CHAPTER 10

Miscellaneous

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Preventive/Rehabilitative Services for Primary Care Enhancement (P/RSPCE)

Preventive and Rehabilitative Services for Primary Care Enhancement (P/RSPCE) are interventions that address medical risk factors that interfere with a patient's ability to maintain an optimal state of health. P/RSPCE support primary medical care. The services are directed toward the maintenance, improvement or protection of health or toward the diagnosis and treatment of illness or disability. These services are funded by State Plan Medicaid.

The goals of P/RSPCE are to:

- Prevent disease, disability, and other health conditions or their progression
- Prolong life
- Promote physical and mental health and efficiency
- Reduce physical or mental disability
- Restore an individual to the best possible functional level
- Promote positive health outcomes

This service is available to Medicaid beneficiaries when medically necessary and must either be (1) required for the development and implementation of a comprehensive plan of care by a physician and other appropriate practitioners, or (2) preventive services identified in the comprehensive P/RSPCE plan that are not otherwise covered under the state plan.

The "Principles for Interaction Between Preventive/Rehabilitative Services for Primary Care Enhancement (P/RSPCE) and Medicaid Home and Community-Based Waiver Programs" attached must be followed for waiver participants receiving P/RSPCE.

For more information about P/RSPCE, see the Enhanced Services Provider Manual at www.scdhhs.gov.

Principles for Interaction Between Preventive/Rehabilitative Services for Primary Care Enhancement (P/RSPCE) and Medicaid Home and Community-Based Waiver Programs

- The short-term, time-limited, medical nature of P/RSPCE and its linkage to primary care are important in understanding the relationship between these two Medicaid services.

- The P/RSPCE provider must fully understand how the waiver program operates, the waiver and state plan services available, and scope of the Community Long Term Care Waiver Case Manager (CM)/Department of Disabilities and Special Needs Waiver Case Manager (CM). This is critical to avoid any unnecessary duplication or overlap services.

- It is important that the P/RSPCE provider and the assigned waiver participant's CM communicate exactly what service(s) will be provided as well as the exact expected outcome of the intervention(s) being provided. This communication is necessary to ensure the participant's waiver plan of care/service is documented appropriately by the CM.

- The P/RSPCE provider will document all telephone or personal contacts with the CM in the client's case record.

- P/RSPCE services provided to waiver participants must be within the 30 units/month limit established by DHHS. These services must be efficient, well managed, and must not duplicate any waiver or state plan services.

- DHHS will monitor the amount of P/RSPCE provided to waiver participants through Medicaid expenditure reports.

- Only nutrition services can be routinely provided to waiver participants under P/RSPCE. Waiver Case Managers need to be aware of any nutritional supplements (if this is offered) to avoid duplication.

- Any other P/RSPCE provided to home and community-based waiver participants must meet one of the criteria below:

    1. Interventions related to a client's complicated medical condition to improve his/her response to treatment or care. There must be clear documentation that the P/RSPCE provider has communicated with the primary care physician and CM concerning the nature of the service(s) to be provided;

    2. Interventions for clients with complicated medical conditions in need of medication management, compliance with a medication regimen, or assistance in procuring medications. Routine situations should be handled through Medicaid state plan (including

Medicaid home health services) or waiver services. P/RSPCE involvement should only be for crisis-type situations that are short-term, time-limited, medical, and carefully coordinated with the CM; or

3. Interventions for clients with complex medical conditions to assure understanding of how multiple medical treatments relate with the effectiveness of the care plan in order to maximize the level of independence and functioning. This may involve attending a discharge or case coordination meeting (with the CM/SC) where a deinstitutionalization is imminent. This cannot duplicate the functions of the CM.

- Waiver participant's meeting any of the above criteria may be referred for P/RSPCE by their CM.

- These procedures will be communicated to the responsible P/RSPCE staff, CLTC staff, and DDSN staff.

