

CHAPTER 10  
SERVICE UNITS REPORTING AND BILLING

- 10.1 Residential Services Reporting and Billing Procedures for RESLOG  
*Applicable to: Directors of Residential Services, Facility Administrators and Administrative Staff responsible for Census Information*
- 10.2 Day Services Reporting and Billing Procedures for DSAL  
*Applicable to: Directors of Day Services, Case Managers, and Administrative Staff responsible for Day Service information*
- 10.3 Day Program Services; (Job Coach) Procedures for Individual Service Reports (ISRs)  
**\*\*\*\*\*Merged with Section 10.2 (Effective 7/1/17)\*\*\*\*\***
- 10.4 Reserved
- 10.5 Board-Billed Assistive Tech, Environmental or Private Vehicle Modifications Payment and Reporting Procedures  
*Applicable to: ID/RD & CSW Waiver Coordinators*
- 10.6 HCB Waiver Respite Care Reporting and Billing Procedures  
*Applicable to: Case Managers*
- 10.7 Supervised Living Program (SLP) I Reporting and Billing Procedures  
*Applicable to: Directors of Residential Services and SLP I Case Managers*
- 10.8 Service Notes Reporting and Billing Procedures for Case Management and Early Intervention Services  
*Applicable to: Case Managers, Early Interventionists*
- 10.9 Early Intervention; Procedures for Individual Service Reports (ISRs)  
**\*\*\*\*\*Merged with Section 10.8 (Effective 7/1/17)\*\*\*\*\***
- 10.10 HCB Waiver Caregiver Services Reporting and Billing Procedures  
*Applicable to: Waiver Coordinators*
- 10.11 Service Provision Logs (SPLs)/Individual Service Reports (ISRs) Mailing Request Procedures  
*Applicable to: Directors of Residential & Day Services, Facility Administrators, Job Coaches, Waiver Coordinators, Case Managers and Early Interventionists*
- 10.12 Service Provision Logs (SPLs)/Individual Service Reports (ISRs) Approval Signature Designation  
*Applicable to: Directors of Residential & Day Services, Facility Administrators, Job Coaches, Waiver Coordinators, Case Managers and Early Interventionists*
- 10.13 Service Error Correction Form (SECF) Procedures  
*Applicable to: Directors of Residential & Day Services, Facility Administrators, Job Coaches, Waiver Coordinators, Case Managers and Early Interventionists*
- 10.14 HASCI Waiver Board-Based Services Reporting and Billing Procedures  
*Applicable to: HASCI Waiver Coordinators*
- 10.15 HASCI Waiver Rehabilitation Supports Reporting and Billing Procedures  
*Applicable to: Provider Finance Officers and Lead Clinical Staff*
- 10.16 Financial Managers and Reporting Documents Procedures  
*Applicable to: Finance Officers and all Program Staff*
- 10.17 ~~HASCI Van Modifications and Reporting Documents Procedures~~  
**\*\*\*\*\*Merged with Section 10.14 (Effective 7/1/17)\*\*\*\*\***
- 10.18 Waiver Credit Report Procedures  
*Applicable to: Provider Finance Officers and Case Managers*

Section 10.1: Residential Services Reporting and Billing Procedures for RESLOG

Providers of Residential Habilitation services for DDSN are required to keep daily census information for each consumer served in their programs. Providers must report that census information through an automated reporting system called the Residential Logs Application or “RESLOG”. RESLOG is located on the DDSN application portal. In order to access RESLOG, users must have a valid portal ID and password. Central Office Information Technology (IT) Division assigns user IDs for the DDSN application portal. To obtain access, contact the IT Helpdesk at 803-898-9767 or [Helpdesk@ddsn.sc.gov](mailto:Helpdesk@ddsn.sc.gov).

1. Residential Service Definitions and Service Codes

A. Residential Habilitation Facilities (R02-R05)

Residential Habilitation Facilities are defined as non-institutional residential settings in which consumers receive care, skills training and supervision according to their needs. The DDSN sponsored facilities are licensed either by DDSN or DHEC. They include Community Training Homes I and II (CTHs I/II), Supervised Living Programs II (SLPs II) or Community Residential Care Facilities (CRCFs).

- SLP II (R02) – Typically an apartment setting in the community for consumers who need intermittent supervision and supports. They can perform most daily living activities independently and only need periodic advice, support and supervision. Trained staff are available either on-site or very nearby 24 hours a day.
- CRCF (R03) – A home-like environment in the community where consumers may receive supervision and a degree of personal care, according to identified needs, delivered by qualified, trained caregivers.
- CTH I (R04) – A home environment in the community for a maximum of 2 people where personalized care, supervision and individualized training are provided according to the person’s plan in the support provider’s home. Consumers are considered one of the family.
- CTH II (R05) – A home-like environment in the community that is either rented or owned by a provider which can provide a home-like environment for a maximum of 4 consumers while under the supervision of qualified and trained staff.

B. Intermediate Care Facilities (R06 & R07)

Intermediate Care Facilities are state-licensed residential facilities that offer active treatment, health or other related services directed toward helping consumers function with as much self-determination and independence as possible.

- ICF/IID (R06) – ICFs offer a community living option to consumers who need maximum support for high levels of need. Twenty-four-hour care, supervision, training, recreation and other activities are provided in a structured environment.
- Regional Centers (R07) – Regional Centers provide 24-hour care, supervision and treatment for the most fragile consumers with the greatest need for support.

For more detailed information on Residential Habilitation definitions and services, please refer to the Residential Habilitation Standards at [www.ddsn.sc.gov](http://www.ddsn.sc.gov) under the Service Provider link.

## 2. Instructions for On-Line Reporting

RESLOG instructional videos are available on the application portal under DDSN > Business Tools > Videos > Application Training > ResLog. These videos are helpful for learning tasks such as how to create, unlock, or reject a system log and how to add a consumer's name to a log.

### A. Production of Residential Logs (Roll Books)

Residential logs are created in RESLOG on the first calendar day of each month based on where Service Tracking System (STS) shows a consumer as receiving residential services. Consumer names, identifying information and service provider location are drawn from STS to generate the logs. If a log displays incorrect information, STS needs to be updated. Until STS is updated, a log will continue to generate with incorrect information. Contact should be made with the consumer's Case Manager. It is the Case Manager's responsibility to ensure that STS is updated when a consumer's service activity changes.

### B. Reporting Attendance

Attendance for every consumer in a Residential Habilitation Facility should be recorded throughout the month. Attendance must be 100% recorded for each facility in order to properly document the costs of residential service. The daily census information entered should always reflect a consumer's location as of 11:59 P.M. each night.

For new Residential Habilitation Facilities, a system log can be created in RESLOG as long as there is at least one consumer shown on STS as residing in that facility. If a new facility log does not appear on your list, click on "create log" to see a list of facilities for which a log has not been created in the current month. If the facility name is not found on this list, a blank log may be used to enter your census information. Blank logs are available on the DDSN application portal. An example of a Residential Census Log for New Residential Facilities is shown on page 10.1 p.6 of this section.

To add a consumer's name to a system log in RESLOG, click on "Add Consumer" at the bottom of the summary screen. Eligible consumer names (based on STS) will appear. If the consumer's name does not appear, contact the consumer's Case Manager to ensure that STS is current.

(1) Residential Habilitation Facilities (R02-R05)

Following are status codes used for reporting attendance in RESLOG under the category of Residential Habilitation Facilities (R02 – R05):

<b>Residential Habilitation Facilities Status Codes (R02 – R05 ONLY)</b>
P – Present
L – On Leave
R – Respite (Hourly)*
S – On a DDSN Sponsored Activity**
D – Discharged

**RESPITE (R02 – R05) \***

**There can never be Respite between like facilities.** For reporting and billing purposes, the Respite (R) status code should never be used when a consumer moves from one Residential Habilitation Facility (R02-R05) to another within the provider’s organization. Respite (R) codes are used when a consumer, who does not receive Residential Habilitation, enters an R02-R05 facility. Recording of the (R) code is for attendance purposes only.

The only form of Respite that can be provided is Hourly Respite (STS code S46), and the Individual Service Report (ISR) must reflect the number of hours and the date Hourly Respite was provided. All Respite (R) services are reported on paper logs, known as Individual Service Reports (ISRs).

**SPONSORED ACTIVITY (R02 – R05) \*\***

The (S) code is used for a consumer who is not present at 11:59 P.M. due to reasonable circumstances, such as he or she is working or away from the facility on an overnight trip.

The (S) code may be used because a consumer from one Residential Habilitation Facility (R02-R05) has temporarily moved to another Residential Habilitation Facility **within** the provider’s organization. The (S) code may be used for reporting purposes at the sending facility for up to 7 days. The receiving facility should report nothing as long as both locations are operated by the same provider. If a consumer continues to stay at the receiving facility from the 8th day on, however, an Admission/Discharge/Transfer process must be completed, as well as updating STS.

