South Carolina Department of Behavioral Health & Developmental Disabilities
Office of Intellectual & Developmental Disabilities
Case Management Administrative Compliance & Individual Services Review
Key Indicator Review Tool for FY2026

The Key Indicators are based on OIDD Service Standards, Agency Directives, and Medicaid Policy/Requirements.

Providers must use designated modules in Therap to document service delivery.
Timelines for implementation of individual Therap Modules may be found at: https://help.therapservices.net/app/south-carolina/

Program Administration

Indicator #	Indicator	Guidance
CM-101	Case Management providers must have a system that allows access to assistance 24 hours daily, 7 days a week.	Source: Case Management Standards.
CM-102	The Provider demonstrates agency-wide usage of Therap for the maintenance of Case Management records according to the implementation schedule approved by OIDD.	Source: OIDD Therap Requirements. Review Therap documentation.

Provider Qualifications

Indicator #:	Indicator	Guidance
CM-201	Case Management Staff meet the minimum education and experience requirements to provide Medicaid Targeted Case Management and OIDD State Funded Case Management.	Refer to Case Management Standards for educational, vocational, and credentialing requirements. Applies to new employees working less than 12 months.
CM-202	Case Management Staff meet the criminal background check requirements to provide Medicaid Targeted Case Management and OIDD State Funded Case Management, prior to employment.	Source: OIDD Directive 406-04-DD. Applies to new employees working less than 12 months.
CM-203	Case Management Staff continue to meet the criminal background check requirements to provide Medicaid Targeted Case Management and OIDD State Funded Case Management, upon required recheck.	Source: OIDD Directive 406-04-DD. Recheck every 3 years.
CM-204	Case Management Staff meet the CMS "List of Excluded Individuals/ Entities" check requirements to provide Medicaid Targeted Case Management and OIDD State Funded Case Management.	Source: OIDD Directive 406-04-DD. Applies to new employees working less than 12 months.
CM-205	Case Management Staff meet the DSS Central Registry check requirements to provide Medicaid Targeted Case Management and OIDD State Funded Case Management.	Source: OIDD Directive 406-04-DD. Applies to new employees working less than 12 months.
CM-206	Case Management Staff meet the Sex Offender Registry check requirements to provide Medicaid Targeted Case Management and OIDD State Funded Case Management.	Source: OIDD Directive 406-04-DD. Applies to new employees working less than 12 months.
CM-207	Case Management Staff meet the TB Testing requirements to provide Medicaid Targeted Case Management and OIDD State Funded Case Management, prior to direct service contact.	Source: OIDD Directive 406-04-DD. Applies to new employees working less than 12 months.
CM-208	Case Management Staff meet the annual TB Screening/ Testing requirements to provide Medicaid Targeted Case Management and OIDD State Funded Case Management.	Source: OIDD Directive 603-06-DD. Annual TB Screening/Testing must be completed by the last day of the month in which it was due.
CM-209	New Case Management Staff have acceptable reference check requirements to provide Medicaid Targeted Case Management and OIDD State Funded Case Management.	Source: OIDD Directive 406-04-DD. Applies to new employees working less than 12 months.
CM-210	Waiver Case Management Staff meet the education and experience requirements for the position.	Refer to OIDD Directive 406-04-DD and WCM Standards for educational, vocational, and credentialing requirements. Applies to new employees working less than 12 months.
CM-211	Waiver Case Management Staff meet the criminal background check requirements for the position, prior to employment.	Refer to OIDD Directive 406-04-DD and WCM Standards for educational, vocational, and credentialing requirements. Applies to new employees working less than 12 months.
CM-212	Waiver Case Management Staff continue to meet the criminal background check requirements, upon required recheck.	Refer to OIDD Directive 406-04-DD and WCM Standards for educational, vocational, and credentialing requirements. A recheck is required every 3 years. Applies to new employees working more than 12 months.
CM-213	Waiver Case Management Staff meet the CMS "List of Excluded Individuals/ Entities" check requirements for the position.	Refer to OIDD Directive 406-04-DD and WCM Standards for educational, vocational, and credentialing requirements. Applies to new employees working less than 12 months.

