Assistive Technology and Appliances Assessment/Consultation

Definition: Assistive Technology and Appliances Assessment/Consultation may be provided (if not covered under the State Plan Medicaid) once a participant's specific need has been identified and documented in the Support Plan. The scope of the work and specifications must be determined. Consultation and assessment may include specific needs related to the participant's disability for which assistive technology and/or appliances will assist the participant to function more independently. Appliances intended for general household utility that do not result in a decrease in need for other waiver services are not covered. This services is not intended to replace traditional household appliances for the convenience of the family/household members or caregivers. Additionally, devices, items, equipment, and/or product systems not proven effective, or deemed trial or experimental are not covered.

Service Limits: The reimbursement for the Consultation/Assessment may not exceed $300.00

Providers: Assistive Technology and Appliances Assessments/Consultations must be completed by either Licensed Medicaid enrolled Occupational or Physical Therapists, Medicaid enrolled Rehabilitation Engineering Technologists, Assistive Technology Practitioners and Assistive Technology Suppliers certified by the Rehabilitation Engineering Society of North America (RESNA), or Medicaid enrolled Environmental Access/Consultants/contractors certified by Professional Resource in Management (PRIME). The DSN Board or Qualified provider may employ or contract for this service however; they are responsible for verifying and documenting licensure or certification.

Arranging for and Authorizing Services: This service is available through the Community Supports Waiver to assess and determine the specific needs related to the participant's disability for which specialized medical equipment or assistive technology will assist him/her to function more independently. The maximum amount allowed for a Consultation for the initial acquisition of an item is $300.

Once the provider is chosen by the participant, a request for service approval is sent to the SCDDSN Waiver Administration Division. To initiate the service following approval by the Waiver Administration Division, an electronic authorization must be completed and submitted to the chosen. The service must be Direct-billed to SCDHHS. This must be indicated on the authorization.

For providers that are contracted by the Financial Manager (to provide Medical Equipment, Medical Supplies and Consultation only), a copy of the authorization must be sent to the Financial Manager and to the SURB Division SCDDSN Central Office Finance.

Monitoring Services: The Waiver Case Manager must monitor the assessment within two (2) weeks of completion to verify that the work is adequate, and satisfactory to the family.

Reduction, Suspension or Termination of Services: If services are to be reduced, suspended or terminated, a written notice must be sent to the participant/representative including the details regarding the change(s) in service, the allowance for appeal, and a ten (10) calendar day waiting period (from the date that the reduction/suspension/termination form is completed) before the reduction, suspension or termination of the waiver service(s) takes effect. See *Chapter 8* for specific details and procedures regarding written notification and the appeals process.