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PROGRAM OVERVIEW

COMMUNITY LONG-TERM CARE (CLTC)

The mission of Community Long-Term Care (CLTC) is to provide a cost-effective alternative to institutional placement for eligible clients with long-term care needs, if they choose, allowing them to remain in a community environment. The Department of Health and Human Services (DHHS) Division of Community Long-Term Care operates several waiver programs, as well as two Department of Disabilities and Special Needs (DDSN) waivers. CLTC also administers the Palmetto SeniorCare program.

The following timeline denotes the services provided by the CLTC program and when they were enacted:

- In December 1984, the Centers for Medicare and Medicaid Services (CMS) approved South Carolina's request for a home- and community- based waiver for the elderly and disabled.
- In 1988, CMS authorized South Carolina to provide services under a Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) waiver to eligible persons with HIV/AIDS.
- In 1989, CMS authorized Palmetto SeniorCare. In 2003, this became a State Plan service.
- In January 1990, the Children's Personal Care Aide (PCA) service was approved as a part of the Medicaid State Plan to provide PCA to children under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.
- In October 1991, CMS authorized South Carolina to provide services under a Mental Retardation/Related Disabilities (MR/RD) waiver to eligible persons.
- In December 1994, CMS authorized South Carolina to provide services under a Mechanical Ventilator Dependent waiver to eligible persons.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM OVERVIEW

COMMUNITY LONG-TERM CARE (CLTC) (CONT'D.)

- In April 1995, CMS authorized South Carolina to provide services to eligible persons with head and spinal cord injuries (HASCI).

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PROGRAM REQUIREMENTS

PROVIDER QUALIFICATIONS

All CLTC services have prerequisites for participation and require enrollment/contracts with DHHS. Certain licensing requirements may also exist. Please see Section 1 of this manual for general Medicaid enrollment and licensing requirements.

Enrollment

CLTC providers are required to complete and sign an individual enrollment form (DHHS 219-CLTCIC or CLTCI-NC) before submitting claims to Medicaid. Group providers must complete a separate form (DHHS 219-CLTCGC or CLTCG-NC). The Forms section of this manual contains copies of the enrollment forms.

Contracted Provider

Providers must have a contract with DHHS to provide CLTC Medicaid services requiring a contract.

Cost Reports

With the exception of respite care, all contracted providers are required to submit a final cost report for each service. The final cost report must cover the entire contract period and be filed no later than 90 days after the end of the reporting period. The cost report shall include the actual cost and service delivery information for the reporting period. If the provider fails to file the cost report within the specified time, all funds due the provider shall be withheld by DHHS until the report is filed. All cost reports should be mailed to:

Department of Health and Human Services
Division of Ancillary Reimbursements
Post Office Box 8206
Columbia, SC 29202-8206

If you have any questions regarding cost reports, contact the SCDHHS Medicaid Provider Service Center at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us.

Non-Contracted Provider

As a condition of participation and payment, CLTC non-contracted providers must complete and sign a Medicaid Enrollment Agreement with DHHS to provide CLTC Medicaid services.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Compliance Review

Before entering into any contractual arrangement with a provider, DHHS will have the Division of Community Long-Term Care conduct a compliance review of the prospective provider. The purpose of this review is to establish that the prospective provider meets the requirements outlined in the applicable Scope of Services. If the provider satisfactorily meets the precontractual compliance review requirements, the contract process will continue.

Compliance reviews are completed approximately 90 days after initiation of services with CLTC. Unannounced reviews are conducted thereafter. At the sole discretion of DHHS/CLTC, special reviews may be conducted at any time.

Field Service Representatives

After enrollment, visits are made to providers periodically and upon request. The purpose of each visit is to coordinate information concerning the Medicaid program and provide technical assistance as required.

Workshops are conducted on a periodic basis to acquaint providers with current Medicaid policy and regulations, changes, or amendments.

Requests for Field Service assistance and questions regarding manuals, bulletins, or workshops should be directed to the SCDHHS Medicaid Provider Service Center at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us.

COMMUNITY LONG-TERM CARE (CLTC) FUNCTIONS

Intake

The intake process in the CLTC area office ensures that all persons with perceived long-term care needs receive every opportunity for exposure to the CLTC program. The process identifies persons who may be eligible for the program and serves as an information and referral source for those who do not meet intake criteria.

Assessment

Assessment uses a comprehensive standard instrument to determine a client's current long-term care needs. Information obtained during the assessment process will assist staff in making a level-of-care decision and initiating a plan of service for discussion with the client and/or family.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Level-of-Care Determination

Level-of-care determination is the process of identifying the extent of a person's medical, psychobehavioral, and functional disability in keeping with the South Carolina Level-of-Care Criteria for Medicaid-Sponsored Long-Term Care. To be eligible for CLTC services, a person must be determined to meet either skilled or intermediate level-of-care criteria, or, in the case of persons with HIV/AIDS, be at risk for hospitalization. These criteria help determine a client's requirement for care.

Service Planning

Service planning encompasses a comprehensive review of the client's problems and strengths. Mutually agreed-upon goals are set based on identified needs. This service planning process allows for participation of the client and/or family, physician, service providers, and the CLTC case management team. Service planning provides involved persons with information necessary to make an informed choice regarding the location of care and services to be utilized. The outcome of this process is a written plan of service.

Service Authorization

A service authorization is a written document that enables contracted/enrolled service providers to initiate CLTC services for Medicaid-eligible clients. The service authorization is based on the CLTC plan of service for individual CLTC clients. With the exception of case management, prior authorizations are required for all CLTC services.

Case Management

CLTC case management is a vital part of the long-term care program that is provided for all waiver clients. (Case management for HASCI and MR/RD waiver clients is provided by DDSN.)

Case management ensures continued access to the long-term care program. It also enables case managers to advise, support, and assist clients and their families in coping with changing needs and in making decisions regarding long-term care.

Case management includes the following five activities: service counseling, service planning, service coordination, monitoring, and re-evaluating.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Prior Authorization of CLTC Services

Client Choice of Providers

CLTC clients are required to choose a service provider from a Client Choice of Provider(s) Form, which lists available providers of each service for the client's waiver of participation. The Client Choice of Provider(s) Form will identify the referring entity and CLTC provider(s) already involved in the care of the client. Any service requiring a referred provider to participate in a bid process is excluded from this policy. For bid process services, the provider submitting the lowest bid will be awarded the referral. If the provider submitting the lowest bid cannot provide the service, the referral will be awarded to the next lowest bidder.

Authorization of Services

Services must be pre-authorized by the CLTC case manager based on the client's plan of service. Authorization will be transmitted to the provider by the completion of a CLTC Service Provision Form (DHHS Form 175). (For an example of this form, please see the Forms section.) Accompanying the authorization will be a copy of the plan of service and, if appropriate, a copy of the physician's order.

Authorization Periods

Authorizations will be issued for all CLTC services indicating the beginning date of the service, the days of the week that the service will be provided, and the number of units of service to be provided. The hours of service will be indicated only if specific times are essential to meeting the client's service needs. For some services, the authorization will designate that the service is to be provided during the morning, afternoon, or evening. The authorization period ending date may or may not be indicated on the Service Provision Form. Authorizations without an ending date will be valid until a revised Service Provision Form is issued to the provider.

Changes in Services Within an Authorization Period

Should the client's needs change during an authorization period, a revised Service Provision Form will be sent to the provider. Changes in frequency of a particular service do not require a new physician's order.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Interruption of Services

Previously authorized Personal Care Aide (PCA) services will be interrupted if the client enters a hospital or institution for a temporary stay or temporarily chooses not to receive services. The interruption of PCA services does not require a revised Service Provision Form, unless the service is to be interrupted for an extended time.

Termination of Authorized Services

Service must be officially terminated whenever it is determined that the client no longer requires an authorized service or becomes either medically or financially ineligible. Both the client and the provider must be notified of the termination of services by personal contact. This verbal notification must be followed with a written confirmation of termination of the service.

DDSN SERVICE COORDINATION FUNCTIONS

Intake

The intake process at the local DDSN board ensures that all persons with perceived long-term care needs receive every opportunity for exposure to their programs. The process identifies persons who are eligible for programs and serves as an information and referral source for those who do not meet intake criteria. For all Head and Spinal Cord Injury client referrals, call 1-866-867-3864.

Assessment

Assessment is a method of determining a client's current long-term care needs. Information obtained during the assessment process will assist the service coordinator in initiating a plan of service for discussion with clients and/or their families.

Service Planning

Service planning encompasses a comprehensive review of the client's problems and strengths. Mutually agreed-upon goals are set based on identified needs. This service planning process allows for participation of the client and/or family, physician, service providers, and the service coordinator. Service planning provides information necessary to make an informed choice regarding the location of care and service to be used to the people involved. The outcome of this process is a written plan of service.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Service Coordination

Service coordination is a vital part of the DDSN programs and is provided for all service beneficiaries. This process ensures continued access to DDSN programs and enables service coordinators to continue advising, supporting, and assisting clients and their families in coping with changing needs and in making decisions regarding DDSN programs.

Service coordination includes the following five activities: service planning, coordinating service, service authorization, monitoring, and re-evaluating.

Prior Authorization of DDSN Services

Based on the client's plan of service, services will be authorized by DDSN's service coordinator and transmitted to the provider on an Authorization Form. Please see the Forms section for copies of MR/RD and HASCI Waiver authorization forms.

