Chapter 6
Waiver Services

HASCI Waiver Procedural Manual

CHAPTER

6

WAIVER SERVICES

The following sections address each service currently available through the HASCI Waiver. Each section gives a definition for the Waiver service, the types of providers, instructions for arranging for the service, helpful information about monitorship and procedures for reduction, suspension or termination of the service.

Prescribed Drugs

Definition

Prescribed drugs are part of the HASCI Waiver as an extended Medicaid State Plan service. The HASCI Waiver allows an additional three (3) prescribed drugs over the state plan limit.

Note: The Medicaid State Plan currently covers all prescribed drugs for Medicaid recipients under age twenty-one (21). Coverage is in effect through the month of their 21st birthday. Medicaid State Plan covers four (4) prescribed drugs per month for individuals age 21 and over.

Note: **Not all drugs prescribed by a physician will be covered. Drugs such as those used for weight control, fertility, smoking cessation, etc. may not be covered.**

Effective July 2001, the State Plan will reimburse for a maximum one-month supply of medication per prescription or refill. Therefore, staggering of medications with a 90-day supply is no longer allowed.

Note: Medicaid policy allows a pharmacist to submit a prescription limit override for the following reasons: (1) the monthly prescription limit has been met, (2) the individual has one of the following conditions, and (3) the prescription is for an essential drug used in the patient's treatment of the following:

- Acute sickle cell disease
- Behavior health disorder
- Cancer
- Cardiac disease
- Diabetes
- End stage lung disease
- End stage renal disease
- HIV/AIDS
- Hypertension
- Life-threatening illness
- Organ transplant
- Terminal state of an illness

The override of the monthly prescription limit is reserved for only those prescriptions that, in the clinical judgment of the pharmacist, meet the prescription limit override criteria. Pharmacists must not use the override code for a prescription until after the monthly prescription limit has been reached.

Providers

Prescribed drugs must be provided by licensed pharmacies enrolled with SCDHHS as Medicaid providers.

Arranging for the Service(s)

When it is determined that prescribed drugs are needed, the individual and/or his/her family should contact a pharmacy enrolled as a Medicaid provider. The offering of a choice of provider must be clearly documented in the individual's file.

The need for the service must be clearly identified in the individual's Plan, including the name of the service, the amount, frequency, duration of the service and the provider.

For prescribed drugs, one unit equals one medication/drug. Once the frequency and amounts are determined, it must be entered into the Waiver Tracking system.

Once the service is approved, the service is authorized when the individual presents his/her Medicaid card imprinted with the statement "HASCI Waiver Client allowed 3 additional prescriptions per month above the current limit" to the enrolled pharmacy.

Billing

Prescribed drugs will **always** be a direct billed service. This means that all providers must be Medicaid enrolled providers and must bill SCDHHS for reimbursement.

Monitorship

When monitoring the provision of prescribed drugs as a HASCI Waiver service, it is important to ensure that the service is being utilized, is effective, and that the individual and/or family is satisfied with the service. If the individual no longer needs certain drugs, or new ones are added, the plan and budget on the Waiver Tracking System must be revised immediately.
Note: See Chapter 5 for monitorship guidelines.

Residential Habilitation

Definition

Residential Habilitation Services include the care, skills training and supervision provided to individuals in a non-institutional setting. The degree and type of care, supervision, and skills are dependent upon the individual's needs. Services include assistance with acquisition, retention, or improvement of activities of daily living, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting.

Payments

Payments for Residential Habilitation are not made for room and board, the cost of the facility maintenance, upkeep and improvement, other than such 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 code. **Payment for Residential Habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family.** Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid.

Providers in Licensed Settings

- **DSN Boards/contracted providers**

  Residential Habilitation Services are provided by staff employed by the DSN Board to work in SCDDSN sponsored residential facilities. These facilities must be licensed by SCDDSN or the SC Department of Health and Environmental Control (SCDHEC) and are classified as Community Training Homes I or II (CTH I or II), Supervised Living Programs I or II (SLP I or II), or Community Residential Care Facilities (CRCF).

  Residential Habilitation services are provided by approved providers of SCDDSN and on the Qualified Provider List (QPL) to serve persons with head injury, spinal cord injury and similar disability.

Residential Habilitation in Unlicensed Settings

Note: If the Service Coordinator determines that the individual is in need of and desires Residential Habilitation in unlicensed settings, he/she must contact the SCDDSN Head and Spinal Cord Injury Division.

A provider of Residential Habilitation in unlicensed settings is an individual employed/contracted as a "life coach" to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings.

Providers in Unlicensed Settings

- **DSN Boards/contracted providers**
- **Medicaid enrolled rehabilitation programs certified by the Commission on the Accreditation of Rehabilitation Facilities (CARF)**
- **Medicaid enrolled Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)**

Transportation

Transportation will be provided between the individual's place of residence and the site of habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

Arranging for the Service(s)

If the individual resides in a SCDDSN sponsored residential facility and is determined to need the care, skills training, and supervision described in the Residential Habilitation services definition (above), the individual's Plan must clearly outline the habilitation services (i.e., care, supervision, skills training) to be provided along with the name of the provider, amount, frequency and duration of services. Residential Habilitation services do not include payment for room and board. For CTH I, CTH II, SLP II, and CRCF, one unit of Residential Habilitation equals one day. One day is measured by the recipient's presence or absence as noted on the facility's daily census. For SLP I, one unit equals one hour of service as documented on the Individual Service Report.

Once the amount of Residential Habilitation has been determined, it should be entered in the budget menu of the Waiver Tracking System. The individual's Plan must be updated to reflect the name of the service, amount, frequency, duration of the service, and the provider.
Once the service is approved, the service is authorized using the Authorization for Habilitation Services (HASCI Form 12A). The authorization should go to the DSN Board that is providing the service.

Billing

Residential Habilitation is currently a Board-billed service. The Authorization for Habilitation Services (HASCI Form 12A) should accurately reflect this and no prior authorization number would be included. The Provider Agency should follow the Procedures to Report and Bill for Board Based Services Provided to HASCI Waiver Participants to receive reimbursement for costs.

Monitorship

The provision of Residential Habilitation Services must be monitored to assure its usefulness and effectiveness, as well as the individual's satisfaction with the service and the provider of the service. Progress toward goals and objectives should be reviewed and documented as a part of monitorship. The frequency of the contact with the individual and the provider of service should be made based on the needs of the individual and the findings during previous monitoring.
Note: See Chapter 5 for monitorship guidelines.

Reduction, Suspension or Termination

If Residential Habilitation Services need to be reduced, suspended or terminated the Service Coordinator must notify the provider to reduce, suspend or stop the service. The Service Coordinator must also notify the individual/legal guardian with a written notice regarding the change(s) in service(s), allowance/process for appeal and a ten (10) calendar day waiting period before proceeding with the reduction, suspension or termination. The Notice of Reduction, Suspension or Termination of Service Form must be completed by the Service Coordinator and forwarded to the provider with a copy to the individual/legal guardian (see Chapter 5 for procedures regarding written notification and the appeals process). (***Note:*** All unused units must be deleted from the Waiver Tracking System and the individual's Plan must be updated as soon as possible.)

Day Habilitation

Definition

Day Habilitation is assistance with acquisition, retention, or improvement of self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home and facility in which the individual resides. Services shall normally be furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week unless provided as an adjunct to other day activities included in an individual's plan.

Day Habilitation Services focus on enabling the individual to attain or maintain his/her maximum functional level and are coordinated with any physical, occupational, or other therapies listed in the Plan. In addition, Day Habilitation Services may serve to reinforce skills or lessons taught in school, therapy or other settings.

Providers

Day Habilitation Services are provided by staff employed by local DSN Boards to work in SCDDSN sponsored day programs. These programs are licensed by SCDDSN as Child Development Programs or Adult Activity Centers.

Arranging for the Service(s)

If an individual wishes to enroll in a Board's Child Development Program (CDP) or Adult Activity Center (AAC), the Service Coordinator must follow the Board's current policy/procedure for enrollment in these programs.

For individuals currently attending and determined to need the kind of assistance described in the Day Habilitation definition, his/her Plan must clearly reflect the specific assistance, name of provider, amount, frequency and duration of the service to be provided. Some examples of this assistance include training to learn to manage his/her own behavior, training to learn to dine independently, assistance with completion of exercises recommended by an Occupational or Physical Therapist, training to learn to interact appropriately with others, etc. For Day Habilitation, one unit equals one day of service.

Once the amount of Day Habilitation has been determined, it should be entered in the budget menu of the Waiver Tracking System. The individual's Plan must be updated to reflect the name of the service, the amount, frequency, duration of the service and the provider.

Once the service is approved, the service is authorized using the Authorization for Habilitation Services (HASCI Form 12A). The authorization should go to the DSN Board providing the service.

Billing

Day Habilitation is currently a Board-billed service. The Authorization for Habilitation Services (HASCI Form 12A) should reflect this and no prior authorization number should be included. The Provider Agency should follow the Procedures to Report and Bill for Board Based Services Provided to HASCI Waiver Participants to receive reimbursement for costs.

Transportation

Transportation will be provided between the individual's place of residence and the site of habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers.

Monitorship

This service must be monitored to determine its usefulness and effectiveness and to determine the individual's satisfaction with the service. Progress toward goals and objectives should be reviewed and documented as a part of monitorship. The frequency of contact with the individual and the provider of service should be made based on the needs of the individual and the findings during previous monitoring. **Note:** See Chapter 5 for monitorship guidelines.

Reduction, Suspension or Termination

If Day Habilitation services need to be reduced, suspended or terminated the Service Coordinator must notify the provider to reduce, suspend or stop the service. The Service Coordinator must also notify the individual/legal guardian with a written notice regarding the change(s) in service(s), allowance/process for appeal and a ten (10) calendar day waiting period before proceeding with the reduction, suspension or termination. The Notice of Reduction, Suspension or Termination of Service form must be completed by the Service Coordinator and forwarded to the provider of service with a copy to the individual/legal guardian (see Chapter 5 for procedures regarding written notification and the appeals process). (***Note:*** All unused units of the service must be deleted from the Waiver Tracking System and the individual's Plan must be updated as soon as possible).

Prevocational Services

Definition

Prevocational Services are aimed at preparing an individual for paid or unpaid employment, but are not job task oriented and are not directed at teaching job specific skills. Activities included in this service are directed at teaching habilitative goals such as attention span or motor skills. Services include teaching concepts such as compliance, attendance, endurance, task completion, problem solving and safety. All prevocational services will be reflected in the individual's plan as directed to habilitative, rather than explicit employment objectives. Documentation will be maintained in the file of each individual stating that this service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or PL 94-142.

Providers

Prevocational Services are provided by staff employed by DSN Boards to work in SCDDSN sponsored day programs. These programs are licensed by SCDDSN as Adult Activity Centers.

Arranging for the Service(s)

If an individual wishes to enroll in a Board's Adult Activity Center (AAC), the Service Coordinator must follow the Board's current policy/procedure for enrollment in this program.

Once the need for the service has been identified, SC Vocational Rehabilitation (SCVR) must be contacted to determine if this service is available through a program funded by SCVR. The Request for Determination of Availability of service (HASCI form 13) should be used to request this determination.

If the service is not otherwise available through SCVR, the Service Coordinator must ensure that the individual's Plan clearly reflects the need for the service. The Plan must reflect the training to be provided along with the name of the provider, amount, frequency and duration with which it is to be provided. Some examples of Prevocational Services include training to work for longer periods of time, training to stay on task for specified periods of time, training on safety skills, etc.

When the need for Prevocational Services has been determined, it should be entered in the budget menu of the Waiver Tracking System. The individual's Plan must be updated with the name of the service, the amount, frequency and duration, and the provider.

When the service is approved, the service is authorized using the Authorization for Habilitation Services (HASCI Form 12A). The authorization should go to the DSN Board that is providing the service.

Billing

Prevocational Services are currently Board-billed. This should be checked on the Authorization for Habilitation Services (HASCI Form 12A) and no prior authorization number should be included. The Provider Agency should follow the Procedures to Report and Bill for Board Based Services Provided to HASCI Waiver Participants to receive reimbursement for costs.

Transportation

Transportation will be provided between the individual's place of residence and the site of habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers.

Monitorship

Prevocational services must be monitored to determine its usefulness and effectiveness and to determine the individual's satisfaction with the service. Progress toward goals and objectives should be reviewed and documented as a part of monitorship. The frequency of contact with the individual and the provider of service should be made based on the needs of the individual and the findings during previous monitoring. **Note:** See Chapter 5 for monitorship guidelines.

Reduction, Suspension or Termination

If Prevocational services need to be reduced, suspended or terminated the Service Coordinator must notify the provider to reduce, suspend or stop the service. The Service Coordinator must also notify the individual/legal guardian with a written notice regarding the change(s) in service(s), allowance/process for appeal and a ten (10) calendar day waiting period before proceeding with the reduction, suspension or termination. The Notice of Reduction, Suspension or Termination of Service Form must be completed by the Service Coordinator and forwarded to the provider with a copy to the individual/legal guardian (see Chapter 5 for procedures regarding written notification and the appeals process). (***Note:*** All unused units must be deleted from the Waiver Tracking System and the individual's Plan must be updated as soon as possible.)

Supported Employment Services

Definition

Supported Employment Services consist of paid employment for persons for whom employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported Employment Services are provided in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported employment includes activities to sustain paid work, including training and supervision. When Supported Employment Services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by the recipient as a result of their disabilities, and will not include payment for those supervisory activities rendered as a normal part of the business setting. Supported Employment Services can be funded by the Waiver only when the services are not otherwise available under a program funded under the Rehabilitation Act of 1973, or PL 94-142.

Providers

Supported Employment Services are provided by staff employed by the DSN Board to provide SCDDSN sponsored Supported Employment Services.

Supported Employment Services may be provided by Medicaid enrolled rehabilitation programs certified by the Commission on the Accreditation of Rehabilitation Facilities (CARF) and Medicaid enrolled Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC). Please refer to Appendix B-2 and Attachment 3 to Appendix B-2 of the HASCI Waiver document for provider qualifications.