The examples cited above are not all inclusive. There may be other circumstances that support the use of the (S) code but unless a consumer is at work, in every case a provider employee must be present with the consumer in order to use the (S) code. Regardless if a situation is one-to-one or one-to-many, no consumer receiving Residential Habilitation should be left alone without proper supervision per DDSN Departmental Directive 510-01-DD: Supervision of People Receiving Services.

(2) Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)  
(R06 & R07)

Following are status codes used for reporting attendance in RESLOG under the category of Intermediate Care Facilities (R06 & R07):

<b>ICF/IID Facilities Status Codes (R06 and R07 ONLY)</b>	
P – Present	H – In Hospital (Outside)
L – On Leave	R – Respite *
T – Therapeutic Leave	D – Discharged
S – On DDSN Sponsored Activity	X – Consumer has Passed Away
A – Absent	Z – Hospice **

**RESPITE (R06 & R07) \***

**There can never be Respite between like facilities.** For ICF Facilities (R06 & R07), the only form of Respite for reporting and billing purposes is Institutional Respite (STS Code S13). All Respite (R) services are reported on paper logs, known as Individual Service Reports (ISRs). In order to use the (R) code for a consumer, first make sure that the Case Manager has entered an S13 code on STS along with a corresponding location code (R06/R07) where the service will be delivered. The (R) code cannot be used until STS has been updated with this information. If a consumer comes from a Residential Habilitation facility (R02-R05), the ICF/IID (R06/R07) should add his or her name to a log recording an (R) value, while the Residential Habilitation facility (R02-R05) records a value of (L) for “Leave” on their log for the consumer.

**HOSPICE (R06 & R07) \*\***

If a consumer begins receiving Hospice (Z) services, DDSN must begin billing the Hospice provider for room and board. The Hospice provider becomes the supplier of any services the consumer may need, except for room and board. The consumer continues to reside in their current Residential Habilitation facility (R06/R07) while receiving Hospice services.

DDSN needs certain billing information to be able to bill the Hospice provider. To obtain this information, regions/providers must complete a Hospice Services Information Sheet and mail it to your District Office. When the District Office has reviewed and signed the form, Districts are to forward the Hospice Information Sheet to **DDSN, Attn: SURB, PO Box 4706, Columbia, SC 29240.** If needed, a blank form is available on the DDSN application portal under Business Tools/Forms. An example is shown on page 10.1 p.7 of this section.

C. Submission of Residential Logs (Roll Books)

System logs must be both “Submitted” and “Approved” on RESLOG **by the 5<sup>th</sup> business day of the following month**. A “Submitter” is defined as the employee who enters attendance data during the month. The Submitter provides the Approver with the completed logs for final approval and closure.

Census information must be recorded on an ongoing basis throughout the month. At the end of the month, after all census information has been recorded, each system log must be “Submitted” for approval. Corrections may continue to be made to a log after it has been submitted all the way up until it has been “Approved.” After a system log has been approved, no changes may be made to it.

DDSN’s Residential Habilitation service providers on the Qualified Provider List (QPL) must submit an invoice to DDSN each month in order to receive reimbursement for services rendered. Invoices must include the following information: (1) consumer name(s), (2) the days served, and (3) the rates approved in the provider’s contract. All Leave days (up to the maximum allowed under the contract) are reimbursed at the base rate without outliers. Vacant days, up to a maximum of 30, are reimbursed based on the funding available for the bed at the base rate without outliers. All invoices should be mailed by the subsequent month of service delivery to **DDSN Finance Division, Attn: SURB, PO Box 4706, Columbia, SC 29240**.

For providers who prefer to upload billing documents electronically, please contact SURB to obtain access to the Reporting and Billing Center (RBC). RBC is a secure system on DDSN’s application portal for uploading confidential billing documents that go to the SURB area. **If you choose to upload documents through RBC, please do not mail the originals.**

D. On-Line History

Approved system logs are maintained on-line for inquiry purposes for eighteen (18) months. These logs may be reviewed, but information may not be changed.

3. Confidentiality of On-Line Reporting Documents

Title II of HIPAA, known as the Administrative Simplification (AS) provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA; Pub.L. 104–191), required the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans and employers. All DDSN providers are required to comply with all applicable standards, orders and regulations pursuant to HIPAA concerning the confidentiality of information shown on all reporting documents.

**SCDDSN Finance Manual**  
**Chapter 10: Service Units Reporting and Billings (SURB)**  
**Residential Services Reporting and Billing**  
**Procedures for RESLOG 10.1**

**Issue Date 7/01/17**

**Supersedes 9/01/13**

New Facility Residential Log:

Sheet1

**South Carolina Department of Disabilities and Special Needs**  
**Residential Census Log**  
**FOR NEW RESIDENTIAL FACILITIES**

Regional Center:   
 Provider:   
 Facility Name:   
 Month:

Individual's Name	Soc Sec #	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total									

Hospice Services Information Sheet:

**SOUTH CAROLINA DEPARTMENT OF DISABILITIES & SPECIAL NEEDS**

**Hospice Services Information Sheet**

**FACILITY INFORMATION**

<b>Provider Name:</b>	<b>Provider Number:</b>
-----------------------	-------------------------

**HOSPICE INFORMATION**

<b>Consumer Name:</b>	
<b>Medicaid Number:</b>	<b>Consumer SSN (Last 4 Digits):</b>
<b>Hospice Admission Date:</b>	<b>Patient ID:</b>
<b>Hospice Provider Name:</b> <b>Address:</b>	<b>Hospice Contact:</b> <b>Phone #:</b>
<b>Hospice Medicaid Provider Number:</b>	
<b>Hospice Primary Nurse (if available):</b>	
<b>Hospice Medical Director (if available):</b>	

*Example*

Form Completed By: \_\_\_\_\_

Contact Phone #/Email: \_\_\_\_\_

**District Office Only:** \_\_\_\_\_

Reviewed By: \_\_\_\_\_  
*District Office Signature*

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Forward to: *DDSN Finance Division, Attn: SURB, PO Box 4706, Columbia SC 29240*

Section 10.2: Day Services Reporting and Billing Procedures for DSAL

Providers of day services for DDSN are required to report those services through an automated system called the Day Supports Attendance Logs Reporting System or “DSAL”. DSAL is accessed through the DDSN application portal. In order to access DSAL, users must have a valid portal ID and password. Central Office Information Technology (IT) Division assigns user IDs for the application portal. Contact the IT Helpdesk at 803-898-9767 or email [Helpdesk@ddsn.sc.gov](mailto:Helpdesk@ddsn.sc.gov) to request security authorization.

1. Adult Day Services Definitions and Service Codes

- A. Career Preparation (S97): Preparing consumers for careers through exposure to and experience with various careers. Compliance, attendance, task completion, problem-solving, safety, self-determination and self-advocacy are taught to produce general results as opposed to learning specific tasks.
- B. Community Services (S86 & S98): Developing one’s awareness of, interaction with, and participation in the community through exposure and experience. Concepts such as self-determination, self-advocacy, and socialization are taught. Community Services are provided in facilities licensed by the state. On-site attendance at a licensed facility is not required to receive services that originate from that facility. There are 2 service codes associated with this service:
  - Community Services/Individual (S86): services are provided on a one-to-one basis. This service is provided under the Community Supports Waiver only.
  - Community Services/Group (S98): services are provided in a group setting. This service is provided under the Community Supports, ID/RD and HASCI Waivers.
- C. Day Activity Services (S96): Providing supports and services in therapeutic settings to enable consumers to achieve, maintain, improve or decelerate the loss of personal care, social or adaptive skills. Services are provided in non-residential settings that are licensed by the state. On-site attendance at the licensed facility is not required to receive services that originate from the facility.
- D. Support Center Service (S09): Providing non-medical care, supervision and assistance in a non-institutional group setting outside of a consumer’s home. This service is for consumers who, because of the level of his or her disability, are unable to care for themselves. Services provided are necessary to prevent institutionalization and to maintain a consumer’s health and safety. Care, supervision and assistance are provided in accordance with an individualized plan of care. An array of non-habilitative activities and opportunities for socialization are offered throughout the day, but not as therapeutic goals.

E. Employment Services (S06 & S11): Providing intensive, on-going supports for consumers for whom competitive employment is not achievable and who, because of the level of his or her disabilities, needs support to perform in a regular work setting. Employment Services may be provided in group settings or individually. There are 2 service codes associated with this service:

- Employment Services/Individual (S06): services are provided on a one-to-one basis such as a community based-individual job placement.
- Employment Services/Group (S11): services are provided in a group setting such as mobile work crews or enclaves.

For more information on Day Services, please refer to the Day Services Standards on the DDSN website ([www.ddsn.sc.gov](http://www.ddsn.sc.gov)).

