DDSN Executive Memo

TO: **EXECUTIVE DIRECTORS, DSN BOARDS**
CEOS, CONTRACTED SERVICE PROVIDERS
CASE MANAGEMENT/WAIVER CONTACTS

FROM: **SUSAN KREH BECK, ED.S., LPES, NCSP** SKB
ASSOCIATE STATE DIRECTOR-POLICY

DATE: **DECEMBER 18, 2018**

RE: **Therap Update and Case Management User Guide**

In response to communication from providers Therap has included several requested changes in their December 17th release.

- Case Notes: Bulk PDF – a new option to download a batch of case notes into PDF format for review.
- A system check will be added to ensure that every need has a six (6) month review entered and that the review has been properly completed.
- The Case Managers will be given the ability to respond to comments from Plan Reviewers when Plans are returned.
- The Support Plan will be updated to allow for more than one (1) attachment to be added.

In addition to the changes above, we continue to work with Therap to make additional changes that were requested as well as moving toward digital service authorizations to support the federally mandated Electronic Visit Verification systems.

Lastly, included with this Memo is a "Case Management Quick Reference Guide to Therap Plans and Plan Changes for Waiver Consumers." The Waiver Administration Division has worked with the Policy divisions to put this guide together to help Case Managers quickly reference material that has been presented in various trainings or communicated over the last year. It is our hope that this will help create more consistency and clarity in the plan development and approval process.

If you have questions, please contact Ben Orner at borner@ddsn.sc.gov or (803) 898-3520.

Case Management Quick Reference Guide to Therap Plans and Plan Changes for Waiver Consumers

Contents (Hold Ctrl and click on a line to jump to that location)

Assessment

The Case Management Annual Assessment (Long Assessment) must be completed for all individuals currently pending or enrolled in a waiver. After an initial assessment is completed in Therap the CM can use the "Copy as Draft" option in the future to speed up the data entry process (this might depend on your agency's policy/procedure so check with your supervisor). If a CM chooses to use this option they are still responsible for ensuring that all information in the assessment is accurate and complete. All changes to the individual's status should be reflected in the new assessment.

Sources of Information

All reference items that were used to complete the Assessment should be listed or attached in this section. This includes but is not limited to: Day or Residential Plans, Service Assessments, Medical documents or notes, and correspondence with other individuals regarding the Assessment of needs.

Comment Boxes

Each section of the Annual Assessment includes a comment box at the end. Additional comments are required so this is a great section to really elaborate and flesh out details that cannot be fully explained in the question/answer format of the assessment. The best assessments utilize this section to really explain the individual's status for that particular section of the assessment.

Face to Face

Case Management Standards require a face to face visit with the consumer, in their home, during the assessment process. The date of this face to face visit should be typed into the "Preparation for Upcoming Plan Meeting" section.

Plan

The Case Management Plans in Therap should always be started by clicking on the "New" option. The "Copy to Draft" option should never be used. If Waiver plans are submitted using the "Copy to Draft" option they will be deleted by the Plan Review Team. Plans should always flow from the Worksheet which flows from the Assessment. For information on how to navigate from Assessment to Worksheet to Plan please see this document: (https://www.therapservices.net/resources/southcarolina/How-to-Assessment-to-Plan-Workflow.pdf)

Plan Dates

Plans must be completed every 364 days and should be submitted at least 15 days (30 days recommended) prior to expiration in order to ensure there is enough time to have the plan approved before the previous plan expires.

Plans in Therap do not become active until approved by DDSN. Therefore, if the plan is completed on the due date and submitted for approval after business hours on that day, it will expire since we will be unable to approve it before it expires.

As soon as the plan is submitted it moves to DDSN for review. Do not submit the plan until you are ready for it to be reviewed and/or approved. If your agency has a policy about Supervisor review prior to submission be sure to follow that policy.

As soon as a plan is approved it becomes the active plan. Therefore, if you have submitted a plan for approval there is very little cause to submit a plan change request on the previous plan. Instead, wait until the new plan is approved and make a change at that point or correspond with the assigned reviewer to address the change prior to approval.

Need Descriptions

While the Case Management Worksheet will pre-populate the Need Descriptions for individuals based on the Annual Assessment, it is not necessary to keep those long, unwieldy statements. Case Managers should feel free to summarize

the description in a way that is more succinct and understandable. That said, CMs should also be aware of the phrasing of a need description so that it does not simply state that an individual needs an item or service. The phrasing should be such that it shows what the individual needs (what need will be met by the item or service).

Need Descriptions cannot be changed after a plan is approved so don't get overly specific. For example, there is no need to list prescriptions in a need description. Listing specifics like that will cause overly-complicated changes later in the plan year as the individual's situation changes.

