

The services listed below must be medically necessary and are subject to utilization review by the South Carolina Department of Health and Human Services (SCDHHS) personnel, and must meet Federal and State laws and regulations.

Prior authorization from the South Carolina Department of Health and Human Services is required before payment will be made for services covered by Medicaid and rendered by an out-of-state provider, excluding those located within a twenty-five (25) mile radius of the South Carolina border.

For referrals out-of-state, the referring physician must obtain PRIOR APPROVAL before out-of-state services are reimbursed. A written request must be submitted to the South Carolina Department of Health and Human Services personnel. Referrals should be made to an out-of-state provider only when the procedure or service is not available within the South Carolina Medical Service Area. All available resources must have been considered and indicated in the request to SCDHHS for the out of state referral.

Out-of-state providers must meet Medicaid enrollment criteria before payment may be made. Payment to out-of-state providers follows federal and state regulations and guidelines as promulgated.

1. INPATIENT HOSPITAL SERVICES. Inpatient Hospital Services must be provided in a general acute care institution licensed as a hospital by the applicable South Carolina licensing authority and certified for participation in the Medicare (Title XVIII) program. Hospital services are subject to the following cost containment measures:

1. Utilization review for appropriateness of treatment and length of stay.
2. Preadmission screening of selected services/procedures.
3. A mandatory outpatient surgery list per fiscal year.

The following procedures are noncovered services: Hospital stays related to clinically unproven procedures and/or experimental procedures, plastic surgical procedures performed for cosmetic reasons, and other procedures determined not be medically necessary.

Abortions and sterilizations are reimbursable in accordance with Federal and State requirements. Coverage for induced abortions is provided when the physician certifies that the pregnancy was a result of rape or incest or the woman suffers from a physical disorder, injury or illness, including a life-endangering physical condition cause or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed.

Effective July 1, 1989 the South Carolina Department of Health and Human Services will sponsor Administrative Day services to recipients who no longer require acute hospital care, but are in need of nursing home placement which is not available at the time. The patient must meet nursing facility level of care. Administrative Days must follow a hospital stay and will be covered in any hospital as long as such care is not available in a nursing home. Swing bed hospitals may furnish Administrative Days provided all swing beds in the hospital are occupied.

2.a OUTPATIENT HOSPITAL SERVICES. Outpatient non-emergency clinic services will be covered.

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2.b. RURAL HEALTH CLINICS. Rural Health Clinic (RHC) services are limited to procedures performed by a physician, physician assistant, nurse practitioner, nurse midwife, or specialized nurse practitioner. RHC services are covered when furnished to patients at the clinic, skilled nursing facility, or the patient's place of residence. Services provided to hospital patients (including emergency room services) are not considered RHC services. All services must be medically necessary and appropriate for the diagnosis and treatment of a specific condition. Reimbursement for RHC services is described in ATTACHMENT 4.19-B.

A maximum of twelve (12) visits per patient per fiscal year for patients age 21 or older. SCDHHS may approve additional ambulatory care visits when medically necessary. Services that exceed the limit may be authorized based on medical necessity or utilization control procedures.

2.c FEDERAL QUALIFIED HEALTH CENTERS. Federally Qualified Health Centers (FQHC's) services are limited to procedures performed by a physician, physician assistant, nurse practitioner, nurse midwife, or specialized nurse practitioner. FQHC services are covered when furnished to patients at the center. These services are to be reimbursed at an all inclusive rate based on 100% of Medicare reasonable costs and other constraints as identified in paragraph 2(c) of 4.19-B. Services provided at a skilled nursing facility, hospital (including emergency services) or a patient's place of residence are not considered FQHC services.

Supplies, lab work and injections are not billable services. These services and supply costs are included in the all inclusive rate.

A maximum of 12 visits per patient per fiscal year for patients age 21 or older. SCDHHS may approve additional ambulatory care visits when medically necessary. Services that exceed the limit may be authorized based on medical necessity or utilization control procedures.

2.d Federally Qualified Health Centers. Federally Qualified Health Center services provided to a pregnant woman or an individual under 21 years of age will not be limited to 12 visits per patient per fiscal year.

2.e Indian Health Service (IHS) Facilities. Services reimbursed at the IHS rate are limited to procedures performed by a physician, physician assistant, nurse practitioner, nurse midwife or specialized nurse practitioner. These services are covered when furnished to a patient at the clinic. These services will be reimbursed at an all-inclusive rate as determined by the IHS.

Supplies, lab work and injections are not billable services. These services and supply costs are included in the all inclusive rate.

3. Other Laboratory and X-Ray Services: Laboratory and X-Ray services shall be covered to the extent permitted in federal Medicaid regulations and must conform to policies, guidelines and limitations as specified in the Physician, Laboratories and other Medical Professional Manuals. Services that exceed the limit may be authorized based on medical necessity or utilization control procedures.

4.a. NURSING FACILITY SERVICES. (For individuals 21 years of age or older). Prior approval for admission (or upon request for payment) and prior approval for level of care certification as appropriate is the responsibility of the Division of Community Long Term Care, South Carolina Department of Health and Human Services (DHHS). This pre-admission screening also includes services provided in a swing bed hospital and includes sub-acute care provided to ventilator dependent patients when contracted to provide this care (effective 04/01/89).

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Basic services and items furnished in a nursing facility that are inclusive in the per diem rate and must not be charged to the patient include the following:

A. Nursing Services - Includes all nursing services to meet the total needs of the resident, the administration of treatments and medications as ordered by the physician, assistance with mobility (walking or wheelchair), and routine nursing supplies. Nursing supplies include, but are not limited to such items as syringes, air mattress, I.V. supplies, adhesive tape, canes, ice bags, crutches, glycerine, mouth swabs, water pitchers, bed pans, thermometers, and urinals.

B. Special Services - Including assistance by the facility social worker, participation in planned activities, physical therapy, speech therapy, occupational therapy and inhalation therapy.

C. Personal Services - Services for the comfort of the resident which include assistance with eating, dressing, toilet functions, baths, brushing teeth, washing and combing hair, shaving and other services necessary to maintain a clean, well kept personal appearance. Includes assistance in walking and wheelchair use when necessary. Diapers and underpads are provided as needed.

D. Room and Board - Includes a semiprivate or ward accommodations, all meals including special diets and snacks ordered by the physician. Includes feeding residents if unable to feed themselves and tube feeding. Housekeeping services and bed and bath linens are included.

E. Safety and Treatment Equipment - Including, but not limited to the following items: standard wheelchairs, infusing equipment, bedside commode, side rails, restraint chairs (Geri-chairs), suction apparatus, walkers, crutches, canes and other equipment that is generally used by multiple residents and does not become the property of the individual resident.

F. Medications - Over-the counter (OTC) non-legend medications are included (except for insulin)

G. Medical Supplies and Oxygen - The following items are included, however, the included items are not limited to this list: oxygen, supplies used for inhalation therapy, catheters and related supplies, dressings, disposable enema equipment or other irrigation supplies, I.V. solutions, disposable instrument trays, levine tubes, and other supplies ordered by the physician or necessary to meet the needs of the resident because of the resident's medical condition.

4.b EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT). The EPSDT program offers special medical services to Medicaid recipients under the age of twenty-one. EPSDT services include dental, vision, hearing services and general health screening. EPSDT services are offered in addition to medically necessary services available to all Medicaid recipients. Additional ambulatory care visits will be made available as necessary.

4.b EPSDT cont.

The State assures that this provision of EPSDT will not restrict an individual's free choice of providers in violation of 1902 (a) (23) of the Act.

1. Eligible recipients will have free choice of providers of EPSDT services. They will have the freedom of choice to switch providers if and when they desire.
2. Eligible recipients will have free choice of providers under other medical care under the State Plan. Providers will assure that freedom of choice of physicians and other medical care providers are maintained at all times.

Assurance 1905(a) Services: The state assures that EPSDT eligible clients have access to Section 1905(a) services not specifically listed in the state plan when they are medically necessary. Services provided as described in Section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions not specified in the state plan will be provided if determined to be medically necessary by the appropriate agency staff. Any services beyond the limitations noted in the State Plan must be available based on a medical necessity determination.

Referrals for rehabilitative therapy services must be made by physician or other licensed practitioner of the healing arts and all Medicaid and state supervisory requirements must be adhered to. Referral means that the physician or other licensed practitioner of the healing arts has asked another qualified health provider to recommend, evaluate or perform therapies, treatment or other clinical activities to or on behalf of the beneficiary being referred. It includes any necessary supplies or equipment.

"Under the direction of" means that for physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders under 42 CFR 440.110, the Medicaid qualified therapists providing direction are licensed practitioners of the healing arts qualified under State law to diagnose and treat individuals with the disability or functional limitations at issue, are working within the scope of practice defined in State law and are supervising each individual's care. The qualified therapists must, at a minimum, have face-to-face contact with the beneficiary initially and periodically as needed, be familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts practicing under State law, have continued involvement in the care provided, and review the need for continued services throughout treatment. The supervising therapists must also assume professional responsibility for the services provided under their direction and monitor the need for continued services. The supervising therapists must spend as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice. Moreover, the supervising therapists must ensure that individuals working under their direction have contact information to permit them direct contact with the supervising therapists as necessary during the course of treatment. In all cases, documentation must be kept supporting the supervision of services and ongoing involvement in the treatment. Absent appropriate service documentation, Medicaid payment for services may be denied providers.

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SUPERSEDES: SC 05-006

4.b EPSDT cont.

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SERVICES FOR INDIVIDUALS WITH SPEECH, HEARING AND LANGUAGE DISORDERS

Physical Therapy Services: In accordance with 42 CFR 440.110(a), physical therapy means services prescribed by a Physician or other Licensed Practitioner of the Healing Arts (LPHA) within the scope of his or her practice under state law and provided to a beneficiary by or under the direction of a qualified Physical Therapist. It includes any necessary supplies and equipment. Physical Therapy Services involve evaluation and treatment to prevent, alleviate, or compensate for movement dysfunction and related functional problems for maximum reduction of physical or mental disability and restoration of a beneficiary to his/her best possible functional level. Specific services rendered: Physical Therapy Evaluation, Individual and Group Therapy (a group may consist of no more than six children).

Specific services provided include:

Physical Therapy Evaluation: A Physical Therapy Evaluation is a comprehensive evaluation that should be conducted in accordance with the American Physical Therapy Association and South Carolina Board of Physical Therapy Examiners guidelines, the physician or other LPHA, the Physical Therapist's professional judgment, and the specific needs of the child. The evaluation should include a review of available medical history records, an observation of the patient, and an interview, when possible. The evaluation must include diagnostic testing and assessment, and a written report with recommendations.

Individual and Group Physical Therapy: Individual or Group Physical Therapy is the implementation of specialized Physical Therapy programs that incorporate the use of appropriate modalities; performance of written and/or oral training of teachers and/or family regarding appropriate Physical Therapy activities/therapeutic positioning in the school or home environment; recommendations on equipment needs; and safety inspections and adjustments of adaptive positional equipment. Physical Therapy performed on behalf of one child should be documented and billed as Individual Physical Therapy. Physical Therapy performed on behalf of two or more children should be documented and billed as Group Physical Therapy. A group may consist of no more than six children.

Providers of Physical Therapy Services include:

- **Physical Therapist (PT).** In accordance with 42 CFR 440.110 (a)(2)(i)(ii), a qualified physical therapist is an individual who is currently licensed by the South Carolina Board of Physical Therapy Examiners. (i) A graduate of a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or its equivalent; and (ii) where applicable, licensed by the State.

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- **Physical Therapist Assistant (PTA)** is an individual who is currently licensed by the South Carolina Board of Physical Therapy Examiners. A physical therapy assistant provides services under the direction of a qualified physical therapist.

Occupational Therapy Services: In accordance with 42 CFR 440.110(b)(1), Occupational Therapy means services prescribed by a Physician or other Licensed Practitioner of the Healing Arts within the scope of his or her practice under state law and provided to a beneficiary by or under the direction of a qualified Occupational Therapist. It includes any necessary supplies and equipment. Occupational therapy services are channels to improve or restore functional abilities for maximum reduction of physical or mental disability and restoration of a beneficiary to his/her best possible functional level. Occupational Therapy Services are related to Self-Help Skills, Adaptive Behavior, Fine/Gross Motor, Visual, Sensory Motor, Postural, and Emotional Development that have been limited by a physical injury, illness, or other dysfunctional condition. Occupational Therapy involves the use of purposeful activity interventions and adaptations to enhance functional performance. Specific services rendered: Occupational Therapy Evaluation, Individual and Group Occupational Therapy (a group may consist of no more than six children), Fabrication of Orthotic, Fabrication of Thumb and Finger Splints.

Specific services provided include:

Occupational Therapy Evaluation: An Occupational Therapy Evaluation is a comprehensive evaluation that should be conducted in accordance with the American Occupational Therapy Association and South Carolina Board of Occupational Therapy guidelines, the physician or other LPHA referral, the Occupational Therapist's professional judgment, and the specific needs of the child. The evaluation should include a review of available medical history records and an observation of the patient and interview, when possible. The evaluation must include diagnostic testing and assessment and a written report with recommendations.

Individual and Group Occupational Therapy: Individual or Group Occupational Therapy is the implementation of specialized Occupational Therapy programs that incorporate the use of appropriate interventions, occupational therapy activities in the school or home environment, and recommendations on equipment needs and adaptations of physical environments. Occupational therapy performed directly to or on behalf of one child should be documented and billed as Individual Occupational Therapy. Occupational Therapy performed for two or more individuals should be documented and billed as Group Occupational Therapy. A group may consist of no more than six children.

Fabrication of Orthotics for upper and lower extremities and Thumb and Finger Splints: Fabrication of Orthotic is the fabrication of orthotics for lower and upper extremities, and the Fabrication of Thumb Splint and Finger Splint is the fabrication of orthotic for the thumb and likewise, the fabrication of Finger Splint is the fabrication of orthotic for the finger.

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Providers of Occupational Therapy include:

- **Occupational Therapist (OT).** In accordance with 42 CFR 440.110 (b)(2)(i)(ii) A qualified occupational therapist is an individual who is - (i) Certified by the National Board of Certification for Occupational Therapy; or (ii) A graduate of a program in occupational therapy approved by the Committee on Allied Health Education and Accreditation of the American Medical Association and engaged in the supplemental clinical experience required before certification by the National Board of Certification for Occupational Therapy.
- **Occupational Therapy Assistant (OTA)** is an individual who is currently licensed as a Certified Occupational Therapy Assistant (COTA/L or OTA) by the South Carolina Board of Occupational Therapy who works under the direction of a qualified occupational therapist pursuant to 42 CFR 440.110(b)(2)(i) or (ii).

Speech-Language Pathology Services: In accordance with 42 CFR 440.110(c)(1), Speech-Language Pathology Services include diagnostic, screening, preventive, or corrective services provided by or under the direction of a Speech-Language Pathologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. It includes any necessary supplies and equipment. Speech-Language Pathology Services means evaluative tests and measures utilized in the process of providing Speech-Language Pathology Services and must represent standard practice procedures. Only standard assessments (i.e., Curriculum-Based Assessments, Portfolio Assessments, Criterion Referenced Assessments, Developmental Scales, and Language Sampling Procedures) may be used. Tests or measures described as "teacher-made" or "informal" are not acceptable for purposes of Medicaid reimbursement. Specific services rendered: Speech Evaluation, Individual Speech Therapy, and Group Speech Therapy (a group may consist of no more than six children).

Specific services provided include:

Speech Evaluation: Upon receipt of the physician or other LPHA referral a Speech Evaluation is conducted. This is a face-to-face interaction between the Speech-Language Pathologist, Speech-Language Pathology, Assistant, Speech-Language Pathology Intern or Speech-Language Pathology Therapist and the child for the purpose of evaluating the child's dysfunction and determining the existence of a speech disorder. Evaluation should include review of available medical history records and must include diagnostic testing and assessment, and a written report with recommendations.

Speech Re-evaluation includes a face-to-face interaction between the Speech-Language Pathologist and the child for the purpose of evaluating the child's progress and determining if there is a need to continue therapy. Reevaluation may consist of a review of available medical records and diagnostic testing and/or assessment, but must include a written report with recommendations.

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Individual Speech Therapy: Individual Speech Therapy is the delivery of remedial services for identified speech and/or language handicaps to a child whose speech and/or language patterns deviate from standard based on evaluation and testing, including training of teacher or parent. Individual Speech Therapy services may be provided in a regular education classroom.

Group Speech Therapy: Group Speech Therapy is the delivery of remedial services for identified speech and/or language handicaps in a group setting to children whose speech and/or language patterns deviate from standard based on evaluation and testing, including training of teacher or parent. A group may consist of no more than six children. Group Speech Therapy services may be provided in a regular education classroom.

Providers of Speech-Language Pathology Services include:

- **Speech-Language Pathologist** in accordance with 42 CFR 440.110 (c)(2)(i)(ii)(iii) is an individual who meets one of the following conditions: (i) Has a Certificate of Clinical Competence from the American Speech and Hearing Association. (ii) Has completed the equivalent educational requirements and work experience necessary for the certificate. (iii) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.
- **Speech-Language Pathology Assistant** is an individual who is currently licensed by the South Carolina Board of Examiners in Speech-Language Pathology. The Speech-Language Pathology Assistant works under the direction of a qualified Speech-Language Pathologist pursuant to 42 CFR 440.110(c)(2)(i) and (ii).
- **Speech-Language Pathology Intern** is an individual who is currently licensed by the South Carolina Board of Examiners in Speech-Language Pathology and is seeking the academic and work experience requirements established by the American Speech and Hearing Association (ASHA) for the Certification of Clinical Competence in Speech-Language Pathology. The Speech-Language Pathology Intern works under the direction of a qualified Speech-Language Pathologist pursuant to 42 CFR 440.110(c)(2)(i) and (ii).
- **Speech-Language Pathology Therapist** is an individual who does not meet the credentials outlined in the 42 CFR 440.110(c)(2)(i)(ii) and (iii) that must work under the direction of a qualified Speech-Language Pathologist. The qualifications for a Speech-Language Pathology Therapist are (a) Bachelor's Degree in Speech-Language Pathology from a school or program approved by the State Board of Education for the preparation of speech language pathologists (b) Minimum qualifying score(s) on the area examination(s) required by the State Board of Education.

Audiological Services: In accordance with 42 CFR 440.110(c)(1), Audiological Services for individuals with hearing disorders means diagnostic, screening, preventive, or corrective services provided by or under the direction of an audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law. A referral occurs when the physician or other LPHA has asked

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a Licensed Audiologist to recommend, evaluate, or perform therapies, treatment, or other clinical activities for the beneficiary. It includes any necessary supplies and equipment. Services involve testing and evaluation of hearing-impaired children less than 21 years of age who may or may not be improved with medication or surgical treatment. This includes services related to hearing aid use.

Specific services rendered: Pure Tone Audiometry, Audiological Evaluation, Audiological Re-Evaluation, Tympanometry (Impedance Testing), Electrocochleography, Auditory Evoked Potentials; Comprehensive, Auditory Evoked Potentials; Comprehensive Re-check, Evoked Otoacoustic Emission; Limited, Evoked Otoacoustic Emissions; Comprehensive or Diagnostic Evaluation, Hearing Aid Examination and Selection, Hearing Aid Check; Hearing Aid Re-Check, Evaluation of Auditory Rehabilitation Status, Fitting/Orientation/Checking of Hearing Aid, Dispensing Fee, Right Ear Impression, Left Ear Impression.

Specific services provided include:

Pure Tone Audiometry: In pure tone audiometry, earphones are placed and the patient is asked to respond to tones of different pitches (frequencies) and intensities. The threshold is recorded for a number of frequencies in each ear. This service may be performed six times during the course of a 12-month period.

Audiological Evaluation: In comprehensive audiometry, earphones are placed and the patient is asked to respond to tones of different pitches (frequencies) and intensities. The threshold is recorded for a number of frequencies on each ear. Bone thresholds are obtained in a similar manner except a bone oscillator is used on the mastoid or forehead to conduct the sounds. The patient is also asked to repeat bisyllabic (spondee) words. The threshold is recorded for each ear. The word discrimination score is the percentage of spondee words that a patient can repeat correctly at a given intensity level above speech reception threshold in each ear. This service may be performed once during the course of a 12-month period.

Audiological Re-Evaluation: An audiological re-evaluation is when appropriate components of the initial evaluation are re-evaluated and provided as a separate procedure. The necessity of an audiological re-evaluation must be appropriately documented. This service may be performed six times during the course of a 12-month period.

Tympanometry (Impedance Testing): Using an ear probe, the eardrum's resistance to sound transmission is measured in response to pressure changes. This service may be performed six times during the course of a 12-month period.

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Electrocochleography: An electrocochleography tests the internal components of the implanted receiver and connected electrode array. This procedure verifies the integrity of the implanted electrode array and is completed immediately after the operation. This procedure is to be completed only by a licensed Audiologist on a cochlear implant team and may be performed once per implantation.

Auditory Evoked Potentials - Comprehensive: Electrodes are placed in various locations on the scalp and electrical recordings are made in response to auditory stimulations. There is no frequency limitation on this procedure.

Auditory Evoked Potentials - Comprehensive Re-Check: Electrodes are placed in various locations on the scalp and electrical recordings are made in response to auditory stimulations. There is no frequency limitation on this procedure.

Evoked Otoacoustic Emission - Limited: A probe tip is placed in the ear canal. The probe tip emits a repeated clicking sound that passes through the tympanic membrane, middle ear space, and then to the outer hair cells of the inner ear. Computerized equipment is then able to record an echo off of the hair cell in the inner ear. There is no frequency limitation on this procedure.

Evoked Otoacoustic Emissions - Comprehensive or Diagnostic Evaluation:

A probe tip is placed in the ear canal. The probe tip emits a repeated clicking sound that passes through the tympanic membrane, middle ear space, and then to the outer hair cells of the inner ear. Computerized equipment is then able to record an echo off of the hair cell in the inner ear. There is no frequency limitation on this procedure.

Hearing Aid Examination and Selection: History of hearing loss and ears are examined, medical or surgical treatment is considered if possible, and the appropriate type of hearing aid is selected to fit the pattern of hearing loss. This service may be performed six times during the course of a 12-month period.

Hearing Aid Check: The audiologist inspects the hearing aid and checks the battery. The aid is cleaned and the power and clarity are checked using a special stethoscope, which attaches to the hearing aid. This service may be performed six times during the course of a 12-month period.

Hearing Aid Re-Check: The audiologist inspects the hearing aid and checks the battery. The aid is cleaned and the power and clarity are checked using a special stethoscope, which attaches to the hearing aid. This service may be performed six times during the course of a 12-month period.

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Evaluation of Auditory Rehabilitation Status: This service involves the measurement of patient responses to electrical stimulation used to program the speech processor and functional gain measurements to assess a patient's responses to his or her cochlear implant. Instructions should be provided to the parent/guardian, teacher, and/or patient on the use of a cochlear implant device to include care, safety, and warranty procedures. This procedure is to be completed only by a licensed Audiologist on a cochlear implant team and may be performed 10 times during the course of a 12-month period.

Fitting/Orientation/Checking of Hearing Aid: Includes hearing aid orientation, hearing aid checks, and electroacoustic analysis. The service may be provided six times during the course of a 12-month period.

Dispensing Fee: The dispensing fee is time spent handling hearing aid repairs. This service may be performed six times during the course of a 12-month period.

Right Ear Impressions: Taking of an ear impression; please specify one or two units for one or two ears. This service may be performed six times during the course of a 12-month period.

Left Ear Impressions: Taking of an ear impression; please specify one or two units for one or two ears. This service may be performed six times during the course of a 12-month period.

Providers of Audiology services include:

Audiologist: All Medicaid-qualified audiology providers (Licensed Audiologists) operating in the State of South Carolina adhere to the provider qualifications found in 42 CFR 440.110(c) (3)

Psychological Evaluation and Testing Services: In accordance with 42 CFR 440.130, Psychological Testing and Evaluation recommended by a physician or other licensed practitioner of the hearing arts, within the scope of his practice under State law, includes evaluation of the intellectual, emotional, and behavioral status and any resulting distress and/or dysfunction. Service components include screening, diagnostic interview, testing and/or assessment.

Providers of Psychological Evaluation and Testing Services include:

Psychologist is an individual that holds a doctoral degree in psychology from an accredited college or university, and has a valid and current state license as a Ph.D. or Psy. D. with a specialty in Clinical, Counseling, or School Psychology as approved by the SC State Board of Examiners in Psychology.

