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CLTC STANDARDS FOR WAIVER SERVICES

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OVERVIEW

South Carolina Medicaid has established standards for providers who wish to render Community Long Term Care (CLTC) waiver services. This section describes the scope of waiver services administered by the Division of Community Long Term Care.

Provider should also visit the SCDHHS Long Term Care and Behavioral Health Services home page for additional CLTC information.

MEDICAID ELIGIBILITY

Providers can verify Medicaid eligibility for CLTC participants in the Phoenix Provider Portal on their dashboard. Providers should also refer to Section 1 of this provider manual for additional information on eligibility determination.

PROVIDER PARTICIPATION

Enrollment

The enrollment process includes screening, licensure verification and site visits (if applicable), to ensure that all enrolling providers are in good standing and meet the requirements for which they are seeking enrollment. Refer to https://www.scdhhs.gov/provider or the eligible provider listing of SC Medicaid provider types and specialties.

Computer Requirements

Prior to the initiation of a contract, potential providers must have a computer, Internet access, and an email address to receive correspondences and authorizations from the Division of Community Long Term Care.

PROVIDER TRAINING

Mandatory Meeting

Providers interested in providing Adult Day Health Care, Case Management, Companion, Nursing, Personal Care I, and Personal Care II must attend a mandatory pre-contractual meeting. A completed online enrollment application must be completed prior to being invited to attend one of the meetings.

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In-Service Training

Providers of the following services must furnish in-service training in accordance with the SCDHHS-approved training list.

- Adult Care Home Services
- Companion Services
- Personal Care I
- Personal Care II

MANDATORY REPORTER

In accordance with S. C. Code of Laws, § 43-35-25, CLTC providers and their staff are mandatory reporters of abuse, neglect or exploitation of adults. Allegations must be reported to South Carolina Department of Social Services (SCDSS) within twenty-four (24) hours or within the next business day of receipt of the allegation or of witnessing the abuse, neglect or exploitation. Reports must be made in writing, or orally by telephone or otherwise.

CLTC providers and their staff are also mandatory reporters of abuse, neglect, or exploitation of children when in a professional capacity under S.C. Code of Laws, § 63-7-310. CLTC providers and their staff must report any information received that suggests the following:

- The reporter believes a child has been or may be abused or neglected as defined in § 63-7-20
- The reporter believes a child's physical or mental health or welfare has been or may be adversely affected by acts or omissions considered to be child abuse or neglect if committed by a responsible party (parent, guardian, or other person responsible for the child's welfare), but the acts or omission were committed by a person other than a responsible party

The reporter must notify the appropriate law enforcement agency. Reports of child abuse or neglect may be made orally by telephone or otherwise to the Department of Social Services county office or to a law enforcement agency in the county where the child resides or is found.

FRAUD

Providers are required to report incidents of suspected fraudulent activity by their employees or by the participant to

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FRAUD (CONT'D.)

SCDHHS-CLTC state office and the local area CLTC office within forty-eight (48) hours or within the next two (2) business days after discovery of the activity. The report must be submitted in writing via email, fax or mail and must include as many details as available regarding the suspected fraudulent activity.

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STANDARDS FOR WAIVER SERVICES

Scopes of services for **Environmental Modification** and **Waiver Medical Supplies** are located in Section 2 of this manual.

MEDICAID HOME AND COMMUNITY-BASED WAIVER SCOPE OF SERVICES FOR ADULT DAY HEALTH CARE SERVICES

A. Objective

The objective of Adult Day Health Care (ADHC) services is to restore, maintain, and promote the health status of Medicaid Home and Community-Based waiver participants through the provision of ambulatory health care and health-related supportive services in an ADHC center.

B. Conditions of Participation

1. The ADHC provider must maintain a current Adult Day Care license from the South Carolina Department of Health and Environmental Control (SCDHEC) or an equivalent licensing agency for an out-of-state provider.

2. The ADHC provider must meet the following requirements per 42. CFR 441.301 (c) (4):

   a. The ADHC center must be integrated in and support full access of individuals receiving Medicaid HCBS to the greater community.

   b. The ADHC center cannot be located on the grounds of, or adjacent to, a public institution. A public institution is defined as an inpatient facility that is financed and operated by a county, state, municipality or other unit of government.

   c. The ADHC center cannot be located on a parcel of land that contains more than one State licensed facility or be located in a building that is publicly or privately operated and provides inpatient institutional treatment.

   d. The ADHC center should not resemble characteristics of an institution (e.g., high walls/fences; have closed/locked gates).

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3. Providers must ensure that participants receive information regarding their Rights and Responsibilities while under the care of the center. These Rights and Responsibilities must include the following information:

   - Information referencing the participant's right to have control over their personal resources while under the care of center
   - Information which offers opportunities for interested participants regarding employment
   - The assurance of the participants rights of privacy and respect and freedom from coercion and restraint
   - Detailed information on how and to whom to file a complaint

4. Providers must use the automated systems mandated by Community Long Term Care (CLTC) to document and bill for the provision of services.

5. Providers must accept or decline referrals from SCDHHS or SCDDSN within two (2) working days. Failure to respond will result in the loss of the referral.

6. The provider will be responsible for verifying the participant's Medicaid eligibility when it has accepted a referral and monthly thereafter to ensure continued eligibility. Providers can verify Medicaid eligibility for CLTC participants in the Phoenix Provider Portal on their dashboard. Providers should also refer to Section 1 of this provider manual for additional information on eligibility determination.

7. Providers may use paperless filing systems. Provider must obtain approval from CLTC Central Office prior to initiating electronic documentation and/or filing systems. Electronic records must be made available upon request, and providers must have a reliable back-up system in the event their computer system shuts down.

C. Description of Services to Be Provided

1. The unit of service will be a participant day of ADHC services consisting of a minimum of five (5) hours in the care of the center. The five (5) hours does not include transportation time. The unit of service will be a minimum of four (4) hours when the participant has a scheduled medical appointment requiring him or her to leave early or arrive late. If a participant arrives late or leaves early due to a medical appointment, the provider must notify the CM/SC.

   Note: When a participant needs to be at the center for more than five (5) hours per day due to no one being at home to care for participant, the ADHC must allow the participant to remain at the center for up to eight (8) hours.

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2. The ADHC center must operate at least eight (8) hours a day Monday through Friday. The center may operate on weekends; if serving Waiver participants on weekends, the five (5) hour minimum standard still applies. The hours of operation may be any eight (8) hours between 7:00 a.m. and 6:00 p.m. The provider understands and accepts that any deviation in hours or days of operation during the contract period requires notice to and approval by the Department Head of Provider Relations and Compliance, Division of CLTC Waiver Management in order for the services to be covered.

3. The number of days a participant attends each week is determined through the Medicaid Home and Community-Based waiver service plan and indicated on the current service authorization.

4. The provider must either provide directly, or make sub-contractual arrangements (only nurses can be sub-contracted), for some but not all of the following non-billable services which are included in the daily rate:

    a. Daily nursing services performed by a RN or under the supervision of a RN as permissible under State law to monitor vital signs as needed; to observe the functional level of the participant and note any changes in the physical condition of each participant; to supervise the administration of medications and observe for possible reactions; to teach positive health measures and encourage self-care; to coordinate treatment plans with the participant and/or family member, the physician, therapist, and other involved service delivery agencies; to supervise the development and implementation of a care plan; to appropriately report to the participant's physician and/or the CM/SC any changes in the participant's condition. The RN must approve the documentation of the services provided.

    b. Supervision of, assistance with and training in personal care and activities of daily living including dressing, personal hygiene, grooming, bathing and clothing maintenance.

    c. Daily planned therapeutic activities to stimulate mental activity, communication and self-expression. These include reality orientation exercises, crafts, music, educational and cultural programs, games, etc. Participants must be given the opportunity to give input regarding the types of activities they would like to do at the center. They must also have alternative activities available in the event they do not want to participate in the planned activity.

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d. Outside activities must be offered for individuals attending the center to afford them the opportunity to interact with individuals without disabilities and in the community outside of the center.

e. One meal and one snack per day with the meal meeting 1/3 of the daily recommended dietary allowances (RDA) for this age group as adopted by the United States Department of Agriculture. Special diets prescribed by the attending physician must be planned and prepared with consultation from a registered dietitian as needed.

5. The provider will incorporate in the center's operational procedures adequate safeguards to protect the health and safety of the participants in the event of a medical or other emergency.

D. Staffing

1. The minimum staffing requirements must be consistent with SCDHEC licensing requirements (i.e., one direct-care staff for every eight participants). In addition to the minimum staffing standards required by SCDHEC licensing, the following staffing standards for nurses and case managers apply whenever Home and Community-Based waiver participants are present. All nurse staffing and care must be provided in accordance with the South Carolina Nurse Practice Act. Should the RN position become vacant, the ADHC Provider must notify the local CLTC office no later than the next business day. The Director of the Division of CLTC must approve any deviations from these staffing patterns in writing.

For 1-44 Home and Community-Based waiver ADHC participants: one RN must be present as follows:

1 – 10 participants	2 hours minimum
11 – 20 participants	3 hours minimum
21 – 25 participants	4 hours minimum
26 – 35 participants	5 hours minimum
36 – 44 participants	6 hours minimum

For 45 – 88 Home and Community-Cased waiver ADHC participants: one RN and one additional RN or LPN must be present for a minimum of five hours whenever Home and Community-Based waiver participants are present.

For 89 – 133 Home and Community-Based waiver ADHC participants:

a. one RN and two additional RNs or LPNs; or

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b. one RN, one additional RN or LPN and one case manager.

Required nursing and case management staff must be present for a minimum of five (5) hours whenever Home and Community-Based waiver participants are present.

For 134 - or more Home and Community-Based waiver ADHC participants:

a. one RN and three additional RNs or LPNs; or,

b. one RN, and two additional RNs or LPNs and one case manager.

Required nursing and case management staff must be present for a minimum of five hours whenever Home and Community-Based waiver participants are present.

2. The provider must have a nursing supervisor on staff with the following qualifications:

   a. A Registered Nurse (RN) currently licensed by the S.C. State Board of Nursing, by a state that participates in the Nursing Compact, or by an appropriate licensing authority of the state in which the ADHC provider is located for an out-of-state provider; and

   b. A minimum of one year's experience in a related health or social services program; and

   c. A minimum of one year's administrative or supervisory experience.

   Provider will verify nurse licensure at time of employment and ensure that the license remains active and in good standing at all times during employment. A copy of the current license must be maintained in the employee's personnel file. Nurse licensure can be verified and printed at the State Board of nursing website:

   http://www.llr.state.sc.us/pol.asp

3. For ADHC providers with eighty-nine (89) or more Home and Community-Based waiver participants who employ a case manager to meet staffing requirements of section D. 1, the case manager must have a bachelor's degree in health or social services.

4. Aides working at the ADHC center must meet minimum staffing requirements consistent with SCDHEC licensing requirements.

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5. The provider must check the CNA abuse registry and the OIG exclusions lists periodically for all staff. A copy of the search results page must be maintained in each employee's personnel file. Anyone appearing on either of these lists is not allowed to provide services to waiver participants or participate in any Medicaid funded programs. The website addresses are listed below:

   CNA Registry: https://www.asisvcs.com/services/registry/search_generic.asp?CPCat=0741NURSE
   OIG Exclusions List: http://www.oig.hhs.gov/fraud/exclusions.asp

6. PPD Tuberculin Test

   Please refer to the SCDHEC website, Regulation 61-75 – Standards for Licensing Day Care Facilities for Adults Sections 807 and 808 for PPD Tuberculin test requirements.

   http://www.scdhec.gov/Agency/RegulationsAndUpdates/LawsAndRegulations/Health/

   For additional information, providers should contact the Tuberculosis Control Division, Department of Health and Environmental Control, 1751 Calhoun Street, Columbia, SC 29201, phone (803) 898-0558.

7. A criminal background check will be required for all potential employees to include employees who will provide direct care to CLTC participants and all administrative/office employees (office employees required to have background checks include: administrator, office manager, supervisor, and persons named on organizational chart in management positions). All criminal background checks must include all data for the individual. The criminal background check must include statewide (South Carolina) data. The statewide data must include South Carolina and any other state or states the worker has resided in within the prior ten (10) years. Potential employees must not have prior convictions or have pled no contest (nolo contendere) to crimes related to theft, abuse, neglect, or exploitation of a child or a vulnerable adult for child or adult abuse, neglect or mistreatment, or a criminal offense similar in nature to the crimes listed in S.C. Code Section 43-35-10 et seq. Potential employees with non-violent felonies dating back ten (10) or more years can provide services to CLTC participants under the following circumstances:

   - Participant/responsible party must be notified of the employee's criminal background, i.e., felony conviction, year of conviction.

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- Documentation signed by the participant/responsible party acknowledging awareness of the employee's criminal background and agreement to attend the center must be placed in the participant record.

Potential administrative/office employees with non-violent felony convictions dating back ten (10) or more years can work in the center at the provider's discretion.

Hiring of employees with misdemeanor convictions will be at the provider's discretion. Employees hired prior to July 1, 2007, and continuously employed since then will not be required to have a criminal background check.

8. Personnel Records

The provider must maintain personnel records, for each employee, including contracted personnel and volunteers, which document that they meet all qualifications as outlined in this document.

E. Conduct of Service

The provider must maintain documentation showing that it has complied with all requirements of this section.

1. The provider will be notified by the CM/SC of the pending referral.

2. Following notification of the referral, the provider will obtain the DHHS form 122DC from the physician and notify the CM/SC when they have received the completed form from the physician. The form must include recommendations regarding limitations of activities, special diet, and medications. The CM/SC will authorize the amount, duration and frequency of services for the participants in accordance with the participants' needs. Subsequent physical examinations or periodic health screening to determine the participant's ability to continue in the program will be required at least every two (2) years. These must contain the same elements as the initial physical examination report. The ADHC provider is responsible for procuring the initial and all subsequent physical examination reports. A blank copy of this form can be obtained in the Help section of the Phoenix Provider Portal.

3. For CLTC waiver participants, the provider's RN will prepare a care plan for the participant that is based on the CLTC service plan. When there is a change in the CLTC service plan that will affect the ADHC service, the provider's RN must update their care plan to reflect the change.

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For DDSN waiver participants, the Service Coordinators will submit a service authorization. The service authorization, in addition to DHHS Form 122DC obtained by the ADHC provider, should be used to develop a care plan.

The participant and/or their family member must be included in the development of their care plan. The care plan must also include information regarding the participant's goals, likes, dislikes, etc.

4. The provider will initiate ADHC services on the date negotiated with the CM/SC and indicated on the service authorization. The CM/SC must be notified if services are not initiated on that date. Services provided prior to the authorized start date are not reimbursable.

5. If a participant is not interested in participating in a planned activity, the center must ensure that alternative activities are available.

6. The provider will develop and maintain a Policy and Procedure Manual, which describes how activities will be performed in accordance with the terms of their contract with SCDHHS.

7. The provider will maintain a daily attendance log documenting the arrival and departure times of each participant. A separate log will be maintained indicating staff in attendance and their arrival and departure times.

8. The provider will notify the CM/SC within two (2) working days of the following participant changes:

    a. Participant's condition has changed or the participant no longer appears to need ADHC services.

    b. Participant is institutionalized, dies or moves out of service area.

    c. Participant no longer wishes to participate in ADHC services.

    d. Provider becomes aware of the participant's Medicaid ineligibility or potential ineligibility.

    e. Participant does not attend the day care on an authorized day and Provider has not been notified of reason for absence.

9. The provider will maintain a record keeping system which establishes a participant profile in support of the units of ADHC services delivered, based on the Medicaid Home and Community-Based waiver service authorization. Individual participant records must be maintained and contain the service

authorization, the ADHC's care plan (which is approved and signed by the provider's RN), the Medicaid Home and Community-Based waiver CLTC Mode of Transportation form, the DHHS Form 122DC, and daily documentation of all care and services provided. Daily documentation must be made available to SCDHHS/SCDDSN upon request.

For SCDHHS authorized services, the ADHC care plan must be based on the CLTC Service Plan and must include input from the participant and/or their representative. The CLTC Service Plan must be maintained in the participant file.

For DDSN waiver participants, the ADHC care plan must be based on the service authorization, the DHHS Form 122DC and must include input from the participant and/or their representative. This information must be maintained in the participant file.

F. Overview of compliance review process

The Division of Long Term Care Waiver Management, Provider Compliance Department has developed this policy for clarification of the provider compliance process. The policy gives detailed information on how provider compliance sanctions are implemented. Provider reviews receive a score based on a sanctioning scale; review scores will determine if the provider will receive a sanction and if so, the level of the sanction. The sanction scoring process was developed to ensure that reviews are equitable and for providers to know what to expect when they are reviewed.

The following chart outlines how reviews are scored:

Sanction Level

- Provider compliance review questions in the Scope of Services are classified into three classes, based on (1) the significance of the question regarding to the services, and (2) the potential influences on providers and participants if the requirement was not met. See the example below:

Severity level: 1=less serious, 2 = serious, 3 = very serious

Client Service Questions	Possible Answers	Severity Level
Was supervisory visit made within 30 days after PC II services initiated?	Y, N, NA	3

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Client Service Questions	Possible Answers	Severity Level
Was the initial supervisory visit documented in Care Call?	Y, N, NA	3
Does provider maintain individual client records?	Y, N	2
Did provider give participant written information regarding advanced directives?	Y, N, NA	1

There are five types of sanctions:

- Plan of Correction - This is the lowest sanction and indicates the provider is in substantial compliance with the contractual requirements. The provider will be required to submit a plan of correction outlining the deficiency (ies), the detailed plan to correct the deficiency and the effective date the plan will be implemented. Any documentation that was not available during the compliance visit will not be accepted as a part of the plan of correction. All documentation must be in the appropriate records at the time of the review.

- 30-day suspension – At this level, new referrals are suspended for thirty (30) days. The provider will also be required to submit a plan of correction. If the plan of correction is approved, the suspension is automatically lifted at the end of the 30-day period. If the corrective action plan is not approved, the Provider will be given an additional ten (10) business days to submit another corrective action plan for review and approval; the suspension will remain in place until an approved corrective action plan is received. If the second submitted corrective action plan is not approved, the provider contract will be terminated. Any documentation that was not available during the compliance visit will not be accepted as a part of the plan of correction. All documentation must be in the appropriate records at the time of the review.

- 60-day suspension – At this level, new referrals are suspended for sixty (60) days. The provider will also be required to submit a plan of correction. If the plan of correction is approved, the suspension is automatically lifted at the end of the 60-day period. If the corrective action plan is not approved, the Provider will be given an additional ten (10) business days to submit another corrective action plan for review and approval; the suspension will remain in place until an approved corrective action plan is received. If the second submitted corrective action plan is not approved, the provider contract will be terminated. Any documentation that was not available during the compliance visit will not be accepted as a part of the

plan of correction. All documentation must be in the appropriate records at the time of the review.

- 90-day suspension – Indicates serious and widespread deficiencies, new referrals are suspended for ninety (90) days. The 90-day suspension of new referrals will only be lifted after an acceptable plan of correction is received. If the corrective action plan is not approved, the Provider will be given an additional ten (10) business days to submit another corrective action plan for review and approval; the suspension will remain in place until an approved corrective action plan is received. If the second submitted corrective action plan is not approved, the provider contract will be terminated. Any documentation that was not available during the compliance visit will not be accepted as a part of the plan of correction. All documentation must be in the appropriate records at the time of the review. In addition, an acceptable follow-up review visit may be conducted if warranted.

- Termination – Indicates a final review score of four hundred (400) or more points or very serious and widespread deficiencies, generally coupled with a history of bad reviews (three (3) consecutive reviews that receive suspension of new referrals).

  Providers who have two (2) consecutive reviews that result in suspension of new referrals, will be terminated if the third consecutive review has a final score that would result in a suspension of new referrals (score of 100 and above).

  We have developed a system to score reviews based on the percentage of the identified deficiency and number of participants surveyed. Following is an outline of how reviews will be scored:

Calculating process

- The level of sanction will be decided based on the total score of the provider‘s current review and the provider’s review history, which is converted from the deficiency percentage.

- Every 5% deficiency counts for 1 point in each class; the total score comes from the total points from each level.

Since each level has different severity, multiple points will be added on each class’s score. Final score = level 3 = unweighted points x 3 + level 2 = unweighted basic points x 2+ level 1 = unweighted points x 1

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Example:

Level	Deficiency percentage	Basic points	Final points
Level 1 (less serious)	28%	5	5x1=5
Level 2 (serious)	20%	4	4x2=8
Level 3 (major)	35%	7	7x3=21
Final score			34

Based on the total score a sanction level is determined. If a provider has no deficiencies, they will not be subject to a sanction. Below is a chart that illustrates the sanction that will be imposed based on the final review score:

Score Scale & Sanction Level

Sanction Type	Final score	With Good History*
Correction Plans	0-99	0-149
30 Days Suspension	100-199	150-249
60 Days Suspension	200-299	250-349
90 Days Suspension	300-399	350-449
Termination	>400	>450

Good History is determined based on previous review scores. For example, if a provider's previous review had a total score of **50** and their current review has a score of **120**, the sanction for the current review will be corrective action rather than 30-day suspension based on the previous review score.

Scores are automatically calculated using a computer generated compliance review program.

Provider records will be reviewed periodically at the provider's office. Onsite visits are un-announced. If a reviewer (CLTC, Program Integrity or any other government entity) arrives at the provider's office to conduct a survey/visit and no one is there, the following sanctions will be imposed:

- First time – thirty (30) day suspension of new referrals
- Second time – ninety (90) day suspension of new referrals
- Third time – contract termination

G. Administrative Requirements

1. The provider must inform SCDHHS of the provider's organizational structure, including the provider personnel with authority and responsibility for

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employing qualified personnel, ensuring adequate staff education and employee evaluations. The provider agency shall notify SCDHHS within three (3) working days in the event of a change in the agency Administrator, address, phone number or an extended absence of the agency administrator.

2. The provider must provide SCDHHS a written document showing the organization administrative control and lines of authority for the delegation of responsibility down to the hands-on participant care level staff at contract implementation. The document should include an organizational chart including names of those currently in the positions. Revisions or modifications to this organizational document must be provided to SCDHHS. It is recommended that this document be readily accessible to all staff.

3. Administrative and supervisory functions shall not be delegated to another agency or organization.

4. The provider agency shall acquire and maintain during the life of the contract liability insurance and workers' compensation insurance as provided in Article IX, Section D of the Contract. The provider is required to list SCDHHS – CLTC as a Certificate Holder for informational purposes only on all insurance policies using the following address: Post Office Box 8206, Columbia, SC 29202-8206.

   Failure to maintain the required insurance will result in termination of your contract with SCDHHS.

5. The provider must update their holidays in Phoenix annually. The provider will not be required to furnish services on their designated holidays. A copy of the scheduled holiday list must be posted in a visible location at the center.

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MEDICAID HOME AND COMMUNITY-BASED WAIVER
SCOPE OF SERVICES
FOR
ADULT DAY HEALTH CARE — NURSING

A. Adult Day Health Care (ADHC) Nursing services are available for those participants attending ADHC under authorization of a Medicaid Home and Community-Based waiver. This service must be ordered by a physician to meet the participant's care needs and must be prior authorized by the Medicaid Home and Community-Based waiver case manager. This service must be provided at the ADHC center by a licensed nurse, on a day the participant is attending Medicaid sponsored ADHC.

B. ADHC Nursing service procedures are limited to those skilled procedures listed below as ordered by a physician:

- Ostomy care
- Urinary catheter care
- Decubitus and/or wound care
- Tracheostomy care
- Tube feedings
- Nebulizer treatments that require medication

One Unit of ADHC Nursing consists of any combination of one or more of the listed ADHC Nursing service procedures listed above provided to a Medicaid Home and Community-Based waiver ADHC participant during one day's attendance at ADHC.

C. Authorization for ADHC Nursing will be separate from the ADHC authorization and will not be day specific unless so ordered by a physician.

D. Services provided prior to the Medicaid authorization date are not reimbursable.

E. The ADHC provider will obtain the physician's orders for the ADHC Nursing service from the physician using DHHS Form 122A.

Physician's orders must be updated at least every ninety (90) days and maintained by the provider in the participant record.

A physician's order is required for any change in the type or frequency of ADHC Nursing services provided to the participant. Within three (3) working days of a

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ADULT DAY HEALTH CARE SERVICES— NURSING

physician's verbal order, the ADHC provider must obtain a written order from the physician, document the order in the participant record and communicate the order to the Home and Community-Based waiver case manager in writing using DHHS Form 122A.

The Home and Community-Based waiver case manager or DDSN service coordinator will review the participant's needs within three (3) working days of receipt of DHHS Form 122A and update the participant record making any necessary changes in the authorization.

F. All ADHC Nursing services must be provided within the scope of the South Carolina Nurse Practice Act or as otherwise provided within State law. Providers in bordering states must comply with all laws applicable to the provision of nursing services in that state.

G. The ADHC Nursing services provider must maintain a client record containing documentation, that supports services provided and billed.

H. Providers of ADHC Nursing services must utilize the automated systems mandated by SCDHHS to document and bill for the provision of services.

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ADULT DAY HEALTH CARE — NURSING

Medicaid Home and Community-Based Waiver

ADULT DAY HEALTH CARE – NURSING

Physician's Orders

To: From:

Phone: Fax:

The client identified below participates in a Medicaid home and community-based waiver and has requested Adult Day Health Care-Nursing services. Please evaluate your patient's appropriateness for this service by completing and signing this form, noting any restrictions or special instructions. Please mail or fax this form to the above address. Thank you for your assistance in providing this service.

Participant: Medicaid ID:

ADHC – Nursing is limited to the following 6 skilled procedures:

1. [ ] **Ostomy Care**

Orders:

2. [ ] **Catheter Care**

Orders:

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3. [ ] **Decubitus/Wound Care** Orders:
4. [ ] **Tracheostomy Care** Orders:
5. [ ] **Tube Feedings** Orders:
6. [ ] **Nebulizer Treatment** Orders:
Physician Signature: Date:
ADHC Nurse Signature: Date:
Date mailed to MD: Date:

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MEDICAID HOME AND COMMUNITY-BASED WAIVER SCOPE OF SERVICES FOR ADULT DAY HEALTH CARE — TRANSPORTATION

A. Adult Day Health Care (ADHC) Transportation service is available to participants authorized for the ADHC service through a Medicaid Home and Community-Based waiver who reside within fifteen (15) miles of the ADHC center. This service will be provided using the most direct route, from the center to the participant's place of residence or other location as agreed to by the provider and as indicated on the service authorization. The service must be prior authorized by the Medicaid Home and Community-Based waiver case manager/service coordinator.

B. ADHC Transportation service must be provided in an enclosed vehicle with adequate ventilation, heat and air conditioning, with provision for wheelchair bound and ambulatory participants as needed. ADHC Transportation does not include ambulance transportation, even when medically necessary.

C. Providers who are directly providing transportation to participants will provide assistance to the participant from the door of the participant's residence to the vehicle and from the vehicle to the door of the participant's residence or other location as agreed to by the provider and as indicated on the service authorization when necessary.

D. Transportation services are reimbursable only when provided to and/or from the ADHC center. For example, if the participant rides to the ADHC center with a family member and the ADHC center transports the participant home in the afternoon, reimbursement for transportation is allowed for one way.

E. Authorization for ADHC Transportation will be separate from the ADHC authorization.

F. Services provided prior to the Medicaid authorization date are not reimbursable.

G. The provider is required to complete a Mode of Transportation form indicating the number of miles the participant lives from the center. If it is determined that the participant is within fifteen (15) miles of the center, the provider is required to notify the case manager that an authorization is needed for ADHC Transportation.

The provider is required to maintain verification of the mileage to a participant's home in the participant's record, such as a MapQuest map stating the mileage.

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ADULT DAY HEALTH CARE SERVICES— NURSING

The provider is required to report any changes in the participant's status that affect ADHC Transportation (e.g., Participant moves and no longer resides within fifteen (15) miles of the center; family member transports participant to and from the center, etc.) to the case manager/service coordinator immediately. If these types of changes occur, ADHC Transportation will no longer be reimbursable.

Drivers employed by or volunteering at the ADHC who transport Home and Community-Based waiver participants must have a valid driver's license and be certified in first aid.

H. The ADHC Transportation service provider must maintain a participant record containing documentation supporting services provided and billed.

I. Providers of ADHC Transportation service must use the automated systems mandated by SCDHHS to document and bill for the provision of services.