Authorization Periods

Authorizations shall be issued for all DDSN services indicating the beginning date and the number of units of service to be provided.

Changes in Services Within an Authorization Period

Should a client's needs change during an authorization period, a revised authorization form shall be sent to the provider.

Termination of Authorized Services

The service coordinator will terminate services when a client no longer requires an authorized service. Providers receive written notice of termination.

PRIOR AUTHORIZATION FOR HOSPICE PARTICIPANTS

In certain situations, Medicaid beneficiaries receiving the State Plan hospice benefit may receive waiver services. Prior authorization by the hospice provider is required in cases where waiver services are authorized for Medicaid hospice beneficiaries. The prior authorization number must be placed on the claim in order for the provider to receive reimbursement. The case manager obtains the prior authorization number from the hospice provider and gives it to the provider of the authorized service. Providers submitting hard copy CMS-1500 claims must place the prior authorization number in field 19, which is the "Reserved for Local Use" field. Providers submitting claims electronically by diskette or magnetic tapes will place the prior authorization number in field 10, which is the "Referring Physician Number" field. Providers who

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

PRIOR AUTHORIZATION FOR HOSPICE PARTICIPANTS (CONT'D.)

receive the 976 edit (hospice beneficiary/service requires prior approval) may resolve the edit by placing the prior authorization number in field 7 on the Edit Correction Form, which is the “PC COORD” field. See Section 3 of this manual for complete billing instructions.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

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SECTION 2 POLICIES AND PROCEDURES

CLTC WAIVER SUPPLY PROVIDERS

HOME AND COMMUNITY BASED WAIVER PROGRAMS

Home and Community Based Waivers (HCBW) are programs that allow individuals who meet an institutional level of care to receive items and services not covered through the South Carolina Medicaid State Plan. These items and services are allowed through the waiver programs to assist individuals in remaining in their own home or other community setting and avoiding institutional placement.

South Carolina currently administers seven waivers that allow for the provision of supplies. The Community Choices, HIV/AIDS, Mechanical Ventilation, and Medically Complex Children waivers are operated by the Department of Health and Human Services. Authorizations for these waivers will be made through the SCDHHS Phoenix web-based case management and authorization system. This system notifies the provider with an email directing the provider to a secure website. The provider will accept authorizations at this website. All providers requesting enrollment as a CLTC provider to distribute waiver supplies must be trained and utilize the Phoenix web-based case management and authorization system.

For waivers operated by the Department of Disabilities and Special Needs (DDSN), which include the Mental Retardation/Related Disability, the Head and Spinal Cord Injury and Community Supports waivers, all authorizations will be faxed to the provider.

Providers of waiver supplies must verify Medicaid eligibility of each participant prior to rendering services and at least one business day prior to transmitting the order. To verify Medicaid eligibility, the provider can, utilize the South Carolina Medicaid Web-Based Claim Submission Tool or by utilizing other point of sale devices.

SECTION 2 POLICIES AND PROCEDURES

CLTC WAIVER SUPPLY PROVIDERS

AUTHORIZATIONS FOR INCONTINENCE PRODUCTS

Providers must deliver products based on authorizations received from case managers/nurses and service coordinators/early interventionists working with participants. SCDHHS/SCDDSN will not authorize or pay for incontinence products for children under age 4.

The authorizations will provide the frequency of delivery and the participant information necessary to provide the incontinence products. Authorizations may provide for monthly, bi-monthly, or other frequency arrangements. However, incontinence products will not be delivered more frequently than monthly for each authorized participant. For authorizations that indicate an amount on a per case basis, the case quantity is as listed on the following table:

Current Reimbursement Rates and Authorization Amounts

Service	Rate	Maximum Frequency	Quantity Authorized	Procedure Code
Bariatric Diaper	$1.27/diaper	Monthly	96	T4543
ADULT x-large	$0.73/diaper	Monthly	96	T4524
Adult Large	$0.56/diaper	Monthly	96	T4523
Adult Medium	$0.46/diaper	Monthly	96	T4522
Adult Small	$0.47/diaper	Monthly	96	T4521
Pediatric Diaper Small	$0.45/diaper	Monthly	96	T4529
Pediatric Diaper Large	$0.45/diaper	Monthly	96	T4530
Pediatric Brief Small	$0.57/diaper	Monthly	80	T4531
Pediatric Brief Large	$0.57/diaper	Monthly	80	T4532
Youth Diaper	$0.47/diaper	Monthly	96	T4533
Adult Brief Extra Large (protective underwear)	$0.78/brief	Monthly	80	T4528
Adult Brief Large (protective underwear)	$0.60/brief	Monthly	80	T4527

SECTION 2 POLICIES AND PROCEDURES

CLTC WAIVER SUPPLY PROVIDERS

AUTHORIZATIONS FOR INCONTINENCE PRODUCTS (CONT'D.)

Service	Rate	Maximum Frequency	Quantity Authorized	Procedure Code
Adult Brief Medium (protective underwear)	$0.54/brief	Monthly	80	T4526
Adult Brief Small (protective underwear)	$0.57/brief	Monthly	80	T4525
Youth Brief (protective underwear)	$0.70/brief	Monthly	80	T4534
Incontinence Pads	$0.21/pad	Monthly	130	T4535
Under Pads	$30.56/case	Monthly	1	A4554
Wipes	$4.89/box	Monthly	70	T5999

All authorizations for incontinence products must utilize the codes established in the table above. The provider is expected to package these items in accordance with the quantity authorized in the table above, even if repackaging is required. After the initial delivery to the participant, future deliveries of the product to the participant must be at the same time of the month as the first delivery and at the frequency established by the authorization.

For any new initial authorizations, the supplies must be shipped within three business days of the provider receiving the authorization and must be received by the participant within one week of the provider's receipt of the authorization.

The provider shall not charge participants additional fees or surcharges; the unit rate reflected in the table above is the price reimbursed to Medicaid providers for incontinence products.

If the provider is unable to provide products as scheduled, the provider must contact the participant by telephone no less than five business days before the scheduled delivery

SECTION 2 POLICIES AND PROCEDURES

CLTC WAIVER SUPPLY PROVIDERS

AUTHORIZATIONS FOR INCONTINENCE PRODUCTS (CONT'D.)

date to inform him/her of the delay in shipment. The provider must offer the participant the option to wait on the product or choose another product that may be delivered on schedule.

- If the provider has made three unsuccessful attempts to contact the participant by telephone, the provider shall send a backorder notification to the participant. The backorder notification must give the participant the option to wait on the product or to choose an alternate product.
- If the provider attempts a delivery and the participant refuses to accept delivery, the provider will provide instructions to the participant on how to obtain the package. The provider must notify the Case Manager/Nurses/Service Coordinator/Early Interventionists if this becomes an issue.

Providers are allowed to ship more than a single months' worth of product to a participant. Providers electing to ship product in advance to a participant's place of residence may not ship more than a full quarters worth of product on any single delivery. Providers opting to ship in this manner accept the risk that the participant may lose Medicaid eligibility prior to the provider being able to bill for a second or third month of product. Authorizations from case managers and service coordinators will still reflect the normal shipment pattern that was originally authorized. The case manager and/or service coordinator will not add comments approving this shipment method. Providers must bill each month of product separately on the first day of the month if they elect to deliver multiple months of product in one shipment.

Incontinence products will be shipped or delivered to participants residing in community residential care facilities, community training homes, supervised living placements, and individual homes (houses, apartments, trailers, rental properties, etc.)

INCONTINENCE PRODUCT QUALITY

All products distributed to home and community based waiver (HCBW) participants must be latex-free and hypoallergenic. Products will not be kept in inventory long enough for the quality to degrade, i.e. adhesives drying out. No damaged or rejected products will be provided to

SECTION 2 POLICIES AND PROCEDURES

CLTC WAIVER SUPPLY PROVIDERS

INCONTINENCE PRODUCT QUALITY (CONT'D.)

(HCBW) participants. All products must not be shipped beyond their expiration date.

- All diapers/briefs must have a closure system, a wetness indicator that is visible to change, a polymer absorbent core in the middle of the product, a hydrophyllic top sheet and a waterproof backing. See the chart entitled, "Adult Briefs," for additional specifications. The provider's products must meet or exceed the requirements of the Standard Product and Universal Requirements.
- Protective underwear must have banding to indicate front and back, contain an absorbent polymer core, have elastic leg gatherings and tear away sides, and be embossed to help with the wicking of liquids away from the skin. See the chart entitled, "Protective Underwear," for additional specifications. The provider's products must meet or exceed the requirements of the Standard Product and Universal Requirements.
- All underpads must have a hydrophilic top sheet that allows fluid to pass quickly into an absorbent core and a polypropylene backsheet that protects against leakage. The underpads should help with wicking of liquid away from the skin.
- A case of medium size underpads must have a minimum count of 200 (minimum size 22"-23"), and a case of large size underpads must have a minimum count of 150 (minimum size 22"-35"). See the chart entitled, "Underpads," for additional specifications. The provider's products must meet or exceed the requirements of the Standard Product and Universal Requirements.
- Incontinence pads, inserts, shields, or liners must have a hydrophilic top sheet, absorbent core, and a waterproof polypropylene backing. The incontinence pad, insert, shield, or liner must be embossed to wick liquids away from the skin. See the chart entitled, "Pads, Inserts, Shields," for additional specifications. The provider's products must meet or exceed the requirements of the Category 2 product in this chart.