CM-214	Waiver Case Management Staff meet the DSS Registry check requirements for the position.	Refer to OIDD Directive 406-04-DD and WCM Standards for educational, vocational, and credentialing requirements. Applies to new employees working less than 12 months.
CM-215	Waiver Case Management Staff meet the Sex Offender Registry check requirements for the position.	Refer to WCM Standards for educational, vocational, and credentialing requirements. Applies to new employees working less than 12 months.
CM-216	Waiver Case Management Staff meet the TB Testing requirements for the position, prior to direct service contact.	Source: WCM Standards and OIDD Directive 603-06-DD Applies to new employees working less than 12 months.
CM-217	Waiver Case Management Staff meet the annual TB Screening/Testing requirements.	Annual TB Screening/Testing must be completed by the last day of the month in which it was due. Source: WCM Standards and OIDD Directive 603-06-DD.
CM-218	New Waiver Case Management Staff have acceptable reference check requirements for the position.	Source: OIDD Directive 406-04-DD. Applies to new employees working less than 12 months.

Provider Training

Indicator #	Indicator	Guidance
CM-301	Case Management Staff must pass mandatory, competency-based ANE training, as required, during pre-service orientation.	Source: Case Management Standards and OIDD Directive 534-02-DD. Applies to new employees working less than 12 months.
CM-302	Case Management Staff, when employed after 1 year, must pass mandatory, competency-based ANE training within 12 months of their prior training date(s).	Source: Case Management Standards and OIDD Directive 534-02-DD. Applies to employees working more than 12 months. Training must be completed by the last day of the month in which the training was due.
CM-303	Case Management Staff are made aware of the False Claims Recovery Act annually, that the Federal government can impose a penalty for false claims, that abuse of the Medicaid Program can be reported, and that reporters are covered by Whistleblowers' laws.	Source: Contract for … Capitated Model and Source: Contract for … Non-Capitated Model. Evidence of staff being made aware of the false claims' recovery act must be provided. This activity must be completed by the last day of the month in which it was due.
CM-304	Waiver Case Managers must pass mandatory, competency-based ANE training, as required, during pre-service orientation.	Source: OIDD Directive 534-02-DD. Applies to new employees working less than 12 months.
CM-305	Waiver Case Management Staff, when employed after 12 months, must pass mandatory, competency-based ANE training within 12 months of their prior training date(s).	Source: OIDD Directive 534-02-DD. Applies to employees working more than 12 months. Training must be completed by the last day of the month in which the training was due.
CM-306	Waiver Case Management Staff have successfully completed SCDHHS WCM training prior to delivery of WCM services.	Applies to new employees working less than 12 months.
CM-307	Waiver Case Management Staff, when employed for more than 12 months, must complete the required DHHS training modules on an annual basis	Training must include the following topic areas: • Confidentiality of Personal Information (OIDD Directive 167-06-DD). • Person-centered planning. • Level of Care. • Annual Assessment and Plans of Support. Applies to employees working more than 12 months. Training must be completed by the last day of the month in which the training was due. Source: OIDD Directive 567-01-DD /WCM Standards
CM-308	Waiver Case Management Staff are made aware of the False Claims Recovery Act annually, that the Federal government can impose a penalty for false claims, that abuse of the Medicaid Program can be reported and that reporters are covered by Whistleblowers' laws.	Source: Contract for … Capitated Model and Source: Contract for … Non-Capitated Model Evidence of staff being made aware of the false claims' recovery act must be provided. This activity must be completed by the last day of the month in which it was due.

Non-Waiver Case Management

Indicator #	Indicator	Guidance
CM-401	The person's file contains approval for Case Management.	Source: Non-Waiver Case Management Standards. Review pre-certification date in CDSS.
CM-402	The person's file contains documentation that establishes the person in a target group, if receiving MTCM.	Source: Case Management Standards. Review documentation in Therap.
CM-403	An assessment of the person's needs is completed.	Source: Case Management Standards. Review documentation in Therap.
CM-404	A face-to-face contact with the person in his/her residence is made at the time of initial/annual assessment.	Source: Case Management Standards. Review documentation in Therap.
CM-405	A plan addressing the person's assessed needs is completed.	Source: Case Management Standards. Review documentation in Therap.
CM-406	The plan contains all required components.	Source: Case Management Standards. Review documentation in Therap.
CM-407	The plan is signed, titled, and dated by the Case Manager.	Source: Case Management Standards. Review documentation in Therap.