## 2. Funding Sources

Program funding sources are determined by DDSN before the onset of services. After a system log has been completed and submitted electronically, one of the following funding sources will appear next to each consumer's name and category totals will appear at the bottom of the log:

- ICF/IID Community (ICF/C)
- ICF/IID Regional (ICF/R)
- Waiver (ID/RD, CSW, HASCI)
- State-Funded

## 3. Instructions for On-Line Reporting

DSAL instructional videos are available on the application portal under DDSN > Business Tools > Videos > Application Training > DSAL. These videos are helpful for learning tasks such as how to create, unlock, or reject a system log and how to add a consumer's name to a log.

### A. Production of Service Logs (Roll Books)

Day Service logs are created in DSAL on the first calendar day of each month based on where the Service Tracking System (STS) shows a consumer as receiving services. When the logs are generated, information such as consumer names, identifying information, and service provider location are drawn from STS data. If a system log shows incorrect information, STS needs to be updated. Until STS is updated, a system log will continue to print incorrect information. Contact should be made with the consumer's Case Manager to ensure that STS is updated promptly.

### B. Reporting Attendance

All program attendance must be tracked throughout the month. Reporting must be done for each consumer on each day of the month by marking under the appropriate date one of the following codes:

- P – Individual Present
- A – Individual not Present (Absent)

**Exception:** Employment Services-IND logs (Service Code S06) are reported in 1 hour units. You must enter the actual time of service instead of selecting present or absent.

**Consumers are automatically recorded as absent on weekend days only. This attendance may be overwritten if a consumer should happen to receive day services on a weekend day.**

DDSN Day Service Standards require that a consumer be present in a day service activity for a minimum of 2 – 3 hours per half day, inclusive of transportation, in order to count the time as a unit of service. Exceptions to the 2 – 3 hours rule may be made for consumers who arrive late or leave early if it is necessary for them to receive other services already identified as part of their program plan. (Examples: doctor’s appointment, therapy, etc.) At no time should a consumer be counted present if he or she receives less than 2 hours of half day service, exclusive of transportation.

If a service log did not generate for a new service location and the provider is certain that a consumer is receiving service there, a log may be created by clicking on “Create Log” from the DSAL menu. Based on STS, eligible consumer names will populate a new log. If no consumers show up on STS as receiving day services at the new service location, a log will not generate and users will see a screen message stating that a log could not be created. To be clear, the condition for creating a new log is that there must be at least one consumer on STS receiving services from the new location.

If a consumer’s name is omitted from a log, the name may be added to the current month’s log by clicking on the “Add Consumer” button at the bottom of the log summary screen. The information on STS determines who appears on the monthly logs. Therefore, information on STS must be correct in order for the logs to generate correctly.

#### C. Submission of the Logs (Roll Books)

System logs must be both “Submitted” and “Approved” on DSAL by the 5<sup>th</sup> business day of the following month. A “Submitter” is defined as the employee who enters attendance data during the month. The Submitter provides the Approver completed logs for final approval and closure.

Attendance must be recorded on an ongoing basis throughout the month. At the end of the month after all attendance for the month has been entered, system logs should be “Submitted” for approval. Corrections may be made to a log after it has been submitted up until it has been “Approved.” After approval, no changes may be made.

#### D. On-Line History

Approved roll books are maintained on-line for inquiry for eighteen (18) months. These finalized reports may be reviewed, but information may not be changed.

### 4. Reimbursement Procedures for Qualified Providers

Financial Managers receive the day service funding for their residential consumers. If a service provider on the Qualified Provider List (QPL) provides day services to a consumer with a Financial Manager, the Qualified Provider should invoice the Financial Manager by providing

a copy of the attendance log as backup documentation. If a Qualified Provider provides day services to a consumer who resides in a SLP or CTH I residential facility, the invoice for the day services should be mailed to **DDSN Finance Division, Attn: SURB, PO Box 4706, Columbia, SC 29240**.

For providers who prefer to upload billing documents electronically, please contact SURB about obtaining access to the Reporting and Billing Center (RBC). RBC is a secure system on DDSN's application portal for uploading confidential billing documents that go to the SURB area. **If you choose to upload documents through RBC, please do not mail the originals.**

#### 5. Confidentiality

Title II of HIPAA, known as the Administrative Simplification (AS) provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA; Pub.L. 104-191), required the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans and employers. All DDSN providers are required to comply with all applicable standards, orders and regulations pursuant to HIPAA concerning the confidentiality of information shown on all reporting documents.

#### 6. Special Notes

- Case Managers are responsible for updating STS to reflect the appropriate service and activity for each consumer. Directors of Day Service and Case Management must ensure updates are current to within two (2) working days of any changes.
- Day Program staff is responsible for accurately reporting attendance for each activity and the service in which the activity was provided.
- Weekends are automatically filled in as "Absent" for each consumer listed. This data may be overwritten if a consumer were to receive day services on a weekend day.
- If a consumer's name is missing from a log in DSAL, click on "Add Consumer" at the bottom of the summary screen. If STS has been updated with the service for that consumer, his or her name will appear on the next screen and may be added to the current month's log. If the correct name does not appear, contact should be made with the consumer's Case Manager to ensure that STS is updated.
- The actual hours and minutes of Employment Services-IND (S06) rendered to a consumer must be filled in on the appropriate date. A unit of service for this code is one (1) hour.
- If a consumer has been discharged, STS must be updated immediately by the consumer's Case Manager, and the Admission/Discharge/Transfer process must be completed as soon as possible.
- If it is discovered that an approved service has been delivered but was not reported and the service occurred during a prior month, a blank roll book must be used to submit the service for billing. **A Service Error Correction Form should never be used to report a previously un-reported service.** A blank Adult Day roll book may be used to report the service. A blank roll book form may be found on the DDSN application portal under Business Tools > Forms > Finance Manual Chapter 10.

---

Section 10.5: Board-Billed Assistive Tech, Environmental or Private Vehicle Modifications Payment and Reporting Procedures

Environmental/Private Vehicle Modifications are physical adaptations made to the environment of a consumer that are required by their support plan and deemed necessary to ensure the health, welfare, safety, and functioning with greater independence thereby preventing the need for institutional placement.

Assistive Technology includes devices, controls or appliances that are specified in a consumer's support plan and which would enable him or her to increase abilities needed to perform activities of daily living or to perceive, control or communicate with the environment in which they live. This service may also include consultation and assessment to determine the specific needs related to a consumer's disability for which specialized assistive technology may assist him or her to function more independently.

For more information regarding the services described above, please refer to the ID/RD and CS Waiver Manuals available on DDSN's website.

Following are instructions for requesting payment of these services under ID/RD waiver funding. Providers are required to keep on file with the paperwork that portion of a consumer's plan that explains the purpose and need for these services.

1. Payment Procedures for ID/RD Waiver Assistive Tech, Environmental or Private Vehicle Modifications

A. Approval Process

(1) Environmental or Private Vehicle Modifications

Providers should secure at least 3 bids as instructed in the DDSN ID/RD Waiver Manual. Once the bids have been received and the costs for the modification have been entered into the Waiver Tracking System, copies of all three bids along with the Waiver Acknowledgement of Lifetime Monetary Cap (Form E-1) should be forwarded to DDSN's **Cost Analysis Division**. If for any reason three bids cannot be obtained, a thorough written explanation is required before approval may be considered by Cost Analysis.

Approval status of an ID/RD modification request may be monitored on the Waiver Tracking System. After a request has been approved, Cost Analysis will forward a copy of the bid along with an internal checklist to SURB. The bid and checklist become part of a suspense file in SURB waiting to be matched with a reimbursement request from the provider.

(2) Assistive Technology

First, providers must determine if an assistive technology item is covered by State Plan Medicaid, per the ID/RD Waiver Manual. Items reimbursed with waiver funds are in addition to medical or equipment supplies furnished under State Plan Medicaid but exclude items which are not of direct medical or remedial benefit to the consumer.

In many cases, assistive technology can be provided by a vendor already enrolled with DHHS as a DME provider. (If a vendor is already enrolled as a DME provider, they may not opt to bill the DDSN Financial Manager.) For those times when a consumer's needs may best be met by a vendor that is not enrolled with DHHS, the selected vendor may contract with the Financial Manager, but only to provide medical equipment, supplies, and/or consultation.

After a vendor has been chosen who is in adherence with state procurement policies and the budget information and comments have been entered into the Waiver Tracking System and approved, the service must then be authorized by using the waiver authorization form "Authorization for Specialized Medical Equipment, Supplies, and Assistive Technology" per the ID/RD Waiver Manual. For vendors contracting with a DDSN Financial Manager, copies of this waiver authorization form should be forwarded to SURB.

#### B. Submitting Invoices

Reimbursement requests should be submitted within a reasonable time frame after payment to the contractor has been made. After a provider has paid for a modification, the provider should send a completed "ID/RD Waiver Request for Payment of Assistive Tech, Environmental or Private Vehicle Modifications" form to SURB (see example on page 10.5 p. 3). A blank request for payment form is available on the DDSN application portal under Business Tools >Forms> Finance Manual Chapter 10. Required attachments to this form are copies of the vendor's invoice, the provider's payment verification, and the waiver service authorization. Failure to submit all of this documentation will delay the reimbursement process.