"Add Funding Source"

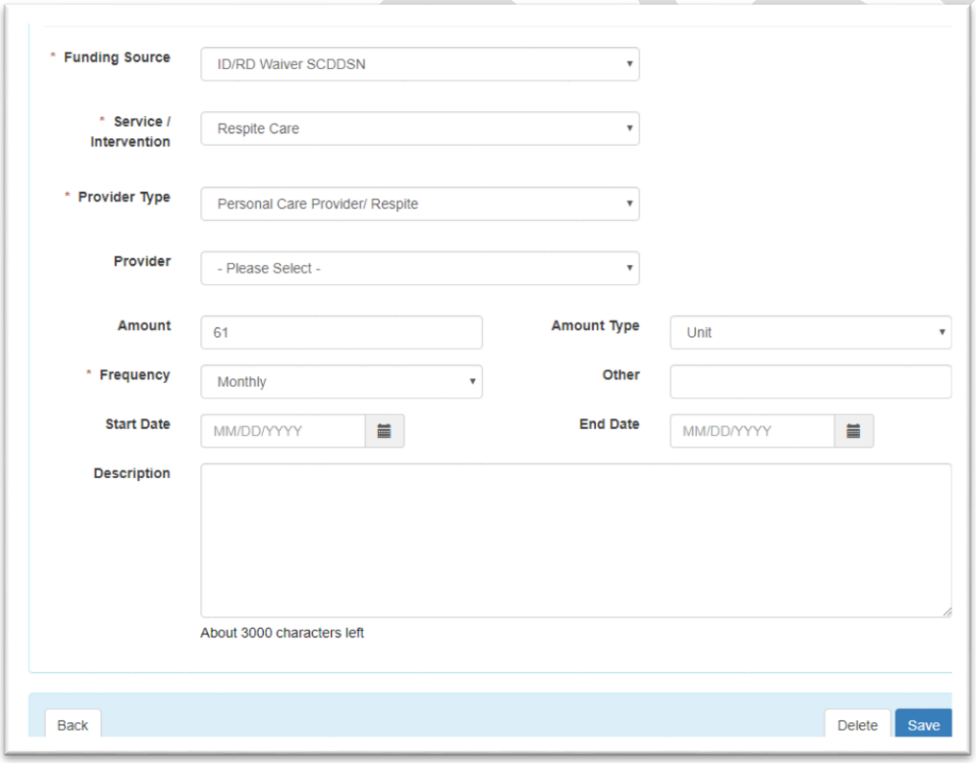
Each Need in Therap has a few different sections. First is the Need Description (see above). After that the case manager is prompted to select if the need relates to a personal goal. The final sections deal with the Funding Source, Service/Intervention, Provider Type and Amount, Frequency and Duration.

There are two different ways of keying this information: 1. use the "Add a Funding Source" button to access the drop down menu, or 2. manually enter the information in the "Other" section.

The first option is using the drop down boxes to specify all of the required items. When there is a need for a waiver service, the "add a funding source" option must be used. This option will bring you to a new screen with drop down selections that will limit you to the appropriate Service types and Provider types based on the funding source.

For non-waiver needs you may use the "Other" boxes. The "Other" boxes require manual entry of the funding source, service/intervention, provider type, and amount/frequency/duration (see next section).

Below is an example of how Respite for the IDRD Waiver should be completed using the "Add a Funding Source" drop downs:



Notice that every field is completed except “Provider” (which is a blank field and cannot be filled in) and “Start Date” and “End Date”. As the Start and End dates will be automatically entered when the plan is approved, the CM should leave them blank when submitting a plan.

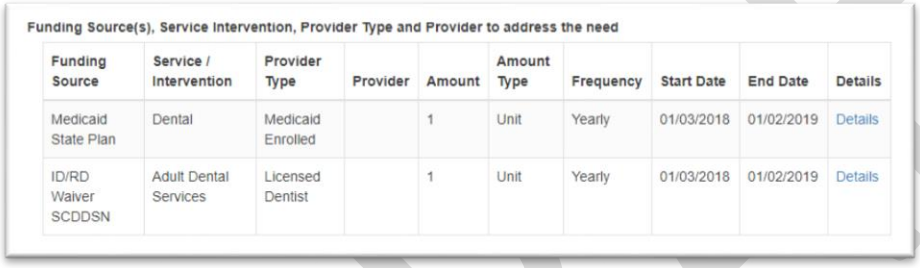
Also note that this is an example of direct bill respite. We can tell it is direct bill because the “Provider Type” is “Personal Care Provider/Respite”. See the attached Provider Type/Billing Type Chart for a complete list of which Provider Types are board billed and which are direct billed.

The Description field should be used for things that need additional specification beyond what is already provided. Information in the description field should not duplicate the information already provided in the drop down menus. Everything required by Medicaid for a waiver need is specified in the fields above. Appropriate entries in the Description field would be things like specifying what the AT item is after you put the dollar amount in the “Amount” field. It can also be used to differentiate between RN or LPN for nursing

Multiple Funding Sources

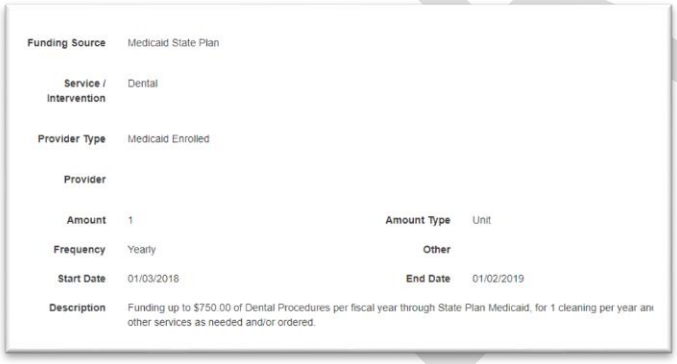
If a need requires more than one funding source, service, or provider type, you will follow the same process as above for each additional entry until all sources are properly entered.