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School Psychologist I-is an individual that is currently certified by the State Department of Education and holds a master's degree from a regionally or nationally accredited college/university with an advanced program for the preparation of school psychologists and qualifying score on the SC State Board of Education required examination.

School Psychologist II- is an individual that is currently certified by the State Department of Education and holds a specialist degree from a regionally or nationally accredited college/university with an advanced program for the preparation of school psychologists, and qualifying score on the SC State Board of Education required examination.

School Psychologist III- is an individual that is currently certified by the State Department of Education and holds a doctoral degree from a regionally or nationally accredited college/university with an advanced program for the preparation of school psychologists, qualifying score on the State Board of Education required examination, and completion of an advanced program approved for the training of school psychologists.

Psycho-educational Specialist is an individual that holds a (60 hour) master's degree plus 30 hours or a doctoral degree in school psychology from a regionally accredited institution approved by NASP or APA or its equivalent, certification by the South Carolina Department of Education as a school psychologist level II or III, two years experience as a certified school psychologist (at least one year of which is under the supervision of a licensed psycho-education specialist), and satisfactory score on the PRAXIS Series II exam. The SC Board of Examiners licenses this individual.

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Orientation and Mobility Services: Are provided to assist individuals who are blind and visually impaired to achieve independent movement within the home, school, and community settings. O&M Services utilize concepts, skills, and techniques necessary for a person with visual impairment to travel safely, efficiently, and independently through any environment and under all conditions and situations. The goal of these services is to allow the individual to enhance existing skills and develop new skills necessary to restore, maximize, and maintain physiological independence.

Orientation and Mobility (O&M) Service Qualifications:

- The service must be recommended by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law.
- The service must be provided for a defined period of time, for the maximum reduction of physical or mental disability and restoration of the individual to his or her best possible functional level.
- The service must be furnished by individuals working under a recognized scope of practice established by the state or profession.

Specific services provided include:

Assessment: An Orientation & Mobility Assessment is a comprehensive evaluation of the child's level of adjustment to visual impairment and current degree of independence with or without assistive/adaptive devices, including functional use of senses, use of remaining vision, tactile/Braille skills, and ability to move safely, purposefully, and efficiently through familiar and unfamiliar environments. Assessment must include a review of available medical history records, diagnostic testing and assessment, and written report with recommendations.

Reassessment: An Orientation & Mobility Reassessment is an evaluation of the child's progress toward treatment goals and determination of the need for continued services. Reassessment may consist of a review of available medical history records and diagnostic testing and assessment, but must include a written report with recommendations. Reassessment must be completed at least annually but more often when appropriate.

Services: Orientation & Mobility Services is the use of systematic techniques designed to maximize development of a visually impaired child's remaining sensory systems to enhance the child's ability to function safely, efficiently, and purposefully in a variety of environments. O&M Services enable the child to improve the use of technology designed to enhance personal communication and functional skills such as the long cane, pre-mobility and adapted mobility devices, and low vision and electronic travel aids. O&M Services may include training in environmental awareness, sensory awareness, information processing, organization, route planning and reversals, and

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training in balance, posture, gait, and efficiency of movement. O&M Services may also involve the child in group-settings to increase their capacity for social participation, or provide adaptive techniques and materials to improve functional activities such as eating, food preparation, grooming, dressing, and other living skills.

Providers of Orientation and Mobility services include:

- **Orientation and Mobility (O&M) Specialist** is an individual who holds a current and valid certification in Orientation and Mobility from the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP) or an individual who holds a current and valid certification in Orientation and Mobility from the National Blindness Professional Certification Board (NBPCB).

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4.b EPSDT continued:

Home Based Private duty nursing services are available in the home to all recipients under age 21 who are found to be in need of such services on the basis of State established medical necessity criteria. The services must be ordered by the attending physician and must be provided by a Licensed Practical Nurse (LPN) or a Registered Nurse (RN), licensed by the State Board of Nursing for South Carolina. Immediate family members cannot be reimbursed for providing these services. Home Based Private duty nursing services meet the requirements at 42 CFR 440.80.

The State will not preclude the provision of private duty nursing services during those hours of the day that the beneficiary's normal life activities take her outside of her home to attend school. Private duty nursing services rendered during those hours when the beneficiary's normal life activities take him or her outside of the home are coverable.

Personal Care services are available to all recipients under age 21 who live at home and who are found to be in need of such services on the basis of state established medical necessity criteria. Personal Care Services are designed to enable participants to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance (performing a task for the person) or cuing to prompt the participant to perform a task. Such assistance may include assistance in activities of daily living (bathing, dressing, toileting, transferring, maintaining continence, etc.). Instrumental Activities of Daily Living (IADL's) including home support (cleaning, laundry, shopping, home safety and errands) may be done as a part of the assistance given in the provision of activities of daily living. Personal care services may be provided on an episodic or on a continuing basis and are preformed by personal care agencies. Personal care services are furnished in the participant's home.

Any services authorized outside a home setting must be prior approved by the State. Personal care agencies must meet SCDHHS scope of service requirements.

A licensed nurse must oversee all direct care staff of a personal care agency. Personal Care Aides must be able to communicate effectively with both participants and supervisors, be fully ambulatory, capable of aiding with recipient's activities of daily living, capable of following a care plan, criminal background checks must verify that the participant has never been involved in substantiated abuse or neglect, be at least 18 years of age, pass a competency test and complete yearly training. The amount and duration of services must be prior authorized and re-authorized based on the recipient/s medical needs at regular intervals by the DHHS. Immediate family members cannot be reimbursed for providing these services.

The following policy applies to both home based private duty nursing and personal care services. Reimbursement for personal care and home based private duty nursing services, may be made to certain family members who meet South Carolina Medicaid provider qualifications. The following family members cannot be reimbursed: The spouse of a Medicaid consumer; A parent of a minor Medicaid consumer; A step parent of a minor Medicaid consumer; A foster parent of a minor Medicaid consumer; Any other legally responsible guardian of a Medicaid consumer. All other qualified family members can be reimbursed for their provision of the services listed above. Should there be any question as to whether a paid caregiver falls in any of the categories listed above, SCDHHS legal counsel will make a determination.

Physical and occupational therapy services as prescribed by a licensed physician, identified as a needed service through an EPSDT exam or evaluation and identified on a prior authorized treatment plan.

SC 11-011
EFFECTIVE DATE: 07/11/11
RO APPROVAL: 02/10/12
SUPERSEDES: SC 08-030

Services may be rendered by physicians and licensed physical and occupational therapists either employed by an approved provider or certified as an independent or group practitioner. Physical and occupational therapy are provided by or under the direction of qualified therapists and physical therapy and occupational therapy services meet the requirements of 42 CFR 440.110.

Psychological testing, evaluation and therapy are covered when prescribed through an EPSDT screen or exam and a prior authorization process. Services may be rendered by a licensed doctoral level psychologist in private practice or employed by an approved and enrolled provider.

Nursing Services for Children Under 21: Skilled intermittent nursing care provided by nurses licensed and regulated by the state to administer medications or treatments to children under 21 in a school based or public medical clinic setting. The nursing care provided is necessary for the maximum reduction of the beneficiaries' physical and/or mental disability and restoration to the best possible functional level.

4.c Effective April 1, 1990, the Omnibus Budget Reconciliation Act, Section 6403 requires that any diagnostic service or treatment determined to be medically necessary as a result of a screening service which is allowed to be covered with Federal matching funds under Medicaid must be provided whether or not such service is covered under this State Plan.

SC 08-030
EFFECTIVE DATE: 05/01/09
RO APPROVAL: 10/20/09
SUPERSEDES: New Page

4.b EPSDT Continued:

Medical Screenings, Vision screenings and Hearing Screenings are provided according to the following periodicity schedule: (1 per range)

Birth - to 1 month	12 months - through 14 months
1 month - through 2 months	15 months - through 17 months
3 months - through 4 months	18 months - through 20 months
5 months - through 7 months	21 months - through 24 months
8 months - through 11 months	

3 years through 21 years - Nineteen screenings are allowed one year apart.

Dental Periodicity Schedule

Dental screening services, to include referral for dental exam and follow-up treatment, as necessary, begins at age 1 or after eruption of the first tooth and are provided every six months thereafter until the last day of the month of the 21st birthday.

Interperiodic dental services are covered at intervals other than those specified in the periodicity schedule when medically necessary to identify and treat a suspected illness or condition.

Dental

Dental Services for recipients under the age of 21 include any medically necessary services are covered.

Vision

Tinted lenses are not a covered service
Lens covered as a separate service (except replacement)
Training lenses
Protective lenses
Oversized lenses are not covered
Lenses for unaided VA less than 20/30 + -.50 sphere
Plastic lenses for prescription less than + or -4 diopters
Visual therapy or training is not covered
There are no allowable benefits for optometric hypnosis, broken appointments, or charges for special reports.

SC 12-012
EFFECTIVE DATE: 07/01/12
RO APPROVAL: 11/21/12
SUPERSEDES: SC 08-001

Hearing

Limited to the provision of hearing aids including batteries, accessories and repairs, and hearing tests for diagnosis and referral.

Prior authorization by consultants is required for specific dental, vision and durable medical equipment, prosthetic and orthotic appliance services, private duty nursing services and personal care aide services. The codes representing covered services are listed in the state agency manuals for Dentistry, Vision Care, Durable Medical Equipment, CLTC Services Provider Manual.

Services not listed as covered services in the state agency manuals/state plan will be provided if determined to be medically necessary by the appropriate agency staff or consultants. The reimbursement rate for these services will be 80% of statewide usual and customary fees. If the provider is a government agency and/or a non-profit organization, the reimbursement will be no greater than actual cost. This is in compliance with 45 CFR Subpart Q.

4.c Family Planning Services

Family Planning services are available to all Medicaid recipients and include all medical and counseling services related to alternatives of birth control and pregnancy prevention services prescribed and rendered by physicians, hospitals, clinics, pharmacies and other practitioners and other Medicaid providers recognized by state and federal laws and enrolled as Medicaid Providers.

Coverage for Adolescent Pregnancy Prevention Services is allowed as described for EPSDT eligible recipients and rendered by approved Medicaid providers.

(Effective 11-1-90)

Adolescent Pregnancy Prevention Services are services available to improve access to quality family planning services for a group at high risk for unintended pregnancy. Adolescent Pregnancy Prevention Services enhance the ability of all adolescents to make responsible decisions about sexual activity, including postponement of sexual activity or use of effective contraception. The result is a lowered incidence of pregnancy and sexually transmitted diseases and improved overall physical and mental health.

Adolescent pregnancy prevention services are defined as follows:

1. Individual counseling is a medical service using a systematic approach that is goal oriented with the purpose of developing a reasoned and responsible approach to family planning, including as appropriate, contraception or delay of sexual activity. Recipients will be informed of how to locate and use resources such as the health department, clinics or other family planning providers.
2. Group counseling is a medical service using group interaction for the same purposes and goals as individual counseling.

SC: MA 90-37
EFFECTIVE DATE: 11/01/90
RO APPROVAL: 6/06/91
SUPERSEDES: MA 90-12

3. Family counseling is a medical service that focuses on how the family can help the individual make responsible decisions in sexual risk reduction, particularly pregnancy prevention and disease prevention. Family Counseling is provided for the purpose of helping the eligible recipient in terms of family planning. It is not intended to provide primary benefit to the family system, some members of which may be ineligible for Medicaid services.
4. Home visits is a medical service used to assess the recipient's level of functioning and his/her needs for family planning services, including identifying obstacles to utilization of family planning services.
5. Group health education is a medical service that focuses on family value systems and their impact on pregnancy prevention; human sexuality; physical development; postponement of sexual activity as a responsible decision; contraception; and decision making skills related to family planning.
6. Referral services will be used to link recipients to family planning providers and other medical providers whose services will help improve the overall functioning of the individual and therefore his ability to exercise good judgment in family planning.
7. Assessment is a medical service used to evaluate the overall family planning needs of the recipient, including counseling services, birth control and other services above.

Eligible providers of Adolescent Pregnancy Prevention Services must meet the standards established by the State Health and Human Services Finance Commission and be approved as providers of this service. Providers may qualify for enrollment upon demonstration of the ability to provide the specified services in accordance with the requirement set forth by Medicaid, and sign an agreement with the State Health and Human Services Finance Commission. Providers may be any qualified individual or organization including but not restricted to state and local health care agencies or clinics regardless of whether they provide other Medicaid services. Individuals providing adolescent pregnancy prevention services must, at a minimum, be licensed or certified by appropriate state authorities as a healthcare professional, or be directly supervised by a licensed or certified health care professional.

Adolescent pregnancy prevention services include assessment; individual, group and family counseling; and health education related to sexuality, reproduction and family planning. Payment for adolescent pregnancy prevention services under the plan does not duplicate payments made to public or private entities under other program authorities for the same purpose.

These services are limited to EPSDT eligible children only. Family planning services are available to all Medicaid recipients under the State Plan. The purpose of this amendment is to ensure that appropriate family planning services are available to adolescents whose needs may be different. All adolescent pregnancy prevention services are comparable

SC: MA 90-37

EFFECTIVE DATE: 11/01/90

RO APPROVAL: 6/06/91

SUPERSEDES: N/A

in amount, duration and scope. Adolescent pregnancy prevention services are not restricted geographically, and are provided on a statewide basis in accordance with section 1902(a)(10)(B). Recipients retain freedom of choice of family planning providers for all family planning services, including adolescent pregnancy prevention. Refusal to accept adolescent pregnancy prevention services does not in any way limit the recipient's right to utilize any family planning services under the State Plan. The state assures that the provision of adolescent pregnancy prevention services does not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.

SC: MA 90-37
EFFECTIVE DATE: 11/01/90
RO APPROVAL: 6/06/91
SUPERSEDES: N/A

5. Physician Services

Physician Services are limited to procedures performed, or directly supervised by a practitioner licensed by the appropriate State Board of Medical Examiners as a doctor of medicine or osteopathy. Services are further limited to those rendered by an enrolled physician provider on behalf of an eligible recipient within the designated South Carolina Service Area. All services must be medically necessary and appropriate for the diagnosis and treatment of a specified condition. Physician Services may be rendered in a physician's office, clinic, hospital, nursing home, patient's home or elsewhere.

Technical Services, including materials that are supplied by a physician in an ambulatory setting are considered part of the physician's professional service unless specifically designated as a separate service in the South Carolina Medicaid Physician, Clinical and Ancillary Services Manual.

Physician supervision is restricted to services provided under the direct supervision of a physician directing a paramedical professional or other licensed individual. The physician must be responsible for all services rendered and be accessible at all times during the diagnosis and treatment of the patient.

Primary Care Providers:

Primary Care Providers are defined as those medical personnel that provide routine or preventive care. Primary care providers include, but are not limited to, Family Practitioners, General Practitioners, Internists, Nurse Practitioners, Osteopaths, OB/GYN, and Pediatricians.

Pediatric Sub-specialist Providers:

Pediatric sub-specialists are defined as those physicians who a) in his/her practice have at least 85% of their patients who are children 18 years or younger; b) practice in the field of Adolescent Medicine, Cardiology, Cardiothoracic Surgery, Child Abuse Pediatrics, Critical Care, Emergency Medicine, Endocrinology, Gastroenterology/Nutrition, Genetics, Hematology/Oncology, Infectious Disease, Nephrology, Neurology, Neurological Surgery, Ophthalmology, Orthopedic Surgery, Otolaryngology, Psychiatry, Pulmonology, Rheumatology, Surgery, Urology and such other pediatric sub-specialty areas as may be determined by the Department of Health and Human Services.

Ambulatory Care Examinations:

Effective October 1, 1991, Ambulatory Care Examinations are limited to twelve (12) visits per State fiscal year (July - June) per recipient. All ambulatory care examinations prior to October 1, 1991, will not count toward the twelve (12) visit limitation. Recipients under the age of 21 years are

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EFFECTIVE DATE: 01/01/15
RO APPROVAL: 06/15/15
SUPERSEDES: MA 05-004

exempt from the twelve (12) visit limitation. Ambulatory care exams include all physician office examinations for general medical diagnoses and specialty care. Included in the ambulatory care restrictions are rural health clinic encounters and initial psychiatric visits. Surgery, therapy, family planning, diagnostic tests, monitoring, and maintenance management are not included in the twelve (12) visits limitation. The South Carolina Department of Health and Human Services may approve additional ambulatory care visits when medically necessary. Limitation will be based on medical necessity. To receive coverage over the 12-visit limit, providers must submit a letter directly to SCDHHS requesting additional visits. The letter must be on office letterhead and include the provider's National Provider Identifier (NPI) number, the patient's name and Medicaid ID number, the medical reason for the request and the physician's signature.

Hospital Services rendered by a physician are not restricted but are subject to the pre-admission review process, medical necessity criteria and the limitations included in the hospital section of the plan.

All services listed in the Current Procedural Terminology Text (CPT), and the HCPCS Supplemental Coding Manual are allowed services unless restricted in the Medicaid Physician, Clinical and Ancillary Services Manual. These services include, but are not limited to, general medical care, diagnostic services, therapeutic services, reconstructive and medically necessary surgeries, maternal care, family planning, rehabilitative and palliative services, lab, x-ray, injectable drugs, and dispensable and supplies not restricted in other areas of the plan or the Medicaid provider manuals.

Speech, physical, and occupational therapy coverage for beneficiaries over the age of 21 is limited to the provision of services when one of the following requirements are met: (1) the attending physician prescribes therapy in the plan of treatment during an inpatient hospital stay and therapy continues on an outpatient basis until that plan of treatment is concluded; (2) the attending physician prescribes therapy as a direct result of outpatient surgery; or (3) the attending physician prescribes therapy to avoid an inpatient hospital admission.

For EPSDT eligible beneficiaries under the age of 21 speech and hearing services are covered based on medical necessity and must be prior authorized by South Carolina Department of Health and Environmental Control (SCDHEC), The Department of Disabilities and Special Needs or a school district. For physical, and occupational therapy, services are available through rehabilitation centers certified by SCDHEC, and through individual practitioners who are licensed by either the South Carolina Board of Physical Therapy Examiners or the South Carolina Board of Occupational Therapy and enrolled in the South Carolina Medicaid program. All Physician services that an optometrist is legally authorized to perform are included in physicians' services under this plan and are reimbursed whether furnished by a physician or an optometrist.

Vision care services are defined as those that are medically necessary for the diagnosis and treatment of conditions of the visual system and the provision of lenses and/or frames as applicable. Routine eye examination with refraction is covered for EPSDT eligible children under the age of 21. This benefit is limited to one every 365 days, if medically necessary. Any other medically necessary vision care services are covered during the 365 day period for adults and EPSDT eligible beneficiaries under the age of 21. One pair of eyeglasses is available during a 365 day period to beneficiaries eligible under the EPSDT program. Additional lenses can be approved if the prescription changes at least one-half diopter (0.50) during the 365-day period.

SC 15-001
EFFECTIVE DATE: 01/01/15
RO APPROVAL:06/15/15
SUPERSEDES: SC 12-019

The following services are excluded from coverage:

- Optometric hypnosis
- Broken appointments
- Special reports
- Progressive and transitional lenses
- Lenses and/or frames that are not included in the Medicaid sample kit
- Extended wear contact lenses
- Oversized lenses or frames, unless medically justified
- Tinted lenses and coatings, unless medically justified, as in the case of albinism or post-cataract patients
- Trifocals
- Executive bifocals, unless medically justified
- Bifocal segment widths in excess of 25 mm unless medically justified

Detail clinical policy is published in the Physician, Laboratories, and Other Medical Professional manual on the South Carolina Department of Health and Human Services website at www.scdhhs.gov.

The South Carolina Department of Health and Human Services may approve additional ambulatory care visits when medically necessary. Limitations will be based on medical necessity.

Preventive Care:

Newborn Care is limited to routine newborn care and follow-up in the hospital. All other well baby services are limited to the provisions defined in the EPSDT section of the plan.

Immunizations for recipients over the age of 21 are limited to influenza, pneumonia, meningitis and hepatitis vaccinations for at risk patients as described in the Physician, Clinical and Ancillary Services Manual.

- 6a. PODIATRIST. Effective February 1, 2011 podiatry services will only be covered for recipients under 21 years of age when medical necessity has been established. Podiatry services must conform to the guidelines and limitations as specified under Muscoluskeletal System/Podiatry Services Section of the Professional Services Manual. Podiatry providers are licensed practitioners and provide services within the scope of practice as defined under State law and in accordance with the requirements of CFR 440.60 (a)
- 6b. OPTOMETRIST. Vision Care services are those which are reasonable and necessary for the diagnosis and treatment of conditions of the visual system and the provision of lenses and/or frames as applicable. Optometry providers are licensed practitioners and provide services within the scope of practice as defined under State law and in accordance with the requirements of CFR 440.60 (a)

Covered Services:

B. Services for EPSDT recipients are as follows:

1. Routine eye examinations with refraction is limited to one every 365 days, when medically necessary.
1. Glasses, if prior approved by the State Health and Human Services Finance Commission.
3. One original and one replacement or repair of the original pair of glasses per fiscal year, if prior approved by the South Carolina State Department of Health and Human Services.

Non-Covered Services:

1. Visual Therapy or training.
2. Tinted lenses.
3. Training lenses.
4. Lenses covered as a separate service (except replacements).
5. Protective lenses.
6. Oversize lenses.
7. Lenses for unaided VA less than 20/30 + or -.50 sphere.
8. Plastic lenses for prescription less than + or -4 diopters.
9. No allowable benefits for optometric hypnosis, broken appointments, or charges for special reports.

- 6c. CHIROPRACTORS: Chiropractic services are those which are limited to manual manipulation of the spine for the purpose of correcting subluxation demonstrated on x-ray. For the purpose of this program, subluxation means an incomplete dislocation, off-centering, misalignment, fixation or abnormal spacing of the vertebrae anatomically that is demonstrable on a radiographic film (x-ray).

SC 10-015
EFFECTIVE DATE: 02/01/11
RO APPROVAL: 05/25/11
SUPERSEDES: SC 06-014

Chiropractic services must conform to policies, guidelines and limitations as specified in the Chiropractic Services Manual. Chiropractic providers are licensed practitioners and provide services within the scope of practice as defined under State law and in accordance with the requirements of CFR 440.60(a)

6.d Other Medical Care or Remedial Care Provided by Other Practitioners

Certified Registered Nurse Anesthetist/AA - Certified Registered Nurse Anesthetist/AA are authorized to perform anesthesia services only. The scope of their practice is limited to that which is allowed under State Law. A copy of their certification must be on file at the practice site.

Nurse Practitioner - Nurse Practitioners are authorized to perform certain services pertaining to their specific approved written protocols. The scope of their practice is limited to that which is allowed under State Law and as documented in written protocol between the nurse practitioners and their physician preceptors. The written protocol must be submitted to SHHSFC prior to enrollment.

Psychologists - Psychological services are covered when prescribed by an EPSDT screen and prior authorization process. Services covered include psychological testing, evaluation and therapy. Reimbursements to practitioners are restricted to psychologists that hold doctoral level diploma, and have a valid state license as a Clinical, psychologist approved by the State Board of Examiners in Psychology.

Licensed Midwife - Medicaid coverage includes all obstetrical services, newborn care and medical services that are published in the South Carolina Medicaid Physician and Clinical Services Manual, with appropriate revisions and updates. All services must be medically justified and rendered in accordance with the standards of care and services prescribed by the appropriate licensing and regulation agency(ies) under the laws of the State of South Carolina.

SSC 11-020
EFFECTIVE DATE: 10/01/11
RO APPROVAL: 07/09/14
SUPERSEDES: SC 08-024

Registered Dietitian - Registered dietitians are authorized to provide medical nutrition therapy services. The duties and responsibilities include nutritional diagnostic, therapy, and counseling services provided for the purpose of managing obesity and other diseases. Covered services will consist of nutrition assessment, interventions, reassessment, and follow-up interventions when it is prescribed/referred by a physician. The scope of practice is limited to that which is allowed under State Law.

7. HOME HEALTH CARE SERVICES - Home health services are provided by a licensed and certified home health agency to eligible beneficiaries who are affected by illness or disability.

