The beneficiary is expected to grow in height.
 - 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 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.

Determinations of least costly alternative consider 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 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 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 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 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 under repair. Payment is based on the type of replacement device provided but will not exceed the rental allowance for the power mobility device under repair.

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 items billed. If submitting an internet "screen print", a signature is required certifying the date, quantity, cost, and description of items billed. If submitting billing cost instead of MSRP, Medicaid will reimburse cost plus 25%. 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 perform 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
- Speech generating device 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 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. An adequate seating system allows 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).
- Crutch or cane holder
- Flat-free inserts (zero pressure tubes): flat-free inserts have a removable ring of firm material 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.
- 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.

NON-COVERED SERVICES

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.

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

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UTILIZATION MANAGEMENT

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.

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 MCMN.

NOTE: At a minimum, the provider is required to obtain and maintain in the beneficiary's file a MCMN for all Healthcare Common Procedure Coding System (HCPCS) codes billed. The procedure code information available on the provider portal further lists specific HCPCS codes that require MCMN submission with the claim and specific HCPCS codes that require PA. Regardless of whether 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:

1. Equipment/Supplies (DME 001)
2. Power/Manual Wheelchairs and/or Accessories (DME 003)
3. Orthotics/Prosthetics/Diabetic Shoes (DME 004)
4. Enteral Nutrition (DME 005)
5. Parenteral Nutrition (DME 006)
6. Oxygen (DME 007)

Please refer to the Forms for this manual located on the provider portal for a copy of these forms. Each MCMN has instructions attached.

Medicaid prohibits DME providers from preparing the entire 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 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 PA, only the date of service field on the MCMN may be completed after the approval is obtained. However, it must be filled in once equipment and supplies are delivered.

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

A 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.

PRIOR AUTHORIZATION

Medicaid PA from QIO

All PA requests for DME codes must be submitted to the QIO for South Carolina Medicaid. The QIO will use nationally developed clinical rules and best practices for medical necessity determinations such as McKesson's InterQual for DME. Providers for these services will continue to submit the Certificate of Medical Necessity (CMN), physician's orders and all pertinent medical documentation. DME services and equipment requiring prior approval are identified in the "[Covered Services and Definitions](#)" section of this manual.

DME will reimburse for medically necessary items only. Items billed as convenience are not covered. DME Providers are responsible for submitting and billing the correct HCPCS procedure code(s). PA requests for miscellaneous codes will be denied if the QIO reviewer determines there are other more specific codes available. A provider must not use a miscellaneous code in place of the recognized HCPCS code for a DME item that is not covered.

Case Managers and Service Coordinators for Community Long-Term Care and the South Carolina Department of Disabilities and Special Needs 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 PA through the 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 PA.

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 the Companion Guide for information on eligibility verification.

Instructions for Obtaining PA

Requests for PAs for the above services can be submitted to the QIO using one of the following methods:

QIO Customer Service Phone: 855-326-5219

QIO Fax: 855-300-0082

For Provider Issues email: atrezzoissues@Kepro.com

Additional information regarding PA will be found by visiting the QIO website at <https://scdhhs.kepro.com>.

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

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 the QIO. If the original denial is upheld, providers may exercise their right to an appeal as outlined in the Companion Guide.

The QIO 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.

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ADDITIONAL REQUIREMENTS

DME OPERATING/DELIVERY PROCEDURES

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 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.

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 public.

Providers must accept the Medicaid payment as payment in full for covered services to patients accepted as Medicaid beneficiaries. (See “Medicaid as Payment in Full” section in the Provider Administrative and Billing Manual on the provider portal 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 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 on the provider portal for more information.

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 are responsible for providing the appropriate equipment/supplies, set-up or necessary assembly of the equipment in the beneficiary’s living space 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 are responsible 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 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. Refer to “Auto-Refilling” in this section for more information.

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.

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.

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.

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 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.

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 (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 DME and medical supply providers and the stockpiling of medical supplies by beneficiaries is 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 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.

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

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BILLING GUIDANCE

PROCEDURE CODES AND MODIFIERS

The most current DME fee schedule is maintained on the SCDHHS website at <https://www.scdhhs.gov/>. A provider must obtain and maintain a valid signed MCMN in the beneficiary's file for each and every HCPCS code billed for reimbursement.

MANUAL PRICING AND NOT OTHERWISE CLASSIFIED (NOC) CODES

DME does not require enrolled providers to submit manufacturer pricing information with PA 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. Procedure codes that require manual pricing 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 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%. Providers will indicate in documentation if pricing is at cost or 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 MCMN to substantiate reimbursements paid for the maximum number of units 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 of 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:

- If previous equipment is operable
- If the item is repairable (Repair options are to be utilized before item is replaced)
- If only to obtain a "newer" model
- If requested as a backup 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 or coverage.

MODIFIERS

The following modifiers are acceptable for durable medical equipment and must be listed on the PA 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 six months beginning on the sixteenth 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)

Capped Rental Equipment

The items listed below are 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.

- Manual hospital bed with mattress side rails
- Respiratory assist device, bi-level pressure capability without backup rate feature
- Respiratory assist device, noninvasive interface
- Respiratory assist device, invasive interface
- CPAP device
- Insulin pump
- Parenteral infusion pump
- Trapeze free stand complete with grab bar
- Gastric suction pump
- Standard manual wheelchair
- Elevating leg rest, pair

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 PA form and accompanied by a CMN. Any pertinent medical records or justification must also accompany this request. Requests for additional months must be resubmitted with a new PA, 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.

- Powered air overlay mattress
- Power pressure-reducing air mattress
- Powered air floatation bed
- Air fluidized bed
- Negative pressure wound therapy electrical pump (Please refer to “Negative Pressure Wound VAC” in this section)
- Osteogenesis stimulator

These items cannot be approved for the purpose of prevention.

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
- 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.

PA 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.

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 PA, the CRLC form and manufacturer's pricing must be submitted to the QIO for PA. For items with established procedure codes not requiring PA, 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 must be billed with all repairs on the same form.

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.

Codes that Require a MCMN be Submitted with the Claim

For a list of codes that require a MCMN to be attached to the CMS-1500 claim form, please refer to the code information located on the provider portal.

Codes Requiring PA from the QIO

For a list of codes that require PA from the QIO, please refer to the code information located on the provider portal linked above.