Arranging for the Service(s)

If an individual wishes to enroll in a Board's Supported Employment Services, the Service Coordinator must follow the Board's policy/procedure for enrollment in the service.

When the need for the service has been identified, SC Vocational Rehabilitation (SCVR) must be contacted to determine if this service is available through a program funded by SCVR. The Request for Determination of Availability of service (HASCI form 13) should be used to request this determination.

If the service is not otherwise available through SCVR, the Service Coordinator must ensure that the individual's Plan clearly reflects the need for the service. The plan must reflect the training or supervision needed to sustain employment, the frequency and duration of the service. For Supported Employment Services, one unit equals one hour of service.

When the amount of Supported Employment Services has been determined, it should be entered in the budget menu of the Waiver Tracking System. The individual's Plan must be updated to reflect the name of the service, the amount, frequency and duration of the service, and the provider.

When the service is approved, the service is authorized using the Authorization for Habilitation Services (HASCI Form 12A). The authorization should go to the DSN Board that is providing the service.

Billing

Supported Employment Services are always Board-billed. This must be checked on the Authorization for Habilitation Services (HASCI Form 12A) and no prior authorization number should be included. The Provider Agency should follow the Procedures to Report and Bill for Board Based Services Provided to HASCI Waiver Participants to receive reimbursement for costs.

Transportation

Transportation will be provided between the individual's place of residence and the site of habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of Supported Employment services. The cost of this transportation is included in the rate paid to providers.

Monitorship

This service must be monitored to determine its usefulness and effectiveness and to determine the individual's satisfaction with the service. The Service Coordinator must ensure that the service is being provided as authorized and the results of the monitoring must be documented in the individual's file.
Note: See Chapter 5 for monitorship guidelines.

Reduction, Suspension or Termination

If Supported Employment Services need to be reduced, suspended or terminated, the Service Coordinator must notify the provider to reduce, suspend or stop the service. The Service Coordinator must also notify the individual/legal guardian with a written notice regarding the change(s) in service(s), allowance/process for appeal and a ten (10) calendar day waiting period before proceeding with the reduction, suspension or termination. The Notice of Reduction, Suspension or Termination of Service Form must be completed by the Service Coordinator and forwarded to the provider with a copy to the individual/legal guardian (see Chapter 5 for procedures regarding written notification and the appeals process). (***Note:*** All unused units of the service must be deleted from the Waiver Tracking System and the individual's Plan must be updated as soon as possible).

Physical Therapy Services

Definition

Physical Therapy Services are included in the HASCI Waiver as an extended Medicaid State Plan service. In the current Medicaid State Plan, specified Physical Therapy services are available to individuals under age 21. The HASCI Waiver removes the age restriction, making the same Physical Therapy Services available to those who are over age 21.

Physical Therapy Services are defined as those services that involve treatment prescribed by a physician to prevent, alleviate, or compensate for movement, dysfunction, and related functional problems. Physical Therapy involves the use of physical agents, mechanical means and other remedial treatments to restore normal physical functioning.

Physical Therapy Services include:

Evaluation—up to two (2) every twelve (12) months
Therapy—up to four (4) units daily [one (1) unit equals fifteen (15) minutes]
Fabrication of Splints or Orthotics—up to four (4) of each every twelve (12) months
Consultation—up to five (5) every twelve (12) months

Note: See the Medicaid Provider Manual for Private Rehabilitative Therapy Services for additional information.

Providers

Physical Therapists licensed in South Carolina and enrolled with SCDHHS as Medicaid Providers of Physical Therapy Services.

Arranging for the Service(s)

If the individual is having difficulty with movement, mobility or ambulation, Physical Therapy Services may be needed. If the Service Coordinator determines that a Physical Therapy evaluation is needed, he/she must document the difficulty that the individual is having which supports the need for the evaluation. The individual and/or family should contact a Medicaid enrolled Physical Therapist. The offering of choice of providers must be clearly documented in the individual's file.

Once a provider is chosen, the Waiver Tracking System must be updated to reflect the addition of the evaluation. The individual's Plan must be updated to reflect the name of the service, amount, frequency, duration and provider. When it is approved, the service is authorized using the Authorization for Physical Therapy Services form (HASCI Form 12B)

Once the evaluation is completed, therapy or the fabrication of splints/orthotics may be recommended. If therapy is recommended, the therapist should provide specific information about the goal, the amount, frequency, and the expected duration of the therapy. This information must be included in the individual's Plan and the Waiver Tracking System should be updated. Once the service is approved, the service is authorized using the Authorization for Physical Therapy Services form (HASCI Form 12B).

If the evaluation determines a need for the fabrication of splints or orthotics, the Plan and the Waiver Tracking System should be updated. Once the service is approved, it is authorized using the Authorization for Physical Therapy Services form (HASCI Form 12B).

If Physical Therapy services are being provided and consultation with the individual, his/her family, teacher, or other professionals is needed, this may be funded through the Waiver. The need must be documented in the Plan and added to the Waiver Tracking system. Once the service is approved, it is authorized using the Authorization for Physical Therapy Services form (HASCI Form 12B).

Billing

For individuals receiving HASCI Waiver funded Residential Habilitation, Day Habilitation, Prevocational Services, or Supported Employment Services, Physical Therapy Services should be billed to the DSN Board. This should be checked on the Authorization for Physical Therapy Services (HASCI Form 12B) and no prior authorization number should be assigned. (***Note:*** **For individual's receiving Board Billed Physical Therapy Services, the DSN Board will <u>not</u> follow procedures to request reimbursement for costs. The cost of Physical Therapy Services is included in the costs paid to the DSN Board for Habilitation Services.**)

For individuals who <u>do not</u> receive HASCI Waiver funded Residential Habilitation, Day Habilitation, Prevocational Services, or Supported Employment Services, Physical Therapy Services must always be billed to SCDHHS. This must be checked on the Authorization for Physical Therapy Services (HASCI Form 12B) and a prior authorization number must be assigned.

Monitorship

The provision of Physical Therapy Services must be monitored to assure its usefulness and effectiveness, as well as the individual's satisfaction with the services and the provider of the service. Progress notes should be reviewed and the individual's file should contain documentation regarding the achievement of goals.
Note: See Chapter 5 for monitorship guidelines.

Reduction, Suspension or Termination

If Physical Therapy Services need to be reduced, suspended or terminated the Service Coordinator must notify the provider to reduce, suspend or stop the service. The Service Coordinator must also notify the individual/legal guardian with a written notice regarding the change(s) in service(s), allowance/process for appeal and a ten (10) calendar day waiting period before proceeding with the reduction, suspension or termination. The Notice of Reduction, Suspension or Termination of Service form must be completed by the Service Coordinator and forwarded to the provider of service with a copy to the individual/legal guardian (see Chapter 5 for procedures regarding written notification and the appeals process). (***Note:*** All unused units of the service must be deleted from the Waiver Tracking System and the individual's Plan must be updated as soon as possible.)

Occupational Therapy Services

Definition

Occupational Therapy Services are included in the HASCI Waiver as an extended Medicaid State Plan service. In the current Medicaid State Plan, specified Occupational Therapy services are available to individuals under age 21. The HASCI Waiver removes the age restriction, making the same Occupational Therapy services available to those who are over age 21.

Occupational Therapy Services involve the treatment prescribed by a physician to develop, restore or improve functional abilities related to self-help, adaptive behavior and sensory, motor, postural, and emotional development that have been limited by a physical injury, illness or other dysfunctional condition. It involves the use of purposeful activity interventions and adaptations to enhance functional performance.

Occupational Therapy services include:

Evaluation—up to two (2) every twelve (12) months
Therapy—up to four (4) units daily [one (1) unit equals fifteen (15) minutes]
Fabrication of Splints or Orthotics—up to four (4) of each every twelve (12) months
Consultation—up to five (5) every twelve (12) months

Note: See the Medicaid Provider manual for Private Rehabilitative Therapy Services for additional information.

Providers

Occupational Therapists licensed in South Carolina and enrolled with SCDHHS as Medicaid Providers of Occupational Therapy Services.

Arranging for the Service(s)

If the Service Coordinator determines that an Occupational Therapy evaluation is needed, he/she must document the difficulty that the individual is having which supports the need for the evaluation. The individual and/or family member should contact a Medicaid enrolled Occupational Therapist. The offering of choice of providers must be clearly documented in the individual's file.

Once a provider is chosen, the Waiver Tracking System must be updated to reflect the addition of the evaluation. The Plan must be updated to reflect the name of the service, amount, frequency, duration and provider. When it is approved, the service is authorized using the Authorization for Occupational Therapy Services form (HASCI Form 12C).

Once the evaluation is completed, therapy or the fabrication of splints/orthotics may be recommended. If therapy is recommended, the therapist should provide specific information about the goal of therapy, the amount, frequency that therapy is recommended, and the expected duration. This information must be included in the individual's Plan and the Waiver Tracking System should be updated. Once the service is approved, the service is authorized using the Authorization for Occupational Therapy Services form (HASCI Form 12C).

If the evaluation determines a need for the fabrication of splints or orthotics, the Plan and the Waiver Tracking System should be updated. Once the service is approved, it is authorized using the Authorization for Occupational Therapy Services form (HASCI Form 12C).

If Occupational Therapy Services are being provided and consultation with the individual, his/her family, teacher, or other professionals is needed, this may be funded through the Waiver. The need must be documented in the Plan and added to the Waiver Tracking System. Once the service is approved, it is authorized using the Authorization for Occupational Therapy Services form (HASCI Form 12C).

Billing

For individuals receiving HASCI Waiver funded Residential Habilitation, Day Habilitation, Prevocational Services, or Supported Employment Services, Occupational Therapy Services should be billed to the DSN Board. This should be checked on the Authorization for Occupational Therapy Services (HASCI Form 12C) and no prior authorization number should be assigned. (***Note:*** **For individuals receiving Board Billed Occupational Therapy Services, the DSN Board will <u>not</u> follow procedures to request reimbursement for costs. The cost for Occupational Therapy Services is included in the costs paid to the DSN Board for Habilitation Services.**)

For individuals who <u>do not</u> receive HASCI Waiver funded Residential Habilitation, Day Habilitation, Prevocational Services, or Supported Employment Services, Occupational Therapy Services must <u>always</u> be directly billed to SCDHHS. This must be checked on the Authorization for Occupational Therapy Services (HASCI Form 12C) and a prior authorization number must be assigned.

Monitorship

The provision of Occupational Therapy Services must be monitored to assure its usefulness and effectiveness, as well as the individual's satisfaction with the service and the provider of the service. Progress notes should be reviewed and the individual's file should contain documentation regarding the achievement of goals.
Note: See Chapter 5 for monitorship guidelines.

Reduction, Suspension or Termination

If Occupational Therapy Services need to be reduced, suspended or terminated the Service Coordinator must notify the provider to reduce, suspend or stop the service. The Service Coordinator must also notify the individual/legal guardian with a written notice regarding the change(s) in service(s), allowance/process for appeal and a ten (10) calendar day waiting period before proceeding with the reduction, suspension or termination. The Notice of Reduction, Suspension or Termination of Service form must be completed by the Service Coordinator and forwarded to the provider of service with a copy to the individual/legal guardian (see Chapter 5 for procedures regarding written notification and the appeals process). (***Note:*** All unused units of the service must be deleted from the Waiver Tracking System and the individual's Plan must be updated as soon as possible.)

Medicaid Waiver Nursing

Definition

Medicaid Waiver Nursing Services are services provided which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse (RN) or licensed practical nurse (LPN).

Providers

Medicaid Waiver Nursing Services are provided by agencies or companies enrolled with SCDHHS to provide "Medicaid Waiver Nursing Services" or by individuals/companies that are employed or contracted through the DSN Board to provide the service.

Note: If Medicaid Waiver Nursing Services are provided by an individual or company that is contracted or employed through the DSN Board, the Board is responsible for ensuring that the individual providing the service has a current nursing license and the Board must have a copy of the nurse's license on file. In addition, the Board must ensure that supervisory requirements for LPNs are properly followed as outlined in the State's Nurse Practice Act. In addition, all nurses contracted through the DSN Board must adhere to the DHHS Scope of Service for Medicaid Waiver Nursing.

Note: The agency should refer to SCDDSN Reference Number: 736-01-DD (Relatives/Family Members Serving as Paid Caregivers of Certain Medicaid Waiver Services. A copy of this guidance is in Chapter 7 of this manual.

Arranging for the Service(s)

Only a physician can determine if nursing services are needed and if needed, the amount needed and skill level required. The need for the service must be documented by the "Physician's Order for Nursing Services" (HASCI Form 15) and in the individual's Plan.

When it is determined that Medicaid Waiver Nursing is needed, the individual and/or his/her family must be offered a choice of providers and asked to select a company and/or individual to provide the services. This offering of choice must be clearly documented in the individual's file.

For Medicaid Waiver Nursing Services, one unit equals one hour of service. The rate paid for each unit depends upon the skill level required (i.e. RN is more expensive than LPN). Once the number of units and skill level required is determined, you should enter the request in the Waiver Tracking System. The individual's Plan must be updated to reflect the name of the service, type of services (RN or LPN), amount, frequency, duration, and the provider.

Note: The maximum number of nursing services/units that can be funded by the HASCI Waiver is 60 hours per week provided by an LPN or 44 hours per week provided by an RN.

Note: The skill level required (RN or LPN) must be noted and followed. A RN can provide care if the physician's order is written for a LPN; however the provider can only claim the LPN rate for the individual when completing billing. A LPN **cannot** provide services when the physician has ordered a RN to provide the services.