SC 13-008
EFFECTIVE DATE: 04/01/13
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SUPERSEDES: SC 11-011

The services are based on physician orders that are reviewed every sixty (60) days. The home health agency must be certified to participate under Title XVIII (Medicare), meet the conditions governing participation as certified by the South Carolina Department of Health and Environmental Control, and have an approved Certificate of Need (CON). The home health agency must also be in compliance with all federal, state, and local laws.

Home health services provided are consistent with 42 CFR 440.70 and include the following mandatory services: skilled nursing services on an intermittent basis, home health aide services and medical supplies, equipment and appliances suitable for use in the home. Optional home health services that may be provided include: physical therapy, speech therapy and occupational therapy.

Covered services must be ordered by the beneficiary's physician as part of a written plan of care consistent with the functions the practitioner is legally authorized to perform. The practitioner must review and sign this plan of care at least every sixty (60) days as stated in 42 CFR 440.70 (a)(2). The practitioner ordering home health services or reviewing the plan of care may not have a significant ownership interest in or a significant financial or contractual relationship with the home health agency.

COVERED SERVICES INCLUDE:

- **NURSING SERVICES:** Nursing services provide direct patient care including, but not limited to, assessment, teaching, injections, changing dressings, catheter care, and skilled monitoring of symptoms. As stated in 42 CFR 440.70, nursing services must be provided on a part-time or intermittent basis by a registered nurse. The nurse must be currently licensed by South Carolina and trained in administrative and clinical record keeping.
- **HOME HEALTH AIDE SERVICES:** Home health aide services are of a personal care nature, are medically oriented, are provided in the home, and include assistance in activities of daily living and retaining self-help skills. These services must be prescribed by a physician in accordance with a plan of care and supervised by a registered nurse. As stated in 42 CFR 484.4, all home health aides must have completed a training and competency evaluation program.
- **MEDICAL SUPPLIES, EQUIPMENT AND APPLIANCES:** As stated in 42 CFR 440.70 (b)(3), medical supplies, equipment, and appliances must be suitable for use in the home. A recipient's need for medical supplies, equipment, and appliances must be reviewed by a physician annually. The frequency of further physician review of a recipient's continuing need for the items is determined on case-by-case basis, based on the nature of the item prescribed.
- **PHYSICAL THERAPY, OCCUPATIONAL THERAPY, and SPEECH THERAPY:** Physical therapy, occupational therapy, or speech pathology services are provided by a home health agency or by a facility licensed by the State of South Carolina to provide medical rehabilitation services. Therapists providing these services meet the provider qualifications at 42 CFR 440.110.

SC 10-015
EFFECTIVE DATE: 02/01/11
RO APPROVAL: 05/25/11
SUPERSEDES: New page

When home health services are provided, the service a patient receives is counted in visits. A visit is a face-to-face encounter between a patient and any qualified home health professional whose services are reimbursed under the Medicaid program and ordered by a physician as part of a written plan of care every sixty (60) days.

Home health agency visits are limited to a total of fifty (50) per recipient per state fiscal year for all mandatory and optional home health services for beneficiaries over the age of 21 and does not apply to children. For situations where it is medically necessary for a beneficiary to exceed the fifty (50) visit limitation, a request for additional visits accompanied by supporting medical documentation which would document the necessity for the additional home health visits will be reviewed by the South Carolina Department of Health and Human Services medical reviewer for approval. In accordance with EPSDT requirements any therapy service that is provided beyond the limits would require prior approval if determined medically necessary.

9. CLINIC SERVICES:

Clinic services are limited to outpatient ambulatory centers that provide medical services which include all primary, preventive, therapeutic, palliative items, and rehabilitative services. All services must be provided by a facility that is not part of a hospital, but is organized and operated to provide medical care to outpatients. All services must be furnished by or under the direction of a physician. Covered Clinic services include:

- a. AMBULATORY SURGICAL CENTERS: Medical coverage is limited to medically necessary services provided by certified and licensed ambulatory surgical centers that meet the conditions for Medicare coverage as established in 42 CFR, Part 416, Subpart B, (Conditions for coverage), and as evidenced by an agreement with HCFA.

The surgical procedures covered are limited to those described under 42 CFR Part 416, Subpart B, (Scope of Benefits), and those procedures published in the South Carolina Medicaid Physician and Clinical Services Manual, with appropriate revisions and updates.

- b. END STAGE RENAL DISEASE CLINICS: Medicaid coverage includes all medically necessary treatments and services for in-center or home dialysis as described in the South Carolina Medicaid Physician and Clinical Services Manual.

SC 11-018
EFFECTIVE DATE: 10/01/11
RO APPROVAL: 05/23/14
SUPERSEDES: SC 10-015

9. Clinic Services Cont.

Medicaid coverage is limited to services provided by licensed ESRD clinics meeting the Medicare requirements outlined in 42 CFR Part 250 and participating in Medicare as evidenced by a Medicare agreement.

- a. MENTAL HEALTH CLINICS: Medicaid coverage is limited to outpatient Mental Health Clinics meeting the standards as determined by the South Carolina Department of Mental Health and services as outlined in the South Carolina Mental Health and Quality Assurance Manuals.
- b. COUNTY HEALTH DEPARTMENT: Medicaid coverage includes all primary, preventive, therapeutic and rehabilitative services that are medically justified and rendered under the supervision of a physician, and a written physician protocol as described in the Physician and Clinical Services Manual and through contract with the Single State Agency.

These services include all primary diagnostic and treatment services, maternal and child health care, and family planning services as described in the Physician and Clinical Services Manual and elsewhere in the State Plan.

Coverage is limited to health clinics licensed by, or contracted with, or under the auspices of the South Carolina Department of Health and Environmental Control.

10. DENTAL SERVICES

Dental services for recipients under 21 include any medically necessary dental services.

Dental services for recipients age 21 and over are limited to the following medically necessary services:

- Extractions and necessary treatment for repair of traumatic injury;
- Dental services delivered in preparation for, or during the course of treatment for organ transplants, radiation of the head or neck for cancer treatment, chemotherapy for cancer treatment, total joint replacement or heart valve replacement.
- Diagnostic services, extractions, fillings and annual cleanings, up to a maximum benefit of \$750 per State fiscal year (July through June).
- Sedation services are available to the following groups of recipients and are excluded from the maximum annual benefit limitation.
 - o Sedation services for oral surgery are available to all adults when determined by the oral surgeon to be medically necessary.
 - o Sedation services for recipients with special needs diagnoses are available when medically necessary.

11.a PHYSICAL THERAPY

Physical Therapy Services:

Other physical therapy services not related to EPSDT must be provided in accordance with SCDHHS hospital, physician, and home health manuals.

11.a PHYSICAL THERAPY Cont.

In accordance with 42 CFR 440.110(a), physical therapy means services prescribed by a Physician or other Licensed Practitioner of the Healing Arts (LPHA) within the scope of his or her practice under state law and provided to a beneficiary by or under the direction of a qualified Physical Therapist. It includes any necessary supplies and equipment.

Providers of Physical Therapy Services include:

- **Physical Therapist (PT).** In accordance with 42 CFR 440.110 (a) (2), a "qualified physical therapist" is an individual who meets personnel qualifications for a physical therapist at 484.4.
- **Physical Therapist Assistant (PTA)** is an individual who is currently licensed by the South Carolina Board of Physical Therapy Examiners. A physical therapy assistant provides services under the direction of a qualified physical therapist.

11.b OCCUPATIONAL THERAPY

Occupational Therapy Services:

Other occupational therapy services not related to EPSDT must be provided in accordance with SCDHHS hospital, physician, and home health manuals.

In accordance with 42 CFR 440.110(b) (1), Occupational Therapy means services prescribed by a Physician or other Licensed Practitioner of the Healing Arts within the scope of his or her practice under state law and provided to a beneficiary by or under the direction of a qualified Occupational Therapist. Occupational Therapy Services are related to Self-Help Skills, Adaptive Behavior, Fine/Gross Motor, Visual, Sensory Motor, Postural, and Emotional Development that have been limited by a physical injury, illness, or other dysfunctional condition. Occupational Therapy involves the use of purposeful activity interventions and adaptations to enhance functional performance.

Providers of Occupational Therapy include:

- **Occupational Therapist (OT).** In accordance with 42 CFR 440.110 (b) (2) (i) (ii) A qualified occupational therapist is an individual who is - (i) Certified by the National Board of Certification for Occupational Therapy; or (ii) A graduate of a program in occupational therapy approved by the Committee on Allied Health Education and

SC 14-003
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SUPERSEDES: 10-011

11.b OCCUPATIONAL THERAPY Cont.

Accreditation of the American Medical Association and engaged in the supplemental clinical experience required before certification by the National Board of Certification for Occupational Therapy.

- **Occupational Therapy Assistant (OTA)** is an individual who is currently licensed as a Certified Occupational Therapy Assistant (COTA/L or OTA) by the South Carolina Board of Occupational Therapy who works under the direction of a qualified occupational therapist pursuant to 42 CFR 440.110(b) (2) (i) or (ii).

11.c Speech-Language Pathology Services

Speech-Language Pathology Services: Other Speech-Language Pathology Services not related to EPSDT must be provided in accordance with SCDHHS hospital, physician and home health manuals. In accordance with 42 CFR 440.110(c) (1), Speech-Language Pathology Services include diagnostic, screening, preventive, or corrective services provided by or under the direction of a Speech-Language Pathologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. It includes any necessary supplies and equipment.

Providers of Speech-Language Pathology Services include:

- **Speech-Language Pathologist** in accordance with 42 CFR 440.110 (c) (2) (i) (ii) (iii) is an individual who meets one of the following conditions: (i) Has a Certificate of Clinical Competence from the American Speech and Hearing Association. (ii) Has completed the equivalent educational requirements and work experience necessary for the certificate. (iii) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.
- **Speech-Language Pathology Assistant** is an individual who is currently licensed by the South Carolina Board of Examiners in Speech-Language Pathology. The Speech-Language Pathology Assistant works under the direction of a qualified Speech-Language Pathologist pursuant to 42 CFR 440.110(c) (2) (i) and (ii).

Audiological Services: Other Audiological Services not related to EPSDT must be provided in accordance with SCDHHS home health manuals. In accordance with 42 CFR 440.110(c) (1), Audiological Services for individuals with hearing disorders means diagnostic, screening, preventive, or corrective services provided by or under the direction of an audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law. It includes any necessary supplies and equipment.

Providers of Audiology services include:

Audiologist: All Medicaid-qualified audiology providers (Licensed Audiologists) operating in the State of South Carolina adhere to the provider qualifications found in 42 CFR 440.110(c) (3)

SC 10-011
EFFECTIVE DATE: 11/01/10
RO APPROVAL: 02/07/11
SUPERSEDES: SC: 08-001

12.a PHARMACY SERVICES. Under the vendor drug program is included the dispensing of certain legend drugs and certain non-legend drugs to eligible recipients. Drugs for which Medical Assistance reimbursement is available are limited to the following:

Covered outpatient drugs of any manufacturer which has entered into and complies with an agreement under Section 1927(a) of the Act which are prescribed for a medically accepted indication.

Only pharmaceuticals which meet Food and Drug Administration requirements and are approved for marketing may be supplied. The patient must have a valid prescription from his physician, dentist, or podiatrist.

Recipients aged 21 and older, are limited to four (4) prescriptions/refills per month. Prescription/refill quantities for all Medicaid eligibles, regardless of age, are limited to a maximum thirty-one (31) day supply. (Certain medications may be exempted from the four (4) prescription limit.) Recipients aged birth through the month of their 21st birthday receive unlimited prescriptions/refills per month.

There is no restriction on the number of prescriptions a Long Term Care (LTC) resident is able to receive.

Based on the requirements of section 4401 of the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), state plan amendment is revised to add the following issues concerning the Drug Rebate Agreements:

- Effective January 1, 1991 Medicaid will cover only drugs of participating manufacturers except 1-A drugs, where state process for approval must be described. (Because of extenuating circumstance waiver, states may cover non-participating manufacturers' drugs for claims with date of service through March 31, 1991.)
- A formulary or other restrictions must permit coverage of participating manufacturers' drugs.
- The state will comply with the reporting requirements for state utilization information and on restrictions to coverage.
- If state has "existing" agreements, these will operate in conformance with law, and for new agreements, require HCFA approval. State must also agree to report rebates from separate agreements.
- A state must allow manufacturers to audit utilization data.
- The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verifications.

SC: 08-022
EFFECTIVE DATE: 10/01/08
RO APPROVAL: 09/16/08
SUPERSEDES: MA 05-006

- Prior authorization programs must provide for a 24 hour turnaround on prior authorization from receipt of request and at least 72 hour supply in emergency situations as in accordance with the provisions of section 1927(d) (5) of the Social Security Act.
- States must cover new drugs of participating manufacturers (except excludable/restrictable drugs) for 6 months after FDA approval and upon notification by the manufacturer of a new drug. The state may put the drug through its formulary but it cannot prior authorize the new drug and, consistent with the second item above, it must cover drug (again with the exception of excludable/restrictable drugs). The state plan must list the classes chosen for exclusion/restriction or if less than the full class, list the drugs within the class chosen for exclusion/restriction.
- The state may not reduce its limits on covered outpatient drugs or dispensing fees effective January 1, 1991, unless it was out of compliance with Federal requirements on November 5, 1990.
- State plan must have been submitted by March 31, 1991, to be effective January 1, 1991. However, because CMS invoked the extenuating circumstances clause in the law, drugs were payable in the first quarter without losing FFP, even if the plan was not submitted by March 31, 1991.

The state is in compliance with Section 1927 of the Social Security Act. Based on the requirements in Section 1927 of the Act, the state has the following policies for the supplemental rebate program for the Medicaid population:

- (A) CMS has authorized the State of South Carolina to enter into the Michigan multi-state pooling agreement (MMSPA) also referred to as the National Medicaid Pooling Initiative (NMPI). The Amendment to the Supplemental Drug Rebate Agreement was submitted to the Center for Medicare and Medicaid Services (CMS) on October 1, 2013 and approved for existing agreements with the pharmaceutical manufacturers.
- CMS authorized the Supplemental Drug-Rebate Agreement submitted to CMS on January 12, 2007 for renewal and new agreements with pharmaceutical manufacturers.
- (B) Supplemental rebates received by the State in excess of those required under the national drug rebate agreement will be shared with the Federal government on the same percentage basis as applied under the national rebate agreement.
- (C) All drugs covered by the program, irrespective of a prior authorization requirement, will comply with provisions of the national drug rebate agreement.
- (D) Any contracts or agreements with pharmaceutical manufacturers not approved by CMS will be submitted for CMS approval.

SC 13-009
EFFECTIVE DATE: 10/01/13
RO APPROVAL DATE: 03/14/14
SUPERSEDES: SC 06-011

GENERAL EXCLUSIONS: As provided by Section 1927(d) of the Social Security Act, certain outpatient drugs may be excluded from coverage. Those excluded are:

- A. Medications used for weight control (except lipase inhibitors).
- B. Pharmaceuticals deemed less than effective by the Drug Efficacy Study Implementation (DESI) Program.
- C. Over-the-counter (OTC) pharmaceuticals that are not in the Medicaid drug rebate program and those products that are otherwise excluded from Medicaid coverage in this section.
- D. Topical forms of minoxidil when used for hair loss.
- E. Agents when used to promote fertility. (Effective March 1, 1991)

As provided by Section 1927(k) (2) of the Social Security Act, certain other exclusions are:

- F. Investigational/experimental pharmaceuticals or products without FDA approval under the Federal Food, Drug, and Cosmetic Act.

As provided by Section 1927(k) (3) of the Social Security Act, certain other exclusions are:

- G. Injectable table pharmaceuticals administered by the physician in his office, in a clinic or in a mental health center.

Drug Prior Authorizations can be requested by the prescribing physician or pharmacist with needed documentation for items excluded from coverage and those drugs requiring special authorization as outlined in the Pharmaceutical Services Medicaid Manual, except those drugs ruled ineffective (DESI) by the Federal Government.

- 12c. PROSTHETIC OR ORTHOTIC APPLIANCES. Approval from the State Office is required prior to the provision of the prosthetic or orthotic appliance. Supplies, equipment, and appliance limitations are specified in the Durable Medical Equipment Provider Manual, and follow Medicare limitations.
- 12d. EYEGLASSES Coverage for eyeglasses will be limited to recipients under 21 years of age when medical necessity has been established. One pair of eyeglasses is available during a 365 day period to beneficiaries eligible under the EPSDT program. Additional lenses can be approved if the prescription changes at least one half diopter (0.50) during the 365 day period.
- 13c. Preventive Services are defined as routine services for adults or children when the procedures are performed in the absence of an illness or complaint(s). Preventative services are subject to certain limitations depending on age, risk factors, and frequency. These best practice recommendations are subject to change as regulations and future clarifications are released by the USPSTF.

SC: 14-017
EFFECTIVE DATE: 09/01/14
RO APPROVAL: 12/02/14
SUPERSEDES: SC 11-020

	Description
Abdominal aortic aneurysm screening: men	The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked.
Alcohol misuse: screening and counseling	The USPSTF recommends that clinicians screen adults age 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.
Blood pressure screening in adults	The USPSTF recommends screening for high blood pressure in adults age 18 years and older.
Breast cancer screening	The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older.
Cervical cancer screening	The USPSTF recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.
Cholesterol abnormalities screening: men 35 and older	The USPSTF strongly recommends screening men age 35 years and older for lipid disorders.
Cholesterol abnormalities screening: men younger than 35	The USPSTF recommends screening men ages 20 to 35 years for lipid disorders if they are at increased risk for coronary heart disease.
Cholesterol abnormalities screening: women 45 and older	The USPSTF strongly recommends screening women age 45 years and older for lipid disorders if they are at increased risk for coronary heart disease.
Colorectal cancer screening	The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.
Depression screening: adolescents	The USPSTF recommends screening adolescents (ages 12-18 years) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.
Depression screening: adults	The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.
Diabetes screening	The USPSTF recommends screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.
Hepatitis C virus infection screening: adults	The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.

SC: 14-017
 EFFECTIVE DATE: 09/01/14
 RO APPROVAL: 12/02/14
 SUPERSEDES: SC 11-020

HIV screening: nonpregnant adolescents and adults	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.
HIV screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.
Intimate partner violence screening: women of childbearing age	The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.
Lung cancer screening	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.
Skin cancer behavioral counseling	The USPSTF recommends counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
Tobacco use counseling and interventions: nonpregnant adults	The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products.
Tobacco use counseling: pregnant women	The USPSTF recommends that clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling to those who smoke.
Tobacco use interventions: children and adolescents	The USPSTF recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.

13c. PREVENTIVE SERVICE FOR PRIMARY CARE ENHANCEMENT

A. Definition of Service - Preventive Services for Primary Care Enhancement (PSPCE) are services, including assessment and evaluation, furnished by physicians or other licensed practitioners of the healing arts acting within the scope of practice under State law which are furnished in order to:

- Prevent disease, disability, and other health conditions or their progression;
- Prolong life; and
- Promote physical and mental health and efficiency.

SC: 14-017
 EFFECTIVE DATE: 09//01/14
 RO APPROVAL: 12/02/14
 SUPERSEDES: New Page

Covered PSPCE must either be: (1) required for the development and implementation of a comprehensive medical plan of care by a physician and other appropriate practitioners, or; (2) medically necessary preventive services identified in the comprehensive PSPCE medical plan which are not otherwise covered under the State plan.

B. PSPCE Plan of Care Requirement - The PSPCE medical plan of care must be designed to enhance the individual's practice of healthy behaviors, prevent deterioration of chronic conditions, and promote the full and appropriate use of primary medical care. A PSPCE medical plan of care must be developed with the following components:

- assessment/evaluation of health status, individual's needs, knowledge level;
- identification of relevant risk factors or needs which justify the medical necessity for PSPCE;
- development of a goal-oriented plan of care (in conjunction with the physician and individual) that addresses risk factors and needs identified in the assessment/evaluation, and which specifies the service(s) necessary to reduce/ameliorate the risk factor(s);
- anticipatory guidance/counseling to limit the development/progression of a disease/condition and to achieve the goals in the medical plan of care.

C. Medical Necessity Criteria for PSPCE Preventive Services - The PSPCE medical plan of care must include findings that preventive services covered as PSPCE are medically necessary due to:

- high risk for developing a disease or experiencing a negative health outcome; or
- mental/physical impairments which result in risk of poor adherence to a plan of care or need for reinforcement to enhance likelihood of full and appropriate use of primary care; or
- need for effective management of a recently diagnosed disease, when such management could prevent further progression of the disease.

D. Special Conditions - In order to be covered as PSPCE, preventive services must: (1) be included in the PSPCE medical plan of care; (2) involve direct, one-on-one individual contact; and (3) be medically-oriented. Group sessions that allow direct one-on-one interaction between the counselor and the individual may also be used to provide some components of this service.

E. Qualification of Providers - Providers of PSPCE are physicians or other practitioners of the healing arts licensed by the State and acting within the scope of their practice under State law (e.g., nurse practitioners, registered dietitians, registered nurses, licensed master social workers, licensed baccalaureate social workers, licensed practical nurses).

SC: MA 96-006
EFFECTIVE DATE: 4/01/96
RO APPROVAL: 2/24/98
SUPERSEDES: MA 90-40

Preventive Services - Disease Management

The State of South Carolina will provide a statewide Disease Management Program to all Medicaid beneficiaries eligible for Title XIX Medicaid coverage under the Categorically Needy Program (CNP) and who receive services through the South Carolina Medicaid fee-for-service (FFS) system.

All FFS beneficiaries will receive basic disease management interventions designed to improve their health status, such as information and educational materials regarding wellness and preventive health measures. FFS beneficiaries who have Asthma, Diabetes or Hypertension will also receive additional interventions specific to their disease. One example of a disease-specific intervention is education regarding self-management of the beneficiary's asthma, diabetes or hypertension.

The State's Disease Management Program is designed to assist beneficiaries with chronic illness achieve the following goals:

1. Increase the beneficiary's (and/or their caregiver's) understanding of their disease so they are:
 - More effective partners in the care of their disease;
 - Better able to understand the appropriate use of resources needed to care for their disease(s);
 - Able to identify when their health is getting worse earlier and seek appropriate attention before they reach crisis levels; and
 - More compliant with medical recommendations.
2. Improve beneficiaries' quality of life by assisting them in "self-management" of their disease and in accessing regular preventive health care;
3. Provide coordination among multiple case managers and health care providers;
4. Improve adherence to national, evidence-based guidelines to improve beneficiaries' health status; and
5. Reduce unnecessary emergency department visits, hospitalizations and hospital lengths of stay.

Individuals Eligible for Services

Target Group: The target group of Medicaid beneficiaries to receive Disease Management services are beneficiaries who:

- Receive medical services through fee-for-service coverage; and
- Are not already receiving care coordination services as residents of an institution, participants in a Medicaid waiver program, enrollees in a hospice program or through an agency developed or other medical home model (e.g., managed care organization).

SC: MA 04-002
EFFECTIVE DATE: 4/01/04
RO APPROVAL: 6/10/04
SUPERSEDES: N/A

Components of Disease Management

All beneficiaries eligible to participate in the Disease Management Program will receive comparable services, based on their level of disease and co-morbid conditions. All beneficiaries will be assessed for their risk level and will receive follow-up education and disease management services appropriate for their risk level.

Disease Management Organizations (DMOs) will provide the services described below to beneficiaries eligible for the program. All FFS beneficiaries will receive the basic disease management interventions described in the first bullet. In addition to receiving the services described in the first bullet, FFS beneficiaries with Asthma, Diabetes and Hypertension will also receive the disease-specific interventions described in the second bullet.

- When necessary, assist in accessing appropriate primary and preventive medical care; care-coordination; referrals for specialty, social and ancillary services; and promotion of self-management. These activities will take place through use of a nurse consultation telephone line in which licensed registered nurses may initiate monitoring and follow-up calls to beneficiaries in the program, as well as to provide twenty-four (24) hour seven (7) days per week access to licensed registered nurse consultation for beneficiary calls about their treatment plan and self-management and management of medical crises. This nurse line will also operate as a means for identifying beneficiaries eligible for the disease management program and those who lack a primary medical home. Additionally field visits by a licensed registered nurse will be made to beneficiaries when appropriate.
- Initial health assessment by a licensed registered nurse and periodic follow-up of the ongoing health status of enrolled beneficiaries. The assessment process includes the development and implementation of an individual plan of care that addresses the beneficiaries' multiple health, behavioral and social needs, and that ensures continuity, quality and effectiveness of care in conjunction with the individual's health care provider (physician, physician's assistant, advanced practice registered nurses). In addition, the licensed registered nurse will: provide the beneficiary with health information related to patient self management skills, patient self-administration of medications, and crisis health care management; evaluate a beneficiary's health condition and make short-term medical recommendations subject to a provider's final approval; and assist the provider with implementation of the provider's care plan for the patient.

