Specialized Medical Equipment, Supplies and Assistive Technology

Definition: Specialized medical equipment, supplies and assistive technology includes 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. For information pertaining to initial consultations, see Specialized Medical Equipment, Supplies and Assistive Technology Assessment/ Consultation section in Chapter 10 of the manual.

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

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.

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

4. **Rentals:** 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 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 Manage, 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.

7. **Remote Supports (T2029 U2)** is a form of assistive technology which includes a person-centered electronic network of devices enabling waiver participants to live more independently through support and monitoring while exercising more control over their own lives. **Remote Supports are limited to medication dispensers, door sensors, window sensors, stove sensors, water sensors, pressure pads, GPS Tracking Watches, and the remote monitoring equipment necessary to operate the remote supports technology**. This service includes the costs for delivery, installation, adjustments, monthly testing, monitoring, maintenance, and repairs to the Remote Supports equipment. Remote Supports can be customized based on the assessed need of the participant and will notify a designated responder when the established alert parameters are met. Notifications can be customized to make this service person-centric and can also be delivered to the responder using various methods (email, text, and phone).

   Remote Supports are limited to participants requiring extensive routine supervision which may be reduced or replaced by Remote Supports. Remote Supports are available to participants who have existing natural supports willing to be identified as designated responders.

   Remote Supports are not available to participants who receive residential habilitation with the exception of residential habilitation services provided in a SLP I setting.

   Remote Supports cannot be used to provide the basic physical requirements for service delivery (internet access, electricity, etc.). Remote Supports must be used directly by the waiver participant and is not intended for the convenience of the caregiver.

   Determinations will be made based on assessed need and the potential to increase the waiver participant's independence and reduce the need for supervision. The amount of technology approved will be determined through a combination of assessment by the remote Supports provider as well as the annual assessment and other relevant documentation.

If the participant is receiving Behavioral Supports, the technology must be consistent with the participant's behavior support plan.

Remote Supports are fully integrated into the participant's overall system of support. Prior to purchasing and installing remote monitoring equipment, the Remote Supports provider is responsible for completing the following:

- An evaluation plan that includes: the need(s) of the participant that will be met by the technology; how the technology will ensure the participant's health, welfare and independence; the training needed to successfully utilize the technology; and the back-up plan to be implemented should there be a problem with the technology.
- An outcome monitoring plan that outlines the outcomes the participant is to achieve by using remote supports, how the outcomes will be measured and the frequency that the monitoring will be completed which must be at least quarterly or more frequently if needed.
- Informing the participant, and anyone identified by the participant, of the impact Remote Supports may have on the participant's privacy. This information must be provided to the participant in a form of communication understood by the participant.

After this has been completed, the Remote Supports provider must obtain either the participant's consent in writing or the written consent of a legally responsible party for the participant. See ***Remote Supports Consent Form and Waiver of Liability*** form in business tools. This process must be completed prior to the utilization of Remote Supports and any time there is a change to the devices or services. This information will be provided to the participant and service plan team for discussion and inclusion of Remote Supports in the support plan.

Service Limits:

Liquid nutrition is defined as macronutrients (i.e., proteins, fats, and carbohydrates) and micronutrients (i.e., vitamins, minerals, and trace elements) delivered primarily in the form of an all-in-one liquid compound. State Plan Medicaid covers liquid nutrition for waiver participants who receive their nutrition either intravenously or by feeding tube. The ID/RD waiver will only cover liquid nutrition for participants who are unable to consume sufficient calories/nutrients from food alone **and** do not use a feeding tube/IV. Coverage is limited to two (2) cases per month, is available in any form (e.g., pudding, powder, or shakes), and is not age restricted. Liquid nutrition must be medically necessary and ordered by a physician. The Physician's Order for Liquid Nutrition form must be completed prior to the initial request for the service and annually during plan development. This form must be submitted with the Support Plan or plan change request prior to authorization. The Physician Order for Liquid Nutrition form is located in Business Tools>Forms>IDRD Waiver.

If more than one form of liquid nutrition is requested, the two case per month limit applies to the combined total. For example, a participant may receive two cases of shakes per month or two cases of pudding per month, not both. A participant may receive one case of shakes and one case of pudding per month.