When approval is received, the Authorization for Medicaid Waiver Nursing Services (HASCI Form 12D) should be completed and sent to the provider. ***Note: If the individual has private insurance that pays for a portion of the needed nursing services, you cannot authorize those units also. The authorization will reflect only the total units to be provided through the Waiver and the Waiver budget will only reflect those hours not covered by insurance. The total number of units cannot exceed 60 for LPN services or 44 for RN services.***

After the initial visit with the individual, the company/Nurse should complete a specific plan for providing Medicaid Waiver Nursing Services. The company/Nurse must also notify you within two (2) working days of any significant changes in the individual's condition or status. You must respond to requests from the company to modify the individual's plan within three (3) days of receipt.

Billing

For individuals receiving HASCI Waiver funded Residential Habilitation, Medicaid Waiver Nursing Services must always be billed to the DSN Board. This must be checked on the Authorization for Medicaid Waiver Nursing Services (HASCI Form 12D) and no prior authorization number should be assigned. For these individuals, the DSN Board should not follow procedures to request reimbursement for costs of services. The cost of Medicaid Waiver Nursing Services is included in the rate paid to the DSN Board for Residential Habilitation.

For individuals who do not receive HASCI Waiver funded Residential Habilitation, Medicaid Waiver Nursing Services may be Board-billed or billed to SCDHHS.

If Medicaid Waiver Nursing Services are provided by an individual/company that is employed/contracted by the DSN Board, the service must be Board-billed. This must be checked on the Authorization for Medicaid Waiver Nursing Services (HASCI Form 12D) and no prior authorization number should be assigned. The agency must follow the Procedures to Report and Bill for Board Based Services Provided to HASCI Waiver Participants to receive reimbursement for costs. These procedures are located in Chapter 7 of this manual.

Note: When an individual receives Medicaid Waiver Nursing Services from an individual/company that is employed/contacted by the DSN Board, the Board is responsible for maintaining documentation that supports that the service was received for each date billed.

If Medicaid Waiver Nursing Services are provided by an agency enrolled with SCDHHS as a Medicaid provider, the service must be billed to SCDHHS. This should be checked on the Authorization for Medicaid Waiver Nursing Services (HASCI Form 12D) and a prior authorization number must be assigned.

Monitorship

The provision of Medicaid Waiver Nursing must be monitored to assure its usefulness and effectiveness as well as the individual's satisfaction with the service and the provider of the service. Note: See Chapter 5 for monitorship guidelines.

Reduction, Suspension or Termination

If Medicaid Waiver Nursing Services need to be reduced, suspended or terminated the Service Coordinator must notify the provider to reduce, suspend or stop the service. The Service Coordinator must also notify the individual/legal guardian with a written notice regarding the change(s) in service(s), allowance/process for appeal and a ten (10) calendar day waiting period before proceeding with the reduction, suspension or termination. The Notice of Reduction, Suspension or Termination of Service Form must be completed by the Service Coordinator and forwarded to the provider of service with a copy to the individual/legal guardian (see Chapter 5 for procedures regarding written notification and the appeals process). (***Note:*** All unused units of the service must be deleted from the Waiver Tracking System and the individual's Plan must be updated as soon as possible).

Psychological Services

Definition

Psychological and Behavioral Services has changed. Psychological and Behavioral Services are two (2) separate services and no longer one (1) service.

Psychological Services address affective, cognitive, and substance abuse problems of an individual. Psychological Services include psychiatric, neuropsychological, and psychological assessment and testing; development of treatment plans; individual/client specific family counseling regarding emotions, behavior or social interaction; cognitive rehabilitation therapy; alcohol/substance abuse counseling; and consultation with family members, friends and service providers to assist the individual with affective, cognitive and substance abuse problems.

Providers

Psychological Services may be provided by individuals who are enrolled with SCDHHS as Psychological Services providers or by individuals who are contracted through the DSN Board to provide the service.

Note: If Psychological Services are provided by an individual contracted through the DSN Board, the Board is responsible for ensuring that the individual meets the minimum qualifications outlined in Appendix B-2 (Attachment 8) of the official HASCI Waiver document. The DSN Board must keep a record on the individual with documentation that supports his/her qualifications to provide the specific level of psychological services.

Psychological services may be provided by Medicaid enrolled rehabilitation programs certified by the Commission on Accreditation of Rehabilitation Facilities (CARF).

Note: If Psychological Services are provided by Medicaid enrolled CARF certified rehabilitation programs the DSN Board is responsible for ensuring that the provider is an approved Medicaid provider of psychological services.

Psychological Services may be provided by Medicaid enrolled providers approved by SCDDSN.

Note: Providers must be referred to the MR/RD Division of SCDDSN for approval.

Note: If Psychological Services are provided by Medicaid enrolled providers approved by SCDDSN the DSN Board is responsible for ensuring that the providers are approved by SCDDSN.

Arranging for the Service(s)

Through an assessment of the individual, the Service Coordinator may determine that he/she is in need of a professional psychological evaluation to determine an individual's need for ongoing or additional psychological services. The need for the service must be clearly documented in the individual's Plan by indicating the behaviors or comments that prompted the Service Coordinator to explore this service.

Once it is determined that an evaluation/assessment is needed, the individual and/or family should be offered a choice of providers and this offering of choice must be clearly documented in the individual's file.

Once a provider is chosen, the Waiver Tracking System must be updated. The individual's Plan must be updated to reflect the name of the service, amount, frequency and duration of the service and the provider. When it is approved, the service is authorized using the Authorization for Psychological Services Form (HASCI Form 12E).

After the assessment is completed, the Service Coordinator should receive and review the results, which should define any recommendations. If the assessment recommends additional psychological services, which could be funded through the HASCI Waiver, the Waiver Tracking System and the individual's Plan must be updated to request the service. Once the service is approved, it is authorized using the Authorization for Psychological Services Form (HASCI Form 12E).

Billing

For individuals receiving HASCI Waiver funded Residential Habilitation, Day Habilitation, Prevocational Services, or Supported Employment Services, Psychological Services will always be billed to the DSN Board. This should be checked on the Authorization for Psychological Services (HASCI Form 12E) and no prior authorization number should be assigned. For these individuals, the DSN Board should <u>not</u> follow procedures to request reimbursement for costs of services. The cost of Psychological Services is included in the rate paid to the DSN Board for all types of Habilitation Services.

For individuals who <u>do not</u> receive HASCI Waiver funded Residential Habilitation, Day Habilitation, Prevocational Services, or Supported Employment, Psychological Services may be board billed or billed to SCDHHS.

If Psychological Services are provided by an individual who is contracted or employed by the DSN Board, the service will be Board billed. This must be checked on the Authorization for Psychological Services (HASCI Form 12E) and no prior authorization number should be assigned. The agency must follow the Procedures to Report and Bill for Board Based Services Provided to HASCI Waiver Participants to receive reimbursement for costs. These procedures are located in Chapter 7 of this manual.

Note: When Psychological Services are provided by an individual who is contracted or employed by the DSN Board, the Board is responsible for maintaining documentation that supports that the service was received for each date billed.

If Psychological Services are provided by an individual who is enrolled with SCDHHS, the service should be billed to SCDHHS. This should be checked on the Authorization for Psychological Services (HASCI Form 12E) and a prior authorization number must be assigned.

Monitorship

The provision of Psychological Services must be monitored to assure its usefulness and effectiveness along with the individual's satisfaction with the service. Assessments are monitored by reviewing the recommendations and ensuring that it addresses the behaviors or comments that necessitated the assessment. The recommendations of the assessment must be reviewed with the individual to ensure their comfort and satisfaction with the professional, especially if ongoing counseling and treatment is recommended.

Ongoing Psychological Services should be monitored by reviewing progress toward the stated goals or intended outcome. The Service Coordinator must determine if progress is being made, and if not, what actions are being taken by the professional to encourage progress. Service Coordinators must review progress notes from the professional to ensure that services are being provided as authorized and they continue to be useful and effective for the individual. (***Note***: This is particularly important when family counseling is being provided. The Service Coordinator must ensure that the counseling is specific to the individual being served in the Waiver.)

Reduction, Suspension or Termination

If Psychological Services need to be reduced, suspended or terminated the Service Coordinator must notify the provider to reduce, suspend or stop the service. The Service Coordinator must also notify the individual/legal guardian with a written notice regarding the change(s) in service(s), allowance/process for appeal and a ten (10) calendar day waiting period before proceeding with the reduction, suspension or termination. The Notice of Reduction, Suspension or Termination of Service form must be completed by the Service Coordinator and forwarded to the provider of service with a copy to the individual/legal guardian (see Chapter 5 for procedures regarding written notification and the appeals process). (***Note:*** All unused units of the service must be deleted from the Waiver Tracking System and the individual's Plan must be updated as soon as possible).

Personal Emergency Response Systems (PERS)

Definition

PERS is an electronic device that enables individuals at high risk of institutionalization to secure help in an emergency. The individual may wear a "help" button to allow for mobility. The system is connected to the individual's phone and programmed to signal a response center that is staffed by trained professionals (see Appendix B-2), once a "help" button is activated. PERS services are limited to individuals who live alone, or who are alone for any part of the day or night and who would otherwise require extensive routine supervision.

Providers

PERS must be provided by vendors who are enrolled with SCDHHS as PERS providers or by vendors who are contracted through the DSN Board to provide the service.

Note: If PERS services are provided by a vendor contracted through the DSN Board, the Board is responsible for ensuring that the vendor meets the minimum qualifications outlined in Appendix B-2 (Attachment 6) of the official HASCI Waiver document. The Board must keep a record of supporting documentation with credentials that qualify the vendor to provide the service.

Arranging for the Service(s)

If the Service Coordinator determines that the individual is in need of PERS, the need must be clearly documented in the individual's Plan. The Plan must clearly reflect that the individual needs help in an emergency situation and lives alone or is alone for any part of the day or night.

When it is determined that the service is needed, the Service Coordinator must give the individual/family a choice of provider of the service. This offering of choice must be clearly documented in the individual's file.

Once a provider is chosen, the Waiver Tracking System must be updated. The individual's Plan must be updated to reflect the name of the service, amount, frequency, duration of the service and the provider. When it is approved, the service is authorized using the Authorization for PERS Services (HASCI Form 12F) Note***:*** **The installation of PERS will be authorized as a one-time service. PERS Monitoring will be authorized as a monthly service.**

Note: An individual may need a modification to the PERS to make it accessible for his/her use. The modification of the system should be requested through Medical Supplies, Equipment and Assistive Technology in the HASCI Waiver.

Billing

For individuals receiving HASCI Waiver funded Residential Habilitation, PERS must always be billed to the DSN Board. This should be checked on the Authorization for PERS services (HASCI Form 12F) and no prior authorization number should be assigned. For these individuals, the DSN Board should not follow procedures to request reimbursement for costs of services. The cost of PERS services is included in the rate paid to the DSN Board for Residential Habilitation.

For individuals who do not receive HASCI Waiver funded Residential Habilitation, PERS services may be Board-billed or billed to SCDHHS.

If PERS is provided by a vendor contracted through the DSN Board, the service will be Board billed. This must be checked on the Authorization for PERS Services (HASCI Form 12F) and no prior authorization number should be assigned. Your agency must follow the Procedures to Report and Bill for Board Based Services Provided to HASCI Waiver Participants to receive reimbursement for costs. These procedures are located in Chapter 7 of this manual.

Note: When an individual receives PERS from a vendor contracted by the DSN Board, the Board is responsible for maintaining documentation that supports that the service was received for each date billed.

If PERS Services are provided by a vendor that is enrolled with SCDHHS as a PERS provider, the service must be billed to SCDHHS. This should be checked on the Authorization for PERS Services (HASCI Form 12F) and an authorization number must be assigned.

Monitorship

When monitoring the provision of PERS, the Service Coordinator must determine the usefulness and effectiveness of the service as well as the individual's satisfaction with the service. The Service Coordinator must monitor the individual's living arrangements to ensure that the individual continues to need the service.
Note: See Chapter 5 for monitorship guidelines.

Reduction, Suspension or Termination

If PERS needs to be reduced, suspended or terminated the Service Coordinator must notify the provider to reduce, suspend or stop the service. The Service Coordinator must also notify the individual/legal guardian with a written notice regarding the change(s) in service(s), allowance/process for appeal and a ten (10) calendar day waiting period before proceeding with the reduction, suspension or termination. The Notice of Reduction, Suspension or Termination of Service form must be completed by the Service Coordinator and forwarded to the provider of service with a copy to the individual/legal guardian (see Chapter 5 for procedures regarding written notification and the appeals process). (***Note:*** All unused units of the service must be deleted from the Waiver Tracking System and the individual's Plan must be updated as soon as possible).

Speech, Hearing and Language Services

Definition

Speech, Hearing and Language Services include speech therapy, audiological and augmentative communication services provided to individuals who have speech, language or hearing problems.

Speech language pathology services include the full range of activities provided by speech language pathologists and speech therapists within the scope of their state licensure.

The services provided by speech language pathologists and professionals practiced in the development and use of augmentative communication systems include screening, assessment, development of therapeutic treatment plans, direct therapeutic intervention, training/assistance with augmentative communication systems, consultation with other service providers and family members pertaining to implementation of consumer specific services, and participating on an interdisciplinary team.

Audiological services consist of the full range of activities provided by audiologists within the scope of their state licensure. These services include screening, assessment, development of therapeutic treatment plans, direct therapeutic intervention, training and assistance with adaptive aids, consultation with other service providers and family members, and participating on an interdisciplinary team.

Providers

Speech, Hearing and Language Services must be provided by individuals/companies who are enrolled with SCDHHS as Speech, Hearing and Language Services providers.

Arranging for the Service(s)

Through an assessment of the individual, the Service Coordinator may determine that he/she is in need of Speech, Hearing and Language Services to address speech, language or hearing problems. If the Service Coordinator determines that an assessment/evaluation is needed, this need must be clearly documented in the individual's Plan. The Plan must clearly reflect the difficulties the individual is experiencing that supports the need for a Speech or Audiological assessment.

When it is determined that an evaluation/assessment is needed, the individual and/or family must be offered a choice of providers and this offering of choice must be clearly documented in the individual's file.