SC: MA 04-002
EFFECTIVE DATE: 4/01/04
RO APPROVAL: 6/10/0
SUPERSEDES: N/A

Choice of Providers

The state assures that there will be no restrictions on a beneficiary's freedom of choice of providers in violation of Section 1902(a)(23) of the Act. Eligible beneficiaries have free choice to receive or not receive disease management services through any DMO that meets the stated criteria below and may change case managers within their DMO at any time. Eligible beneficiaries also have free choice of the providers of other medical care under the Medicaid program.

Criteria for the Disease Management Organization (DMO)

- a. All Disease Management case managers shall be licensed registered nurses and/or licensed social workers who meet the requirements of the contracted DMO.
- b. DMOs that contract with the South Carolina Department of Health and Human Services to provide disease management services must meet the following conditions:
 1. Has a minimum of three years' experience providing disease management services;
 2. Has an evidenced-based healthcare practice guideline for each specific disease state being managed;
 3. Has an established collaborative healthcare practice model to include the State's current providers, community-based partners including, but not limited to, faith based organizations, school nursing programs and other support-service providers.
 4. Has patient self-care management educational materials and methods appropriate to each targeted disease population;
 5. Has internal quality assurance/improvement, outcomes measurement, evaluation and management systems;
 6. Provides access to a call center 24-hours-a-day, seven-days-per-week with licensed medical personnel who have training and/or are credentialed in the disease specific areas. All staff must be trained in at least the areas of establishing rapport, cultural sensitivity, and stages of change. The helpline must also be equipped with appropriate technology to accept calls from all members, ensuring program responsiveness and access to all services for people with limited English proficiency;
 7. Has the ability to guarantee program savings;
 8. Meets applicable federal and state laws and regulations governing the participation of providers and beneficiaries in the Medicaid program.

SC: MA 04-002
EFFECTIVE DATE: 4/01/04
RO APPROVAL: 6/10/04
SUPERSEDES: N/A

Comparability of Services

All beneficiaries eligible to participate in the Disease Management Program will receive comparable services, based on their level of disease and co-morbid conditions. All beneficiaries will be assessed for their risk level and will receive follow-up education and disease management services appropriate for their risk level.

Enrollment/Disenrollment Process

This Disease Management Program is a voluntary program. While all eligible beneficiaries will be automatically enrolled in the Disease Management Program, any beneficiary may disenroll through the following methods:

- a. Beneficiaries may request disenrollment by calling their DMO. This process is referred to as "opting out" of the Disease Management Program.
- b. DMOs may recommend disenrollment to the SCDHHS through an approved process.
- c. SCDHHS may disenroll if:
 - A beneficiary's eligibility ends;
 - A beneficiary enrolls in a home and community-based waiver or hospice; or
 - A beneficiary joins an agency-developed or other medical home model, such as a managed care organization.

Beneficiaries may also re-enroll in or "opt-in" the Disease Management Program by calling their DMO.

**SC: MA 04-002
EFFECTIVE DATE: 4/01/04
RO APPROVAL: 6/10/04
SUPERSEDES: N/A**

13.c. Preventive Services - Diabetes Management

- A. Definition of Service - Diabetes Management Services provide medically necessary, comprehensive diabetes management and counseling services to diabetics of any age who the primary care provider determines will benefit from management services. The program is intended to improve and/or maintain the health of beneficiaries by providing counseling, education and instructions to beneficiaries in the successful health self-management of diabetes. After a medical assessment and referral by their primary care provider, beneficiaries receive services that help them adhere to their medical plan of care. Individual and/or group interventions encourage patient education related to his/her diabetes (e.g., nutrition, wound care, foot care) and behavior modification to encourage lifestyle changes that will improve health and reduce the severity of diabetes. Feedback to the primary care provider assists with medical monitoring of the beneficiary. The primary objective of Diabetes Management Services is to help the Medicaid-eligible beneficiary adapt to the chronic diagnosis of diabetes by learning self-management skills.
- B. Plan of Care Requirements - The Diabetes Management Plan of Care must be designed to enhance the beneficiary's ability to understand and manage his/her medical condition relative to diabetes and the possible complications resulting from that disease state. The plan of care must include the following:
- Assessment/evaluation of the beneficiary's health status, individual needs, and knowledge level of his/her disease.
 - Development of a goal-oriented plan of care (in conjunction with the physician and beneficiary) that addresses identified needs and specifies the services necessary and specifies on-going communication with the primary care provider; and
 - Guidance/counseling to limit the development/progression of the disease
- C. Medical Necessity Criteria for Diabetes Management Services - The plan of care must include findings that Diabetes Management Services are medically necessary to help the individual Medicaid-eligible beneficiary adapt to the chronic diagnosis of diabetes by learning self-management skills. The primary care provider must refer the beneficiary for services and the provider will maintain communication with the referring primary care provider.
- D. Special Conditions - In order to be covered services, they must be included in the plan of care and involve direct contact. Services may be rendered in either individual or group settings.

SC: 05-014
EFFECTIVE DATE: 01/01/06
RO APPROVAL: 09/29/06
SUPERSEDES: New page

E. Qualification of Providers - Providers of Diabetes Management must be practitioners of the healing arts licensed by the State acting within the scope of their practice under State law (e.g., physicians, pharmacists, nurse practitioners, registered dietitians, registered nurses, licensed master social workers, licensed baccalaureate social workers, licensed practical nurses). Providers must also meet the requirements established by South Carolina Department of Health and Human Services for enrollment and billing, which includes one of the following criteria:

- Provider adheres to National Standards for Diabetes Self-Management Education which requires programmatic management by a Certified Diabetes Educator (CDE), or
- Provider is an American Diabetes Association (ADA) recognized program, or
- Provider is recognized by the Indian Health Service (IHS)

F. Sickle Cell Disease Management (SCDM) is available to Medicaid eligible individuals determined to have a confirmed diagnosis of Sickle Cell Disease as defined by the Sickle Cell Disease Association of America and the Centers for Disease Control and Prevention (CDC). See the Sickle Cell Management Policies and Procedures (as amended) in the Medicaid manual for requirements. Covered services must either be: (1) required or recommended for the implementation of a comprehensive medical plan of care by a physician and other appropriate practitioners, or; (2) medically necessary services identified in the SCDM treatment plan, approved by a physician, and (3) services which are not otherwise covered or duplicated services under the State Plan.

A. SCDM Definition:

SCDM is a set of interventions designed to improve the health of beneficiaries with Sickle Cell Disease and avoid or reduce sickle cell disease related complications and crises. Program Services:

- identify needed interventions;
- enhance patient management of the disease and promote adherence to individualized treatment;
- provide evidence-based medical information and monitoring;
- include routine reporting and feedback with the beneficiary and primary care providers to promote continuity of care; and
- measure outcomes and provide information to update care, as needed

SCDM includes the following assistance: Providers of Sickle Cell Disease Management must be registered nurses, licensed social workers, and licensed practical nurses.

B. SCDM includes the following assistance:

1. Face-to-Face comprehensive assessments and periodic reassessments of individual needs, to determine the need for any medical, educational, psychosocial or other services. These assessment activities include:

SC: 14-006
EFFECTIVE DATE: 05/01/14
RO APPROVAL: 09/23/14
SUPERSEDES: SC 05-014

- a) taking client history;
- b) medical assessment to identify the beneficiary's needs; and,
- c) gathering information from medical providers and other caregivers.

Assessments shall be conducted at least every 180 days, but may occur more frequently when significant changes occur or new needs are identified.

- 2. Development (and periodic revision) of a specific individual treatment plan that is shared with the primary care provider and based on the information collected through the assessment that:
 - a) specifics the goals and actions to improve or maintain the health of the beneficiary;
 - b) identifies activities that are necessary to respond to the assessed needs of the eligible beneficiary;
 - c) includes patient education and instruction in health self-management needs; and,
 - d) lists the minimal individual medical monitoring schedule to support primary care giver treatments and instructions.
- 3. SCDM services are activities necessary to ensure the care plan is implemented and adequately address the beneficiary's needs. Medicaid will make payment for two (2) hours per day, 24 hours per state fiscal year for face-to-face Sickle Cell disease Patient Education visits. This limitation may be exceeded based on medical necessity, services that exceed the limit will be prior authorized by the Quality Improvement Organization contracted by the state. Services may be provided individually or in group settings. Services must meet the following conditions for beneficiaries in the program.
 - a) Face-to-Face visits:
 - o provide services in accordance with the beneficiary's care plan, including counseling, disease education, and self-management skills;
 - o monitor the beneficiary's compliancy with primary care provider treatments; and
 - o include observation and data collection of the beneficiary's health status to determine if adjustments may be needed to the care plan or if health care referrals are indicated.
 - Face-to-Face visits are made with the eligible beneficiary to ensure appropriateness of continued services; and at least one visit every 180 days in the beneficiary's natural environment to ensure appropriateness of services;
 - A Face-to-Face home visit will be conducted after a nurse receives a medical consultation telephone line call from a beneficiary in the program.

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EFFECTIVE DATE: 05/01/14
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SUPERSEDES: New Page

b) Patient Education:
Patient Education means face-to-face educational services provided to patients with Sickle Cell Disease. A provider is authorized to bill up to a maximum of two (2) hours per day, 24 hours per state fiscal year for Sickle Cell disease Patient Education. Services may be provided individually or in group settings. Focus of training must be age appropriate sickle cell disease management and include training on preventing infections, preventing crisis, etc. The frequency and type of service should be tailored to the beneficiary's needs.

4. Access to licensed medical staff trained and/or credentialed in Sickle Cell Disease management for SCDM medical consultation by telephone will be available to established patients 24 hours a day, seven days a week.
5. Periodic case plan progress reports must be sent to a primary care provider. SCDM providers should consult with the primary care provider as often as needed to ensure relevant services are provided.

C. SCDM Staff Qualifications

Providers of Sickle Cell Disease Management Services of assessments, service plan development and face-to-face visits must be registered nurses, licensed social workers, and/or licensed practical nurses. The RN must have at least one year experience working with individuals in a health/human service environment and must attend an evidence-based training related to sickle cell disease annually.

Services delegated to Licensed Practical Nurses (LPN) must be within the scope of practice of the LPN and must be under the direction of the supervising Registered Nurse. The registered Nurse will be responsible for all services rendered by the LPN. Licensed Social Workers acting within the scope of their practice under State Law may provide SCDM services.

The Registered Nurse and Licensed Social Worker providing SCDM must meet all provider enrollment requirements and provide services in accordance with the South Carolina State Plan's *Criteria for the Disease Management Organization (DMO)*. DMO criteria are located at page 6a.1 of the plan. The DMO will be responsible for ensuring that all SCDM providers receive appropriate and up-to-date evidence-based training related to sickle cell disease.

D. Beneficiary Requirements:

Services are available to non-institutionalized beneficiaries who have a confirmed laboratory diagnosis of sickle cell disease which include the sickle hemoglobinopathies (Hb SS, Hb SC, Hb S Beta- Thalassemia, Hb SD, Hb SE, and Hb SO) and are not simultaneously receiving Targeted Case Management or any other coordination/management service for Sickle Cell Disease. This Disease Management Program is a voluntary program. Beneficiaries may request disenrollment by calling their DMO. This process is referred to as "opting out" of the Disease Management Program.

SUPERSEDES: New Page

13d. REHABILITATIVE SERVICES.

Behavioral health services are available to all Medicaid beneficiaries who meet the medical necessity criteria for these services. Except where indicated, all services apply to both children and adults. Rehabilitative behavioral health services are provided to, or directed exclusively toward, the treatment of the Medicaid eligible beneficiary. Services are provided by qualified service providers for the purpose of ameliorating disabilities, improving the beneficiary's ability to function independently, and restoring maximum functioning through the use of diagnostic and restorative services.

Rehabilitative behavioral health services are medical or remedial services that have been recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice, under South Carolina State Law and as may be further determined by the South Carolina Department of Health and Human Services (SCDHHS) for maximum reduction of physical or mental disability and restoration of a beneficiary to their best possible functional level. The following services, as defined by SCDHHS, are considered Medicaid Rehabilitative behavioral health services:

Behavioral Health Screening: The purpose of this brief screening is to provide early identification of behavioral health issues and to facilitate appropriate referral for assessment and/or treatment services.

This service is provided by qualified clinical professionals as listed in the Staff Qualifications section. This service may be offered in all settings in the community. The unit of measure for this service is fifteen (15) minutes.

Diagnostic Assessment: The purpose of this face-to-face assessment is to determine the need for rehabilitative behavioral health services, to establish or confirm a diagnosis (diagnoses), to assist in the development of an individualized plan of care based upon the beneficiary's strengths and deficits, or to assess progress in and need for continued treatment. This assessment includes a comprehensive biopsychosocial interview and review of relevant psychological, medical, and education records.

- When a determination of the appropriateness of initiating or continuing the use of psychotropic medication is required, the diagnostic assessment must be carried out by a physician/psychiatrist or advanced practice registered nurse with prescriptive authority. The unit of measure for this service is an encounter that equates to a ninety (90) minute session.
- When the administration and interpretation of psychological tests is required to aid in the determination of diagnoses and level of impairment, a psychologist must carry out the diagnostic assessment. The unit of measure for this service is an hour (60 minutes).

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This service is provided by qualified clinical professionals as listed in the Staff Qualifications section. This service may be offered in all settings in the community. The unit of measure for this service is an encounter that equates to a forty-five (45) minute session.

Substance Abuse Examination: The purpose of this examination is to assess the extent of withdrawal symptoms and medical problems to determine the method for substance abuse treatment. This service is provided to beneficiaries who have received a Diagnostic Assessment, have been determined to have a behavioral health disorder, and are in need of substance abuse treatment. Delivery of this service involves a face-to-face interaction between a substance abuse professional and the beneficiary to assess the beneficiary's status and provide diagnostic evaluation and screening as a mechanism to provide referral for substance abuse treatment services. This service includes a physical assessment of the identified beneficiary to determine the level of dependency and/or the readiness for treatment. This examination may be a component of the process to establish medical necessity for the provision of substance abuse treatment services.

This service is provided by qualified clinical professionals as listed in the Staff Qualifications section. This service may be offered in all settings in the community. The unit of measure for this service is fifteen (15) minutes.

Service Plan Development: The purpose of this service is the development of a plan of care (POC) for the beneficiary. The POC, which may be developed by an interdisciplinary team, establishes the beneficiary's needs, goals, and objectives and identifies appropriate treatment/services needed by the beneficiary to meet those goals. An interdisciplinary team is typically composed of the beneficiary, his/her family and/or other individuals significant to the beneficiary, treatment providers, and care coordinators. The POC will incorporate information gathered during screening and assessment. The POC will be person/family centered; beneficiaries must be given the opportunity to determine the direction of his/her POC. An interdisciplinary team may be responsible for periodically reviewing progress made toward goals and modifying the POC as needed.

This service is provided by qualified clinical professionals as listed in the Staff Qualifications section. This service may be offered in all settings in the community. The unit of measure for this service is fifteen (15) minutes.

Individual Therapy: The purpose of this face-to-face intervention is to assist the beneficiary in improving his/her emotional and behavioral functioning. The therapist assists the individual in identifying maladaptive behaviors and cognitions, identifying more adaptive alternatives, and learning to utilize those more adaptive behaviors and cognitions.

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Group Therapy: The purpose of this face-to-face intervention is to assist several beneficiaries, who are addressing similar issues, in improving their functioning. The group process allows members to offer each other support, share common experiences, identify strategies that have been successful for them, and to challenge each other's behaviors and cognitions. The therapist guides the group to ensure that the process is productive for all members and focuses on identified issues.

Family Therapy: The purpose of this face-to-face intervention is to address the interrelation of the beneficiary's functioning with the functioning of his/her family unit. The therapist assists the family members in developing a greater understanding of the beneficiary's psychiatric/behavioral disorder and appropriate treatment for this disorder, identifying maladaptive interaction patterns between family members and how they contribute to the beneficiary's impaired functioning, and identifying and developing competence in utilizing more adaptive patterns of interaction. Family Therapy addresses goals established in the plan of care to help families or individuals within a family understand and improve the way family members interact and communicate with each other and promote and encourage the family's support to facilitate a beneficiary's improvement. Treatment is focused on changing the family dynamics and attempting to reduce and manage conflict. The goal of family therapy is to get family members to recognize and address the problem by establishing roles that promote individuality and autonomy, while maintaining a sense of family cohesion.

Individual, Group and Family Therapy services are provided by qualified professionals as listed in the Staff Qualifications section. These services may be offered in all settings in the community. The unit of measure for these services is thirty (30) minutes.

Substance Abuse Counseling: The purpose of this face-to-face intervention is to assist beneficiaries in their recovery process. The counseling is focused on acknowledging the consequences of continued substance abuse, identifying triggers for substance use, and developing alternative coping strategies. This service provides reinforcement of the beneficiary's ability to function within the confines of society without having to rely on addictive substances. This service address goals identified in the plan of care that involves the beneficiary relearning basic coping mechanisms, understanding related psychological problems that trigger addictive behavior, and encouraging the beneficiary to recognize opportunities and how to achieve them.

This service is provided by qualified professionals as listed in the Staff Qualifications section. This service may be offered in all settings in the community. The unit of measure for this service is thirty (30) minutes.

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Crisis Management: The purpose of this face-to-face or telephonic, short-term service is to assist a beneficiary, who is experiencing a marked deterioration of functioning related to a specific precipitant, in restoring his/her level of functioning. The goal of this service is to maintain the beneficiary in the least restrictive, clinically appropriate level of care. The clinician must assist the beneficiary in identifying the precipitating event, in identifying personal and/or community resources that he/she can rely on to cope with this crisis, and in developing specific strategies to be used to mitigate this crisis and prevent similar incidents.

This service is provided by qualified clinical professionals as listed in the Staff Qualifications section. This service may be offered in all settings in the community. The unit of measure for this service is fifteen (15) minutes.

Medication Management: The purpose of this face-to-face service is to educate the beneficiary about his/her medication, to determine any physiological and/or psychological effects of medication(s) on the beneficiary and to monitor the beneficiary's compliance with his/her medication regime. Education is focused on topics such as possible side effects of medications, possible drug interactions, and the importance of compliance with medication.

This service is provided by qualified clinical professionals as listed in the Staff Qualifications section. This service may be offered in all settings in the community. The unit of measure for this service is fifteen (15) minutes.

Rehabilitative Psychosocial Services: The purpose of this face-to-face service is to assist beneficiaries in the restoration or strengthening of skills needed to promote and sustain independence and stability in their living, learning, social and working environments. RPS is a form of skill building support, not a form of therapy or counseling. This service includes activities that are necessary to achieve goals in the plan of care in the areas of 1) skills development related to life in the community and to increasing the beneficiary's ability to manage their illness, to improve their quality of life and to live as actively and independently in the community as possible 2) basic living skills development in understanding and practice of daily and healthy living habits and self-care skills, 3) interpersonal skills training that enhance the beneficiary's self-management and communication skills, cognitive functioning and ability to develop and maintain environmental supports; and 4) consumer empowerment that improves the beneficiary's basic decision making and problem solving skills.

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This service is provided by qualified clinical professionals as listed in the Staff Qualifications section. This service is offered in all settings in the community. The unit of measure for this service is fifteen (15) minutes.

Behavior Modification: This service is provided to children ages 0-21 The purpose of this face-to-face service is to provide the beneficiary with in vivo redirection and modeling of appropriate behaviors in order to enhance his/her functioning within his home or community. The individual's plan of care should determine the focus of this service.

This service is provided by qualified clinical professionals as listed in the Staff Qualifications section. This service may be offered in all settings in the community. The unit of measure for this service is fifteen (15) minutes.

Family Support: The purpose of this face-to-face or telephonic service is to enable the family/ caregiver (parent, guardian, custodian or persons serving in a caregiver role) to serve as a knowledgeable member of the beneficiary's treatment team and to develop and/or improve the ability of families/caregivers to appropriately care for the beneficiary.

Family Support (FS) is a medical supportive service with the primary purpose of treatment of the beneficiary's condition. FS is the process of family participation with the services provider in the treatment process of the Medicaid beneficiary. FS should result in an intervention that changes or modifies the structure, dynamics and interactions that act on the beneficiary's emotions and behavior.

FS does not treat the family or family members other than the identified beneficiary. FS is not for the purpose of history taking or coordination of care. This service includes the following discrete services when they are relevant to the goal in the individualized plan of care: providing guidance to the family/caregiver on navigating systems that support individuals with behavioral health needs, such as behavioral health advocacy groups and support networks; fostering empowerment of family/caregiver by offering supportive guidance for families with behavioral health needs and encouraging participation in peer/parent support and self-help groups; and modeling these skills for parent/guardian/caregivers. The Family Support service does not include respite care or child care services.

This service is provided by qualified clinical professionals as listed in the Staff Qualifications section. This service may be offered in all settings in the community. The unit of measure for this service is fifteen (15) minutes.

Peer Support Service: The purpose of this service is to allow people with similar life experiences to share their understanding to assist beneficiaries in their recovery from mental illness and/or substance abuse disorders. The Peer Support Specialist gives advice and guidance, provides insight, shares information on services and empowers the

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beneficiary to make healthy decisions. The unique relationship between the Peer Support Specialist and the beneficiary fosters understanding and trust in beneficiaries who otherwise would be alienated from treatment. The beneficiary's plan of care determines the focus of this service.

This service is person centered with a recovery focus and allows beneficiaries the opportunity to direct their own recovery and advocacy process. The service promotes skills for coping with and managing symptoms while utilizing natural resources and the preservation and enhancement of community living skills.

The Peer Support Specialist will utilize their own experience and training to assist the beneficiary in understanding how to manage their illness in their daily lives by helping them to identify key resources, listening and encouraging beneficiaries to cope with barriers and work towards their goals. The Peer Support Specialist will also provide ongoing support to keep beneficiaries engaged in proactive and continual follow up treatment.

The Peer Support Specialist actively engages the beneficiary to lead and direct the design of the plan of care and empowers the beneficiary to achieve their specific individualized goals. Beneficiaries are empowered to make changes to enhance their lives and make decisions about the activities and services they receive. The Peer Support Specialist guides the beneficiary through self-help and self-improvement activities that cultivate the client's ability to make informed, independent choices and facilitates specific, realistic activities that lead to increased self-worth and improved self-concepts.

The Peer Support Specialists must successfully complete a pre-certification program that consists of forty (40) hours of training. The curriculum must include the following topics: recovery goal setting; wellness recovery plans, problem solving; person centered services; and advocacy. Additionally, Peer Support Specialists must complete a minimum of twenty (20) hours of continuing education training annually, of which at least twelve (12) hours must be face-to-face training. All trainings must be approved by DHHS or other authorized entity.

Peer Support Service is provided by a Peer Support Specialist under the supervision of a qualified clinical professional, as specified under the Staff Qualifications section. The degree of supervision will be contingent upon the qualifications, competencies and experience of the peer support provider. This service may be offered in all settings in the community. The unit of measure for this service is fifteen (15) minutes.

The Peer Support Specialist must possess, at a minimum, a high school diploma or GED, he/she must have successfully completed the pre-certification training program, and he/she must be a current or former consumer of behavioral health services. The criteria for meeting the consumer of services qualification are: 1) have had a diagnosis of mental illness or substance abuse disorder, as defined by the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders and received treatment for the disorder of 2) self-identify as having had a mental illness and/or substance abuse disorder; or 3) be in a dual recovery program.

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Staff Qualifications

Providers of service must fulfill the requirements for South Carolina licensure/certification and appropriate standards of conduct by means of evaluation, education, examination, and disciplinary action regarding the laws and standards of their profession as promulgated by the South Carolina Code of Laws and established and enforced by the South Carolina Department of Labor Licensing and Regulation. Professionals, who have received appropriate education, experience and have passed prerequisite examinations as required by the applicable state laws and licensing/certification board and additional requirements as may be further established by DHHS, may qualify to provide Rehabilitative behavioral health services. The presence of licensure/certification means the established licensing board in accordance with SC Code of Laws has granted the authorization to practice in the state. Licensed professionals must maintain a current license and/or certification from the appropriate authority to practice in the State of South Carolina and must be operating within their scope of practice.