SECTION 2 POLICIES AND PROCEDURES

CLTC WAIVER SUPPLY PROVIDERS

INCONTINENCE PRODUCT QUALITY (CONT'D.)

- Disposable wipes must be at a minimum size of six inches by six inches, provided in at least a seventy-count tub, have a pre-moistened, alcohol-free formula, and be safe for use on the skin.
- All pediatric diapers/briefs and protective underwear must be quality premium brands by nationally recognized manufacturers Covidien (Kendall), First Quality, Kimberly Clark, Medline or Proctor and Gamble.

In addition to the other requirements stated above, the provider must:

- Maintain products in inventory for no longer than two months before being delivered to customers
- Maintain climate control measures in its storage facilities to ensure product quality

SCDHHS may perform an audit at any time. The audit may also include but is not limited to pricing and distribution of product adherence, responses to complaints, grievances, or inquiries. SCDHHS reserves the right to audit the provider's performance at any time.

SECTION 2 POLICIES AND PROCEDURES

CLTC WAIVER SUPPLY PROVIDERS

INCONTINENCE PRODUCT QUALITY (CONT'D.)

Adult Briefs

Recommendation:		Two protection levels - Standard and Premium, differentiated by lab performance.	
Product Specification	Size	Overall Length and Width; waist range is for reference only.	
	Performance	Use standard lab measurements as detailed in Attachment A and B	
		Rate of Acquisition (ROA) & Rewet	100 ml fluid add-on for Youth and Small
			200 ml for all others
		Capacity	As per ISO Method
Product Preparation:		Trim waist elastic and leg gathers, if present; fold under the front and back wing flaps	

Standard Brief				Product Performance [1]		
Size	Minimum Length[2]	Minimum Width[3]	Waist Range	ROA ≤	Rewet ≤	Capacity ≥
	inches	inches	inches	seconds	grams	grams
Youth	21.0	15.0	15 - 22"	65.0	4.0	900
Small	26.0	17.5	20 - 31"	65.0	4.0	1,100
Medium	31.0	24.0	32 - 44"	65.0	6.0	1,400
Regular	33.0	27.0	40 - 48"	65.0	6.0	1,400
Large	36.5	29.5	45 - 58"	65.0	6.0	1,700
Extra Large	38.0	31.0	56 - 64"	65.0	6.0	1,700
Extra Extra Large	38.0	33.5	62 - 67"	65.0	6.0	1,700

Premium Brief				Product Performance [1]		
Size	Minimum Length[2]	Minimum Width[3]	Waist Range	ROA ≤	Rewet ≤	Capacity ≥
	inches	inches	inches	seconds	grams	grams
Youth	21.0	15.0	15 - 22"	60.0	2.0	1,100
Small	26.0	17.5	20 - 31"	60.0	2.0	1,300
Medium	31.0	24.0	32 - 44"	60.0	2.5	1,800
Regular	33.0	27.0	40 - 48"	60.0	2.5	1,800
Large	36.5	29.5	45 - 58"	60.0	2.5	2,100
Extra Large	38.0	31.0	56 - 64"	60.0	2.5	2,100
Extra Extra Large	38.0	33.5	62 - 67"	60.0	2.5	2,100

Notes

[1] To qualify for inclusion on the formulary, products need to meet or exceed two of the three performance standards and be within 15% of the third standard

[2] Measured by cutting leg elastic and stretching flat

[3] Measured at non-tape end

Universal Requirements

1. Designed with wetness indicator visible on the outside of the brief
2. Designed with a side closure system (if tape tab, mimimum of 2 per sie and width ≥ 5/8")
3. Designed with multi-elastic leg gathers
4. Backing is waterproof

SECTION 2 POLICIES AND PROCEDURES

CLTC WAIVER SUPPLY PROVIDERS

INCONTINENCE PRODUCT QUALITY (CONT'D.)

PROTECTIVE UNDERWEAR

Recommendation		One protection level	
Product Specification	Dimension	Waist	Measure inside width fully stretched out under tension
		Length	Cut product at side seams
			Measure length fully stretched out under tension
	Performance	Rate of Acquisition & Rewet	100 ml fluid add-on for all products
		Total Capacity	As per ISO Method
	Product Preparation	Cut product at side seams Pin the product down so it lies flat	

Size	Minimum Inside Width [2]	Minimum Length [3]	Product Performance [1] ROA	Rewet	Capacity
			≤	≤	≥
	inches	inches	seconds	grams	grams
Small	18	23	60.0	2.0	900
Medium	22	28	60.0	2.0	1,000
Large	27	31	60.0	2.0	1,100
Extra Large	31	32	60.0	2.0	1,200

Universal Requirements

1. Designed with a continuous elasticized waistband and side panels.
2. Designed with multi-elastic leg gathers
3. Backing is waterproof

Notes

[1] To qualify for inclusion on the formulary, products need to meet or exceed two of the three performance standards and be within 15% of the third standard

[2] Measure inside width stretched out under full tension

[3] Measured by cutting product at side seams and fully stretching flat under tension.

SECTION 2 POLICIES AND PROCEDURES

CLTC WAIVER SUPPLY PROVIDERS

INCONTINENCE PRODUCT QUALITY (CONT'D.)

Underpads

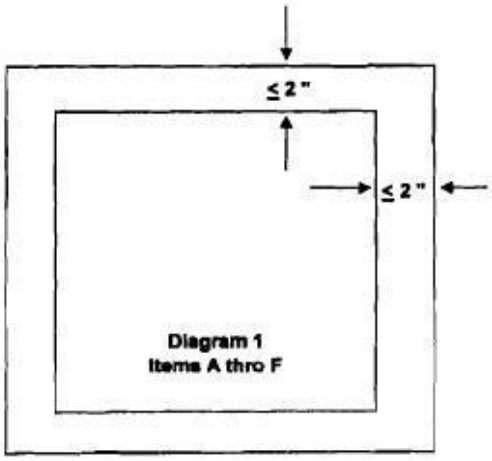
Recommendation: Seven sizes of Underpads in two protection levels
To ensure acceptable performance levels, minium absorbent core area is also specified.

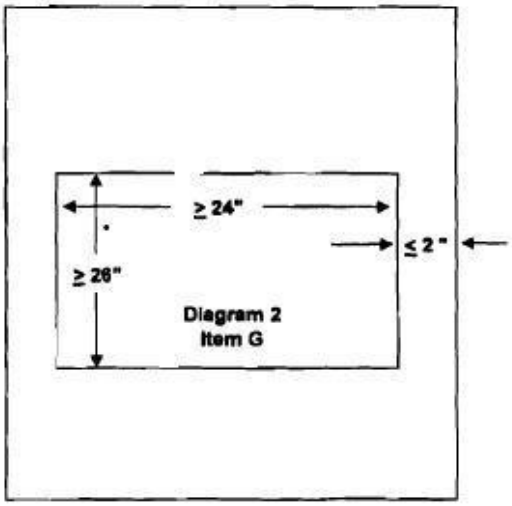
Performance: Determined by ISO Capacity Method.

	Size +/- 2 "	Minimum Mat Size	Product Performance Standard	Product Performance Premium
			≥	≥
	inches	inches	grams	grams
A	17 x 24	See Diagram 1 below	200	500
B	23 x 23			
C	23 x 36		300	1,200
D	30 x 30			
E	30 x 36		700	1,700
F	36 x 36			
G	28 x 70	24 X 26		

Universal Requirements

1. Mat size should be large enough that the border (non absorbent area) is ≤ 2.0" (see diagrams)





SECTION 2 POLICIES AND PROCEDURES

CLTC WAIVER SUPPLY PROVIDERS

INCONTINENCE PRODUCT QUALITY (CONT'D.)

PADS, INSERTS, SHIELDS

Recommendation:		Three categories; based on capacity.	
Product Specification	Size	One size	
	Performance	Use standard lab measurements as detailed in Attachment A and B	
		Rate of Acquisition (ROA) & Rewet	100 ml fluid add-on
		Capacity	As per ISO Method
Product Preparation		Unfold; trim waist elastic and leg gathers, if present	

				Product Performance [1]		
		Width	Length	ROA	Rewet	Capacity
		inches	inches	≤	≤	≥
Category 1	Light	- na -	- na -	NA	NA	250
Category 2	Moderate	- na -	- na -	NA	NA	500
Category 3	Heavy	≥ 8.0	≥ 22.0	60	2.0	1,000

The products must have one of the following attributes:

1. Embossed or channeled absorbent mat
2. Elastic gathers
3. Super absorbent polymer
4. Waterproof backing

Notes:

[1] For category 3 only, to qualify for inclusion on the formulary, products need to meet or exceed two of the three performance standards and be within 15% of the third standard

SECTION 2 POLICIES AND PROCEDURES

CLTC WAIVER SUPPLY PROVIDERS

AUTHORIZATIONS FOR ORAL NUTRITIONAL SUPPLEMENTS

Providers must deliver products based on authorizations received from case managers/nurses and service coordinators/early interventionists working with participants. The authorizations will provide the frequency of delivery and the participant information necessary to provide the oral nutritional supplements, including the correct procedure code and amount to bill for DDSN participants. Each can of nutrient must have a minimum of 225 cals/250 ml and come in a 24-count case in order to qualify for Medicaid reimbursement.