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MEDICAID HOME AND COMMUNITY-BASED WAIVER SCOPE OF SERVICES FOR INDIVIDUAL ATTENDANT CARE PROVIDER STANDARDS AND DUTIES

A. Minimum Qualifications

1. Attendant Care providers, i.e., attendants, must meet the following minimum qualifications:

   a. Demonstrate an ability to read, write and speak English;

   b. Fully ambulatory;

   c. Capable of aiding in the activities of daily living; physically capable of performing duties which may require physical exertion such as lifting, transferring, etc. if necessary;

   d. Capable of following a service plan with participant and/or representative supervision;

   e. Be at least 18 years of age;

   f. Capable of following billing procedures and completing required paperwork;

   g. No known conviction for abuse, neglect, or exploitation of adults (as defined in the Omnibus Adult Protection Act, S.C. Code Ann. Title 43, Chapter 35) or of children (as defined in the Children's Code, S.C. Code Ann. Title 63, Chapter 7);

   h. No known conviction for any crime against another person;

   i. No known felony conviction of any kind;

   j. No known conviction of any kind concerning the misuse or abuse of any public assistance program (including, but not limited to, fraudulently obtaining benefits, engaging in fraudulent billing practices, and embezzling or otherwise misusing public assistance funds in any manner);

   k. No exclusion from the Medicare or Medicaid Programs;

   l. Upon request will provide references to the participant and/or representative;

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m. All Attendants shall submit the results of a PPD tuberculin (TB) skin test that was administered within one year prior to the Attendants Medicaid enrollment date. All attendants whose PPD skin test is over a year old at the time of actual enrollment must have a new PPD skin test to remain enrolled and to be eligible to serve participants as an attendant. The two-step procedure is advisable for initial testing in order to establish a reliable baseline. (If the reaction to the first test is classified as negative, a second test should be given a week later. If the second test is classified as negative, the person is considered as being uninfected. A positive reaction to a third test (with an increase of more than 10 mm) in such a person within the next few years is likely to represent the occurrence of infection with M. Tuberculosis in the interval. If the reaction to the second of the initial two tests is positive, this probably represents a boosted reaction, and the person should be considered as being infected).

Attendants with reactions of 10 mm and over to the pre-enrollment tuberculin test, those with newly converted skin tests, and those with symptoms suggestive of tuberculosis (e.g., cough, weight loss, night sweats, fever, etc.) regardless of skin test status, shall be given a chest radiograph to determine whether tuberculosis disease is present. If tuberculosis is diagnosed, appropriate treatment should be given, and the person must not be allowed to work until declared noncontagious by a licensed physician.

Routine chest radiographs are not required on attendants who are asymptomatic with negative tuberculin skin tests.

Attendants with negative tuberculin skin tests shall have an annual tuberculin skin test. Forty-five (45) days prior to the expiration date, USC-CDR will notify active enrolled attendants of the expiration of their TB test results. If the attendant has not submitted the required information by the expiration date, USC-CDR will notify the CLTC Central Office. Current services of the attendant will be terminated after reasonable notice (two (2) weeks) to participants has been given so participants can find replacement services. The CLTC Compliance Office will suspend new referrals to the attendant effective on the date suspension is submitted.

New attendants who have a history of a positive TB skin test shall send a copy of their most recent chest x-ray and complete a signs and symptoms questionnaire, or have certification by a licensed physician or local health department TB staff prior to enrollment as a Medicaid

provider that they are not contagious. Attendants who are known or suspected to have tuberculosis shall be required to be evaluated by a licensed physician or local health department TB staff, and must not return to work until they have been declared noncontagious.

Preventative treatment should be considered for all infected attendants having direct participant contact who have positive skin tests but show no symptoms of tuberculosis. Routine annual chest radiographs are not a substitute for preventative treatment. Attendants who complete treatment, either for disease or infection, may be exempt from further routine radiographic screening unless they develop symptoms of tuberculosis. Attendants with a history of a positive TB skin test will be required to complete a tuberculosis signs and symptoms questionnaire to assess for Tuberculosis annually.

Post exposure skin test should be obtained for tuberculin negative attendants within twelve (12) weeks after termination of contact to a documented case of infection.

Attendants needing additional information should contact the Tuberculosis Control Division, Department of Health and Environmental Control, 2600 Bull Street, Columbia, SC 29201, phone (803) 898-0558.

B. MinimumTraining Requirements

The following are the minimum training requirements for attendants:

1. Prior to the first authorization being issued, all attendants who have been matched with their first participant are required to attend Care Call/billing training in the CLTC office which covers the geographical area where the participant resides.

2. Training may be furnished by the licensed nurse of USC-CDR while the attendant is furnishing care to the participant. USC-CDR may also identify additional training needs and assist the attendant with locating training to address those needs. Participant-specific training for the attendant and/or participant/ representative may be provided as deemed necessary based on the professional judgment of the licensed nurse of USC-CDR or when the participant/representative or attendant requests assistance with training related to specific tasks.

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C. Supervision

The attendant will be supervised by the participant or representative for whom the safety and efficacy of participant/representative supervision has been certified by the licensed nurse of USC-CDR. The licensed nurse of USC-CDR will determine when a participant or representative is no longer certified to provide supervision for the attendant.

D. Infection Control

The attendant must adhere to basic infection control procedures at all times while providing attendant care services.

E. Description of Services to be Provided

1. The Unit of Service is authorized in one (1) hour increments and will consist of direct Attendant Care services provided in the participant's home (except when services such as laundry, shopping or escort must be done off-site). The amount of time authorized does not include the attendant's transportation time to and from the participant's home.

2. The number of units and service provided to each participant is dependent upon the individual participant's needs as set forth in the participant's approved Service Plan. Services must be participant specific and for the direct benefit of the participant.

3. Attendant Care services include:

   a. Support for activities of daily living e.g., assistance with bathing, dressing, feeding, personal grooming, personal hygiene, transferring and mobility

   b. Meal or snack preparation, planning and serving, cleaning up afterwards, following specially prescribed diets as necessary and encouraging participants to adhere to any specially prescribed diets

   c. General housekeeping includes cleaning, laundry, and other activities as needed to maintain the participant in a safe and sanitary environment; Housekeeping only includes areas specific to the participant such as the participant's bedroom, bathroom, etc.

   d. Assistance with communication which includes, but is not limited to, placing a phone within participant's reach and physically assisting participant with use of the phone, and orientation to daily events

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e. Monitoring medication, e.g., the type that would consist of informing the participant that it is time to take medication as prescribed by his or her physician and as written directions on the box or bottle indicate. It does not mean that the attendant is responsible for giving the medicine; however, it does not preclude the attendant from handing the medicine container or medicines already set up in daily containers to the participant

F. Record Keeping

The attendant shall maintain an individual participant record for each participant. This participant record is subject to the confidentiality rules for all Medicaid providers and shall be made available to CLTC upon request. This record shall include the following:

1. Current and historical Service Provision Forms specifying units and services/duties to be provided;

2. The CLTC participant's Service Plan;

3 The attendant will complete a daily log reflecting the attendant care services provided for the participant and must submit the logs to the appropriate entity at appropriate times for review

and

4. A copy of the participant's back-up plan for service provision when the primary attendant is unable to provide services. (The participant/representative must make prior arrangements with family members, other formal or informal supports or another enrolled attendant for care provision in the absence of the primary attendant).

G. Conduct of Services

1. The attendant will initiate attendant care services on the date agreed upon by the participant/representative, attendant and the case manager. This date will be the start date on the written authorization for services. Services provided prior to the authorized start date as stated on the Service Provision Form will not be reimbursed.

2. The case manager will authorize attendant care services by designating the authorized units of services in accordance with the participant's Service Plan.

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The attendant must adhere to those duties. The participant and/or representative will self-direct the provision of care and coordinate with the attendant for the time for service delivery and specific tasks to be performed. The amount of time authorized does not include transportation time to and from the participant's home.

3. If the attendant or the participant/representative identifies attendant care duties that would be beneficial to the participant's care but are not specified in the CLTC service plan, the attendant or participant/representative must contact the case manager to discuss the possibility of having these duties included in the service plan. The decision to modify the duties to be performed by the attendant is the responsibility of the case manager.

4. The attendant will notify the case manager immediately of the following participant changes:

   a. Participant's condition has changed and the Service Plan no longer meets participant's need or the participant no longer appears to need attendant care services.

   b. Participant/representative no longer appears capable of providing supervision for the attendant.

   c. Participant/representative no longer wants to serve as Employer of Record/ representative.

   d. Participant dies or moves out of the service area.

   e. Participant/representative no longer wishes to receive attendant care services.

   f. Knowledge of the participant's Medicaid ineligibility or potential ineligibility.

5. The attendant will notify Adult Protective Services if he/she has knowledge of, or reason to believe that the participant has been or is likely to be abused, neglected or exploited.

6. The participant must have an effective back-up service provision plan in place to ensure that the participant receives services in the absence of the primary attendant. However, if/when the attendant determines that services cannot be provided by the attendant as authorized, the attendant must immediately notify the case manager and the participant/representative by telephone.

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7. When two consecutive attempted visits occur, the local CLTC office must be notified immediately. An attempted visit is when the attendant arrives at the home and is unable to provide the assigned tasks because the participant is not at home or refuses services.

8. For all participants the attendant is responsible for verifying the participant's Medicaid eligibility each month.

9. The attendant will notify the case manager immediately if the attendant wishes to terminate as the provider.

10. The attendant is responsible for giving participants a written description of the state law concerning advance directives in accordance with the Patient Self-Determination Act. USC-CDR will assist attendants in meeting this requirement.

11. The attendant shall adhere to all SCDHHS policies, procedures and Medicaid provider manuals including policies regarding billing, claims adjustments, Fiscal Intermediary requirements, etc.

12. The attendant must comply with all Care Call requirements for all participants.

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MEDICAID HOME AND COMMUNITY-BASED WAIVER
SCOPE OF SERVICES
FOR
CASE MANAGEMENT SERVICES

A. Objective

The objective of Case Management Services is to assist Participants in gaining access to needed waiver and other State plan services; as well as medical, social, educational, and other services, regardless of the funding source for those services. Case Managers are responsible for the ongoing monitoring and coordination of the provision of services included in the participant's person-centered service plan.

B. Provider Conditions of Participation

1. The Provider must have demonstrated experience providing Case Management in a health and human services setting.

2. The Provider must be licensed to operate a business in the State of South Carolina and be in good standing with the State and counties served.

3. Upon application, the provider must demonstrate knowledge of the SC long-term care continuum and community resources.

4. The Provider must have four (4) or more employees, two (2) of which must be a licensed Social Worker; or have a Bachelor's degree or Master's degree with at least two years of assessment and care planning experience with clients. Independent providers contracted prior to September 1, 2016, may continue to provide case management activities to participants served under this waiver.

5. The Provider must be capable of providing case management services in the entire geographical area of at least one (1) CLTC Regional Office. The Provider must not refuse to accept cases within its area of service based on geographical location.

6. The Provider and its staff must be independent of the service delivery system and not a provider of services that could be incorporated into a CLTC participant's plan of care ("conflict free case management"). These services include, but are not limited to, CLTC waiver services, home health services, and hospice services. CLTC is the final decision authority regarding questions concerning conflict free case management.

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7. The Provider must provide all supplies, tools, equipment, and technology necessary for its Case Managers and Case Management Supervisors to carry out case management functions. SCDHHS will post equipment requirements in the "Help" section of Phoenix.

8. The Provider will ensure that Case Managers and Case Management Supervisors do not serve members of their own families.

9. The Provider must ensure that its Case Managers and Case Management Supervisors meet all conditions in the Conduct of Service.

   Provider agencies must be housed in an office that is in a commercial zone. Any agency not housed within a commercial location must be prior approved by SCDHHS to enroll as a case management provider. Requirements for agencies not in commercial locations include all of the following:

   a. Has a county/municipal zoning permit to operate a business in a residential setting if required

   b. Holds appropriate business licenses

   c. Meets applicable county/municipal, mixed-use zoning guidelines for a home-based business in a primarily residential neighborhood

   d. Has a business entrance door which is separate from a residential living area

   e. Uses office space devoted entirely for the business; space must be enclosed and have a locking door which uses a different key from other locks in the home

   f. Has an outside business sign conforming to county/municipal sign and zoning codes for its neighborhood

   Independent providers are not required to maintain office space, administrative reviews will be conducted with the Case Manager present in the CLTC area office.

C. Conduct of Service

1. The Provider must ensure that its Case Managers are available by telephone to SCDHHS staff Monday through Friday, 8:30 a.m. to 5:00 p.m.

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2. The Provider must ensure that its Case Managers are available to Participants from 8:30 a.m. to 5:00 p.m., Monday through Friday, and as required by Participant needs.

3. The Provider must ensure that if a Case Manager has other employment, it does not prevent the case manager from performing case management activities between 8:30 a.m. and 5:00 p.m., Monday through Friday, and as required by Participant needs. The Provider must ensure that any Case Manager hired after August 1, 2014, does not have other employment for more than four (4) hours between 8:30 a.m. and 5:00 p.m., Monday through Friday. The Provider must also ensure that its Case Managers hired before August 1, 2014, do not accept additional employment that will exceed this rule if they are not currently employed beyond this requirement. The Provider must ensure accessibility of its Case Managers to CLTC program staff, service providers, and participants.

4. The Provider must ensure that its Case Managers are available to meet with SCDHHS staff in area offices or by phone as required for case management activities. These activities include, but are not limited to:

    a. Discussing quality assurance findings,

    b. Participating in team staffing of existing and new cases,

    c. Attending training and meetings on policy updates (off-site as required),

    d. Conducting case transfers , and

5. The Provider must ensure that its Case Managers check voice mail and respond appropriately at least twice daily, Monday through Friday, excluding state holidays.

6. The Provider must ensure that its Case Managers return calls related to participant care in a timely manner. Calls received by the Case Manager before noon must be returned by 5:00 p.m. that day; calls received after noon must be returned by noon on the next business day.

7. The Provider must ensure the secure and accurate maintenance of all electronic and hard-copy participant records assigned to its Case Managers,

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8. All hardcopy records will be housed in the participant's assigned Area Office. Records removed from the Area Office must be signed out and returned per CLTC office policy.

9. The Provider must ensure that its Case Managers adhere to the documentation policy posted in the "Help" section of Phoenix.

10. The Provider must ensure that it's Case Managers check and respond to email daily, Monday through Friday.

11. The Provider must ensure that its Case Managers use the Electronic Visit Verification System (EVV). Documentation must be completed according to the current policy. For home visits, the EVV must be utilized while in the Participant's home.

12. The Provider must ensure that each of its Case Managers and Case Management Supervisors providing Case Management services uses the Phoenix System and/or other systems as designated by SCDHHS for all case management activities, including but not limited to, re-evaluations, service planning, documentation, and verification of continued financial eligibility.

13. The Provider must have an effective, written back-up service provision plan in place to ensure that participants receive case management services as authorized when the assigned Case Manager is not available to provide services.

    The plan must include:

    a. The name of the Case Manager(s) who will cover the cases while the regular Case Managers is away,

    b. (For Independent Case Managers only) A signed agreement between the assigned Case Manager and the back-up Case Manager who will cover the cases during the period when the assigned Case Manager is away,

    c. The procedure for notifying the Participant when the back-up plan will be used,

    d. The procedure for transferring cases to the back-up Case Manager in Phoenix, and

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e. The procedure for notifying the Area Administrator/Lead Team Case Manager when the back-up plan is initiated.

If the Provider determines that services cannot be provided as authorized, the Area Administrator/Lead Team Case Manager must be notified by telephone immediately.

14. The Provider must ensure that each Case Manager meets the Training Requirements in Article F of this document.

15. The Provider must ensure that its Case Managers serve a maximum of two contiguous CLTC Area Offices unless approved by Central Office. Case Managers serving two Area Offices must designate one CLTC Area Office as the primary office for training and meetings.

16. Violations of the Conduct of Service will result in sanctions. See Sanction Guidelines posted in the "Help" section of Phoenix.

C. Description of Services to Be Provided

1. The unit of service will be specified in the approved waiver document.

2. The Provider must ensure that its Case Managers use professional judgment in allotting an appropriate amount of time to complete each participant-related activity for which billing is submitted. These activities include Case Management Contacts and Initial, Quarterly, and Re-evaluation Visits. If the amount of time spent to complete the billed activities for a particular day does not meet CLTC's expectations of the time necessary to complete those activities, then CLTC SCDHHS, in its sole discretion, may conduct an investigation and impose sanctions.

3. SCDHHS sets minimum and maximum limits on caseload sizes. The Provider must ensure that its Case Managers abide by these limits, which are available in the "Help" section of Phoenix. Once a case is accepted, it must be retained by the Provider and assigned Case Manager for ninety (90) days unless otherwise requested by the participant. The maximum caseload limit takes into consideration all participants assigned to a Case Manager/Case Management Supervisor in a given month, including assignments for a partial month

4. The Provider must ensure that cases are maintained through an entire month unless otherwise requested by the Participant. Central Office and Area Office(s) should be notified as soon as possible of any pending cases to be

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relinquished. The Provider must justify any notification that is provided less than fourteen days prior to the end of the month. The Provider must immediately notify Central Office when an employee with access to Phoenix separates from the case management Provider.

D. Case Management

1. Cases are referred to Providers in accordance with the Participant's choice. In no case shall a Provider solicit any waiver Participant. If a Case Manager leaves the Provider, that Case Manager may not solicit the Participant to follow him/her. Solicitation is cause for immediate termination.

2. The Provider must notify SCDHHS within two (2) business days to accept or decline a referral for Participant service. Once a Participant is accepted, team staffing must occur within two (2) business days.

3. Case Management services include the following:

   a. Regularly contacting the Participant during initial visits, monthly contacts, quarterly visits, and re-evaluation visits. The Provider must ensure that At least one of these case management activities and all of its necessary components are completed every month and documented appropriately

   b. In conjunction with the Participant, developing and monitoring needs and personal goals and performing ongoing evaluation of the service plan to include team staffing.

   c. Completing authorizations for waiver services (including initial authorization, changes, and terminations).

   d. Resource assessment and development, with referrals to other agencies as needed.

   e. Service coordination, to include coordination of community-based support and participation in interagency case staffing.

   f. Ongoing Case monitoring and problem solving to address participant's needs throughout the month.

   g. Re-evaluation activities including but not limited to team staffing with designated reviewers.

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h. Service counseling with participant and families.

i. Case termination and transfer.

4. The Provider must ensure that Case Management services and other related activities provided by its Case Managers and Case Management Supervisors are provided in accordance with the CLTC Services Provider manual, CLTC program policies and procedures, any applicable SCDHHS policies and procedures, the SCDHHS Case Management contract, and any applicable federal and state statutes and regulations. All of the foregoing provisions, policies, procedures, statutes, and regulations (together with any subsequent amendments) are hereby incorporated as an integral part of this Scope of Service.

5. When a case has been relinquished or transferred to another provider, the Provider must cease any contact with the Participant and/or primary contact.

E. Staffing

The Provider must adhere to the following provisions related to staffing:

Case Manager and Case Management Supervisor

1. Case Management Providers must **employ** Case Managers and Case Management Supervisors. Sub-contracting arrangements between Providers and individuals to provide case management services are not permitted. Case Managers and Case Management Supervisors must not be employed by multiple CLTC Case Management Providers.

2. Case Management Providers must employ a Supervisor(s) who meets the qualifications of a Case Manager and who will provide technical assistance, perform quality assurance, and provide training to all Case Managers employed by the agency. Case Management Supervisors must attend and complete initial CLTC training for supervisors and pass a competency exam prior to assuming supervisory duties. A Case Management Supervisor who previously served as a CLTC Case Manager may request an exemption. Supervisors must also attend ongoing training as presented by CLTC.

3. Requirements for ratio of Case Management Supervisors to Participants and/or Case Managers are published in the Help section of Phoenix.

4. The Provider must ensure that Case Managers and Case Management Supervisors do not have a felony conviction of any kind. A national

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background check must be completed and maintained in the personnel record for all case managers and Case Management Supervisors and made available to CLTC upon request. A new background check must be obtained every five years. Hiring of employees with misdemeanor convictions will be at the discretion of the Provider.

5. Providers must check the Office of Inspector General (OIG) exclusions list at least once a year for all staff. A copy of the search results page must be maintained in each employee's personnel file. Anyone appearing on the list will not be allowed to provide services to Waiver participants or participate in any Medicaid -funded programs. The website address is listed below:

   OIG Exclusions List: http://www.oig.hhs.gov/fraud/exclusions.asp

6. The Provider must ensure that each Case Manager and Case Manager Supervisor has a current, valid driver's license. The Provider must obtain a copy of the case Manager's driving record and verify that the license is valid at the time of hiring and then again every five years. Copies of the driving records must be maintained in the employee's file and provided to SCDHHS upon request.

7. The Provider must ensure that its Case Managers and Case Management Supervisors have demonstrated skills in computer hardware/software access and usage.

8. The Provider must ensure that, when serving Participants, its Case Managers and Case Management Supervisors display a photo identification badge identifying the Provider and the employee.

9. The Provider must ensure that its Case Managers record a voice mail greeting that clearly identifies the name of the Case Manager and the Provider.

10. The Provider must ensure that Routine ongoing Case Management activities are conducted by one of the following:

    a. Social Workers licensed by the state of South Carolina,

    b. Individuals with a Bachelor's or Master's degree in a health or human services field from an accredited college or university, who have at least two (2) years of assessment and care planning experience with clients (experience cannot include more than six (6) months of internship),

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c. Registered nurses currently licensed by the state of South Carolina or by a state that participates in the Nursing Compact,

d. Certified Geriatric Care Managers with two (2) years of assessment and care planning experience with clients,

e. Certified Case Managers with two (2) years of assessment and care planning experience with clients. All Case Managers who have professional licenses must comply with the continuing education requirements necessary for their specific licensure,

f. Any Case Managers/Supervisors who do not have professional licenses must have a minimum of ten (10) hours relevant in-service training per calendar year. The annual ten-hour requirement will be on a pro-rated basis during the first year of employment. Documentation of training must include topic, name and title of trainer, training objectives, and outline of content and length of training, location, and outcome of training. Topics for specific in-service training may be mandated by SCDHHS.

g. The Provider must ensure that its Case Managers and Case Management Supervisors are aware that they are mandated reporters of Abuse, Neglect and Exploitation (ANE). Failure to report ANE will result in immediate action up to and including termination of serving CLTC participants and the Case Manager/Supervisor being reported to the appropriate authority.

11. PPD Tuberculin Test

Please refer to the Department of Health and Environmental Control (DHEC) website for PPD Tuberculin test requirements.

http://www.scdhec.gov/Health/DiseasesandConditions/InfectiousDiseases/BacterialDiseases/Tuberculosis/

12. Diseases/Tuberculosis

If Provider requires additional information, Provider should contact the Tuberculosis Control Division, Department of Health and Environmental Control, 1751 Calhoun Street, Columbia, SC 29201, phone (803) 898-0558.

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13. Personnel folders: Individual records will be maintained to document that each member of the staff has met the above requirements. When requested by SCDHHS, documents will be uploaded to Phoenix.

F. Case Management Training

1. Case Management Providers will be responsible for training employees as required by SCDHHS. This training will be in conjunction with any training directly provided by SCDHHS.

2. Case Management providers will be responsible for training costs and attending training required by SCDHHS. SCDHHS will not reimburse expenses for Case Managers, Case Management Supervisors, or other Provider staff associated with attending required SCDHHS training.

3. All new Case Managers and Case Management Supervisors must complete the SCDHHS CLTC Training curriculum to include home visits with SCDHHS staff.

4. Case Managers and Case Management Supervisors must obtain passing scores on all tests administered by SCDHHS. Case Managers and Case Management Supervisors who do not obtain a passing score on any test given during SCDHHS initial training will not be assigned any cases and must repeat the training and retake any required tests. If he/she fails on the second attempt, he/she will not be allowed to provide case management for CLTC participants. If a Case Management Supervisor does not pass required tests, he/she cannot be designated nor act as a supervisor.

5. After passing all initial tests and attending CLTC Area office(s) orientation, Case Managers and Case Management Supervisors will be eligible to be assigned cases based on participant choice. Case Managers and Case Management Supervisors must take an additional competency test after having cases for ninety (90) days. If the Case Manager or Case Management Supervisor fails this test, he/she will be allowed to retake it once. If he/she fails on the second attempt, he/she will not be allowed to provide Case management services to CLTC participants.

6. The types and number of Case assignments during the first ninety (90) days must be coordinated with a regional trainer to ensure adequate case coverage, with no assignments of re-evaluations to any new employee without prior approval. Caseloads may not exceed approved levels during the training cycle.

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7. The Provider must ensure that its Case Managers and Case Management Supervisors have business cards available to give to Participants no later than their first scheduled home visit after completion of training and on an ongoing basis thereafter.

8. The Provider must ensure that any of its Case Managers or Case Management Supervisors who are identified by quality reviews as needing remedial training attend that training and obtain passing scores on all required competency tests.

G. Compliance

Quality Assurance and case management reviews are performed randomly and when failures to comply with contract or scope requirements are detected. CLTC can also conduct unscheduled compliance visits during regular office hours.

Following is the sanction process for Case Management Providers that will apply when minimum standards as set forth by CLTC are not adhered to by Providers and Case Managers. CLTC will review the provider's compliance with Case Management program requirements on an ongoing basis. Failure to comply with the program requirements will result in the application of sanctions against the Provider. Case Manager, and/or Case Management Supervisor as follows:

1. Strike: Case Managers and Case Management Supervisors will receive strikes for actions that are out of compliance with policy. Case Managers and Case Management Supervisors can receive up to six (6) strikes per year. After the sixth strike, recoupment will occur for any additional instances of non-compliance. All Strikes are removed annually on the Case Manager's hire date.

2. Recoupment: Case Management services that have been billed but are out of compliance with policy and procedures may be recouped from the Provider.

3. Caseload reductions: The caseload of the Case Manager or Case Management Supervisor will be reduced by a minimum of 10 percent (10%) for a minimum of ninety (90) days. Case managers and Case Management Supervisors must comply with corrective action plans before any cases are reassigned.

4. At its discretion, SCDHHS may require that a Provider's Case Manager or Case Management Supervisor can no longer work with CLTC Participants.

5. Suspension: The Case Management provider is removed from the provider choice list for the duration of the sanction. The minimum period of suspension is one (1) month. Providers who are suspended must complete an acceptable

corrective action plan before the suspension is lifted. Suspension will be for all geographic areas the Provider covers.

6. Termination: The cancellation of the Provider's enrollment in the Medicaid CLTC program resulting in the denial of Medicaid participation for a period of three (3) years. After two (2) suspensions for any reason, a third suspension in a two (2) year period will result in termination. Termination will also occur if the provider is substantially out of compliance with contractual requirements. See compliance guideline sheet for specifics on sanctions based on Provider/Case Manager actions.

H. Administrative Requirements

1. The Provider must use the Phoenix system to enter a list of regularly scheduled holidays, on which it will not be required to furnish services. The Provider must not be closed for more than two (2) consecutive days, except when a holiday falls in conjunction with a weekend. If a holiday falls in conjunction with a weekend, the Provider may be closed for not more than four (4) consecutive days.

2. The Provider will specify in Phoenix's Provider Portal the hours of operation.

3. The Provider must maintain an up-to-date organizational chart that is available to each employee.

4. The Provider must maintain written bylaws or the equivalent for governing the Provider's operations.

5. The Provider must maintain a written employee handbook that contains a Fragrance -Free Policy and a dress code requiring business casual attire when conducting SCDHHS business.

6. The Provider must assure SCDHHS that a governing body or person(s) so functioning shall assume full legal authority for the operation of the provider agency.

7. The Provider shall acquire and maintain, during the life of the contract, general liability insurance and worker's compensation insurance as required in the SCDHHS contract. The Provider is required to list SCDHHS-CLTC as certificate holder for notice purposes on all insurance policies using the following address: Post Office Box 8206, Columbia, SC 29202-8206.

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CASE MANAGEMENT

8. Upon request by SCDHHS, the Provider will be responsible for appropriate participation in the SCDHHS Appeals and Hearings process with respect to appeals of any action involving the Provider.

9. The Provider is subject to recoupment for payments made for all waiver services as a result of authorizations issued by provider staff not consistent with CLTC policies and procedures and in accordance with the CLTC Case Management Recoupment Guidelines.

10. The Provider must disclose to SCDHHS the names and relationships of any relatives of the Provider or its staff who provide items or services to Medicaid Participants. For purposes of this Contract, the Provider means all owners, partners, managing employees, directors and any other person involved in the direct management and/or control of the business of the Provider. The Provider's staff includes everyone who works for or with the Provider, including independent contractors, in the provision of or billing for services described in this Contract. Relative means persons connected to the Provider by blood or marriage.