The following professionals possessing the required education and experience are considered clinical professionals/paraprofessionals and may provide Medicaid Rehabilitative behavioral health services in accordance with SC State Law:

Title of Professional	Level of Education/Degree /or Experience Required	License or Certification Required	Supervision	State or Licensure Law	Services Able to Provide
Psychiatrist	Doctor of medicine or osteopathy and has completed a residency in psychiatry.	Licensed by SC Board of Medical Examiners	None required.	40-47-5 et seq,	All Services, except PSS
Physician	Doctor of medicine or osteopathy.	Licensed by SC Board of Medical Examiners	None required.	40-47-5 et seq.	All Services, except PSS
Psychologist	Doctorate degree in psychology.	Licensed by SC Board of Psychology Examiners	None required.	40-55-20 et seq.	BHS, DA, SPD, IT, GT, FT, CM, RPS, BMod, FS
Physician Assistant	Completion of an educational program for physician assistants approved by the Commission on Accredited Allied Health Education Programs	Licensed by SC Board of Medical Examiners	Physician with permanent SC licenses, physically present at least seventy-five percent of the time the physician assistant is providing services.	40-47-905 et seq.	All Services, except PSS

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Title of Professional	Level of Education/Degree /or Experience Required	License or Certification Required	Supervision	State or Licensure Law	Services Able to Provide
Pharmacist	Doctor of Pharmacy degree from an accredited school, college, or department of pharmacy as determined by the Board, or has received the Foreign Pharmacy Graduate Equivalency Certification issued by the National Association of Boards of Pharmacy (NABP).	Licensed by SC Board of Pharmacy	None required.	40-43-10 et seq.	MM
Advanced Practice Registered Nurse (APRN)	Doctorate, post-nursing master's certificate, or a minimum of a master's degree that includes advanced education composed of didactic and supervised clinical practice in a specific area of advanced practice registered nursing.	Licensed by SC Board of Nursing; must achieve and maintain national certification, as recognized by the board, in an advanced practice registered nursing specialty.	A supervising physician who is readily available for consultation and shall operate within approved written protocols.	40-33-10 et seq.	All Services except PSS
Registered Nurse (RN)	At a minimum, an associate's degree in nursing from a Board approved nursing education program and one year of experience working with the population to be served.	Licensed by SC Board of Nursing.	Under the supervision of an APRN or licensed physician.	40-33-10 et seq.	BHS, DA, SAE, SPD, MM, CM, RPS, BMod, FS

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Title of Professional	Level of Education/Degree /or Experience Required	License or Certification Required	Supervision	State or Licensure Law	Services Able to Provide
Licensed Practical Nurse (LPN)	High school diploma or equivalent and completion of an accredited nursing program approved by the Board of Nursing and one year of experience working with the population to be served.	Licensed by SC Board of Nursing	Under the supervision of an APRN, RN, licensed physician, or other practitioner authorized by law to supervise LPN practice.	40-33-10 et seq.	RPS, SAE, BMod, MM, FS
Licensed Independent Social Worker - Clinical Practice (LISW-CP)	Master's or Doctorate degree from a Board-approved social work program and one year of experience working with the population to be served.	Licensed by SC Board of Social Work Examiners		40-63-5 et seq.	BHS, DA, SPD, IT, GT, FT, CM, RPS, BMod, FS
Licensed Independent Social Worker-Advanced Practice (LISW-AP)	Master's or Doctorate degree from a Board-approved social work program and one year experience with the population to be served.	Licensed by SC Board of Social Work Examiners	None required.	40-63-5 et seq.	BHS, DA, SPD, IT, GT, FT, CM, RPS, BMod, FS
Licensed Masters Social Worker (LMSW)	Masters or a Doctorate degree from a social work program, accredited by the Council on Social Work Education and one year of experience working with the population to be served.	Licensed by SC Board of Social Work Examiners	None required	40-63-5 et seq.	BHS, DA, SPD, IT, GT, FT, CM, RPS, BMod, FS
Licensed Marriage and Family Therapist (LMFT)	A minimum 48 graduate semester hours or 72-quarter hours in marriage and family therapy along with an earned master's degree,	Licensed by SC Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists and	None required.	40-75-5 et seq.	BHS, DA, SPD, IT, GT, FT, CM, RPS, BMod, FS

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Title of Professional	Level of Education/Degree/or Experience Required	License or Certification Required	Supervision	State or Licensure Law	Services Able to Provide
	specialist's degree or doctoral degree. Each course must be a minimum of at least a 3-semester hour graduate level course with a minimum of 45 classroom hours or 4.5-quarter hours; one course cannot be used to satisfy two different categories.	Psycho-Educational Specialists			
Licensed Professional Counselor (LPC)	A minimum of forty-eight graduate semester hours during a master's degree or higher degree program and have been awarded a graduate degree as provided in regulation. All course work, including any additional core coursework, must be taken at a college or university accredited by the Commission on the Colleges of the Southern Association of Colleges and Schools, one of its transferring regional associations, the Association of Theological Schools in the United States and Canada, or a post-degree program accredited by the Commission on Accreditation for Marriage and Family Therapy Education or a regionally accredited institution of higher learning subsequent to receiving the graduate degree.	Licensed by SC Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists and Psycho-Educational Specialists	None required.	40-75-5 et seq.	BHS, DA, SPD, IT, GT, FT, CM, RPS, BMod, FS

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Title of Professional	Level of Education/Degree/or Experience Required	License or Certification Required	Supervision	State or Licensure Law	Services Able to Provide
Certified substance Abuse Professional	Master's degree in counseling, social work, family therapy, nursing psychology, or other human services field, plus 250 hours of approved training related to the core functions and certification as an addictions specialist.	SC Association of Alcoholism and Drug Abuse Counselors Certification Commission and/or NAADAC Association for Addiction Professionals	None required.	Allowed by 40-75-300 and 40-63-290 for example	BHS, DA, SPD, IT, GT, FT, SAC, CM, RPS, BMod, FS
Licensed Bachelor of Social Work (LBSW)	Bachelor's degree in Social Work. (The practice of Baccalaureate Social Work is a basic generalist practice that includes assessment, planning, intervention, evaluation, mediation, case management, information and referral, counseling, advocacy, supervision of employees, consultation, client education, research, community organization, and the development, implementation, and administration of policies, programs, and activities. Baccalaureate Social Workers are not qualified to diagnose and treat mental illness nor provide psychotherapy	Licensed by SC Board of Social Work Examiners	Limited practice scope . Under the supervision of a master's level clinical professional or licensed practitioner of the healing arts (LPHA) as follows: Physician, Psychiatrist, Psychologist, Physician's Assistant, Registered Nurse with a Master's degree in Psychiatric Nursing, Advanced Practice Registered Nurse, Independent Social Worker - Clinical Practice, Marriage and Family Therapist, Master Social Worker or Professional Counselor.	40-63-5 et seq.	BHS, SPD, CM, RPS, BMod, FS

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Title of Professional	Level of Education/Degree /or Experience Required	License or Certification Required	Supervision	State or Licensure Law	Services Able to Provide
	<p>services. Baccalaureate Social Work is practiced only in organized settings such as social, medical, or governmental agencies and may not be practiced independently or privately.)</p>				
Clinical Chaplain	<p>Master of Divinity from an accredited theological seminary and have two years of pastoral experience as a priest, minister, or rabbi and one year of Clinical pastoral education that includes a provision for supervised clinical services and one year of experience working with the population to be served.</p>	<p>Documentation of training and experience.</p>	<p>None required.</p>	<p>40-75-290 40-63-290, as examples</p>	<p>BHS, DA, SPD, IT, GT, FT, CM, RPS, BMod, FS</p>
Mental Health Professional (MHP)	<p>Master's or doctoral degree from a program that is primarily psychological in nature (e.g. counseling, guidance, or social science equivalent) from an accredited university or college and one year of experience working with the population to be served.</p>	<p>DHHS approved credentialing program.</p>	<p>Under the supervision of a master's level clinical professional or licensed practitioner of the healing arts (LPHA) as follows: Physician, Psychiatrist, Psychologist, Physician's Assistant, Registered Nurse with a Master's degree in Psychiatric Nursing,</p>	<p>Such as 40-75-290 & 40-63-290.</p>	<p>BHS, DA, SPD, IT, GT, FT, CM, RPS, BMod, FS</p>

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Title of Professional	Level of Education/Degree /or Experience Required	License or Certification Required	Supervision	State or Licensure Law	Services Able to Provide
			Advanced Practice Registered Nurse, Independent Social Worker - Clinical Practice, Marriage and Family Therapist, Master Social Worker or Professional Counselor.		
Certified Substance Abuse Professional (CSAP)	Bachelor's degree in a health or human services related field and certification as a certified addiction counselor or in the process of becoming SCAADAC credentialed or by certified by SCAADAC.	SC Association of Alcoholism and Drug Abuse Counselors Certification Commission	Under the supervision of a master's level clinical professional or licensed practitioner of the healing arts (LPHA) as follows: Physician, Psychiatrist, Psychologist, Physician's Assistant, Registered Nurse with a Master's degree in Psychiatric Nursing, Advanced Practice Registered Nurse, Independent Social Worker - Clinical Practice, Marriage and Family Therapist, Master Social Worker or Professional Counselor.	Allowed by 40-75-300 and 40-63-290	BHS, DA, SAC, SPD, IT, GT, FT, CM, RPS, BMod, FS

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Title of Professional	Level of Education/Degree /or Experience Required	License or Certification Required	Supervision	State or Licensure Law	Services Able to Provide
Behavior Analyst (Master's Level)	Must possess at least a Masters Degree, have 225 classroom hours of specific Graduate-level coursework, meet experience requirements, and pass the Behavior Analysis Certification Examination.	Behavior Analyst Certification Board	None required.	63-290 for example	RPS, BMod, FS BHS, DA, SPD
Behavior Analyst (Bachelor's Level)	A Board Certified Associate Behavior Analyst must have at least a Bachelors Degree, have 135 classroom hours of specific coursework, meet experience requirements and pass the Associate Behavior Analyst Certification Examination.	Behavior Analyst Certification Board	Under the supervision of a master's level clinical professional or licensed practitioner of the healing arts (LPHA) as follows: Physician, Psychiatrist, Psychologist, Physician's Assistant, Registered Nurse with a Master's degree in Psychiatric Nursing, Advanced Practice Registered Nurse, Independent Social Worker - Clinical Practice, Marriage and Family Therapist, Master Social Worker or Licensed Professional Counselor.	63-290 for example	RPS, BMod, FS

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Title of Professional	Level of Education/Degree /or Experience Required	License or Certification Required	Supervision	State or Licensure Law	Services Able to Provide
Child Service Professional	Bachelor's degree from an accredited university or college in psychology, social work, early childhood education, child development or a related field or a bachelors degree in another field and has a minimum of 45 documented training hours related to child development and children's mental health issues and treatment. of the Healing arts with one year documented experience working with infants and toddlers, early childhood development or childhood disabilities.	None required. Training as specified by the agency and as approved by DHHS.	Under the supervision of a master's level clinical professional or licensed practitioner of the healing arts (LPHA) as follows: Physician, Psychiatrist, Psychologist, Physician's Assistant, Registered Nurse with a Master's degree in Psychiatric Nursing, Advanced Practice Registered Nurse, Independent Social Worker - Clinical Practice, Marriage and Family Therapist, Master Social Worker or Professional Counselor.	N/A	RPS, BHS BMod, FS
Mental Health Specialist	At a minimum, a high school diploma or GED equivalent and have three years of documented direct care experience working with the identified target population or completion of an	DHHS approved training program consisting of the topics to include but not limited to the following: Children with serious emotional disturbance: Childhood and adolescent development,	Under the supervision of a master's level clinical professional or licensed practitioner of the healing arts (LPHA) as follows:	N/A	RPS, BMOD, FS

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Title of Professional	Level of Education/Degree /or Experience Required	License or Certification Required	Supervision	State or Licensure Law	Services Able to Provide
	approved 30 hour, training and certification program.	Emotional disorders/mental illnesses of childhood and adolescence, Family dynamics, Parenting skills/strategies, Human service system for children (courts, schools, special education, child welfare, etc and Special education/school system, Adults with serious and persistent mental illness: Signs and symptoms of major mental illness, Acute symptoms of mental illness, Medications used to treat symptoms of mental illness, and their common side effects, Community supports/resources for persons with serious persistent mental illness and their families, recovery models.	Physician, Psychiatrist, Psychologist, Physician's Assistant, Registered Nurse with a Master's degree in Psychiatric Nursing, Advanced Practice Registered Nurse, Independent Social Worker - Clinical Practice, Marriage and Family Therapist, Master Social Worker or Professional Counselor.		
Substance Abuse Specialist	At a minimum, a high school diploma or GED equivalent and have three years of documented direct care experience working with the identified target population or completion of an approved training and certification program.	DHHS approved training program consisting of the topics to include but not limited to the following: Theories of addiction, signs and symptoms of substance abuse, Signs and symptoms of major mental illness, Issues unique to co-occurring mental illness and substance abuse, Medications used to treat and	Under clinical supervision of a Certified Substance Abuse Professional (CSAP) or licensed practitioner of the healing arts (LPHA) as follows: Physician, Psychiatrist, Psychologist, Physician's Assistant, Registered Nurse with a	N/A	RPS, BMOD, FS

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Title of Professional	Level of Education/Degree /or Experience Required	License or Certification Required	Supervision	State or Licensure Law	Services Able to Provide
		Community resources and supports available to persons with substance abuse and their families.	Master's degree in Psychiatric Nursing, Advanced Practice Registered Nurse, Independent Social Worker - Clinical Practice, Marriage and Family Therapist, Master Social Worker or Professional Counselor.		
Peer Support Specialist (PSS)	High school diploma or GED equivalent Peer support specialists must successfully complete a pre-certification program that consists of forty (40) hours of training. The curriculum must include the following topics: recovery goal setting; wellness recovery plans, problem solving; person centered services; and advocacy. Additionally, peer support specialists must complete a minimum of twenty (20) hours of continuing education training annually, of which at least twelve (12) hours must be face-to-face training.	Certification as a Peer Support Specialist.	Under the supervision of a master's level clinical professional or licensed practitioner of the healing arts (LPHA) as follows: Physician, Psychiatrist, Psychologist, Physician's Assistant, Registered Nurse with a Master's degree in Psychiatric Nursing, Advanced Practice Registered Nurse, Independent Social Worker - Clinical Practice, Marriage and Family Therapist, Master Social Worker or Professional Counselor.	N/A	PSS

*All references are to Title-Chapter-Section of the South Carolina Code of Laws

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Supervision Requirements

Rehabilitative behavioral health services provided by licensed/certified professionals must follow supervision requirements as required by SC State Law for each respective profession. Rehabilitative behavioral health services provided by any unlicensed/uncertified professional must be supervised by a master's level clinical professional or licensed practitioner of the healing arts (LPHA). Substance Abuse Professionals who are in the process of becoming credentialed must be supervised by a Certified Substance Abuse Professional or LPHA.

The following licensed professionals are considered a LPHA: psychiatrist, physician, psychologist, physician's assistant, advanced practice registered nurse, registered nurse with a Master's degree in psychiatric nursing, licensed independent social worker - clinical practice, licensed master social worker, licensed marriage and family therapist and licensed professional counselor.

Service	Abbrev	Service	Abbrev
Behavior Modification	BMod	Individual Therapy	IT
Behavioral Health Screening	BHS	Medication Management	MM
Crisis Management	CM	Peer Support Service	PSS
Diagnostic Assessment	DA	Rehabilitative Psychosocial Services	RPS
Family Support	FS	Service Plan Development	SPD
Family Therapy	FT	Substance Abuse Counseling	SAC
Group Therapy	GT	Substance Abuse Examination	SAE

REHABILITATIVE SERVICE FOR PRIMARY CARE ENHANCEMENT

A. Definition of Service - Rehabilitative Services for Primary Care Enhancement by the State, within the scope of their practice under State law, w(RSPCE) are services recommended by a physician or other licensed practitioner of the healing arts which are furnished by (or under the supervision of) physicians or other practitioners of the healing arts licensed by the State, within the scope of their practice under State law, which are furnished in order to:

- reduce physical or mental disability, and
- restore an individual to their best possible functional level.

Covered RSPCE must either be: (1) required for the development and implementation of a comprehensive medical plan of care by a physician and other appropriate practitioners, or (2) medically necessary rehabilitative medical services identified in the comprehensive RSPCE medical plan which are not otherwise covered under the State Plan.

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- B. RSPCE Plan of Care Requirement - The RSPCE medical plan of care must be designed to promote changes in behavior, improve health status, and develop healthier practices to restore and maintain the individual at the highest possible functioning level. The RSPCE must include the following components:
- assessment/evaluation of health status, individual's needs, knowledge level;
 - identification of relevant health risk factors or health needs which justify the medical necessity for RSPCE;
 - development/revision of a goal-oriented plan of care (in conjunction with the physician and individual) that addresses needs identified in the assessment/evaluation and which specifies the service(s) necessary to restore the patient to an optimal state of health;
 - monitoring of health status, patient needs, skill level, and knowledge base/readiness; and
 - counseling regarding identified risk factor(s) to achieve the goals in the medical plan of care.
- C. Medical Necessity Criteria for RSPCE Rehabilitative Services - The RSPCE medical plan of care must include findings that rehabilitative services covered as RSPCE are required because of the individual's medical condition based on the following:
- failure to attain an optimal level of health within primary care delivery continuum; or
 - entrance into the health care delivery continuum with an advanced degree of disease/condition as evidenced by a clinical evaluation and documentation in the medical plan of care; or
 - a demonstrated pattern of non-compliance with the medical plan of care.
- D. Special Conditions - In order to be covered as RSPCE, rehabilitative services must: (1) be included in the RSPCE medical plan of care; (2) be recommended by a physician or other licensed practitioner of the healing arts; (3) involve direct patient contact, and (4) be medically-oriented. RSPCE may include counseling services to build client and care giver self-sufficiency through structured, goal-oriented individual interventions. Group sessions that allow direct one-to-one interaction between the counselor and the individual recipient may also be used to provide some components of this service.

Qualifications of Providers - Providers of RSPCE are physicians, other licensed practitioners of the healing arts acting within the scope of their practice under State law, and unlicensed health professionals operating under the supervision of a licensed professional and furnishing services which are within the scope of practice of the licensed professional.

Personal Care Aide Service: Personal care services provided to Medicaid eligible individuals who are identified through an initial medical assessment to have a minimum of two functional dependencies or one functional dependency and cognitive impairment. The services provided will

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be based on the individual's needs and set forth in a care plan developed by licensed practitioner of the healing arts, within their scope of practice under South Carolina law. All requirements of 42 CFR 440.167 will be met.

Personal care service will be available to eligible individuals who require an integrated set of services available on a 24-hour basis. Services are provided in a non-medical environment that promotes individuals to reach and maintain their peak functional level and delay the need for nursing facility care. The medical criteria will include the following elements:

- Inability to live alone due to an inadequate support system;
- In need of assistance to sustain maximum functional level; and
- A minimum of two functional dependencies or one functional dependency and one cognitive impairment.

[Eligible providers must be able to provide the personal care services on a 24-hour basis and maintain a standard license under South Carolina Department of Health and Environmental Control Regulation 61-84, community residential care facilities.

The personal care service provider must directly provide the following services, which must be specified in the resident's care plan:

- Medical monitoring,
- Medication administration, and
- Provision of assistance with ADL's.

[Payment will be made to the employer of the personal care aide providing care. Personal Care services shall be paid by unit. A unit is one hour of service. No more than four units will be authorized per day. Reimbursement will be based on a rate determined from analyzing available comparable services and cost data. Qualified staff render the person care services directly and administer medication. A nurse provides supervision and oversight to the personal care aide and provides medical monitoring of the resident.

- 14.b Skilled Nursing Facility Services for Individuals Age 65 or Older in Institutions for Mental Disease. (a) Must meet utilization control criteria for admission. (b) Must meet standards for certification of need.

Basic services and items furnished in an IMD facility that are included in the per diem rate and must not be charged to the patient include the following:

- A. Nursing Services - Include all nursing services to meet the total needs of the resigned, the administration of treatments and medications as ordered by the physician, assistance with mobility (walking or wheelchair), and routine nursing supplies. Nursing supplies include, but are not limited to such items as syringes, air mattress, I.V. supplies, adhesive tape, canes, ice bags,

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SUPERSEDES: SC 05-007

crutches, glycerine, mouth swabs, water pitchers, bed pans, thermometers, and urinals.

- B. Special Services - Including assistance by the facility social worker, participation in planned activities, physical therapy, speech therapy, occupational therapy and inhalation therapy.
- C. Personal Services - Services for the comfort of the resident which include assistance with eating, dressing, toilet functions, baths, brushing teeth, washing and combing hair, shaving and other services necessary to maintain a clean, well kept personal appearance. Includes assistance with walking and wheelchair use when necessary. Diapers and under pads are provided as needed.
- D. Room and Board - Includes a semi-private or ward accommodations, all meals including special diets and snacks ordered by the physician. Includes feeding residents if unable to feed themselves and tube feedings. Housekeeping services and bed and bath linens are included.
- E. Safety and Treatment Equipment - Including, but not limited to the following items: standard wheelchairs, infusion equipment, bedside commode, side rails, restraint chairs (Geri-chairs), suction apparatus, walkers, crutches, canes and other equipment that is generally used by multiple residents and does not become the property of the individual resident.
- F. Medications - Over-the-counter (OTC) non-legend medications are included (except for insulin).
- G. Medical Supplies and Oxygen - The following items are included, however, the included items are not limited to this list: oxygen, supplies used for inhalation therapy, catheters and related supplies, dressings, disposable enema equipment or other irrigation supplies, I.V. solutions, disposable instrument trays, levine tubes, and other supplies ordered by a physician or necessary to meet the needs of the resident because of the resident's medical condition.

15. INTERMEDIATE CARE FACILITY FOR MENTAL RETARDATION SERVICES. Prior approval for admission (or upon request for payment) is required. The Department of Mental Retardation is delegated the responsibility for level of care determination and prior approval for admission.

Basic services and items furnished in an ICF/MR facility that are included in the per diem rate and must not be charged to the resident include the following:

- A. Nursing Services - Includes all nursing services to meet the total needs of the resident, the administration of treatments and medications as ordered by the physician, assistance with mobility (walking or wheelchair), and routine nursing supplies. Nursing supplies include, but are not limited to such items as syringes, air mattresses, I.V. supplies, adhesive tape, canes, ice bags, crutches, glycerine, mouth swabs, water pitchers, bed pans, thermometers and urinals.
- B. Special Services - Including assistance by the facility social workers, participation in planned activities and therapeutic recreation, dental services, psychological services, physical therapy, speech therapy and hearing services, occupational therapy and inhalation therapy.
- C. Personal Services - Training and assistance with eating, dressing, toilet functions, baths, brushing teeth, washing and combing hair, shaving and other services necessary to maintain a clean, well kept personal appearance. Includes assistance with walking and wheelchair use when necessary. Diapers and underpads are provided as needed.
- D. Room and Board - Includes a semiprivate or ward accommodations, all meals including special diets and snacks ordered by the physician. Includes feeding residents if unable to feed themselves and tube feedings. Housekeeping services and bed and bath linens are included.
- E. Safety and Treatment Equipment - Including, but not limited to the following items: standard wheelchairs, infusion equipment, bedside commode, side rails, restraint chairs (Geri-chairs), suction apparatus, walkers, crutches, canes and other equipment that is generally used by multiple residents and does not become the property of the individual resident. Also included are eyeglasses, hearing aids and other prosthetic or adaptive equipment as needed. Maintenance in good repair of dentures, eyeglasses, hearing aids, braces and other aids prescribed by appropriate specialists.
- F. Medications - Over-the-counter (OTC) non-legend medications are included (except for insulin).