The ID/RD waiver does not cover traditional food, drinks, or nutritional supplements. Nutritional supplements include (but not limited to) vitamins, minerals, herbs, sports nutrition/electrolyte replacement products, and/or 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.

Providers: Specialized Medical Equipment, Supplies and Assistive Technology are provided by vendors enrolled with SCDHHS as a DME provider. It is the WCM's responsibility to ensure providers are on the list of qualified providers.

Conflict Free Case Management: To honor choice and prevent conflicts of interest, providers of Waiver Case Management services must not provide any other waiver service to the same person. When there is a conflict, the WCM will help the participant understand why a conflict exists and offer a choice of either another WCM provider or another waiver service provider. The Case Manager must then transition the participant to the chosen provider within 60 days.

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 Specialized Medical Equipment, Supplies and Assistive Technology will meet or address the need, **the Waiver Case Manager (WCM) must determine if State Plan Medicaid covers the item(s).**

State Plan Medicaid covers some 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, crutches, oxygen, bandages, etc. The WCM must document attempts to determine if the needed items are covered by the State Plan.

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 provides 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.

To determine if an item is covered by State Plan Medicaid, the WCM will refer to the SCDHHS *Durable Medical Equipment Manual* https://www.scdhhs.gov/provider-type/durable-medical-equipment-manual-120104-edition-posted-111905 and *DME Fee Schedule* https://www.scdhhs.gov/resource/fee-schedules. Equipment and supply lists are under "Procedure Codes" in Section 4 of the manual. If an item is not listed in either the manual or fee schedule, the item is not covered by the State Plan.

The State plan imposes limits for covered supplies. Requests for additional supplies over the established limits will not be considered through the waiver. The SCDHHS Durable Medical Equipment manual provides instructions to providers on how to request additional supplies when medically necessary.

If a service covered through the State plan is **denied***, the DME provider **must** go through the SCDHHS appeal process for adjudication. Waiver will only consider **non-covered*** items. DME providers can find the SCDHHS appeal process in Section 1 of the SCDHHS Durable Medical Equipment Provider Manual located on the SCDHHS website (see link above).

***Denied** is defined as an item that **is listed** in the DME manual or fee schedule as covered by State Plan Medicaid but is not considered justified or medically necessary.

***Non-covered** is defined as an item **not listed** in the DME manual or fee schedule or if the item does not meet the State Plan's definition of durable medical equipment or supply.

For medical equipment and assistive technology to be considered through the ID/RD Waiver, it must be reasonable and medically necessary. The following should be considered to determine if the request is reasonable:

1. Is the item cost effective compared to other potential methods of meeting the need?
2. Does the item serve essentially the same purpose as equipment already available to the participant?
3. Does the request include "deluxe" features or features for added convenience?

Requests must include the lowest cost item that provides the intended medical benefit. “Deluxe” features or upgrades added solely for convenience will not be considered.

Quick Reference Guide:

To obtain Specialized Medical Equipment, Supplies and Assistive Technology through the ID/RD Waiver the following steps must be followed (see above narrative):

- Determine the item needed and the direct medical benefit to the consumer.
- Determine if the item is cost effective.
- Determine if the item is covered by State Plan Medicaid. If yes, the DME provider will directly bill Medicaid for the item.
- Is there is a comparable item that will meet the need covered by State Plan Medicaid? If yes, the DME provider will directly bill Medicaid for the item.
- Obtain necessary documentation to verify medical necessity.

State Procurement Policy:

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 needs 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 more than $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 more than $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. The name of the item being authorized, the cost authorized per item and the frequency must be specified in the comments section of the authorization. Authorizations should only include one item. There must not be multiple items listed on one authorization.

Monitoring Services: The WCM 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 WCM monitors this service when it begins and as changes are made. Monitoring should be conducted within two (2) weeks of receipt of one-time items.

The following guidelines should be followed when monitoring Specialized Medical Equipment, Supplies, and Assistive Technology:

Monitoring must be conducted as frequently as necessary 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 reconsideration, 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 reconsideration/appeals process.