All reimbursement requests received in SURB are matched and cross-checked to the suspense file. If an invoice cannot be matched with a bid and checklist, SURB will initiate contact with Cost Analysis.

If a provider incurs environmental/private vehicle modification costs without obtaining the proper approval, reimbursement requests for those costs should not be submitted to DDSN.

**Special Note for HASCI Waiver consumers:** Paid invoices and check copies should accompany the "Individual and Monthly Summary" form per Finance Manual Chapter 10, **Section 10.14: HASCI Waiver Board-Based Services Reporting and Billing Procedures.**

The form “ID/RD Waiver Request for Payment of Assistive Tech, Environmental or Private Vehicle Modifications” must contain the following information:

- The name and address of the provider responsible for overseeing the modification.
- The contact information of the employee at the provider agency overseeing the work.
- The consumer’s name and last four digits of his/her social security number.
- The type of modification.
- The cost of the modification.
- The date the work was completed.
- Copies of the invoice, waiver authorization and provider’s payment must accompany the request.

**ID/RD Waiver Request for Payment of Assistive Tech, Environmental or Private Vehicle Modifications**

Provider Agency: [REDACTED]		
Address: [REDACTED]		
City: [REDACTED]	State: [REDACTED]	Zip: [REDACTED]
Contact Person: [REDACTED]	Phone Number: [REDACTED]	

Consumer's Name: [REDACTED]	SSN # (Last 4): [REDACTED]
Type of Modification: [REDACTED]	
Cost of Modification (Amount Requested): [REDACTED]	
Date of Completion: [REDACTED]	

Please attach a copy of the following documentation:

- ▶ Vendor's invoice.
- ▶ Waiver Authorization.
- ▶ Provider's payment to the Vendor as verification.

*Failure to submit all required documentation will delay payment.*

**PROVIDER CERTIFICATION:** *The modification listed on this form has been provided to the individual named above as per the attached documentation.*

[REDACTED]	[REDACTED]	[REDACTED]
Signature	Title	Date

<b>For SURB Use</b> <i>The appropriate documentation has been received for this environmental modification. This invoice may be released for payment.</i>		<b>For Accounts Payable Use</b> <i>The Accounts Payable audit is complete.</i>	
Initials:	Date:	Initials:	Date:

The request for payment form must be signed and dated by the contact person at the provider responsible for overseeing the modification process. Copies of the paid invoice, the provider’s check, and the waiver service authorization must be attached. The invoice copy should have a clear, handwritten note on it stating that the invoice has been paid and for what consumer the work was done. The form and its attachments should be mailed to: **DDSN, ATTN: SURB, P.O. Box 4706, Columbia, SC 29240.**

If providers prefer to upload these documents electronically, please contact SURB about obtaining access to the Reporting and Billing Center (RBC). RBC is a secure system on DDSN’s portal for uploading confidential documents intended for SURB. **If you choose to upload documents through RBC, please do not mail the originals.**

Following are instructions for reporting modifications provided under CS waiver funding. Providers are required to keep on file with the paperwork that portion of a consumer’s plan that explains the purpose and need for these services.

2. Reporting Procedures for Community Supports Waiver (CSW) Assistive Tech, Environmental or Private Vehicle Modifications

A. Approval Process

Providers should secure bids according to the procedures in the DDSN Community Supports Waiver Manual. Once the bids have been received, the costs for the modification should be entered into the Waiver Tracking System.

B. Service Reporting Requirements

After the completion of a modification for a consumer with Community Supports Waiver funding, the provider should forward to SURB a completed “Community Supports Waiver Service Documentation for Assistive Tech, Environmental or Private Vehicle Modification” form (see example) along with a copy of the vendor’s invoice, the check submitted to the vendor, and the appropriate waiver authorization so that Medicaid can be billed for the service. A blank form is available on the DDSN application portal under Business Tools >Forms >Finance Manual Chapter 10. Providers should either mail the form and its attachments to: **DDSN, Attn: SURB, PO Box 4706, Columbia SC 29240** or upload the documents in a PDF format to the Reporting and Billing Center (RBC) on the application portal.

**Community Supports Waiver – Service Documentation**  
Environmental Modifications/Assistive Technology/Private Vehicle Modifications  
for Services billed to the DSN Board

Provider Agency: [REDACTED]		
Address: [REDACTED]		
City: [REDACTED]	State: [REDACTED]	Zip: [REDACTED]
Contact Person: [REDACTED]	Phone Number: [REDACTED]	
Consumer's Name: [REDACTED]	SSN # (Last 4): [REDACTED]	
Modification Type & Description: [REDACTED]		
Cost: \$ [REDACTED]	Date of Completion: [REDACTED]	

**PROVIDER CERTIFICATION:** *The item listed on this form has been provided to the consumer named above as per the attached documentation.*

Signature	Title	Date
-----------	-------	------

Please attach a copy of the following documentation:

1. Vendor's Invoice AFTER work is completed.
2. Check submitted to Contractor.
3. Completed Authorization for Service form.

***This form and the documentation listed above MUST be submitted to SURB either through the RBC System or by U.S. Mail at SCDDSN Attn: SURB, PO Box 4706, Columbia, SC 29240***

<b>FOR DDSN/SURB USE ONLY</b>	
<i>This service has been billed to Medicaid.</i>	
Signature:	Date:

3. Confidentiality

Title II of HIPAA, known as the Administrative Simplification (AS) provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA; Pub.L. 104–191), required the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans and employers. All DDSN providers are required to comply with all applicable standards, orders and regulations pursuant to HIPAA concerning the confidentiality of information shown on all reporting documents.

Section 10.6: HCB Waiver Respite Care Reporting and Billing Procedures

Respite services are personal care and assistance provided to consumers unable to care for themselves, and they are furnished on a short-term basis because of the absence of or need for relief by those who normally provide care. For more programmatic information, see DDSN's ID/RD and CSW Waiver Manuals located on DDSN's website ([www.ddsn.sc.gov](http://www.ddsn.sc.gov)).

The Statewide Respite Program reporting and billing processes were initiated in March 2015. For participating providers, Fiscal Agents *Jasper County DSN Board* and the *Charles Lea Center* are responsible for reporting hourly respite services to DDSN on behalf of providers. After a consumer transitions to statewide respite, a monthly provision log will no longer print for them because STS has been updated to reflect the change to statewide respite. Reporting hourly respite services will now be done via timesheets prepared by the caregiver and forwarded to the designated Fiscal Agent.

1. Procedures for Reporting and Billing of Respite ServicesA. Production of Individual Service Reports (ISRs)

Each month, Respite ISRs are generated from Service Tracking System (STS) data and printed according to case manager numbers. At the time of printing, if a consumer is shown on STS as being eligible to receive Institutional Respite (S13) or Hourly Respite (S46), an ISR will print. If no ISR generates for a consumer that you need to report services on, a blank ISR may be used. Blank ISRs are provided at the end of each print job.

ISRs for the next month's services are mailed out around the 25<sup>th</sup> of the month. To ensure the appropriate provider staff receives these ISRs, please complete a DDSN SPL/ISR Mailing Request Form (see Section 10.11: SPL/ISR Mailing Request Form Instructions) and forward it to DDSN Finance Division, Attn: SURB, PO Box 4706, Columbia, SC 29240. The SPL/ISR Mailing Request form is available on the DDSN application portal.

B. Instructions for Completing Individual Service Reports (ISRs)

ISRs are divided into two parts. The left side is used for Non-Facility Based (Daily and Hourly) Respite, and the right side is used for Facility Based (Institutional) Respite (see example on page 10.6 p.3 of this section).

Record respite services under the appropriate section as follows:

- (1) Non-Facility Based – Hourly (S46): Respite was provided in a consumer's place of residence, foster home or private facility approved by the state (other than an ICF/IID).

For Hourly Respite, case managers should enter the date respite was provided first, followed by the beginning time and ending time of the service. If respite crosses from one calendar day to the next, record each day separately with the first day ending at 11:59 P.M. and the next day beginning at 12:00 A.M.

Example: Respite beginning at 7:00 PM on March 2<sup>nd</sup> and ending at 9:00 AM on March 4<sup>th</sup> would be recorded as follows:

3/02/XX	7:00 PM to 11:59 PM
3/03/XX	12:00 AM to 11:59 PM
3/04/XX	12:00 AM to 9:00 AM

- (2) Facility Based – Institutional (S13): Respite was provided on a daily basis in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or in a DDSN Regional Center. The unit of service is one day when the consumer is present at midnight.

It is possible for a consumer to receive both non-facility-based and facility-based respite in one month. This type of service situation may be recorded on the same ISR, but make sure to complete the appropriate section as it applies.

If no respite service was provided during the month for a consumer, write “no service” in the comment section of the ISR. If a consumer is added during the month, a blank ISR should be used for recording respite services in the appropriate category and his or her name should be added to the Summary Report. Ensure that the Service Tracking System is updated to show eligibility for the service before adding.