Once a provider is chosen, the Waiver Tracking System must be updated. The individual's Plan must be updated to reflect the name of the service, amount, frequency

and duration, and the provider. When it is approved, the service is authorized using the Authorization for Speech, Hearing and Language Services Form (HASCI Form 12G).

After the assessment is completed, the Service Coordinator should receive the results which define any recommendations. All recommendations should be included in the individual's Plan. If the assessment recommends additional communication services which could be funded through the HASCI Waiver, the Waiver Tracking System and the individual's Plan must be updated. Once the service is approved, it is authorized using the Authorization for Speech, Hearing and Language Services Form (HASCI Form 12G).

Note: If a Medicaid recipient needs an Augmentative Communication Device, the device may be funded by the State Plan as durable medical equipment (DME). Individuals needing Augmentative Communication devices must pursue them through State Plan Medicaid before a request can be made through the HASCI Waiver. Information on obtaining Augmentative Communication devices through the State Plan is attached to this section.

Billing

For individuals receiving HASCI Waiver funded Residential Habilitation, Day Habilitation, Prevocational Services, or Supported Employment Services, Speech Hearing and Language Services must always be billed to the DSN Board. This should be checked on the Authorization for Speech, Hearing and Language Services (HASCI Form 12G) and no prior authorization number should be assigned. For these individuals, the DSN Board should not follow procedures to request reimbursement for costs of services. The cost of Speech, Hearing and Language Services is included in the rate paid to the DSN Board for all types of Habilitation Services.

For individuals who do not receive HASCI Waiver funded Residential Habilitation, Day Habilitation, Prevocational Services, or Supported Employment Services, Speech Hearing and Language Services must always be billed to SCDHHS. This should be checked on the Authorization for Speech, Hearing and Language services (HASCI Form 12-G) and a prior authorization number must be assigned.

Monitorship

The provision of Speech, Hearing and Language Services must be monitored to assure its usefulness and effectiveness, as well as the individual's satisfaction with the service and the provider of the service. Assessments are monitored by reviewing the findings of the professional. You should also review the recommendations of the assessment with the individual to ensure their comfort and satisfaction with the professional, especially if ongoing speech therapy is recommended.

Ongoing Speech, Hearing and Language Services should be monitored by reviewing progress toward the stated goals or intended outcome. The Service Coordinator must review progress notes from the professional to ensure that services are being provided as authorized and they continue to be useful and effective for the individual.

Reduction, Suspension or Termination

If Speech, Hearing and Language Services need to be reduced, suspended or terminated the Service Coordinator must notify the provider to reduce, suspend or stop the service. The Service Coordinator must also notify the individual/legal guardian with a written notice regarding the change(s) in service(s), allowance/process for appeal and a ten (10) calendar day waiting period before proceeding with the reduction, suspension or termination. The Notice of Reduction, Suspension or Termination of Service Form must be completed by the Service Coordinator and forwarded to the provider of service with a copy to the individual/legal guardian (see Chapter 5 for procedures regarding written notification and the appeals process). (***Note:*** All unused units of the service must be deleted from the Waiver Tracking System and the individual's Plan must be updated as soon as possible).

Respite Care

Definition

Respite Care is defined as services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing care. Respite services are provided in a variety of settings and may be provided on an hourly or daily basis.

"Hourly respite" can be provided up to eight (8) hours per day and in a variety of settings such as the recipient's home, or a licensed respite care facility.

"Daily respite" is eight (8) hours or more of respite provided in a day. Daily respite can be provided in a variety of settings such as the recipient's home, a group home, a licensed respite care facility, or a licensed Community Residential Care Facility (CRCF).

"Institutional respite" is respite services provided on a daily basis in a Licensed/Medicaid Certified Nursing Facility (NF), Medicaid Certified Hospital, Medicaid Certified Intermediate Care Facility for the Mentally Retarded (ICF/MR, a SCDDSN Regional Center), or a community based ICF/MR (Match Community Facilities cannot be utilized for institutional respite-see list of facilities attached to this section).

Providers

Daily and hourly respite can be provided in the individual's home or place of residence by companies enrolled with SCDHHS as Respite Providers or by people who are hired/contracted by the DSN Board.

Note: If the Respite Care Services provider is hired/contracted through the DSN Board, he/she must meet the minimum qualifications as outlined in the Official HASCI Waiver document in Appendix B-2 (Attachment 1). The agency should use SCDDSN's "Waiver Funded Home Supports, Caregiver Certification" for guidance. A copy of this document can be found in Chapter 7 of this manual. The agency must also use SCDDSN Reference Number: 735-02-DD (Relatives/Family Members Serving as Paid Caregivers of Respite Services). A copy of this document can be found in Chapter 7 of this manual.

If daily or hourly respite is provided outside of the recipient's home, the location at which the respite service is provided must be licensed. These locations may be licensed by SCDDSN as a Community Training Home I or II (CTH I or II) or respite care facility. Community Residential Care Facilities (CRCFs) must be licensed by the South Carolina Department of Health and Environmental Control (SCDHEC) and enrolled with SCDHHS as a respite provider.

If institutional respite is provided, it must be provided in a facility that is licensed and certified by SCDHEC as a Nursing Facility (NF), Intermediate Care Facility for the Mentally Retarded (ICF/MR), or Hospital.

Arranging for the Service(s)

When it is determined that Respite Care Services are needed, this need must be clearly documented in the individual's Plan.

For hourly respite, one unit equals one hour. For daily respite, one unit equals more than eight (8) hours in one day. For institutional respite, one unit equals one day when the individual is present in the institution at midnight.

Individuals and/or their families must be given the choices of the different types of respite services available through the HASCI Waiver. They must be offered a choice of providers of the specific type of respite needed and this offering of choice must be clearly documented in the individual's file.

Once a provider is chosen, the Waiver Tracking System must be updated to reflect the service. The individual's Plan must be updated to reflect the name of the service, amount, frequency and duration of the service, and the provider. When it is approved, the service is authorized using the Authorization for Respite Services Form (HASCI Form 12H).

If institutional respite is to be provided in a SCDDSN Regional Center (Center-Based), the Authorization for Respite Services (Form 12-H) should be sent to the Claims and Collections Officer for the designated center (see list of Claims and Collections Officers attached to this section).

If institutional respite is to be provided in a community-based ICF/MR, the Authorization for Respite Services (Form 12-H) should be sent to the Provider/DSN Board Finance Director.

Note: Additional procedures/forms may be required for individuals receiving institutional respite. These procedures will be specific to the type of institutional respite provider and each of their internal procedures. Once a provider of institutional respite is identified for an individual, the Service Coordinator should inquire about any particular procedures required by that institution. The DHHS Form 122 is also required for institutional respite and hospital-based respite care services.

Billing

For individuals receiving HASCI Waiver funded Residential Habilitation, Respite Care Services will always be billed to the DSN Board. This should be checked on the Authorization for Respite Services (HASCI Form 12H) and no prior authorization number should be assigned. For these individuals, the DSN Board should not follow procedures to request reimbursement for costs of services. The cost of Respite Services is included in the rate paid to the DSN Board for all types of Habilitation Services.

For individuals who do not receive HASCI Waiver funded Residential Habilitation, Respite Care Services may be Board-billed or billed to SCDHHS.

If Respite Care Services are provided by an individual or company that is contracted or employed by the DSN Board, the service must be Board billed. This must be checked on the Authorization for Respite Services (HASCI Form 12H) and no prior authorization number should be assigned. The agency must follow the Procedures to Report and Bill for Board Based Services Provided to HASCI Waiver Recipients to receive reimbursement for costs. These procedures are located in Chapter 7of this manual.

Note: If Respite Care Services are provided by an individual/company that is employed or contracted by the DSN Board, the Board is responsible for maintaining documentation that supports that the service was received for each date billed.

If Respite Care Services are provided by an individual who is enrolled with SCDHHS as a Respite provider, the service must be billed to SCDHHS. This should be checked on the Authorization for Respite Services (HASCI Form 12H) and a prior authorization number must be assigned.

Monitorship

The provision of Respite Care Services must be monitored to assure its usefulness and effectiveness, as well as the individual's satisfaction with the service and the provider of the service.

Reduction, Suspension or Termination

If Respite Care Services need to be reduced, suspended or terminated the Service Coordinator must notify the provider to reduce, suspend or stop the service. The Service Coordinator must also notify the individual/legal guardian with a written notice regarding the change(s) in service(s), allowance/process for appeal and a ten (10) calendar day waiting period before proceeding with the reduction, suspension or termination. The Notice of Reduction, Suspension or Termination of Service form must be completed by the Service Coordinator and forwarded to the provider of service with a copy to the individual/legal guardian (see Chapter 5 for procedures regarding written notification and the appeals process). (***Note:*** All unused units of the service must be deleted from the Waiver Tracking System and the individual's Plan must be updated as soon as possible). **Note: If institutional respite is provided in a SCDDSN Regional Center, the Notice of Reduction, Suspension, or Termination of Service Form must be sent to the Claims and Collections Officer of the particular Regional Center. If institutional respite is provided in a community-based ICF/MR, the Notice of Reduction, Suspension or Termination of Service Form must be sent to the DSN Board/provider Finance Director.**

Medical Supplies, Equipment and Assistive Technology

Definition

Medical Supplies, Equipment and Assistive Technology are defined as specialized medical supplies and equipment (to include devices, controls or appliances) specified in the plan, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the state plan or which are not available under the state plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of the manufacturer, design and installation. Cost of items may include consultation and assessments to determine the specific needs, follow-up inspection after items are received, training in use of equipment/assistive technology, repairs not covered by warranty, and replacement or parts or equipment.

Providers of Medical Supplies, Equipment and Assistive Technology

Medical Supplies, Equipment and Assistive Technology must be provided by vendors who are enrolled with SCDHHS as Durable Medical Equipment (DME) providers, Licensed Occupational or Physical Therapists, Medicaid enrolled independent Rehabilitation Engineering Technologists, assistive technology suppliers certified by the Rehabilitation Engineering Society of North American, Medicaid enrolled independent Environmental Access Consultants/contractors certified by Professional Resources in Management (PRIME) or by vendors who are contracted through the local DSN Board to provide the service.

Providers of Products and Services

Products and services (including assessment, installation, follow-up inspection, and training in use) may by obtained from or contracted with durable medical equipment providers, vendors with a retail or wholesale business license, technicians or professionals certified in the installation and repair of manufacturer's equipment, licensed occupational or physical therapists, PRIME certified environmental access consultants/contractors, or RESNA certified
Rehabilitation Engineering technologists, assistive technology practitioners, and assistive technology suppliers.

Note: All products must meet specifications in the individual's plan and be in accordance with all applicable state and local codes. Bids must be obtained and submitted to SCDDSN in accordance with SCDDSN directive 250-08-DD, "Procurement Requirements for Local DSN Boards." At a minimum, the DSN Boards procurement policies must adhere to the SCDDSN directive 250-08-DD.
Note: If Medical Supplies, Equipment and Assistive Technology are provided by a vendor contracted through the DSN Board, the Board is responsible for ensuring that

the vendor meets the minimum qualifications outlined in Appendix B-2 (Attachment 5) of the official HASCI Waiver document. The Board must keep documentation on the vendor with credentials that qualify them to provide the service.

Arranging for the Service(s)

Once an individual's need has been identified and documented in the Plan, the Service Coordinator must first determine if the needed equipment or supplies are available through private insurance, Medicare, or the Medicaid State Plan. The State Plan includes the service Durable Medical Equipment (DME) that is available to all Medicaid recipients and covers some types of medical equipment when ordered by a Physician. Some examples of items covered under DME are hospital beds, wheelchairs, shower chairs, back and leg braces, oxygen, bandages, etc. To determine if an item is covered by the State Plan, the Service Coordinator must review the equipment and supply lists included in the Medicaid Provider Manual for Durable Medical Equipment. If additional assistance is needed, the Service Coordinator should contact the Medicaid DME Representative at SCDHHS that covers your area. A list of the current DME representatives is included as an attachment to this section. The Service Coordinator must document attempts to determine if the needed items are covered by the State Plan (***Note:*** This includes attempts to receive Special Authorization for exceeding frequency limits to items covered by the State Plan). The Service Coordinator must document attempts to determine if the needed items are covered by private insurance or Medicare. **In situations where an individual's private insurance, Medicare, or the State Plan will cover a portion of the cost of the medical supplies, equipment or assistive technology, the Waiver cannot be used to fund any portion of the cost (co-payment). Only after it is determined that the needed equipment or supply is <u>not</u> covered by private insurance, Medicare or the State Plan can the item be requested through the HASCI Waiver.**

When it is determined and documented that Medical Supplies, Equipment or Assistive Technology is needed, the individual/family must be offered a choice of providers. This offering of choice must be clearly documented in the individual's file. For any single item costing less than $1500, it is only necessary to get one price quote (from the provider chosen by the individual and/or family). For any single item costing more than $1500, the individual and/or family must select three (3) vendors to supply quotes. These three (3) quotes must be in writing.

Once a provider is chosen by the individual or selected as the "lowest bidder", the request should be entered into the Waiver Tracking System and quotes should be forwarded to Central Office, HASCI Division. The individual's Plan must be updated to reflect the name of the service, amount, frequency and duration, and the provider. When the service is approved, the service is authorized using the Authorization for Medical Supplies, Equipment and Assistive Technology Form (HASCI Form 12I). ***Note:*** When using the HASCI Form 12I, the "Medical Supplies, Equipment and Assistive Technology" category should be used for all items except Diapers and Underpads. These items have specific billing codes, firm pricing and limits established by SCDHHS. These guidelines limit the availability of diapers and underpads to three

(3) cases per month of each and set price limits on the items. One case of diapers can cost no more than $72.00 and each case must contain 54 extra large, 72 size large or 96 size medium/small diapers. One case of underpads can cost no more than $45.00. The case of medium underpads contains at least 200 and the minimum size is 22”x23”. The case of large underpads contains at least 150 and the minimum size is 22”x35”. Please see the exception policy attached to this section of the manual for exceptions to this policy.