Example of two funding sources for Adult Dental Services:



Funding Source(s), Service Intervention, Provider Type and Provider to address the need

Funding Source	Service / Intervention	Provider Type	Provider	Amount	Amount Type	Frequency	Start Date	End Date	Details
Medicaid State Plan	Dental	Medicaid Enrolled		1	Unit	Yearly	01/03/2018	01/02/2019	Details
ID/RD Waiver SCDDSN	Adult Dental Services	Licensed Dentist		1	Unit	Yearly	01/03/2018	01/02/2019	Details



Funding Source Medicaid State Plan

Service / Intervention Dental

Provider Type Medicaid Enrolled

Provider

Amount 1 **Amount Type** Unit

Frequency Yearly **Other**

Start Date 01/03/2018 **End Date** 01/02/2019

Description Funding up to $750.00 of Dental Procedures per fiscal year through State Plan Medicaid; for 1 cleaning per year an other services as needed and/or ordered.

Funding Source ID/RD Waiver SCDDSN

Service / Intervention Adult Dental Services

Provider Type Licensed Dentist

Provider

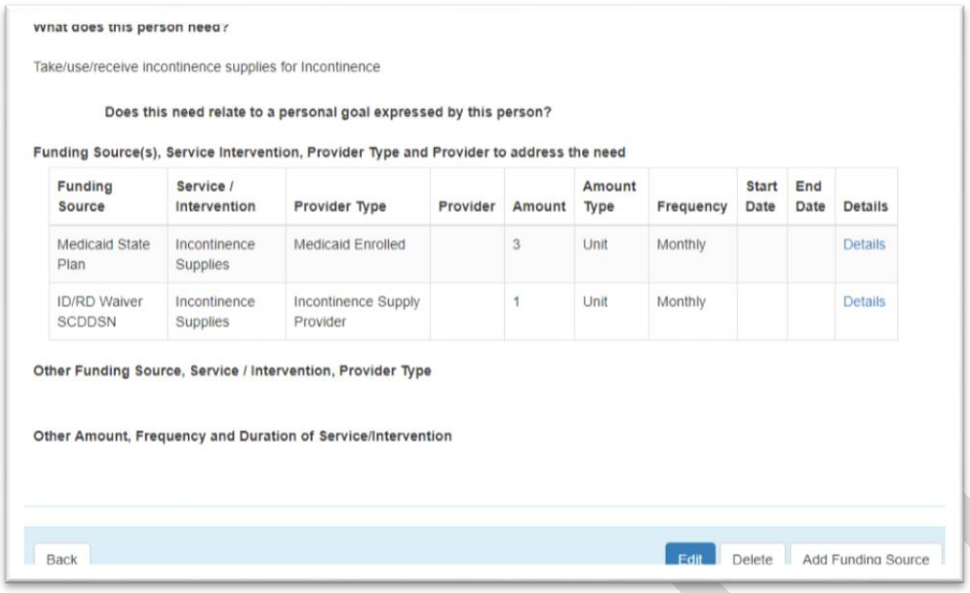
Amount 1 **Amount Type** Unit

Frequency Yearly **Other**

Start Date 11/05/2018 **End Date** 11/04/2019

Description Upon exhaustion of the State Plan Dental service, then the ID/RD Waiver may be used for 1 cleaning/exam and other services as needed and/or ordered

Example of two funding sources for Incontinence Supplies divided between Medicaid and Waiver:



What does this person need?

Take/use/receive incontinence supplies for Incontinence

Does this need relate to a personal goal expressed by this person?

Funding Source(s), Service Intervention, Provider Type and Provider to address the need

Funding Source	Service / Intervention	Provider Type	Provider	Amount	Amount Type	Frequency	Start Date	End Date	Details
Medicaid State Plan	Incontinence Supplies	Medicaid Enrolled		3	Unit	Monthly			Details
ID/RD Waiver SCDDSN	Incontinence Supplies	Incontinence Supply Provider		1	Unit	Monthly			Details

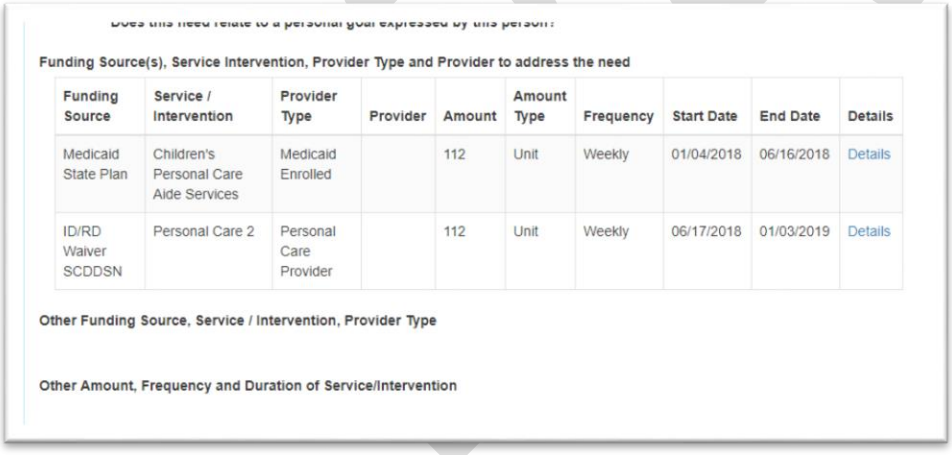
Other Funding Source, Service / Intervention, Provider Type

Other Amount, Frequency and Duration of Service/Intervention

Back | Edit | Delete | Add Funding Source

Multiple entries with different Service Names, Provider Types, or even start/end dates can be used if they are relevant to the same Need.