    The Provider must disclose all such relationships via email to provider-distribution@scdhhs.gov within two (2) days of learning of the relationship. The Provider, in executing this Contract, certifies that it has in place policies, procedures or other mechanisms acceptable to SCDHHS to identify and report these relationships. Failure to report a relationship timely or to have the appropriate policies and procedures in place may result in sanctions by SCDHHS up to and including termination of this Contract for cause.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

CASE MANAGEMENT

CLTC Case Management Compliance Guidelines

1. Late Level of Care/Re-evaluation (without an approved reason)
   a. If late recoup for every month late from appropriate entity
   b. If completed within the month but out of compliance, recoup for the month
   c. If level of care date is inaccurate, recoup
   d. Late Initial Visit (without approved reason) – Recoup

2. No Case Activity or Inappropriate Case Activity
   a. Recoup if CM service has been billed but record reflects no case activity
   b. If Narrative & Checklist are incomplete, the CM will be considered out of compliance – CM will receive one strike per incident, after 6th strike any additional instances of this type will be recouped
   c. No activity and not billed – strike

      ****Exception: If adequate documentation is noted that CM (throughout the month) was unable to reach participant/ family/Provider to complete contact, then a CLTC Notification (10-day notice) need to be sent and annotated in the narrative.**

   d. Quarterly due; however Monthly Contact was completed without a valid reason narrated – strike **and** recoup for each month the quarterly is not completed

3. Closed Cases
   a. If authorizations are not terminated at case closure resulting in provider payment for services – Strike **and** recoup
   b. Failure to notify provider by phone or Phoenix conversation of service termination – Strike
   c. Failure to send CLTC notification with Appeal Notice to participant/family at case closure – Strike **and** recoup

4. Billing prior to Service Delivery
   a. Recoup if Care Call reports indicate Case Management Service billing occurred before monthly activity was performed

5. Timeliness
   a. If documentation is completed outside of timeliness standards – Strike

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CASE MANAGEMENT

b. If documentation is recorded late in the Service Plan or left blank in the Service Plan – Recoup. Recoup for each month the Service Plan was not completed.

6. Overlap Claims

a. If a pattern of overlapped claims is identified and substantiated, the provider will be informed that the case manager will no longer be allowed to manage waiver participants; independent case manager's contract will be terminated.

7. Monitoring APS cases

a. Failure to follow-up monthly on APS case/referral

1st action – A reminder will be sent via email to Case Manager, Provider Agency, and AA/LTCM by CLTC Central Office QA staff with notification of the email sent in the complaint form. The email will include a reminder for the CM/Provider Agency to contact the AA/LTCM for assistance with contacting APS if needed (refer to APS Policy-Chapter 5). ****If no response/documentation from CM within five (5) working days of the email, move to 2nd action.**

2nd action – A letter will be sent to the Case Manager and Provider Agency by CLTC Central Office Provider Compliance staff with notification of the letter sent in the complaint form. **** CM or Provider Agency has five (5) working days from the date letter sent to document contact/follow-up with APS staff before 3rd action is taken.**

3rd action – A Case Manager and Provider Agency will not receive new referrals for sixty (60) days.

b. Failure to file a complaint in Phoenix

1st offense – A letter will be sent to the Case Manager and Provider Agency by Central Office staff after area office staff sends in a complaint on the Case manager.

2nd offense – A Case Manager and Provider Agency will not receive new referrals for sixty (60) days.

c. Failure to make APS referral **(we are mandated reporters)**

i. If mandatory reporter who has actual knowledge of the abuse, neglect or exploitation of a vulnerable adult fails to report, he or she can be charged with a misdemeanor. If convicted, he or she may be fined up to $2,500 or sentenced to not more than one (1) year in prison.

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CASE MANAGEMENT

ii. Failure to report abuse, neglect, or exploitation of a vulnerable adult may jeopardize the Provider's professional license.

8. Other Compliance issues

All of the following compliance issues will result in the CM's agency being contacted to address and correct the issue (Independent CM's will be addressed directly by CLTC staff). If the behavior continues and/or a pattern of the behavior is established, CLTC will no longer allow the worker to provide services for waiver participants. The Independent CM will be terminated.

a. Failing to timely (within 24 hours) follow-up on participant's issues, concerns, requests, Care Call issues, etc.

b. Failure to attend scheduled monthly training/policy update meetings without receiving an excused absence

c. Failure to respond to emails in a timely manner per Scope of Services (daily)

d. Failure to return phone calls to CLTC staff

Note: New Case Managers will have a sixty (60) day grace period after Phoenix registration date; the CM will not receive any strikes or recoupments during the grace period. All strikes will be accumulated to total six (6) occurrences. All occurrences after the sixth strike will be subject to recoupment. The strike period will be one (1) year and will go back to zero on the worker's Phoenix registration anniversary date.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

MEDICAID HOME AND COMMUNITY-BASED WAIVER
SCOPE OF SERVICES
FOR
COMPANION SERVICES

A. Objectives

The objectives of Companion services are to provide short-term relief for caregivers and to provide needed supervision of Medicaid Home and Community-Based waiver participants.

B. Conditions of Participation

1. Agencies must utilize the automated systems mandated by Community Long Term Care (CLTC) Division to document and bill for the provision of services.

2. Pursuant to enactment and implementation of S.C. § Code 44-70-10 all providers of personal care services will require a license to provide personal care services. Providers are required to renew their license annually. Providers who do not maintain their In Home Care provider license will be terminated. Providers who are not licensed by the South Carolina Department of Health and Environmental Control will not be allowed to enroll as a Medicaid provider for these services.

3. Provider agencies must be housed in an office that is in a commercial zone. Any agency not housed within a commercial location must be prior approved by SCDHHS to enroll as a companion provider. Requirements for agencies not in commercial locations include all of the following:

   a. Has a county/municipal zoning permit to operate a business in a residential setting if required

   b. Holds appropriate business licenses

   c. Meets applicable county/municipal, mixed-use zoning guidelines for a home-based business in a primarily residential neighborhood

   d. Has a business entrance door which is separate from a residential living area

   e. Uses office space devoted entirely for the business; space must be enclosed and have a locking door which uses a different key from other locks in the home

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COMPANION SERVICES

f. Has an outside business sign conforming to county/municipal sign and zoning codes for its neighborhood

4. The Provider must ensure that, when serving Participants, its Companions and Supervisors display a photo identification badge identifying the Provider and the employee.

5. Providers must accept or decline referrals from CLTC within two (2) working days. Failure to respond will result in the loss of the referral.

6. The provider will be responsible for verifying the participant's Medicaid eligibility when it has accepted a referral and monthly thereafter to ensure continued eligibility. Providers can verify Medicaid eligibility for CLTC participants in the Phoenix Provider Portal on their dashboard. Providers should also refer to Section 1 of this provider manual for additional information on eligibility determination.

7. Providers may use paperless filing systems. Provider must obtain approval from CLTC Central Office prior to initiating electronic documentation and/or filing systems. Electronic records must be made available upon request, and providers must have a reliable back-up system in the event their computer system shuts down.

C. Description of Services to be provided

1. The unit of service is one (1) hour of direct services provided in the participant's residence or away from the participant's residence for shopping, laundry services, other offsite services or escort services. The amount of time authorized does not include the companion's transportation time to and from the participant's residence.

2. The number of units and services provided to each participant is dependent upon the participant's needs as set forth in the participant's Service Plan.

3. Services to be provided include:

a. Socialization - Reading, conversation, assistance with mail and other interaction with participant as appropriate

b. Assistance with or supervision of meal/snack preparation

c. Assistance with or supervision of participant laundry (washing clothes and linens)

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COMPANION SERVICES

d. Assistance with or supervision of participant's shopping

e. Incidental light housekeeping (dusting, sweeping or other light chores to maintain participant in a safe clean environment)

f. Sitting service focusing on the participant including supervision, orientation, making appropriate contact in case of emergency

D. Staffing

The Provider must maintain individual records for all employees. All required documentation indicated in this section must be filed in the personnel record no less than fifteen (15) days after employment.

1. The Provider must maintain the following (supervisory positions may be sub-contracted):

   a. A supervisor who meets the following requirements:

      i. High school diploma or equivalent;

      ii. Capable of evaluating companions in terms of their ability to carry out assigned duties and their ability to relate to the participant; and

      iii. Able to assume responsibility for in-service training for companions.

   b. Companions who meet the following minimum qualifications:

      i. Able to read, write and communicate effectively with participant and supervisor;

      ii. Able to use the Care Call EVV system;

      iii. Capable of following a care plan with minimal supervision; and

      iv. At least eighteen (18) years of age.

   c. Companions must complete four (4) hours of relevant in service training per calendar year in the following areas:

      i. Maintaining a safe, clean environment and utilizing proper infection control techniques;

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ii. Following written instructions;

iii. Ethics and interpersonal relationships;

iv. Documenting services provided; and

v. Other areas of training as appropriate.

The annual four-hour requirement will be on a pro-rated basis during the companion's first year of employment.

2. Agency staff may be related to participants served by the agency within limits allowed by the South Carolina Family Caregiver Policy. The following family members cannot be a paid caregiver:

a. The spouse of a Medicaid participant

b. A parent of a minor Medicaid participant

c. A step parent of a minor Medicaid participant

d. A foster parent of a minor Medicaid participant

e. Any other legally responsible guardian of a Medicaid participant

Qualified family members can be reimbursed for their provision of Companion services.

3. PPD Tuberculin Test

Please refer to the Department of Health and Environmental Control (DHEC) website for PPD Tuberculin test requirements.

http://www.scdhec.gov/Health/DiseasesandConditions/InfectiousDiseases/BacterialDiseases/Tuberculosis/

For additional information, providers should contact the Tuberculosis Control Division, Department of Health and Environmental Control, 1751 Calhoun Street, Columbia, SC 29201, phone (803) 898-0558.

4. A criminal background check will be required for all potential employees to include employees who will provide direct care to CLTC participants and all administrative/office employees (office employees required to have background checks include: administrator, office manager, supervisor, and persons named on

organizational chart in management positions). All criminal background checks must include all data for the individual. The criminal background check must include statewide (South Carolina) data. The statewide data must include South Carolina and any other state or states the worker has resided in within the prior ten years. Potential employees must not have prior convictions or have pled no contest (nolo contendere) to crimes related to theft, abuse, neglect or mistreatment, or a criminal offense similar in nature to the crimes listed in S.C. Code Section 43-35-10 et seq. Potential employees with non-violent felonies dating back ten (10) or more years can provide services to CLTC participants under the following circumstances:

- Participant/responsible party must be notified of the aide's criminal background, and
- Documentation must be placed in the participant's record and signed by the participant/responsible party acknowledging awareness of the aide's criminal background and agreement to have the aide provide care.

Potential administrative/office employees with non-violent felony convictions dating back ten (10) or more years can work in the agency at the Provider's discretion.

Hiring of employees with misdemeanor convictions will be at the Provider's discretion.

E. Conduct of Service

The Provider must maintain documentation showing that it has complied with the requirements of this section.

1. The Provider must obtain the Service Plan and/or authorization from the case manager/service coordinator prior to the provision of services. The authorization will designate the amount, frequency and duration of service for participants in accordance with the participant's Service Plan/Authorization which will have been developed in consultation with the participant and others involved in the participant's care. The provider will receive new authorizations only when there is a change to the authorized service. The Provider must adhere to those duties which are specified in the authorization in developing the provider task list. The provider task list must be developed by the supervisor. If the provider identifies Companion duties that would be beneficial to the participant's care but are not specified in the authorization, the Provider must contact the case manager to discuss the possibility of having these duties included in the Authorization. **Under no circumstances will any type of skilled medical service or hands on care be performed by a companion.** The case manager/service coordinator will make the decision as to whether the CLTC Service Plan/DDSN Authorization should be

amended to include the additional duty. This documentation will be maintained in the participant files.

2. The supervisor of Companion services must:

   a. Perform an initial visit to the participant's home within 90 days of the start of services and provide on-site supervision at least once every 365 days thereafter for each participant and phone contact with the participant or responsible party as needed.

   b. Each supervisory visit, including the initial visit, will be documented in the participant's file and recorded in Care Call. In the event the participant is inaccessible during the time the visit would have normally been made, the visit must be completed within five (5) working days of the resumption of Companion services. The Supervisor's report of the on-site visits must include, at a minimum:

      i. Documentation that services are being delivered consistent with the Service Plan/Authorization;

      ii. Documentation that the participant's needs are being met;

      iii. Reference to any complaints which the participant or family member/responsible party has lodged; and,

      iv. A brief statement regarding any changes in the participant's service needs.

   c. Supervisors will provide assistance to companions as necessary.

   d. Supervisors will be immediately accessible by phone and/or beeper during any hours services are being provided under this contract. If the supervisor position becomes vacant, SCDHHS must be notified within two (2) business days.

   e. If there is a break in service which lasts more than sixty (60) days, the supervisor must conduct a visit within ninety (90) days of the resumption of services.

5. In addition, the Provider must maintain an individual participant record that documents the following items:

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COMPANION SERVICES

a. The Provider will initiate Companion services on the date negotiated with the CM/SC and indicated on the authorization. Services must not be provided prior to the authorized start date and must be provided according to the schedule as indicated on the authorization.

b. The Provider will notify the CM within two (2) working days of the following participant changes:

   i. Participant's condition has changed and the Service Plan/Authorization no longer meets participant's needs or the participant no longer appears to need Companion services.

   ii. Participant dies, is institutionalized, or moves out of the service area.

   iii. Participant no longer wishes to participate in a program of Companion services.

   iv. Provider becomes aware of the participant's Medicaid ineligibility or potential ineligibility.

   The Provider will maintain a record keeping system which documents the delivery of services in accordance with the Service Plan. The Provider shall not ask the participant/responsible person to sign any log or task sheet. Task sheets must be reviewed, signed, with original signature (rubber signature stamps are not acceptable), and dated every two (2) weeks by the supervisor. Task sheets must be filed in the participant's record within thirty (30) days of service delivery.

c. **For SCDDSN participants:** The delivery of services and units must be provided in accordance with the Authorization. The provider will maintain daily logs reflecting Companion services provided for the participants and the actual amount of time expended for the service. The daily logs must be initialed daily by the participant or family member and the Companion and must be signed weekly by the participant or family member as verification of the total daily and weekly hours. Daily logs must be reviewed, signed, with original signature (rubber signature stamps are not acceptable), and dated every two (2) weeks by the supervisor. Daily logs must be filed in the participant's record within thirty (30) days of service delivery. Daily logs must be made available to SCDHHS/SCDDSN upon request.

d. All active participant records must contain at least two (2) years of documentation to include task sheets/daily logs, service plans, authorizations, supervisory visit documentation and any complaints, etc.

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Per Medicaid policy all records must be retained for at least five (5) years. Active records must contain **all** authorizations.

e. Whenever two consecutive attempted or missed visits occur, the local CLTC office/SCDDSN office must be notified. An attempted visit is when the companion arrives at the home and is unable to provide the assigned tasks because the participant is not at home or refuses services. A missed visit is when the provider is unable to provide the authorized service. Missed visits must be documented in the participant record as well as in Care Call.

f. The Provider will inform participants of their right to complain about the quality of Companion services provided and will give participants information about how to register a complaint. Complaints which are made against companions will be assessed for appropriateness and for investigation by the Provider. All complaints which are to be investigated will be referred to the supervisor who will take any appropriate action.

E. Compliance Review Process

The Division of Long Term Care Waiver Management, Provider Compliance Department has developed this policy for clarification of the provider compliance process. The policy gives detailed information on how provider compliance sanctions are implemented. Provider reviews receive a score based on a sanctioning scale; review scores will determine if the Provider will receive a sanction and if so, the level of the sanction. The sanction scoring process was developed to ensure that reviews are equitable and for providers to know what to expect when they are reviewed.

The following chart outlines how reviews are scored:

Sanction Level

- Provider compliance review questions in the Scope of Services are classified into three classes, based on (1) the significance of the question regarding to the services, and (2) the potential influences on providers and participants if the requirement was not met. See the example below:

Severity level: 1=less serious, 2 = serious, 3 = very serious

Client Service Questions	Possible Answers	Severity Level
Was supervisory visit made within 30 days after PC II services initiated?	Y, N, NA	3

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Client Service Questions	Possible Answers	Severity Level
Was the initial supervisory visit documented in Care Call?	Y, N, NA	3
Does provider maintain individual client records?	Y, N	2
Did provider give participant written information regarding advanced directives?	Y, N, NA	1

There are five types of sanctions:

- Plan of Correction – This is the lowest sanction and indicates the provider is in substantial compliance with the contractual requirements. The Provider will be required to submit a plan of correction outlining the deficiency (ies), the detailed plan to correct the deficiency and the effective date the plan will be implemented. Any documentation that was not available during the compliance visit will not be accepted as a part of the plan of correction. All documentation must be in the appropriate records at the time of the review.

- 30-day suspension – At this level, new referrals are suspended for thirty (30) days. The Provider will also be required to submit a plan of correction. If the plan of correction is approved, the suspension is automatically lifted at the end of the 30-day period. If the corrective action plan is not approved, the Provider will be given an additional ten (10) business days to submit another corrective action plan for review and approval; the suspension will remain in place until an approved corrective action plan is received. If the second submitted corrective action plan is not approved, the provider contract will be terminated. Any documentation that was not available during the compliance visit will not be accepted as a part of the plan of correction. All documentation must be in the appropriate records at the time of the review.

- 60-day suspension – At this level, new referrals are suspended for sixty (60) days. The Provider will also be required to submit a plan of correction. If the plan of correction is approved, the suspension is automatically lifted at the end of the 60-day period. If the corrective action plan is not approved, the Provider will be given an additional ten (10) business days to submit another corrective action plan for review and approval; the suspension will remain in place until an approved corrective action plan is received. If the second submitted corrective action plan is not approved, the provider contract will be terminated. Any documentation that was not available during the compliance visit will not be accepted as a part of the plan of correction. All documentation must be in the appropriate records at the time of the review.

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COMPANION SERVICES

- 90-day suspension – Indicates serious and widespread deficiencies, new referrals are suspended for ninety (90) days. The 90-day suspension of new referrals will only be lifted after an acceptable plan of correction is received. If the corrective action plan is not approved, the Provider will be given an additional ten (10) business days to submit another corrective action plan for review and approval; the suspension will remain in place until an approved corrective action plan is received. If the second submitted corrective action plan is not approved, the provider contract will be terminated. In addition, an acceptable follow-up review visit may be conducted if warranted. Any documentation that was not available during the compliance visit will not be accepted as a part of the plan of correction. All documentation must be in the appropriate records at the time of the review.

- Termination – Indicates a final review score of four hundred (400) or more points or very serious and widespread deficiencies, generally coupled with a history of bad reviews (three (3) consecutive reviews that receive suspension of new referrals)

Providers who have two (2) consecutive reviews that result in suspension of new referrals, will be terminated if the third consecutive review has a final score that would result in a suspension of new referrals (100 and above).

We have developed a system to score reviews based on the percentage of the identified deficiency and number of participants surveyed. Following is an outline of how reviews will be scored:

Calculating process

- The level of sanction will be decided based on the total score of the provider‘s current review and the provider’s review history, which is converted from the deficiency percentage.

- Every 5% deficiency counts for 1 point in each class; the total score comes from the total points from each level.

- Since each level has different severity, multiple points will be added on each class’s score. Final score = level 3 = unweighted points x 3 + level 2 = unweighted basic points x 2+ level 1 = unweighted points x 1

Example:

Level	Deficiency percentage	Basic points	Final points
Level 1 (less serious)	28%	5	5x1=5
Level 2 (serious)	20%	4	4x2=8
Level 3 (major)	35%	7	7x3=21
Final score			34

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COMPANION SERVICES

Based on the total score a sanction level is determined. If a provider has no deficiencies, they will not be subject to a sanction. Below is a chart that illustrates the sanction that will be imposed based on the final review score:

Score Scale & Sanction Level

Sanction Type	Final score	With Good History*
Correction Plans	0-99	0-149
30 Days Suspension	100-199	150-249
60 Days Suspension	200-299	250-349
90 Days Suspension	300-399	350-449
Termination	>400	>450

Good History is determined based on previous review scores. For example, if a provider's previous review had a total score of **50** and their current review has a score of **120**, the sanction for the current review will be corrective action rather than 30-day suspension based on the previous review score.

Scores are automatically calculated using a computer generated compliance review program.

Provider records will be reviewed periodically at the Provider's office. Onsite visits are unannounced. If the reviewer (CLTC, Program Integrity or other Government Entity) arrives at the provider's office to conduct a survey and no one is there, the following sanctions will be imposed:

- First time – thirty (30) day suspension of new referrals
- Second time – ninety (90) day suspension of new referrals
- Third time – contract termination

G. Administrative Requirements

1. The Provider must inform CLTC of the provider's organizational structure, including the provider personnel with authority and responsibility for

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COMPANION SERVICES

employing qualified personnel, ensuring adequate staff education, in-service training, and employee evaluations. The Provider shall notify SCDHHS within three (3) working days in the event of a change in or the extended absence of the personnel with the above listed authority.

2. The Provider must provide SCDHHS a written document showing the organization administrative control and lines of authority for the delegation of responsibility down to the hands-on participant care level staff at contract implementation. The document should include an organizational chart including names of those currently in the positions. Revisions or modifications to this organizational document must be provided to SCDHHS. It is recommended that this document be readily accessible to all staff.

3. Administrative and supervisory functions shall not be delegated to another organization.

4. The Provider shall acquire and maintain for the duration of the contract liability insurance and workers' compensation insurance as provided in Article IX, Section D of the Contract. The Provider is required to list SCDHHS – CLTC as a Certificate Holder for informational purposes only on all insurance policies using the following address: Post Office Box 8206, Columbia, SC 29202-8206.

5. Failure to maintain the required insurance will result in termination of your contract with SCDHHS.

6. The Provider will develop and maintain a Policy and Procedure Manual that describes how activities will be performed in accordance with the terms of the requirements of the contract. The Policy and Procedure Manual shall be available during office hours for the guidance of the governing body, personnel and will be made available to SCDHHS upon request.

7. The Provider agency shall ensure that key agency staff is accessible in person, by telephone, or by beeper during compliance review audits conducted by SCDHHS.

8. The Provider shall update holidays in Phoenix; the Provider is not required to furnish services on those days. The Companion provider agency must not be closed for more than two (2) consecutive days at a time, except when a holiday falls in conjunction with a weekend. If a holiday falls in conjunction with a weekend, a Companion provider agency may be closed for not more than four (4) consecutive days.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

MEDICAID HOME AND COMMUNITY-BASED WAIVER
SCOPE OF SERVICES
FOR
MEDICAID HOME DELIVERED MEALS

A. Objective

The objective of Home Delivered Meal Services is to provide at least one nutritionally sound meal per day to persons unable to care for their nutritional needs because of a functional disability/dependency and who require nutrition assistance to remain in the community.

B. Condition of Participation

1. Agencies desiring to be a provider of Home Delivered Meals (HDM) Services must have demonstrated experience. Experience to include no less than one year in food service meal planning and preparation.

2. Providers must use the automated systems mandated by CLTC to document and bill for the provision of services.

3. Providers must accept or decline referrals from CLTC or SCDDSN within two (2) working days. Failure to respond will result in the loss of the referral.

4. The provider will be responsible for verifying the participant's Medicaid eligibility when it has accepted a referral and monthly thereafter to ensure continued eligibility. Providers can verify Medicaid eligibility for CLTC participants in the Phoenix Provider Portal on their dashboard. Providers should also refer to Section 1 of this provider manual for additional information on eligibility determination.

5. Providers may use paperless filing systems. Provider must obtain approval from CLTC Central Office prior to initiating any electronic documentation and/or filing systems. Electronic records must be made available upon request, and providers must have a reliable back-up system in the event their computer system shuts down.

C. Description of Services

1. The Unit of Service is one meal delivered to a participant's residence, or other location, as agreed to by the provider and as indicated on the service authorization. Each meal must provide a minimum of one-third of the current recommended dietary allowance (RDA) for the age group as adopted by the

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HOME DELIVERED MEALS

United States Department of Agriculture. The number of units of service provided to each participant is determined by the participant's service plan, which is established by the case manager in consultation with the participant.

2. Modified Diet menus must be developed using Dietary Guidelines for Americans and must be reviewed and approved by a registered dietitian. The provider must have procedures in place to assure that each participant requiring a modified meal receives only the meal ordered for that individual.

3. Home delivered meals are made available at a minimum Monday through Friday.

D. Conduct of Service

1. The provider must obtain the authorization from the CLTC Case Manager prior to the provision of services. The authorization will designate the amount, frequency and duration of service for participants in accordance with the participant's service plan which will be developed in consultation with the participant and/or responsible party. More than one meal for each day's consumption may be delivered if authorized by CLTC. The authorization will indicate if the person requires a modified diet due to diabetes or some other condition.

2. The provider will initiate home delivered meals on the date negotiated with the case manager and indicated on the service authorization. Services must not be provided prior to the authorized start date as stated on the service authorization**.**

3. Each provider must offer one (1) hot meal per day, five (5) or more days each week, and any additional authorized meals may be hot or cold. Shelf stable meals may be provided if authorized by the Case Manager and the participant or responsible party requests this type of meal. A hot meal, for the purposes of this program, is one in which the main food item is hot at the time of serving. A blast-frozen meal, if authorized, meets the hot meal requirement for this standard. (If the participant or responsible party agrees and/or requests shelf stable meals, we will allow this option in lieu of hot or frozen meals.)

4. No home-canned or home-prepared food shall be used in the preparation and service of the meals.

5. The facility at which the meals are prepared and/or packaged, as well as the manner of handling, transporting, serving and delivery of these meals must meet all applicable health, fire safety and sanitation regulations.

6. Only single service covered aluminum foil or Styrofoam divided containers can be used for hot food. Each tray compartment must be large enough to contain the required portions without spillover.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

HOME DELIVERED MEALS

7. Unless providing a blast frozen meal or shelf stable meal, hot and cold food shall be portioned and packed separately to ensure retention of heat or cold and shall be transported in approved insulated carriers which will maintain the required hot (130 degrees Fahrenheit or above) and cold (45 degrees Fahrenheit or below) temperatures until the time of delivery to the participant. Blast frozen meals must be transported in approved insulated carriers which will maintain the meals in a frozen state until the time of delivery to the participant.

8. Delivery routes must be clearly established. No more than three (3) hours shall elapse between the time of packaging and the time of delivery of the last hot meal on the route. Delivery of a cold meal beyond the three (3) hour limit for a participant who lives too far away may be made upon written approval of the Head of the Provider Relations and Compliance Department, CLTC Division of Waiver Management.

9. Meals must be received, in hand, by an individual at the participant's door or at another location as agreed to by the provider and as indicated on the service authorization.

10. The provider shall give initial and on-going training in the proper service, handling, and delivery of food to all staff, both volunteer and paid.

11. The provider will maintain a record keeping system which establishes an eligible participant profile in support of units of Home Delivered Meal service provided, based on the service authorization**.**

12. The provider shall regularly observe, or at a minimum inquire about, the participant's condition and will confirm at least monthly that the participant continues to reside in the home and is available to receive the meals. The provider will notify the case manager as soon as possible, but no more than two (2) working days, after the provider becomes aware of the following participant changes:

    a. Participant's condition has changed or participant no longer appears to need home delivered meal services; or**,**

    b. Participant is institutionalized**,** dies or moves out of service area; or,

    c. Participant no longer wishes to receive home delivered meal services; or,

    d. Knowledge of the participant's Medicaid ineligibility or potential ineligibility.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

HOME DELIVERED MEALS

E. Administrative Requirements

1. The provider must inform CLTC of the Provider's organizational structure, including the provider personnel with authority and responsibility for employing qualified personnel, ensuring adequate staff education, in-service training and employee evaluations. The provider shall notify SCDHHS within three (3) working days in the event of a change in or the extended absence of the personnel with the above listed authority.

2. The provider must provide SCDHHS a written document showing the organization administrative control and lines of authority for the delegation of responsibility down to the hands-on participant care level staff at contract implementation. The document should include an organizational chart including names of those currently in the positions. Revisions or modifications to this organizational document must be provided to SCDHHS. It is recommended that this document be readily accessible to all staff.

3. Administrative and supervisory functions must not be delegated to another agency or organization.

4. The provider agency must acquire and maintain for the duration of the contract liability insurance and worker's compensation insurance as provided in Article IX, Section D of the Contract. The provider is required to list SCDHHS – CLTC as a Certificate Holder for informational purposes only on all insurance policies using the following address: Post Office Box 8206, Columbia, SC 29202-8206.

