

**CHAPTER**  
**12**

**MISCELLANEOUS**

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

Principles for Interaction Between P/RSPCE and Medicaid HCB Waiver Programs

ID/RD Waiver and Hospice Services

Out of State Travel for ID/RD Waiver Participants

Income Trust

Purging a ID/RD Waiver File

Emergency Service Approval

## **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.

Its goals 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 attached "Principles for Interaction Between Preventive/Rehabilitative Services for Primary Care Enhancement (P/RSPCE) and Medicaid Home and Community-Based Waiver Programs" 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](http://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 case manager (CM)/Department of Disabilities and Special Needs Waiver Case Manager. 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 WCM 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 WCM.
- The P/RSPCE provider will document all telephone or personal contacts with the WCM 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. Service Coordinators need to be aware of any liquid nutrition provided to avoid duplication of services.
- 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 WCM 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 WCM; 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 WCM) where a deinstitutionalization is imminent. This cannot duplicate the functions of the WCM.
- Waiver participant's meeting any of the above criteria may be referred for P/RSPCE by their WCM.
- These procedures will be communicated to the responsible P/RSPCE staff, CLTC staff, and DDSN staff.

## ***For Your Information:***

### **ID/RD Waiver and Hospice Services**

When an ID/RD 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). Once the Hospice Authorization/Medicaid Legacy Provider number has been obtained, The Waiver Case Manager must complete the Hospice Services Information Form located in business tools – forms and submit it to the DDSN Waiver Enrollment Coordinator. This form can be found in business tools. Business Tools > Forms > ID/RD Waiver .

The Waiver Enrollment Coordinator will be responsible for reporting this information to the Residential Provider, and the Waiver Case Manager will be responsible for reporting this information to all other waiver service providers. No ID/RD Waiver services may be authorized for participants who elect to receive Hospice services funded by State Plan Medicaid without a prior authorization number (also referred to as the Medicaid Legacy Provider Number) from the Hospice provider.

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

**Adults** (age 21 and up) enrolled in the ID/RD 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.

The ID/RD Waiver services in the left column of the table below may be routinely authorized by DDSN for **adult** participants, if appropriate. Those services in the right column may **NOT** be authorized for adult participants while receiving the Hospice benefit:

#### **ADULTS Only:**

<b>May be routinely authorized if appropriate</b>	<b>May not be authorized</b>	
Residential Habilitation	Nursing Services	
Personal Emergency Response System (PERS)	Adult Day Health Care	
Adult Dental Services	Adult Day Health Care –Nursing	
Adult Vision	Audiology Services	
Incontinence Supplies	Respite Care	
Waiver Case Management	Behavior Support Services	
*Specialized Medical Equipment, Supplies and Assistive Technology *Note: this service 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 Companion Services Attendant Care Personal Care Environmental Modifications Private Vehicle Modifications	Day Activity Career Preparation Employment Services Community Services Support Center

#### **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:***

### **Out of State Travel**

ID/RD 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:*****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 AN ID/RD 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.
- 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 should remain in the working file.
- The Freedom of Choice, Waiver Enrollment letter, Notice of Slot Allotment (ID/RD Form 5), and all Level of Care determinations remain in the working file.

## **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.



**SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS**  
***Intellectual Disability/Related Disability Waiver***  
**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 or fax to the attention SCDDSN Waiver Administration Division at (803) 898-2242.

Individuals' Name:		Date:	
Waiver Case Manager (WCM):			
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: \_\_\_\_\_

<b>CENTRAL OFFICE USE ONLY</b>	
<input type="checkbox"/> Approved <input type="checkbox"/> Denied	
Signature _____	Date _____