In this example, an individual turned 21 on 6/17/18 and the Medicaid funded Children's Personal Care Service had to be transitioned to Waiver funded Personal Care 2:



Funding Source(s), Service Intervention, Provider Type and Provider to address the need

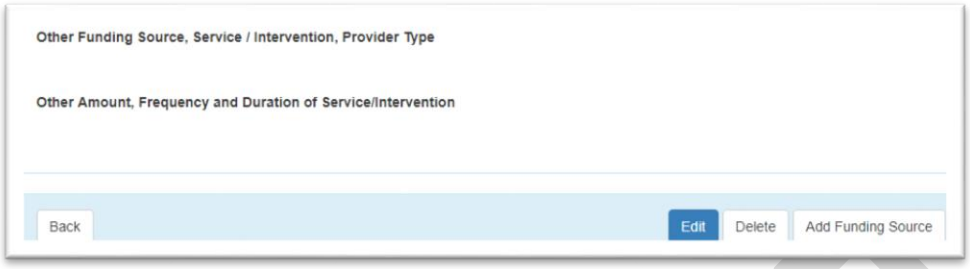
Funding Source	Service / Intervention	Provider Type	Provider	Amount	Amount Type	Frequency	Start Date	End Date	Details
Medicaid State Plan	Children's Personal Care Aide Services	Medicaid Enrolled		112	Unit	Weekly	01/04/2018	06/16/2018	Details
ID/RD Waiver SCDDSN	Personal Care 2	Personal Care Provider		112	Unit	Weekly	06/17/2018	01/03/2019	Details

Other Funding Source, Service / Intervention, Provider Type

Other Amount, Frequency and Duration of Service/Intervention

"Other" boxes

The "Add a Funding Source" option may not be suitable for all needs. Some needs will require a service or funding source that is not available from the drop down menu. In these situations you can use the "Other" boxes.

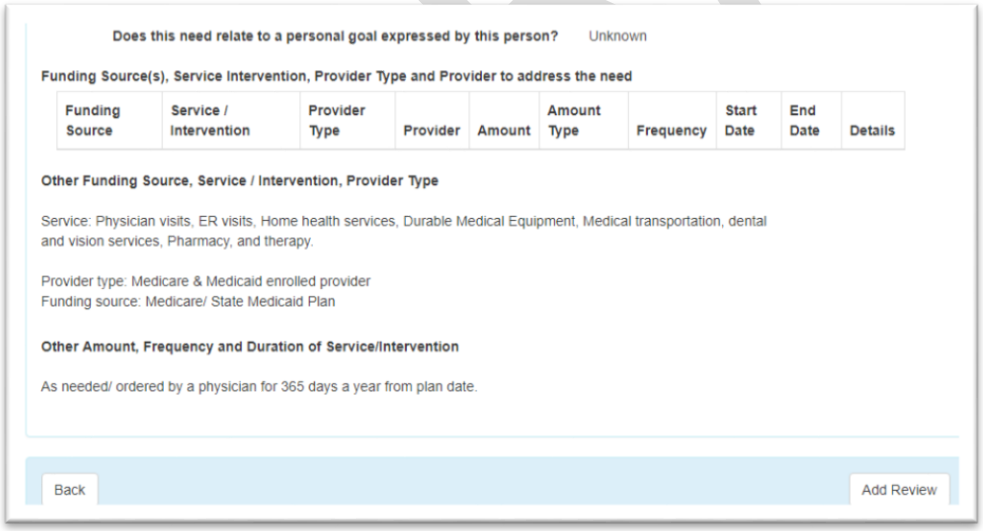


These boxes can be edited by clicking on the "Edit" button. Case Managers can use these sections to manually enter the Funding Source, Service, Provider or Amount, Frequency, and Duration. The "Other" boxes should not be used for any waiver funded services.

If a service is selected in the drop down (Add Funding Source) option then the CM should not duplicate the information in these "Other" boxes as it creates more potential for errors in the plan as it evolves and changes for that individual. If the drop down option is used then that is sufficient for that need.

Needs such as the General Medicaid Need are a good use of the "Other" fields. If you are using the "Other" boxes you do not need to use the drop down boxes at all.

In this example, the "Other" box is used to list all routine care services that might be needed during the plan year along with the appropriate sources, service names, provider types and amount/frequency/duration:



Plan Changes

After the initial approval of a plan the plan is "locked" and the only way to make changes to a plan is through the Plan Change Request process. To add a change request click the Add Change Request button in Therap at the bottom of the plan. This will bring up a new form.

Filling out the form

When filling out the plan change form there are 2 options:

1. Add a new Need / Service Intervention
2. Change a Need / Service Intervention

The top portion of the form will vary depending on which option you are using but the bottom portion remains the same. In the bottom portion you will have to give the "Change Reason" and the "Requested Change Description".