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EFFECTIVE DATE: 01/01/06
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SUPERSEDES: MA 90-43

- G. Medical Supplies and Oxygen - The following items are included, however, the included items are not limited to this list: oxygen, supplies used for the inhalation therapy, catheters and related supplies, dressings, disposable enema equipment or other irrigation supplies, I.V. solutions, disposable instrument trays, levine tubes, and other supplies ordered by a physician or necessary to meet the needs of the resident because of the resident's medical condition.
- H. Transportation services are required to provide other services, including vehicles with lifts or adaptive equipment as needed.
- 16.a Inpatient Psychiatric Facility Services: All admissions will be prior approved by the Medicaid agency or its representative based on medical necessity criteria.
- 16.b Psychiatric Residential Treatment Facility Services: All admissions will be prior approved by the Medicaid agency or its representative based on medical necessity criteria.
17. Nurse Midwife Services - Nurse midwives are authorized to perform services within their scope of practice authorized by State law and as documented in protocol between the nurse midwife and their physician preceptor. This protocol must be submitted to DHHS as part of the enrollment process. These services are not restricted to the maternity cycle.
18. Hospice Services - Benefit periods will be structured to coincide with those specified for the Medicare Hospice program.

Within two days of the beginning of each benefit period, the Medical Director must certify that the individual's prognosis is that his or her life expectancy is six months or less if the illness runs its normal course.

Services provided by certain Medicaid providers for care not related to the terminal illness must be prior approved by the hospice provider. The Medicaid provider will contact the hospice provider to obtain authorization that the service does not relate to the terminal illness and a prior authorization number to be included on that provider's claim form. The hospice prior authorization number on the claim certifies that the services provided are not related to the terminal illness or are not included in the hospice plan of care and will be reimbursed through other Medicaid benefits. If the authorization number is not included on the claim form, it will be rejected and returned to the provider. Services that require prior authorization are:

Hospital, Pharmacy, Audiology, Psychologist Services, Speech Therapy, Occupational Therapy, Ambulatory Surgery Clinics, Medical Rehabilitation Services, School Based services, Physical Therapy, Private Duty Nursing, Podiatry, Health Clinics, County Health Departments, Home Health, Home and Community Based Services, Durable Medical Equipment, and Mental Health, Drug, Alcohol and Substance Abuse Services.

The Hospice Agency will bill Medicaid for the room and board provided to Medicaid beneficiaries who elect hospice and who continue to reside in nursing facilities or intermediate care facilities for the mentally retarded. Upon receipt of the Medicaid reimbursement, the Hospice providers will forward the reimbursement to the facility in which the Medicaid beneficiary resides.

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EFFECTIVE DATE: 07/01/05
RO APPROVAL: 07/12/06
SUPERSEDES: MA 98-003

19. CASE MANAGEMENT - (MENTAL RETARDATION)

Under the authority of Section 1915 (g)(1) of the Social Security Act, Case Management Services will be covered without regard to the requirements of Section 1902 (a)(10)(B) of the Act and will be targeted to specific population groups.

A. Coverage is limited to non-institutionalized patients with mental retardation and related disabilities as diagnosed and determined under the criteria established by the South Carolina Department of Mental Retardation (SCDMR). This criteria establishes mental retardation as a person with an IQ of 70 or less which is accompanied by significant delays in adaptive behavior. Individuals with related disabilities have a severe, chronic disability that meets all of the following conditions:

- (1) It is attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, found to be closely related to mental retardation.
- (2) It is manifested before the person reaches age 22.
- (3) It results in substantial functional limitations in three or more of the following areas of major life activity:
 - (a) Self care;
 - (b) Understanding and use of language;
 - (c) Learning;
 - (d) Mobility;
 - (e) Self-direction; and
 - (f) Capacity for independent living.

B. Case management for individuals with mental retardation and related disabilities is not restricted geographically, and is provided on a statewide basis in accordance with Section 1902(a)(10)(B).

C. All case management services for this targeted population are comparable in amount, duration, and scope.

D. Definition of Services:

Case management services are defined as those services necessary to coordinate an optimum life style for a targeted patient population through a coordinated effort of monitoring the patient's needs; with a systematic referral process to providers for medical, education, legal, and rehabilitative services, with documented follow-up. No counseling services will be delivered by the case manage.

SC: MA 95-011
EFFECTIVE DATE: 10/01/95
RO APPROVAL: 12/18/95
SUPERSEDES: MA 91-09

Case Management services will ensure that necessary services are available and accessed for each eligible recipient.

A comprehensive Individual Needs Assessment and/or a Plan of Service will assist the case manager in providing follow-up with the patient to ensure that recommended services were accessed. A case management tracking system will be used to monitor compliance, access to services rendered, and accumulated costs.

4. Qualification of Providers:

Provider enrollment is limited to MR Programs meeting the criteria, as set forth in the "Standards for Provider Agencies Serving DMR Clients", published by the South Carolina Department of Disabilities and Special Needs (DDSN). Individual case managers assisting the patients must hold a Master's or Bachelor's degree in Social Work or a related field from an accredited university or college OR a Bachelor's degree in an unrelated field of study from an accredited university or college and have one (1) year of experience working with individuals with mental retardation or related disabilities or in a case management program. If the 1 year of experience is unrelated to working with individuals with mental retardation or related disabilities, the case manager must participate in in-service training concerning mental retardation and related disabilities. Any public or private program meeting the standards may contract with the DDSN to provide case management services.

Required credentials for a Case Manager Assistant will include no less than a high school diploma or GED, and skills/competencies sufficient to perform assigned tasks or the capacity to acquire those skills/competencies.

F. FREE CHOICE OF PROVIDERS

All patients eligible for Medicaid, deemed mentally retarded or an individual with related disabilities, and living in a community setting (not an intermediate care facility) will have the option of receiving case management services.

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services. They will have the freedom of choice to switch case managers if and when they desire.
2. Eligible recipients will have free choice of the providers of other medical care under the State Plan. Case managers will assure that freedom of choice of physicians and other medical care providers is maintained at all times.

G. Payment for case management services under the plan does not duplicate payments made to the public agencies or private entities under other program authorities for this same purpose.

SC: MA 98-006
EFFECTIVE DATE: 7/01/98
RO APPROVAL: 9/22/98
SUPERSEDES: MA 91-09

19. CASE MANAGEMENT - Limitations

Under the authority of Section 1915 (g)(1) of the Social Security Act, Case Management Services will be covered without regard to the requirements of Section 1902 (a)(10)(B) of the Act and will be targeted to specific population groups.

- A. Coverage is limited to severely emotionally disturbed children as determined by criteria established by the Continuum of Care for Emotionally Disturbed Children (CCEDC). This criteria includes the failure of other psychological or psychiatric service providers to positively impact the child. Medicaid eligible children being case managed by the CCEDC will have a history of these failures and therefore will meet the criteria for chronically mentally ill. In South Carolina severely emotionally disturbed children are considered chronically mentally ill.
- B. Case management for severely emotionally disturbed children is not restricted geographically, and is provided on a statewide basis out of five (5) regional offices in accordance with Section 1902(a)(10)(B).
- C. All case management services for this targeted severely emotionally disturbed children population are comparable in amount, duration, and scope.

D. DEFINITION OF SERVICES:

Case management services are defined as those services necessary to assure that the targeted client has access to a full array of needed medical, educational, legal, social, treatment and rehabilitative services. A mechanism for referral will exist as an integral aspect of this service, as will a process for follow-up monitoring.

Case management for severely emotionally disturbed children will enable these children to have timely access to the services and programs that can best deal with their needs. The case managers will have small case loads which will facilitate assessment of and quick response to situations which need immediate attention.

All services will be appropriately documented in the clients case management file. Plan of care updates will occur periodically to assure that needed services are accessed.

D. QUALIFICATION OF PROVIDERS:

Provider enrollment is limited to the Continuum of Care for Emotionally Disturbed Children (CCEDC) which is an agency of the State of South Carolina. Because of the severity of the emotional disturbance present in these children and their history of unresponsiveness to other agencies and providers, CCEDC is the only provider in South Carolina qualified to case manage this population.

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EFFECTIVE DATE: 04/01/89
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SUPERSEDES: N/A

Individual case managers serving this population must, at a minimum, hold a Master's degree in social work, psychology, counseling, special education or in a closely related field; or a Bachelor's degree in social work or child welfare; or a Bachelor's degree in psychology, counseling, special education or in a closely related field and have at least one (1) year of experience performing clinical or case work activities; or a Bachelor's degree in an unrelated field of study and have at least three (3) years of experience performing clinical or case work activities; or a Registered Nurse licensed to practice nursing in the State of South Carolina and at least three (3) years of experience performing clinical or case work activities.

Required credentials for a Case Manager Assistant will include no less than a high school diploma or GED, and skills/competencies sufficient to perform assigned tasks or the capacity to acquire those skills/competencies.

F. FREE CHOICE OF PROVIDERS

All children under age 21 and eligible for Medicaid and deemed severely emotionally disturbed will be eligible to receive these case management services.

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.

2. Eligible recipients will have free choice of case managers and the freedom to switch case managers if and when they desire.
3. Eligible recipients will have free choice of providers of other medical care under the State Plan. Case managers will assure that freedom of choice of physicians and other medical care providers is maintained at all times

G. Payment for case management services under the plan does not duplicate payments made to the public agencies or private entities under other program authorities for this same purpose.

SC: MA 98-006
EFFECTIVE DATE: 7/01/98
RO APPROVAL: 9/22/98
SUPERSEDES: MA 94-015

19. CASE MANAGEMENT - Limitations

Under the authority of Section 1915 (g)(1) of the Social Security Act, Case Management Services will be covered without regard to the requirements of Section 1902 (a)(10)(B) of the Act and will be targeted to specific population groups.

- A. Coverage is limited to Psychiatrically Disable adults as determined by criteria established by the South Carolina Department of Mental Health (SCDMH). These criteria include diagnosis of major mental disorder included in DSM III classification under schizophrenia disorders, major affective disorder, severe personality disorder in the absence of serious antisocial behavior, psychotic disorder, and delusional (paranoid) disorders or diagnosis of a mental disorder and at least one hospitalization for treatment of a mental disorder and therefore will meet the criteria for Chronically Mentally Ill. No clients participating in any waiver program which includes case management services will be case managed under this program.
- B. Case management for chronically mentally ill adults is not restricted geographically, and is provided in accordance with Section 1902(a)(10)(B) on a statewide basis out of seventeen (17) Community Mental Health Centers.
- C. All case management services for this targeted chronically mentally ill adult population are comparable in amount, duration, and scope.

D. DEFINITION OF SERVICES:

Case management services are defined as those services necessary to assure that the targeted client has access to a full array of needed medical, educational, vocational, social, treatment and rehabilitative services. A mechanism for referral will exist as an integral aspect of this service, as will a process for follow-up monitoring.

Case management for chronically mentally ill adults will enable these clients to have timely access to the services and programs that can best deal with their needs. The case managers will have case loads which will facilitate assessment of and quick response to situations which need immediate attention.

All services will be appropriately documented in the client's file. Plan of care updates will occur periodically to assure that needed services are accessed.

E. QUALIFICATION OF PROVIDERS:

Provider enrollment is limited to the seventeen (17) Community Mental Health Centers which are entities of the South Carolina Department of Mental Health (SCDMH). SCDMH is an agency of the State of South Carolina. Because of the chronic nature of the mental illness present

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SUPERSEDES: N/A

in these adults, SCMDH is the only provider in South Carolina qualified to case manage this population.

Individual case managers serving this population must, at a minimum, hold a Ph.D. or a MSW or a masters degree in psychology, counseling, or a closely related field or a bachelors degree in the above mention disciplines.

Required credentials for a Case Manager Assistant will include no less than a high school diploma or GED, and skills/competencies sufficient to perform assigned tasks or the capacity to acquire those skills/competencies.

F. FREE CHOICE OF PROVIDERS

All adults eligible for Medicaid and deemed chronically mentally ill will be eligible to receive these case management services.

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of case managers and the freedom to switch case managers if and when they desire.
2. Eligible recipients will have free choice of providers of other medical care under the State Plan. Case managers will assure that freedom of choice of physicians and other medical care providers is maintained at all times

G. Payment for case management services under the plan does not duplicate payments made to the public agencies or private entities under other program authorities for this same purpose.

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EFFECTIVE DATE: 7/01/98
RO APPROVAL: 9/22/98
SUPERSEDES: MA 89-16

19. CASE MANAGEMENT - Limitations

Under the authority of Section 1915 (g) (1) of the Social Security Act, Case Management Services will be covered without regard to the requirements of Section 1902 (a) (10) (B) of the Act and will be targeted to specific population groups.

- A. Coverage is limited to seriously emotionally disturbed children as determined by criteria established by the South Carolina Department of Mental Health (SCDMH). This criteria includes a DSM III-R diagnosis for emotional disturbance or neurological impairment and a serious emotional disturbance with a duration of more than six months or projected to continue for more than six months, or needing services of more than two agencies or needing more than two types of mental health services, or has been served in a psychiatric hospital or intensive residential program or needs such services and therefore will meet the criteria of Seriously Emotionally Disturbed. Because of the seriousness and complexity of their mental illness, in South Carolina this population is considered chronically mentally ill.
- B. Case management for seriously emotionally disturbed children is not restricted geographically, and is provided in accordance with Section 1902(a) (10) (B) on a statewide basis out of seventeen (17) Community Mental Health Centers.
- C. All case management services for this targeted population of seriously emotionally disturbed children are comparable in amount, duration, and scope.
- D. DEFINITION OF SERVICES:

Case management services are defined as those services necessary to assure that the targeted client has access to a full array of needed medical, educational, vocational, social, treatment and rehabilitative services. A mechanism for referral will exist as an integral aspect of this service, as will a process for follow-up monitoring.

Case management for seriously emotionally disturbed children will enable these clients to have timely access to the services and programs that can best deal with their needs. It will also assure follow up on placements and services to assure that these children are in the programs best suited to their respective needs. Case management will provide a quick response to issues which need immediate attention through timely and appropriate referrals.

All services will be appropriately documented in the client's file. Treatment Plan updates will occur periodically to assure that needed services are accessed.

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SUPERSEDES:N/A

E. Qualification of Providers:

Provider enrollment is limited to the seventeen (17) Community Mental Health Centers which are entitles of the South Carolina Department of Mental Health (SCDMH). SCDMH is an agency of the State of South Carolina. Because of the chronic nature of the mental illness present in these children, SCMDH is the provider in South Carolina that can assure appropriate and timely case management services for this population.

Individual case managers serving this population must, at a minimum, hold a Ph.D. or a MSW or a masters degree in psychology, counseling, or a closely related field or a bachelors degree in the above mention disciplines.

Required credentials for a Case Manager Assistant will include no less than a high school diploma or GED, and skills/competencies sufficient to perform assigned tasks or the capacity to acquire those skills/competencies.

F. FREE CHOICE OF PROVIDERS

All children through age 21 eligible for Medicaid and deemed seriously emotionally disturbed will be eligible to receive these case management services.

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of case managers and the freedom to switch case managers if and when they desire.
2. Eligible recipients will have free choice of providers of other medical care under the State Plan. Case managers will assure that freedom of choice of physicians and other medical care providers is maintained at all times.

G. Payment for case management services under the plan does not duplicate payments made to the public agencies or private entities under other program authorities for this same purpose. There will be no duplication of case management services.

19. Case Management - Limitations

A. Coverage is limited to Medicaid pregnant women determined to be "at risk during their pregnancy and to their infants up to one year after delivery. "At risk" status will be defined as any client included in one or more of the following:

1. Medical condition: Patients scoring 10 or more on the State Maternity Assessment Tool (DHEC 1615 Rev.) and women at risk of delivering a low birth weight baby.
2. Age: Age 20 and younger or age 34 and older.
3. Previous Pregnancy: Received no prenatal care or began prenatal care in the third trimester or received less than five prenatal visits.
4. Exempt High Risk Patients: High risk patients exempt from the High Risk Channeling Project.
5. Patients who have no "at risk" factor which would place them in groups 1-4 (medical condition, age, previous pregnancy, or exempt High Risk Channeling Project patient) but are considered by the Case Manager to have a special need for case management (i.e. death of a child, inadequate housing, family tensions or other psycho-social problems). Data concerning these patients could be used to provide expansion of the "at risk" factors.

B. Case Management for "at risk" Medicaid pregnant women and their infants will be provided on a statewide basis.

Women participating in the High Risk Channeling Project (HRCP) will not participate in "at risk" case management. Patients participating in the "at risk" case management who become high risk would be entered into the HRCP and their participation in "at risk" case management terminated.

C. All case management services for this targeted "at risk" pregnant group of women and their infants are comparable in amount, duration and scope.

D. Definition of Services:

Case management services are defined as those services necessary to assure that the targeted patient has access to any array of medical services, health education services and psycho-social services. A mechanism for referral will exist as an integral part of this service, including a process for follow-up monitoring and tracking to reinforce/support patient compliance with necessary services.

Case management for "at risk" maternity patients and their infants will enable these patients to have timely access to care and programs that are appropriate for their needs. The case managers will refer these patients to services and review patients' needs on a regular basis. They will also provide necessary case management interventions to support/reinforce patient compliance with necessary services.

SC: MA 94-009
EFFECTIVE DATE: 4/01/94
RO APPROVAL: 1/25/95
SUPERSEDES: MA 92-03

All services will be appropriately documented in the patient's record.

E. Qualification of the Providers:

Providers of case management may be any entity/individual including, but not restricted to, local health departments, community health clinics and rural health centers regardless of whether they provide other Medicaid service. Case management providers may qualify upon demonstration of ability to provide case management services in accordance with the requirements set forth by Medicaid and sign an agreement with the State Health and Human Services Finance Commission.

Initial assessment of patients, as well as supervision of the associate case manager and reviews of all records prior to closing, must be performed by a Senior Case Manager as defined by the Finance Commission.

A Senior Case Manager who is a Registered Nurse (RN) must be licensed in South Carolina and have a minimum of twelve months experience in direct nursing practice, preferably with experience in maternal and infant care. A Senior Case Manager who is not a RN must have, at minimum, a Bachelor's Degree in social work or related health or human services field with a minimum of twelve months experience, preferably in maternal and infant care.

An Associate Case Manager is defined, at minimum, as a high school graduate/GED with one (1) year experience in a health or human services related field.

Case management interventions (e.g. monitoring, following-up, referrals) may be performed by a Senior Case Manager or an Associate Case Manager. However, only Senior Case Managers can open and close cases.

F. Free Choice of Providers

All "at risk" Medicaid pregnant women and their infants will be eligible to receive case management services up to one year after delivery.

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a) (23) of the Act.

1. Eligible recipients will have free choice of case managers and the right to change or terminate case managers if and when they desire.
2. Eligible recipients will have free choice of providers of other medical care under the State plan. Case managers will assure that freedom of choice of physicians and other medical care providers is maintained at all times.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other programs authorized for this same purpose.

SC: MA 94-009
EFFECTIVE DATE: 4/01/94
RO APPROVAL: 1/25/95
SUPERSEDES: MA 92-03

19. CASE MANAGEMENT - Substance Abuse

Under the authority of Section 1915(g)(1) of the Social Security Act, Case Management Services will be covered without regard to the requirements of Section 1902(a)(10)(B) of the Act and will be targeted to specific population groups.

- A. Coverage is limited to alcohol and/or drug abusers as determined by criteria established by the State Health and Human Services Finance Commission and the South Carolina Commission on Alcohol and Drug Abuse. These criteria include a diagnosis of psychoactive substance abuse, psychoactive substance dependency, and psychoactive substance-induced organic mental disorders as delineated by DSM-III-R classifications, or; referral to a certified alcohol and drug abuse provider for problems resulting from or related to substance use which do not meet DSM-III-R criteria for psychoactive substance abuse/dependence, or; having received treatment in an intensive alcohol and drug abuse treatment program or chemical dependence hospital or in need of these services.
- B. Case management for substance abuse is not restricted geographically, and is provided in accordance with Section 1902(a)(10)(B) on a statewide basis.

All requirements of Section 1902(a)(32) of the Social Security Act will be met. Each certified alcohol and drug abuse service provider will be enrolled as a Medicaid provider with their own six (6) digit Medicaid provider identification number. Medicaid payments are made to these provider identification numbers.

- C. All case management services for this targeted population of alcohol and drug abusers are comparable in amount, duration and scope.
- D. Definition of Services:

Case management services are defined as those services necessary to assure that the targeted client has access to a full array of needed medical, educational, social, treatment, and rehabilitative services. A mechanism for referral will exist as an integral aspect of this service, as will a process for follow up monitoring. Case management for alcohol and drug abusers will enable these clients to have timely access to the services and programs that can best deal with their needs.

All case management services will be appropriately documented in the client record. Plan of care updates will occur periodically to assure that needed services are accessed.

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SUPERSEDES: MA 89-24

E. Qualification of Providers:

Provider enrollment is available to any provider who can meet the specific enrollment criteria for alcohol and drug abuse service providers certified by the Department of Alcohol and Other Drug Abuse Services (DAODAS), which is an agency of the State of South Carolina.

Individual case managers serving this population must, at a minimum, be credentialed by DAODAS as a Clinical Counselor or Intervention Specialist, or; hold a master's degree in a social science or related discipline, or; hold a bachelor's degree in the above mentioned disciplines and one year experience in service provision to alcohol and drug abuse or mental health clients, or; hold a master's or bachelor's degree in any discipline, and within nine (9) months from the initiation of service provision, demonstrate successful completion of the case management training curriculum Developed and provided by DAODAS and approved by the South Carolina Department of Health and Human Services (DHHS).

Required credentials for a Case Manager Assistant will include no less than a high school diploma or GED, and skills/competencies sufficient to perform assigned tasks or the capacity to acquire those skills/competencies.

F. Free Choice of Providers:

All Medicaid recipients deemed alcohol and drug abusers will be eligible to receive these case management services.

At no time will any client receiving case management services from a case manager be required to receive clinical or rehabilitative services from that same staff person. No client will be required to receive services from the same alcohol and drug service provider which employs the case manager, nor required to receive services from any alcohol and drug service provider. Freedom of choice of case managers, clinic, or rehabilitative service providers will be maintained at all times. Freedom of choice of all providers will be maintained at all times. Also, no provider of one service will be required to provide other services.

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of case managers and the freedom to switch case managers if and when they desire.
2. Eligible recipients will have free choice of providers of other medical care under the State Plan. Case managers will assure that freedom of choice of physicians and other medical care providers is maintained at all times.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

19. CASE MANAGEMENT - Sickle Cell Disease

Under the authority of Section 1915(g)(1) of the Social Security Act, case management services will be covered without regard to the requirements of Section 1902(a)(10)(B) of the act and will be targeted to persons with sickle cell disease.

A. Coverage is limited to non-institutionalized Medicaid recipients determined to have a confirmed laboratory diagnosis of sickle cell disease which include the sickle hemoglobinopathies (Hb SS, Hb SC, Hb SD and Hb S-Thal). In addition, the Medicaid recipients have to meet one or more of the following criteria:

1. Young children, to age 4 years, who are diagnosed to have sickle cell disease and whose families need assistance in understanding care for these children and accessing medical care.
2. Children (ages 4 years to 21) who are medically unstable, who have difficulty accessing medical care or who have no consistent medical care giver.
3. Adults assessed and determined at risk. At risk criteria includes those who have had a history of medical instability, and thus lack understanding in the disease; lack the ability to assess their own medical care system; who have no consistent medical care giver; or as a result of pain therapy have developed problems with substance dependency.

B. Case management for clients with sickle cell disease is not restricted geographically, and is provided on a statewide basis in accordance with Section 1902(a)(10)(B).

C. All case management services for this targeted Medicaid population are comparable in amount, duration and scope.

D. DEFINITION OF SERVICES:

Case management services are defined as those services necessary to assure that the targeted population has access to a full array of needed medical services, health education services and psycho-social services. Assessments will be provided to identify the individual's need for case management services including documentation of the child and family's strengths, needs and resources will be carefully coordinated and integrated. Case management assessment will not include the actual performance of physical/psychological examinations or evaluations. A mechanism for referral will exist as an integral part of this service, including a process for follow-up monitoring and tracking. Case management for Medicaid clients with sickle cell disease will enable the

recipients to have timely access to care and programs that are appropriate for their needs. The treatment goals are developed in conjunction with the recipient/family and are based on mutually determined goals. The case manager must maintain adequate records to ensure that the approved plan of care and all services that were deemed necessary were actually utilized. A plan of care will be reviewed at least on a quarterly basis to assure that needed services are accessed.

E. QUALIFICATION OF PROVIDERS:

Providers of case management may be any public or private entity, including, but not restricted to, local health departments, community health clinics, rural health centers and non-profit sickle cell organizations regardless of whether they provide other Medicaid services. Case management providers may qualify for enrollment upon demonstration of the ability to provide case management services in accordance with the requirements set forth by Medicaid and by signing an agreement with the State Department of Health and Human Services as a case manager provider for sickle cell disease.