AUTHORIZATIONS FOR MISCELLANEOUS SUPPLIES AND EQUIPMENT

Providers must deliver products based on authorizations received from case managers/nurses and service coordinators/early interventionists working with participants. The authorizations will provide the frequency of delivery and the participant information necessary to provide the supplies and equipment, including the correct procedure code and amount authorized to bill for DDSN participants. When billing for DDSN participants, all supplies and equipment delivered and authorized on the same date of service, under the miscellaneous procedure code should be combined and billed as a single line item when filing the claim for payment.

STAFFING AND OPERATING PROCEDURES

The provider shall employ staff to receive authorizations electronically via secure website, fax, or mail. The provider must maintain all authorizations for products on file for audit purposes. The provider must have adequate staff to:

- Contact participants to coordinate service delivery
- Package or repackage products to coordinate precisely with authorizations
- Handle complaints and grievances received from participants, case managers/nurses, and service coordinators/early interventionists
- Obtain authorizations from the secure website, fax, or mail
- Input product shipment and billing information into SCDHHS' Care Call system for the waivers operated by SCDHHS. For those waivers operated by SCDDSN product information and billing will be done via the South Carolina Medicaid Web-

SECTION 2 POLICIES AND PROCEDURES

CLTC WAIVER SUPPLY PROVIDERS

STAFFING AND OPERATING PROCEDURES (CONT'D.)

Based Submission Tool, tape, diskette, or hardcopy.

Providers must fill orders from its own inventory, or must contract with other companies for the purchase of items necessary to fill the order. A provider must not contract with any entity currently excluded from any state or federal health care programs.

Providers must notify beneficiaries of warranty coverage and honor all warranties under applicable state law, and repair or replace free of charge Medicaid-covered items that are under warranty.

Providers cannot initiate telephone contact with participants, CLTC staff, or case management providers in order to solicit new business. The Provider shall not market directly to potential or current Medicaid waiver participants (including direct mail advertising, door-to-door, telephonic, or other "cold-call" marketing).

Cold-call marketing is any unsolicited personal contact by the Provider with a potential or current Medicaid waiver participant.

Marketing is any communication from the Provider to a potential or current participant that can reasonably be interpreted as intended to influence the participant to choose to receive services from the Provider or to not receive services from another Provider.

The Provider is prohibited from giving anything of value to a state employee or contract employee associated with the CLTC program. Providers may be suspended, terminated, or otherwise sanctioned for violating this requirement.

Providers must answer questions, respond to complaints from participants, and maintain documentation of contacts in response to complaints. Complaint records must include the name, address, telephone number, and Medicaid number of the participant, a summary of the complaint and any actions taken to resolve it.

Providers are responsible for delivery and must instruct beneficiaries on use of Medicaid-covered items, and maintain proof of delivery. Please see the section labeled documentation requirements for more information regarding proof of delivery.

Providers must accept returns of substandard (less than full

SECTION 2 POLICIES AND PROCEDURES

CLTC WAIVER SUPPLY PROVIDERS

STAFFING AND OPERATING PROCEDURES (CONT'D.)

quality for the particular item) or unsuitable items (inappropriate for the participant at the time it was fitted or sold) from participants.

Providers must disclose to SCDHHS any person having ownership, financial, or control interest in the agency. A provider must not convey or reassign a provider number (i.e., the provider may not sell or allow another entity to use its Medicaid billing number).

DOCUMENTATION REQUIREMENTS

Providers of waiver supplies are responsible for delivery. The provider may deliver directly to the participant or a designee. Noted the relationship of the designee to the beneficiary on the delivery slip and the signature should be legible. Providers, their employees, and others with a financial interest in the delivery of the item are prohibited from signing and accepting an item on behalf of the participant (i.e., acting as a designee on behalf of the participant).

Providers must maintain proof of the delivery of supplies (i.e., return receipt to include the participant's name, quantity delivered, detailed description of the delivered item, brand name, serial number) in their place of business for a minimum of five years. Proof of delivery documentation must be made available to Medicaid upon request. Any claims for services that do not have a documented proof of delivery from the supplier shall be denied and payments recovered.

Delivery confirmation slips must show ship dates, mailing dates, delivered dates, and addresses to which deliveries were made. The delivery confirmation slip must document if someone signed for the package, or if it was delivered without a signature, and where it was left for the participant.

Medical supply providers can access the delivery confirmation information maintained by the delivery companies online. Providers must keep delivery confirmation records for five years. Medicaid will not accept a tracking number without the follow-up delivery confirmation data.

SECTION 2 POLICIES AND PROCEDURES

CLTC WAIVER SUPPLY PROVIDERS

BILLING PROCEDURES AND SERVICE MONITORING

The provider must agree to participate in all components of SCDHHS' Care Call monitoring and payment system when providing services for participants of the Community Choices, HIV/AIDS, Mechanical Ventilation, and Medically Complex Children's waivers. The Care Call system is an automated system used for service documentation, service monitoring, web-based reporting, and billing to the Medicaid Management Information System (MMIS). The provider will document its provision of incontinence products for all SCDHHS operated waivers in the Care Call system via a web-based claims submission process. Providers will be required to bill claims on this website in a timely manner, claims at a minimum must be entered into the site within the quarter after the date of service. In all cases, services documented are compared with the prior authorization to determine if the service was provided appropriately.

For monitoring of service delivery and reporting, real time reports allow providers and case managers/nurses to monitor participants more closely to ensure receipt of services. On a bi-weekly basis, Care Call generates electronic billing to MMIS for services provided. Only authorized services and the total units provided (up to the maximum authorization) are submitted to MMIS for payment. This billing ensures accuracy of claim processing.

For all instances in which a participant did not receive an authorized shipment for waivers operated by SCDHHS, the provider must indicate the reason why the shipment was not delivered on the Care Call website. For each month in which the delivery of the product was not provided, the provider must indicate the reason on the website by the close of business the following week.

The Mental Retardation/Related Disabilities, Community Supports, and Head and Spinal Cord Injury waiver currently do not require the use of the Care Call billing system and claims may be submitted electronically via the South Carolina Medicaid Web-based Claim Submission Tool, tape or diskette, or hard copy.

SCDHHS reserves the right to perform on-site reviews during normal business hours to ensure compliance with policies and procedures.

SECTION 2 POLICIES AND PROCEDURES

CLTC WAIVER SUPPLY PROVIDERS

MEDICAID POLICY ADHERENCE

Providers must comply with all South Carolina Medicaid policies and procedures as outlined by SCDHHS. The provider will use the Care Call system to bill claims by the end of the quarter following service delivery. For claims not using the Care Call system, the provider must submit edit-free claims for reimbursement to MMIS within one year from the date of service following up-to-date policies and procedures and in accordance with correct coding.

SECTION 2 POLICIES AND PROCEDURES

CLTC WAIVER SUPPLY PROVIDERS

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SECTION 2 POLICIES AND PROCEDURES

CLTC ENVIRONMENTAL MODIFICATION PROVIDERS

Environmental modification services provide pest control and physical adaptations or modifications to the home that are necessary to ensure the health, welfare, and safety of the client. Environmental modifications enable clients to function with greater independence in the home. An example of such a modification is the construction of a ramp. All environmental modification providers must have a residential or general contractor's license to provide services. In addition to this requirement providers must have general liability and workers compensation insurance.

GENERAL RAMP SPECIFICATIONS

These specifications are to be used as a guide to our providers. They will not be used to diminish in any way local, state, and national codes. These specifications are a summary of information gathered using the International Building Code (2010 Edition), ICC, ANSI A117.1 1998 and ADA Standards for Accessible Design.

General Notes:

- **Permits are the responsibility of the provider.**
- Ramps are to be firm, stable, slip resistant, and safe.
- Ramps and landings with drop offs will have a minimum 4" curb and railings.
- Ramps will be built using pressure (weather) treated lumber.
- **Please advise clients that ramps need to be treated/weatherproofed annually.**
- Ramps and landings are measured by the **clear** space provided, 56"x56" landings will not be counted as 5' x 5' landings and will be re-built.
- No toenailing of railings between posts is permitted.
- **All screws will be predrilled with pilot holes to prevent splitting.**

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

GENERAL RAMP SPECIFICATIONS (CONT'D.)

- There is only one type/ size of ramp, no more heavy duty**.**

General Materials:

- 4x4 posts
- 2x6 (min.) joists
- 2x6 or 5/4x6 decking
- 2x4 (min.) **curbing,** top, and top support rail
- **2x2 pickets**
- 1 ¼" galvanized pipes (fence top rails) are to be used as handrails with galvanized "C" clamps and PVC caps.
- 2x4x4" or 2x4x6 handrail spacers
- **3" ring-shanked exterior nails and 3" and 2 ½" decking screws**
- 2500 PSI cement

Foundations:

- Posts must be a minimum 4x4 CCA lumber
- Posts must be sunk a minimum **12"** into the ground and set in concrete (min. 25lbs)
- Exception – if post is set on cement walkway or driveway, post may be anchored with a post base attached to the cement, **and/or** cross- braced for stability.
- Foundation posts are to be set no more than 8' apart.
- **Set the final post back 8" from the end of the ramp.**

Floor Framing:

- Outside joists shall consist of 2x6 (min) lumber connected to the foundation posts.
- Inside joists shall be 2 x 6 (min) and shall be connected to the foundation posts using a header board and proper joist hangers.
- There shall be no more than 16" between joists.
- There shall be four total joists: (2) inside and (2) outside.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

GENERAL RAMP SPECIFICATIONS (CONT'D.)