Change Reason

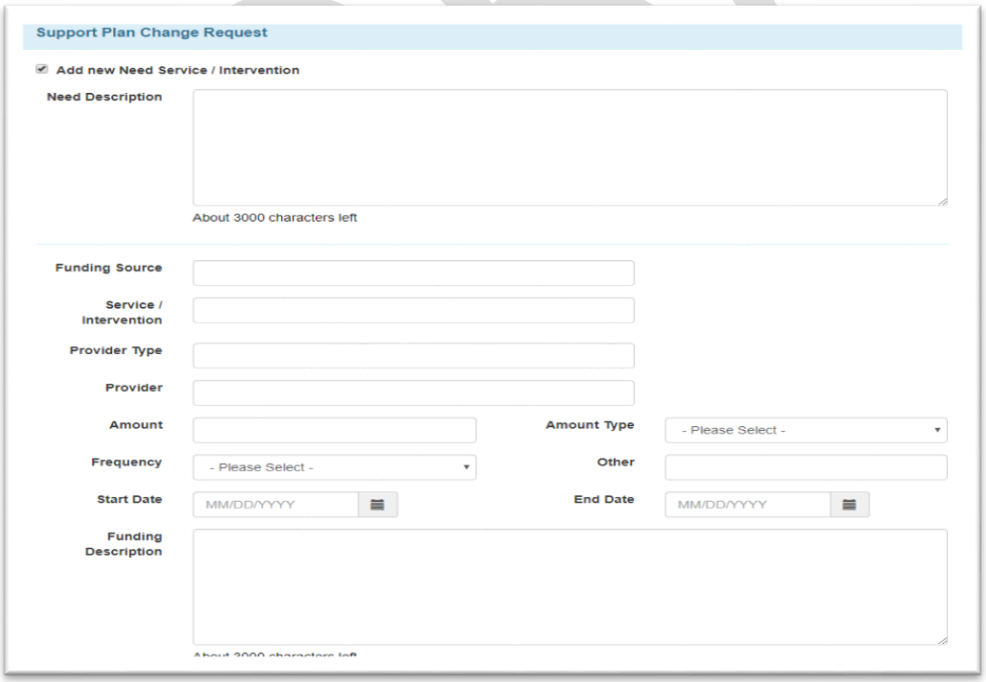
This section is used to describe why you are asking for the change. This section should contain more detail than simply "adding a service" or "revision needed". What happened to cause the change? Use this section to explain how the need was identified and/or what caused the change. This is where the CM provides information on the justification for the service/intervention that is requested (i.e. how will this service meet the need that has been identified).

Requested Change Description

Use this section to clearly state what you would like to change. If you are adding a need you can use this section to add any additional information that might be needed. When changing a need it is helpful in this section to state what you are changing the need from and what you want it to change to.

Adding a Need

When adding a new need you have the ability to fill out the following fields:



Need Description: This is where the need statement from the CM Worksheet will auto-populate. You can (and should in most cases) rewrite the need statement to make it more concise and appropriate. What does the individual need? A good rule is to avoid using the service name within the need statement. Instead say what they need that the service will address.

Funding Source: This describes the funding source that is expected to be used to meet the need. If unknown at the time, simply put "TBD" or "To be determined".

Service Intervention: This is the name of the Service that will be used to meet the need, if known. Remember that the Service Name is often very prescriptive for some funding sources so try to list only Service Names that are an option based on your funding source (See the table at the end of this guide).

Provider Type: This will be the type of provider (as possible based on the funding source and service name) that will be providing the service. These types of provider are prescribed in the Waiver Document and in the Waiver Manual for each service.

Provider: This section can be left blank

Amount: This is the amount of the service that will be needed to meet the need (either as a whole number for units or as a dollar amount).

Amount type: This is where you differentiate between Units or Dollar amounts for the previous field.

Frequency: You should select the frequency of the service at the amount listed above.

Other: Use this field only if you have selected "Other" in frequency and use it to describe the frequency.

Start Date/End Date: These represent the "duration" of the need. These dates will usually correspond with the date the need is added and the last day of the plan but if it is a shorter period you should note that here.

Funding Description: This box is used for any additional details that have not already been covered regarding the need, service, provider, amount, frequency, or duration. For example you could note here that the nursing service is RN instead of LPN. This section should not contain information that is already present above (in the drop downs).

What's required?

When submitting a plan change request you should always include the necessary information that is listed in the sections above. In addition to this information you should be sure to provide as much justification and background as possible. The best way to approach it is to look at the service definition in the waiver manual and then justify why you think this change helps meet a need for that individual while making sure that it stays within the service definition.

If you are submitting a change request for a service with a specific assessment then those must be attached to the plan change request (example: Respite, Personal Care, New requests for Incontinence Supplies).

AT/DME and Medicaid/Medicare

What's needed?

The waiver programs are always the funding source of last resort and therefore it is important to rule out other funding sources before pursuing waiver funding. For AT/DME this is done through documentation from the provider that the item was or will be denied by Medicaid/Medicare. Many times this can be difficult to obtain and the next section explains how to go about searching policy to determine if something is covered. Keep in mind that just because the provider says it is not covered does not mean Medicaid/Medicare do not cover a similar item that will also meet the need.

