

Specialized Medical Equipment, Supplies and Assistive Technology

Definition: Specialized medical equipment, supplies and assistive technology to include devices, controls, or appliances, specified in the Support Plan, which enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under State Plan Medicaid. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.

Note: The provision of assistive technology must eliminate/reduce the need for either personal care or another direct care service.

Note: Durable Medical Equipment (DME) is the name of a service available to all Medicaid beneficiaries in South Carolina. It is not the name of an ID/RD Waiver service.

Service Limits: Liquid nutrition is limited to two (2) cases per month for waiver participants of all ages who do not use a feeding tube. Liquid nutrition for waiver participants who use a feeding tube is provided by State Plan Medicaid and is not covered by the waiver. Liquid nutrition is only for participants who are unable to consume sufficient calories/nutrients from food alone. It does not include medicines, vitamins or mineral supplements. Liquid nutrition must be medically necessary and prescribed by a physician. If the liquid nutrition comes in other forms (e.g. pudding, powder or shakes), it can be covered by the waiver as long as it is ordered by a physician. Liquid nutrition in other forms is also subject to the two (2) cases per month limit. Most powders come four (4) cans per case. Shakes and pudding are comparable to conventional liquid nutrition case sizes. If more than one form of liquid nutrition is received, the two case per month limit applies to the combined total (i.e. one cannot receive, as an example, two cases of shakes and two cases of pudding in the same month).

Note: Nutritional supplements are not available through the ID/RD Waiver. Non-covered nutritional supplements include vitamins, minerals, herbs, meal supplements, sports nutrition products, natural food supplements and other related products used to boost the nutritional content of the diet or to aid in the digestion/absorption of food/supplements/nutrients or to reduce or eliminate side effects of medications/supplements. No food or nutritional supplement may be authorized.

Note: For waiver participants under the age of 21, all requests for Specialized Medical Equipment, Supplies and Assistive Technology must be reviewed for State Plan Medicaid funding under Early Periodic Screening, Diagnostic, and Treatment (EPSDT). If the request is determined to not meet EPSDT guidelines, but does provide a specific, direct benefit to the participant (i.e. enable him/her to overcome a barrier clearly linked to his/her disability) and eliminate/reduce the need for either Personal Care or another direct care service, the request can be reviewed for waiver funding.

Providers: Specialized Medical Equipment, Supplies and Assistive Technology must be provided by vendors who are enrolled with SCDHHS as Waiver Durable Medical Equipment (DME) providers or by DDSN/DSN Boards/contracted providers. **A vendor enrolled with SCDHHS as a DME provider cannot opt to bill the Financial Manager.** The provider list for this service is located on DDSN's website.

In most instances, Specialized Medical Equipment, Supplies and Assistive Technology is provided by a vendor enrolled with SCDHHS as a DME provider. There may, however, be circumstances where a

participant's needs can be met by a vendor that is not enrolled with SCDHHS. Vendors who are not enrolled with SCDHHS **must** contract with the Financial Manager to provide Medical Equipment, Supplies and Assistive Technology.

Arranging for and Authorizing Services: Once the participant's need has been identified and documented in the Support Plan, and it is determined that the provision of equipment or supplies will meet or address the need, the Waiver Case Manager must determine if State Plan Medicaid covers the items. **The State Plan covers DME, which is available to all Medicaid beneficiaries, and includes equipment or supplies ordered by a Physician, such as, hospital beds, wheelchairs, back and leg braces, shower chairs, crutches, oxygen, bandage, etc. Furthermore, liquid nutrition is covered by State Plan Medicaid when the product is the person's sole source of nutrition. If an individual, has a feeding tube, then liquid nutrition can be funded by State Plan Medicaid. The State Plan covers some Durable Medical Equipment (DME). The Waiver Case Manager must document attempts to determine if the needed items are covered by the State Plan.**

The following procedures should be used to determine if an item is covered by State Plan Medicaid:

The Waiver Case Manager will refer to the SCDHHS *Durable Medical Equipment manual*, which is published by SCDHHS at www.scdhhs.gov. Click on "For Providers" and "Provider Manuals" in the center of the home page and scroll down to "Durable Medical Equipment." Equipment and supply lists are under "Procedure Codes" in Section 4 of the manual. If an item is not listed in the section, the item is not covered by the State Plan.

Additional State plan covered supplies will not be considered through waiver. The SCDHHS Durable Medical Equipment manual provides instructions to providers on how to request additional supplies if medically necessary.

State procurement policy must be followed as appropriate:

A. \$10,000 or less NO COMPETITION:

Small purchases not exceeding \$10,000 may be accomplished without securing competitive quotations if the prices are considered reasonable. The purchasing office must annotate the purchase requisition "Price is fair and reasonable" and sign. The purchases must be distributed equitably among qualified suppliers. When practical, a quotation must be solicited from a provider other than the previous supplier before placing a repeat order. The administrative cost of verifying the reasonableness of the price of purchase "not in excess of" may more than offset potential savings in detecting instances of overpricing. Action to verify the reasonableness of the price need be taken only when the procurement officer of the governmental body suspects that the price may not be reasonable, comparison to previous price paid, or personal knowledge of the item involved.