5. The provider must update their holidays in Phoenix. The provider is not required to furnish services on those days.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

MEDICAID HOME AND COMMUNITY-BASED WAIVER
SCOPE OF SERVICES
FOR
INDIVIDUAL COMPANION PROVIDERS STANDARDS AND DUTIES

A. Minimum Qualifications

Individual companions must meet the following minimum qualifications:

1. Demonstrate an ability to read, write and speak English;

2. Fully ambulatory;

3. Capable of performing all companion care duties;

4. Capable of following a service plan with participant and/or representative supervision;

5. Be at least 18 years of age;

6. Capable of following billing procedures and completing required paperwork;

7. No known conviction of abuse, neglect, or exploitation of adults (as defined in the Omnibus Adult Protection Act, S.C. Code Ann. Title 43, Chapter 35) or of children (as defined in the Children's Code, S.C. Ann. Title 63, Chapter 7);

8. No known conviction for any crime against another person;

9. No known felony conviction of any kind;

10. No known conviction of any kind concerning the misuse or abuse of any public assistance program (including, but not limited to, fraudulently obtaining benefits, engaging in fraudulent billing practices, and embezzling or otherwise misusing public assistance funds in any manner);

11. No record of exclusion or suspension from the Medicare or Medicaid Programs;

12. Upon request will provide references to the participant and/or representative;

13. All Companions shall submit the results of a PPD tuberculin (TB) skin test that was administered within one year prior to the Companions Medicaid enrollment date. All Companions whose PPD skin test is over a year old at the time of actual

enrollment must have a new PPD skin test to remain enrolled and to be eligible to serve participants as a companion. The two-step procedure is advisable for initial testing in order to establish a reliable baseline. (If the reaction to the first test is classified as negative, a second test should be given a week later. If the second test is classified as negative, the person is considered as being uninfected. A positive reaction to a third test (with an increase of more than 10 mm) in such a person within the next few years is likely to represent the occurrence of infection with M. Tuberculosis in the interval. If the reaction to the second of the initial two tests is positive, this probably represents a boosted reaction, and the person should be considered as being infected). Companions with reactions of 10 mm and over to the pre-enrollment tuberculin test, those with newly converted skin tests, and those with symptoms suggestive of tuberculosis (e.g., cough, weight loss, night sweats, fever, etc.) regardless of skin test status, shall be given a chest radiograph to determine whether tuberculosis disease is present. If tuberculosis is diagnosed, appropriate treatment should be given, and the person must not be allowed to work until declared noncontagious by a licensed physician.

Routine chest radiographs are not required on companions who are asymptomatic with negative tuberculin skin tests.

Companions with negative tuberculin skin tests shall have an annual tuberculin skin test. Forty- five (45) days prior to the expiration date, USC-CDR will notify active enrolled companions of the expiration of their TB test results. If the companion has not submitted the required information by the expiration date, USC-CDR will notify the CLTC Central Office. Current services of the companion will be terminated after reasonable notice (2 weeks) to participants has been given so participants can find replacement services. The CLTC Compliance Office will suspend new referrals to companions effective on the date suspension is submitted. If the companion has not submitted the information within six (6) months of the suspension date, USC-CDR will notify CLTC Central Office to initiate steps to terminate the companion's enrollment in the Medicaid Program.

New companions who have a history of positive TB skin test shall send a copy of their most recent chest x-ray and complete a signs and symptoms questionnaire, or have certification by a licensed physician or local health department TB staff prior to enrollment as a Medicaid provider that they are not contagious. Companions who are known or suspected to have tuberculosis shall be required to be evaluated by a licensed physician or local health department TB staff, and must not return to work until they have been declared noncontagious.

Preventative treatment should be considered for all infected companions having direct participant contact who have positive skin tests but show no symptoms of tuberculosis. Routine annual chest radiographs are not a substitute for

preventative treatment. Companions who complete treatment, either for disease or infection, may be exempt from further routine radiographic screening unless they develop symptoms of tuberculosis. Companions with a history of a positive TB skin test will be required to complete a tuberculosis signs and symptoms questionnaire to assess for Tuberculosis annually.

Post exposure skin test should be obtained for tuberculin negative companions within twelve (12) weeks after termination of contact to a documented case of infection.

Companions needing additional information should contact the Tuberculosis Control Division, Department of Health and Environmental Control, 2600 Bull Street, Columbia, SC 29201, phone 803-898-0558.

14. The companion must adhere to basic infection control procedures at all times when providing companion services.

15. All new companion providers must complete companion/Care Call training in the CLTC area office prior to or during the first week of authorized companion services.

B. Conduct of Service

1. The companion will begin services on the date agreed upon by the participant/representative, companion and case manager. This date will be the start date on the written authorization for services. Services provided prior to the authorized start date as stated on the Service Provision Form will not be reimbursed.

2. The case manager will authorize companion services by designating the authorized units of service in accordance with the participant's Service Plan. The companion must adhere to those duties. The participant/representative will self-direct the provision of care and coordinate with the companion regarding the time for service delivery and specific tasks to be performed. Services must be participant specific and for the direct benefit of the participant.

3. The unit of service is authorized in one (1) hour increments and will consist of companion service provided in the participant's home or other setting as may be appropriate to support the duties preformed. The amount of time authorized does not include transportation time to and from the participant's home.

4. If the companion or the participant/representative identify companion duties that could be beneficial to the participant's care but are not specified on the CLTC

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

INDIVIDUAL COMPANION

Service Plan, the companion or participant/representative must contact the case manager to discuss the possibility of having these duties included on a new service provision form and the Service Plan. Under no circumstances will any type of skilled medical services be performed by a companion. The decision to modify the duties to be performed by the companion is the responsibility of the case manager.

5. The companion will notify the case manager immediately of the following participant changes:

   a. Participant's condition has changed and the Service Provision form no longer meets the participant's needs or the participant no longer appears to need companion services.

   b. Participant/representative no longer appears capable of providing supervision for the companion services.

   c. Participant/representative no longer wants to serve as Employer of Record/representative.

   d. Participant dies or moves out of the service area.

   e. Participant/representative no longer wants to receive companion services.

   f. Participant becomes Medicaid ineligible or potentially ineligible for Medicaid.

6. The companion will notify Adult Protective Services if he/she has knowledge of or reason to believe that the participant has been or is likely to be abused, neglected or exploited.

7. If/when the companion determines that services cannot be provided as authorized, the companion must immediately notify the case manager and the participant/representative by telephone.

8. When two consecutive attempted visits occur, the companion must contact the local CLTC office. An attempted visit is when the companion arrives at the home and is unable to provide the assigned duties because the participant is not at home or refuses services.

9. The companion is responsible for verifying the participant's Medicaid eligibility each month.

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INDIVIDUAL COMPANION

10. The companion will notify the case manager or USC-CDR immediately if the companion wishes to terminate as the provider.

11. The companion is responsible for giving participants a written description of the state law concerning advance directive in accordance with the Patient Self Determination Act. USC-CDR will assist companions in meeting this requirement.

12. The companion shall adhere to all SCDHHS policies, procedures and Medicaid provider manuals including policies regarding billing, claims adjustments, Fiscal Intermediary requirements, etc.

13. The companion must comply with all Care Call requirements.

C. Record Keeping

The companion shall maintain an individual participant record for each participant. The participant record is subject to the confidentiality rules for all Medicaid providers and shall be made available to CLTC upon request. This record shall include the following:

1. Current and historical Service Provision/Termination Forms specifying units and duties to be provided.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

MEDICAID HOME AND COMMUNITY-BASED WAIVER
SCOPE OF SERVICES
FOR
NURSING SERVICES

A. Objective

The objective of nursing services is to provide skilled medical monitoring, direct care, and intervention to maintain the participant through home support. This service is necessary to avoid institutionalization.

B. Conditions of Participation

1. Agencies desiring to be a provider of Medicaid Nursing services must have demonstrated experience in providing Nursing services or a similar service. Experience must include at least three (3) years of health care experience, one of which must be in administration.

2. Provider agencies must be housed in an office that is in a commercial zone. Any agency not housed within a commercial location must be prior approved by SCDHHS to enroll as a personal care provider. Requirements for agencies not in commercial locations include all of the following:

   a. Has a county/municipal zoning permit to operate a business in a residential setting if required

   b. Holds appropriate business licenses

   c. Meets applicable county/municipal, mixed-use zoning guidelines for a home-based business in a primarily residential neighborhood

   d. Has a business entrance door which is separate from a residential living area

   e. Uses office space devoted entirely for the business; space must be enclosed and have a locking door which uses a different key from other locks in the home

   f. Has an outside business sign conforming to county/municipal sign and zoning codes for its neighborhood

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3. Agencies must utilize the automated systems mandated by SCDHHS to document and bill for the provision of services.

5. Providers must accept or decline referrals from SCDHHS or SCDDSN within two (2) working days. Failure to respond will result in the loss of the referral.

6. The provider must verify the participant's Medicaid eligibility when it accepts an authorization and monthly thereafter to ensure continued eligibility. Agencies can verify Medicaid eligibility for CLTC participants in the Phoenix Provider Portal on their dashboard. Providers should also refer to Section 1 of this provider manual for additional information on eligibility determination.

7. Providers may use paperless filing systems. Provider must obtain approval from CLTC Central Office prior to initiating electronic documentation and/or filing systems. Electronic records must be made available upon request, and providers must have a reliable back-up system in the event their computer system shuts down.

C. Description of Services to be Provided

1. The unit of service is one (1) hour of direct nursing care provided to the participant in the participant's natural environment. Services are not allowable when the participant is in an institutional or school setting. The amount of time authorized does not include travel time. Services provided without a current, valid authorization are not reimbursable.

2. The number of units and services provided to each participant are determined by the individual participant's needs as set forth in the Person Centered Service Plan/Authorization.

3. Nursing services providers will provide skilled nursing services as ordered by the physician performed by a registered nurse (RN) or licensed practical nurse (LPN) in accordance with state law. In addition, providers will assist with/perform ADL's as needed.

D. Staffing

1. The provider must maintain individual records for all employees.

2. The provider must employ a RN or LPN that meets the following requirements:

   a. Supervised by a RN

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b. Licensed to practice nursing by the State of South Carolina

c. Has at least one (1) year of experience in public health, hospital, or long term care nursing; and

d. Has a minimum of six (6) hours relevant in-service training per calendar year (The annual six-hour requirement will be pro-rated during the nurse's first year of employment with the provider)

e. Ensure that nurses serving pediatric participants have at least one year of pediatric nursing experience in a clinical setting or have successfully completed a SCDHHS-approved pediatric training program. Providers interested in presenting their pediatric training program to SCDHHS for review should contact the Children's Private Duty Nursing (CPDN) Program Coordinator. SCDHHS will inform the provider in writing of the results of the SCDHHS review. Once approved, providers may not make changes to their pediatric training program without prior approval by SCDHHS.

f. Ensure that nurses serving pediatric participants are additionally trained in caring for children with a tracheostomy, mechanical ventilation, gastric or jejeunostomy tubes, and indwelling catheters.

3. PPD Tuberculin Test

Please refer to the Department of Health and Environmental Control (DHEC) website for PPD Tuberculin test requirements.

http://www.scdhec.gov/Health/DiseasesandConditions/InfectiousDiseases/BacterialDiseases/Tuberculosis/

For additional information, providers should contact the Tuberculosis Control Division, Department of Health and Environmental Control, 1751 Calhoun Street, Columbia, SC 29201, phone (803) 898-0558.

4. The provider must conduct a criminal background check for all potential employees to include employees who will provide direct care to SCDHHS/SCDDSN participants and all administrative/office employees. All criminal background checks must include all data for the individual with no less than a ten (10) year timeframe being searched. The criminal background check must include statewide (South Carolina) data. The statewide data must include South Carolina and any other state or states the worker has resided in within the prior ten years. Potential employees with felony convictions within the last ten

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(10) years cannot provide services to SCDHHS/SCDDSN participants or work in an administrative/office position. Potential employees with non-violent felonies dating back ten (10) or more years can provide services to SCDHHS/SCDDSN participants under the following circumstances:

- Participant/responsible party must be notified of the nurse's criminal background.
- Provider must obtain a written statement, signed by the participant/responsible party acknowledging awareness of the nurse's criminal background and agreement to have the nurse provide care; this statement must be placed in the participant record.

Potential administrative/office employees with non-violent felony convictions dating back ten (10) or more years can work in the agency at the discretion of the provider.

Hiring of employees with misdemeanor convictions will be at the discretion of the provider.

5. The provider must check the Office of Inspector General (OIG) exclusions list for all staff. A copy of the search results page must be maintained in each employee's personnel file. Anyone appearing on this list is not allowed to provide services to waiver participants or participate in any Medicaid funded programs.
The website address is:

   OIG Exclusions List - http://www.oig.hhs.gov/fraud/exclusions.asp

   The provider must verify nurse licensure and license status at the State Board of Nursing website: http://www.llr.state.sc.us/pol.asp. A copy of the current license must be maintained in the employee's personnel file. The provider must periodically verify that the nurse license is active and in good standing.

6. Each September the provider must submit a statement certifying that all professional staff is appropriately and currently licensed.

7. In addition, services must also adhere to the following:

   a. The RN supervisor must be accessible via beeper/phone at all times the RN or LPN is on duty; and,

      The RN supervisor must decide the frequency of supervisory visits based on his/her professional knowledge of the participant's situation and health status; however, this may be no less frequently than every ninety (90) days for LPNs and every 180 days for RNs. In the event the participant is

inaccessible during the time the visit would have normally been made, the visit must be completed within five (5) working days of the resumption of Nursing services. These visits will include a re-evaluation of the participant's condition as well as updating of the plan of care.

All required documentation must be filed in staff records within 15 days of employment or of receipt of the documentation.

E. Conduct of Service

The provider must maintain documentation showing that it has complied with the requirements of this section. An individual participant record must be maintained.

1. The provider must obtain the Plan of Service/Authorization from the SCDHHS/SCDDSN prior to the provision of services. The authorization will designate the amount, frequency, and duration of service for participants in accordance with the participant's Plan of Service. This documentation must be maintained in the participant's file.

2. Prior to the initiation of nursing services, the provider must conduct an assessment and develop a plan of care. This must be done by a RN. If services are to be provided by an LPN, the plan of care must be developed by the RN supervisor. The provider must maintain the initial and subsequent care plans in the participant's record. If applicable, recommendations to change the service schedule from the initial authorization may be sent to SCDHHS/SCDDSN.
For SCDHHS Participants: This visit must be recorded in Care Call.

3. If there is a break in service which lasts more than sixty (60) days, the supervisor is required to conduct a new initial visit and subsequent visits as indicated above.

4. The provider is responsible for procuring the direct care skilled nursing orders from the physician. The orders must specify the skilled needs of the participant and include the medication administration record (MAR). The provider must communicate with the participant's physician(s) in order to maintain current physician orders. The physician's orders must be updated no less than every ninety (90) days. Participant records must be maintained by the provider and made available to the nurse providing care.

5. Nursing services must begin on the date negotiated by SCDHHS/SCDDSN and the Nursing services provider. Payment will not be made for nursing services provided prior to the authorized start date.

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6. The provider must notify SCDHHS/SCDDSN within two (2) working days of the following participant changes:

   a. Participant's condition has changed, and the Plan of Service no longer meets the participant's needs, or the participant no longer needs nursing services;

   b. Participant is institutionalized, dies or moves out of the service area;

   c. Participant no longer wishes to receive the Nursing services; or

   d. Knowledge of the participant's Medicaid ineligibility or potential ineligibility.

7. The provider must maintain a record keeping system which documents:

   a. **For SCDHHS participants:** The delivery of services in accordance with the SCDHHS Service Plan. The provider will maintain daily notes including MAR that reflect the nursing services provided to the participants. The provider shall not ask the participant/responsible party to sign any nursing notes. The nurse's note must be reviewed, signed, with original signature (rubber signature stamps are not acceptable), and dated every two weeks by the supervisor. Nursing notes must be filed in the participant's record within thirty (30) days of service delivery

   b. **For SCDDSN participants:** The delivery of services and units provided in accordance with the service authorization. The provider will maintain daily notes including MAR that reflect the Nursing services provided by the nurse for the participants and the actual amount of time expended for the service. The daily logs must be signed weekly by the participant or family member. The nurse's note must be reviewed, signed with original signature (rubber signature stamps are not acceptable) and dated every two weeks by the Supervisor. Nursing notes must be filed in the participant's record within thirty (30) days of service delivery.

   c. All active participant records must contain at least two (2) years of documentation to include nurse's notes, service plans, authorizations, supervisory visit documentation, etc. Per Medicaid policy, all records must be retained for a period of at least five (5) years. Daily logs must be made available to SCDHHS/SCDDSN upon request.

8. A summary of services provided must be sent to SCDHHS/SCDDSN monthly. This summary must be documented on the monthly summary form.

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Documentation of supervisory visits must be sent to SCDHHS/SCDDSN quarterly on the supervisory visit form and maintained in the participant record. Providers serving pediatric participants must document on the Pediatric Monthly Summary and Pediatric Supervisory Visit forms. All of these forms can be obtained on the Phoenix Provider Portal Help section.

F. Overview of compliance review process

The Division of Long Term Care Waiver Management, Provider Compliance Department has developed this policy for clarification of the provider compliance process. The policy gives detailed information on how provider compliance sanctions are implemented. Provider reviews receive a score based on a sanctioning scale; review scores will determine if the provider will receive a sanction and if so, the level of the sanction. The sanction scoring process was developed to ensure that reviews are equitable and for providers to know what to expect when they are reviewed.

Following is a chart that outlines how reviews are scored:

Sanction Level

- Provider compliance review questions in the Scope of Services are classified into three classes, based on (1) the significance of the question regarding to the services, and (2) the potential influences on providers and participants if the requirement was not met. See the example below:

Severity level: 1=less serious, 2 = serious, 3 = very serious

Client Service Questions	Possible Answers	Severity Level
Was supervisory visit made within 30 days after PC II services initiated?	Y, N, NA	3
Was the initial supervisory visit documented in Care Call?	Y, N, NA	3
Does provider maintain individual client records?	Y, N	2
Did provider give participant written information regarding advanced directives?	Y, N, NA	1

There are five types of sanctions:

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- Plan of Correction – This is the lowest sanction and indicates the provider is in substantial compliance with the contractual requirements. The provider will be required to submit a plan of correction outlining the deficiency (ies), the detailed plan to correct the deficiency and the effective date the plan will be implemented. Any documentation that was not available during the compliance visit will not be accepted as a part of the plan of correction. All documentation must be in the appropriate records at the time of the review.

- 30-day suspension – At this level, new referrals are suspended for thirty (30) days. The provider will also be required to submit a plan of correction. If the plan of correction is approved, the suspension is automatically lifted at the end of the 30-day period. If the corrective action plan is not approved, the Provider will be given an additional ten (10) business days to submit another corrective action plan for review and approval; the suspension will remain in place until an approved corrective action plan is received. If the second submitted corrective action plan is not approved, the provider contract will be terminated. Any documentation that was not available during the compliance visit will not be accepted as a part of the plan of correction. All documentation must be in the appropriate records at the time of the review.

- 60-day suspension – At this level, new referrals are suspended for sixty (60) days. The provider will also be required to submit a plan of correction. If the plan of correction is approved, the suspension is automatically lifted at the end of the 60-day period. If the corrective action plan is not approved, the Provider will be given an additional ten (10) business days to submit another corrective action plan for review and approval; the suspension will remain in place until an approved corrective action plan is received. If the second submitted corrective action plan is not approved, the provider contract will be terminated. Any documentation that was not available during the compliance visit will not be accepted as a part of the plan of correction. All documentation must be in the appropriate records at the time of the review.

- 90-day suspension – Indicates serious and widespread deficiencies, new referrals are suspended for ninety (90) days. The 90-day suspension of new referrals will only be lifted after an acceptable plan of correction is received. If the corrective action plan is not approved, the Provider will be given an additional ten (10) business days to submit another corrective action plan for review and approval; the suspension will remain in place until an approved corrective action plan is received. If the second submitted corrective action plan is not approved, the provider contract will be terminated. In addition, an acceptable follow-up review visit may be conducted if warranted. Any documentation that was not available during the compliance visit will not be accepted as a part of the plan of correction. All documentation must be in the appropriate records at the time of the review.

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- Termination – Indicates a final review score of four hundred (400) or more points and/or very serious and widespread deficiencies, generally coupled with a history of bad reviews (three (3) consecutive reviews that receive suspension of new referrals).

  Providers who have two (2) consecutive reviews that result in suspension of new referrals, will be terminated if the third consecutive review has a final score that would result in a suspension of new referrals (100 and above).

  We have developed a system to score reviews based on the percentage of the identified deficiency and number of participants surveyed. Following is an outline of how reviews will be scored:

Calculating process

- The level of sanction will be decided based on the total score of the provider‘s current review and the provider’s review history, which is converted from the deficiency percentage.

- Every 5% deficiency counts for 1 point in each class; the total score comes from the total points from each level.

- Since each level has different severity, multiple points will be added on each class’s score. Final score = level 3 = unweighted points x 3 + level 2 = unweighted basic points x 2+ level 1 = unweighted points x 1

  Example:

Level	Deficiency percentage	Basic points	Final points
Level 1 (less serious)	28%	5	5x1=5
Level 2 (serious)	20%	4	4x2=8
Level 3 (major)	35%	7	7x3=21
Final score			34

Based on the total score a sanction level is determined. If a provider has no deficiencies, they will not be subject to a sanction. Below is a chart that illustrates the sanction that will be imposed based on the final review score:

Score Scale & Sanction Level

Sanction Type	Final score	With Good History*
Correction Plans	0-99	0-149
30 Days Suspension	100-199	150-249

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60 Days Suspension	200-299	250-349
90 Days Suspension	300-399	350-449
Termination	>400	>450

Good History is determined based on previous review scores. For example, if a provider's previous review had a total score of **50** and their current review has a score of **120**, the sanction for the current review will be corrective action rather than 30-day suspension based on the previous review score.

Scores are automatically calculated using a computer generated compliance review program.

Provider records will be reviewed periodically at the provider's office. Onsite visits are un-announced. If the reviewer (CLTC, Program Integrity or other government entity) arrives at the provider's office to conduct a survey and no one is there, the following sanctions will be imposed:

- First time – thirty (30) day suspension of new referrals
- Second time – ninety (90) day suspension of new referrals
- Third time – contract termination

G. Administrative Requirements

1. The provider must inform SCDHHS of the provider's organizational structure, including the provider personnel with authority and responsibility for employing qualified personnel, ensuring adequate staff education, in-service training, and employee evaluations. The provider shall notify SCDHHS within three (3) working days in the event of a change in or the extended absence of the personnel with the above listed authority.

2. The provider must provide SCDHHS with a written document showing the organization, administrative control and lines of authority for the delegation of responsibility down to the hands-on participant care level staff at contract implementation. The document shall include an organizational chart including names of those currently in the positions. Revisions or modifications to this organizational document must be provided to SCDHHS. It is recommended that this document be readily accessible to all staff.

3. Administrative and supervisory functions shall not be delegated to another agency or organization.

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4. The provider agency must acquire and maintain for the duration of the contract liability insurance and worker's compensation insurance as provided in Article IX, Section D of the Contract. The provider is required to list – SCDHHS as a Certificate Holder for informational purposes only on all insurance policies using the following address: Post Office Box 8206, Columbia, SC 29202-8206.

5. The provider will ensure that its office is staffed by qualified personnel during the hours of 10:00 a.m. to 4:00 p.m. Outside of these hours; the provider agency must be available by telephone during normal business hours, 8:30 a.m. to 5:00 p.m., Monday through Friday. Failure to maintain an open and staffed office as indicated will result in sanctions as outlined in section F, last paragraph. The provider must also have a number for emergencies outside of normal business hours. Participant and personnel records must be maintained at the address indicated in the contract and must be made available, upon request, for review by SCDHHS.

6. The provider must develop and maintain a policy and procedure manual which describes how it will perform its activities in accordance with the terms of the contract. The Policy and Procedure Manual shall be available during office hours for the guidance of the governing body, personnel and will be made available to SCDHHS upon request.

7. The provider must have an effective written back-up service provision plan in place to ensure that the participant receives the nursing services as authorized. Whenever the provider determines that services cannot be provided as authorized, the SCDHHS/SCDDSN must be notified by telephone immediately.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

NURSING

MEDICAID HOME AND COMMUNITY-BASED WAIVER
SCOPE OF SERVICES
FOR
NURSING SERVICES

ADDENDUM

Nursing Services to High Risk/High Tech Children:

The Department of Health and Human Services has established a separate classification and compensation plan for Registered Nurses (RN) and Licensed Practical Nurses (LPN) who provide services to medically fragile children under the age of 21 who are ventilator dependent, respirator dependent, intubated and require parental feeding or any combination of these conditions.

In addition to the staffing requirements outlined in Section D.1, the RN or LPN must have documented experience to care for these children that is over and above normal home care or school based nurses.

If the above requirements are met, the provider will be paid an enhanced rate for High Risk/High Tech RN and LPN services as indicated on the rate sheet included in the contract.

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MEDICALLY COMPLEX CHILDREN'S WAIVER
SCOPE OF SERVICES
FOR
PEDIATRIC MEDICAL DAY CARE

A. Objective

The purpose of Pediatric Medical Day Care (PMDC) is to provide physician ordered, comprehensive nursing care services in a licensed day care center to waiver Participants who have medically complex needs in accordance with the Participant's approved person centered service plan (PCSP).

B. Description of Services to Be Provided

PMDC, which must be provided in accordance with the Treatment Plan, MCC waiver, MCC policy and procedure, SCDHHS policies and procedures and applicable federal and state statutes and regulations, includes the following services:

1. Three meal and at least one snack per day, including formula or enteral nutrition, either provided by the PMDC or the participant's parent or legal guardian.

2. Daily planned therapeutic activities to promote developmentally age appropriate mental stimulation, communication and self-expression. These activities may include exercises, crafts, music, educational programs, and games, which address cognitive, motor, speech, and emotional needs of children.

3. PMDC services must be coordinated with the participant's person centered service plan (PCSP), which is under the direction of the RN Care Coordinator and a Treatment Plan must be kept on file, which must include:

    a. Patient contact information

    b. History and physical from the child's primary care physician

    c. Specific medical treatment plan which outlines doctor's orders specific to the child's needs

4. The daily physician prescribed nursing services provided in the PMDC performed by or under the supervision of a registered nurse (RN) as permissible under State law must comply with the MCC Policy and Procedure Manual.

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5. When medically necessary, the provider will contact the waiver participant's physician.

C. Staffing

1. The Provider must employ:

a. A Nursing Supervisor who:

i. Hires qualified personnel,

ii. Ensures adequate staff education,

iii. Conducts employee evaluations,

iv. Has the following qualifications:

a. Is a RN currently licensed by an appropriate licensing authority of the state in which the PMDC is located;

b. Has a minimum of three (3) years of experience in pediatric nursing care or three (3) years of social services experience involving the pediatric population; and

c. Has a minimum of one (1) year of administrative or supervisory experience.

b. Nurses who:

i. Are licensed by the State of South Carolina, the State of Georgia, or by a state that participates in the Nursing Compact as a RN or Licensed Practical Nurse (LPN);

ii. Have two (2) years of pediatric experience with medically complex or chronically ill children unless otherwise approved by SCDHHS;

iii. Attend all mandatory SCDHHS training programs and adhere to the training requirements; and

iv. Provide skilled nursing services within the scope of the respective State Nurse Practice Act.

c. Direct Care staff that are:

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i. RNs, LPNs, Certified Nursing Assistants (CNAs), Nursing Aides, or teaching assistants who:

a. Must be present in a ratio of one (1) for every three (3) participants in the PMDC at any given time.

b. Must have a minimum of one (1) year of pediatric experience or six (6) months of pediatric experience in a hospital setting (other than nurses**).**

2. There must be one (1) RN in the PMDC at all times when MCC participants are present. The supervisor may be the one (1) RN required.

3. The PMDC must maintain a ratio of one (1) RN or LPN for every six (6) participants.

4. Should the provider find itself unable to meet the staffing requirements outlined in this section due to vacancies or for any other reason, the provider must notify SCDHHS immediately. Any deviation from the staffing ratios and requirements must be approved in writing by the SCDHHS MCC waiver administrator.

5. All direct care staff must be trained regarding specific or singular needs of the medically complex participants supervised by the RN on staff. Orientation must be accomplished by observing direct hands on care with specific procedures documented for the employee record.

D. Conditions of Participation

1. The provider must maintain a current day care license through the South Carolina Department of Social Services or their state's respective day care licensing body.

2. The PMDC must be able to accommodate handicapped participants.

3. The PMDC must be equipped with medical equipment appropriate to address the needs of the MCC waiver participants.

4. **The provider must participate in the Care Call monitoring and payment system.**

a. Care Call billing activity must be completed at the time the service is rendered.

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b. For units of service, the Care Call documentation should be completed immediately upon assuming care of the Participant.

5. The provider shall not delegate administrative and supervisory functions to another agency or organization.

6. The provider shall not enter into any subcontract to provide any services or functions covered under this Contract without prior written approval from SCDHHS.

7. The provider must comply with the South Carolina Child Protection Reform Act (S.C. Code Ann. §63-7-10 et seq. (Supp. 2008)), which requires the reporting of any suspected abuse, neglect or exploitation of a child age 17 and under as defined in the Act or the respective state's child protection laws..

8. The provider must maintain a business continuity plan, which will be made available to SCDHHS upon request.

9. The provider must maintain a personnel file for each staff member and document that she/he has met all requirements set forth herein.

10. The provider must conduct a criminal background check for all potential employees to include employees who will provide direct care to participants and all administrative/office employees. All criminal background checks must include all data for the individual with no less than a ten (10) year timeframe being searched. The criminal background check must include statewide data. The statewide data must include South Carolina and any other state or states the worker has resided in within the prior ten years. Potential employees with felony convictions within the last ten (10) years cannot provide services to participants or work in an administrative/office position. Potential employees with non-violent felonies dating back ten (10) or more years can provide services to participants under the following circumstances;

    a. Participant/responsible party must be notified of the nurse's criminal background.

    b. Provider must obtain a written statement, signed by the Participant/responsible party acknowledging awareness of the nurse's criminal background and agreement to have the nurse provide care; this statement must be placed in the Participant record.