Case managers should complete and sign each ISR. Case manager supervisors should complete and sign the Provider Summary Report that comes with the ISRs each month (see example on page 10.6 p.3 of this section). Under the “Service Rendered” column, write “yes” or “no” for services rendered.

#### C. Submission of the ISRs

At the end of each month, the case manager supervisor should forward the Summary Report and all supporting ISRs to their executive director for approval. The executive director, or his/her designee, should sign the Provider Summary Report certifying that the reported activities are accurate. (Please make sure that your organization has submitted a signature designation form to DDSN if another staff person is authorized to sign in place of the executive director. Refer to DDSN Finance Manual Chapter 10, Section 10.12: SPL/ISR Approval Signature Designation Form Instructions.

The original completed ISRs and signed Summary Report(s) should be mailed to **DDSN Finance Division, ATTN: SURB, Post Office Box 4706, Columbia, South Carolina 29240**. Mailings must be post marked by the 5th working day of the subsequent month.

For providers who prefer to upload these documents electronically, please contact SURB about obtaining access to the Reporting and Billing Center (RBC). RBC is a secure system on DDSN’s application portal for uploading confidential billing documents that go to the SURB area. Uploads should be done by the end of the 5<sup>th</sup> working day of the subsequent month. If you choose to upload documents through RBC, please do not mail the originals.



---

Section 10.7: Supervised Living Program I (SLP I) Reporting and Billing Procedures

Providers of SLP I services are required to complete and submit an Individual Service Report (ISR) monthly for each consumer they serve. For these billing purposes, there is no difference between waiver and non-waiver recipients.

1. Procedures for Reporting and Billing

A. Production of Individual Service Reports (ISRs)

SLP I Individual Service Reports (ISRs) are generated monthly from Service Tracking System (STS) data and printed by Financial Manager number. At the time of printing, if a consumer is shown on STS as having a residential service code of R01, an ISR will print. (See ISR example on page 10.7 p.3 of this section.)

ISRs for the next month's services are mailed out on or around the 25th. To ensure the correct staff receives them, please complete an SPL/ISR Mailing Request Form (see Section 10.11: SPL/ISR Mailing Request Form Instructions). Forward the Mailing Request form to **DDSN Finance Division, Attn: SURB, PO Box 4706, Columbia, SC 29240**.

B. Instructions for Completing Individual Service Reports (ISRs)

The date, hours and minutes of service rendered by the SLP I Coordinator for a consumer must be documented on an ISR.

ISRs must be completed during the month of service and submitted to DDSN **by the 5<sup>th</sup> working day of the subsequent month**. The appropriate supporting documentation must be placed in each consumer's record to support the service rendered. If no service is rendered during the month, write "no service" in the comment section of the space provided on the ISR. If a new consumer enters an SLP I during the month, a blank ISR may be used to record the consumer's information. The consumer should also be added to the Provider Summary Report.

A follow-up with the consumer's Case Manager should be initiated when an activity changes (such as starts or stops) to ensure that STS is updated quickly. After totaling the hours of service on each consumer's ISR, transfer each individual's information to the Provider Summary Report (see example on page 10.7 p.3 of this section). SLP I Coordinators must sign the ISRs certifying that services were rendered, and the Executive Director or his/her designee must sign the Provider Summary Report.

C. Submission of Individual Service Reports (ISRs)

At the end of each month, the SLP I coordinator should forward the Provider Summary Report and all supporting ISRs to their Executive Director (or designee) for approval. The signature certifies the reported activities are accurate. Providers should ensure that a Signature Designation form has been submitted to DDSN if another staff person is authorized to sign the ISRs in place of the Executive Director. (See Section 10.12: SPL/ISR Approval Signature Designation Form Instructions.)

Mail the original completed Individual Service Reports and signed Summary Reports to **DDSN Finance Division, ATTN: SURB, Post Office Box 4706, Columbia, South Carolina 29240. Mailings must be post marked by the 5th working day of the subsequent month.** If a provider prefers to upload these documents electronically, please contact SURB about obtaining access to the Reporting and Billing Center (RBC). RBC is a secure system on DDSN's portal for uploading confidential billing documents that go to the SURB area. **If you choose to upload these documents to RBC, please do not mail the originals.**

2. Confidentiality of Reporting Documents

Title II of HIPAA, known as the Administrative Simplification (AS) provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA; Pub.L. 104-191), required the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans and employers.

All DDSN providers are required to comply with all applicable standards, orders and regulations pursuant to HIPAA concerning the confidentiality of information shown on all on-line reporting documents.



**Chapter 10: Service Units Reporting and Billings (SURB)****Service Notes Reporting and Billing Procedures for Case Management and Early Intervention Services 10.8** **Supersedes 9/01/13**Section 10.8: Service Notes Reporting and Billing Procedures for Case Management and Early Intervention Services

Unless under a funding band contract with DDSN, providers of Service Coordination and Early Intervention are required to document such activity provided to DDSN consumers through an automated system called “Service Notes.” Service Notes is a module of the Consumer Data Support System (CDSS) located on the DDSN application portal. In order to access Service Notes, users must have a valid portal ID and password with the appropriate security levels. Central Office Information Technology (IT) Division assigns user IDs for the application portal as well as secure pin numbers for use with Service Notes. For questions concerning access, contact the IT Helpdesk at 803-898-9767 or Helpdesk@ddsn.sc.gov.

**1. Procedures for Service Note Entries**

User credentials, along with an assigned secure pin number, serve as a unique electronic signature for Service Note entries. Entries must be completed within the timeframe stated in the DDSN Program Standards or it must be marked as a “late entry”. After an entry has been completed and submitted electronically, no option changes may be made to that entry. Only minor changes to text in the body of the entry may be made up until the end of the 5<sup>th</sup> business day of the subsequent month. Instructional videos for working in Service Notes are available on the application portal under Business Tools > Videos > Application Training > Service Notes. These are helpful for learning how to enter, complete or edit Service Notes.

**2. Production of Invoices**

On the evening of the 5<sup>th</sup> business day of the month, invoices are generated from data pulled from the Service Notes System. The following morning, invoices may be accessed and printed using R2D2 (the Actuate Reporting System) on the DDSN Portal.

**3. Submission of Invoices**

Once invoices have been verified and signed by the Executive Director or his/her designee, they should be mailed to **DDSN Finance Division, Attn: SURB, PO Box 4706, Columbia SC 29240**. If a provider prefers to upload these invoices electronically, please contact SURB about obtaining access to the Reporting and Billing Center (RBC). RBC is a secure system on DDSN’s portal for uploading confidential billings documents that go to the SURB area. **If you choose to upload these documents through RBC, please do not mail the originals.**

**4. Confidentiality of Reporting Documents**

Title II of HIPAA, known as the Administrative Simplification (AS) provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA; Pub.L. 104–191), required the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans and employers. All DDSN providers are required to comply with all applicable standards, orders and regulations pursuant to HIPAA concerning the confidentiality of information shown on all on-line reporting documents.

Section 10.10: HCB Waiver Caregiver Services Reporting and Billing Procedures

Caregiver services are supports provided for adults age 21 or older that are non-medical and generally address achievement of therapeutic goals or specific independent living activities as stated in a consumer's plan.

Caregiver services are billed under one of three service categories: Companion, Personal Care I or Personal Care II.

1. Definitions

A. Companion Services (This service is typically billed by DDSN)

Companion services are described as non-medical care, supervision and socialization provided to an adult (age 21 or older). Companions may assist or supervise with tasks such as meal preparation, laundry or shopping but they don't perform these activities as a separate service. Companion services are provided in accordance with stated therapeutic goals or activities recorded in a consumer's plan.

Companion services are limited to a maximum of 28 hours per week. A unit of service is 1 hour. When Companion services are authorized in conjunction with Adult Attendant Care and/or Personal Care II, the combined total hours per week of services may not exceed 28. Unused units from one week cannot be banked (held in reserve) for use later on.

**Please note:** Consumers receiving Residential Habilitation may not receive Companion services through the IR/RD Waiver.

B. Personal Care Services (This service is typically direct-billed by an enrolled Medicaid Provider)

Personal care services are described as active, hands-on assistance in the performance of daily living activities as defined in a consumer's plan. This may include assistance with eating, bathing, dressing, toileting, transferring, maintaining continence, and ambulation. It may also include assistance with home safety, communication, medication monitoring, light housework, laundry and shopping.

Personal care authorizations are given on two levels depending on the level of care needed. Following are definitions for Personal Care 1 and Personal Care 2 services:

1) Personal Care I (Direct-Billed)

Services are generally limited to home support activities such as assistance with meal preparation and household care.

Personal Care I is limited to a maximum of 6 hours (24 units) per week. A unit of service is 15 minutes.

2) Personal Care II (Direct-Billed)

Services are provided at a higher level based on assessed need and may include assistance with instrumental activities of daily living such as light housework, laundry, meal preparation and shopping.