B. \$10,001 to \$25,000 THREE WRITTEN QUOTES:

Written request for written quotes from a minimum of three (3) qualified sources of supply may be made and, unless adequate public notice is provided in the South Carolina Business Opportunities, documentation of at least three (3) bona fide, responsive, and responsible quotes must be attached to the purchase requisition for a small purchase not in excess of \$25,000. The award must be made to the lowest responsive and responsible sources. The request for quotes must include a purchase description. Requests must be distributed equitably among qualified suppliers unless advertised as provided above.

C. \$25,000.01-\$100,000 ADVERTISED SMALL PURCHASE:

Written solicitation of written quotes, bids, or proposals may be made for a small purchase not in excess of \$100,000. The procurement 250-08-DD, February 20, 2020, Page 4 must be advertised at least once in the South Carolina Business Opportunities publication. A copy of the written solicitation and written quotes must be attached to the purchase requisition. The award must be

made to the lowest responsive and responsible source or, when a request for proposal process is used, to the highest ranking offeror.

Once the provider is chosen by the participant or selected as the lowest [pre-tax] bidder among the providers from whom bids were solicited and the request has been submitted to the SCDDSN Waiver Administration Division and approved, the service can be authorized. To initiate the service following approval from the Waiver Administration Division, an electronic authorization must be completed and submitted to the chosen provider. Ongoing services must be authorized annually at the time of the Support Plan, and as changes are made to the service throughout the plan year.

If the authorized provider is enrolled with SCDHHS as a DME provider, the item or service must be Direct-billed to SCDHHS. This must be indicated on the authorization.

If the authorized provider is a DSN Board or other DDSN-contracted provider, the service must be Board-billed to the participant's SCDDSN Financial Manager agency. This must be indicated on authorization. If the provider of a Board Billed service is not directly enrolled as a Medicaid Provider and is not on the DDSN QPL but will be invoicing the financial manager for services, the "non-shareable" indicator should be selected when authorizing the service and the authorization can be printed and faxed to the provider. For providers that are contracted by the Financial Manager, a copy of the authorization must be sent to the Financial Manager and to the SURB Division SCDDSN Central Office Finance.

1. **Medical Supplies (T2028)** are those non-durable supplies that are not available through the Medicaid State Plan and that are of direct medical benefit to the participant. This may include liquid nutrition (when the participant does not have a feeding tube), but will not include toiletries or other hygienic products.
2. **Medical Equipment (T2029)** is any durable or non-durable equipment item that is not covered by the Medicaid State Plan and that is of direct medical or remedial benefit to the participant. Even when an item serves a useful medical purpose, one must also consider to what extent, if any, it would be reasonable for the ID/RD Waiver to pay for the item prescribed.

Any equipment covered through the State plan that is denied for any reason, must go through the SCDHHS appeal process for adjudication before being considered through the ID/RD Waiver. The SCDHHS appeal process is found in the SCDHHS Durable Medical Equipment Provider Manual (Section 1).

Proper documentation showing the outcome of the appeal must accompany the request for waiver consideration.

The following considerations should enter into the determination of what is reasonable:

1. Is the item substantially more costly than a medically appropriate and realistically feasible alternative pattern of care?
2. Does the item serve essentially the same purpose as equipment already available to the participant?

For medical equipment to be covered through the ID/RD Waiver, it must be reasonable and medically necessary. Excessive expenses for "deluxe" features or added convenience are not considered reasonable; therefore, the least costly alternative item that provides the intended medical benefit will be considered first.

Quick Reference:

In order to obtain Medical Equipment through the ID/RD Waiver the following steps must be followed (for full explanation see the narrative above):

1. Determine what item is needed and what the direct medical benefit to the consumer will be.
 2. Is it reasonable to obtain the item? (see narrative above).
 3. Is the item covered by State Plan? If yes, the DME provider will directly bill Medicaid for the item. If no, go to step 5.
 4. Is there a comparable item covered by State Plan? Check the DME Provider Manual. If yes, the DME provider will directly bill Medicaid for the item.
 5. Obtain necessary documentation to verify medical necessity. CM can request the item through the waiver.
3. **Assistive Technology** (authorized as Medical Equipment – T2029) includes items that are assistive in nature, such as large button telephones, strobe light fire alarms, and flashing light alarm clocks. These items must provide a specific benefit to the participant (i.e. enable him/her to overcome a barrier clearly linked to his/her disability) and eliminate/reduce the need for either Personal Care or another direct care service.