    Potential administrative/office employees with non-violent felony convictions dating back ten (10) or more years can work in the agency at the discretion of the Provider.

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Hiring of employees with misdemeanor convictions will be at the discretion of the Provider.

11. The Provider must verify nurse licensure and license status at the State Board of Nursing website:

http://www.llr.state.sc.us/pol.asp.

A copy of the current license must be maintained in the employee's personnel file.

12. Provider will verify nurse licensure at time of employment and will ensure that the license remains active and in good standing at all times during employment. Provider must maintain a copy of the current license in the employee's personnel file. Nurse licensure can be verified at the State Board of nursing website.

http://www.llr.state.sc.us/pol.asp

13. PPD Tuberculin Test

Please refer to the South Carolina Department of Health and Environmental Control (SCDHEC) website for PPD Tuberculin test requirements.

http://www.scdhec.gov/Health/DiseasesandConditions/InfectiousDiseases/BacterialDiseases/Tuberculosis/

For additional information, providers should contact the Tuberculosis Control Division, South Carolina Department of Health and Environmental Control, 1751 Calhoun Street, Columbia, SC 29201, phone (803) 898-0558.

14. All staff employed must hold Basic Life Support Certification, which includes Adult, Infant, and Child CPR with First Aid. Copies of the certification must be maintained at the provider's facility.

E. Administrative Requirements

1. The provider will maintain current licensure information in each employee's personnel file.

2. The provider shall ensure that key organization staff, including the administrator, is accessible during compliance review audits conducted by SCDHHS and/or its agents.

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3. The provider must provide all necessary documentation, data and support, including witness testimony, if required, for the SCDHHS Appeals and Hearings process with respect to appeals of any action involving the Provider within the scope of this Contract.

4. The provider must incorporate in the operation procedures of the PMDC adequate safeguards to the health and safety of the participants in the event of a medical or other emergency.

5. The provider shall notify SCDHHS within three (3) business days in the event of a change in the administrator, the administrator's extended absence or a change in the provider's address, telephone or fax number.

6. SCDHHS shall be given a point of contact for the provider which has legal authority.

7. The provider must develop and maintain a Policy and Procedure Manual that describes how activities will be performed in accordance with the requirements of the Contract. The Policy and Procedure Manual shall be available during office hours and will be made available to SCDHHS upon request.

8. The provider will ensure that its office is staffed by qualified personnel during hours of operation. The provider must also have an emergency contact number for emergencies occurring outside of normal business hours. Participant and personnel records must be maintained at the address indicated in the Contract and must be made available, upon request, for review by SCDHHS or its designee.

9. The provider shall provide SCDHHS a list of regularly scheduled holidays for the coming calendar year each September. The provider is not required to furnish services on regularly scheduled holidays. The provider must not be closed for more than two (2) consecutive days, except when a holiday falls in conjunction with a weekend. In that case, the provider may be closed for not more than four (4) consecutive days.

10. The PMDC must be open Monday through Friday at least six (6) hours a day.

11. The provider shall conform to applicable federal, state, and local health and safety rules and regulations, and have an on-going program to prevent the spread of infectious diseases among its employees.

12. The provider must adhere to any other criteria as established by SCDHHS.

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MEDICAID HOME AND COMMUNITY-BASED WAIVER SCOPE OF SERVICES FOR PERSONAL CARE I (PC I) SERVICES

A. Objectives

The objectives of PC I Services are to preserve a safe and sanitary home environment, assist participants with home care management duties and to provide needed supervision of Medicaid Home and Community-Based waiver participants.

B. Conditions of Participation

1. Agencies desiring to be a provider of PC I services must have demonstrated experience in providing home care management.

2. Pursuant to enactment and implementation of S.C. § Code 44-70-10 all providers of personal care services will require a license to provide personal care services. Providers are required to renew their license annually. Providers who do not maintain their In Home Care provider license will be terminated. Providers who are not licensed by the South Carolina Department of Health and Environmental Control will not be allowed to enroll as a Medicaid provider for these services.

3. Provider agencies must be housed in an office that is in a commercial zone. Any agency not housed within a commercial location must be prior approved by SCDHHS to enroll as a personal care provider. Requirements for agencies not in commercial locations include all of the following:

   a. Has a county/municipal zoning permit to operate a business in a residential setting if required

   b. Holds appropriate business licenses

   c. Meets applicable county/municipal, mixed-use zoning guidelines for a home-based business in a primarily residential neighborhood

   d. Has a business entrance door which is separate from a residential living area.

   e. Uses office space devoted entirely for the business; space must be enclosed and have a locking door which uses a different key from other locks in the home

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f. Has an outside business sign conforming to county/municipal sign and zoning codes for its neighborhood

4. The Provider must ensure that, when serving Participants, its Aide and Supervisors display a photo identification badge identifying the Provider and the employee.

5. Providers must utilize the automated systems mandated by CLTC to document and bill for the provision of services.

6. Providers must accept or decline referrals from South Carolina Department of Health and Human Services (SCDHHS) or SCDDSN within two (2) working days. Failure to respond will result in the loss of the referral.

7. The provider must verify the participant's Medicaid eligibility when it accepts an authorization and monthly thereafter to ensure continued eligibility. Agencies can verify Medicaid eligibility for CLTC participants in the Phoenix Provider Portal on their dashboard. Providers should also refer to Section 1 of this provider manual for additional information on eligibility determination.

8. Providers may use paperless filing systems. Provider must obtain approval from CLTC Central Office prior to initiating electronic documentation and/or filing systems. Electronic records must be made available upon request, and providers must have a reliable back-up system in the event their computer system shuts down.

C. Description of Services To Be Provided

1. The Unit of Service is one (1) hour of direct services provided in the participant's residence for shopping, laundry services, other off-site services or escort services. The amount of time authorized does not include the aide's transportation time to and from the participant's residence.

2. The number of units and services provided to each participant are determined by the individual participant's needs as set forth in the participant's Service Plan/Authorization.

3. Under no circumstances will a PC I furnish any type of skilled medical service.

4. Services to be provided include:

a. Meal planning and preparation:

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- Cleaning
- Laundry
- Shopping
- Home safety
- Errands
- Escort services

b. Limited assistance with financial matters, such as delivering payments to designated recipients on behalf of the participant. Receipts for payment should be returned to the participant.

c. Assistance with communication which includes, but is not limited to, placing phone within participant's reach and physically assisting participant with use of the phone, and orientation to daily events.

d. Observing and reporting on participant's condition.

D. Staffing

The provider must maintain individual records for all employees.

The provider must maintain all of the following (supervisory positions can be sub-contracted):

1. A supervisor who meets the following requirements:

   a. High school diploma or equivalent

   b. Capable of evaluating aides in terms of their ability to carry out assigned duties and their ability to relate to the participant

   c. Able to assume responsibility for in-service training for aides by individual instruction, group meetings, or workshops

2. Aides who meet the following minimum qualifications:

   a. Able to read, write and communicate effectively with participant and supervisor

   b. Able to use the Care Call IVR system

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c. Capable of following a care plan with minimal supervision

d. Be at least 18 years of age

e. Have documented record of having completed six (6) hours of training in the areas indicated in Section D.2.f, prior to providing services or documentation of personal, volunteer or paid experience in the care of adults, families and/or the disabled, home management, household duties, preparation of food, and be able to communicate observations verbally and in writing

f. Complete at least six (6) hours in-service training per calendar year in the following areas:

i. Maintaining a safe, clean environment and utilizing proper infection control techniques;

ii. Following written instructions;

iii. Providing care including individual safety, laundry, meal planning, preparation and serving, and household management;

iv. First aid;

v. Ethics and interpersonal relationships;

vi. Documenting services provided;

vii. Home support:

- Cleaning
- Laundry
- Shopping
- Home safety
- Errands
- Observing and reporting the participant's condition

The annual six (6) hour requirement will be on a pro-rated basis during the aide's first year of employment.

3. Agency staff may be related to participants served by the agency within limits allowed by the South Carolina Family Caregiver Policy. The following family members cannot be a paid caregiver:

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a. The spouse of a Medicaid participant

b. A parent of a minor Medicaid participant

c. A step parent of a minor Medicaid participant

d A foster parent of a minor Medicaid participant

e. Any other legally responsible guardian of a Medicaid participant

Family members who are primary caregivers will not be reimbursed for HASCI respite services. All other qualified family members can be reimbursed for their provision of PC I services.

4. PPD Tuberculin Test

Please refer to the Department of Health and Environmental Control (DHEC) website for PPD Tuberculin test requirements.

http://www.scdhec.gov/Health/DiseasesandConditions/InfectiousDiseases/BacterialDiseases/Tuberculosis/

For additional information, providers should contact the Tuberculosis Control Division, Department of Health and Environmental Control, 1751 Calhoun Street, Columbia, SC 29201, phone (803) 898-0558.

5. A criminal background check is required for all potential employees to include employees who will provide direct care to SCDHHS/SCDDSN participants and all administrative/office employees (office employees required to have background checks include: administrator, office manager, nurse supervisor, and persons named on organizational chart in management positions). All criminal background checks must include all data for the individual with no less than a ten (10) year timeframe being searched. The criminal background check must include statewide data. The statewide data must include South Carolina and any other state or states the worker has resided in within the prior ten years. Potential employees with felony convictions within the last ten (10) years cannot provide services to SCDHHS/SCDDSN participants or work in an administrative/office position. Potential employees with non-violent felonies dating back ten (10) or more years can provide services to SCDHHS/SCDDSN participants under the following circumstances:

- Notification of participant/responsible party of aide's criminal background

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- Provider must obtain a written statement, signed by the participant/responsible party acknowledging awareness of the aide's criminal background and agreement to have the aide provide care; this statement must be placed in the participant record.

Potential administrative/office employees with non-violent felony convictions dating back ten (10) or more years can work in the agency at the discretion of the provider.

Hiring of employees with misdemeanor convictions will be at the discretion of the provider.

All required staff documentation must be filed in the employee file within 15 days of employment or of receipt.

E. Conduct of Service

The provider must maintain documentation showing that it has complied with the requirements of this section.

1. The provider must obtain the Service Plan/Authorization from the Case Manager/Service Coordinator prior to the provision of services. The authorization will designate the amount, frequency and duration of service for participants in accordance with the participant's SCDHHS (CLTC) Service Plan/SCDDSN Authorization which will have been developed in consultation with the participant and others involved in the participant's care. The provider will receive new authorizations only when there is a change to the authorized service amount, frequency or duration. The provider must adhere to those duties which are specified in the SCDHHS (CLTC) Service Plan/SCDDSN Authorization in developing the Provider task list. This provider task list must be developed by the supervisor. If the provider identifies PC I duties that would be beneficial to the participant's care but are not specified in the SCDHHS (CLTC) Service Plan/SCDDSN Authorization, the Provider must contact the Case Manager/Service Coordinator to discuss the possibility of having these duties included in the SCDHHS (CLTC) Service Plan/SCDDSN Authorization. **Under no circumstances will any type of skilled medical service be performed by an aide.** The Case Manager/Service Coordinator will make the decision as to whether the SCDHHS (CLTC) Service Plan/DDSN Authorization should be amended to include the additional duty. This documentation will be maintained in the participant files.

2. As part of the conduct of service, the supervisor of PC I services must:

   a. Provide an initial visit prior to the start of PC I services for the purpose of reviewing SCDHHS CLTC plan of care, developing a task list for the aide,

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(this task list must be developed prior to the provision of any PC I services), giving the participant written information regarding advanced directives and informing participants of their right to complain about the quality of PC I services provided. The supervisor must give participants information about how to register a complaint. Complaints against aides must be investigated by the Provider and appropriate action taken. Documentation must be maintained in the participant and the aide's file.

b. Provide on-site supervision at least once every 365 days for each participant and phone and/or on-site contact with the participant at least once every 120 days. Supervisors must make phone contacts or conduct on-site supervision more frequently if warranted by complaints or indications of substandard performance by the aide.

c. Each supervisory visit, including the initial visit, must be documented in the participant's file and recorded in Care Call. The Supervisor's report of the on-site visits must include, at a minimum:

   i. Documentation that services are being delivered consistent with the SCDHHS CLTC Service Plan/SCDDSN Authorization

   ii. Documentation that the participant's needs are being met

   iii. Reference to any complaints which the participant or family member/responsible party has lodged:

   - A brief statement regarding any changes in the participant's service needs; and
   - Supervisor's original signature and date. Rubber signature stamps are not acceptable.
   - Documentation of all supervisory visits must be filed in the participant's record within thirty (30) days of the date of the visit.

d. Supervisors must provide assistance to aides as necessary.

e. Supervisors must be accessible by phone and/or beeper during any hours services are being provided under this contract. If the PC I supervisory position becomes vacant, SCDHHS must be notified no later than the next business day.

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f. If there is a break in service which lasts more than sixty (60) days, the supervisor will be required to complete a new initial visit.

3. In addition, the provider must maintain an individual participant record that documents the following items:

a. Initiation of PC I services on the date negotiated with the Case Manager/Service Coordinator and indicated on the Medicaid Home and Community-Based waiver authorization. Services must not be provided prior to the authorized start date and must be provided according to the schedule as indicated on the SCDHHS CLTC Service Plan/SCDDSN Authorization.

b. Notification to the Case Manager/Service Coordinator within two (2) working days of the following participant changes:

i. Participant's condition has changed and the SCDHHS CLTC Service Plan/SCDDSN Authorization no longer meets participant's needs or the participant no longer appears to need PC I services.

ii. Participant dies, is institutionalized or moves out of the service area.

iii. Participant no longer wishes to participate in a program of PC I services.

iv. Knowledge of the participant's Medicaid ineligibility or potential ineligibility.

c. The provider will maintain a record keeping system that document:

i. **For SCDHHS participants:** The delivery of services in accordance with the SCDHHS CLTC Service Plan. The provider shall not ask the participant/responsible person to sign any log or task sheet. Task sheets must be reviewed, signed, with original signature (rubber signature stamps are not acceptable), and dated, every two (2) weeks by the supervisor. Task sheets must be filed in the participant’s file within thirty (30) days of service delivery.

ii. **For SCDDSN participants:** The delivery of services and units provided in accordance with the service authorization. The provider will maintain daily logs reflecting the PC I services provided by the aides for the participants and the actual amount of

time expended for the service. The daily logs must be initialed daily by the participant/family member and the aide, and must be signed weekly by the participant/family member and signed, with original signature (rubber signature stamps are not acceptable), and dated by the Supervisor at least once every two weeks. Daily logs must be filed in the participant's file within thirty (30) days of service delivery.

All documentation must be made available to SCDHHS/SCDDSN upon request.

d. **For SCDHHS participants only:** For all instances in which a participant did not receive an authorized daily service, providers must indicate on the Care Call web site the reason why the service was not delivered. The provider must do this both when the provider was unable to complete the visit and when the participant was not available to receive the visit. For each week in which there are missed visits, the provider must indicate the reason on the web site by the close of business the following week. A missed visit report is not required for SCDDSN participants.

e. Whenever two consecutive attempted visits occur, the local SCDHHS/ SCDDSN office must be notified. An attempted visit is when the aide arrives at the home and is unable to provide the assigned tasks because the participant is not at home or refuses services.

F. Overview of Compliance Review Process

The Division of Long Term Care Waiver Management, Provider Compliance Department has developed this policy for clarification of the provider compliance process. The policy gives detailed information on how provider compliance sanctions are implemented. Provider reviews receive a score based on a sanctioning scale; review scores will determine if the provider will receive a sanction and if so, the level of the sanction. The sanction scoring process was developed to ensure that reviews are equitable and for providers to know what to expect when they are reviewed.

Following is a chart that outlines how reviews are scored:

Sanction Level

- Provider compliance review questions in the Scope of Services are classified into three classes, based on (1) the significance of the question regarding to the services, and (2) the potential influences on providers and participants if the requirement was not met. See the example below:

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Severity Level: 1=less serious, 2 = serious, 3 = very serious

Client Service Questions	Possible Answers	Severity Level
Was supervisory visit made within 30 days after PC II services initiated?	Y, N, NA	3
Was the initial supervisory visit documented in Care Call?	Y, N, NA	3
Does provider maintain individual client records?	Y, N	2
Did provider give participant written information regarding advanced directives?	Y, N, NA	1

There are five types of sanctions:

- Plan of Correction – This is the lowest sanction and indicates the provider is in substantial compliance with the contractual requirements. The provider will be required to submit a plan of correction outlining the deficiency (ies), the detailed plan to correct the deficiency and the effective date the plan will be implemented. Any documentation that was not available during the compliance visit will not be accepted as a part of the plan of correction. All documentation must be in the appropriate records at the time of the review.

- 30-day suspension – At this level, new referrals are suspended for thirty (30) days. The provider will also be required to submit a plan of correction. If the plan of correction is approved, the suspension is automatically lifted at the end of the 30-day period. If the corrective action plan is not approved, the Provider will be given an additional ten (10) business days to submit another corrective action plan for review and approval; the suspension will remain in place until an approved corrective action plan is received. If the second submitted corrective action plan is not approved, the provider contract will be terminated. Any documentation that was not available during the compliance visit will not be accepted as a part of the plan of correction. All documentation must be in the appropriate records at the time of the review.

- 60-day suspension – At this level, new referrals are suspended for sixty (60) days. The provider will also be required to submit a plan of correction. If the plan of correction is approved, the suspension is automatically lifted at the end of the 60-day

period. If the corrective action plan is not approved, the Provider will be given an additional ten (10) business days to submit another corrective action plan for review and approval; the suspension will remain in place until an approved corrective action plan is received. If the second submitted corrective action plan is not approved, the provider contract will be terminated. Any documentation that was not available during the compliance visit will not be accepted as a part of the plan of correction. All documentation must be in the appropriate records at the time of the review.

- 90-day suspension – Indicates serious and widespread deficiencies, new referrals are suspended for ninety (90) days. The 90-day suspension of new referrals will only be lifted after an acceptable plan of correction is received. If the corrective action plan is not approved, the Provider will be given an additional ten (10) business days to submit another corrective action plan for review and approval; the suspension will remain in place until an approved corrective action plan is received. If the second submitted corrective action plan is not approved, the provider contract will be terminated. In addition, an acceptable follow-up review visit may be conducted if warranted. Any documentation that was not available during the compliance visit will not be accepted as a part of the plan of correction. All documentation must be in the appropriate records at the time of the review.

- Termination – Indicates a final review score of four hundred (400) or more points and/or very serious and widespread deficiencies, generally coupled with a history of bad reviews (three (3) consecutive reviews that receive suspension of new referrals).

Providers who have two (2) consecutive reviews that result in suspension of new referrals, will be terminated if the third consecutive review has a final score that would result in a suspension of new referrals (100 and above).

We have developed a system to score reviews based on the percentage of the identified deficiency and number of participants surveyed. Following is an outline of how reviews will be scored:

<u>Calculating process</u>

- The level of sanction will be decided based on the total score of the provider‘s current review and the provider’s review history, which is converted from the deficiency percentage.

- Every 5% deficiency counts for 1 point in each class; the total score comes from the total points from each level.

- Since each level has different severity, multiple points will be added on each class’s score. Final score = level 3 = unweighted points x 3 + level 2 = unweighted basic points x 2+ level 1 = unweighted points x 1

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Example:

Level	Deficiency percentage	Basic points	Final points
Level 1 (less serious)	28%	5	5x1=5
Level 2 (serious)	20%	4	4x2=8
Level 3 (major)	35%	7	7x3=21
Final score			34

Based on the total score a sanction level is determined. If a provider has no deficiencies, they will not be subject to a sanction. Below is a chart that illustrates the sanction that will be imposed based on the final review score:

Score Scale & Sanction Level

Sanction Type	Final score	With Good History*
Correction Plans	0-99	0-149
30 Days Suspension	100-199	150-249
60 Days Suspension	200-299	250-349
90 Days Suspension	300-399	350-449
Termination	>400	>450

Good History is determined based on previous review scores. For example, if a provider's previous review had a total score of **50** and their current review has a score of **120**, the sanction for the current review will be corrective action rather than 30-day suspension based on the previous review score.

Scores are automatically calculated using a computer generated compliance review program.

Provider records will be reviewed periodically at the provider's office. Onsite visits are un-announced. If the reviewer (CLTC, Program Integrity or other government entity) arrives at the provider's office to conduct a survey and no one is there, the following sanctions will be imposed:

- First time – thirty (30) day suspension of new referrals
- Second time – ninety (90) day suspension of new referrals
- Third time – contract termination

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G. Administrative Requirements

1. The provider must inform SCDHHS of the Provider's organizational structure, including the provider personnel with authority and responsibility for employing qualified personnel, ensuring adequate staff education, in-service training, and employee evaluations. The provider shall notify SCDHHS within three (3) working days in the event of a change in or the extended absence of the personnel with the above listed authority.

2. The provider must provide SCDHHS with a written document showing the organization, administrative control and lines of authority for the delegation of responsibility down to the hands-on participant care level staff at contract implementation. The document should include an organizational chart including names of those currently in the positions. Revisions or modifications to this organizational document must be provided to SCDHHS. It is recommended that this document be readily accessible to all staff.

3. Administrative and supervisory functions shall not be delegated to another organization.

4. The provider shall acquire and maintain for the duration of the contract liability insurance and worker's compensation insurance as provided in Article IX, Section D of the Contract. The provider is required to list SCDHHS – CLTC as a Certificate Holder for informational purposes only on all insurance policies using the following address: Post Office Box 8206, Columbia, SC 29202-8206.

5. The provider will develop and maintain a Policy and Procedure Manual that describes how activities will be performed in accordance with the terms of the requirements of the contract. The Policy and Procedure Manual shall be available during office hours for the guidance of the governing body, personnel and will be made available to SCDHHS upon request.

6. The provider must comply with Article IX, Section Z of the Contract regarding safety precautions. The provider must also have an on-going infectious disease program to prevent the spread of infectious diseases among its employees.

7. The provider agency shall ensure that key agency staff is accessible in person, by telephone, or by beeper during compliance review audits conducted by SCDHHS and/or its agents.

8. The provider will ensure that its office is staffed by qualified personnel during the hours of 10:00 a.m. to 4:00 p.m., Monday through Friday. Outside of these hours, the Provider agency must be available by telephone during normal business hours,

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

PERSONAL CARE I

8:30 a.m. to 5:00 p.m., Monday through Friday. Failure to maintain an open and staffed office as indicated will result in sanctions as outlined in section F, last paragraph. The provider must also have a number for emergencies outside of normal business hours. Participant and personnel records must be maintained at the address indicated in the contract and must be made available, upon request, for review by SCDHHS.

9. The provider shall update holidays in Phoenix; the provider is not required to furnish services on those days. The PC I provider agency may not be closed for more than two (2) consecutive days except when a holiday falls in conjunction with a weekend. If a holiday falls in conjunction with a weekend, a PC I provider agency may be closed for not more than four (4) consecutive days.

10. The provider must have an effective written back-up service provision plan in place to ensure that the participant receives the PC I services as authorized. Whenever the provider determines that services cannot be provided as authorized, the Case Manager/Service Coordinator must be notified by telephone immediately.

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MEDICAID
SCOPE OF SERVICES
FOR
PERSONAL CARE II (PC II), HASCI ATTENDANT CARE,
HASCI RESPITE, ID/RD RESPITE and CS RESPITE SERVICES

A. Objectives

The objectives of the PC II/HASCI Attendant Care, HASCI Respite, ID/RD Respite, and CS Respite services are to restore, maintain, and promote the health status of Medicaid Home and Community-Based waiver participants through home support, medical monitoring, escort/transportation services, and assistance with activities of daily living**.**

B. Conditions of Participation

1. Agencies desiring to be a provider of PC II/HASCI Attendant Care, HASCI Respite, ID/RD Respite and CS Respite services must have demonstrated experience in In-Home personal care services or a similar service. For providers contracting after July 1, 2011, the owner or administrator of the agency must have at least three (3) years of administrative experience in the health care field. If the owner will also be the administrator, he or she is required to have at least three (3) years of administrative experience in the health care field.

2. Pursuant to enactment and implementation of S.C. § Code 44-70-10 all providers of personal care services will require a license to provide personal care services. Providers are required to renew their license annually. Providers who do not maintain their In-Home Care provider license will be terminated. Providers who are not licensed by the South Carolina Department of Health and Environmental Control will not be allowed to enroll as a Medicaid provider for these services.

3. Provider agencies must be housed in an office that is in a commercial zone. Any agency not housed within a commercial location must be prior approved by SCDHHS to enroll as a personal care provider. Requirements for agencies not in commercial locations include all of the following:

   a. Has a county/municipal zoning permit to operate a business in a residential setting if required

   b. Holds appropriate business licenses·

   c. Meets applicable county/municipal, mixed-use zoning guidelines for a home-based business in a primarily residential neighborhood

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d. Has a business entrance door which is separate from a residential living area

e. Uses office space devoted entirely for the business; space must be enclosed and have a locking door which uses a different key from other locks in the home

f. Has an outside business sign conforming to county/municipal sign and zoning codes for its neighborhood

g. Providers who are out of compliance with these requirements will have thirty (30) days to come into compliance. Failure to do so will result in contract termination.

4. The Provider must ensure that, when serving Participants, its Aide and Supervisors display a photo identification badge identifying the Provider and the employee.

5. Agencies must utilize the automated systems mandated by South Carolina Department of Health and Human Services (SCDHHS) Community Long Term Care (CLTC) Division to document and bill for the provision of services.

6. Providers must accept or decline referrals from SCDHHS or South Carolina Department of Disabilities and Special Needs (SCDDSN) within two (2) working days. Failure to respond will result in the loss of the referral.

7. The provider must verify the participant's Medicaid eligibility when it accepts an authorization and monthly thereafter to ensure continued eligibility. Agencies can verify Medicaid eligibility for CLTC participants in the Phoenix Provider Portal on their dashboard. Providers should also refer to Section 1 of this provider manual for additional information on eligibility determination.

8. Providers may use paperless filing systems. Provider must obtain approval from CLTC Central Office prior to initiating electronic documentation and/or filing systems. Electronic records must be made available upon request, and providers must have a reliable back-up system in the event their computer system shuts down.

9. The provider must agree to use any Competency Test provided by CLTC.

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C. Description of Services to be Provided

1. The unit of service is one (1) hour of direct PC II/HASCI Attendant Care/HASCI Respite/IDRD Respite/CS Respite provided in the participant's place of residence and/or natural environment. PC II/HASCI Attendant Care/HASCI Respite/IDRD Respite/CS Respite may be provided in other locations when the participant's record documents the need and when prior approved by the Case Manager/Service Coordinator (CM). Services are not allowed when the participant is in an institutional setting and/or ADHC setting. The amount of time authorized does not include provider transportation time to and from the participant. Services provided without a current, valid authorization are not reimbursable.

2. The number of units and services provided to each participant are dependent upon the individual participant's needs as set forth in the participant's Service Plan/Authorization. If it is determined that a participant requires more than one aide for lifting, transfers, etc., this must be prior approved by SCDHHS/ SCDDSN.

3. When services are authorized for more than one SCDHHS/SCDDSN participant in the same home, the provider must document and deliver the total amount of hours authorized for each participant. For example if both participants are authorized for two (2) hours of PC II per day; the aide must provide a total of four (4) hours per day in the home or natural environment.

4. **Under no circumstances will any type of skilled medical service be performed by an aide.** HASCI Attendants/or HASCI Respite caregivers may provide skilled services as authorized by the county DSN Board Service Coordinator. All skilled needs for HASCI services are determined by RN delegation.

5. Services to be provided include:

   a. Support for activities of daily living, e.g.,
      - eating
      - bathing (bed bath, bench shower, sink bath)
      - personal grooming including dressing
      - personal hygiene
      - provide skin care (applying lotion, oil, etc.)
      - meal planning and preparation
      - assisting participants in and out of bed
      - repositioning participants as necessary
      - assisting with ambulation
      - toileting and maintaining continence

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b. Home support, e.g.,
-cleaning
-laundry
-shopping
-home safety
-errands

c. Monitoring of the participant's condition e.g., the type of monitoring that would be done by a family member such as monitoring temperature, checking pulse rate and observation of respiratory rate.

d. Monitoring medication (for example, informing the participant that it is time to take medication as prescribed by his, or her, physician and as written directions on the box, or bottle, indicate). **The aide cannot administer the medicine**; however, this does not preclude the aide from handing the medicine container to the participant.

e. Escort services when necessary. Transportation may be provided when necessary and included in the participant's Service Plan/Authorization. The provision of transportation is optional and will depend on the provider's policy in this regard.

f. Strength and balance training.