If an item is on the plan and already being funded through the waiver but during a plan review it is determined that the item should be covered by Medicaid/Medicare, the reviewer will approve the plan with a 90 day term on the waiver funded item. During this 90 day period the CM should work with the provider to begin billing Medicaid/Medicare. The provider should attempt to bill and obtain denial documentation during the 90 day period. If the provider bills Medicaid/Medicare but is denied funding, they can still bill the waiver during the 90 day period. If the provider obtains denial documentation (and they have submitted all the required documentation as part of their billing) then that documentation can be used in a Plan Change request to request continued waiver funding.

How do I find if something is covered?

The best starting point is to find what that item's HCPCS billing code would be. Google is your friend. Simply search for the item name and "HCPCS code" and you should be able to find a code. Keep in mind that the billing codes are generic. You won't find a code for a specific item but rather for general groups of items.

Medicare:

In order to check and see if something is covered by Medicare you can use this website: https://cgsmedicare.com/jc/coverage/lcdinfo.html

In order to access this site you will have to accept the Terms and Conditions. After accepting the terms and conditions you can do a search of the page (Ctrl + F) to find the item you are looking for. Keep in mind that you should not search brand names but rather search for generic terms describing the item (example: search for "lifts" instead of "Surehands"). You can also search for a billing code to find items that way.

Once you find the group you are looking for you can click the "EXT" box to get more information on the requirements for that item.

You will again have to scroll to the bottom of the page and "Accept" the terms. You will then see a page with lots of information on how the item is provided. The "Coverage Guidance" section is a good place to start as it will explain what is required in order to have that item provided. If an item is listed on this website and the individual meets the criteria then they should be able to obtain the item through Medicare.

Medicaid:

To determine if an item is covered by Medicaid you will need to find the HCPCS code for that item and compare it to the DME Fee Schedule. The DME manual does not contain an exhaustive list of codes/items but the fee schedule shows every code covered by Medicaid in SC. You can find the fee schedule on the DHHS website (www.scdhhs.gov) under the "For Providers" tab. (https://www.scdhhs.gov/resource/fee-schedules) When you click the link for DME Fee Schedule it downloads an excel sheet that you can then use to search for the code. If the code is on the fee schedule with a cost

next to it then it is covered and the waiver cannot fund it. If there is no cost next to the code then that means the item is only covered for individuals under 21 through EPSDT.

A note regarding Medicaid and Providers:
Providers can choose to serve or not serve individuals who need their services but once they take the individual on as a "Medicaid Client" they must provide all AT/DME that the individual needs that Medicaid covers. Providers cannot say that they will provide Item A to the consumer each month but not Item B. If Medicaid covers both items the provider has to provide all or none. This is especially relevant when providers do not want to provide an item due to low Medicaid reimbursement rates.

EPSDT

Federal requirements mandate that children under 21 be provided with items that are medically necessary as part of a program called EPSDT (Early Periodic Screening, Diagnosis and Treatment). As such, any AT/DME items requested for individuals under 21 will need to first be submitted through Medicaid for review of medical necessity. This can be done by the AT/DME Provider. The provider will send the request, with supporting documentation, to KEPRO (Medicaid's prior authorization contractor) and KEPRO will make the determination. If the determination indicates the item in question is not medically necessary, the CM can request it through the waiver. The subsequent request for waiver funding must justify how the item provides a remedial benefit for the individual if a medical benefit was ruled out. If the KEPRO denial indicates that there was not sufficient documentation to support the need then the provider will need to gather more documentation and resubmit before Waiver funding can be considered.

When submitting a request for AT/DME for individuals under 21 the KEPRO information should be attached to the plan change request or uploaded into document storage for retrieval. If you upload it to document storage please note that in the plan or plan change form.

Denials/Reductions/Terminations

Occasionally there will be a need to Deny, Reduce, or Terminate waiver services. Case Managers should be aware that they have the full authority to do any of these things at their discretion without first sending it to DDSN. Case Managers are responsible for assessing services and needs and then recommending the appropriate service to meet that need. If a family requests something through the waiver that does not meet the service definition or is clearly not justified, the CM should deny the request. CMs should follow the waiver manual chapter's guidance for these procedures.

Denials

When denying a service there is no need to add it to the plan, the CM can record the request in a case note and note the denial. If a CM feels a service/intervention is appropriate but DDSN denies it as part of the Plan/Change request process then the change request will be "Rejected" and an explanation will be sent to the CM. Under no circumstances should the denial form sent to the family state that the reason for the denial was "DDSN (or Plan Review/Waiver Admin) denied the request." The reason for denial should be the reason that the CM and/or DDSN indicated that the service should be denied (Ex: Did not meet the service definition, Amount not justified based on documentation, etc.).

Reductions

When a service is reduced there is (in most situations) a requirement for a 10 day notice from the time the Notice of Reduction form is sent to the family. During that time the service will need to remain active on the plan. If the CM reduces a service as part of a new plan, a 10 day period with the previously approved amounts should be included on the plan prior to the start date of the reduction. This can be done by utilizing two rows of "Funding Sources" on the need. If a need is reduced through the Plan Review Process, the reviewer will provide a 15 day window before the reduction occurs on the plan. This allows the CM 5 days to complete and send the reduction form. If for some reason

the form is not sent within the 5 day period, the effective date of the reduction will need to be pushed back. It is the CM's responsibility to submit a Plan Change Request to adjust the service dates to ensure that the plan accurately represents what was authorized.