Effective Date: September 1, 1998

Community Supports Waiver and Hospice Services

When a Community Supports Waiver participant elects to also receive State Plan Hospice Services, the Hospice provider becomes the "Authorizer" of all State Plan Medicaid and Waiver services. As a result, the Waiver Case Manager must obtain authorization from the Hospice provider before waiver services can be provided. The Waiver Case Manager must obtain the Hospice authorization number from the Hospice service provider when notified of the waiver participant's admission to Hospice services. The Hospice Authorization number is also known as the Medicaid Legacy Provider number (e.g. HSP028).

No Community Supports Waiver services may be authorized for participants who elect to receive Hospice services funded by State Plan Medicaid without authorization from the Hospice provider.

Once the Hospice Authorization/Medicaid Legacy Provider number has been obtained, The Waiver Case Manager must complete the Hospice Services Information form and submit the form to the DDSN Waiver Enrollment Coordinator. This form can be found in business tools.
Business Tools > Forms > CS Waiver > CSW Manual Forms.

The Waiver Case Manager will be responsible for reporting this information to all waiver service providers. Case Managers must include the Hospice Authorization/Medicaid Legacy Provider number in the comment section of each authorization. Do not use the shared comments section of the authorization.

Children (age 0-21) enrolled in the Community Supports Waiver receiving State Plan Medicaid Hospice services **are eligible to receive any needed Community Supports Waiver funded services** if the service is provided in accordance with waiver service definitions and policies.

Adults (age 21 and up) enrolled in the Community Supports Waiver may receive services listed in the left column of the table below authorized by a DDSN Case Manager if appropriate. The services in the right column may **NOT** be authorized for adult participants while receiving the Hospice benefit.

ADULTS only:

May be routinely authorized, if appropriate	May not be authorized
Assistive Technology and Appliances Incontinence Supplies Waiver Case Management ***Note**: These services will be limited to those items already identified on the plan of service. These services will not be authorized for newly requested items for waiver clients entering hospice.*	Adult Day Health Care Adult Day Health Care –Nursing In-Home Support Respite Care PERS Personal Care Behavior Support Services Environmental Modifications Private Vehicle Modifications Day Activity Employment Services Career Preparation Support Center Community Services

Dually Eligible Beneficiaries

If an individual is eligible for Medicare as well as Medicaid, the hospice benefit must be elected and revoked simultaneously under both programs. In other words, if a Medicaid beneficiary elects the hospice Medicaid benefit and is also eligible for Medicare, then the beneficiary must also elect the Medicare hospice benefit. If a Medicare beneficiary elects the hospice Medicare benefit and is also eligible for Medicaid, then the beneficiary must also elect the Medicaid hospice benefit. For dually eligible beneficiaries, Medicare is the primary payer for the hospice benefit, though the Medicaid hospice election process must also be completed.

Authorizing/Billing Waiver Services for Participants Receiving State Plan Hospice Services

Claims submitted for waiver services must include the Hospice Authorization/Medicaid Legacy ID. Therap does not have the ability to add this information for billing purposes. Therefore, services typically billed through Therap must be billed through the Medicaid Web Portal while a participant is receiving Hospice Services. The Hospice Authorization/Medicaid Legacy Provider number must be submitted on the claim in the "MHN Referral Number" field located under the "Misc Info" tab in the Web Portal.

For Your Information

Subject: Out of State Travel

CS Waiver participants may travel out of state and retain a waiver slot under the following conditions:

- the trip is planned and will not exceed 90 consecutive days;
- the participant continues to receive a waiver service consistent with SCDDSN policy;
- the waiver service received is provided by a South Carolina Medicaid provider;
- South Carolina Medicaid eligibility is maintained.

During travel, waiver services will be limited to the frequency of service currently approved in the participant's plan. Services must be monitored according to SCDDSN policy.

The parameters of this policy are established by SCDHHS for all HCB Waiver participants.

For Your Information

Subject: Income Trust

If a potential participant is deemed "not eligible" for Medicaid due to excessive income, he/she may become eligible after an "Income Trust" is established. The potential participant must meet all other Medicaid eligibility criteria.