The case manager shall be a Registered Nurse (R.N.)and/or a Social Worker. The R.N. must be licensed in South Carolina and have either: a) a minimum of one year adult medical/surgical clinical experience plus either an additional six months experience in pediatrics, or have taken a pediatric assessment course in the last six months, or; b) have the minimum of one year pediatric experience plus either an additional six months experience in adult medical/surgical experience or have taken an adult assessment course in the last six months. The nurse should also attend at least one in-service training related to sickle cell disease approved by DHHS annually.

The Social Worker must either have: Master of Social Work Degree or Bachelor of Social Work Degree, licensed as LMSW, LISW or LBSW by the South Carolina Board of Social Work Examiners. The LBSW must be under the supervision of masters level social worker (LMSW, LISW). A social worker must have at least one year's experience working with individuals in a health/human service environment and must attend at least one in-service training related to sickle cell disease approved by DHHS annually.

Required credentials for a Case Manager Assistant will include no less than a high school diploma or GED, and skills/competencies sufficient to perform assigned tasks or the capacity to acquire those skills/competencies.

F. FREE CHOICE OF PROVIDERS:

Case management services for Medicaid patients with sickle cell disease will comply with CFR Regulation regarding Freedom of Choice. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.

1. Eligible recipients will have free of choice of case managers and the right to change or terminate case managers if and when they desire.

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EFFECTIVE DATE: 7/01/98
RO APPROVAL: 9/22/98
SUPERSEDES: MA 97-003

2. Eligible recipients will have free choice of providers of other medical care under the State Plan. Case managers will assure that freedom of choice of physicians and other medical care providers is maintained at all times.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other programs authorized for this same purpose. Sickle cell case management must not duplicate any other Medicaid case management or wavered service.
19. CASE MANAGEMENT - Physically Handicapped Children

Under the authority of Section 1915 (g)(1) of the Social Security Act, case management services will be covered without regard to the requirements of Section 1902 (a) (10)(B) of the act and will be targeted to physically handicapped Children.

A. Coverage is limited to noninstitutionalized physically handicapped children as diagnosed and determined under the criteria established by the South Carolina Department of Health and Environmental Control's Children's Rehabilitative Services (CRS) program and the Department of Health and Human Services. This criteria establishes physically handicapped children as individuals below the age of 18 with one or more of the following organic diseases, defects or conditions which may hinder the achievement of normal growth and development:

1. Diseases of the bones and joints
2. Hearing disorders and aural pathologies
3. Congenital anomalies
4. Epilepsy
5. Cardiac defects including rheumatic fever
6. Cleft lip/palate or other craniofacial anomalies
7. Cerebral palsy and other central nervous system disorders
8. Cystic fibrosis
9. Endocrine disorders
10. Hemophilia
11. Developmental delays, such as speech/language, motor and growth abnormalities.

B. Case management for physically handicapped children is not restricted geographically, and is provided on a statewide basis in accordance with section 1902(a)(10)(B).

C. All case management services for this targeted physically handicapped population are comparable in amount, duration and scope.

D. DEFINITION OF SERVICES:

Case management services are defined as those services necessary to assure that the targeted patient population has access to a full array of needed medical, health education, social, treatment, and rehabilitative services. A mechanism for referral will exist as an integral aspect of this service, as well as a process for follow-up monitoring.

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EFFECTIVE DATE: 4/01/97
RO APPROVAL: 7/03/97
SUPERSEDES: MA 94-009

Case management services for physically handicapped children will assure that: these children obtain necessary services in a timely manner and are carefully coordinated and integrated. Assessments will be provided to identify the child's need for case needs and resources. Case management assessments will not include the actual performance of physical/psychological examinations or evaluations. Treatment goals and interventions shall be developed in conjunction with the family, based on mutually identified needs, and that services are child and family centered and community based.

The case manager must follow-up with the patient to ensure that all recommended services were accessed. The case manager must maintain adequate records to ensure that the approved plan of care is appropriate and all services that were deemed necessary were actually utilized. A plan of care will be updated periodically to assure that needed services are accessed.

E. QUALIFICATIONS OF PROVIDERS:

Providers of case management services may be any entity/individual including, but not restricted to, local health departments and community health clinics regardless of whether they provide other Medicaid services.

Individual case managers serving this target population must, at a minimum, hold a Masters degree in Social Work, Nursing or Nutrition and/or meet the qualifications established by the State Merit System for a Social Worker III or IV, Senior Public Health Nurse (SPHN) or Nutritionist II.

F. FREE CHOICE OF PROVIDERS:

All physically handicapped children under age 18 and eligible for Medicaid must be eligible to receive these case management services.

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902 (a) (23) of the Act.

1. Eligible recipients will have free choice of case managers and the freedom to switch case managers if and when they desire.
2. Eligible recipients will have free choice of providers of other medical care under the State Plan. Case managers will assure that freedom of choice of physicians and other medical care providers is maintained at all times.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

19. CASE MANAGEMENT - Limitations

Under the authority of Section 1915(g)(1) of the Social Security Act, Case Management Services will be covered without regard to the requirement of Section 1902(a)(10)(B) of the Act and will be targeted to specific population groups.

- A. Coverage is limited to foster children who are in the care, custody, or control of the state or receiving state agency or of an agency in another state and placed in South Carolina. This population consists of children age 0-21 who are placed (in the community) outside of the home due to abuse, neglect, or other conditions which contribute to a child's physical, emotional, and/or social deterioration. These children are in the care, custody, or control of the State of South Carolina due to:
1. The judicial or legally sanctioned determination that the child must be protected by the State as dependent or a child in need of supervision as determined by the Family Court of South Carolina; or
 2. The judicial determination or statutory authorized action by the State to protect the child from actual or potential abuse/neglect under the South Carolina Children's Code, Section 20-7-610 and Section 20-7-736, or other statute; or
 3. The voluntary placement agreement, or an agreement for foster care, between the State and the child's parent(s), custodians, or guardian; or
 4. Children placed in South Carolina pursuant to the Inter-State Compact for Children who are placed by an Agency from another state.

In addition, children under the age of 21 who are receiving post-adoption services under the auspices of an Adoption Agreement will be eligible to receive case management services.

Case management services are provided to all children (Medicaid as well as non-Medicaid eligible) in the target population. Payment sources will be Medicaid, third party payors which reimburse for case management services, and Title IV-B. Services for children who are insured by a third party payor which covers the cost of case management will be reimbursed by the third party payor. Title XIX funds will be used when a child has no third party coverage and is eligible for Medicaid. The remaining children will have their case management services funded by Title IV-B.

- B. See pre-print page, Supplement 1 to Attachment 3.1-A, Page 1(1).
- C. See pre-print page, Supplement 1 to Attachment 3.1-A, Page 1(1).

D. Definition of Services:

Case management services are defined as those services which will assist individuals eligible under the Plan in gaining access to needed medical, social, educational, and other services. The core elements of the case management services are described as follows:

A comprehensive needs assessment will be completed by the case manager which identifies the service needs of the child. A service plan will also be developed to assist the case manager in a) making needed referrals; b) assuring access to services; and c) providing follow-up to ensure that recommended services are accessed. The service plan will be developed with input received from the client as age appropriate, the family, significant others, and involved service/treatment providers. On-going monitorship and follow-up of the plan (face-to-face contacts and telephone contacts) will be rendered to a) assure that the plan is being followed, b) identify whether progress is being achieved on plan objectives and if not, to make needed revisions to the plan, and c) to ensure that services are coordinated with the active participants in the child's life.

Case management services will enable the target population to have timely access to the services and programs which can best meet their individual needs. Case management will provide a quick response to issues that need immediate attention through timely and appropriate referrals. A referral mechanism will exist as an integral aspect of the service as will the process for follow-up monitoring.

The service plan will be updated as needed, but at a minimum, annually. Case management services will be appropriately documented in the client record.

E. Qualification of Providers

Providers must:

A. Provide all core elements of case management services including:

1. Comprehensive needs assessment which addresses client service needs.
2. Comprehensive service plan development.
3. Linking/coordination of services to meet individual, and as appropriate, family needs. Only Medicaid eligible recipients that fall within the target population will receive services.

4. Reassessment of client status and needs/follow-up;
 5. Crisis assessment and referral. Contact with family, guardian, or others to assess the current situation and need for emergency/alternative service provision; contact with client to assess service needs; and making referrals to an appropriate emergency provider.
 6. Assuring access to needed services and that services are coordinated to meet identified needs while the child is in the care and custody of the state, arranging the necessary support services to reunite the child with the family, and assuring that out-of-home placements) meets the child's needs.
- B. Have experience working with abused and neglected children in out-of-home placements.
- C. Have experience in service planning and meeting the service needs of foster children.
- D. Have experience in coordinating and linking community resources required by children in foster care.
- E. Establish and maintain a referral process consistent with Section 1902 (a) (23), freedom of choice of provider.
- F. Establish and maintain case management records in accordance with state and federal policies and regulations.
- G. Establish and maintain a quality assurance process which ensures a quality case management program and that the services delivered are appropriate to meet individual needs.
- H. Establish and maintain a financial management system which provides documentation of services and costs.

Case management provider entities must be certified (by a provider review team responsible to the Medicaid agency) as a Medicaid case management provider and must maintain that certification. Provider certification will consist of an audit of a random sample of case management records to review compliance with Medicaid policy. Each case management provider will be subject to an initial certification audit with post-certification monitoring reviews conducted periodically to ensure continued qualification as a Medicaid provider. If a case management provider fails to receive or maintain certification, the provider may not bill Medicaid until such time as a corrective action plan is implemented and certification is granted.

Individual case managers must meet the following minimum qualifications:

1. A Bachelor of Arts or a Bachelor of Science degree, preferably in a human services field;

OR

2. Four years of professional social service or case management experience, and be licensed as a social worker by the state of South Carolina Board of Social Work examiners or meet provider qualifications under the grandfathering clause;

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SUPERSEDES: MA 90-29

AND

3. Complete training in a case management curriculum approved by the State Health and Human Services Finance Commission.

Required credentials for a Case Manager Assistant will include no less than a high school diploma or GED, and skills/competencies sufficient to perform assigned tasks or the capacity to acquire those skills/competencies.

F. Free Choice of Providers

All children age 0-21, eligible for Medicaid and who are placed in the custody of the state will be eligible to receive these case management services.

The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of case managers and the freedom to switch case managers if and when they desire.
2. Eligible recipients will have free choice of providers of other medical care under the state plan. Case managers will assure that freedom of choice of physicians and other medical care providers is maintained at all times.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Services for children who are insured by a third party payor which covers the cost of case management will be reimbursed by the third party payor. Title XIX funds will be used when a child has no third party coverage and is eligible for Medicaid. The few remaining children will have their case management services funded by Title IV-B.

19. CASE MANAGEMENT - Individuals with Head and Spinal Cord Injuries and Related Disabilities

Under the authority of Section 1915 (g)(1) of the Social Security Act, case management services will be covered without regard to requirements of section 1901(a)(10) of the act and will be targeted to individuals with head and spinal cord injury.

- A. Coverage is limited to non-institutionalized Medicaid recipients determined to have a head and spinal cord injury or related disability. In addition, the Medicaid recipients must be below the age of 55 years when opened to case management services.
- B. Case management for clients with head and spinal cord injury or related disability is not restricted geographically, and is provided on a statewide basis in accordance with section 1902(a)(1).
- B. All case management services for this targeted Medicaid population are comparable in amount, duration and scope.

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EFFECTIVE DATE: 7/01/98
RO APPROVAL: 9/22/98
SUPERSEDES: MA 94-009

D. Definition of Services:

Case management services are defined as those services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services. Case management components are intake/assessment, care coordination and intervention. Assessments will be provided to identify the individuals need for case management. Service needs and resources identified will be coordinated and integrated. A mechanism for referral will exist as an integral part of this service, including a process for follow-up monitoring and tracking.

Case management for Medicaid clients with head and spinal cord injury or a related disease will enable the recipients to have timely access to care and programs that are appropriate for their needs. The plan of care is developed in conjunction with the recipient/family and are based on mutually determined goals. The case manager must maintain adequate records to ensure that the approved plan of care and all services that were deemed necessary were actually utilized. A plan of care will be reviewed at least on a semi-annual basis to assure that needed services are accessed.

E. Qualification of Provider:

The Case Manager must have a master's degree and one (1) years experience in health and human services. All case managers will receive twenty (20) hours of training from the University of South Carolina Center for Disabilities. The training shall consist of an overview of head, spinal cord injuries and related disabilities to include some anatomy, family dynamics, case consultation, community resources, networking, policies and procedures, preparation of paperwork, and crisis intervention.

Required credentials for a Case Manager Assistant will include no less than a high school diploma or GED, and skills/competencies sufficient to perform assigned tasks or the capacity to acquire those skills/competencies.

F. Free Choice of Providers:

Case management services to Medicaid patients with Head and Spinal Cord Injuries will comply with CFR Regulation regarding Freedom of Choice. The State assures that the provision of case management services will not restrict an individuals free choice of providers in violation of Section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of case managers and the right to change or terminate case managers if and when they desire.
2. Eligible recipients will have free choice of providers of other medical care under the state plan. Case managers will assure that freedom of choice of physicians and other medical care providers is maintained at all times.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other programs authorized for this same purpose. The Head and Spinal Cord case management must not duplicate any other Medicaid case management or waived service.

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SUPERSEDES: MA 94-009

Case Management - Individuals with sensory impairment.

Under the authority of Section 1915 (g) (1) of the Social Security Act, case management services will be covered without regard to the requirements of Section 1902 (a) (10) (B) of the act and will be targeted case management for sensory impaired individuals.

A. Coverage is limited to non-institutionalized Medicaid recipients determined to be sensory impaired. Additional criteria is listed as follows:

(1) diagnosed as legally blind or visually impaired, or deaf or hard of hearing or multi-handicapped by a qualified specialist in the areas of vision and hearing.

(2) eligible for services as determined by criteria established by South Carolina Commission for the Blind or South Carolina School for the Deaf and Blind or be an applicant in the intake process.

(3) between the ages of birth through sixty-four (64) years of age at the time of application.

(4) a resident of South Carolina.

(5) a Medicaid recipient.

B. Case management for the sensory impaired population is not restricted geographically, and is provided on a statewide basis in accordance with section 1902 (a) (10) (B).

C. All case management services for this targeted sensory impaired population are comparable in amount, duration and scope.

D. Definition of Services:

Case management services are defined as those services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services. Case management components are intake/assessment, care coordination and intervention. Assessments will be provided to identify the individual's need for case management. Service needs and resources identified will be coordinated and integrated. A mechanism for referral will exist as an integral part of this service, including a process for follow-up monitoring and tracking.

Case management services for the sensory impaired population will enable the recipients to have timely access to care and programs that are appropriate for their needs. The plan of care is developed in conjunction with recipient/family and are based on mutually determined goals. The case manager must maintain adequate records to ensure that the approved plan of care and all services that were deemed necessary were actually utilized. A plan of care will be reviewed at least on a semi-annual basis to assure that needed services were accessed.

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RO APPROVAL: 1/25/95
SUPERSEDES: MA 90-31

E. Qualifications of Providers:

Individual case managers serving this target population must, at a minimum, hold a master's degree in human services (social or behavioral), allied health, or special education field and one (1) year experience performing rehabilitation, clinical or casework activities, preferably with sensory impaired individuals; or a bachelor's degree in the above and (3) years experience in performing rehabilitation, clinical or casework activities, or a bachelor's degree with a combination of education and experience listed above. The case manager must successfully complete the established training curriculum for case management of sensory impaired children.

Required credentials for a Case Manager Assistant will include no less than a high school diploma or GED, and skills/competencies sufficient to perform assigned tasks or the capacity to acquire those skills/competencies.

F. Free Choice of Providers:

All sensory impaired individuals birth through sixty-four years of age who are eligible for Medicaid are eligible to receive these case management services.

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902 (a) (23) of the Act.

1. Eligible recipients will have free choice of case managers and their freedom to switch case managers if and when they desire.
2. Eligible recipients will have free choice of providers of other medical care under the State Plan. Case managers will assure that freedom of choice of physicians and other medical care providers is maintained at all times.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for the same purpose. The case management will not duplicate any other Medicaid case management or waived service.

19. CASE MANAGEMENT - Juvenile Justice Children Ages 0-21

Under the authority of Section 1915(g) (1) of the Social Security Act, case management services will be covered without regard to the requirement of Section 1902(a) (1) of the Act and will be targeted to specific population groups.

A. Coverage is limited to children ages 0-21 receiving community services (non-institutional level) in association with the juvenile justice system in South Carolina. The population to be served consists of children receiving community services under statutory authorization promulgated under the South Carolina Children's Code, Section 20-7-3210.

Case management services are provided to all children (Medicaid as well as non-Medicaid eligible) in the target population. In addition to Medicaid, third party payors which reimburse for case management will be a payment source. Title XIX funds will be used when a child has no third party coverage and is eligible for Medicaid.

- B. Case Management for juvenile justice children is not restricted geographically, and is provided on a statewide basis in accordance with Section 1902(a)(1).
- C. All case management services for this targeted population of children are comparable in amount, duration and scope.
- D. Definition of Services:

Case management services are defined as those services necessary to assure that the targeted client has access to a full array of needed community services, to include appropriate medical, social, educational, treatment, and rehabilitative services. A mechanism for referral will exist as an integral aspect of the service as will a process for follow-up monitoring.

Case management services will enable children within the juvenile justice system of care to have timely access to the services and programs which can best meet individual needs. Case management will provide a quick response to issues that need immediate attention through timely and appropriate referrals.

A comprehensive Service Plan and/or Assessment will assist the case manager in providing follow-up to ensure that recommended services were accessed. Services will be appropriately documented in the client record.

A tracking system will be used to monitor compliance, access to services rendered, and accumulated costs.

- E. Qualification of Providers:

Providers must:

- A. Provide all core elements of case management services including the following:
 - 1. Comprehensive client needs assessment which addresses service needs;
 - 2. Comprehensive service plan development;
 - 3. Linkage/coordination of services to meet individual needs.
 - 4. Reassessment of client status and needs/follow-up;
 - 5. Crisis assessment and referral;
 - 6. Assuring access to needed community services, ensuring the appropriateness of services and effectively coordinating services for juvenile justice children in community placements.

- B. Have experience working with juvenile justice children receiving community services. This includes experience in service planning and coordinating and linking needed community resources.
- C. Ensure each child accesses appropriate services as agreed upon in the Service Plan and have the cooperation of other service agencies in order for effective interventions and successful outcomes to occur.
- D. Develop alternative plans for services should the child's response to the original plan not provide sufficient intervention.
- E. Monitor service provision ensuring an appropriate continuum of interventions/services which may include contact with law enforcement, Family Court and a full array of community based residential and other treatment options.
- F. Establish and maintain a referral process consistent with Section 1902 (a) (23), freedom of choice of provider.
- G. Establish and maintain a quality assurance process which ensures a quality case management program and that the services delivered are appropriate to meet individual needs.
- H. Establish and maintain a financial management system which provides documentation of services and costs.
- I. Establish and maintain case management records in accordance with state and federal policies and regulations.

Individual case managers must meet the following minimum qualifications:

1. Hold a college degree in the field of social science or an equivalent degree from an accredited university or college;
- AND
2. Complete training in a case management curriculum approved by the State Health and Human Services Finance Commission.

Required credentials for a Case Manager Assistant will include no less than a high school diploma or GED, and skills/competencies sufficient to perform assigned tasks or the capacity to acquire those skills/competencies.

F. Free Choice of Providers:

All children meeting the target population criteria and eligible for Medicaid and who are associated with the juvenile justice system will be eligible to receive these case management services.

The state assures the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a) (23) of the Act.

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EFFECTIVE DATE: 7/01/98
RO APPROVAL: 9/22/98
SUPERSEDES: MA 94-010

1. Eligible recipients will have free choice of case managers and the freedom to switch case managers if and when they desire.
 2. Eligible recipients will have free choice of providers of other medical care under the state plan. Case managers will assure that freedom of choice of physicians and other medical care providers is maintained at all times.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Monitoring services will ensure that inappropriate duplication does not exist.

19. CASE MANAGEMENT - ADULT PROTECTIVE SERVICES

Under the authority of Section 1915(g)(1) of the Social Security Act, Case Management Services will be covered without regard to the requirement of Section 1902(a)(10)(B) of the Act and will be targeted to specific population groups.

- A. Coverage is limited to vulnerable adults in need of protective services due to abuse or neglect or exploitation or to protect an incapacitated person from him/herself and from others due to developmental disability, senility or other like incapacities.

1. A vulnerable adult is eligible for case management service if:
 - a. The person who needs or believes s/he needs protective service seeks such services;
 - b. An interested person requests services on behalf of a person in need of services;
 - c. The Department of Social Services determines the person who is the subject of a report is in need of protective services; or
 - d. The court requests such services.
2. Definitions relative to these services as defined in Section 43, Chapter 35- "Omnibus Adult Protective Act" of 1993.
 - a. "Protective Services" means those services whose objective is to protect a vulnerable adult from harm caused by the vulnerable adult or another person.
 - b. "Vulnerable adult" means a person eighteen years of age or older who has a physical or mental condition which substantially impairs the person from adequately providing for his or her own care or protection. This includes a person who is impaired in the ability to adequately provide for the person's own care or protection because of the infirmities of aging including, but not limited to, organic brain damage, advanced age, and physical, mental or emotional dysfunction.

- c. Physical Abuse, as defined in Section 43-35-10, means intentionally inflicting or allowing to be inflicted physical injury on a vulnerable adult by an act or failure to act.
 - d. "Neglect means the failure or omission of a caregiver to provide the care, goods, or services necessary to maintain the health, safety, shelter, supervision, and medical services. Neglect may be repeated conduct or a single incident which has produced or can be proven to result in serious physical or psychological harm or substantial risk of death.
 - e. "Exploitation" means an unjust or improper use of another person for one's own profit or advantage.
- B. See pre-print page, Supplement 1 to Attachment 3.1-A, Page 1 (1).
 - C. See pre-print page, Supplement 1 to Attachment 3.1-A, Page 1 (1).
 - D. Definition of Services:

Case management services are defined as those services which will assist individuals eligible under the Plan in gaining access to needed medical, social, educational and other services. The core elements of the case management services are described as follows:

A comprehensive needs assessment will be completed by the case manager which identifies the service needs of the adult. A service plan will also be developed to assist the case manager in a) making needed referrals; b) assuring access to services; and c) providing follow-up to ensure that recommended services are accessed. The service plan will be developed with input received from the client, the family (if appropriate), significant others, and involved service/treatment providers. On-going monitorship and follow-up of the plan (face-to-face contacts and telephone contacts) will be rendered to a) assure that the plan is being followed, b) identify whether progress is being achieved on plan objectives and if not, to make needed revisions to the plan, and c) to ensure that services are coordinated with the active participants in the adult's life.

Case management services will enable the target population to have timely access to the services and programs which can best meet their individual needs. Case management will provide a quick response to issues that need immediate attention through timely and appropriate referrals. A referral mechanism will exist as an integral aspect of the service as will the process for follow-up monitoring.

The service plan will be updated as needed, but at a minimum, annually. Case management services will be appropriately documented in the client record.

- E. Qualification of Providers

Provider must:

- A. Provide all core elements of case management services including:

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EFFECTIVE DATE: 4/01/97
RO APPROVAL: 5/30/97
SUPERSEDES: N/A

1. Comprehensive needs assessment which addresses client service needs.
 2. Comprehensive service plan development.
 3. Linking/coordination of services to meet individual needs. Only Medicaid eligible recipients that fall within the target population will receive services.
 4. Reassessment of client status and needs/follow-up;
 5. Crisis assessment and referral. Contact with family, guardian, or others to assess the current situation and need for emergency/alternative service provision; contact with client to assess service needs; and making referrals to an appropriate emergency provider.
 6. Assuring access to needed services and that services are coordinated to meet identified needs while the adult is in the care and custody of the state, arranging the necessary support services, and assuring that out-of-home placement(s) meets the adult's needs.
- B. Have experience working with abused and neglected adults.
- C. Have experience in service planning and meeting the service needs of vulnerable adults.
- D. Have experience in coordinating and linking community resources required by vulnerable adults.
- E. Establish and maintain a referral process consistent with Section 1902(a)(23), freedom of choice of provider.
- F. Establish and maintain case management records in accordance with state and federal policies and regulations.
- G. Establish and maintain a quality assurance process which ensures a quality case management program and that the services delivered are appropriate to meet individual needs.
- H. Establish and maintain a financial management system which provides documentation of services and costs.