CM-408	The plan is signed by the person or his/her representative.	Source: Case Management Standards. Review documentation in Therap.
CM-409	The person must be provided a copy of the plan.	Source: Case Management Standards. Review documentation in Therap.
CM-410	Annually, people are provided information about abuse, neglect and exploitation and information about critical incidents.	Source: Case Management Standards. Review documentation in Therap. "Annually" is defined as within every 12 months and/or during the annual planning process.
CM-411	Contact (face-to-face, email or telephone) is made with the person, his/her family or representative or a provider who provides a service to the person at least every 60 days.	Source: Case Management Standards. Review documentation in Therap.
CM-412	The Case Management Assessment and Plan must be reviewed at least 180 days from the Date of the Plan.	Source: Case Management Standards. Review documentation in Therap.
CM-413	The 180 Day Plan Review must be completed in consultation with the person/his/her representative. Consultation must include a face-to-face visit in the person's natural environment.	Source: Case Management Standards. Review documentation in Therap.
CM-414	Case notes are appropriately documented and include all Case Management activity on behalf of the person and justify the need for Case Management.	Source: Case Management Standards. Review documentation in Therap.

Waiver Case Management Activities

Indicator #	Indicator	Guidance
CM-501	For newly enrolled waiver participants, the first non-face-to-face contact is completed within the month of waiver enrollment.	Source: WCM Standards Review documentation in Therap.
CM-502	For newly enrolled waiver participants, the first quarterly face-to-face visit is completed within three months of waiver enrollment.	Source: WCM Standards Review documentation in Therap.
CM-503	Each month, except during the months when required quarterly face-to-face visits are completed, a non-face-to-face contact is made with the participant or his/her representative and documented appropriately.	Source: WCM Standards Review documentation in Therap.
CM-504	At least one face-to-face contact must take place in the person's residence every six months.	Source: WCM Standards Review documentation in Therap.
CM-505	Quarterly face-to-face visits are appropriately documented.	Source: WCM Standards Review documentation in Therap.
CM-506	Participants receive two (2) waiver services every month, with the exception of the initial enrollment period (up to 60 days).	Source: WCM Standards Review documentation in Therap.
CM-507	Case notes intended to document Waiver Case Management activities are sufficient in content to support Medicaid billing and entered within 7 calendar days.	Source: WCM Standards Review documentation in Therap.

Waiver Activities

Indicator #	Indicator	Guidance
CM-601	The Plan is developed as required.	Source: Guidelines for the OIDD Planning Process, WCM Standards. Review documentation in Therap.
CM-602	Service needs outside the scope of Waiver services are identified in Plans and addressed.	Source: Waiver Manual, HCBS Regulatory Requirement. Review documentation in Therap.
CM-603	Needs in the Plan are justified by formal or informal assessment information in the record.	Source: Guidelines for the OIDD Planning Process, Waiver Manual. Review documentation in Therap.
CM-604	Assessment(s) justify the need for all Waiver services included on the plan.	Source: Waiver Manual Review documentation in Therap.
CM-605	Services/ Interventions are appropriate to meet assessed needs.	Source: Waiver Manual
CM-606	The Plan is provided to the participant/ representative within 3 months of completion.	Source: WCM Standards, HCBS Regulatory requirement. Review Case Note documentation.
CM-607	The Plan is revised when warranted by a change in the person's needs or as requested by the person.	Source: Guidelines for the OIDD Planning Process and WCM Standards, HCBS Regulatory requirement. Review documentation in Therap.
CM-608	The Plan is signed by the person or his/her representative within 3 months of completion.	Source: Waiver Case Management Standards, HCBS Regulatory requirement. Review documentation in Therap.
CM-609	The person/legal guardian (if applicable) will receive information on abuse and neglect annually.	Source: WCM Standards. Review documentation in Therap.
CM-610	For ID/RD and CS Waiver: At the time of annual planning, all children enrolled in the ID/RD and CS Waiver receiving CPCA services must have a newly completed physician's order (Physician's Information Form – MSP Form 1), and	Source: Waiver Manual Review documentation in Therap on Plan or Assessment. See MSP forms/attachments in the CPA section of the ID/RD and CS Waiver Manuals.