Under this option, the potential participant establishes a trust account into which all of his/her income is deposited. Each month, after appropriate deductions for living expenses and other fees, Medicaid bills the trust for any Medicaid services provided.

Specific and detailed information about Income Trusts is available from the South Carolina Department of Health and Human Services (SCDHHS/Eligibility).

Trusts must be set up by an attorney or trust professional and must be set up according to the specific guidelines set by SCDHHS/Eligibility.

PURGING A CS WAIVER FILE

- Clearly denote on the working file that there is a back-up file by placing a **Back-Up File Available** sticker on the front of the file or follow your agency's policy for denoting a Back-Up File Available.
- All material (except waiver information) should be purged by calendar year and put in a file that is set up like the working file and labeled as a back-up file.
- The original Social History and all Social Updates remain in the file.
- All Service Agreements will be maintained in the working file.
- Client Rights and Review of Record Form remains in the working file.
- Voter Registration Information remains in the working file.
- Retain previous and current Plan in the working file.
- Current medical exam and medical records should be in the file.
- All psychological evaluations remain in the working file.
- Current and previous IEP/IPP, if applicable, should be retained in the working file.
- The DDSN Eligibility letter regarding eligibility should remain in the working file.
- Contact notes will be purged according to calendar year. The current year should remain along with two previous years to coincide with the budgets.
- The Freedom of Choice, Waiver Enrollment letter, Notice of Slot Allotment, and all Level of Care determinations remain in the working file.
- Waiver budget information should be purged according to fiscal year (e.g. 7/1/10-6/30/11) along with pertinent documents (e.g. referrals, monthly utilization forms, requisitions/invoices and progress notes) regarding waiver services. The current contract period should remain along with the previous contract period. This should coincide with contact notes (i.e. if the current contract period is 7/1/10-6/30/11, then this information must be retained in the working file along with 7/1/09-6/30/10 budget information and supporting documents which coincide with service notes from 2009-2011 – the service notes would be purged back to 1/1/09).

Emergency Service Approval

An emergency situation is when the health and/or safety of a Waiver participant is in serious jeopardy and immediate action is required. The circumstances could not have been reasonably anticipated to allow ordinary service authorization procedures. Expedited authorization of one or more Waiver services is necessary.

Emergency service approval allows the Waiver Case Manager to send an authorization to a provider before the participant's Support Plan is updated. The Waiver Case Manager will ensure that the plan update is submitted to the Waiver Administration Division as soon as possible, but no more than 2 business days after emergency approval. If an emergency arises during normal office hours, the Waiver Case Manager must receive verbal approval from the Waiver Administration Division prior to service authorization. Whenever there is emergency service authorization, the Waiver Case Manager must document details of the emergency situation in a service note. This must include explanation why ordinary service authorization procedures could not be followed.

For emergency service approval, the Waiver Case Manager must send a completed Request for Emergency Service Approval to the SCDDSN Waiver Administration Division. The Division will return the form with approval or disapproval indicated. Approval may be given by telephone or email/Therap SCOMM if there will be delay in returning the form. Receipt of approval or denial must be documented in a service note. A copy of the form must be maintained in the participant's file.

REQUEST FOR EMERGENCY SERVICE APPROVAL

Please Type or Print

Emergency authorization of services should only be requested in situations that involve current or imminent life/safety (physical environment) or health/safety (medical) issues. This form, along with any supporting documentation, is to be sent to the SCDDSN Waiver Administration Division at, gmack@ddsn.sc.gov or fax to the attention SCDDSN Waiver Administration Division at (803) 898-2242.

Individuals' Name:		Date:	
Waiver Case Manager			
CM Provider :			

Information Required:

A. Brief Description of Emergency Situation (must include an explanation as to why the circumstances could not have been reasonably anticipated to allow for the ordinary service authorization procedures)

B. Current Services

C. Service(s) as Requested by Waiver Case Manager. (including frequency, duration, amount and provider of service(s)

1. ______
2. ______
3. ______

Waiver Case Manager: ______

CENTRAL OFFICE USE ONLY

☐ Approved ☐ Denied

Signature ______ Date ______