Billing

For individuals receiving HASCI Waiver funded Residential Habilitation, Medical Supplies, Equipment and Assistive Technology must always be billed to the DSN Board. This should be checked on the Authorization for Medical Supplies, Equipment and Assistive Technology (HASCI Form 12I) and no prior authorization number should be assigned. For these individuals, the DSN Board should not follow procedures to request reimbursement for costs of services. The cost of Medical Supplies, Equipment and Assistive Technology is included in the rate paid to the DSN Board for Residential Habilitation.

For individuals who do not receive HASCI Waiver funded Residential Habilitation, Medical Supplies, Equipment and Assistive Technology may be board billed or billed to SCDHHS.

If Medical Supplies, Equipment and Assistive Technology are provided by an individual or company that is contracted or employed by the DSN Board, the service must be Board billed. This must be checked on the Authorization for Medical Supplies, Equipment and Assistive Technology (HASCI Form 12I) and no prior authorization number should be assigned. The agency must follow the Procedures to Report and Bill for Board Based Services Provided to HASCI Waiver Participants to receive reimbursement for costs. These procedures are located in Chapter 7 of this manual.

Note: When Medical Supplies, Equipment and Assistive Technology are provided by a vendor that is contracted through the DSN Board, the Board is responsible for maintaining documentation that supports that the service was received for each date billed.

If Medical Supplies, Equipment and Assistive Technology are provided by an individual who is enrolled with SCDHHS as a provider, the service must be billed to SCDHHS. This should be checked on the Authorization for, Medical Supplies, Equipment and Assistive Technology (HASCI Form 12I) and a prior authorization number must be assigned.

Monitorship

The provision of Medical Supplies, Equipment and Assistive Technology must be monitored to determine the usefulness and effectiveness of the service as well as the

individual's satisfaction with the service and the provider of the service. Ongoing supplies should be monitored by contacting the individual within two weeks of the start date of the service and at least every three months (90 days) thereafter to monitor the usefulness, effectiveness, satisfaction, and to ensure the service has been provided as authorized. If the individual changes his/her provider of the ongoing Waiver service, the Service Coordinator must again contact the individual within two weeks of the change to ensure that the service has begun and the individual is satisfied with the Waiver service and the provider of the service.

One-time requests must be monitored by contacting the individual within two weeks of the receipt of any one-time Waiver services. Any one-time service that costs less than $1500, Service Coordinators are required to monitor the service to ensure the usefulness and effectiveness of the service along with the individual's satisfaction with the service.

One-time items that cost over $1500 (such as expensive pieces of medical equipment) must be monitored on-site within 2 weeks of receipt of the item. The on-site visit must be documented including information about the receipt of the equipment/item and it's usefulness and effectiveness for the individual. The visit must be documented and include a statement regarding the usefulness and effectiveness of the equipment/item and the individual's satisfaction with the equipment/item and the provider of the service.

Reduction, Suspension or Termination

If Medical Supplies, Equipment and Assistive Technology Services need to be reduced, suspended or terminated the Service Coordinator must notify the provider to reduce, suspend or stop the service. The Service Coordinator must also notify the individual/legal guardian with a written notice regarding the change(s) in service(s), allowance/process for appeal and a ten (10) calendar day waiting period before proceeding with the reduction, suspension or termination. The Notice of Reduction, Suspension or Termination of Service Form must be completed by the Service Coordinator and forwarded to the provider of service with a copy to the individual/legal guardian (see Chapter 5 for procedures regarding written notification and the appeals process). (***Note:*** All unused units of the service must be deleted from the Waiver Tracking System and the individual's Plan must be updated as soon as possible).

Attendant Care/Personal Assistance Services

Definition

Attendant Care/Personal Assistance Services are defined as assistance related to the performance of activities of daily living and/or instrumental activities of daily living and personal care which may include hands-on care, of both a **medical** and **non-medical** supportive and health related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. This service may include skilled or nursing care to the extent permitted by State law.

Housekeeping activities provided under attendant care/personal assistance services are specific in the Plan and are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family.

Any community access activities must be directly related to the individuals care and must be specified in the plan. Transportation may be provided as a component of the service when it is related to the performance of daily living activities. The cost of this transportation is included in the rate paid to the providers of attendant care/personal assistance services. This service may be conducted in a variety of settings as outlined in the Plan. This service will only be provided when attendant care/personal assistance is not already available in a community setting.

The determination of appropriate use of attendant care/personal assistance will be subject to DDSN's multi-level approval process. This includes review by the local Service Coordination Supervisor, and Central Office staff of the Head and Spinal Cord Injury Division.

Supervision Requirements:

- Supervision will be provided by a Nurse, licensed to practice in the state. The frequency and intensity of supervision will be specified in the individual's written Plan; or
- Supervision may be furnished directly by the individual or responsible party, when the individual/responsible party has been trained to perform this function, and when the safety and efficacy of consumer-provided supervision has been certified in writing by a registered nurse or otherwise as provided in State law. This certification must be based on direct observation of the consumer/responsible party and the specific attendant care/personal assistance provider, during the actual provision of care. **Documentation of this certification must be maintained in the individual's file and will be documented in the individual's Plan.**

Providers:

Attendant Care/Personal Assistance services may be provided by:

- an agency enrolled with SCDHHS as an Attendant Care provider,
- an individual enrolled with SCDHHS as an independent Attendant Care provider (UAP Attendant Care program)
- an individual or agency who is employed or contracted through the local DSN Board to provide the service

Note: If Attendant Care/Personal Assistance Services are provided by an Attendant enrolled with SCDHHS under the UAP Attendant Care Program, the policies and procedures of that service must be followed. These procedures are attached to this section of the manual.

Note: If Attendant Care/Personal Assistance services are provided by an individual or company that is contracted or employed through the DSN Board, the Board is responsible for ensuring that the provider meets the minimum qualifications outlined in the Appendix B-2 (Attachment 7) of the official HASCI Waiver document. The agency should use SCDDSN's "Waiver Funded Home Supports, Caregiver Certification" for guidance. A copy of this document can be found in Chapter 7 of this manual. ***Additionally, the DSN Board will be responsible for ensuring that the proper type of supervision is provided to the specific attendant providing care for the individual.***

Arranging for the Service(s)

If the HASCI Service Coordinator determines that an individual is in need of attendant care/personal assistance services, he/she should discuss the different types of attendant care/personal assistance services available so that the individual and/or family can make a decision about the best type to meet their needs. The amount of service needed, tasks to be completed, and the choice of provider must be discussed and clearly documented in the individual's Plan.

Note: For Children under age 21, Personal Care Services are available under the Medicaid State Plan. Please refer to the attachment to this section regarding State Plan Medicaid funding of Children's PCA services.

Note: If an individual will be receiving skilled care as a function of Attendant Care/Personal Assistance, the individual's file must contain documentation that each skilled task that will be performed by the attendant has been delegated by a Nurse licensed to practice in the state. This must be in writing from the nurse noting the specific tasks that have been delegated to particular attendants. If the individual changes attendant care providers or the nurse supervising the care changes, the Service Coordinator must obtain new delegation documentation. ***Independent attendants enrolled under the UAP Attendant Care Program cannot perform skilled tasks under any circumstances.***

Once the provider is chosen, the amount, type and frequency of the service is determined, it should be entered into the Waiver Tracking System. The individual's

Plan must be updated to reflect the name of the service, amount, frequency and duration of the service, and the provider.

When it is approved, the service is authorized using the Authorization for Attendant Care/Personal Assistance Services-billed to the South Carolina Department of Health and Human Services (HASCI Form 12J), Authorization for Attendant Care/Personal Assistance Services-billed to the DSN Board (HASCI Form 12J-1) or Authorization for UAP Attendant Care Services (HASCI Form 12AA) depending on what type of attendant care service is requested.

Billing

For individuals receiving HASCI Waiver funded Residential Habilitation, Attendant Care/Personal Assistance Services will always be billed to the DSN Board. This should be checked on the Authorization for Attendant Care/Personal Assistance (HASCI Form 12J-1) or the Authorization for UAP Attendant Care Services (HASCI Form 12AA) and no prior authorization number should be assigned. For these individuals, the DSN Board should not follow procedures to request reimbursement for costs of services. The cost of Attendant Care/Personal Assistance is included in the rate paid to the DSN Board for Residential Habilitation.

For individuals who do not receive HASCI Waiver funded Residential Habilitation, Attendant Care/Personal Assistance Services may be Board-billed or billed to SCDHHS.

If Attendant Care/Personal Assistance Services are provided through the UAP, the service must be Board-billed. This should be checked on the Authorization for UAP Attendant Care Services (HASCI Form 12AA) and no prior authorization number must be assigned.

If Attendant Care/Personal Assistance Services are provided by an individual/company that is employed/contracted by the DSN Board, the service will be Board-billed. This must be checked on the Authorization for Attendant Care/Personal Assistance Services (HASCI form 12J-1) and no prior authorization number should be assigned. The agency must follow the Procedures to Report and Bill for Board Based Services Provided to HASCI Waiver Recipients to receive reimbursement for costs. These procedures are located in Chapter 7 of this manual.

Note: When Attendant Care/Personal Assistance Services are provided by an individual/company that is employed or contracted through the DSN Board, the Board is responsible for maintaining documentation that supports that the service was received for each date billed. Attached to this section are several samples of daily logs that can be used by attendants.

If Attendant Care/Personal Assistance Services are provided by an agency that is enrolled with SCDHHS as a Medicaid provider of Attendant Care Services, the service must be billed to SCDHHS. This should be checked on the Authorization for

Attendant Care/Personal Assistance Services (HASCI Form 12J) and a prior authorization number must be assigned.

Monitorship

The provision of Attendant Care/Personal Assistance Services must be monitored to assure its usefulness and effectiveness, as well as the individual's satisfaction with the service and the provider of the service (please refer to Chapter 5 for monitoring requirements).

Service Coordinators should request and review copy of daily logs from Attendant Care/Personal Assistance Services providers. Service Coordinators should review daily logs to monitor the duties performed and the number of hours billed to ensure that the service is being provided as authorized. Any discrepancies must be addressed immediately. **In addition, Service Coordinators are responsible for ensuring that the Attendant is being properly supervised. For attendants who are monitored by a Nurse, supervisory reports should be requested and reviewed as part of monitorship.**

Note: The Service Coordinator must ensure that the Attendant Care/Personal Assistance is specific to the individual being served in the Waiver.

Reduction, Suspension or Termination

If Attendant Care/Personal Assistance Services needs to be reduced, suspended or terminated the Service Coordinator must notify the provider to reduce, suspend or stop the service. The Service Coordinator must also notify the individual/legal guardian with a written notice regarding the change(s) in service(s), allowance/process for appeal and a ten (10) calendar day waiting period before proceeding with the reduction, suspension or termination. The Notice of Reduction, Suspension or Termination of Service Form must be completed by the Service Coordinator and forwarded to the provider of service with a copy to the individual/legal guardian (see Chapter 5 for procedures regarding written notification and the appeals process).
Note: All unused units of the service must be deleted from the Waiver Tracking System and the individual's Plan must be updated as soon as possible.

South Carolina Department of Disabilities and Special Needs
Head and Spinal Cord Injury Division
Procedures for UAP Attendant Care Service
REVISED 3/24/2008

1. HASCI Waiver Participant Identification

A. **Service Coordinator** discusses self-directed care service with the Waiver participant.

B. **Service Coordinator** completes the self-directed prescreen for the Waiver participant using the most current Form 1718. If the Waiver participant has been assessed using the ICF/MR level of care, the service coordinator will use the DDSN ICF/MR self directed Prescreen. If the Waiver participant does not pass the self-directed prescreening process, the Service Coordinator will notify the Waiver Participant that they are not appropriate for self-directed care. The option of Responsible Party Directed care will be discussed. If an appropriate Responsible Party is determined, the Responsible Party prescreen is completed.

2. HASCI Waiver Participant Referral

A. If the Waiver participant passes the prescreening process, the **Service Coordinator** will make a referral to the UAP. The referral consists of the appropriate (either a self-directed, DDSN ICF/MR self directed prescreen or responsible party-directed) Prescreen Form, the entire 1718, and the Personal Care Needs Form. Also included on the bottom of the referral is/are the name(s) of potential or preferred attendant(s) identified by the Waiver participant. The referral can be faxed to 803-935-5250 or mailed to:

Attendant Care Services
Center for Disability Resources
Department of Pediatrics
USC School of Medicine
Columbia, SC 29208

For questions, UAP may be reached by phone at 803-935-5297, by fax at 803-935-5250 or by emailing UAP@SCDHHS.gov

3. Initial Phone Contact

A. The referral is received and reviewed by the UAP. If clarification is needed, the UAP RN will contact the Service Coordinator. The UAP RN will make an initial phone contact with the Waiver Participant/RP within 14 calendar days. This phone contact will include discussion of the attendant care service and how it works. The UAP RN will also evaluate the Waiver Participant's/RP's understanding of the Personal Care Needs Form and their ability to direct/supervise the attendant. Included in this discussion are the number of hours the Waiver Participant/RP is expected to have with the Attendant Care Service and how they anticipate using these hours. Also included will be discussion on the following:

1. Attendant/responsibilities and duties
2. Infection control practices
3. Back-up plan
4. Advance Directives
5. Safety checklists
6. Recruitment and interviewing of attendants
7. Importance and how to do reference checks
8. Enrollment requirements for attendants
9. Employer of Record Responsibilities
10. Enrollment with the fiscal agent, Jasper County Board of Disabilities
11. Attendant billing/Direct Deposit
12. Conflict resolution
13. How to handle termination of an attendant

The Waiver Participant/RP will be instructed to notify the UAP of their preferred attendant's name once they have identified their attendant(s).

If requested by the **Service Coordinator** or if during initial phone contact, the UAP RN feels Waiver Participant/RP needs a face-to-face visit, an appointment for a home visit will be made. The **Service Coordinator** may come to the visit if he/she prefers. The Service Coordinator may request an initial home visit on the initial referral or by email or phone.