Personal Care II is limited to maximum of 28 hours (112 units) per week. A unit of service is 15 minutes. When Personal Care II is authorized in conjunction with Adult Companion or Attendant Care Services, the combined total hours per week may not exceed 28. Unused units may not be banked (held in reserve) for use later on.

For more information on the above mentioned services, please see DDSN's ID/RD and CSW Waiver Manuals located on the DDSN website [www.ddsn.sc.gov](http://www.ddsn.sc.gov) under the Service Providers area.

2. Procedures for Reporting and Billing of Companion Services

A. Production of Individual Service Reports (ISRs)

Caregiver ISRs are generated monthly from Service Tracking System (STS) data and printed by Financial Manager number. At the time of printing, if a consumer is shown on STS as being eligible to receive Companion services (support service S29 or S67), a Caregiver ISR will print. If no ISR generates for a consumer that you need to have reported, a blank ISR may be used. Blank ISRs are provided at the end of each print job.

ISRs for the next month's services are mailed out on or around the 25<sup>th</sup> of the month. To ensure the appropriate staff receives these ISRs, please complete a DDSN SPL/ISR Mailing Request Form (see Section 10.11: SPL/ISR Mailing Request Form Instructions) and forward it to **DDSN Finance Division, Attn: SURB, PO Box 4706, Columbia, SC 29240**. The SPL/ISR Mailing Request form is available on the DDSN application portal.

B. Instructions for Completing Caregiver Individual Service Reports (ISRs)

The date, hours and minutes of service rendered by a caregiver for a consumer must be documented on an ISR. Caregiver ISRs contain two columns of rows. Each row represents a single day of the month. The cumulative amount of time that Companion services were provided to a consumer per day should be written next to the date field (see example on page 10.10 p.3 of this section.) Each completed ISR should be signed by the case manager.

ISRs should only contain services rendered during the current billing month. If no Caregiver services were provided in the current billing month, write "no service" in the comment section of the space provided on the ISR. If a new consumer enters the system during the month, a blank ISR may be used to record the consumer's information. The consumer's name should be added to the Provider Summary Report, and a follow-up with the consumer's Case Manager should be initiated when activity starts or stops to ensure that STS is updated quickly.

After totaling the hours of service on each consumer's ISR, transfer this information to the Provider Summary Report (see example on page 10.10 p.4 of this section). Under the "Services Rendered" column, write "yes" for services rendered.

**C. Submission of the ISRs**

At the end of each month, the Case Manager Supervisor or designee should sign the Caregiver Services Summary Report certifying that the reported activities are accurate.

All original completed Individual Service Reports and all signed Summary Reports should be mailed to **DDSN Finance Division, ATTN: SURB, Post Office Box 4706, Columbia, South Carolina 29240**. **Mailings must be post-marked by the 5th of the following month**. If a provider prefers to upload these documents electronically, please contact SURB about obtaining access to the Reporting and Billing Center (RBC). RBC is a secure system on DDSN's portal for uploading confidential billing documents that go to the SURB area. **If you choose to upload documents through RBC, please do not mail the originals**.

**2. Confidentiality of Reporting Documents**

Title II of HIPAA, known as the Administrative Simplification (AS) provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA; Pub.L. 104–191), required the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans and employers.

All DDSN providers are required to comply with all applicable standards, orders and regulations pursuant to HIPAA concerning the confidentiality of information shown on all on-line reporting documents.

**SCDDSN Finance Manual**  
**Chapter 10: Service Units Reporting and Billings (SURB)**  
**HCB Waiver Caregiver Services Reporting & Billing**  
**Procedures 10.10**

**Issue Date 7/01/17**

**Supersedes 9/01/13**

Caregiver Services ISR and Summary Report Examples:

CAREGIV SOUTH CAROLINA DEPARTMENT OF DISABILITIES & SPECIAL NEEDS PAGE: 1

CAREGIVER SERVICES  
INDIVIDUAL SERVICE REPORT  
COMPANION SERVICES - REGULAR  
FOR MONTH/YEAR

FINANC MGR REGION: MIDLANDS INDIVIDUAL: Last Name, First Name  
FINANC MGR PROVIDER: ID NUMBER: XXX-XX-XXXX  
260 FAIRFIELD DSN BD MEDICAID#: 1234567890  
PAID NUMBER: 123456  
SERVICE COORDINATOR'S NAME: 1234 - First Name, Last Name  
SERVICE COORDINATOR'S SIGNATURE: *Signature*

TYPE OF SERVICE: COMPANION SERVICES (S67)  
EACH SERVICE REPORTED MUST BE DOCUMENTED IN INDIVIDUAL'S FILE

DATE OF SERVICE	TIME HRS : MINS	DDSN USE	DATE OF SERVICE	TIME HRS : MINS	DDSN USE
7/1/13	5 : 00	5	/ /	:	
7/2/13	5 : 00	5	/ /	:	
7/3/13	5 : 00	5	/ /	:	
7/8/13	5 : 00	5	/ /	:	
7/9/13	5 : 00	5	/ /	:	
7/10/13	5 : 00	5	/ /	:	
7/15/13	5 : 00	5	/ /	:	
7/16/13	5 : 00	5	/ /	:	
7/17/13	5 : 00	5	/ /	:	
7/22/13	5 : 00	5	/ /	:	
7/23/13	5 : 00	5	/ /	:	
7/24/13	5 : 00	5	/ /	:	
/ /	:		/ /	:	
/ /	:		/ /	:	
/ /	:		/ /	:	
TOTAL :					

COMMENTS: \_\_\_\_\_

ATTN: COMMENTS ARE REQUIRED IF NO ACTIVITY IS RENDERED

SOUTH CAROLINA DEPARTMENT OF DISABILITIES & SPECIAL NEEDS

CAREGIVER SERVICES  
SUMMARY REPORT  
FOR MONTH/YEAR

FINANC MGR REGION: MIDLANDS  
FINANC MGR PROVIDER:  
260 FAIRFIELD DSN BD  
SERVICE COORDINATOR: 1234 - First Name, Last Name

ISR PAGE#	INDIVIDUAL NAME	PAID#	SERVICES RENDERED (YES/NO)	ISR RECEIVED (DDSN USE)
01	Last Name, First Name	123456	yes	
02				
03				
04				
05				

I CERTIFY THAT SERVICES AS REPORTED PER INDIVIDUAL SERVICE REPORT HAVE BEEN RENDERED AND ARE PROPERLY DOCUMENTED IN THE INDIVIDUAL'S FILE.  
DESIGNATED AUTHORIZED SIGNATURE: *Signature*

====> PLEASE MAIL THIS REPORT TO:  
SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS  
FINANCE DIVISION  
P. O. BOX 4706  
COLUMBIA, SOUTH CAROLINA 29240  
ATTN: SURB

Section 10.11: Service Provision Logs (SPLs)/Individual Service Reports (ISRs) Mailing Request Procedures

An SPL/ISR Mailing Request form should be used to notify SURB the names of staff who should receive printed SPLs or ISRs by mail. This form is available on the DDSN application portal.

Complete the top portion with your provider name and the date of request. Complete the rest of the form as follows:

**First Column:**

Write the type of log you are to receive and the program/facility name.  
 For example, Service Provision Logs, Evergreen, CTH I.

**Second Column:**

Write the name and mailing address of the staff person who should receive the documents.

**Third Column:**

Write the name of the Program Director on the first line.  
 If a provider does not have a Program Director, the request must be made by the Executive Director.  
 Write the requester's title on the second line.  
 A signature is required on the third line.

This one sheet may be used for up to four separate requests. Mail the completed form to **DDSN Attn: SURB, PO Box 4706, Columbia, SC 29240**. If a provider prefers to upload this document electronically, please contact SURB about obtaining access to the Reporting and Billing Center (RBC). RBC is a secure system on DDSN's application portal for uploading confidential billing documents that go to the SURB area. **If you choose to upload documents through RBC, please do not mail the original(s).**

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS  
 Service Units Reporting and Billing (SURB)  
**SPL/ISR MAILING REQUEST FORM**

Provider:  Date of Request:

Document Type, Program/Facility	Name/Address of SPL/ISR Recipient	Requested By: Your Name, Title & Signature
1)		
2)		
3)		
4)		

Mail completed form to: SC Department of Disabilities and Special Needs  
 ATTN: SURB  
 P. O. Box 4706  
 Columbia, SC 29240

SCDDSN USE ONLY  
 Address the request

---

Section 10.12: Service Provision Logs (SPLs)/Individual Service Reports (ISRs) Approval Signature Designation

1. Signature Rules for Service Reporting Documents

A. Executive Directors

Provider executive directors already have the authority to sign service reporting documents. They also have the option of selecting specific employees to assign signature authority for specific service reporting documents. These staff should have at a minimum the same authority as a supervisor and they should be familiar with the service reporting documents and their purpose.

B. Designated Employees

Provider executive directors may choose an employee from each program area to sign the service reporting documents for their specific program area only. For example, the Director and/or Assistant Director of a residential program could be given the authority to sign the reporting documents for their residence only. These employees must be in a position of supervision over the preparation of the reporting documents.