D. Staffing

1. The provider must provide all of the following staff members; supervisory nurses may be provided through subcontracting arrangements:

   a. A registered nurse(s) (RN) or licensed practical nurse(s) (LPN) who meets the following requirements:

      i. Currently licensed by the S.C. State Board of Nursing

      ii. Capable of evaluating the aide's competency in terms of his or her ability to carry out assigned duties and his/her ability to relate to the participant

      iii. Able to assume responsibility for in-service training for aides by individual instruction, group meetings or workshops

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iv. Must have had background and/or training on the complex treatment issues regarding the care of the head and spinal cord injured

v. Provider will verify nurse licensure at time of employment and will ensure that the license remains active and in good standing at all times during employment. Provider must maintain a copy of the current license in the employee's personnel file. Nurse licensure can be verified at the State Board of nursing website

http://www.llr.state.sc.us/pol.asp

b. Aides who meet the following minimum qualifications:

i. Able to read, write, and communicate effectively with participant and supervisor

ii. Able to use the Care Call IVR system

iii. Capable of assisting with the activities of daily living

iv. Capable of following a care plan with minimal supervision.

v. Have a valid driver's license if transporting participants. The provider must ensure the employee's license is valid while transporting any participants by verifying the official highway department driving record of the employed individual initially and every two (2) years during employment. Copies of the initial and subsequent driving records must be maintained in the employee's personnel file.

vi. Are at least 18 years of age

vii. Have passed competency testing or successfully completed a competency training and evaluation program performed by a RN or LPN prior to providing services to Home and Community-Based waiver participants. The competency evaluation must contain all elements of the PC II services in the Description of Services listed above. The competency training should also include training on appropriate record keeping and ethics and interpersonal relationships.

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If an LPN performs the competency evaluation, the LPN must be supervised by a RN and report all competency evaluation results to the RN supervisor. The LPN and the supervising RN, as a confirmation of the delegation of this responsibility, must sign and date the form. All signatures must be original, signature stamps are not acceptable.

Proof of the competency evaluation must be recorded and filed in the personnel record prior to the aide providing care to waiver participants. The Division of CLTC has developed a form called "Competency Evaluation Documentation" form which must be used to document the competency evaluation results.

All aides including those who are Certified Nursing Assistant's (CNA), are required to complete the competency testing or training and evaluation outlined above.

viii. Have a minimum of ten (10) hours relevant in-service training per calendar year. The annual 10-hour requirement will be on a pro-rated basis during the aide's first year of employment. Documentation shall include topic, name and title of trainer, training objectives, outline of content, length of training, list of trainees, and location. This documentation will be maintained in an annual in-service manual for all employees. In addition, each staff member's personnel file must contain a summary of their in-service training for the year.

The summary must include the date of the training, the subject or title of the training and the total number of in-service hours earned. Topics for specific in-service training may be mandated by SCDHHS CLTC Division. In-service training may be furnished by the nurse supervisor while the aide is furnishing care to the participant. Additional training may be provided as deemed necessary by the Provider. All instructor-led and self-study training programs, not on the prior approved list must be approved for content and credit hours by SCDHHS prior to being offered. Self-study training hours may not exceed six (6) of the ten (10) in-service annual training hours. The Provider shall submit proposed programs not on the prior approved list to the SCDHHS CLTC Central Office at least forty-five (45) days prior to the planned implementation. All approved training topics are at the SCDHHS agency website:

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https://www.scdhhs.gov/historic/insideDHHS/Bureaus/BureauofLongTermCareServices/pc_2.html

ix. Aides must complete a training program in the following areas:

- Confidentiality, accountability and prevention of abuse and neglect
- Fire safety/disaster preparedness related to the specific location of services
- First aid for emergencies, monitoring medications, and basic recognition of medical problems
- Documentation and record keeping
- Ethics and interpersonal relationships
- Orientation to traumatic brain injury, spinal cord injury and similar disability
- Training in lifting and transfers

2. Agency staff may be related to participants served by the agency within limits allowed by the South Carolina Family Caregiver Policy. The following family members cannot be a paid caregiver:

   a. The spouse of a Medicaid participant;

   b. A parent of a minor Medicaid participant;

   c. A step parent of a minor Medicaid participant;

   d. A foster parent of a minor Medicaid participant;

   e. Any other legally responsible guardian of a Medicaid participant

   Family members who are primary caregivers will not be reimbursed for HASCI Respite, ID/RD Respite, and CS Respite. All other qualified family members can be reimbursed for their provision of PC I/PC II/HASCI Attendant Care, ID/RD Respite, and CS Respite.

3. PPD Tuberculin Test

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Please refer to the Department of Health and Environmental Control (DHEC) website for PPD Tuberculin test requirements.

http://www.scdhec.gov/Health/DiseasesandConditions/InfectiousDiseases/BacterialDiseases/Tuberculosis/

For additional information, providers should contact the Tuberculosis Control Division, Department of Health and Environmental Control, 1751 Calhoun Street, Columbia, SC 29201, phone (803) 898-0558.

4. Individual records must be maintained that document that each staff member has met all staffing requirements. Required documentation must be filed in the personnel file within fifteen (15) days of employment or of receipt.

5. A criminal background check is required for all potential employees to include employees who will provide direct care to SCDHHS/SCDDSN participants and all administrative/office employees (office employees required to have background checks include: administrator, office manager, nurse supervisor, and persons named on organizational chart in management positions). All criminal background checks must include all data for the individual with no less than a ten (10) year timeframe being searched. The criminal background check must include statewide data. The statewide data must include South Carolina and any other state or states the worker has resided in within the prior (10) ten years. Potential employees with felony convictions within the last ten (10) years cannot provide services to SCDHHS/SCDDSN participants or work in an administrative/office position. Potential employees with non-violent felonies dating back ten (10) or more years can provide services to SCDHHS/SCDDSN participants under the following circumstances:

   - Participant/responsible party must be notified of the aide's criminal background, i.e., felony conviction, and year of conviction;

   - Provider must obtain a written statement, signed by the participant/responsible party acknowledging awareness of the aide's criminal background and agreement to have the aide provide care; this statement must be placed in the participant record.

Potential administrative/office employees with non-violent felony convictions dating back ten (10) or more years can work in the agency at the provider's discretion.

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Hiring of employees with misdemeanor convictions will be at the provider's discretion. Employees hired prior to July 1, 2007, and continuously employed since then will not be required to have a criminal background check.

6. Providers will be required to check the CNA registry and the Office of Inspector General (OIG) exclusions list periodically for all staff. A copy of the search results page must be maintained in each employee's personnel file. Anyone appearing on either of these lists is not allowed to provide services to Waiver participants or participate in any Medicaid funded programs. The website addresses are listed below:

   CNA Registry - https://www.asisvcs.com/services/registry/search_generic.asp?CPCat=0741NURSE
   OIG Exclusions List - http://www.oig.hhs.gov/fraud/exclusions.asp

E. Conduct of Service

The provider must maintain documentation showing that it has complied with the requirements of this section.

1. The provider must obtain a Service Plan Authorization for PC II/HASCI Attendant Care, HASCI Respite, ID/RD Respite, or CS Respite from the CM or CC. The authorization will designate the amount, frequency and duration of service for participants in accordance with the participant's Service Plan/Authorization. The provider must obtain an updated SCDHHS CLTC Service Plan from the case manager yearly. CLTC Service plans are updated in Phoenix and available on the provider's dashboard; the current and annual service plans must be printed and placed in the participant's record. The provider will receive new authorizations only when there is a change to the authorized service amount, frequency, or duration. The provider must adhere to those duties which are specified in the Service Plan Authorization in developing the provider task list. This provider task list must be developed by a RN or LPN. If the provider identifies PC II/HASCI, Attendant Care, HASCI Respite, ID/RD Respite, or CS Respite service duties that would be beneficial to the participant's care but are not specified in the Service Plan Authorization, the provider must contact the CM or CC to discuss the possibility of having these duties included in the Service Plan Authorization. The CM or CC will make the decision as to whether the Service Plan/Authorization should be amended to include the additional service duty. This documentation will be maintained in the participant files. For CLTC and SCDDSN participants, no skilled services may be performed by an aide except as allowed by the Nurse Practice Act and prior approved by a licensed physician. For HASCI participants, skilled services may be performed if authorized by the

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Service Coordinator and overseen by RN or LPN delegation.

2. As part of the conduct of service, PC II/HASCI Attendant Care, HASCI Respite, ID/RD Respite, and CS Respite services must be provided under the supervision of a RN or LPN who meets the requirements as stated in this Scope and who will:

   a. Visit the participant's home prior to the start of PC II/HASCI Attendant Care, HASCI Respite, ID/RD Respite, and CS Respite services. This visit by the provider's nurse must be recorded in Care Call from the participant's home at the time of the visit and documented in the record. If the participant has already been receiving another similar service (i.e., Personal Care I), a new initial visit is required prior to the start date of Personal Care II service. The purpose of this visit is to:

      i. Review the Service Plan/Authorization and develop a task list for the aide. (This task list must be developed prior to the provision of PC II/HASCI Attendant Care, HASCI Respite, ID/RD Respite, and CS Respite services.)

      ii. Give the participant written information regarding advanced directives; the participant is required to sign and date a statement that they have received this information; the nurse supervisor is also required to sign and date the statement.

      iii. Inform participants of their right to complain about the quality of PC II/HASCI Attendant Care, HASCI Respite, ID/RD Respite, and CS Respite services provided; the participant is required to sign and date a statement that they have received this information; the nurse supervisor is also required to sign and date the statement.

      The nurse supervisor will give participants information about how to register a complaint. Complaints against aides must be investigated by the provider and appropriate action taken. Documentation must be maintained in the participant and aide's file.

   b. Nurse supervisors and/or aides may not discuss services authorized by SCDHHS or SCDDSN with the participant. If participants of any waiver ask about either the level of service they are receiving or the different services offered in one of the waivers the nurse supervisor and/or aide must refer that participant back to their case manager/service coordinator for additional information.

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c. Be accessible by phone and/or beeper during any hours services are being provided under this contract. If the nurse supervisor position becomes vacant, SCDHHS must be notified no later than the next business day.

d. Provide and document supervision of, training for, and evaluation of aides.

e. Make a supervisory visit to the participant's place of residence within thirty (30) days after the PC II/HASCI Attendant Care service is initiated.

f. After the thirty (30) day supervisory visit, make a supervisory visit to the participant's place of residence at least once every four (4) months for each participant. Four (4) month supervisory visits must be conducted by the end of the fourth month. The aide must be present during at least one (1) of the supervisory visits during each twelve (12) month period. For the HASCI Attendant Care service, all supervisory visits scheduled will be arranged in consultation with the DSN Board and documented in the participant record. For SCDHHS/SCDDSN participants, supervisory visits, including the initial visit, must be documented in the participant record and recorded in Care Call, for CLTC only, from the participant's home at the time of the visit. In the event the participant is inaccessible during the time the supervisory visit would have normally been made, the visit must be completed within five (5) working days of the resumption of PC II/HASCI Attendant Care services. The supervisor's report of the on-site visits must include, at a minimum:

   i. Documentation that services are being delivered consistent with the Service Plan/Authorization;

   ii. Documentation that the participant's needs are being met;

   iii. Reference to any complaints which the participant or family member/responsible party has lodged;

   iv. A brief statement regarding any changes in the participant's service needs; and,

   v. Supervisor's original signature and date. Signature stamps are not acceptable.

g. Assist aides as necessary as they provide individual personal care services as outlined by the Service Plan Authorization. Any supervision given must be documented in the individual participant's record.

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3. Documentation of all supervisory visits must be filed in the participant's record within thirty (30) days of the date of visit.

   Supervisory visits should be conducted as necessary if there are indications of substandard performance by the aide.

   If there is a break in service which lasts more than sixty (60) days, the supervisor must complete a new initial visit when services are resumed. If the participant's condition changes enough to warrant a new service plan, the supervisor must update the task sheet to reflect the new duties.

4. The provider must maintain an individual participant record which documents the following:

   a. The provider will initiate PC II/HASCI Attendant Care, HASCI Respite, ID/RD Respite, and CS Respite services on the date negotiated with the CM or CC and indicated on the Medicaid authorization. Services must not be provided prior to the authorized start date and must be provided according to the schedule as indicated on the Service Plan/Authorization.

   b. The provider will notify the CM or CC within two (2) working days of the following:

      i. Participant's condition has changed and the Service Plan no longer meets participant's needs or the participant no longer appears to need PC II/HASCI Attendant Care, HASCI Respite, ID/RD Respite, and CS Respite services.

      ii. Participant is institutionalized, dies or moves out of the service area.

      iii. Participant no longer wishes to receive PC II/HASCI Attendant Care, HASCI Respite, ID/RD Respite, and CS Respite services.

      iv. Knowledge of the participant's Medicaid ineligibility or potential ineligibility.

   c. The provider will maintain a record keeping system which documents:

      i. **For SCDHHS (CLTC) participants:** The delivery of services in accordance with the SCDHHS CLTC Service Plan. The provider

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shall not ask the participant/responsible party to sign any log or task sheet. The task sheet must be reviewed, signed, with original signature (signature stamps are not acceptable), and dated every two weeks by the supervisor. Task sheets must be filed in the participant's record within 30 days of service delivery.

Services provided by the personal care aide must also be documented in Care Call at check out.

ii. Task sheets/Daily logs can include multiple services on the same sheet as long as the services can be easily identified and tasks performed can be distinguished. For example if a participant receives PC II and PC I services, both can be documented on the same sheet as long as each service can be easily identified.

iii. **For SCDDSN participants:** The delivery of services and units provided must be in accordance with the Authorization. The provider will maintain daily logs reflecting the PC II/HASCI Attendant Care, HASCI Respite, ID/RD Respite, and CS Respite services provided by the aides for the participants and the actual amount of time expended for the service. The daily logs must be initialed daily by the participant or family member and the aide, and must be signed weekly by the participant or family member and signed with original signature (signature stamps are not acceptable), and dated by the supervisor at least once every two (2) weeks. Daily logs must be filed in the participant's record within thirty (30) days of service delivery. Daily logs must be made available to SCDHHS/SCDDSN upon request.

iv. All active participant records must contain at least two (2) years of documentation to include task sheets, service plans, supervisory visit documentation, any complaints, etc. Per Medicaid policy all records must be retained for at least five (5) years. Active records must contain **all** authorizations.

d. **For SCDHHS (CLTC) participants:** For all instances in which a participant did not receive an authorized daily service, providers must indicate on the Care Call website the reason why the service was not delivered. The provider must do this both when the provider was unable to complete the visit and when the participant was not available to receive the visit. For each week in which there are missed visits, the provider must indicate the reason on the website by the close of business the

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following week. A missed visit report is not required for SCDDSN/HASCI/IDRD/CS participants.

e. Whenever two (2) consecutive attempted or missed visits occur, the local SCDHHS/SCDDSN office must be notified. An attempted visit is when the aide arrives at the home and is unable to provide the assigned tasks because the participant is not at home or refuses services. A missed visit is when the provider is unable to provide the authorized service. These instances must be documented in the participant's record as well as in Care Call.

4. Providers must adhere to all Care Call and Phoenix policies and procedures as indicated in the Phoenix IVR Provider User Guidelines, which can be obtained from the Phoenix Provider portal (https://providers.phoenix.scdhhs.gov/) in the Help section.

F. Children's Personal Care Requirements

The requirements listed in this section are in addition to the requirements as listed in this scope for PC II services. Children's PC services are reimbursable when the following conditions are met:

1. Child is under age 21

2. Provided in the participant's place of residence

3. Authorized by SCDHHS/SCDDSN

The CM will determine the need for personal care services and develop a service plan that outlines the child's needs. This service plan will only be updated as needed.

Children's Personal Care services must be supervised by a Registered Nurse (RN).

G. Compliance Review Process

The SCDHHS Division of Long Term Care Waiver Management, Provider Compliance Department has developed this policy for clarification of the provider compliance process. The policy gives detailed information on how provider compliance sanctions are implemented. Provider reviews receive a score based on a sanctioning scale; review scores will determine if the provider will receive a sanction and if so, the level of the sanction. The sanction scoring process was developed to ensure that reviews are equitable and for providers to know what to expect when they are reviewed.

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The following chart outlines how reviews are scored:

Sanction Level

- Provider compliance review questions in the Scope of Services are classified into three classes, based on (1) the significance of the question regarding to the services, and (2) the potential influences on providers and participants if the requirement was not met. See the example below:

Severity Level: 1=less serious, 2 = serious, 3 = very serious

Client Service Questions	Possible Answers	Severity Level
Was supervisory visit made within 30 days after PC II services initiated?	Y, N, NA	3
Was the initial supervisory visit documented in Care Call?	Y, N, NA	3
Does provider maintain individual client records?	Y, N	2
Did provider give participant written information regarding advanced directives?	Y, N, NA	1

There are five types of sanctions:

- Plan of Correction – This is the lowest sanction and indicates the provider is in substantial compliance with the contractual requirements. The provider will be required to submit a plan of correction outlining the deficiency (ies), the detailed plan to correct the deficiency and the effective date the plan will be implemented. Any documentation that was not available during the compliance visit will not be accepted as a part of the plan of correction. All documentation must be in the appropriate records at the time of the review.

- 30-day suspension – At this level, new referrals are suspended for thirty (30) days. The provider will also be required to submit a plan of correction. If the plan of correction is approved, the suspension is automatically lifted at the end of the 30-day period. If the corrective action plan is not approved, the Provider will be given an additional ten (10) business days to submit another corrective action plan for review and approval; the suspension will remain in place until an approved corrective action plan is received. If the second submitted corrective action plan is not approved, the provider contract will be terminated. Any documentation that was not available

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during the compliance visit will not be accepted as a part of the plan of correction. All documentation must be in the appropriate records at the time of the review.

- 60-day suspension – At this level, new referrals are suspended for sixty (60) days. The provider will also be required to submit a plan of correction. If the plan of correction is approved, the suspension is automatically lifted at the end of the 60-day period. If the corrective action plan is not approved, the Provider will be given an additional ten (10) business days to submit another corrective action plan for review and approval; the suspension will remain in place until an approved corrective action plan is received. If the second submitted corrective action plan is not approved, the provider contract will be terminated. Any documentation that was not available during the compliance visit will not be accepted as a part of the plan of correction. All documentation must be in the appropriate records at the time of the review.

- 90-day suspension – Indicates serious and widespread deficiencies, new referrals are suspended for ninety (90) days. The 90-day suspension of new referrals will only be lifted after an acceptable plan of correction is received. If the corrective action plan is not approved, the Provider will be given an additional ten (10) business days to submit another corrective action plan for review and approval; the suspension will remain in place until an approved corrective action plan is received. If the second submitted corrective action plan is not approved, the provider contract will be terminated. In addition, an acceptable follow-up review visit may be conducted if warranted. Any documentation that was not available during the compliance visit will not be accepted as a part of the plan of correction. All documentation must be in the appropriate records at the time of the review.

- Termination – Indicates a final review score of four hundred (400) or more points and/or very serious and widespread deficiencies, generally coupled with a history of bad reviews three (3) consecutive reviews that receive suspension of new referrals)

Providers who have two (2) consecutive reviews that result in suspension of new referrals, will be terminated if the third consecutive review has a final score that would result in a suspension of new referrals (100 and above).

We have developed a system to score reviews based on the percentage of the identified deficiency and number of participants surveyed. Following is an outline of how reviews will be scored:

<u>Calculating process</u>

- The level of sanction will be decided based on the total score of the provider‘s current review and the provider’s review history, which is converted from the deficiency percentage.

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- Every 5% deficiency counts for 1 point in each class; the total score comes from the total points from each level.

- Since each level has different severity, multiple points will be added on each class's score. Final score = level 3 = unweighted points x 3 + level 2 = unweighted basic points x 2+ level 1 = unweighted points x 1

Example:

Level	Deficiency percentage	Basic points	Final points
Level 1 (less serious)	28%	5	5x1=5
Level 2 (serious)	20%	4	4x2=8
Level 3 (major)	35%	7	7x3=21
Final Score			34

Based on the total score a sanction level is determined. If a provider has no deficiencies, they will not be subject to a sanction. Below is a chart that illustrates the sanction that will be imposed based on the final review score:

Score Scale & Sanction Level

Sanction Type	Final score	With Good History*
Correction Plans	0-99	0-149
30 Days Suspension	100-199	150-249
60 Days Suspension	200-299	250-349
90 Days Suspension	300-399	350-449
Termination	>400	>450

Good History is determined based on previous review scores. For example, if a provider's previous review had a total score of **50** and their current review has a score of **120**, the sanction for the current review will be corrective action rather than 30-day suspension based on the previous review score.

Scores are automatically calculated using a computer generated compliance review program.

Provider records will be reviewed periodically at the provider's office. Onsite visits are un-announced. If the reviewer (CLTC, Program Integrity or other government entity) arrives at the provider's office to conduct a survey and no one is there, the following sanctions will be imposed:

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- First time – thirty (30) day suspension of new referrals
- Second time – ninety (90) day suspension of new referrals
- Third time – contract termination

G. Administrative Requirements

1. The provider must inform SCDHHS of the provider's organizational structure including the Provider personnel with authority and responsibility for employing qualified personnel, ensuring adequate staff education, in-service training and employee evaluations. The provider agency shall notify SCDHHS within three (3) working days in the event of a change in the agency administrator, address, phone number or an extended absence of the agency administrator.

2. The provider must provide SCDHHS with a written document showing the organization, administrative control and lines of authority for the delegation of responsibility down to the hands-on participant care level staff at contract implementation. The document should include an organizational chart including names of those currently in the positions. Revisions or modifications to this organizational document must be provided to SCDHHS. It is recommended that this document be readily accessible to all staff.

3. Administrative and supervisory functions shall not be delegated to another agency or organization.

4. The provider agency shall acquire and maintain for the duration of the contract liability insurance and worker's compensation insurance as provided in Article IX, Section D of the Contract. The provider is required to list SCDHHS – CLTC as a Certificate Holder for informational purposes only on all insurance policies using the following address: Post Office Box 8206, Columbia, SC 29202-8206.

5. The provider will develop and maintain a Policy and Procedure Manual that describes how activities will be performed in accordance with the terms of the requirements of the contract. The Policy and Procedure Manual shall be available during office hours for the guidance of the governing body and personnel and will be made available to SCDHHS upon request.

6. The provider must comply with Article IX, Section Z of the Contract regarding safety precautions. The provider must also have an on-going infectious disease program to prevent the spread of infectious diseases among its employees.

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7. The provider shall ensure that key agency staff is accessible in person, by phone, or by beeper during compliance review audits conducted by SCDHHS and/or its agents.

8. The provider will ensure that its office is open and staffed by qualified personnel during the hours of 10:00 a.m. to 4:00 p.m., Monday through Friday. Outside of these hours, the Provider agency must be available by telephone during normal business hours, 8:30 a.m. to 5:00 p.m., Monday through Friday. Failure to maintain an open and staffed office as indicated will result in sanctions as outlined in section G, last paragraph. The provider must also have a number for emergencies outside of normal business hours. Participant and personnel records must be maintained at the address indicated in the contract and must be made available, upon request, for review by SCDHHS.

9. The provider must have an effective written back-up service provision plan in place to ensure that the participant receives the PC II/HASCI Attendant Care, HASCI Respite, ID/RD Respite, and CS Respite services as authorized. Whenever the provider determines that services cannot be provided as authorized, the CM/SC must be notified by telephone immediately.

10. The provider shall update holidays in Phoenix; the provider is not required to furnish services on those days. PC II/HASCI Attendant Care, HASCI Respite, ID/RD Respite, and CS Respite provider agency must not be closed for more than two (2) consecutive days at a time, except when a holiday falls in conjunction with a weekend. If a holiday falls in conjunction with a weekend, a PC II/HASCI Attendant Care, HASCI Respite, ID/RD Respite, and CS Respite provider agency may be closed for not more than four (4) consecutive days.

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MEDICAID HOME AND COMMUNITY-BASED WAIVER SCOPE OF SERVICES FOR PERSONAL EMERGENCY RESPONSE (PERS) SERVICES

A. Objectives

The objective of Personal Emergency Response Service (PERS) is to provide Medicaid Home and Community-Based waiver Participants with twenty-four (24) hour monitoring and live telephone contact in case of emergency or urgent concern. The service must provide the ability to initiate alerts for safety and emergencies both automatically and manually twenty-four (24) hours per day.

B. Conditions of Participation

1. Provider must have a unit that meets the following requirements:

   a. FCC Part 68 – telecom terminal equipment approval

   b. UL (Underwriters Laboratories) and/or ETL (Equipment Testing Laboratories) approved as a "health care signaling product

   c. The product has to be registered with the FDA as a medical device under the classification "powered environments control signaling product"

2. The unit must have three components:

   a. A small radio transmitter (a help button carried or worn by the user)

   b. A console when emergency help (medical, fire, or police) is needed

   c. Emergency Response Center to determine the nature of the calls

3. Providers must utilize the automated systems mandated by SCDHHS to document and bill for the provision of services.

4. Provider must accept or decline referrals from Community Long Term Care (CLTC) or South Carolina Department of Disabilities and Special Needs (SCDDSN) within two (2) working days. Failure to respond will result in the loss of the referral.

5. The provider must verify the participant's Medicaid eligibility when it accepts an authorization and monthly thereafter to ensure continued eligibility. Agencies can verify Medicaid eligibility for CLTC participants in the Phoenix Provider Portal

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PERSONAL EMERGENCY RESPONSE SERVICES (PERS)

on their dashboard. Providers should also refer to Section 1 of this provider manual for additional information on eligibility determination.

6. Provider may use paperless filing systems Provider must obtain approval from CLTC Central Office prior to initiating electronic documentation and/or filing systems. Electronic records must be made available upon request, and Provider must have a reliable back-up system in the event its computer system shuts down.

7. Provider must have qualified technicians for the installation of the PERS units, as explained in Section D.4 hereof.

8. Provider must have at least one (1) year of experience or otherwise demonstrated competency in the provision of the PERS service.

C. Description of Services to Be Provided

When emergency help is needed, the PERS user presses the transmitter help button. It sends a radio signal to the console. The console automatically dials one or more pre-selected emergency telephone numbers. The system must be able to dial even if the telephone is off the hook or in use. The PERS unit should be programmed to telephone the response center where the caller is identified. The center will determine the nature of the emergency and contact the appropriate person. The contact will include calling a primary and back-up number in emergency cases. Within two (2) working days, the Provider shall report through the Phoenix System operated by CLTC all contacts made to the Participant indicating the nature of the contact.

Reimbursement for the PERS service includes a one-time installation and monthly monitoring. These reimbursements are inclusive of all equipment installation, and training on its use and care while the equipment is in the Participant's home. These reimbursements also include all, visits or calls made to the home to follow up with Participants and/or caregivers, telephone calls made that are necessary while the Participant is receiving the PERS service and equipment removal when the service is no longer authorized for the Participant.

The Provider shall provide the PERS service seven (7) days per week for all authorized time periods.

D. Staffing

1. The Response center staff must be able to monitor the PERS unit twenty-four (24) hours a day, seven (7) days a week.

2. Response center staff must be trained to perform duties related to monitoring the PERS unit.

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3. Response center staff must be able to test the PERS unit in the home monthly.

4. Technicians that install equipment must meet the following requirements:

   a. Qualified as a technician to install PERS equipment.

   b. Capable of evaluating whether or not the equipment is functioning properly.

   c. Able to assume responsibility for training Participants and/or caregivers in the use of PERS equipment.

5. A criminal background check is required for all potential employees including technicians, response center staff and administrative/office employees (office employees required to have background checks include: administrator, office manager, supervisor, and persons named on organizational chart in management positions). All criminal background checks must include all data for the individual with not less than a ten (10) year search. The criminal background check must include statewide (South Carolina) data. The statewide data must include South Carolina and any other state or states the worker has resided in within the prior ten years. Potential employees with felony convictions within the last ten (10) years cannot provide services to Participants or work in an administrative/office position.

   Potential employees with non-violent felony convictions dating back ten (10) or more years can work at the Provider's discretion.

   Hiring of employees with misdemeanor convictions shall be at the Provider's discretion.

6. Personnel folders: Individual records shall be maintained to document that each member of the staff has met the above requirements.

E. Conduct of Service

The Provider must maintain documentation showing that it has complied with the requirements of this section.

The Provider must obtain the authorization from the case manager/service coordinator (CM/SC) prior to the provision of services. The authorization will designate the amount, frequency and duration of service for Participants in accordance with the Participant's CLTC/SCDDSN Authorization which will have been developed in consultation with the Participant and others involved in the Participant's care.

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Participants and/or caregivers shall choose among qualified providers of the PERS service, once Provider has been chosen by the Participant and/or caregiver, the PERS provider shall receive a referral that will have information on the condition of the Participant. PERS providers must accept or decline referrals from SCDHHS within two (2) working days. Failure to respond shall result in the loss of the referral.