B. After receiving the referral, UAP mails a packet of information to the Waiver Participant/RP. The following items are included in the packet and discussed by phone with the Waiver Participant/RP during the Initial Phone Contact:

1. Red Cross Emergency Checklist for people with mobility problems
2. Advanced Directives brochure
3. Hiring and Managing Personal Care Assistants booklet developed by Vocational Rehabilitation
4. Plan of Care Agreement
5. Brochure from SC Legal Services

4. Certification and Match Visit

A. After the identified/chosen attendant meets the requirements to enroll as a DDSN provider, the UAP RN will schedule a match visit within 14 calendar days of the attendant's enrollment as a DDSN provider. During the certification and match visit, the UAP RN will review information discussed during the initial phone contact. The UAP RN will also observe the actual performance of care by the attendant, even if the attendant was observed with another Waiver Participant. The personal care needs form will be reviewed with the attendant and the Waiver Participant/RP.

B. Duties **not** allowed under the Attendant Care Service will be discussed. The duties **not** allowed include: transportation, medication administration, and skilled nursing care. Attendant responsibilities will also be reviewed along with a check off on vital signs for individuals who have the needed equipment (instruction will be provided as needed). The back-up plan is listed on paper and signed by the Waiver Participant/RP. The health care rights of the Waiver Participant/RP are discussed and documented.

C. Being an employer of record will be discussed with the Waiver Participant/RP. A W-4 will be completed by the attendant DDSN provider/employee. Both the Waiver Participant/RP/employer and the attendant/DDSN provider/employee will complete an I-9. The I-9, photocopies of the employee's IDs and the W-4 along with a copy of the Attendant responsibilities form and the Liability form will be faxed to the fiscal agent, the Jasper County Board of Disabilities or given to the Service Coordinator, if present at the match visit, to fax to the Jasper Disabilities and Special Needs Board. Instruction on the billing process is discussed/explained to the attendant and reviewed with the Waiver Participant.

D. Conflict resolution is reviewed. Both Waiver Participant/RP and attendant are instructed to give two weeks notice before termination of services unless personal safety is an issue. Annual requirements of attendant are also discussed. The Waiver Participant/RP and attendant will both sign a Liability Statement after the UAP RN discusses and reviews the form. Under South Carolina Law employers who have 4 or more employees are required to have a Workman's Compensation Insurance Policy. **For this reason no Waiver participant/RP/employer may have more than 3 employees authorized without having proof of a Workman's Compensation Insurance Policy.**

E. Attendants who serve HASCI Waiver participants will be required to receive and maintain certification in Basic First Aid. The attendant must become certified in Basic First Aid during the first year of providing service and must receive re-certification every 3 years. The attendant will be oriented by the Waiver participant/RP and UAP-RN to the habits, preferences and interests of the Waiver participant both in the Waiver participant's home and in the community prior to assuming responsibility for attendant care services.

UAP-RN may also identify training needs and assist the attendant with locating training needs and resources for access to the training. Additionally, Waiver participant-specific training may be provided as deemed necessary based on the professional judgment of the UAP-RN or when the Waiver participant/RP or attendant requests assistance with training.

F. Upon completion of the match visit, the UAP RN will email or mail a written certification for self-directed care or responsible party directed care, an evaluation of the attendant and Waiver Participant/RP, and a certification of the ability of the attendant to provide care as supervised by the Waiver Participant/RP to the Service Coordinator within 7 working days.

5. Service Authorization

A. The unit of service is one (1) hour. Service will be authorized by the **Service Coordinator** on the service authorization form (HASCI Form 12AA). The number of hours authorized is based on the Waiver participant's needs as approved on his/her budget. **The service authorization is completed with the DDSN Provider's name and address not UAP's name and address.** The **Service Coordinator** will authorize the total # of hours per week and the Waiver participant and attendant are responsible for negotiating the times of service. When more than one attendant/DDSN provider is authorized to provide services, all providers will be authorized for the full number of hours. The schedule of hours is up to the Waiver Participant and attendant. The Waiver Participant and attendant are instructed that billing for hours over the number of hours authorized will result in non-payment.

In some cases, it may be appropriate to authorize attendant care and PCA services for the same Waiver Participant.

The Service Coordinator must complete a new service authorization form(s) if there is a change in the number of hours of service to be provided to the Waiver participant. Copies of all service authorizations and updated Personal Care Needs Forms will be sent to the attendant(s) and UAP RN.

6. Follow Up Visits

Problem resolution visits are made at the request of the Waiver participant/RP, attendant, or **Service Coordinator** or if the UAP RN determines there is a need. Representatives of as many disciplines as needed will be invited to meet to resolve any problems.

7. Service Coordinator On-going Responsibilities

A. **Service Coordinator** will review the provision of attendant care according to HASCI Waiver monitorship requirements.

B. If the Waiver participant/RP is suspected of not being capable of supervision, the **Service Coordinator** will inform UAP. UAP will review this within 14 calendar days of the referral from the **Service Coordinator.** Other disciplines can be involved as needed for successful resolution.

C. **Service Coordinator** will mail a copy of any Personal Care Needs Form revisions and any new service authorization forms to the attendant(s) of the Waiver participant and to UAP.

D. **Service Coordinator** will notify UAP of any changes in Waiver participant's condition or his/her situation that may impact the attendant care service.

8. Attendant

A. Referral
A potential attendant may be referred at any time by sending UAP his/her name, phone number, and/or address. The above information must be submitted one of the ways listed below:

1. Mailed to the following address:
   Attendant Care Service
   Center for Disability Resources
   USC School of Medicine
   Columbia, SC 29208,
2. Called in to the UAP at 803-935-5297,
3. Faxed to 803-935-5250, or
4. Emailed to uap@scdhhs.gov

Attendants may also be referred on the bottom of the Prescreen Form. If referred by phone, please state the name of the Waiver participant interested in the attendant, if applicable.

Potential attendants who are referred to the UAP will be sent an attendant information letter, FIRST AID Agreement, Payment Agreement, and an Attendant Responsibilities Sheet.

B. Enrollment

Individual DDSN providers i.e., attendants, must meet the following minimum qualifications:

a. Demonstrate an ability to read, write and speak English;
b. Be fully ambulatory;
c. Capable of aiding in the activities of daily living; Physically capable of performing duties which may require physical exertion such as lifting, transferring, etc. if necessary;
d. Capable of following the personal care needs form with Waiver participant and/or responsible party supervision;
e. Be at least 18 years of age;
f. Capable of following billing procedures and completing required paperwork.
g No known conviction for abuse, neglect, or exploitation of adults (as defined in the Omnibus Adult Protection Act, S.C. Code Ann. Title 43, Chapter 35) or of children (as defined in the Children's Code, S.C. Code Ann. Title 20, Chapter 7);
h. No conviction for any crime against another person;
i. No felony conviction of any kind
j. No conviction of any kind concerning the misuse or abuse of any public assistance program (including, but not limited to, fraudulently obtaining benefits, engaging in fraudulent billing practices, and embezzling or otherwise misusing public assistance funds in any manner);
k. No record of exclusion or suspension from the Medicare or Medicaid Programs.
l. Attendants serving HASCI Waiver participants must be certified in Basic First Aid during the first year of providing attendant care. Basic First Aid re-certification must be completed every 3 years.
m. Will provide references to the Waiver participant.

n. All attendants shall have a PPD tuberculin (TB) skin test, which is not over a year old, unless a previously positive reaction can be documented. The two-step procedure is advisable for initial testing in order to establish a reliable baseline.

Note: If the reaction to the first test is classified as negative, a second test should be given a week later. If the second test is classified as negative, the person is considered as being uninfected. A positive reaction to a third test (with an increase of more than 10mm) in such a person within the next few years, is likely to represent the occurrence of infection with M. Tuberculosis in the interval. If the reaction to the second of the initial two tests is positive, this probably represents a boosted reaction, and the person should be considered as being infected.

Attendants with reactions of 10 mm and over to the pre-employment tuberculin test, those with newly converted skin tests, and those with symptoms suggestive of tuberculosis (e.g., cough, weight loss, night sweats, fever, etc.) regardless of skin test status, shall be given a chest radiograph to determine whether tuberculosis disease is present.

If tuberculosis is diagnosed, appropriate treatment should be given, and the person must not be allowed to work until declared non-contagious by a licensed physician.

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

New attendants who have a history of tuberculosis disease shall be required to have a certification by a licensed physician or local health department TB staff (prior to enrollment as a Medicaid provider and annually) that they are not contagious. Regular attendants who are known or suspected to have tuberculosis shall be required to be evaluated by a licensed physician or local health department TB staff, and must not return to work until they have been declared non-contagious.

Preventive treatment should be considered for all infected attendants having direct Waiver participant contact who are skin test positive but show no symptoms of tuberculosis. Routine annual chest radiographs are not a substitute for preventive treatment. Attendants who complete treatment, either for disease or infection, may be exempt from further routine radiographic screening, unless they develop symptoms of tuberculosis. Attendants who do not complete adequate preventive therapy should have an annual assessment for symptoms of tuberculosis.

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

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

After these requirements are met the attendant will be submitted to SCDDSN (HASCI Division) to become enrolled as a DDSN provider. **Service Coordinators** will give updated provider lists to Waiver participants during home visits or as requested. UAP will also send provider lists as requested by the Waiver participant/RP or the **Service Coordinator.**

C. Annual Requirements

1. Forty-five (45) days prior to the attendant's enrollment month/ date, UAP-RN will notify active enrolled attendants of the annual requirement of submitting his/her TB test results.

2. To maintain enrollment attendants must maintain CNA status and must be in good standing with the Nurse aide registry if applicable.

3. Attendants with negative tuberculin skin tests shall have an annual tuberculin skin test and submit test results to the UAP. Attendants with a history of a positive TB skin test must submit to an annual assessment for symptoms of TB by UAP RN. If an updated chest x-ray is done attendant is to provide a copy of the results to the UAP.

4. Attendants must also continue to meet standards which include but are not limited to criminal records. Attendants must update First Aid.

D. Suspension

1. If the attendant has not submitted the required information by the expiration date, UAP-RN will notify the SCDDSN (HASCI Division).
2. Once annual requirements are met; the attendant will be submitted to the SCDDSN (HASCI Division), to be taken off suspension and placed on the active provider list.

E. Termination

1. If an attendant requests in writing to terminate a provider, UAP will notify SCDDSN (HASCI Division) to terminate.
2. If an attendant moves outside the 25-mile border of South Carolina as documented by forwarding address on returned mail the attendant will be submitted for termination by the UAP to the SCDDSN (HASCI Division).

Private Vehicle Modifications

Definition

Modifications to a privately owned vehicle to be driven by or routinely used to transport the participant. Includes any equipment necessary to make the vehicle accessible to the participant. Modifications of a vehicle owned by a publicly funded agency are not permitted.

Private Vehicle Modifications include consultation and assessment to determine the specific modifications/equipment needed, follow-up inspection after modifications are completed, training in the use of equipment, repairs and replacement of parts or equipment not covered by warranty.

The approval process for Private Vehicle Modifications is initiated based upon the needs specified in the participant's plan and following confirmation of the availability of a privately owned vehicle to be driven or routinely used to transport the participant. The approval process is the same for any private vehicle modification regardless of ownership. Each request must receive prior approval following programmatic and fiscal review and shall be subject to the state procurement act. Programmatic approval alone may be given for emergency repair of equipment to ensure the safety of the participant. The vehicle modification service will be subject to the guidelines established by DDSN and must be within the cap of $30,000 per vehicle modification.

Providers of Private Vehicle Modifications

Private Vehicle Modifications must be provided by vendors who are enrolled with SCDHHS as Durable Medical Equipment (DME) providers, Licensed Medicaid enrolled Occupational or Physical Therapists, Medicaid enrolled Rehabilitation Engineering Technologists, Assistive Technology Practitioners and Assistive Technology Suppliers certified by the Rehabilitation Engineering Society of North America (RESNA), Medicaid enrolled Environmental Access Consultants/contractors certified by Professional Resources in Management (PRIME) or by vendors who are contracted through the DSN Board to provide the service. Please refer to Appendix B-2 and Attachment 10 to Appendix B-2 of the HASCI Waiver document.

Providers of Products and Services

Products and services (including assessment, installation, follow-up inspection, and training in use) must be obtained from or contracted with Medicaid enrolled Durable Medical Equipment providers, vendors with a retail or wholesale business license contracted to provide services, technicians or professionals who are certified in the installation and repair of manufacturer's equipment, licensed occupational or physical therapists, RESNA certified Rehabilitation Engineering Technologists, assistive technology practitioners and assistive technology suppliers and PRIME certified environmental access consultants/contractors.

Note: All products must meet specifications in the individual's plan and be in accordance with all applicable state and local codes. Bids must be obtained and submitted to SCDDSN in accordance with SCDDSN Directive 250-08-DD, "Procurement Requirements for Local DSN Boards." At a minimum, the DSN Board's procurement policies must adhere to SCDDSN Directive 250-08-DD.

Technicians or professionals must be certified in the installation and repair of manufacturer's equipment.

Note: If Private Vehicle Modifications are provided by a vendor contracted through the DSN Board, the Board is responsible for ensuring that the vendor meets the minimum qualifications outlined in Appendix B-2 (Attachment 10) of the official HASCI Waiver document. The Board must keep documentation on the vendor with credentials that qualify them to provide the service.

Arranging for the Service(s)

Only after it is determined that the needed private vehicle modifications are not covered under warranty, private insurance or the State Plan can the item be requested through the HASCI Waiver.

Note: Service Coordinators must follow the HASCI Division Guidance For Environmental and Private Vehicle Modifications when considering the request of vehicle modifications through the HASCI Waiver. Please refer to Chapter 7 for the Guidance For Environmental and Private Vehicle Modifications.