2. Completion of the Signature Designation Form

The SPL/ISR Approval Signature Designation Form should be used to notify Central Office that signature authority has been assigned to another staff member to sign billing documents in the absence of the Executive Director. The form is available on the DDSN application portal.

Complete the top portion with your provider name and the date of request. Complete the rest of the form as follows:

First Column:

Write the type of log you receive, the program name and facility name.  
For example, Service Provision Logs, Evergreen, CTH I

Second Column:

On the first line, write the name of the employee receiving signature authority. Print that employee's title on the second line. The third line is for that employee's signature.

Third Column:

Write the name of the executive director on the first line.  
Write the title on the second line.  
The signature of the executive director is required on the third line.

Up to three separate requests may be made on one page. If more space is needed, use a copy of this form. Mail the completed form(s) to **DDSN Finance Division, Attn: SURB, PO Box 4706, Columbia, SC 29240**. If providers prefer to upload this document electronically, please contact SURB about obtaining access to the Reporting and Billing Center (RBC). RBC is a secure system on DDSN's application portal for uploading confidential billing documents that go to the SURB area. If you choose to upload documents through RBC, please do not mail the original(s).

SOUTH CAROLINA DEPARTMENT OF DISABILITIES  
& SPECIAL NEEDS

*Service Units Reporting and Billing (SURB)*

**SPL/ISR APPROVAL SIGNATURE  
DESIGNATION FORM**

Provider: <input type="text"/>		Date of Request: <input type="text"/>
DOCUMENT TYPE PROGRAM/FACILITY	AUTHORIZED SIGNATURE (Name, Title, Signature)	REQUESTED BY (Your Name, Title, Signature)
1.		
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>		
2.		
<input type="text"/>	<i>Example</i>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>		
3.		
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>		

Mail completed form to: **SC Department of Disabilities and Special Needs  
ATTN: SURB  
P. O. Box 4706,  
Columbia, SC 29240**

Section 10.13: Service Error Correction Form (SECF) Procedures

Occasionally, an error in reporting services will occur. These errors may be found during reviews done by supervisors, district staff, central office staff, or provider staff responsible for reporting services. **If a service was rendered but not reported, do not use a Service Error Correction Form to report the service.** In this case, the service should be reported as normal using the current applicable reporting method. In some cases this will mean manually creating a reporting document. Most reporting forms are available on the DDSN application portal under Business Tools >Forms >Finance Manual Chapter 10.

Following are some examples of circumstances which would require an SECF:

- The consumer's plan was out of date.
- The Level of Care (LOC) was out of date.
- The service was not documented in the consumer's plan.
- No VR letter was available for supported employment.
- There was no medical necessity for Rehab Supports.
- The service was provided but it was an inappropriate service and should not have been reported.
- The reported service was not delivered.
- The reported service was fraudulent.

If it is found that a rendered service was erroneously reported, a correction should be requested using a Service Error Correction Form (SECF). You may only enter one consumer and one service per form. (For examples of completed Service Error Correction Forms, please see pages 10.13 p.3 - 10.13 p.6.) For audit purposes make a copy of each SECF to place in the appropriate consumer's record and attach a copy to the original reporting document.

1. SECF Instructions

- a) Pull the original reporting document to verify the correct document, names and numbers.
- b) Enter the document code for the reporting document that is to be corrected using the codes supplied in the first section of the form. For example, if a Respite ISR needs correction, enter the code "REISR" on the line provided.
- c) Enter the provider name and provider number in the spaces provided.
- d) Enter the name of the staff person who originally reported the service and their case load number, when applicable.
- e) Enter the name and **last four digits** of the consumer's social security number for whom services were reported in error, followed by the consumer's Medicaid number.

Reminder: Enter one name and one service per form.

- f) Enter the date(s) of service for the document code entered at the top of the form. Extra spaces are provided on page 2, if needed.

g) Enter the reason code using the codes printed at the bottom left side of the form.

**Note: For reason code “9” a full explanation of the error is required.**

h) Enter the found-by code using the codes printed at the bottom right side of the form.

i) Enter the date the form was completed.

j) Obtain the signature of either the executive director or his/her designated employee who has been given signature authority. (See Section 10.12: SPL/ISR Approval Signature Designation.)

2. Submission of the SECF

Completed Service Error Correction Forms should be mailed to: **DDSN, ATTN: SURB, Post Office Box 4706, Columbia, South Carolina 29240**. Errors reported to Central Office will be reviewed to determine if refund of a Medicaid payment is needed. If a refund is necessary, SURB will coordinate the refund with DHHS.

For providers who prefer to upload billing related documents electronically, please contact SURB about obtaining access to the Reporting and Billing Center (RBC). RBC is a secure system on DDSN’s application portal for uploading confidential billing documents that go to SURB. **If you choose to upload documents through RBC, please do not mail the originals.**

Early Intervention SECF Example

*SC Department of Disabilities & Special Needs  
 Post Office Box 4706  
 Columbia, South Carolina 29240*

**SERVICE ERROR CORRECTION FORM**

This form should be used to correct services reported in error. If services were rendered but not reported, they should be reported by recording the service and the associated date on the current reporting documents (ISR, SPL, etc.). If a correction is needed other than reporting additional services, send the correction in writing to the attention of SURB Division, DDSN Central Office Finance.

**\*\*\*ONE CONSUMER AND ONE SERVICE PER SECF\*\*\***

ENTER THE CODE OF THE DOCUMENT TO BE CORRECTED: EIISR

Case Management SPL's [SCSPL]	Residential [RESID]
Early Intervention ISR's [EIISR]	SLPI [SLPII, CTHI, CTHII or CRCF]
Day Program (Adult) [AROLL]	Day Program (Child) [CROLL]
Respite ISR's [REISR]	Rehabilitation [REHAB]
Job Coach ISR's [JCISR]	Caregiver Services [CRGVR]
HASCI [HASCI]	

PROVIDER NAME: LOWCOUNTRY DSN PROVIDER NUMBER: XXX  
 RESPONSIBLE STAFF INITIALLY MARY  
 REPORTING SERVICE: COORDINATOR CASE LOAD NUMBER: XXXX

CONSUMER'S NAME: MARY CONSUMER CONSUMER'S SSN: XXX-XX-XXXX  
 CONSUMER'S MEDICAID NUMBER (IF KNOWN): XXXXXXXXXX

**THE FOLLOWING SERVICES WERE REPORTED IN ERROR:**  
*(Use page 2 to record more dates of service)*

DATE OF SERVICE	REASON CODE	FOUND BY CODE	DATE OF SERVICE	REASON CODE	FOUND BY CODE
12/31/05	9	1	01/15/06	3	1
/ /			/ /		
/ /			/ /		
/ /			/ /		

**Reason Codes:**

1. Plan out of date
2. Level of Care (LOC) out of date
3. Service not documented in plan
4. No VR letter available for supported employment
5. No medical necessity statement for Rehab Supports
6. Service was provided but was inappropriate and should not have been reported
7. No service was delivered
8. A service was indicated through fraud
9. Other (explain below: wrong service, over-reported, wrong date, etc.)

**Found By Codes:**

1. Responsible staff person who initially completed the original report
2. Supervisor Review
3. District/Central Office Review

SC REPORTED AS 1HR 15MINS S/B SC 1HR

NOTE: WHEN REPORTING NO SERVICE RENDERED NOTE WHICH SERVICE

OR ALL SERVICES RENDERED ON DATE *(If more room is needed, please use comments section on page 2.)*

10/31/06  
DATE

Suzy Smith  
SUPERVISOR SIGNATURE

Case Management SECF Example:

*SC Department of Disabilities & Special Needs  
 Post Office Box 4706  
 Columbia, South Carolina 29240*

**SERVICE ERROR CORRECTION FORM**

This form should be used to correct services reported in error. If services were rendered but not reported, they should be reported by recording the service and the associated date on the current reporting documents (ISR, SPL, etc.). If a correction is needed other than reporting additional services, send the correction in writing to the attention of SURB Division, DDSN Central Office Finance.