For information pertaining to initial consultations, please refer to the SME&AT Assessment/Consultation section in Chapter 10 of the waiver manual.

4. **Rental:** In certain circumstances, needs for equipment or supplies may be time-limited (e.g. a participant is scheduled to undergo surgery and will need a bedside commode during recovery). Time-limited rental should be used when a particular item is not needed for longer than 3 months. In these circumstances, the Waiver Case Manager should authorize rental of the needed item from the participant's choice of providers. The Waiver Case Manager must initially verify that the rental costs cannot be covered by the State Plan. If the State Plan does not cover the rental for the particular piece of equipment needed, then the cost of the rental can be funded through Specialized Medical Equipment, Supplies and Assistive Technology. Rentals are authorized as Medical Equipment (T2029).
5. **Repairs:** and replacement of parts that are not covered by warranty may be funded through Specialized Equipment, Supplies and Assistive Technology for equipment that was obtained through this waiver service. Equipment obtained through funding sources other than the waiver (e.g. private insurance, State Plan Medicaid, etc.) are not eligible for waiver-funded repairs or parts replacement. Repairs and/or replacements of equipment may not be granted if it is determined that there has been abuse/misuse of the equipment or if the same repair has been done on the same piece of equipment more than twice in twelve (12) calendar months. Consideration for further repairs requires documentation describing extenuating circumstances. Some things to consider when determining and documenting if abuse/misuse contributed to the need for repair are:
 - How was the item damaged?
 - Has this happened before with this item/individual?
 - Consult other individuals who work/live with the consumer (Residential/Day Program Staff, Teachers etc.) to determine how damage occurred.
 - The Waiver Case Manager should gather this information and use professional judgment when determining whether abuse/misuse of equipment has occurred. Repairs are authorized as Medical Equipment (T2029).

6. Repair Assessment (T2029): When an item funded by the waiver requires a repair and the item cannot be transported to the provider for assessment, an assessment to determine the scope of the repairs needed can be funded by the waiver. Reimbursement for the assessment covers travel time mileage, and labor costs and may not exceed \$75. The Repair Assessment must be submitted to the Case Manager, and must include a summary of the work completed, findings from the assessment and a determination of the repairs needed. The determination of the repairs needed must be detailed and include all necessary steps to complete the repair. The assessment must include the specified parts needed and cost.

The name of the item being authorized, the cost authorized and the frequency must be specified for equipment and supplies.

Note: When a new service authorization is sent to a provider, it nullifies any previous authorization to that provider for ongoing supplies. For this reason, **any new authorizations must include those supplies provided on a regular schedule that continue to be needed as well as the new supplies.**

Note: When a notice of termination, reduction or suspension of Specialized Medical Equipment, Supplies and Assistive Technology is completed, that termination, reduction or suspension applies for all procedure codes on the authorization and cannot single out a specific medical supply. If one medical supply is to be terminated, reduced or suspended, but other supplies provided by that same provider are to continue to be received, the notice of termination, reduction or suspension must be followed by a new authorization for the supplies that are to continue to be provided on a regular schedule.

Monitoring Services: The Waiver Case Manager must monitor the service for effectiveness, usefulness and participant satisfaction. Monitoring may be completed with the participant, representative, service providers, or other relevant entities. Information gathered during monitoring may lead to a change in the service, such as an increase/decrease in units authorized, change of provider, change to a more appropriate service, etc. DDSN recommends that the Waiver Case Manager monitors this service when it begins and as changes are made. The following guidelines should be followed when monitoring Specialized Medical Equipment, Supplies, and Assistive Technology:

- Monitoring should be conducted within two (2) weeks of receipt of one-time items.

Monitoring must be conducted as frequently as necessary in order to ensure:

- the health, safety and well-being of the participant;
- the service adequately addresses the needs of the participant;
- the service is being furnished by the chosen provider in accordance with the authorization, relevant policies and quality expectations;
- the participant/representative is satisfied with their chosen provider/s.

Some questions to consider during monitoring include:

One-Time Items

- ❖ Did the participant receive the item?
- ❖ What is the benefit of the item to the participant?
- ❖ Is the item being used as prescribed?
- ❖ Is the participant satisfied with the provider?
- ❖ Is the provider responsive to the participant's needs?

On-going items

- ❖ Has the participant's health status changed since your last monitoring? If so, do all authorized supplies need to continue at their current amounts and frequencies?
- ❖ Are the specific brands appropriate for the participant's needs, or does a change need to be made?

- ❖ Are additional supplies needed at this time? Are there any new needs?
- ❖ Does the participant receive his/her monthly supplies in a timely manner?
- ❖ What is the benefit of the item to the participant?
- ❖ Are the items being used as prescribed?
- ❖ Is the participant satisfied with the provider?
- ❖ Is the provider responsive to the participant's needs?

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 9* for specific details and procedures regarding written notification and the appeals process.