Some repairs (such as a wheelchair lift) to a modified vehicle will be of an emergency nature. An "emergency repair" is defined as follows: "a mechanical, electrical, or hydraulic failure that renders a wheelchair lift, chassis-mounted power door operating device, or other essential piece of primary adaptive equipment totally non-useable to routinely use and/or depend on for daily use." **Note: The HASCI Division must be notified of the need for an "emergency repair" and may grant "emergency" approval for the repair to ensure the safety of the individual.**

When the individual's specific need has been identified, the scope of the modification to be completed should be documented in the Plan. This should be done with the individual and his/her family and should define the expected modification as clearly as possible.

The required procedures for requesting Private Vehicle Modifications/repairs must be reviewed and followed. Please refer to the "Guidance For Environmental and Private Vehicle Modifications."

Upon approval of vehicle eligibility from the HASCI Division, the Service Coordinator must offer the individual/family a choice of provider of the service. This offering of

choice must be clearly documented in the individual's file. For any private vehicle modification costing less than $1500, it is only necessary to get one price quote (from the provider chosen by the individual and/or family). For any private vehicle modification costing more than $1500, the individual and/or family must select three (3) providers to supply quotes. These three (3) quotes must be in writing.

Once a provider is chosen by the individual or selected as the "lowest bidder", the request should be entered into the Waiver Tracking System (WTS) and quotes should be forwarded to the Central Office, HASCI Division. The individual's Plan must be updated to reflect the name of the service, frequency and duration, amount and the provider.

When the service is approved, the Service Coordinator must follow procedures in the "Guidance for Environmental and Private Vehicle Modifications. The Service Coordinator will proceed with authorizing the service using the Authorization for Private Vehicle Modifications Form (HASCI Form 12K).

Billing

For individuals receiving HASCI Waiver funded Residential Habilitation, Private Vehicle Modifications must always be billed to the DSN Board. This should be checked on the Authorization for Private Vehicle Modifications (HASCI Form 12K) and no prior authorization number should be assigned. For these individuals, the DSN Board should not follow procedures to request reimbursement for costs of services. The cost of Private Vehicle Modifications is included in the rate paid to the DSN Board for Residential Habilitation.

For individuals who do not receive HASCI Waiver funded Residential Habilitation, Private Vehicle Modifications may be board billed or billed to SCDHHS.

Private Vehicle Modifications are provided by an individual or company that is contracted or employed by the DSN Board, the service must be Board billed. This must be checked on the Authorization for Private Vehicle Modifications (HASCI Form 12K) and no prior authorization number should be assigned. The agency must follow the Procedures to Report and Bill for Board Based Services Provided to HASCI Waiver Participants to receive reimbursement for costs. These procedures are located in Chapter 7of this manual.

Note: When Private Vehicle Modifications are provided by a vendor that is contracted through the DSN Board, the Board is responsible for maintaining documentation that supports that the service was received for each date billed.

Private Vehicle Modifications are provided by an individual who is enrolled with SCDHHS as a provider, the service must be billed to SCDHHS. This should be checked on the Authorization for Private Vehicle Modifications (HASCI Form 12K) and a prior authorization number must be assigned.

Monitorship

The provision of Private Vehicle Modifications must be monitored to assure its usefulness and effectiveness, as well as the individual's satisfaction with the services and the provider of the service. Private Vehicle Modifications must be monitored by conducting an on-site visit with the individual within two (2) weeks of completion and before payment is requested and issued. The visit must be documented and include a statement regarding the usefulness and effectiveness of the modifications and the individual's satisfaction with the modifications and the provider.

Reduction, Suspension or Termination

If Private Vehicle Modifications need to be reduced, suspended or terminated the Service Coordinator must notify the provider to reduce, suspend or stop the service. The Service Coordinator must also notify the individual/legal guardian with a written notice regarding the change(s) in service(s), allowance/process for appeal and a ten (10) calendar day waiting period before proceeding with the reduction, suspension or termination. The Notice of Reduction, Suspension or Termination of Service Form must be completed by the Service Coordinator and forwarded to the provider of service with a copy to the individual/legal guardian (see Chapter 5 for procedures regarding written notification and the appeals process). (***Note:*** All unused units of the service must be deleted from the Waiver Tracking System and the individual's Plan must be updated as soon as possible).

Environmental Modifications

Definition

Environmental Modifications are defined as those physical adaptations to the home, required by the individuals Plan, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home. **The home must be a privately owned residence occupied by the participant. Modifications to publicly funded group homes or community residential facilities are not permitted.** Such adaptations may include the installation of ramps and grab-bars, widening of doorways and automatic door systems, modification of bathroom or kitchen facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual, **floor covering to facilitate wheelchair access, fencing necessary for a participants safety. Environmental modifications may also include consultation and assessments to determine the specific needs and follow-up inspections upon completion of the project.**

Excluded are those adaptations or improvements to the home, which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. **Environmental modifications will not be approved solely for the needs or convenience of other occupants of the home or care providers. Modifications that add to the total square footage of the home are available only when this modification proves to be the most cost effective solution.** All services shall be provided in accordance with applicable state and local building codes **and shall be subject to the state procurement act. The environmental modification service will be subject to the guidelines established by DDSN and must be within the cap of $20,000 per modification.**

Providers of Environmental Modifications

Environmental Modifications must be provided by vendors who are enrolled with SCDHHS as Durable Medical Equipment (DME) providers, Licensed Occupational and Physical Therapists, Medicaid enrolled Rehabilitation Engineering Technologists, assistive technology suppliers certified by the Rehabilitation Engineering Society of North America (RESNA), Medicaid enrolled independent Environmental Access Consultants/contractors certified by Professional Resources in Management (PRIME) or by vendors who are contracted through the local DSN Board to provide the service.

Note: All products must meet specifications in the individual's plan and be in accordance with all applicable state and local codes. Bids must be obtained and submitted to SCDDSN in accordance with SCDDSN directive 250-08-DD, "Procurement Requirements for Local DSN Boards." At a minimum, the DSN Boards procurement policies must adhere to the SCDDSN directive 250-08-DD.

Providers of Products and Services

Products and services (including assessment, installation, follow-up inspection, and training in use) may by obtained from or contracted with Medicaid enrolled Durable Medical Equipment providers, licensed contractors, vendors with a retail or wholesale business license contracted to provide services, technicians or professionals certified in the installation and repair of manufacturer's equipment, licensed occupational or physical therapists, RESNA certified Rehabilitation Engineering Technologists, Assistive Technology Practitioners, and Assistive Technology Suppliers and PRIME certified Environmental Access Consultants/contractors.

Note: All adaptations/modifications to the home that require building of any type, for example, using hammer and nails must be done by contractors that are licensed by the State of South Carolina through the SC Department of Labor, Licensing and Regulation, Contractor's Licensing Board.

Note: All products must meet specifications in the individual's plan and be in accordance with all applicable state and local codes. Bids must be obtained and submitted to SCDDSN in accordance with SCDDSN directive 250-08-DD, "Procurement Requirements for Local DSN Boards." At a minimum, the DSN Boards procurement policies must adhere to the SCDDSN directive 250-08-DD.

Note: If Environmental Modifications are provided by a vendor contracted through the DSN Board, the Board is responsible for ensuring that the vendor meets the minimum qualifications outlined in Appendix B-2 (Attachment 4) of the official HASCI Waiver document. The Board must keep documentation on the vendor with credentials that qualify them to provide the service.

Arranging for the Service(s)

Only after it is determined that the needed environmental modifications are not under warranty, private insurance, or the Medicaid State Plan can the item be requested through the HASCI Waiver.

Note: Service Coordinators must follow the HASCI Division Guidelines for Environmental and Vehicle Modifications when considering the request of environmental modifications through the HASCI Waiver.

Once the individual's specific need has been identified and documented in the Plan, the scope of the work to be completed should be documented in the Plan. This must be done with the individual and his/her family and must define the expected modification as clearly as possible.

When it is determined and documented that modifications are needed, the individual and/or family must be offered a choice of providers.

This offering of choice must be clearly documented in the individual's file. For any modification costing less than $1500, it is only necessary to get one price quote (from

the provider chosen by the individual and/or family). For any single item costing more than $1500, the individual and/or family must select three (3) contractors to supply quotes. All quotes, regardless of the price of the modifications, must be in writing.

Environmental Modifications through the HASCI Waiver must always be completed by Contractors, licensed or certified through the SC Department of Labor, Licensing and Regulation, Contractor's Licensing Board.

Once a provider is chosen by the individual or selected as the "lowest bidder", the request should be entered into the Waiver Tracking System and quotes should be forwarded to the Central Office, HASCI Division. The individual's Plan must be updated to reflect the name of the service, frequency, duration, amount and the provider. When the service is approved, the service is authorized using the Authorization for Environmental Modifications Form (HASCI Form 12L).

Billing

Environmental Modifications may be board billed or billed to SCDHHS. ***If Environmental Modifications are provided by an individual or company that is contracted or employed by the DSN Board,*** the service must be Board billed. This must be checked on the Authorization for Environmental Modifications (HASCI Form 12L) and no prior authorization number should be assigned. The agency must follow the Procedures to Report and Bill for Board Based Services Provided to HASCI Waiver Participants to receive reimbursement for costs. These procedures are located in Chapter 7 of this manual.

Note: When Environmental Modifications are provided by a vendor that is contracted through the DSN Board, the Board is responsible for maintaining documentation that supports that the service was received for each date billed.

If Environmental Modifications are provided by an individual who is enrolled with SCDHHS as a provider, the service must be billed to SCDHHS. This must be checked on the Authorization for Environmental Modifications (HASCI Form 12L) and a prior authorization number must be assigned.

Monitorship

When monitoring the provision of Environmental Modifications, you must determine the usefulness and effectiveness of the service as well as the individual's satisfaction with the service. For Environmental Modifications, Service Coordinators are required to make an on-site visit during the modification process and within two (2) weeks of completion. The on-site visit must be documented and include a statement regarding the completion of the modification as specified and the individual's satisfaction with the modification.

Reduction, Suspension or Termination

If Environmental Modifications need to be reduced, suspended or terminated the Service Coordinator must notify the provider to reduce, suspend or stop the service. The Service Coordinator must also notify the individual/legal guardian with a written notice regarding the change(s) in service(s), allowance/process for appeal and a ten (10) calendar day waiting period before proceeding with the reduction, suspension or termination. The Notice of Reduction, Suspension or Termination of Service form must be completed by the Service Coordinator and forwarded to the provider of service with a copy to the individual/legal guardian (see Chapter 5 for procedures regarding written notification and the appeals process). (***Note:*** All unused units of the service must be deleted from the Waiver Tracking System and the individual's Plan must be updated as soon as possible).

Behavioral Support Services

Definition

Psychological and Behavioral Services have changed. Psychological and Behavioral Services are two (2) separate services and no longer one (1) service.

Behavioral Support Services address problem behaviors of an individual by using validated practices to identify causes and appropriate interventions that prevent or reduce occurrence. Behavioral Support Services include functional behavior assessments and analyses; development of behavioral support plans; implementing interventions designated in behavioral support plans; training key persons to implement interventions designated in behavioral support plans; monitoring effectiveness of behavioral support plans and modifying as necessary; and educating family, friends, or service providers concerning strategies and techniques to assist the participant in controlling/modifying inappropriate behaviors.

Providers

Behavioral Support Services must be provided by individuals who are enrolled with SCDHHS as Behavioral Support providers or by individuals who are contracted through the DSN Board to provide the service.

Note: If Behavioral Support Services are provided by an individual contracted through the DSN Board, the Board is responsible for ensuring that the individual meets the minimum qualifications outlined in Appendix B-2 (Attachment 9) of the official HASCI Waiver document. The Board must keep a record on the individual with documentation that supports his/her qualifications to provide the specific level of behavioral support services.

Behavioral Support Services may be provided by Medicaid enrolled rehabilitation programs certified by the Commission on Accreditation of Rehabilitation Facilities (CARF).

Note: If Behavioral Support Services are provided by Medicaid enrolled CARF certified rehabilitation programs the DSN Board is responsible for ensuring that the provider is an approved Medicaid provider of behavioral support services.

Behavioral Support Services may be provided by Medicaid enrolled provider approved by SCDDSN.

Note: Providers must be referred to the MR/RD Division of SCDDSN for approval.

Arranging for the Service(s)

If the Service Coordinator determines that the individual is in need of and desires Behavioral Support Services, the need for the service must be clearly documented in the individual's Plan by indicating the behaviors that prompted the Service Coordinator to explore this service.

When it is determined that an evaluation/assessment is needed, the individual and/or family must be offered a choice of providers and this offering of choice must be clearly documented in the individual's file.

Once a provider is chosen, the Waiver Tracking System must be updated. The individual's Plan must be updated to reflect the name of the service, amount, frequency and duration of the service and the provider. When it is approved, the service is authorized using the Authorization for Behavioral Support Services Form (HASCI Form 12M).

After the assessment is completed, the Service Coordinator should receive and review the results, which should define any recommendations. If the assessment recommends additional behavioral support services, which could be funded through the HASCI Waiver, the Waiver Tracking System and the individual's Plan must be updated to request the service. When the service is approved, it is authorized using the Authorization for Behavioral Support Services Form (HASCI Form 12M).

Billing

For individuals receiving HASCI Waiver funded Residential Habilitation, Day Habilitation, Prevocational Services, or Supported Employment Services, Behavioral Support services must always be billed to the DSN Board. This must be checked on the Authorization for Behavioral Support Services (HASCI Form 12M) and no prior authorization number should be assigned. For these individuals, the DSN Board should not follow procedures to request reimbursement for costs of services. The cost of Behavioral Support Services is included in the rate paid to the DSN Board for all types of Habilitation Services.

For individuals who do not receive HASCI Waiver funded Residential Habilitation, Day Habilitation, Prevocational Services, or Supported Employment, Behavioral Support Services may be board billed or billed to SCDHHS.

If Behavioral Support Services are provided by an individual who is contracted or employed by the DSN Board, the service must be Board billed. This must be checked on the Authorization for Behavioral Support Services (HASCI Form 12M) and no prior authorization number should be assigned. The agency must follow the Procedures to Report and Bill for Board Based Services Provided to HASCI Waiver Participants to receive reimbursement for costs. These procedures are located in Chapter 7 of this manual.