- All framing will be attached with 3" ring-shanked nails or 3" decking screws.
- The 1st three decking boards at either end of the ramp must be attached with screws.

Slopes:

- All landings must be level (slope no greater than 1:50)
- All cross slopes must not exceed 1:50
- Ramps will have a maximum slope of 1:12 with few exceptions.
- In the RARE case a steeper slope is needed, the following will apply:
  - A 1:10 slope is permitted for no more than a 6" rise.
  - A 1:8 slope is permitted for no more than a 3" rise.

Ramps:

- Shall not rise more than 30" between landings.
- Shall lead to a firm stable landing, provider is responsible for the area at the end of a ramp.
- The ramp will be finished with concrete a minimum of 1" deep, 12" long, and the width of the ramp to aid in transition to the ground.
- Shall be level with a cross slope of no more than 1:50
- Shall have a clear width of **41**".
- With a drop off of more than 2" shall have a minimum 4" curb.
- Shall allow for water to run off and not collect.
- Must be slip resistant (floor areas painted with a non- slip paint).
- Must use 2'x6" or 5/4"x6" as decking.
- Ramps are not to be built attached to the house unless necessary (2' spacing).
- Ramps for clients using stretchers should avoid turns and be angled if possible.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

GENERAL RAMP SPECIFICATIONS (CONT'D.)

The end of the ramp will be finished with concrete.

Landings (General):

- Must be level – slope less than 1:50, must be stable and slip resistant.
- Landing will have pickets.
- Landings must have top rail, **top support rail**, and curbing.
- Must be at least 60" x 60" **clear** space if the ramp changes direction.
- "Straight through" landings must be the width of the ramp and 5' long.
- "Switchback landings" will be at least 60"x 96" **clear** space.
- **Joists will be no more than 16" apart.**

Landings at Doorways:

- Shall have no more than a ½" beveled threshold between landing and interior floor.
- Must have a minimum 18" + of clear space past the latch side of the door (24" preferred).
- Will minimum have 60" x 60" clear space.
- Railings are required for drop offs of more than 2".
- Must not be positioned in such a way as to expose people to the danger of falling, (**i.e., railings blocking exposed steps).**

Handrails:

- **Will be made from 1 ¼" galvanized pipes (fence top rail) with support blocking every 5'.** Poles come in 10' lengths and are tapered to fit together.
- **Blocking will be screwed into the top rail.**
- **Shall be attached to blocking with galvanized "C" clamps and glued on PVC caps.**
- Shall run parallel to the floor of the landing or ramp.
- Shall be continuous on both sides.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

GENERAL RAMP SPECIFICATIONS (CONT'D.)

- **Shall extend 6" past the end of the last block, but not past the end of the ramp.**
- Shall have a 1 ½" clearance between handrail and top rail and any wall.
- Shall be between 34" and 38" high.
- Shall not rotate within its fittings, **drill a screw into galvanized pipes at every block.**
- Must be able to withstand **350 Lbs.** of pressure.

Top rails, side rails, and curbing:

- **All lumber above the floor level is to be attached using decking screws.**
- Top rail must have a side support rail on the inside of the ramp.
- All rails shall be attached on the inside of the ramp to the 4x4 posts (no toe- nailing between posts).
- **2x2 pickets will be placed no more than 4" apart, will be pre-drilled and installed with a 2 ½" decking screw, a 2x4 will be substituted for the last picket at the end of the ramp.**
- **Pickets will be screwed into the top rail, curbing, and the ramp frame.** Brad nailing pickets into place before screwing can save time.
- Curbing shall be attached on the inside of the ramp to the 4x4 posts (no toe- nailing between posts) and be **2"** off the ramp.

Heavy Duty Ramps and Landings:

- Ramps and landings for clients above 250 lbs. shall be built to accommodate the extra weight.
- These ramps shall use: 2 x 6 decking boards; 2 x 8 joists every 16"; and be a minimum of 44" wide clear space.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

CLTC STANDARDS FOR BATHROOM SAFETY PRODUCTS

Specs for Raised Toilet Seats:

- Maximum weight capacity – 250 lbs.
- Seat width – 15”
- Seat depth – 15”
- Seat height – 5”
- Installation

Specs for Bariatric Raised Toilet Seats:

- Minimum weight capacity – 500 lbs.
- Seat width – 15”
- Seat depth – 15”
- Seat height – 4”
- Locking
- Installation

Specs for Transfer Benches:

- Adjustable height from 17” to 23”
- Backrest
- Arm rail
- Seat depth – 18”
- Seat width – 33” minimum
- Maximum Weight capacity – 350 lbs.
- Installation, assembly and adjustment

Specs for Bariatric Shower Transfer Benches:

- Minimum weight capacity – 500 lbs.
- Backrest
- Seat depth – 16”
- Seath width – 28”
- Seat height – 16” minimum
- Installation

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

CLTC STANDARDS FOR BATHROOM SAFETY PRODUCTS (CONT'D.)

Specs for Shower Chair with Back:

- Back rest
- Maximum 300 lbs weight capacity
- Adjustable
- Seat height- 17" to 21"
- Seat width – 20"
- Seat depth – 18"
- Installation

Specs for Bariatric Shower Seat:

- Back rest
- Minimum weight capacity – 500 lbs.
- Seat height – 16" minimum
- Seat width – 17"
- Seat depth – 16"
- Installation

Specs for Hand-Held Showers:

- Minimum 6' hose
- Pause/ shut off function
- Installation with Teflon tape

Specs for Oil Filled Space Heaters:

- Reimbursement - $61.75
- Minimum 1 year warranty
- Wheels/ Casters
- 3 heat settings
- The oil filled space heaters must be delivered and set up
- Accepted brands for oil filled space heaters: Honeywell (Walmart), Pelonis (Home Depot), DeLonghi (Lowes)

Alternative Space Heaters that may be shipped:

- Lasko2 heat tower electric space heater Model 6251 Item # 142570 (Available at Lowes)

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

CLTC STANDARDS FOR BATHROOM SAFETY PRODUCTS (CONT'D.)

- Warmwave 1500 watt ceramic portable tower heater Model HPQ15M (Available at Home Depot)

These products can be shipped to participants.

No substitutions are allowed unless prior approval is given in writing.

SANCTION PROCESS CLTC ENVIRONMENTAL MODIFICATION PROVIDERS

Community Long Term Care (CLTC) will review provider compliance with environmental modification program requirements on an ongoing basis. The department's environmental modification specialist will complete reviews. Failure to comply with the environmental modification requirements will result in the application of sanctions, either suspension and/or termination.

Suspension: The environmental modification provider is removed from the provider choice list. The provider will not be allowed to bid or be listed on the participant's choice list for the duration of the sanction. The minimum period of suspension is 1 month. Providers who are suspended must complete all outstanding jobs to the specifications indicated by the environmental modification specialist before being allowed to perform new work with CLTC.

Termination: The cancellation of your enrollment in the Medicaid (CLTC) program resulting in denial of Medicaid participation for a period of three (3) years. After two suspensions for any reason, a third suspension in a two (2) year period from July-June will lead to termination from Medicaid participation.

Compliance Issues Resulting in Suspension and/or Termination

Refusing to complete jobs that the provider has bid on and won: Providers are expected to complete any job where they are the winning bidder. If the winning bidder **accepts the job, then** refuses to complete the project the provider will be subject to the following sanctioning process.

First offense - Suspend one (1) month

Second offense- Suspend two (2) months (within 1 year of first offense)

Third offense - Termination (within 1 year of first offense)

Example: The provider bids and accepts jobs in several different areas. He or she gets to the jobsite and decides he

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Compliance Issues Resulting in Suspension and/or Termination (Cont'd.)

or she has underbid the project and/or does not have the time or manpower to complete the job, and refuses to honor his bid. This action will result in sanctioning of the provider.

Failure to complete jobs timely as defined by the date on the environmental modification specialists bid notification in Phoenix: Providers are expected to complete work in a timely manner. If it is identified that there are three (3) occurrences of this type within a six (6) month time period of January through June and/or July through December the following sanctions will apply.

A) Suspension for two (2) months

B) Each subsequent occurrence - Suspension for two (2) months

Example: The provider accepts a project through Phoenix which has an expected date of completion on it; if the provider accepts the job he is accepting the completion time frame. If the environmental modification specialist discovers that the provider is not completing this project in the allotted time frame indicated on the bid in Phoenix this action will result in sanctioning of the provider indicated above.

SCDHHS environmental modification Inspector returning to jobsite due to poor workmanship: Providers are expected to comply with the standards set forth by the environmental modification inspector. If the SCDHHS inspector must return to the jobsite due to poor workmanship the following sanctioning process will occur.

A) Three (3) substantiated returns in any quarter - Suspend two (2) months

B) Six (6) substantiated returns in any quarter - Terminate

Example: The provider accepts a project through Phoenix and completes the job. The environmental modification specialist will then review the work done. If the environmental modification specialist determines the project was not done to general contracting standards a letter will be sent to the provider indicating the corrections that need to be completed on the job. If this occurs sanctioning of the provider will occur on the schedule mentioned above.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Compliance Issues Resulting in Suspension and/or Termination (Cont'd.)