The Provider shall initiate PERS services on the date negotiated with the CM/SC and indicated on the Medicaid Home and Community-Based waiver service authorization. The CM/SC must be notified if services are not initiated on that date. Services provided prior to the service authorization date are not reimbursable.

The CM/SC shall notify the provider immediately if services to a Participant are to be terminated. However, the Provider should refer to the language in the CLTC Services Provider Manual in Section 1, General Information and Administration, regarding the Provider's responsibility in checking the Participant's Medicaid eligibility status.

The Provider must maintain an individual Participant record which documents the following items:

1. The Provider will initiate PERS on the date negotiated with the CM/SC and indicated on the Medicaid authorization. Services must not be provided prior to the authorized start date and must be provided according to the schedule as indicated on the authorization.

2. **For SCDDSN:** The Provider must document all contacts made to the Participant. This documentation must include the nature of the contact, all actions taken and the outcome. Documentation of the contact must be filed in the participant’s record within two (2) working days of the contact.

3. **For CLTC:** The Provider must report through Phoenix all contacts made to the Participant indicating the nature of the contact, the action taken and the outcome within two (2) working days.

4. The Provider will notify the CM/SC within two (2) working days of the following:

    a. Participant is institutionalized, dies or moves out of the service area.

    b. Participant no longer wishes to receive PERS services.

    c. Knowledge of the Participant's Medicaid ineligibility or potential ineligibility.

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PERSONAL EMERGENCY RESPONSE SERVICES (PERS)

d. All active Participant records must contain the lesser of two (2) years or the complete record of documentation to include authorizations, documentation of PERS installation, monitoring records, any complaints, etc. All records must be retained for at least five (5) years. Records must contain **all** authorizations in the Participant's active record.

F. Administrative Requirements

1. The Provider must inform SCDHHS of the Provider's organizational structure, including the Provider personnel with authority and responsibility for employing qualified personnel, ensuring adequate staff education, and employee evaluations. The Provider shall notify SCDHHS within three (3) working days in the event of a change in or the extended absence of the personnel with the above listed authority.

2. The Provider must provide SCDHHS with a written document showing the organization, administrative control and lines of authority for the delegation of responsibility down to the technical staff at contract implementation. The document should include an organizational chart including names of those currently in the positions. Revisions or modifications to this organizational document must be provided to SCDHHS. It is recommended that this document be readily accessible to all staff.

3. Administrative and supervisory functions shall not be delegated to another organization.

4. The Provider shall acquire and maintain for the duration of the contract liability insurance as provided in Article IX, Section D of the Contract. The Provider is required to list SCDHHS – CLTC as a Certificate Holder for informational purposes only on all insurance policies using the following address: Post Office Box 8206, Columbia, SC 29202-8206.

5. The Provider will develop and maintain a Policy and Procedure Manual that describes how activities will be performed in accordance with the terms of the requirements of the contract. The Policy and Procedure Manual shall be available during office hours for the guidance of the governing body, personnel and will be made available to SCDHHS upon request.

6. The Provider agency shall ensure that key agency staff is accessible during compliance review audits conducted by SCDHHS and/or its agents.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

MEDICAID
THE SCOPE OF SERVICES
FOR
RESIDENTIAL PERSONAL CARE II

A. Objectives

The objective of the Residential Personal Care II (RPC II) services are to restore, maintain, and promote the health status of Medicaid Home and Community Based waiver participants who choose to transition from their homes into the residential facilities or for individuals who wish to remain in the community residential care facilities and meet the intermediate nursing home level of care.

B. Conditions of Participation

1. The Provider of RPC II services in a CRCF must meet all SCDHEC standards for licensure and must comply with all requirements of this Scope of Services.

2. The Provider must have demonstrated experience in personal care services. The Provider's administrator must have at least three (3) years of administrative experience in the health care field.

3. The Provider shall accept or decline referrals from Community Long Term Care (CLTC) within two (2) working days. Failure to respond within this timeframe will result in the loss of the referral.

4. The Provider will be responsible for verifying the Participant's Medicaid eligibility when it has accepted a referral and monthly thereafter to ensure continued eligibility. The Provider shall refer to the OSS Provider Manual for instructions on how to verify Medicaid eligibility.

5. The Provider shall not be at risk of classification as a Resident Case Mix. The OSCAP facility that is licensed for more than sixteen (16) beds or is part of a larger entity that exceeds sixteen (16) beds shall not admit or maintain a census of more than 45% of residents whose current need for placement as determined by SCDHHS is due to a mental illness. The policies and procedures outlining the process for determining the CRCF's risk for resident case mix are located in the OSS Provider Manual.

6. The Provider shall utilize the automated systems mandated by SCDHHS CLTC Division to document and bill for the provision of services.

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7. The Provider may use paperless filing systems. When using electronic filing systems any documentation requiring signatures must be signed prior to scanning. Electronic records must be made available upon request, and providers must have a reliable back-up system in the event their computer system shuts down.

8. The Provider shall submit upon execution of the Contract and as requested by SCDHHS thereafter evidence of working capital that will show that the Provider has the capability to operate for a minimum of sixty (60) days in the event Medicaid reimbursement is delayed or withheld for any reason. This evidence shall be a certified written statement from an officer of a financial institution or a certified accountant.

   The minimum working capital levels are:

   - 4-10 Beds – $2,500
   - 11-25 Beds – $5,000
   - 26 and above – $10,000

C. Description of Services to be provided

1. The Provider shall ensure that the facility meet specific basic requirements of the Americans with Disabilities Act, as outlined in the OSS Provider Manual (as amended).

2. The unit of service will be a patient day which is defined as a twenty-four (24) hour period, including the day of admission and excluding the day of discharge. The per diem rate will include all those items and supplies associated with patient care, except prescribed drugs and personal items. These items cannot be billed to Medicaid.

3. The number of units and services provided to each Participant are dependent upon the individual Participant's needs as set forth in the Participant's Service Plan.

4. Under no circumstances will any type of skilled medical service be performed in a CRCF.

5. Services to be provided in a CRCF include:

   a. Support for activities of daily living which include:

      - Eating
      - Bathing (bed bath, bench shower, sink bath)

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- Personal grooming including dressing
- Personal hygiene
- Provide necessary skin care
- Assisting participants in and out of bed
- Repositioning participants as necessary
- Assisting with ambulation
- Toileting and maintaining continence

b. Monitoring of the Participant's condition, e.g., the type of monitoring that would be done by a family member such as monitoring temperature, checking pulse rate, observation of respiratory rate, and blood pressure.

D. Staffing

1. The Provider shall maintain staffing accordance with the OSS Provider Manual.

2. The Provider's staff may have a familiar relationship to a participant served by the Provider within limits allowed by the South Carolina Family Caregiver Policy. The following family members cannot be a paid caregiver:

   a. The spouse of a Medicaid participant;

   b. A parent of a minor Medicaid participant;

   c. A step parent of a minor Medicaid participant;

   d. A foster parent of a minor Medicaid participant;

   e. Any other legally responsible guardian of a Medicaid participant.

3. PPD Tuberculin Test

   Please refer to the Department of Health and Environmental Control (DHEC) website for PPD Tuberculin test requirements.

   http://www.scdhec.gov/Health/DiseasesandConditions/InfectiousDiseases/BacterialDiseases/Tuberculosis/

   For additional information, providers should contact the Tuberculosis Control Division, Department of Health and Environmental Control, 1751 Calhoun Street, Columbia, SC 29201, phone (803) 898-0558.

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4. Individual records must be maintained that document that each staff member has met all staffing requirements.

5. A criminal background check is required for all potential employees to include employees who will provide direct care to SCDHHS participants and all administrative/office employees (office employees required to have background checks include: administrator, office manager, nurse supervisor, and persons named on organizational chart in management positions). All criminal background checks must include all data for the individual with no limit on the timeframe being searched. Criminal background checks that cover a specific time period such as seven or ten year searches are not acceptable. The criminal background check must include statewide (South Carolina) data. Potential employees with felony convictions within the last ten (10) years cannot provide services to SCDHHS/SCDDSN participants or work in an administrative/office position. Potential employees with non-violent felonies dating back ten (10) or more years can provide services to SCDHHS/SCDDSN participants under the following circumstances:

   a. Participant/responsible party must be notified of the aide's criminal background, i.e., felony conviction, and year of conviction;

   b. Provider must obtain a written statement, signed by the participant/responsible party acknowledging awareness of the aide's criminal background and agreement to have the aide provide care; this statement must be placed in the participant record.

   Potential administrative/office employees with non-violent felony convictions dating back ten (10) or more years can work in the agency at the provider's discretion.

   Hiring of employees with misdemeanor convictions will be at the provider's discretion. Employees hired prior to July 1, 2007, and continuously employed since then will not be required to have a criminal background check.

6. Providers will be required to check the CNA registry and the Office of Inspector General (OIG) exclusions list periodically for all staff. A copy of the search results page must be maintained in each employee's personnel file. Anyone appearing on either of these lists is not allowed to provide services to Waiver participants or participate in any Medicaid funded programs. The website addresses are listed below:

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CNA Registry - https://www.asisvcs.com/services/registry/search_generic.asp?CPCat=0741NURSE
OIG Exclusions List - http://www.oig.hhs.gov/fraud/exclusions.asp

E. Conduct of Service

The Provider must maintain documentation showing that it has complied with the requirements of this section.

1. The Provider must obtain a Service Plan for RPC II services from the CM. The authorization will designate the amount, frequency and duration of service for Participants in accordance with the Participant's Service Plan. The Provider must obtain an updated SCDHHS CLTC Service Plan from the case manager yearly. The Provider will receive new authorizations only when there is a change to the authorized service amount, frequency or duration. The Provider must adhere to those duties which are specified in the Service Plan in developing the provider task list. This provider task list must be developed by a RN or LPN. No direct care staff or nurse will perform any job/task related to OSCAP while on duty at any other health care entity. Any substantial finding that such a violation has occurred will be reported to the Board of Nursing, Board of Long Term Health Care Administrators, the Bureau of Long Term Care Certification, and the Attorney General office

2. As part of the conduct of service, the PRC II services must be under the supervision of a RN or LPN who meets the requirements as stated in the scope of services and who will:

   a. Develop an Individual Care Plan (ICP) for each Participant receiving OSCAP services. The ICP for current Participants will be updated to reflect the Participant's status in OSCAP. The ICP is to be developed with participation by the Participant, administrator (or designee), the responsible party when appropriate, and the facility's nurse within seven (7) days of admission or within seven (7) days of the change to OSCAP.

      i. The initial ICP will be developed utilizing information from the SCDHHS nurse's assessment and Service Plan, along with any other relevant Participant information obtained from the Provider's staff, the Participant, and if appropriate, the party responsible for the Participant. The ICP is to direct the services provided to the Participant and the resident care log.

      ii. The ICP must be reviewed by the Participant, facility administrator, and responsible party, when appropriate, every six

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(6) months or after being reviewed and/or revised by the facility's nurse. The ICP must be signed and dated by the Participant, facility administrator, responsible party when appropriate, and the facility's Nurse. The revisions signed and dated by the CRCF registered nurse must be maintained in the resident's record.

iii. All ICP's must be maintained in the Participant's permanent record, and should be available for a SCDHHS representative to review upon request.

b. Not discuss services authorized by SCDHHS with the Participant. If Participants of any waiver ask about either the level of service they are receiving or the different services offered in one of the waivers, the nurse supervisor and/or aide must refer that Participant back to their CM for additional information.

c. Be accessible by telephone during any hours services are being provided under this Contract.

d. Provide and document supervision of, training for, and evaluation of aides.

e. Assist aides as necessary as they provide individual personal care services as outlined by the Service Plan. Any supervision given must be documented in the individual Participant's record.

3. If the nurse supervisor position becomes vacant, SCDHHS must be notified no later than the ten (10) business day**.**

4. Documentation of all supervision must be filed in the Participant's record within thirty (30) days of the date of the contact.

Supervisory contacts should be conducted as necessary if there are indications of substandard performance by the aide.

If there is a break in service which lasts more than sixty (60) days, the supervisor must develop a new IPC when services are resumed. If the participant's condition changes enough to warrant a new service plan, the supervisor must update the task sheet to reflect the new duties.

5. The Provider must maintain an individual Participant record which documents the following:

a. The Provider will initiate RPC II services on the date negotiated with the CM and indicated on the Medicaid authorization. Services must not be

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provided prior to the authorized start date and must be provided according to the schedule as indicated on the Service Plan

b. The Provider will notify the CM within two (2) working days of the following:

i. If Participant's condition has changed and the Service Plan/Authorization no longer meets Participant's needs or the Participant no longer appears to need – RPC II

ii. If Participant is institutionalized, dies or moves out of the service area

iii. If Participant no longer wishes to receive RPC II

iv. Knowledge of the Participant's Medicaid ineligibility or potential ineligibility

c. The Provider will maintain a record keeping system which documents the delivery of services in accordance with the Service Plan. The Provider shall not ask the Participant/responsible party to sign any log or task sheet. The task sheet must be reviewed, signed, with original signature (signature stamps are not acceptable), and dated every two weeks by the supervisor. Task sheets must be filed in the Participant's record within thirty (30) days of service delivery.

d. For all instances in which a Participant did not receive an authorized daily service, the Provider must indicate on the Care Call web site the reason why the service was not delivered. The Provider must do this both when the Provider was unable to complete the visit and when the Participant was not available to receive the visit. For each week in which there are missed visits, the Provider must indicate the reason on the web site by the close of business the following week.

e. Whenever two consecutive attempted or missed visits occur, the local SCDHHS office must be notified. An attempted visit is when the aide is unable to provide the assigned tasks because the participant is not at the facility or refuses services. A missed visit is when the Provider is unable to provide the authorized service. These instances must be documented in the participant record as well as in Care Call.

5. Providers must adhere to all Care Call and Phoenix policies and procedures as indicated in the Phoenix IVR Provider User Guidelines, which can be obtained from

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the Phoenix Provider portal (https://providers.phoenix.scdhhs.gov) in the Help section.

F. Compliance Review Process

The compliance review and sanction scoring process is located in the OSS Provider Manual (as amended) and is designed to ensure that reviews are fair and the Provider know what to expect when reviewed.

SCDHHS reserves the right to perform on-site compliance reviews during normal business hours. The Provider must permit SCDHHS staff to conduct unannounced on-site inspections of any and all of Provider's locations. At the sole discretion of SCDHHS, reviews may be conducted at any time. Failing to permit access for on-site visits may result in termination of the OSCAP Contract.

Sanctions

SCDHHS may use three types of sanctions under this Contract:

- Corrective Action Plan (CAP) – The Provider who is in substantial compliance with the Contract but has some minor compliance issues may be required to submit a corrective action plan within thirty (30) days of notice of the deficiencies detailing how and when deficiencies will be corrected (or have been corrected) and how the Provider will avoid future deficiencies. If the Provider fails to submit the CAP within thirty (30) days, the Provider may be subject to suspension as provided herein. This sanction will be imposed until the Provider develops and adheres to a corrective action plan to adequately address any concerns.

- Suspension – SCDHHS may suspend the Provider for moderate deficiencies, failure to submit a required CAP within thirty (30) days, or failure to comply with the Contract. SCDHHS shall notify the Provider of the deficiencies and the suspension of new referrals/admissions for a minimum of thirty (30) days. The Provider must submit a written CAP addressing the deficiencies to SCDHHS within fifteen (15) days from the institution of the suspension. SCDHHS has fifteen (15) days to review the CAP to determine whether the response is acceptable. If the CAP is not acceptable, SCDHHS will request clarification or additional information. The suspension will be lifted fifteen (15) days from SCDHHS' acceptance of the CAP. A suspension lasting more than ninety (90) days will result in termination.

- Termination – Indicates very serious and/or widespread deficiencies, generally coupled with a history of bad reviews.

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- Substantiated finding of failure to follow policy for the administration of the participant's personal needs accounts.

G. Administrative Requirements

1. The Provider must inform SCDHHS of the Provider's organizational structure including the Provider personnel with authority and responsibility for employing qualified personnel, ensuring adequate staff education, in-service training and employee evaluations during the enrollment process. The Provider shall notify SCDHHS within three (3) working days in the event of a change in the agency administrator, address, phone number or an extended absence of the agency administrator.

2. The Provider must provide SCDHHS with a written document showing the organization, administrative control and lines of authority for the delegation of responsibility down to the hands-on participant care level staff at contract implementation.

3. The Provider shall not delegate administrative and supervisory functions to another agency or organization.

4. The Provider will develop and maintain a Policy and Procedure Manual that describes how activities will be performed in accordance with the terms of the requirements of the Contract. The Policy and Procedure Manual shall be available during office hours for the guidance of the governing body and personnel and will be made available to SCDHHS upon request.

5. The Provider shall ensure that key agency staffs are accessible in person or by telephone during compliance review audits conducted by SCDHHS and/or its agents.

6. The Provider will ensure that its office is open and staffed by qualified personnel during normal business hours. Participant and personnel records must be maintained at the address indicated in the Contract and must be made available, upon request, for review by SCDHHS.

7. The Provider must have an effective written back-up service provision plan in place to ensure that the Participant receives the RPC II services as authorized. Whenever the Provider determines that services cannot be provided as authorized, the CM must be notified by telephone immediately.

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MECHANICAL VENTILATOR DEPENDENT WAIVER
SCOPE OF SERVICES
FOR
IN-HOME RESPITE

A. Objective

The objective of In-home Respite Services is to provide temporary care in the home for mechanical ventilator dependent participants who live at home and are cared for by their families or other informal support systems. This service will provide temporary relief for the primary caregivers and maintain the participant at home. This service is necessary to avoid institutionalization.

B. Description of Services to be Provided

1. The unit of service will be a twenty-four hour period.

2. The number of units and services provided to each participant will be dependent upon the individual participant's needs as established or approved by the Case Manager and set forth in the participant's Service Plan. In-home respite services may be provided for a period not to exceed fourteen (14) days per State fiscal year (July 1-June 30) in accordance with the provider contracting period.

3. In-home respite services will provide skilled medical services as ordered by the physician and will be performed by a Registered Nurse, or Licensed Practical Nurse, who will perform their duties in compliance with the Nurse Practice Act and S. C. Code of Laws, Regulations, Chapter 91, State Board of Nursing.

4. In-home respite services will include, but are not limited to, any household care, meal preparation and personal care services as needed by the participant during the in-home respite period. All other waiver services will be discontinued during the in-home respite period.

5. Agencies must utilize the automated systems mandated by CLTC to document and bill for the provision of services.

6. Providers must accept or decline referrals from CLTC or SCDDSN within two (2) working days. Failure to respond will result in the loss of the referral.

7. The provider must verify the participant’s Medicaid eligibility when it accepts an authorization and monthly thereafter to ensure continued eligibility. Agencies can

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verify Medicaid eligibility for CLTC participants in the Phoenix Provider Portal on their dashboard. Providers should also refer to Section 1 of this provider manual for additional information on eligibility determination.

8. Providers may use paperless filing systems. Provider must obtain approval from CLTC Central Office prior to initiating electronic documentation and/or filing systems. Electronic records must be made available upon request, and providers must have a reliable back-up system in the event their computer system shuts down.

C. Staffing

1. A licensed practical nurse or registered nurse who meets the following requirements:

   a. Currently licensed by the state of South Carolina.

   b. At least one (1) year experience in public health, hospital, or long term care nursing.

   c. Please refer to the Department of Health and Environmental Control (DHEC) website for PPD Tuberculin test requirements.

      http://www.scdhec.gov/Health/DiseasesandConditions/InfectiousDiseases/BacterialDiseases/Tuberculosis/

      For additional information, providers should contact the Tuberculosis Control Division, Department of Health and Environmental Control, 1751 Calhoun Street, Columbia, SC 29201, phone (803) 898-0558.

2. Minimum training for registered nurses:

   a. The provider assures CLTC that the nurse has adequate experience and expertise to perform the skilled services ordered by the physician including the care required by individuals requiring mechanical ventilator assistance.

   b. The provider will provide a minimum of six (6) hours relevant in-service training per year (based on date of employment) for each nurse.

D. Conduct of Service

1. The name of a designated person(s) and telephone number(s) will be furnished to CLTC in order to provide CLTC seven (7) day twenty-four (24) hour accessibility.

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2. An individual participant record must be maintained. The record must include the following:

    a. CLTC authorization

    b. Skilled nursing orders signed and dated by the physician

    c. Plan of Care

    d. Documentation of daily care and services provided

3. The provider will be responsible for procuring the skilled nursing orders from the physician.

4. In-home Respite Services must begin on the date negotiated by the case manager and the provider.

5. The provider must send a plan of care to the case manager which includes goals, after completion of the first in-home respite nursing visit. If applicable, recommendations to change the service schedule from that on the initial Service Provision Form may be sent to the Case Manager at that time.

6. The In-home Respite Service must not be provided prior to the authorized start date as stated on the Service Provision Form.

7. The provider will notify the Case Manager within two (2) working days of the following participant changes:

    a. Participant's condition has changed and the Service Plan no longer meets the participant's needs or the participant no longer needs In-home Respite Services.

    b. Participant dies or moves out of the Service area.

    c. Participant no longer wishes to receive the In-home Respite Service.

    d. Knowledge of the participant's Medicaid ineligibility or potential ineligibility.

8. A record keeping system will be maintained which establishes an eligible participant profile in support of units of In-home Respite Services. A daily log will reflect the services provided by the nurse and the time expended for this service.

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9. The provider must develop and maintain a state approved Policy and Procedure Manual which describes how it will perform its activities in accordance with the terms of the contract.

10. The case manager will authorize In-home Respite Services by designating the amount, frequency, and duration of service for participants in accordance with the participant's Service Plan. This documentation will be maintained in the participant's file.

11. The case manager will obtain the initial physician's order for In-home Respite Services. A copy will be sent to the provider to be placed in the participant's file.

12. The provider will be responsible for procuring the direct care physician's orders.

13. The case manager will review the participant's Service Plan within three (3) days of receipt of the provider's request to modify the plan.

14. The case manager or CLTC will notify the provider immediately if a participant becomes medically ineligible for CLTC services.

E. Administrative Requirements

1. The provider must inform CLTC of the provider's organizational structure, including the provider personnel with authority and responsibility for employing qualified personnel, ensuring adequate staff education, in-service training, and employee evaluations. The provider shall notify SCDHHS within three (3) working days in the event of a change in or the extended absence of the personnel with the above listed authority.

2. The provider must provide SCDHHS with a written document showing the organization, administrative control and lines of authority for the delegation of responsibility down to the hands-on participant care level staff at contract implementation. The document shall include an organizational chart including names of those currently in the positions. Revisions or modifications to this organizational document must be provided to SCDHHS. It is recommended that this document be readily accessible to all staff.

3. Administrative and supervisory functions shall not be delegated to another agency or organization.

4. The provider agency must acquire and maintain for the duration of the contract liability insurance and worker's compensation insurance as provided in Article IX, Section D of the Contract. The provider is required to list SCDHHS – CLTC

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as a Certificate Holder for informational purposes only on all insurance policies using the following address: Post Office Box 8206, Columbia, SC 29202-8206.

5. The provider will ensure that its office is staffed by qualified personnel during the hours of 10:00 a.m. to 4:00 p.m. Outside of these hours, the provider agency must be available by telephone during normal business hours, 8:30 a.m. to 5:00 p.m., Monday through Friday. The provider must also have a number for emergencies outside of normal business hours. Participant and personnel records must be maintained at the address indicated in the contract and must be made available, upon request, for review by SCDHHS.

6. The provider must develop and maintain a policy and procedure manual which describes how it will perform its activities in accordance with the terms of the contract. The Policy and Procedure Manual shall be available during office hours for the guidance of the governing body, personnel and will be made available to SCDHHS upon request.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

RESPITE CARE

MEDICAID HOME AND COMMUNITY-BASED WAIVER
SCOPE OF SERVICES
FOR
RESPITE CARE IN A COMMUNITY RESIDENTIAL CARE FACILITY

A. Objective

The objective of Respite Care services in a Community Residential Care Facility (CRCF) is to provide temporary care for Medicaid waiver participants who live at home and are cared for by their families or other informal support systems.

B. Conditions of Participation

Providers of Respite Care services in a CRCF must meet all SCDHEC standards for licensure and must comply with all requirements of this Scope of Services.

Providers must accept or decline referrals from CLTC or DDSN within two (2) working days. Failure to respond will result in the loss of the referral.

The provider will be responsible for verifying the participant's Medicaid eligibility when it has accepted a referral and monthly thereafter to ensure continued eligibility. Providers can verify Medicaid eligibility for CLTC participants in the Phoenix Provider Portal on their dashboard. Providers should also refer to Section 1 of this provider manual for additional information on eligibility determination.

Providers may use paperless filing systems. When using electronic filing systems any documentation requiring signatures must be signed prior to scanning. Electronic records must be made available upon request, and providers must have a reliable back-up system in the event their computer system shuts down.

C. Description of Services to be Provided

1. Respite care will be provided in a licensed CRCF which is contracted with SCDHHS to provide Respite Care services to Medicaid waiver participants.

2. The facility must be wheelchair accessible as well as equipped with a handicapped bathroom.

3. The unit of service will be a patient day which is defined as a twenty-four (24) hour period, including the day of admission and excluding the day of discharge.

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4. Total patient days allowed per fiscal year (July 1 – June 30) is twenty-eight (28). This includes any Institutional Respite days, if applicable.

5. The number of units of service provided to each participant is dependent upon the individual participant's needs as set forth in the participant's service plan, which is established or approved by the CM/SC. Services will be based on physician's orders.

6. The per diem rate will include all those items and supplies associated with patient care, except prescribed drugs and personal items. These items cannot be billed to Medicaid or the participant by the Respite Care provider.

   An example of items included in the per diem rate is: non-durable medical equipment, such as diapers and underpads.

   Items that are to be supplied by the participant and/or the responsible party are prescription and non-prescription medications and personal care items such as soap, mouthwash, deodorant, shampoo, and clothing.

7. Respite Care services will not be authorized for: (1) participants who are dependent upon oxygen or on a mechanical ventilator; (2) Participants who require tube feedings; (3) Participants who are diagnosed with either dementia or traumatic brain injury and have a history of wandering, unless there is documentation that appropriate safety measures are in place and have been reviewed and approved by the CLTC/SCDDSN state office prior to admission; or (4) participants who meet the Medicaid Nursing Facility skilled level of care (LOC) unless it is determined by the CLTC/SCDDSN state office prior to admission, that the participants do not require the daily attention of a nurse.

D. Staffing

The facility must be staffed by alert, oriented and appropriately dressed staff when a Medicaid Home and Community–Based waiver participant is in the facility. At a minimum, a certified nursing assistant must be on duty at all times when a Medicaid Home and Community-Based waiver participant is in the facility.

E. Conduct of Service

1. The CM/SC will authorize Respite care services by designating the amount, frequency and duration of the services for the participant in accordance with the participant's service plan. Services must not be provided prior to the authorized start date as stated on the service authorization form.

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Upon request of the CM/SC for Respite care services, the provider will secure a prior admission agreement with the primary caregiver or responsible party. This agreement will set forth the scheduled period of placement, specifying admission and discharge dates, and will include a statement of understanding for the responsible party to resume care of the participant after the authorized respite period.

2. The CM/SC will use the SCDHHS Form 122RC to obtain the physician's order for Respite Care, which includes the participant's medical history and a report of a physical examination that occurred no more than thirty (30) days prior to admission. SCDHHS Form 122RC will be sent to the provider prior to or at the time of the participant's admission to Respite care.

3. Upon request of the CM/SC for Respite care services, the provider will secure a prior admission agreement with the primary caregiver or responsible party. This agreement will set forth the scheduled period of placement, specifying admission and discharge dates, and will include a statement of understanding for the primary caregiver or responsible party to resume care of the participant after the authorized respite period.

4. The provider will establish a participant file, which includes the physician's respite orders, the prior admission agreement, the Home and Community-Based waiver authorization, the facility's plan of care and documentation of all care and services provided.

5. The Provider will notify the CM/SC within twenty-four (24) hours if the participant is admitted to the hospital, dies, returns home or no longer requires Respite care services.

F. Administrative Requirements

1. The Provider must inform CLTC of the provider's organizational structure, including the provider personnel with authority and responsibility for employing qualified personnel, ensuring adequate staff education, in-service training, and employee evaluations. The Provider shall notify SCDHHS within three (3) working days in the event of a change in or the extended absence of the personnel with the above listed authority.

2. The Provider must provide SCDHHS with a written document showing the organization, administrative control and lines of authority for the delegation of responsibility down to the hands-on participant care level staff at contract implementation. The document should include an organizational chart including names of those currently in the positions. Revisions or modifications to this

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organizational document must be provided to SCDHHS. It is recommended that this document be readily accessible to all staff.