Under no circumstances should the notice of reduction form sent to the family state that the reason for the reduction was "DDSN (or Plan Review/Waiver Admin) denied the request." The reason for reduction should be the reason that the CM and/or DDSN indicted that the service should be reduced (Ex: Amount not justified based on documentation, additional services put in place to meet need, etc.).

Terminations

When a service is terminated there is (in most situations) a requirement for a 10 day notice from the time the Notice of Termination form is sent to the family. During that time the service will need to remain on the plan. If the CM terminates a service as part of a new plan, a 10 day period with the previously approved amounts should be included on the plan prior to the termination date of the service. If a service is terminated through the Plan Review Process, the reviewer will provide a 15 day window before the termination occurs on the plan. This allows the CM 5 days to complete and send the termination form. If for some reason the form is not sent within the 5 day period, the effective date of termination will need to be pushed back. It is the CM's responsibility to submit a Plan Change Request to adjust the service dates to ensure that the plan accurately represents what was authorized.

Under no circumstances should the notice of termination form sent to the family state that the reason for the reduction was "DDSN (or Plan Review/Waiver Admin) denied the request." The reason for termination should be the reason that the CM and/or DDSN indicated that the service should be terminated (Ex: Item covered through State Plan Medicaid, Alternative services put in place to meet need, etc.).

Service Name and Provider Type (Board Billed or Direct Billed?)

FUNDING	SERVICE	PROVIDER TYPE	Board (M)/Direct (D)
CSW	Adult Day Health	Adult Day Health Care Provider	D
CSW	Behavior Support Services	Behavior Support Provider	D
CSW	Environmental Modifications	Environmental Modification Providers	D/M
		DDSN/DSN Boards/Contracted Providers	M
CSW	Personal Care 1	Personal Care Providers	D
CSW	Personal Care 2	Personal Care Providers	D
CSW	Personal Emergency Response System	Personal Emergency Response Provider (PERS)	D
CSW	Private Vehicle Modifications	DDSN/DSN Board/Contracted Provider	M
		DHHS Enrolled Providers	D
CSW	Respite	DDSN	M
		Licensed Community Residential Care Facility	M
		Personal Care Provider	D
		DSS Licensed Foster Home	M
		Medicaid Certified Nursing Facility	D
		Medicaid Certified ICF/IID	M
CSW	Day Activity	DDSN (Day Services Provider)	M
CSW	Career Preparation Services	DDSN (Day Services Provider)	M
CSW	Support Center Services	DDSN (Day Services Provider)	M
CSW	Assistive Technology and Appliances	DDSN/DSN Boards/Contracted Provider	M
		DHHS Enrolled Providers	D
CSW	In-Home Support Services	Independent In-Home support providers	M
CSW	Adult Day Health Transportation	Adult Day Health Care Agency	D
CSW	Adult Day Health Nursing	Adult Day Health Care Agency	D
CSW	Employment Services - Group	Employment Services Provider	M
CSW	Employment Services - Individual	Employment Services Provider	M
CSW	Community Services - Individual	DDSN (Day Services Provider)	M

CSW	Community Services - Group	DDSN (Day Services Provider)	M
CSW	Incontinence Supplies	Incontinence Supply Provider	D
CSW	Assistive Technology and Appliances Assessment/Consultation	DDSN/DSN Boards/Contracted Providers	M
CSW		DHHS Enrolled Providers	D
CSW	Private Vehicle Assessment/Consultation	DDSN/DSN Board/Contracted Provider	M
CSW		DHHS Enrolled Providers	D
HASCI	Environmental Modifications	DDSN/DSN Boards/Contracted Providers	M
		Rehabilitation Engineering Technologists, Assistive Technology Practitioners and Assistive Technology Suppliers Certified by the Rehabilitation Engineering Society of North America (RESNA)	M
		Vendors with a retail or wholesale business license contracted to provide services	M
		Licensed Occupational and Physical Therapists	M
		Licensed Contractors	M
		Certified ADA Coordinators	D
HASCI	Health Education for Participant-Directed Care	DSN Board/Contracted Providers	M
HASCI	Medicaid Waiver Nursing	Nursing Agencies	D
		Registered Nurses	D
HASCI	Peer Guidance for Participant-Directed Care	DSN Board/Contracted Providers	M
HASCI	PERS	Personal Emergency Response Providers	D
HASCI	Physical Therapy	Physical Therapists	D
		Physical Therapy Groups	D
HASCI	Private Vehicle Modifications.	DDSN/DSN Board/Contracted Providers	M
		DHHS Enrolled Providers	D
HASCI	Private Vehicle Assessment/Consultation	DDSN/DSN Board/Contracted Provider	M
		OT, PT, Rehabilitation Engineering Technologists, Assistive Technology Practitioners, Assistive Technology Suppliers, Environmental Access/Consultants/contractors	D