Documenting in Phoenix that a job is complete and/or billing for services through Care Call prior to completion of job: Providers cannot bill Medicaid prior to the completion of an environmental modification project. If providers are found to have billed Medicaid or documented in Phoenix that the job was completed prior to job completion the following sanctioning process will apply:

Recoupment of inappropriate payment, if found job is not completed plus

A) First offense – Suspend for one (1) month

B) Second offense – Suspend two (2) months

C) Third offense- Termination

Example: The provider accepts a project through Phoenix and goes to work on the job. The crew tells the provider they have completed the job and the provider indicates this in the Phoenix system and/or bills for the job through Care Call. The environmental modification specialist and/or participant determine that project was not complete prior to indicating it in phoenix and/or billing through Care Call will result in the sanctioning of the provider on the schedule mentioned above.

Refusal or inability to complete job to the specifications set forth by the Environmental Modification inspector: Providers are expected to complete jobs within the standards set forth by the environmental modification specialist. Any job not completed to general contracting specifications will receive a corrective action letter that must be followed. If the provider does not follow the corrective action letter and the deficiencies are not corrected within two (2) weeks all funds will be recouped and the provider will be automatically suspended from providing services to Medicaid participants until the job has been completed. The provider will be reinstated one month after the date of completion of the job.

A second offense of the type described above will result in being suspended for two months after the correction of the deficiencies and a third offense will result in automatic termination as a Medicaid provider.

Example: The provider accepts a project through Phoenix and completes the job. The environmental modification

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Compliance Issues Resulting in Suspension and/or Termination (Cont'd.)

specialist will then review the work that was done. If the environmental modification specialist determines that the project was not done to general contracting standards a letter will be sent to the provider indicating the corrections that need to be completed on the job. If the provider does not correct the deficiencies within two weeks this will lead to the sanctioning process mentioned above.

Home and Community Based Waivers (HCBW) are programs that allow individuals who meet an institutional level of care to receive items and services not covered through the South Carolina Medicaid State Plan. These items and services are allowed through the waiver programs to assist individuals in remaining in their own home or other community setting and avoiding institutional placement.

PEST CONTROL STANDARDS FOR COMMUNITY LONG TERM CARE PARTICIPANTS

Conditions of Participation

All providers must verify participant's Medicaid eligibility upon acceptance of an authorization for pest control and any time services are rendered thereafter to ensure continued eligibility.

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

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

Conduct of Service

The Provider must obtain an authorization for pest control services from CLTC. The authorization will designate the amount, frequency and duration of service for participants. Pest control authorizations are for a maximum of once every other month. The Provider will receive new authorizations only when there is a change to the authorized service amount, frequency or duration.

All instructions on the authorization for service must be followed in order to be reimbursed for the pest control service. Pest control services must be completed by the provider within 14 days of acceptance of the CLTC authorization for service.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Conduct of Service (Cont'd.)

Pest Control treatments need to include both in-home and exterior treatment. All providers must go into the participants home to inspect and treat the residence and call in the service to Care Call. If a participant is not at the residence at the time of the treatment the provider will need to reschedule for a time when the participant will be present in the home.

Providers can only utilize a cell phone to call in claims if the participant does not have a home phone.

If for any reason a provider is not able to make the call for pest control the day of the treatment then the claim will need to be submitted via the Care Call website. Providers who are not routinely calling in claims for this service through the Care Call phone system will be terminated from South Carolina Medicaid.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

PROGRAM SERVICES

COMMUNITY CHOICES WAIVER

The Community Long-Term Care (CLTC) Community Choices Waiver is designed to serve Medicaid-eligible individuals who are age 18 or older and have long-term care needs. To avoid or delay costly nursing home admission, clients are able to access the services necessary to receive care at home through careful assessment, service planning, care coordination, and monitoring.

Covered Services

Adult Day Health Care Services

Based on the client's identified needs, Adult Day Health Care centers provide a range of health care and support services. The center provides planned therapeutic activities to stimulate mental activity, communication, and self-expression. The center staff provides meals and supervision of personal care. The center also transports clients to and from home, if they live within fifteen miles of the center. With special approval, the center may also provide additional services.

A limited number of skilled procedures are available to persons receiving Adult Day Health Care. A licensed nurse, as ordered by a physician, provides the skilled procedures in the Adult Day Health Care center. Nursing care is provided to:

- Monitor the client's vital signs and ability to function
- Supervise intake of medication and possible reactions
- Teach health care and self-care
- Oversee treatment in conjunction with a client's physician and case manager

The South Carolina Department of Health and Environmental Control (DHEC), or the equivalent licensing agency for out-of-state facilities, must license all adult day care centers. Furthermore, centers must have adequate procedures for medical emergencies and must meet the minimum staffing requirements as specified by the contract.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Attendant Care Services

Attendant care services are provided by qualified individuals to help clients by offering support for activities of daily living and monitoring the medical condition of clients. The kinds of activities that an attendant provider performs include the following:

- Assistance with personal hygiene, feeding, bathing, and meal preparation
- Encouraging clients to adhere to specially prescribed diets
- General housekeeping duties
- Shopping assistance
- Assistance with communication
- Monitoring medication

Supervision may be furnished directly by the client when the client has been trained to perform this function, and when the safety and efficacy of client-provided supervision has been certified in writing by an RN or otherwise as provided within state law. This certification must be based on actual observation of the client and the specific attendant care provider during the actual provision of care.

Case Management

A qualified case manager provides CLTC case management for all waiver clients. The objective of case management is to counsel regarding services and support. Case management assists clients in coping with changing needs and in making decisions regarding long-term care. It also ensures continued access to appropriate and available services.

Companion

Companion services provide short-term relief for caregivers and supervision of clients.

Home Delivered Meals

Nutritionally sound meals are delivered to clients at their homes. All menus must be reviewed and approved by a registered dietitian and meals must be prepared and delivered according to the standards developed by CLTC.

Nursing Home Transition Services

The goal of Nursing Home Transition Services is to properly identify and transition current nursing home residents who desire to return to the community. The services assist elderly individuals with disabilities and

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Nursing Home Transition Services (Cont'd.)

clients with mental health conditions. The following one-time services are available for clients transitioning to a community waiver program from a nursing home:

- **Appliances:** This service is intended to provide necessary appliances.
- **Furniture procurement:** Funds are used to purchase minimal furnishings necessary to establish a home in the community.
- **Rent/utility assistance:** One-time rent/utility assistance is available for clients who need financial help to secure a community residence.

Personal Care II (PC II) Services

Personal Care II (PC II) services are designed to help clients with normal daily activities and monitor the medical conditions of functionally impaired/disabled clients. The kinds of activities that the PC II aide performs are comparable to those that family members would perform for the person in need. PC II aides provide assistance with walking, bathing, dressing, toileting, grooming, preparing meals, and feeding. The aide also helps to maintain the home environment, including light cleaning, laundry, shopping, and keeping the home safe. The client's vital signs, such as respiratory rate, pulse rate, and temperature, are observed. The aide may also remind the client to take prescribed medication(s) and, when necessary, transport and/or escort the client.

PC II aides work under the supervision of a registered nurse (RN) or a licensed practical nurse (LPN) in the client's home.

Under no circumstances may a PC II aide perform any type of skilled medical service.

Respite Care

Many clients with long-term care needs are cared for at home by family members or other caregivers. Respite care services are intended to provide temporary around-the-clock relief for caregivers by placing the client in an institutional setting for up to fourteen days per state fiscal year. The provider of respite care services must be licensed and certified by DHEC as a hospital, nursing home, or Intermediate Care Facility for People with Mental Retardation (ICF/MR). Out-of-state providers must be licensed by an equivalent agency of that state. They must

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Respite Care (Cont'd.)

also have a valid Medicaid contract with the Department of Health and Human Services (DHHS).

Respite Care in a Community Residential Care Facility

Respite care services may be provided for caregivers by placing the client in a community residential care facility for up to 28 days per state fiscal year. The facility must be licensed by DHEC and have a valid Medicaid contract with DHHS for these services.

HIV/AIDS WAIVER

The CLTC Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Waiver is designed to serve Medicaid-eligible HIV/AIDS clients, regardless of age, who choose to live at home but have long-term care needs and are at risk for hospitalization.

Covered Services

Attendant Care Services

Attendant care services are provided by qualified individuals to help clients by offering support for activities of daily living and monitoring the medical condition of clients. The kinds of activities that an attendant provider performs include the following:

- Assistance with personal hygiene, feeding, bathing, and meal preparation
- Encouraging clients to adhere to specially prescribed diets
- General housekeeping duties
- Shopping assistance
- Assistance with communication
- Monitoring medication

The client may directly supervise the attendant when the client has been trained to perform this function, and when the safety and efficacy of client-provided supervision has been certified in writing by an RN or otherwise as provided within state law. This certification must be based on actual observation of the client and the specific attendant care provider during the actual provision of care.

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PROGRAM SERVICES

Case Management

A qualified case manager provides CLTC case management for all waiver clients. The objective of case management is to counsel clients regarding services and support. The case manager assists clients in coping with changing needs and in making decisions regarding long-term care. He or she also ensures continued access to appropriate and available services.

Companion

Companion services provide supervision of clients and short-term relief for caregivers.

Environmental Modification

Environmental modification services provide pest control and physical adaptations or modifications to the home that are necessary to ensure the health, welfare, and safety of the client. Environmental modifications enable clients to function with greater independence in the home. An example of such a modification is the construction of a ramp.