Regular program quality assurance reviews will be conducted to determine whether Adult Protective Services programs have maintained the established program standards.

Individual case managers must meet the following minimum qualifications:

1. A Bachelor of Arts or a Bachelor of Science degree, preferably in a human services field;

OR

2. Four years of professional social service or case management experience, and be licensed as a social worker by the state of South Carolina Board of Social Work examiners or meet provider qualifications under the grandparenting clause;

AND

3. Complete training in a case management curriculum approved by the South Carolina Department of Health and Human Services.

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SUPERSEDES: N/A

Required credentials for a Case Manager Assistant will include no less than a high school diploma or GED, and skills/competencies sufficient to perform assigned tasks or the capacity to acquire those skills/competencies.

F. Free Choice of Providers

All adults eligible for Medicaid and the subject of an abuse or neglect report referred to the South Carolina Department of Social Services will be eligible to receive these case management services. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of case managers and the freedom to switch case managers if and when they desire.
2. Eligible recipients will have free choice of providers of other medical care under the state plan. Case managers will assure that freedom of choice of physicians and other medical care providers is maintained at all times.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Services for clients who are insured by a third party payor which covers the cost of case management will be reimbursed by the third party payor. Title XIX funds will be used when a client has no third party coverage and is eligible for Medicaid. The few remaining clients will have their case management services funded by Social Services Block Grant or state funds.

As of June 30, 2006, services will no longer be covered and reimbursed.

SC 06-010
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SUPERSEDES: MA 03-017

19.b **Tuberculosis (TB) related services under section 1902(z) (2) (A) - (D) and (F) of the Act**

TB related services are available for persons identified as having active TB disease, or who have been exposed to TB. Recipients who are identified with TB disease or TB infection who are in other eligibility category and those who qualify for TB Only Related Services will be covered. TB-related services listed in section 1902(z) (2) (A)-(D) are furnished to the same extent as these services are available to other categorically needy individuals when the service is related to the diagnosis, treatment or management of the eligible individual's TB.

Services include:

- Prescribed drugs;
- Physician services and services related to TB including outpatient hospital services, public health clinics, rural health clinic services, and federally qualified health center services;
- Laboratory and X-ray services (including those to confirm the presence of infection or disease);

Directly Observed Therapy (DOTDOT) services are covered where patients are observed to ingest each dose of anti-tuberculosis medications, to maximize the likelihood of completion of therapy. DOT services includes medication monitoring.

Non-Covered Services

- This plan does not cover hospital stays or room and board.

Providers Eligible to Bill for this Service

The South Carolina Department of Health and Environmental Control (SCDHEC) is the single state agency that is responsible to protect the citizens by treating both TB and latent TB, identifying and testing individuals exposed to TB, and screening and testing persons who might have a high risk of getting the disease. SCDHEC clinic providers and all Medicaid enrolled providers with prescriptive authority are responsible for prescribing an appropriate medication regimen and also for ensuring successful completion of established SCDHEC TB protocols.

To be eligible to bill for TB services a provider shall:

- a. meet South Carolina Medicaid qualifications for participation;
- b. be currently Medicaid - enrolled; and
- c. bill only for procedures and services that are within the scope of their clinical practice, as defined by S. C. Labor Licensing and Regulation.

The following providers in a health department setting are eligible to perform this service:

- a. Physicians
- b. Nurse practitioners
- c. Physician assistants
- d. Public Health Nurses (A public Health Nurse is a Registered Nurse or Nurse Practitioner that is working under the approved protocol of a Public Health Physician)

20.a Extended Services To Pregnant Women
&

20.b In an effort to improve access and a continuum of care for pregnant women, the following measures have been implemented. All services are available to all pregnant women and their infants to ensure early and adequate access to prenatal care, a medical home, health education, nutritional counseling, follow-up for compliance with social, medical and home environmental assessment and counseling.

Available Services:

A. Risk Assessment

All pregnant women should be evaluated for medical risks at the earliest possible time after confirmation of pregnancy. The assessment is in addition to the initial maternal care examination. A subsequent assessment is appropriate if and when the patient's risk status changes.

Another risk assessment is allowed for the infant and should be completed as soon after birth as possible.

A risk assessment is the "gateway" service that determines whether the patient is medically high risk. It is the determinant of whether the patient should receive coordinated high risk services or be offered non-high risk services.

B. Healthy Mothers/Healthy Futures Program

To encourage appropriate access and adequate medical care, all pregnant women may receive enhanced educational and referral services. All Primary Care providers enrolled may render and bill for delivery of the enhanced services as published in the Healthy Mothers/Healthy Futures Program.

Providers who participate in the Healthy Mothers/Healthy Futures program may bill using enhanced service codes which reflect the following services:

- Initial Maternal Care - This services takes place in a medical setting at the initial maternal visit. During this exam, the patient receives standard medical services from a physician including a physical examination, medical history and laboratory tests. The physician seeks to identify problems that may jeopardize birth outcomes. It includes health education, referral to Women, Infant and Children (WIC) and to any additional services considered appropriate. Reimbursement for this service is based only on referral, not on whether the patient chooses to pursue the services provided by these referrals. It is expected that the medical provider will inquire as to whether the patient pursued the referrals.
- Antepartum Exam With Additional Services - This service involves follow-up to determine whether the patient has chosen to pursue referrals and follow-up on missed appointments.

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SUPERSEDES: MA 90-007

- Postpartum Care With Additional Services - This service includes referral for family planning to WIC and parenting education. Reimbursement is not based on the patient's acceptance of a family planning method.

C. Postpartum Home Visit

The postpartum home visit is ordered by a primary medical care provider and provided by a licensed registered nurse. It focuses on the mother/infant within six weeks after delivery by identifying postpartum/newborn needs of the patient.

Postpartum home visit providers will:

- Perform a medical assessment of the postpartum mother/infant;
- Assess household components to determine barriers to health;
- Provide counseling regarding postpartum recovery, family planning, needs of a newborn; and
- Assist the family in establishing a primary source of care and a primary care provider (i.e., ensure that the mother/infant has a postpartum/newborn visit scheduled).

One repeat visit is allowed to follow up any identified medical needs (e.g., the postpartum mother had a fever at the time of the initial visit).

A pre-discharge home visit is allowed to assess the condition of the home of an infant who is, or has been, a patient in a Neonatal Intensive Care Unit (NICU) or, has had a significant medical problem. The goal is to ensure a safe household, conducive to the health of the infant, after discharge from the hospital. The visit must be made in response to a referral by a physician directly involved in the care of the infant while he or she is hospitalized.

Services may be provided by public (e.g., state/county health departments) or private (e.g., Federally Qualified Health Centers, home health companies, etc.) entities.

D. Enhanced Services

All non-high risk pregnant women are eligible for nutrition, health education and psycho-social assessments to determine factors that may negatively impact birth outcomes. If appropriate and deemed necessary after the evaluation, all pregnant women may receive nutrition and educational services in addition to psycho-social counseling. All appropriate referrals for treatment are covered if the patient is referred to an approved provider.

These services include the following:

1. Psycho-Social Intervention (PSI) - Assessment and treatment provided to maternity patients through face-to-face encounters. The assessment identifies psycho-social factors (e.g., spouse abuse, co-dependency, etc.) that may negatively impact the pregnancy and birth outcome. Problems that are identified by the assessment will be addressed through psycho-social follow-up/treatment services provided on an individual basis and based on a plan of care. These services may be provided in the clinic, home or other appropriate settings.

Appropriate Provider Staff: Must have master of social work degree or Bachelor of Social Work Degree, licensed as LMSW, LISW, or LBSW by the South Carolina Board of Social Work Examiners. The LBSW must be under the supervision of a masters level social worker (LMSW, LISW).

SC: MA 04-001

EFFECTIVE DATE: 07/01/04

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SUPERSEDES: MA 90-007

2. Nutritional Services - Assessment and treatment provided to referred maternity patients in the clinic or home through face-to-face encounters. The goal of nutrition services is to promote health by achieving and maintaining optimal nutritional status throughout the pregnancy. Nutrition services are an integral part of all health care. Conditions during the pregnancy which frequently necessitate referral include patients who are underweight/overweight or have low iron stores. A comprehensive nutritional assessment will be completed on any low risk maternity patient who is referred to a nutritionist. Prenatals should receive this nutritional service in such a timely manner that the greatest benefit from this service will be realized (e.g., early in gestation). The nutritional assessment must be in addition to the required WIC food frequency and nutrition education encounters. Nutrition follow-up/treatment is provided on an individual basis, based on a treatment plan.

Appropriate Provider Staff: Nutritionist with Master's Degree in Public Health Nutrition, Community Nutrition, Dietetics or a related field; or a Bachelor's Degree in Public Health Nutrition, Community Nutrition, Dietetics or related field; or a Bachelor's Degree and successful completion of a dietetic internship or a coordinated undergraduate program in dietetics.

3. Health Education - Information and process oriented activities provided on an individual or group basis. These services are based upon individual needs assessments and are designed to predispose, enable or reinforce the voluntary adaptation of behavior by the pregnant woman that is conducive to health and positive birth outcomes. Examples: parenting, smoking cessation, alcohol and other drug effects. Health education services will be provided in accordance with published guidelines, which include SHHSFC approval of curricula and providers.

Health Education Visits - Visits accommodate the need for confidential discussion, scheduling convenience and other learner needs.

Collaborative Group Instruction is learning through collaboration and involves at least three learners. Focused interaction is the essential element of this type of health education service.

Information Group Instruction allows and encourages interaction between learners; however, the primary focus is to distribute essential information in an attractive and stimulating format.

Appropriate Provider Staff: Health Education Specialist, Health educator I, II and III or appropriate designees (medical, nursing and allied health professionals).

SC: MA 90-007
EFFECTIVE DATE: 4/01/90
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SUPERSEDES: N/A

E. Family Planning

Family planning services should be an integral part of the medical and social care of the Medicaid eligible pregnant woman and parent of a newborn infant. The patient should be encouraged to seek and adhere to a family planning program of her choice. Family planning services are documented in the appropriate Medicaid Provider Manuals.

Existing family planning services focus on physical examinations to determine the appropriateness of a birth control method and the dispensing of the method (e.g., birth control pills, condoms). The enhanced family planning services provide for counseling and education to help pregnant women a) plan for their postpartum birth control method; b) make informed decisions regarding sterilization; and c) become aware of the potential health hazards of another pregnancy before the body has had time to heal from the current one. Existing family planning codes are not reimbursable at rates that include a provider's cost for the additional staff time to provide intensive counseling and education components. These enhanced services assure that the patient receives the vital information by accommodating the additional cost. The patient's freedom of choice for family planning services and/or family planning providers will not be restricted.

F. General Maternal Care

Antepartum and postpartum examinations are unlimited and not restricted by the Ambulatory Care visit limitations. All medical services including laboratory and x-ray are provided as medically indicated without limitations.

24.a **Transportation Services**

GENERAL DESCRIPTION OF SERVICES

In accordance with federal regulations (42 CFR 431.53), the NET program offers transportation services for Medicaid beneficiaries who need to secure necessary health care and have no other means of transportation. The South Carolina Medicaid program covers transportation to and from health care services when those services are covered under the Medicaid State Plan. The State Medicaid Agency utilizes a brokerage service responsible for the administration and provision of non-emergency transportation through a network of services delivery providers. The broker is responsible for determining the most appropriate level of transportation for beneficiaries and for ensuring safe and timely transportation. The broker network of providers includes non-emergency ambulance services for beneficiaries restricted to transport in a supine or prone position. Medicaid access to emergency ambulance service is unaffected.

SC: 11-002
EFFECTIVE DATE: 03/01/11
RO APPROVAL: 05/27/11
SUPERSEDES: SC 06-008

A. Provisions For Brokered Services

The Broker(s) shall provide administrative oversight and reporting, recruit and negotiate contracts with transportation providers, payment administration, gate-keeping, certification and verification of need and cost-effectiveness, reservations, scheduling and trip assignments, and quality assurance. The broker is not a government entity. The broker is an independent entity and may not itself provide transportation under the contract with the State, or refer to or subcontract with a transportation provider with which it has a financial relationship, unless there are no other available qualified providers of transportation.

Non-Emergency Transportation Services

Non-Emergency Transportation (NET) services provides for beneficiary transport to and from medically necessary covered services under the Medicaid State Plan. NET services shall be provided within each region as defined by the State through the broker and in accordance with Medicaid generally accepted normal service delivery areas as required to meet the needs of the general Medicaid beneficiary population to include but not limited to dialysis, foster care and special populations for both normal business hours and after normal business hours, including weekends and holidays, as needed. Broker(s) are responsible for provision of all non-emergency transportation to include ensuring the transportation of all Medicaid eligible beneficiaries and escorts from a stated point of origin which may include prior approved lodging facilities to a specific Medicaid covered service and from the covered service back to the stated point of origin.

Transportation services mode of transport will include:

- wheelchair van
- taxi
- bus passes
- airline tickets
- minibus
- passenger automobile
- van
- minivan
- non-emergency ambulance transportation (stretcher)
- stretcher van

Other Types of Transport Services (Brokered)

NET services shall be provided within each region as defined by the State through the broker and in accordance with Medicaid generally accepted normal service delivery areas as required to meet the needs of the Foster Care Medicaid beneficiary population. Foster care providers are responsible for Medicaid eligible children in non-custodial and non-parental circumstances and furnish transportation by privately-owned vehicle transportation for beneficiaries to and from approved Medicaid services.

SC: 11-002
EFFECTIVE DATE: 03/01/11
RO APPROVAL: 05/27/11
SUPERSEDES: SC 06-008

Non-Emergency Ambulance Services

Non-emergency ambulance services are provided to a Medicaid covered service only when medically necessary. Medical necessity for non-emergency ambulance transport is established when the beneficiary's medical condition prohibits any other means of transportation. Non-emergency ambulance transportation is medically necessary when the beneficiary is unable to ambulate without assistance or where it is documented that other methods of transportation would endanger the beneficiary's health. Non-emergency ambulance services are provided when the beneficiary is non-ambulatory, restricted to transport in a supine or prone position and a health care professional certifies through SCDHHS Form 216 that the beneficiary's health condition requires the use of an ambulance transport. Non-emergency ambulance transportation may include basic life support (BLS) and convalescent.

Coverage of Meals, Lodging and Escorts

- (1) In-state services for lodging and meals for beneficiaries and escorts related to transport to Medicaid covered services, to include those provided by NET broker shall be made available to beneficiaries and attendants (escorts) and limited to prior approved arrangements and reimbursement as determined to be appropriate. When the State, in its sole discretion, determines it to be efficient, cost effective and medically necessary, an attendant may accompany the recipient to and from covered medical services. SCDHHS in its role as the Medicaid State Agency shall provide final approval for meals, lodging, an attendant (escort) and any other payments. The Broker will make a case-by-case determination of the type of lodging arrangements and amount of reimbursement as may be appropriate for in-state lodging and meals for beneficiaries and attendant (escorts).
- (2) Out-of-state transportation services shall be made available to beneficiaries and escorts and limited to the arrangement or reimbursement, as may be appropriate for air fare, lodging, meals and ground transportation vehicle mileage to obtain an approved Medicaid service. When the State, in its sole discretion, determines it to be efficient, cost effective and medically necessary, an attendant may accompany the recipient to and from covered medical services. SCDHHS in its role as the Medicaid State Agency shall provide final approval for meals, lodging, and attendant (escort). The Broker will make a case-by-case determination of the type of lodging arrangements and amount of reimbursement as may be appropriate for out-of-state mode of transport (air, ground, taxi shuttle service or rental care) lodging and meals for beneficiaries and escorts. The Medicaid State Agency will make the determination of medical necessity for beneficiaries to access out-of-state services and pre-authorize all transportation related services.

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EFFECTIVE DATE: 03/01/11
RO APPROVAL: 05/27/11
SUPERSEDES: SC 06-008

Prior Approval For In-State and Out-of-State Transportation and Other Related Travel Expenses

As a condition of reimbursement for Medicaid beneficiaries and approved escort transportation and other related travel services, prior approval is required by the Medicaid State Agency. Prior approval pertains to medical necessity of the service and reasonableness and appropriateness of mode of transport and related services (meals, lodging, attendant (escort) and ground transportation) for the Medicaid beneficiary and approved escort as provided by established Medicaid State Agency protocol. The Medicaid State Agency shall authorize:

- a. Arrangement or reimbursement for out-of-state air fare within limits established by the state.
- b. Reimbursement for in-state and out-of-state lodging and meals en route to and from medical care and while receiving medical care within guidelines established by the State for reimbursement for state employee travel.
- c. Reimbursement at the established state rates for out-of-state ground vehicle rental or ground vehicle mileage for travel directly related to the origination and designation for the approved medical services facility. Coverage for vicinity mileage is limited to travel directly related to the point of origination from lodging to the point of designation to the approved medical service facility
- d. Prior approval is required for transportation outside the South Carolina Medical Service Area (SCMSA) to an approved medical service facility considered in-state. The South Carolina Medical Service Area (SCMSA) is the area of the state of South Carolina and the area within twenty-five (25) miles of the South Carolina border. If any part of the metropolitan area of a city, such as Charlotte, Augusta, Savannah, etc., is within twenty-five (25) miles of the state border, the entire metropolitan area is considered as being within the SCMSA.

Non-Covered Ambulance Services

Ambulance services are not covered without medical justification or compliance with established Medicaid State Agency protocol in the following circumstances:

- (1) Routine service to and from a physician's office.
- (2) Service for ambulatory beneficiaries whose illness or injury does not justify medical necessity.
- (3) If the beneficiary was pronounced dead at the scene by authorized personnel; (i.e., coroner, M.D., etc).
- (4) Service to or from a hospital outpatient department for regularly scheduled treatment.
- (5) Service to or from a nursing facility to a hospital outpatient department for routine medical services.

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SUPERSEDES: SC 06-008

- (6) Service from a hospital to a nursing facility which is out of the locality of the hospital.
- (7) The ambulance was used solely because other means of transportation were unavailable, untimely or an inconvenience.
- (8) The beneficiary was transferred to another facility at his/her request or that of the family for convenience.

Note: Exceptions to all of the above will be reimbursed only if the documented diagnosis, medical necessity, and circumstances adequately justify the services.

Access to Non-emergency Transportation for Dual Eligible Beneficiaries Receiving Medicare Part D Outpatient Drugs

Transportation to and from a pharmacy to obtain Part D prescription drugs is covered for full-benefit dual eligible beneficiaries and is provided through the Broker. No transportation to and from a pharmacy is available when the pharmacy delivers or can provide medications by mail order.

B. Provisions For Non-Brokered Services (FEE FOR SERVICE)

Emergency Ambulance Services

Emergency ambulance services are provided to a Medicaid covered service only when medically necessary. Medical necessity for ambulance transport is established when the beneficiary's condition warrants and the use of any other method of transport is inappropriate. Ambulance transportation is medically necessary when the beneficiary was transported in an emergency situation (e.g., as a result of an accident, injury or acute illness). Emergency ambulance services shall include air ambulance transport by fixed and rotary wing aircraft.

Special Needs Transportation

Special Needs transportation services by specially adapted school bus are provided directly by the Local Education Agencies for Special Needs Medicaid eligible pupils when Medicaid reimbursable services are provided either on-site or through referral to school-based services subcontractors and the Medicaid reimbursable services and transportation is identified in the Individual Education Plan (IEP).

Other Types of Transport Services (Non-Brokered)

- (1) NET services are provided to Medicaid eligible children who may require non-parental escort to receive therapeutic, behavioral and other Medicaid state plan services by enrolled/contracted local community-based providers. Transports are provided for Medicaid eligible children to receive such services under the Medicaid State Plan in the community or a non-school setting.

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SUPERSEDES: SC 06-008

- (2) NET broker services are not furnished for beneficiary transport to an Adult Day Health Care center within an exclusion zone of 15 mile radius of an Adult Day Health Care facility. Beneficiary transport within the 15 mile zone is the responsibility of the Adult Day Health Care provider. The cost of beneficiary transportation to Adult Day Health Care service within a 15 mile radius of a facility is borne by the Adult Day Health Care Provider.
- (3) State agencies provide NET for transportation of special populations (e.g., generally comprised of unescorted children, consumer of mental health and therapeutic services and other special Medicaid eligible beneficiaries who require Medicaid covered services. Transports are generally provided for Medicaid eligible beneficiaries to receive mental health or behavioral treatment services at community-based providers.
- (4) NET services are provided by local education agencies for off campus transport of Medicaid eligibles to and from medically necessary Medicaid covered services. Transportation services are provided during school hours for Medicaid eligible to receive Medicaid services at community-based providers or through referral to school-based services subcontractors. Transportation services are typically provided from the school to the Medicaid services and return trip to school or home. Administrative costs for schools to arrange transportation are not included in the school-based transportation program provided for in the State Plan and reimbursed by the Medicaid agency.

SC: 11-002
EFFECTIVE DATE: 03/01/11
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SUPERSEDES: SC 06-008

24.d NURSING FACILITY SERVICES (FOR PATIENTS UNDER 21 YEARS OF AGE). Prior approval for admission (or upon request for payment) and/or prior approval for resident case mix classification as appropriate is the responsibility of the Division of Community Long Term Care, SCDHHS. Annual validation of resident case mix clarification based upon a random sample of 20% of facility residents shall be performed for SCDHHS, under contract by DHEC. Includes services provided in a swing bed hospital. Includes subacute care provided to ventilator dependent patients when contracted to provide this care (effective 04/01/89).

Basic services and items furnished in a nursing facility that are included in the per diem rate and must not be charged to the patient include the following:

- A. Nursing Services - Includes all nursing services to meet the total needs of the resident, the administration of treatments and medications as ordered by the physician, assistance with mobility (walking and wheelchair), and routine nursing supplies. Nursing supplies include, but are not limited to such items as syringes, air mattresses, I.V. supplies, adhesive tape, canes, ice bags, crutches, glycerine, mouth swabs, water pitchers, bed pans, thermometers and urinals.
- B. Special Services - Including assistance by the facility social worker, participation in planned activities, physical therapy, speech therapy, occupational therapy and inhalation therapy.
- C. Personal Services - Services for the comfort of the resident which include assistance with eating, dressing, toilet functions, baths, brushing teeth, washing and combing hair, shaving and other services necessary to maintain a clean, well kept personal appearance. Includes assistance with walking and wheelchair use when necessary. Diapers and underpads are provided as needed.
- D. Room and Board - Includes a semiprivate or ward accommodations, all meals including special diets and snacks ordered by the physician. Includes feeding residents if unable to feed themselves and tube feedings. Housekeeping services and bed and bath linens are included.
- E. Safety and Treatment Equipment - Including, but not limited to the following items: standard wheelchairs, infusion equipment, bedside commode, side rails, restraint chairs (Geri-chairs), suction apparatus, walkers, crutches, canes and other equipment that is generally used by multiple residents and does not become the property of the individual resident.
- F. Medications - Over-the-counter (OTC) non-legend medications are included (except for insulin).

SC 05-013
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SUPERSEDES: MA 99-002

- G. Medical Supplies and Oxygen - The following items are included, however, the included items are not limited to this list: oxygen, supplies used for inhalation therapy, catheters and related supplies, dressings, disposable enema equipment or other irrigation supplies, I.V. solutions, disposable instrument trays, levine tubes and other supplies ordered by a physician or necessary to meet the needs of the resident because of the resident's medical condition.
- 24.e EMERGENCY HOSPITAL SERVICES - These services are subject to the limitations found in the introduction to the Limitation Supplement to Attachment 3.1-A.
- 28(i) Licensed or Otherwise State-Approved Freestanding Birth Centers: - Medicaid will provide coverage for Birthing Centers as long as they are licensed by the appropriate licensing and regulation agency(ies) and are an enrolled provider in Medicaid. Services will be limited to obstetrical services, newborn care and routine maternal care.
- 28(ii) Licensed or otherwise State-Recognized covered professionals providing services in the Freestanding Birthing Center: - Medicaid coverage for Licensed Midwives and Certified Nurse Midwives includes all obstetrical services, newborn care and medical routine maternal care. All services must be medically necessary.

SC 11-016
EFFECTIVE DATE: 09/15/11
RO APPROVAL: 12/21/11
SUPERSEDES: SC 08-024