Note: When Behavioral Support Services are provided by an individual who is contracted or employed by the DSN Board, the Board is responsible for maintaining documentation that supports that the service was received for each date billed.

If Behavioral Support Services are provided by an individual who is enrolled with SCDHHS, the service must be billed to SCDHHS. This must be checked on the Authorization for Behavioral Support Services (HASCI Form 12M) and a prior authorization number must be assigned.

Monitorship

The provision of Behavioral Support Services must be monitored to assure its usefulness and effectiveness along with the individual's satisfaction with the service. Behavioral assessments are monitored by reviewing the recommendations and ensuring that it addresses the behaviors or comments that necessitated the assessment. The recommendations of the assessment must be reviewed with the individual to ensure their comfort and satisfaction with the professional, especially if ongoing behavior supports and treatment is recommended.

Ongoing services must be monitored by reviewing progress toward the stated goals or intended outcome of the behavior support plan. The Service Coordinator must determine if progress is being made, and if not, what actions are being taken by the professional to encourage progress or what actions are being taken to modify the behavior support plan as necessary. Service Coordinators must review progress notes from the professional to ensure that services are being provided as authorized and they continue to be useful and effective for the individual. (***Note***: This is particularly important when educating family, friends or service providers concerning strategies and techniques to assist the individual in controlling/modifying inappropriate behaviors. The Service Coordinator must ensure that the behavior support plan is specific to the individual being served in the Waiver.)

Reduction, Suspension or Termination

If Behavioral Support Services need to be reduced, suspended or terminated the Service Coordinator must notify the provider to reduce, suspend or stop the service. The Service Coordinator must also notify the individual/legal guardian with a written notice regarding the change(s) in service(s), allowance/process for appeal and a ten (10) calendar day waiting period before proceeding with the reduction, suspension or termination. The Notice of Reduction, Suspension or Termination of Service Form must be completed by the Service Coordinator and forwarded to the provider of service with a copy to the individual/legal guardian (see Chapter 5 for procedures regarding written notification and the appeals process). (***Note:*** All unused units of the service must be deleted from the Waiver Tracking System and the individual's Plan must be updated as soon as possible).

Health Education for Consumer-Directed Care

Definition

Health Education for Consumer-Directed Care prepares and assists capable individuals who desire to manage their own personal care or family members who desire to manage the personal care of an individual not capable of self-management.

Health Education for Consumer-Directed Care is instruction provided by a licensed registered nurse regarding the nature of their specific medical condition and the promotion of good health, and prevention/monitoring of secondary medical conditions.

The RN will utilize the "Key to Independence Manual" from the Shepherd Center in Atlanta, Georgia or a curriculum approved by DDSN as a guide in providing education on bladder and bowel care, skin care, respiratory care, sexuality, substance abuse issues, and monitoring of health status.

Providers

Health Education for Consumer-Directed Care may be provided by the following:

- DSN Boards/contracted providers that employ/contract with licensed RNs
- Medicaid enrolled rehabilitation programs certified by the Commission on Accreditation of Rehabilitation Facilities (CARF) that employ/contract with licensed RNs
- Medicaid enrolled provider agencies which employ/contract with licensed RNs
- Medicaid enrolled licensed RNs

Registered nurses who directly provide Health Education for Consumer-Directed Care must:

- Be licensed by the South Carolina Board of Nursing or the equivalent in North Carolina and Georgia
- Use the "Key to Independence Manual" and/or a curriculum approved by SCDDSN, as a guide, in providing health education to participants who desire to manage their own personal care, or to family members who desire to manage the personal care of an individual not capable of self-management

Note: The individual/legal guardian must choose a qualified provider of services. The RN must provide instruction to the individual if he/she is capable of managing his/her own personal care. If an individual is not capable of managing his/her own personal care, instruction may be provided to a family member who desires to manage the care. Instruction must address the individual's specific medical condition(s), promotion of good health and prevention/monitoring of secondary medical conditions. The RN must provide education on bladder and bowel care, skin care, respiratory care, sexuality, substance abuse issues and monitoring of health status.

Arranging for the Service(s)

If the Service Coordinator determines that the individual is in need of and desires Health Education for Consumer-Directed Care, the need for the service must be clearly documented in the individual's Plan. The Plan must clearly indicate the specific medical conditions of the individual and the desire to manage his/her own personal care or the family member who desires to manage the personal care if the individual is not capable of self-management.

When it is determined and documented that Health Education for Consumer-Directed Care is needed and desired, the individual and/or family member must be offered a choice of providers. This offering of choice must be clearly documented in the individual's file.

For Health Education for Consumer-Directed Care, one unit equals one hour of service. The services must be provided by a licensed Registered Nurse.

Note: Health Education for Consumer-Directed Care is limited to 10 units per year (calendar year).

Once a provider is chosen, the Waiver Tracking System must be updated. The individual's Plan must be updated to reflect the name of the service, amount, frequency and duration of the service and the provider. When it is approved, the service is authorized using the Authorization for Health Education for Consumer-Directed Care Services Form (HASCI Form 12N).

Billing

For individuals receiving HASCI Waiver funded Residential Habilitation, Day Habilitation, Prevocational Services, or Supported Employment Services, Health Education for Consumer-Directed Care Services will always be billed to the DSN Board. This should be checked on the Authorization for Health Education for Consumer-Directed Care (HASCI Form 12N) and no prior authorization number should be assigned. For these individuals, the DSN Board should not follow procedures to request reimbursement for costs of services. The cost of Health Education for Consumer-Directed Care is included in the rate paid to the DSN Board for any type of Habilitation Services.

For individuals who do not receive HASCI Waiver funded Residential Habilitation, Day Habilitation, Prevocational Services, or Supported Employment, Health Education for Consumer-Directed Care may be Board billed or billed to SCDHHS.

If Health Education for Consumer-Directed Care is provided by a licensed RN who is contracted or employed by the DSN Board, the service must be Board billed. This must be checked on the Authorization for Health Education for Consumer-Directed Care (HASCI Form 12N) and no prior authorization number is assigned.
The agency must follow the Procedures to Report and Bill for Board Based Services Provided to HASCI Waiver Participants to receive reimbursement for costs. These procedures are located in Chapter 7 of this manual.

Note: When Health Education for Consumer-Directed Care is provided by a licensed RN who is contracted or employed by the DSN Board, the Board is responsible for maintaining documentation that supports that the service was received for each date billed.

If Health Education for Consumer-Directed Care is provided by a CARF-certified rehabilitation program or a licensed RN enrolled with SCDHHS, the service must be billed to SCDHHS. This should be checked on the Authorization for Health Education for Consumer-Directed Care (HASCI Form 12N) and a prior authorization number must be assigned. These providers are responsible to maintain documentation to support that the service was received on each date billed. RNs who provide the instruction must maintain service notes for each contact.

Monitorship

The provision of Health Education for Consumer-Directed Care Services must be monitored to assure its usefulness and effectiveness, as well as the individual's satisfaction with the service and the provider of the service. Health Education for Consumer-Directed Care is monitored by reviewing the recommendations and notes of the RN and ensuring that it addresses the individual's medical condition and his/her management of his/her personal care or family member management of the individual's personal care if not capable of self-management.

The Service Coordinator must monitor the services by reviewing the progress notes from the RN to ensure that services are being provided as authorized and continue to be useful and effective for the individual.

Note: The Service Coordinator must ensure that the Health Education for Consumer-Directed Care is specific to the individual being served in the Waiver.

Reduction, Suspension or Termination

If Health Education for Consumer-Directed Care needs to be reduced, suspended or terminated the Service Coordinator must notify the provider to reduce, suspend or stop the service. The Service Coordinator must also notify the individual/legal guardian with a written notice regarding the change(s) in service(s), allowance/process for appeal and a ten (10) calendar day waiting period before proceeding with the reduction, suspension or termination. The Notice of Reduction, Suspension or Termination of Service Form must be completed by the Service Coordinator and forwarded to the provider of service with a copy to the individual/legal guardian (see Chapter 5 for procedures regarding written notification and the appeals process).
Note: All unused units of the service must be deleted from the Waiver Tracking System and the individual's Plan must be updated as soon as possible.

Peer Guidance for Consumer-Directed Care

Definition

Peer Guidance for Consumer-Directed Care prepares and assists capable individuals who desire to manage their own personal care. It is information, advice, and encouragement provided by a trained Peer Supporter to help a person with spinal cord injury/severe physical disability in recruiting, training and supervising primary and back-up attendant care/personal assistance providers.

The Peer Supporter is a person with a spinal cord injury/severe physical disability who successfully lives in the community with a high degree of independence and who directs his/her personal care. The Peer Supporter serves as a role model and shares information and advice from his/her own experiences.

The Peer Supporter will use the "Peer Support Curriculum" from the Shepherd Center in Atlanta, Georgia or a curriculum approved by SCDDSN.

Providers

Peer Guidance for Consumer-Directed Care may be provided the following:

- DSN Boards/contracted providers
- Medicaid enrolled rehabilitation programs certified by the Commission on Accreditation of Rehabilitation Facilities (CARF)

Individual's employed/contracted as Peer Supporters must meet the following minimum qualifications:

- Have a spinal cord injury/severe physical disability and live successfully in the community
- Be at least 18 years of age with the maturity and ability to deal effectively with the demands of the job
- Have a high degree of independence and direct his/her own personal care
- Able to read, write, and speak English, as well as communicate effectively
- Must be free from communicable diseases
- Provide a statement that he/she has never been convicted of a felony. The service provider must verify the statement by a criminal investigation.
- Be trained/approved by and registered with the South Carolina Spinal Cord Injury Association
- Use the "Peer Support Curriculum" from the Shepherd Center in Atlanta, Georgia and/or a curriculum approved by SCDDSN, as a guide in providing peer guidance to persons with spinal cord injury/severe physical disability who desire to manage their own personal care

Arranging for the Service(s)

If the Service Coordinator determines that the individual is in need of and desires Peer Guidance for Consumer-Directed Care, the need and desire for the service must be clearly documented in the individual's Plan. The Plan must indicate the desire of the individual to manage his/her own personal care including recruiting, training and supervising primary and back-up attendant care/personal assistance providers.

When it is determined that Peer Guidance for Consumer-Directed Care is needed and desired, the individual must be offered a choice of providers and this offering of choice must be clearly documented in the individual's file.

For Peer Guidance for Consumer-Directed Care, one unit equals one hour of service. The service provider must be approved, trained and registered with the South Carolina Spinal Cord Injury Association.

Note: Peer Guidance for Consumer-Directed Care is limited to 12 units per year (calendar year).

After a qualified provider is chosen, the Waiver Tracking System must be updated. The individual's Plan must be updated to reflect the name of the service, amount, frequency and duration of the service and the provider. When approved, the service is authorized using the Authorization for Peer Guidance for Consumer-Directed Care Services Form (HASCI Form 12O).

Billing

For individuals receiving HASCI Waiver funded Residential Habilitation, Day Habilitation, Prevocational Services, or Supported Employment Services, Peer Guidance for Consumer-Directed Care must always be billed to the DSN Board. This should be checked on the Authorization for Peer Guidance for Consumer-Directed Care Services (HASCI Form 12O) and no prior authorization number should be assigned. For these individuals, the DSN Board should not follow procedures to request reimbursement for costs of services. The cost of Peer Guidance for Consumer-Directed Care Services is included in the rate paid to the DSN Board for all types of Habilitation Services.

For individuals who do not receive HASCI Waiver funded Residential Habilitation, Day Habilitation, Prevocational Services, or Supported Employment, Peer Guidance for Consumer-Directed Care may be board billed or billed to SCDHHS.

If Peer Guidance for Consumer-Directed Care is provided by an individual who is contracted or employed by the DSN Board, the service will be Board billed. This must be checked on the Authorization for Peer Guidance for Consumer-Directed Care (HASCI Form 12O) and no prior authorization number is assigned. Your agency must follow the Procedures to Report and Bill for Board Based Services Provided to HASCI Waiver Participants to receive reimbursement for costs. These procedures are located in Chapter 7 of this manual.

Note: When Peer Guidance for Consumer-Directed Care is provided by an individual who is contracted or employed by the DSN Board, the Board is responsible for maintaining documentation that supports that the service was received for each date billed.

If Peer Guidance for Consumer-Directed Care is provided by a CARF-certified rehabilitation program enrolled with SCDHHS, the service should be billed to SCDHHS. This should be checked on the Authorization for Peer Guidance for Consumer-Directed Care (HASCI Form 12O) and a prior authorization number must be assigned. The rehabilitation program is responsible for maintaining documentation that supports the service was received fro each date billed.

Monitorship

The provision of Peer Guidance for Consumer-Directed Care must be monitored to assure its usefulness and effectiveness along with the individual's satisfaction with the service and the provider of the service. Peer Guidance for Consumer-Directed Care is monitored by reviewing comments of the Peer Supporter and ensuring that the service addresses the individual's desire to manage his/her own personal care, including recruiting, training and supervising attendant care/personal assistance providers.

The Service Coordinator must monitor the services by reviewing the comments of the Peer Supporter to ensure that services are being provided as authorized.

Note: The Service Coordinator must ensure that the Peer Guidance for Consumer-Directed Care is specific to the individual being served in the Waiver.

Reduction, Suspension or Termination

If Peer Guidance for Consumer-Directed Care needs to be reduced, suspended or terminated the Service Coordinator must notify the provider to reduce, suspend or stop the service. The Service Coordinator must also notify the individual/legal guardian with a written notice regarding the change(s) in service(s), allowance/process for appeal and a ten (10) calendar day waiting period before proceeding with the reduction, suspension or termination. The Notice of Reduction, Suspension or Termination of Service Form must be completed by the Service Coordinator and forwarded to the provider of service with a copy to the individual/legal guardian (see Chapter 5 for procedures regarding written notification and the appeals process). (***Note:*** All unused units of the service must be deleted from the Waiver Tracking System and the individual's Plan must be updated as soon as possible).