Home Delivered Meals

Nutritionally sound meals are delivered to clients at their homes. Based on a physician's orders, meals may include standard diets or therapeutic and/or modified diets. All menus must be reviewed and approved by a registered dietitian and meals must be prepared and delivered according to the standards developed by CLTC.

Personal Care I (PC I) Services

Personal Care I (PC I) services are designed to help preserve a safe and sanitary home environment, provide short-term relief for caregivers, and assist clients with personal care. These services supplement, but do not replace, the care provided to clients. The kinds of services performed by the PC I aide include the following:

- Meal planning and preparation
- General housekeeping
- Assistance with shopping
- Companion or sitter services
- Assistance with financial matters, such as delivering payments to designated recipients on behalf of the client
- Assistance with communication
- Observing and reporting on the client's condition

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Personal Care II (PC II) Services

Personal Care II (PC II) services are designed to help clients with normal daily activities and to monitor the medical conditions of functionally impaired/disabled clients. The kinds of activities that the PC II aide performs are comparable to those that family members would perform for the person in need. PC II aides provide assistance with walking, bathing, dressing, toileting, grooming, preparing meals, and feeding. The aide also helps to maintain the home environment, including light cleaning, laundry, shopping, and keeping the home safe. The client's vital signs, such as respiratory rate, pulse rate, and temperature, are observed. The aide may also remind the client to take prescribed medication(s) and, when necessary, transport and/or escort the client.

PC II aides work under the supervision of an RN or LPN in the client's home. Under no circumstances may a PC II aide perform any type of skilled medical service.

PC II aides who provide services to HIV/AIDS clients should be trained in infection control. The Centers for Disease Control and Prevention (CDC) precautions must be followed when rendering care to protect the client and the PC II aide.

Nursing Services

Nursing services provide skilled medical monitoring, direct care, and interventions that meet the medical needs of the client with HIV/AIDS at home. The client's condition may require 24-hour continuous care for a short duration due to an episodic condition.

PERVASIVE DEVELOPMENTAL DISORDER WAIVER

The Pervasive Developmental Disorder (PDD) waiver provides for early intensive behavioral intervention services (EIBI) to children who have been diagnosed with a pervasive developmental disorder, including autism and Asperger's Syndrome and who meet the ICF-MR level of care criteria. The Department of Disabilities and Special Needs operates the waiver with administrative oversight from DHHS. The waiver is for children who are ages three through ten. These services are provided in non-educational settings. The waiver develops the skills of children in the areas of cognition, behavior, communication, and social interaction. To learn more about the PDD waiver and DDSN services please visit http://www.state.sc.us/ddsn or call DDSN at 1-888-376-4636.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Covered Services

Case Management

Case managers assist participants in gaining access to needed waiver and other State plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services to which access is gained.

The following minimum standards will apply for the provision of case management:

- Case managers will provide a monthly contact with the EIBI service provider and/or family.
- On a quarterly basis, there will be a review of the entire waiver plan of care, which includes the most recent EIBI service provider quarterly progress report and a contact with the participant's family.
- If progress toward established goals does not meet expectations, then consultation with DDSN will occur.
- On an annual basis, there will be a face-to-face contact with the family.

MECHANICAL VENTILATOR DEPENDENT PROGRAM

The Mechanical Ventilator Dependent Program is designed to serve Medicaid-eligible persons age 21 or older who are dependent on mechanical ventilation and have long-term care needs. Clients are able to receive services to supplement care in their home through careful assessment, service planning, and service coordination.

Covered Services

Environmental Modification

Environmental modification services provide pest control and physical adaptations or modifications to the home that are necessary to ensure the health, welfare, and safety of the client. Environmental modifications enable clients to function with greater independence in the home. Examples of modifications may include construction of ramps, installation of grab bars, widening of doorways, or installation of specialized electric and plumbing systems that are necessary to accommodate medical equipment.

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PROGRAM SERVICES

Nursing Services

Nursing services provide skilled medical monitoring, direct care, and interventions that meet the medical needs of a client dependent upon mechanical ventilation at home.

Personal Care I (PC I) Services

Based on the client's assessed needs, PC I services provide general household activities, meal preparation, and routine household care.

Personal Care II (PC II) Services

PC II services are designed to help clients with normal daily activities and to monitor the medical conditions of functionally impaired/disabled clients. The kinds of activities that the PC II aide performs are comparable to those that family members would perform for the person in need. PC II aides provide assistance with walking, bathing, dressing, toileting, grooming, preparing meals, and feeding. The aide also helps to maintain the home environment, including light cleaning, laundry, shopping, and keeping the home safe. The client's vital signs, such as respiratory rate, pulse rate, and temperature, are observed. The aide may also remind the client to take prescribed medication(s) and, when necessary, transport and/or escort the client.

PC II aides work under the supervision of an RN or LPN in the client's home. Under no circumstances may a PC II aide perform any type of skilled medical service.

Respite Care

Many clients with long-term care needs are cared for at home by family members or other caregivers. Respite care services are intended to provide temporary around-the-clock relief for caregivers by placing the client in an institutional setting for up to fourteen days per state fiscal year. The provider of respite care services must be licensed and certified by DHEC as a hospital, nursing home, or ICF/MR. Out-of-state providers must be licensed by an equivalent agency in that state. They must also have a valid Medicaid contract with DHHS.

Respite (In-Home)

In-home respite services provide temporary care in the home for mechanical ventilator dependent clients living at home and cared for by their families or other informal support systems. These services maintain clients and provide temporary relief for the primary caregivers.

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PROGRAM SERVICES

CHILDREN'S PERSONAL CARE AIDE (PCA) SERVICES

Children's PCA services provide PC aide services in the community to Medicaid-eligible children under 21 years of age who meet established medical necessity criteria.

Covered Services

Personal Care II (PC II) Services

PC II services are designed to help clients with normal daily activities and to monitor the medical conditions of functionally impaired/disabled clients. The kinds of activities that the PC II aide performs are comparable to those that family members would perform for the person in need. PC II aides provide assistance with walking, bathing, dressing, toileting, grooming, preparing meals, and feeding. The aide also helps to maintain the home environment, including light cleaning, laundry, shopping, and keeping the home safe. The client's vital signs, such as respiratory rate, pulse rate, and temperature, are observed. The aide may also remind the client to take prescribed medication(s) and, when necessary, transport and/or escort the client.

PC II aides work under the supervision of an RN or LPN in the client's home. Under no circumstances may a PC II aide perform any type of skilled medical service.

PALMETTO SENIORCARE (PSC) PROGRAM

Palmetto SeniorCare (PSC) is a federal Medicaid and Medicare capitated program serving clients in the greater Columbia area (Richland and Lexington counties) who meet all of the following criteria:

- Are age 55 or older
- Meet nursing home level of care
- Wish to remain in the community
- Choose to participate in the program

Participants in Palmetto SeniorCare receive all services through PSC either directly from PSC staff health care professionals or through subcontracted health care entities. Many of the services provided are centered in the PSC Adult Day Health Centers.

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PROGRAM SERVICES

HEAD AND SPINAL CORD INJURY (HASCI) WAIVER

In a joint effort, DHHS and the Department of Disabilities and Special Needs (DDSN) are providing a broad range of home- and community-based waiver services to Medicaid-eligible individuals with the most severe physical impairments involving head and spinal cord injuries. Head and Spinal Cord Injury (HASCI) Waivers are designed to help clients who would otherwise require services in a nursing facility or ICF/MR to remain independent in the community.

DHHS serves as an administrative oversight and monitoring entity to ensure the health, safety, and welfare of the waiver beneficiaries. DHHS is responsible for ensuring that a formal system is in place to periodically review clients' services and to ensure that those in place are consistent with identified needs of clients. DDSN has the primary responsibility for the daily operation of the HASCI program.

Covered Services

Attendant Care Services

Attendant care services assist with the performance of activities of daily living and personal care, which may include hands-on care, of both a medical and non-medical supportive nature, specific to the needs of a medically stable, physically handicapped individual. These services may include skilled medical care to the extent permitted by state law. Housekeeping and community access activities that are incidental to the performance of the client-based care may also be furnished as part of this activity.

Transportation may be provided as a component of the service when it is related to the performance of daily living skills. The cost of this transportation is included in the rate paid to the providers of attendant care services. These services may be conducted in a variety of settings as outlined in the DDSN plan of service. These services shall not duplicate any other service. An RN licensed to practice in the state must provide supervision. The frequency and intensity of supervision will be specified in the client's written plan of service by the DDSN service coordinator.

Supervision may be furnished directly by the client when the client has been trained to perform this function, and when the safety and efficacy of client-provided supervision

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PROGRAM SERVICES

Attendant Care Services (Cont'd.)

has been certified in writing by an RN or otherwise as provided within state law. This certification must be based on actual observation of the client and the specific attendant care provider during the actual provision of care. Documentation of the certification will be maintained in the client's individual plan of service.

Environmental Modification, Specialized Supplies, and Adaptations

Environmental modification services provide physical adaptations to the home required by a client's plan of service necessary to ensure the health, welfare, and safety of the client. Environmental modifications are changes that enable clients to function with greater independence in the home and without which the client would require institutionalization. Under HASCI waivers, adaptations may include the following:

- Installation of ramps and grab bars
- Widening of doorways
- Modification of personal transportation, bathrooms, or kitchen facilities
- Fencing, when necessary for personal safety
- Installation of specialized electric and plumbing systems required to accommodate the medical equipment and supplies necessary for the welfare of clients

Excluded are those adaptations or improvements to the home that are of general utility and have no direct medical or remedial benefit to the client. Services must be provided for the client's benefit, not for the convenience of other occupants. Environmental modifications shall meet all applicable state and local building codes. In those counties without local building codes, all services shall be provided in accordance with standard building codes as set forth in the South Carolina Code of Laws § 6-9-10 *et seq*.