3. Administrative and supervisory functions shall not be delegated to another agency or organization.

4. The provider agency must acquire and maintain for the duration of the contract liability insurance and worker's compensation insurance as provided in Article IX, Section D of the Contract. The Provider is required to list SCDHHS – CLTC as a Certificate Holder for informational purposes only on all insurance policies using the following address: Post Office Box 8206, Columbia, SC 29202-8206.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

RESPITE CARE

MEDICAID HOME AND COMMUNITY-BASED WAIVER
SCOPE OF SERVICES
FOR
INSTITUTIONAL RESPITE CARE

A. Objective

The objective of Institutional Respite Care Services is to provide temporary institutional care for Medicaid waiver clients who live at home and are cared for by their families or other informal support systems.

B. Conditions of Participation

1. The Institutional Respite Care Provider must maintain a current license from SCDHEC or an equivalent licensing agency for an out-of-state provider.

2. Providers must accept or decline referrals from CLTC or SCDDSN within two (2) working days. Failure to respond will result in the loss of the referral.

3. The provider will be responsible for verifying the participant's Medicaid eligibility when it has accepted a referral and monthly thereafter to ensure continued eligibility. Providers can verify Medicaid eligibility for CLTC participants in the Phoenix Provider Portal on their dashboard. Providers should also refer to Section 1 of this provider manual for additional information on eligibility determination.

4. Providers may use paperless filing systems. When using electronic filing systems any documentation requiring signatures must be signed prior to scanning. Electronic records must be made available upon request, and providers must have a reliable back-up system in the event their computer system shuts down.

C. Description of Services to be Provided

1. Respite care will be provided in a hospital, nursing facility (NF), or an Intermediate Care for Individuals with Intellectual Disabilities (ICF/IID) that has been approved by the state and is not a private residence.

2. The unit of service will be a patient day. A patient day is defined as a twenty-four (24) hour period, including the day of admission and excluding the day of discharge.

3. Total patient days allowed per fiscal year (July 1 – June 30) is fourteen (14). This includes any Community Residential Care Facility Respite days, if applicable.

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RESPITE CARE

The 14-day limit does not apply to DDSN waiver participants.

4. The number of units of service provided to each participant is dependent upon the individual participant's needs as set forth in the participant's service plan, which is established or approved by the CM/SC.

5. The per diem rate will include all those items and supplies associated with patient care, except prescribed drugs and personal items. These items cannot be billed by the Provider to Medicaid or the participant.

   Examples of items included in the per diem rate are: durable medical equipment, nonprescription drugs, underpads, suctioning equipment and supplies, and NG tube equipment and feeding supplies. Other examples include supplies necessary for dressing changes, ostomy catheters, and tracheostomy care items.

   Examples of personal care items are soap, mouthwash, deodorant, shampoo, and clothing.

6. Respite Care Services will be based on the Physician's orders.

D. Conduct of Service

1. The CM/SC will authorize Institutional Respite Care Services by designating the amount, frequency and duration of the services for the participant in accordance with the participant’s service plan. Services must not be provided prior to the authorized start date as stated on the service authorization form.

2. Prior to the time of admission to Institutional Respite Care , the CM/SC will send the provider the Respite services form (SCDHHS Form 122RC) which includes the physician’s admission order, the participant’s medical history, a physical examination report that is not over five (5) days old and the participant’s service plan. If it is not possible to obtain the SCDHHS Form 122RC prior to admission, the CM/SC will send a copy of the medical information from the Medicaid waiver assessment form in lieu of the medical history and the provider must obtain a physical examination report within forty eight (48) hours of admission.

3. Upon request of the CM/SC for Institutional Respite Care services, the provider will secure a prior admission agreement with the primary care giver or responsible party. This agreement will set forth the scheduled period of placement, specifying admission and discharge dates, and will include a statement of understanding and agreement for the responsible party to resume care of the participant after the authorized respite period.

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4. The provider will establish a participant file, which includes the physician's respite orders (SCDHHS Form 122RC), the Home and Community-Based waiver service authorization, the facility plan of care and documentation of all care and services provided.

5. The provider will notify the CM/SC within twenty-four (24) hours if the participant is admitted to the hospital, dies, returns home or no longer requires Institutional Respite Care services.

6. For DDSN waiver participants, institutional respite services may not be billed in conjunction with the residential habilitation service.

E. Administrative Requirements

1. The provider must inform CLTC of the provider's organizational structure, including the provider personnel with authority and responsibility for employing qualified personnel, ensuring adequate staff education, in-service training, and employee evaluations. The provider shall notify SCDHHS within three (3) working days in the event of a change in or the extended absence of the personnel with the above listed authority.

2. The provider must provide SCDHHS with a written document showing the organization, administrative control and lines of authority for the delegation of responsibility down to the hands-on participant care level staff at contract implementation. The document should include an organizational chart including names of those currently in the positions. Revisions or modifications to this organizational document must be provided to SCDHHS. It is recommended that this document be readily accessible to all staff.

3. Administrative and supervisory functions shall not be delegated to another agency or organization.

4. The provider agency must acquire and maintain for the duration of the contract liability insurance and worker's compensation insurance as provided in Article IX, Section D of the Contract. The provider is required to list SCDHHS – CLTC as a Certificate Holder for informational purposes only on all insurance policies using the following address: Post Office Box 8206, Columbia, SC 29202-8206.

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MEDICAID HOME AGAIN PROGRAM
SCOPE OF SERVICE
FOR
TRANSITION COORDINATION SERVICE

A. Objective

The objective of Transition Coordination is to provide assistance with the transition process to Home Again participants. The Transition Coordination service will support the participants in order to make a successful transition into the community. The Transition Coordination service will also ensure continued access to appropriate and available services for participants to remain in the community.

B. Conditions of Participation

1. The Provider and provider staff delivering Transition Coordination Service must be one of the following: Licensed Baccalaureate Social Worker (LBSW), Licensed Master Social Worker (LMSW), Case Manager Certified (CMC), Registered Nurse (RN), or individuals with a Bachelor's degree in a health or human services field from an accredited college or university.

2. The license and certification must be in the state of South Carolina and in good standing, if applicable.

3. The Provider must have demonstrated at least two (2) years of case management experience with one (1) of the Home Again target populations; either older adults or people with physical disabilities.

4. The Provider must be able to provide the specified geographical area (counties) in which they will deliver the Transition Coordination service. Transition Coordinators servicing multiple area offices must designate a CLTC office for training and meetings.

5. The Provider will be responsible for provision of all supplies and tools necessary to carry out Transition Coordinator Functions. The Provider will be responsible for assuring each Transition Coordinator has a laptop computer meeting South Carolina Department of Health and Human Services (SCDHHS) specifications.

6. The Provider will ensure that Transition Coordinator does not service members of his/her own immediate family.

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TRANSITION COORDINATION SERVICE

7. The Provider should be available by telephone to participants and SCDHHS staff Monday through Friday, 8:30 a.m. to 5:00 p.m., and, if there is other employment, it shall not prevent the Transition Coordinator from performing Transition Coordination during these hours. The Provider will guarantee accessibility to participants and the program staff.

8. The Provider must also be available to meet with SCDHHS staff by either face-to-face or by phone.

9. The Provider must check voice mail at least twice daily Monday through Friday, excluding state holidays.

10. The Provider must sync with the Phoenix System prior to any field activity to verify services and daily if any work has been performed.

11. The Provider is responsible for secure and accurate maintenance of all participant records.

12. The Provider must scan into Phoenix all consumer specific documents received from outside sources. All hardcopy records shall remain in the participant's assigned Area Office.

13. The Provider must check and respond to e-mails daily, Monday through Friday.

14. The Provider must return calls related to participant care within 24 hours.

15. The Provider will ensure that each Transition Coordinator utilizes the Care Call System. Care Call documentation must be completed upon each transition coordination visit and transition coordination contact. For home visits, the call to the Care Call System must be completed while in the Participant's home.

16. The Provider will ensure that each Transition Coordinator providing Transition Coordination services uses the Phoenix System to document all Transition Coordination activities, as specified in Section G.

17. The Provider must complete documentation in the Phoenix System within 48 hours after the visit and contact.

18. The Provider will ensure that each Transition Coordinator meets the Training Requirements set out in Article F of this document.

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TRANSITION COORDINATION SERVICE

C. Description of Services to be Provided

1. The Provider must use the Phoenix System to enter a list of regularly scheduled holidays; the Provider shall not be required to furnish services on those days. The Provider must not be closed for more than two consecutive days at a time, except when a holiday falls in conjunction with a weekend. If a holiday falls in conjunction with a weekend, the Provider may be closed for not more than four consecutive days.

2. The Provider must make provisions for coverage during times when the Provider is unavailable. Providers must have an office location.

3. Transition Coordination services must be performed as set forth in the CLTC Area Office Home Again Policy.

4. The Transition Coordinator must use professional judgment in allotting a sufficient amount of time to complete activities, including all visits and contacts. Following is the minimum visit and contact schedule that the Provider must conduct:

    a. Pre-transition planning: The Provider must complete an initial visit to the potential participant in a skilled nursing facility. A home visit is also required once housing is identified in the community.

    b. The Provider must be present either at the facility or at home in the community on the transition date.

    c. During the first two (2) months, there must be two (2) face-to-face visits and two (2) telephone calls per month.

    d. During months 3-12, the Providers will perform one (1) face-to-face visit every other month and one (1) monthly telephone call.

    e. Additional visits and contact may be required as needed or if the transition is in jeopardy. If Care Call reflects that the amount of time spent to complete the billed activities for a particular day does not meet Home Again staff's expectations of the time necessary to complete those activities, then at SCDHHS's sole discretion, Home Again staff may conduct an investigation and may recoup payments for those activities from the Provider.

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

TRANSITION COORDINATION SERVICE

D. Transition Coordination

1. Cases will be assigned in accordance with the Participant's choice.

2. Provider must notify SCDHHS within two (2) working days of its intent to accept or decline a referral for Participant service.

3. The Transition Coordination service includes the following but is not limited to:

   a. Initial visit to a skill nursing facility and a home in the community to determine transition possibility

   b. Conducting comprehensive assessment to identify the participant's needs

   c. Developing and monitoring transition plan with a participant and assist the transition process

   d. Assist the participant with housing needs and ensure that the participant is moving into a qualified "Home and Community based residence"

   e. Consult with Case Manager II in the CLTC Area Office for setting up Service Plan, provider choices, referrals, and authorizations prior to the transitioning

   f. Ongoing problem solving to address participant's needs

   g. Maintain a 24/7 backup plan for critical services, as is requirement to be a provider.

   h. Evaluate needs for Expanded and Goods and Services and submit filled out Home Again Sales Quotation form to Home Again staff, if needed

   i. Case termination and transferring

   j. Any additional work required by Home Again staff and which is amended to the scope of service

4. The Provider must provide Transition Coordination services in accordance with Home Again policies and procedures, applicable SCDHHS policies and procedures, and applicable federal and state statutes and regulations. All of the

SECTION 6 CLTC STANDARDS FOR WAIVER SERVICES

TRANSITION COORDINATION SERVICE

foregoing provisions, policies, procedures, statutes and regulations (together with any subsequent amendments) are hereby incorporated as an integral part of this Scope of Service.

5. Once a case has been relinquished or transferred to another provider, Provider must cease any contact with the Participant and/or primary contact.

E. Staffing

Provider must adhere to the following provisions related to staffing:

1. Transition Coordinators cannot simultaneously be working as a Medicaid Waiver Case Manager with the same participant.

2. Transition Coordinators must have a current valid driver's license.

3. When servicing Participants, Transition Coordinators must display a picture identification badge identifying agency/organization or independent status.

4. Transition Coordinators must comply with the continuing education requirements necessary for their licensure/certificate.

5. Transition Coordinators must have demonstrated skills in computer hardware/ software access and usage.

6. Transition Coordinators must agree to accept a minimum of one (1) case and cannot carry a caseload of over fifteen (15) cases at the same time without the approval of the Home Again staff.

7. PPD Tuberculin Test

Please refer to the Department of Health and Environmental Control (DHEC) website for PPD Tuberculin test requirements.

http://www.scdhec.gov/Health/DiseasesandConditions/InfectiousDiseases/BacterialDiseases/Tuberculosis/

If Provider requires additional information, Provider should contact the Tuberculosis Control Division, Department of Health and Environmental Control, 1751 Calhoun Street, Columbia, SC 29201, phone (803) 898-0558.

8. Personnel folders: Individual records will be maintained to document that each member of the staff has met the above requirements.

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TRANSITION COORDINATION SERVICE

F. Transition Coordination Training

1. Transition Coordinators must attend Medicaid sponsored Transition Coordination training, either in person or via online prior to be enrolled as the provider in Phoenix.

2. All new Transition Coordinators must meet or do conference call with Transition Coordination Manager prior to take the first case.

G. Transition Coordination Activities and Rates

1. The provider will be paid based on each milestone: a) pre-transition planning, b) transitioning, c) six month milestone from transition date, and d) one year milestone from transition date. See appendix A for the rates.

2. Providers have a responsibility to notify Home Again staff once each milestone has been met. The provider must complete the activities below in order to request the payments.

Pre-transition planning

a. Make initial visit to a nursing facility to meet with the potential participant

b. Conduct the Risk Assessment to determine transition safety and possibility

c. Document all visits and contacts into Phoenix System

d. Conduct a visit to the participant's home in the community and determine home modification needs

e. Complete Quality of Life survey 3 weeks prior to transitioning

f. Discuss possible waiver services for the participant with CLTC Case Manager II in the Area Office and follow up on the case to make appropriate referrals and authorizations

g. Ensure participants recurring income is transferred from nursing facilities to the participants

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h. Complete all pre-transition planning checklist up to "1-2 days prior to move" tab in Phoenix System

i. Make sure medications and/or prescriptions are acquired prior to the discharge date

Note: The Provider will be paid $200 if the transition is deemed unsafe and the case terminated

Transitioning

a. Be present at the nursing facility or at the participant's home on the transition date

b. Document all visits and contacts into Phoenix System

c. Explain to the participant all services the person will be receiving, including Home Again demonstration program, waiver services, and any additional community services

d. Ensure each waiver authorization has a service start date

e. Monitor if the necessary Home Modifications are completed and identify if house set up is completed

f. Complete activities on the "Day of Move" tab in Phoenix System

g. Report Home Again staff and make a narrative in Phoenix if any Critical Incident occurs. Critical Incidents include hospitalizations, deaths due to abuse/neglect, deaths, contact with the criminal justice System, and medication errors.

Six month milestone from transition date

a. Comply with minimum visit/contact schedule as followed:

- Month 1-2: two (2) face-to-face visits and two (2) telephone calls
- Month 3-12: one (1) face-to-face visit every other month and one (1) telephone call each month

b. Document all visits/contacts into Phoenix System.

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TRANSITION COORDINATION SERVICE

c. Complete activities on the "1st Week after Move" and "1st Month after Move" tabs in Phoenix System

d. Report Home Again staff and make a narrative in Phoenix if any Critical Incident occurs

One year milestone from transition date

a. Comply with visit/contact schedule, at least one face-to-face visit every other month and one (1) telephone call each month.

b. Document all visits/contacts into Phoenix System.

c. Complete activities on the "11 Months after Move" tab in Phoenix System.

d. Conduct new Quality of Life survey in 11th month from the transition date.

e. Follow case transferring policy and procedures after 365 days from the transition date.

f. Report Home Again staff and make a narrative in Phoenix if any Critical Incident occurs.

H. Administrative Requirements

1. The Provider must maintain an up-to-date organizational chart that is available to each employee.

2. The Provider must maintain written bylaws (or the equivalent) for governing the Provider's operations.

3. The Provider must assure SCDHHS that a governing body or person(s) so functioning shall assume full legal authority for the operation of the provider agency.

4. The Provider shall acquire and maintain, during the life of the contract, general liability insurance and worker's compensation insurance. The Provider is required to list SCDHHS-Home Again as certificate holder for notice purposes on all

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insurance policies using the following address: Post Office Box 8206, Columbia, SC, 29202-8206.

5. The Provider must have an effective written back-up service provision plan in place to ensure that the participant receives the Transition Coordination services. Whenever the Provider determines that services cannot be provided as authorized, the Provider shall immediately notify Home Again Transition Coordination Manager and the waiver Case Manager by telephone.

6. The Provider will be responsible for continuing Transition Coordination activity for all cases in the Provider's caseload. Should the Provider be unable to cover a case(s), the Provider shall immediately notify Transition Coordination Manager by telephone.

7. Upon request by SCDHHS, the Provider will be responsible for appropriate participation in the SCDHHS Appeals and Hearings process with respect to appeals of any action involving the Provider.

8. The Provider is subject to recoupment for payments made for services as a result of authorizations issued by provider staff not consistent with Home Again policies and procedures and in accordance with the Transition Coordination Scope of Service.

9. The Provider must disclose to SCDHHS the names and relationships of any relatives of the Provider or its staff who provide items or services to Medicaid Participants. For purposes of this Contract, the Provider means all owners, partners, managing employees, directors and any other person involved in the direct management and/or control of the business of the Provider. The Provider's staff includes everyone who works for or with the Provider, including independent contractors, in the provision of or billing for services described in this Contract. Relative means persons connected to the Provider by blood or marriage.

   The Provider must disclose all such relationships in writing to Home Again, SCDHHS, within two (2) days of learning of the relationship. The Provider, in executing this Contract, certifies that it has in place policies, procedures or other mechanisms acceptable to SCDHHS to identify and report these relationships.

   Failure to report a relationship timely or to have the appropriate policies and procedures in place may result in sanctions by SCDHHS up to and including termination of this Contract for cause.

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MEDICAID HOME AGAIN PROGRAM
SCOPE OF SERVICE
FOR
TELEMONITORING SERVICE

A. Objectives

The objectives of the Telemonitoring service are to maintain and promote the health status of Medicaid home and community-based waiver participants through medical telemonitoring of body weight, blood pressure, oxygen saturation, blood glucose levels, and basic heart rate information.

B. Conditions of Participation – Providers

1. Providers must have equipment that records at a minimum the participant's body weight, blood pressure, oxygen saturation, blood glucose levels, and basic heart rate information. All agencies must also have nursing personnel and health care professionals able to carry out the duties of the service described below.

3. Providers must agree to participate in all components of the Care Call payment system and have the capability to receive and respond to authorizations for service in an electronic format.

4. Providers must have at least one (1) year of experience or otherwise demonstrate competency in the provision of this service.

C. Conditions of Participation – Community Choices Waiver Participants

Community Choices waiver participants must meet the following criteria in order to be considered for the Telemonitoring service:

1. Have a primary diagnosis of Insulin Dependent Diabetes Mellitus, Hypertension, Chronic Obstructive Pulmonary Disease, and/or Congestive Heart Failure; and

2. Have a history of at least two hospitalizations and/or emergency room visits in the past twelve (12) months; and

3. Have a primary care physician that approves the use of the telemonitoring service and is solely responsible for receiving and acting upon the information received via the telemonitoring service; and

4. Be capable of using the telemonitoring equipment and transmitting the necessary data or have an individual available to them that is capable of utilizing the telemonitoring equipment and transmitting data to the telemonitoring provider.

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At a minimum, South Carolina Department of Health and Human Services (SCDHHS) shall perform a reassessment of the telemonitoring service need at re-evaluation of level of care. The reassessment by SCDHHS shall be done to assess whether or not any of the above conditions have changed and to assess the continuing need for the service.

D. Description of Services to be Provided

2. The Unit of Service is one (1) day of direct telemonitoring provided to/for a participant in the participant's place of residence.

3. Home telemonitoring equipment must record, at a minimum, body weight, blood pressure, oxygen saturation, blood glucose, and basic heart rate information. The data must be transmitted electronically, and any transmission costs shall be incurred by the provider of the telemonitoring service. Medical professionals shall receive the data and determine if readings are within normal limits based upon guidelines provided by the physician.

4. The daily reimbursement rate for the Telemonitoring service is inclusive of monitoring of data, charting data from the monthly monitoring, visits or calls made to the home to follow up with participants and/or caregiver, phone calls made to primary care physician(s) that are necessary while the participant is receiving the telemonitoring service, all installation of the equipment in the home, and training on the equipment's use and care while it is in the participant's home. This also includes equipment removal when the service is no longer authorized for the participant.

4. The Provider shall provide the Telemonitoring service seven (7) days per week for all authorized time periods.

E. Staffing

The provider must provide all of the following (some, but not all of which, may be provided through subcontracts):

1. A registered nurse (RN) who meets the following requirements:

   a. Currently licensed by the S.C. State Board of Nursing or by a state that participates in the Nursing Compact

   b. At least one (1) year of experience as a RN in public health, hospital or long term care nursing

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c. Capable of evaluating and monitoring vital signs and physiological data transmitted from the participant's residence

d. Able to assume responsibility for monitoring and training participants and/or caregivers in the use of telemonitoring equipment

e. Able to use the Care Call IVR system

2. Technicians that install telemonitoring equipment must meet the following requirements:

a. Qualified as a technician to install telemonitoring equipment

b. Capable of evaluating whether or not the telemonitoring equipment is functioning properly

c. Able to assume responsibility for training participants and/or caregivers in the use of telemonitoring equipment

d. Able to use the Care Call IVR system

3. Agency staff may be related to participants served by the agency within limits allowed by the South Carolina Family Caregiver Policy. Copies of this policy are available upon request.

4. A criminal background check is required for all potential employees to include employees who shall provide direct care to SCDHHS participants and all administrative/office employees (office employees required to have background checks include: administrator, office manager, nurse supervisor, and persons named on organizational chart in management positions). All criminal background checks must include all data for the individual with no less than a ten (10) year search. The criminal background check must include statewide (South Carolina) data. The statewide data must include South Carolina and any other state or states the worker has resided in within the prior ten (10) years. Potential employees with felony convictions within the last ten (10) years cannot provide services to SCDHHS participants or work in an administrative/office position. Potential employees with non-violent felonies dating back ten (10) or more years can provide services to SCDHHS participants under the following circumstances:

- Participant/responsible party must be notified of the RN or technician's criminal background.

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- Documentation signed by the participant/responsible party acknowledging awareness of the criminal background and agreement to have the RN or technician provide care must be placed in the participant record.

Potential administrative/office employees with non-violent felony convictions dating back ten (10) or more years can work in the agency at the Provider's discretion.

Hiring of employees with misdemeanor convictions shall be at the Provider's discretion.

5. Personnel folders: Individual records shall be maintained to document that each member of the staff has met the above requirements.

F. Conduct of Service

The provider must maintain documentation showing that it has complied with the requirements of this section.

1. Participants and/or caregivers shall choose among qualified providers of the telemonitoring service. Once a provider has been chosen by the participant and/or caregiver, the Telemonitoring provider shall receive a referral that will have information on the participant's condition. Telemonitoring providers must accept or decline referrals from SCDHHS within two (2) working days. Failure to respond shall result in the loss of the referral.

2. If the referral is accepted, the provider shall obtain the physician's authorization for the Telemonitoring service. The provider shall notify the Case Manager when it has received the signed physician authorization for Telemonitoring form. A blank copy of the physician authorization form can be obtained on our website.
3. The provider shall initiate Telemonitoring services on the date negotiated with the Case Manager and indicated on the service authorization. The Case Manager must be notified if services are not initiated on that date. Services provided prior to the service authorization date are not reimbursable.

4. The Case Manager shall authorize Telemonitoring services by designating the amount, frequency and duration of service for participants in accordance with the participant's Service Plan. The Service Plan shall be developed utilizing the telemedicine assessment criteria and in consultation with the participant and others involved in the participant's care. The Case Manager must update the Service Plan yearly, or more frequently as needed, and send to the Provider.

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5. The Case Manager shall notify the provider immediately if services to a participant are to be terminated. However, the provider should refer to the language in the Community Long Term Care Services Provider Manual in section 1, General Information and Administration, regarding the Provider's responsibility in checking the participant's Medicaid eligibility status.

6. The provider shall install the equipment in the home and train the participant and/or caregiver in the use of the telemonitoring equipment. The installation and training must be done by a trained technician and/or RN knowledgeable of the equipment and able to address issues that may arise during training and in the installation of the product. The daily monitoring fee is inclusive of installation and training.

7. As part of the conduct of service, Telemonitoring must be provided by a RN (or physician) who meets the requirements as stated in the scope and shall:

    a. Be responsible for daily medical telemonitoring of body weight, blood pressure, blood glucose levels, and basic heart rate information. Each day when the physiological data is conveyed, the nurse shall analyze and interpret the data. If the data continues to remain within normal limits, information shall be conveyed at least quarterly, or more often if requested by the primary care physician accepting responsibility for the telemonitoring information. The telemonitoring agency and primary care physician accepting responsibility for the data shall maintain a written protocol that indicates the manner in which data shall be shared in the event of emergencies or other medical complications that arise during the monitoring service.

    b. Call the participant at least monthly to determine if the participant and/or caregiver are utilizing the equipment correctly and that the equipment continues to operate appropriately.

8. The provider shall notify the Case Manager in the event the provider becomes aware of any of the following situations:

    - Participant is institutionalized, dies or moves out of the service area
    - Participant no longer wishes to receive telemonitoring services
    - Knowledge of the participant's Medicaid ineligibility or potential ineligibility
    - Participant is not able to utilize the telemonitoring equipment any longer

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9. Telemonitoring equipment located in the participant's home must, at a minimum, be a FDA Class II Hospital grade medical device that includes a computer/ monitor that is programmable for a variety of disease states and for rate and frequency. The equipment must have a digital scale that measures accurately to at least 400 lbs. that is adaptable to fit a glucometer and a blood pressure cuff. All installed equipment must be able to measure, at a minimum, blood pressure, heart rate, oxygen saturation, blood glucose, body weight. Telephones, facsimile machines, and electronic mail systems do not alone meet the requirements of the definition of Telemonitoring, but may be utilized as a component of the telemonitoring system. All data must be transmitted electronically and any fees or costs associated with the transmission are the sole responsibility of the Provider. The maintenance, repair and/or replacement of any damaged telemonitoring equipment are the Provider's sole responsibility and are not a reimbursable Medicaid service. Major telemonitoring equipment failures which affect the ability to transmit or receive data must be repaired within two (2) working days. Any failure in the individual components of a telemonitoring system such as adaptability with a glucose monitor will need to be corrected within one week of discovering the problem associated with the additional equipment.

10. The provider must maintain an individual participant record which documents the following items:

    a. Documentation that Telemonitoring services were initiated on the date negotiated with the Case Manager and indicated on the Medicaid authorization. Services must not be provided prior to the authorized start date and must be provided according to the schedule as indicated on the Service Provision Form/Authorization.

    b. The written protocol for notifying the primary care physician of all Telemonitoring services.

    c. The provider shall maintain a record keeping system which documents:

        i. The delivery of services in accordance with the SCDHHS CLTC Service Plan. Monitoring sheets that are reviewed and signed, by the RN, must be filed in the participant's record within two (2) weeks of service delivery.

        ii. Documentation that a participant phone call has been made on at least a monthly basis to determine that the participant and/or caregiver are utilizing the equipment correctly and that the equipment continues to operate appropriately.

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iii. In the event services cannot be provided as authorized, the provider must maintain documentation of the reason(s) why services were not completed as specified by the Service Provision Form/ Authorization.

G. Administrative Requirements

1. The Provider must inform SCDHHS of the Provider's organizational structure including the Provider personnel with authority and responsibility for employing qualified personnel, ensuring adequate staff education, in-service training and employee evaluations. The Provider shall notify SCDHHS within three (3) working days in the event of a change in or the extended absence of the personnel with the above listed authority.

2. The Provider must provide SCDHHS with a written document showing the organization, administrative control and lines of authority for the delegation of responsibility down to the hands-on participant care level staff at contract implementation. The document should include an organizational chart including names of those currently in the positions. Revisions or modifications to this organizational document must be provided to SCDHHS. It is recommended that this document be readily accessible to all staff.

3. Administrative and supervisory functions shall not be delegated to another agency or organization.

4. The Provider agency shall acquire and maintain, for the duration of the contract liability, insurance and worker's compensation insurance as provided in Article IX, Section D of the Contract. The Provider is required to list SCDHHS – CLTC as a Certificate Holder for informational purposes only on all insurance policies using the following address: Post Office Box 8206, Columbia, SC 29202-8206.

5. The Provider shall develop and maintain a Policy and Procedure Manual that describes how activities shall be performed in accordance with the terms of the contract. The Policy and Procedure Manual shall be available during office hours for the guidance of the governing body and personnel and shall be made available to SCDHHS upon request.

6. The Provider must comply with Article IX, Section AA of the Contract regarding safety precautions. The Provider must also have an on-going infectious disease program to prevent the spread of infectious diseases among its employees.

7. The Provider shall ensure that key agency staff is accessible in person, by phone, or by beeper during compliance review audits conducted by SCDHHS and/or its agents.

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8. The Provider shall ensure that its office is open and staffed by qualified personnel during the hours of 10:00 a.m. to 4:00 p.m., Monday through Friday. Outside of these hours, the Provider agency must be available by telephone during normal business hours, 8:30 a.m. to 5:00 p.m., Monday through Friday. The Provider must also have a number for emergencies outside of normal business hours. Participant and personnel records must be maintained at the address indicated in the contract and must be made available, upon request, for review by SCDHHS.

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