	assessment (OIDD Personal Care/Attendant Care Assessment). Physician's order and assessment are required annually.	
CM-611	Documentation is present verifying choice of provider was offered to the participant/family for each new Waiver service.	Source: Waiver Manual. Review documentation in Therap. Required any time a new Waiver service is authorized.
CM-612	The Freedom of Choice Form is present.	Source: Waiver Manual
CM-613	The Initial Level of Care is present.	Source: Waiver Manual Review documentation in Therap. Review the initial LOC determination to verify it was completed within 30 days prior to or on the date of Waiver enrollment.
CM-614	The most current Level of Care Determination is completed appropriately and dated within 365 days of the last Level of Care determination and is completed by the appropriate entity.	Source: Waiver Manual Review documentation in Therap.
CM-615	For HASCI: The Acknowledgement of Choice and Appeal Rights Form completed prior to Waiver enrollment and annually.	Source: Waiver Manual. If participant was a competent adult at time of Waiver initial enrollment or re-enrollment, but physically unable to sign, both the form and a Case Note should indicate why participant's signature was not obtained.
CM-616	Acknowledgement of Rights and Responsibilities is completed annually.	Source: Waiver Manual
CM-617	Waiver services are provided in accordance with the service definitions found in the Waiver document.	Source: Waiver Manual
CM-618	For ID/RD and HASCI Waiver: If Nursing Services are provided, an order from the physician is present and is consistent with the authorization form.	Source: Waiver Manual. Not required annually. Only required at the time of first authorization and as changes occur.
CM-619	Authorization forms are properly completed for services as required, prior to service provision.	Source: Waiver Manual. Review documentation in Therap for authorizations completed in Therap. Request copies of others.
CM-620	Authorized waiver services are suspended when the waiver participant is hospitalized or temporarily placed in an NF or ICF/IID.	Source: Waiver Manual. Review documentation in Therap. NOTE: Not intended for Institutional Respite cases.
CM-621	Waiver termination is properly completed.	Source: Waiver Manual
CM-622	The Participant/Legal Guardian (if applicable) was notified in writing regarding any denial, termination, reduction, or suspension of Waiver services with accompanying reconsideration/appeals information.	Source: Waiver Manual Review Case Notes documentation in Therap. Not required in the case of death.
CM-623	Information including the benefits and risks of participant/representative directed care is provided to the participant/representative prior to the authorization of Adult Attendant Care (ID/RD), Attendant Care (HASCI), Respite (ID/RD, CS, HASCI) or In-Home Supports (CS).	Source: Waiver Manual
CM-624	Before authorization of participant/representative directed Adult Attendant Care Services (ID/RD), Attendant Care (HASCI), Respite (ID/RD, CS, HASCI) or In-Home Supports (CS), the absence of cognitive deficits in the participant that would preclude the use of participant/representative directed care is assessed and documented.	Source: Waiver Manual
CM-625	Before authorization of participant/representative directed Adult Attendant Care Services (ID/RD), Attendant Care (HASCI), Respite (ID/RD, CS, HASCI) or In-Home Supports (CS), the participant/representative is provided information about hiring management and termination of workers as well as the role of the Financial Management System.	Source: Waiver Manual
CM-626	The non-availability of a Waiver service provider is documented and actively addressed.	Source: Waiver Manual Review documentation in Therap.
CM-627	For HASCI Waiver – Copies of Daily Logs for Self-Directed Attendant Care are received, and the service is monitored.	Source: HASCI Waiver Manual
CM-628	For individuals awarded a waiver slot within the review period, the waiver enrollment timeline was followed to receive the Freedom of Choice or the Waiver Declination form or to follow the Waiver Non-Signature Declination process.	Source: Waiver Manual Review documentation in Therap.
CM-629	For individuals awarded a waiver slot within the review period, the waiver enrollment timeline was followed to request the Level of Care or to follow the Waiver Non-Signature Declination process.	Source: Waiver Manual Review documentation in Therap.
CM-630	For individuals awarded a waiver slot within the review period, the waiver enrollment timeline was completed to get the individual enrolled in the waiver.	Source: Waiver Manual Review documentation in Therap.
CM-631	Waiver Case Management is provided separate from the delivery of services. Cases that enter conflict must be de-conflicted within 60 days.	Source: 535-17-DD Conflict Free Case Management Directive