Habilitation Services (Day)

Day habilitation services provide assistance with the acquisition, retention, or improvement of self-help, socialization, and adaptive skills that take place in a non-residential setting, separate from the home or facility in which the client resides. Normally, these services are furnished four or more hours a day, on a regularly scheduled basis, for one or more days a week unless provided as an adjunct to another day activity included in

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Habilitation Services (Day) (Cont'd.)

the beneficiary's plan of service. Day habilitation services focus on enabling clients to attain or maintain their maximum functional level. They shall also be coordinated with any physical, occupational, or speech therapies listed in the plan of service. Additionally, day habilitation services reinforce skills or lessons taught in school, therapy, or other settings.

Habilitation Services (Prevocational)

Prevocational habilitation services are not available under a program funded under Section 110 of the Rehabilitations Act of 1973 or Section 602 (16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 (16 and 17)). Activities included in this service are not directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the client's plan of service as directed to habilitative rather than explicit employment objectives. These services teach concepts such as compliance, attendance, task completion, problem solving, and safety, to prepare clients for paid and unpaid employment.

Excluding supported employment programs, prevocational habilitation services are provided to clients not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year. When compensated, individuals are paid less than 50 percent of minimum wage.

Documentation will be maintained in each client's file that the service is not otherwise available under the program funded under the Rehabilitation Act of 1973 or P.L. 94-142.

Habilitation Services (Residential)

Residential habilitation services include the care, skills training, and supervision provided to clients in a non-institutional setting. The degree and type of care, supervision, skills training, and support of clients will be based on the plan of service and the client's individual needs. Services include assistance with the following:

- The acquisition, retention, or improvement of skills related to activities of daily living, such as personal grooming and cleanliness
- Household chores and bed-making
- Eating and preparation of food

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PROGRAM SERVICES

Habilitation Services (Residential) (Cont'd.)

- Social and adaptive skills necessary to enable the individual to reside in a non-institutional setting

Other than costs that are for modifications or adaptations to a facility required to assure the health and safety of residents or meet the requirements of the applicable life safety codes, payments for residential habilitation are not made for the following:

- Room and board
- Costs of facility maintenance
- Upkeep
- Improvement

Payments for residential habilitation do not include those made, directly or indirectly, to members of the client's immediate family. Payments will not be made for the routine care and supervision provided by a family or group home provider or for activities or supervision covered by a source other than Medicaid.

Nursing Services

Nursing services provide skilled medical monitoring, direct care, and interventions that meet the medical needs of clients at home. Nursing services prevent institutionalization.

Respite Care Services

Respite care is provided for caregivers of clients unable to care for themselves; it is provided on a short-term basis as a response to the absence or need for relief of those persons normally providing the care. Respite services may be provided in clients' homes, licensed respite facilities, nursing facilities, ICF/MRs, or other facilities approved by the state. Such facilities may include the private residence of an Independent Respite Provider who meets the DDSN Standards for Respite Care Providers.

Respite Care in a Community Residential Care Facility

Respite care services may be provided for caregivers by placing the client in a community residential care facility for up to 28 days per state fiscal year. The facility must be licensed by DHEC and have a valid Medicaid contract with DHHS for these services.

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PROGRAM SERVICES

Supported Employment Services

Supported employment services consist of paid employment for clients for whom competitive employment at or above minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly work sites in which people without disabilities are employed. These services include activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment services are provided at a work site where there are employees without disabilities, payment will be made only for the adaptation, supervision, and training required by clients receiving waiver services because of their disabilities. Payment for supervisory activities rendered as a normal part of the business setting are not included.

Supported employment services furnished under the waiver are not available under any programs funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in each client's file that it is not otherwise available under a program funded under the Rehabilitation Act of 1973 or P.L. 94-142.

Federal financial payments will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

- Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program
- Payments that are passed through to users of supported employment programs
- Payments for vocational training that is not directly related to an individual's supported employment program

MENTAL RETARDATION/ RELATED DISABILITIES (MR/RD) WAIVER

In a cooperative effort, DHHS and DDSN are providing a broad range of special home- and community-based waiver services to Medicaid-eligible individuals with mental retardation or related disabilities to help them live in the community rather than in an institution. DDSN has the primary responsibility for the daily operation of the MR/RD Waiver program.

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PROGRAM SERVICES

MENTAL RETARDATION/ RELATED DISABILITIES (MR/RD) WAIVER (CONT'D.)

DHHS serves as an administrative oversight and monitoring entity to ensure the health, safety, and welfare of the waiver beneficiaries. DHHS is responsible for ensuring that a formal system is in place to periodically review client services and ensure those in place are consistent with the client's identified needs.

Covered Services

Adult Day Health Care Services

Based on the client's identified needs, adult day health care centers provide a range of health care and support services. A center provides planned therapeutic activities to stimulate mental activity, communication, and self-expression. The center staff provides meals and supervision of personal care. The center also transports clients to and from home if they live within fifteen miles of the center. With special approval, the center may also provide additional services.

A limited number of skilled procedures are available to participants receiving adult day health care. A licensed nurse, as ordered by a physician, provides the skilled procedures in the adult day health care center. Nursing care is provided to:

- Monitor the client's vital signs and ability to function
- Supervise intake of medication and possible reactions
- Teach health care and self-care
- Oversee treatment in conjunction with a client's physician and case manager

DHEC, or the equivalent licensing agency for out-of-state facilities, must license all adult day health care centers. Centers must have adequate procedures for medical emergencies and must meet the minimum staffing requirements as specified by the contract.

Personal Care I (PC I) Services

PC I services provide general household services for clients, such as meal preparation and routine household care as authorized in their plan of service by DDSN. Meal preparation includes planning meals, cooking, serving, and cleaning afterwards. Household care includes cleaning,

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Personal Care I (PC I) Services (Cont'd.)

laundry, and other activities as needed to properly maintain the client's residence.

Procedure codes for DDSN waiver services **must** be used when submitting claims for MR/RD waiver services.

Personal Care II (PC II) Services

Personal Care II (PC II) services are designed to help clients with normal daily activities and monitor the medical conditions of functionally impaired/disabled clients. The kinds of activities that the PC II aide performs are comparable to those that family members would perform for the person in need. PC II aides provide assistance with walking, bathing, dressing, toileting, grooming, preparing meals, and feeding. The aide also helps to maintain the home environment, including light cleaning, laundry, shopping, and keeping the home safe. The client's vital signs, such as respiratory rate, pulse rate, and temperature, are observed. The aide may also remind the client to take prescribed medication(s) and, when necessary, transport and/or escort the client.

PC II aides work under the supervision of an RN. Prior authorization is required for PC II services, with an indication of the amount, frequency, duration, and type of services required.

The DDSN service coordinator shall obtain a physician's order requesting PC II services for individuals under the age of 21. A physician's order is not required for those MR/RD waiver beneficiaries over the age of 21.

Nursing Services

Nursing services provide skilled medical monitoring, direct care, and interventions that meet the medical needs of clients at home. Nursing services prevent institutionalization.

Habilitation Services (Day)

Day habilitation services provide assistance with the acquisition, retention, or improvement of self-help, socialization, and adaptive skills. These services take place in a non-residential setting, separate from the home or facility in which the client resides. Normally, these services are furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, unless provided as an adjunct to other day activities included in the beneficiary's plan of service. Day habilitation services focus on enabling clients to attain or maintain their

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Habilitation Services (Day) (Cont'd.)

maximum functional level. They shall also be coordinated with any physical, occupational, or speech therapies listed in the plan of service. Additionally, day habilitation services reinforce skills or lessons taught in school, therapy, or other settings.

Habilitation Services (Prevocational)

Prevocational habilitation services are not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or Section 602 (16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Activities included in this service are not directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the client's plan of service as directed to habilitative rather than explicit employment objectives. These services teach concepts such as compliance, attendance, task completion, problem solving, and safety, to prepare clients for paid and unpaid employment.

Excluding supported employment programs, prevocational habilitation services are provided to clients not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year. When compensated, individuals are paid less than 50 percent of minimum wage.

Documentation will be maintained in each client's file that the service is not otherwise available under the program funded under the Rehabilitation Act of 1973 or P.L. 94-142.

Habilitation Services (Residential)

Residential habilitation services include the care, skills training, and supervision provided to clients in a non-institutional setting. The degree and type of care, supervision, skills training, and support of clients will be based on the plan of service and the client's individual needs. Services include assistance with acquisition, retention, or improvement of skills related to activities of daily living, such as personal grooming and cleanliness; household chores and bed-making; eating and preparation of food; and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting.

Other than costs for modifications or adaptations to a facility required to assure the health and safety of residents or to meet the requirements of the applicable life safety

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Habilitation Services (Residential) (Cont'd.)

codes, payments for residential habilitation are not made for the following:

- Room and board
- Costs of facility maintenance
- Upkeep
- Improvement

Payments for residential habilitation do not include those made, directly or indirectly, to members of the client's immediate family. Payments will not be made for the routine care and supervision provided by a family or group home provider or for activities or supervision covered by a source other than Medicaid.