HASCI	Psychological	Psychological Service Provider	D
HASCI	Residential Habilitation	DSN Board/Contracted Providers	M
HASCI	Respite	Medicaid Certified ICF-ID	M
		Foster Home	M
		Medicaid Certified Nursing Facility	D
		Respite Provider Agencies	D
		Hospital	M
		Community Residential Care Facility	M
		DDSN/DSN Board/Contracted Providers	M
HASCI	Day Activity	DSN Board/Contracted Providers	M
HASCI	Employment Services - Group	DDSN/DSN Board/Contracted Provider	M
HASCI	Employment Services - Individual	DDSN/DSN Board/Contracted Provider	M
HASCI	Incontinence Supplies	Incontinence Supply Provider	D
HASCI	Attendant Care/Personal Assistance	Attendant Care Provider Agencies	D
		Independent Attendant Care Providers	M
		DSN Board/contracted providers	M
HASCI	Behavior Support	Behavior Support Provider	D
HASCI	Career Preparation	DSN Board/Contracted Providers	M
HASCI	Speech and Hearing Services	Speech Therapy Group	D
		Audiology Groups	D
		Audiologists	D
		Speech Pathologists	D
		Speech Pathology Groups	D
		Speech Therapists	D

HASCI	Supplies, Equipment, and Assistive Technology	Durable Medical Equipment Providers	D
		Technicians or professionals certified in the installation and repair of manufacturer's equipment	M
		Rehab Engineering Technologist (RET) certified by Rehabilitation Engineering Society of North America (RESNA)	M
		DDSN/DSN Board/Contracted Providers	M
		Licensed Contractor	M
HASCI	Equipment and Assistive Technology Assessment/Consultation	Occupational Therapist	D
		Physical Therapist	D
		Rehabilitation Engineering Technologist	D
		Assistive Technology Practitioners	D
		Assistive Technology Suppliers	D
		Environmental Access/Consultants/Contractors	D
HASCI	Occupational Therapy	Occupational Therapists	D
		Occupational Therapy Groups	D
HASCI	Pest Control Treatment	Licensed Business	D
HASCI	Pest Control Bed Bugs	Licensed Business	D
ID/RD	Adult Attendant Care Services	Independent Attendant Care Providers	M
ID/RD	Adult Companion Services	DSN Board/Contracted Providers for Adult Companion Providers	M
ID/RD	Adult Day Health	Adult Day Health Care Providers Contracted with SCDHHS	D
ID/RD	Adult Day Health Care Nursing	Adult Day Health Care Providers	D
ID/RD	Adult Dental Services	Licensed Dental Hygienist	D
		Licensed Dentist	D
		Licensed Dentists	D
		Board Certified Oral Surgeon	D
		Board Certified Oral Surgeons	D
		Licensed Dental Hygienists	D

ID/RD	Adult Vision	Licensed Optometrists, Licensed Ophthalmologists, or Licensed Opticians	D
ID/RD	Audiology Services	Licensed Audiologists	D
		Licensed Audiology Providers	D
ID/RD	Behavior Support Services	Behavior Support Provider	D
ID/RD	Environmental Modifications	DDSN/DSN Board/Contracted Provider	M
		Licensed Contractors	D/M
ID/RD	Nursing Services	Nursing Agencies	D
ID/RD	Personal Care 1	Personal Care Provider	D
ID/RD	Personal Care 2	Personal Care Provider	D
ID/RD	Personal Emergency Response System	Personal Emergency Response Providers	D
		DSN Boards/Contracted Providers	M
ID/RD	Private Vehicle Modifications	DDSN/DSN Board/Contracted Provider	M
		Durable Medical Equipment Provider	D
ID/RD	Residential Habilitation	Residential Habilitation Providers	M
		Supported Living Providers	M
ID/RD	Respite	Medicaid Certified Nursing Facility	D
		Medicaid Certified ICF/ID	M
		DSS Licensed Foster Home	M
		DDSN/DSN Board/Contracted Provider	M
		Licensed Community Residential Care Facility	M
		Certified Respite Caregiver	M
		Personal Care Provider/ Respite	D
ID/RD	Specialized Medical Equipment, Supplies and Assistive Technology	Durable Medical Equipment Providers	D
		DDSN/DSN Board/Contracted Providers	M
ID/RD	Day Activity	Day Activity Provider	M
ID/RD	Career Preparation Services	Career Preparation Provider	M
ID/RD	Community Services	Community Services Provider	M
ID/RD	Support Center Services	Support Center Services Provider	M
ID/RD	Adult Day Health Transportation	Adult Day Health Care Providers	D

ID/RD	Employment Services - Group	Employment Services Providers	M
ID/RD	Employment Services - Individual	Employment Services Providers	M
ID/RD	Incontinence Supplies	Incontinence Supply Provider	D
ID/RD	Pest Control Bed Bugs	Licensed Business	D
ID/RD	Pest Control Treatment	Licensed Business	D
ID/RD		DDSN/DSN Board/Contracted Provider	M
ID/RD	Private Vehicle Assessment/Consultation Private Vehicle Assessment/Consultation	OT, PT, Rehabilitation Engineering Technologists, Assistive Technology Practitioners, Assistive Technology Suppliers, Environmental Access/Consultants/Contractors	M
ID/RD	Specialized Medical Equipment and Assistive Technology Assessment/Consultation	OT, PT, Rehabilitation Engineering Technologists, Assistive Technology Practitioners, Assistive Technology Suppliers, Environmental Access/Consultants/Contractors	M

Change Log:

November 18, 2018 – First Draft Finalized