**\*\*\*ONE CONSUMER AND ONE SERVICE PER SECF\*\*\***

ENTER THE CODE OF THE DOCUMENT TO BE CORRECTED: SCSPL

Case Management SPL's	[SCSPL]	Residential	[RESID]
Early Intervention ISR's	[EISR]	SLPI	[SLPI, CTHI, CTHII or CRCF]
Day Program (Adult)	[AROLL]	Day Program (Child)	[CROLL]
Respite ISR's	[REISR]	Rehabilitation	[REHAB]
Job Coach ISR's	[JCISR]	Caregiver Services	[CRGVR]
HASCI	[HASCI]		

PROVIDER NAME: LOWCOUNTRY DSN PROVIDER NUMBER: XXX  
 RESPONSIBLE STAFF INITIALLY MARY  
 REPORTING SERVICE: COORDINATOR CASE LOAD NUMBER: XXXX

CONSUMER'S NAME: MARY CONSUMER CONSUMER'S SSN: XXX-XX-XXXX  
 CONSUMER'S MEDICAID NUMBER (IF KNOWN): XXXXXXXXXX

**THE FOLLOWING SERVICES WERE REPORTED IN ERROR:**  
*(Use page 2 to record more dates of service)*

DATE OF SERVICE	REASON CODE	FOUND BY CODE	DATE OF SERVICE	REASON CODE	FOUND BY CODE
12/31/05	9	1	/ /		
/ /			/ /		
/ /			/ /		
/ /			/ /		

- |  |  |
|--|--|
| <p><b>Reason Codes:</b></p> <ol style="list-style-type: none"> <li>1. Plan out of date</li> <li>2. Level of Care (LOC) out of date</li> <li>3. Service not documented in plan</li> <li>4. No VR letter available for supported employment</li> <li>5. No medical necessity statement for Rehab Supports</li> <li>6. Service was provided but was inappropriate and should not have been reported</li> <li>7. No service was delivered</li> <li>8. A service was indicated through fraud</li> <li>9. Other (explain below: wrong service, over-reported, wrong date, etc.)</li> </ol> | <p><b>Found By Codes:</b></p> <ol style="list-style-type: none"> <li>1. Responsible staff person who initially completed the original report</li> <li>2. Supervisor Review</li> <li>3. District/Central Office Review</li> </ol> |
|--|--|

SERVICE REPORTED AS PRIMARY S/B CONCURRENT

*(If more room is needed, please use comments section on page 2.)*

10/31/06  
DATE

Suzy Smith  
SUPERVISOR SIGNATURE

Day Service SECF Example:

*SC Department of Disabilities & Special Needs  
 Post Office Box 4706  
 Columbia, South Carolina 29240*

**SERVICE ERROR CORRECTION FORM**

This form should be used to correct services reported in error. If services were rendered but not reported, they should be reported by recording the service and the associated date on the current reporting documents (ISR, SPL, etc.). If a correction is needed other than reporting additional services, send the correction in writing to the attention of SURB Division, DDSN Central Office Finance.

**\*\*\*ONE CONSUMER AND ONE SERVICE PER SECF\*\*\***

ENTER THE CODE OF THE DOCUMENT TO BE CORRECTED: AROLL

Case Management SPL's [SCSPL]	Residential [RESID]
Early Intervention ISR's [EISR]	SLPI [SLPI, CTHI, CTHII or CRCF]
Day Program (Adult) [AROLL]	Day Program (Child) [CROLL]
Respite ISR's [REISR]	Rehabilitation [REHAB]
Job Coach ISR's [JCISR]	Caregiver Services [CRGVR]
HASCI [HASCI]	

PROVIDER NAME: LOWCOUNTY DSN PROVIDER NUMBER: XXX

RESPONSIBLE STAFF INITIALLY REPORTING SERVICE: MARY COORDINATOR CASE LOAD NUMBER: XXXX

CONSUMER'S NAME: MARY CONSUMER CONSUMER'S SSN: XXX-XX-XXXX

CONSUMER'S MEDICAID NUMBER (IF KNOWN): XXXXXXXXXX

**THE FOLLOWING SERVICES WERE REPORTED IN ERROR:**  
*(Use page 2 to record more dates of service)*

DATE OF SERVICE	REASON CODE	FOUND BY CODE	DATE OF SERVICE	REASON CODE	FOUND BY CODE
<u>01/01/05</u>	<u>9</u>	<u>1</u>	<u>01/02/05</u>	<u>9</u>	<u>1</u>
<u>01/03/05</u>	<u>9</u>	<u>1</u>	<u>01/04/05</u>	<u>9</u>	<u>1</u>
<u>01/05/05</u>	<u>9</u>	<u>1</u>	<u>01/06/05</u>	<u>9</u>	<u>1</u>
<u>01/07/05</u>	<u>9</u>	<u>1</u>	<u>01/08/05</u>	<u>9</u>	<u>1</u>

**Reason Codes:**

1. Plan out of date
2. Level of Care (LOC) out of date
3. Service not documented in plan
4. No VR letter available for supported employment
5. No medical necessity statement for Rehab Supports
6. Service was provided but was inappropriate and should not have been reported
7. No service was delivered
8. A service was indicated through fraud
9. Other (explain below: wrong service, over-reported, wrong date, etc.)

**Found By Codes:**

1. Responsible staff person who initially completed the original report
2. Supervisor Review
3. District/Central Office Review

SERVICE DELIVERED ACT-PVC/FUNDING-STATE

\_\_\_\_\_

*(If more room is needed, please use comments section on page 2.)*

DATE

SUPERVISOR SIGNATURE



Section 10.14: HASCI Waiver Board-Based Services Reporting & Billing Procedures

All services provided to HASCI waiver program consumers must be authorized prior to delivery. DDSN pays providers for board-based HASCI services based on their guarantee of service delivery and individually approved rates in consumers' budgets. It is the responsibility of each provider to arrange for HASCI board-based services (within the waiver programmatic guidelines) either through vendor purchases, service contracts or employment of personnel. Providers are also responsible for paying their service providers based on agreed upon arrangements. Each provider should ensure that their costs for these financial arrangements do not exceed their rate-based revenue.

Budget requests for these services should originate at the provider level, coordinating with DDSN's HASCI and Cost Analysis Divisions for approval before a budget can be authorized. HASCI Waiver budgets are approved on DDSN's Waiver Tracking System (WTS). Inquiries may be made on WTS at any time to see if requests, additions, changes or deletions have been approved.

For service delivery information such as definitions, restrictions and authorization requirements, Case Managers are directed to DDSN's HASCI Waiver Manual located on DDSN's website: [www.ddsn.sc.gov](http://www.ddsn.sc.gov).

Following is a list of established HASCI Waiver Services.

<u>STS CODE / HASCI SERVICE NAME</u>	<u>INVOICE CODE</u>	<u>UNIT</u>
S21 Assistive Technology – DME	AT/DME	N/A
S72 Attendant Care – Agency (UAP)	ATTC	Hour
S50 Attendant Care – Individual (Personal Assistance)	ATTC	Hour
S62 Communication – Assessment	COM-AS	Visit
S25 Communication – Audiology	COM-AU	Hour
S51 Communication – Therapy (Speech, Hearing, Language)	COM-TH	Hour
S82 Day Habilitation***		Day
S54 Drug & Alcohol Counseling	PSY-D&A	Hour
S26 Environmental Modification*	ENMOD	N/A
S65 Family/Individual Therapy - BAMH Practitioner	F/I-BAMH	Hour
S55 Family/Individual Therapy - Licensed Clinical Social Worker	F/I-LCSW	Hour
S64 Family/Individual Therapy – Psychological	F/I-PCHO	Hour
S60 Licensed Practical Nurse	PN-LPN	Hour
S57 Neuro-Psychological Evaluation	NPEVAL	Visit
S49 Personal Emergency Response System Installation	PERS-I	N/A
S49 Personal Emergency Response System Maintenance	PERS-M	Month
S83 Prevocational Services***		Day
S74 Private Vehicle Modification*		N/A

S56	Psychiatry	PSYCHI	Hour
S52	Psychological Assessment	PSY-A	Visit
S53	Cognitive Rehabilitation Therapy	PSY-RT	Hour
S66	Rehab Therapy – Other	PSY-RO	Hour
S63	Respite - Institution - Hospital Based	RES-ISB	Day
S46	Respite - Non Institution – Hourly**	RES-H	Hour
S12	Respite-Institutional – Nursing Home	RES-INST	Day
S13	Respite-Institutional – ICF/MR Based	RES-INST	Day
S59	Registered Nurse	PN-RN	Hour
S81	Residential Habilitation		Day
S84	Supported Employment		Hour

\*S26 & S74: Environmental Modification and Private Vehicle Modification require providers to submit a copy of their payment as evidence the work has been completed and paid for. Copies should be attached to the Individual Summary of Board-Based HASCI Services form.

During the budget approval process for Environmental Modification (S26), a HASCI Waiver Environmental Modification Checklist (see example on 10.14 p.6) is initiated by the Central Office HASCI Waiver Coordinator and Cost Analysis. When budget approval is final, Cost Analysis forwards this form to the SURB Division. Budget approvals for Private Vehicle Modifications (S74) are initiated by Vocational Rehabilitation (VR). If the cost is in excess of \$30,000 and DDSN is participating in a cost sharing agreement with VR, documentation of a HASCI Private Vehicle Modification (T2039) will come from VR (see example on 10.14 p.7).

\*\*S46: DDSN pays the current hourly rate up to 24 hours per day for HASCI Respite Services.

\*\*\*S82 & S83: Day Habilitation and Prevocational services are recorded in STS as S96 to enable the consumer to appear on a DSAL log.

## 1. Reporting and Billing Procedures

### A. Reporting Services

HASCI services should be reported on an “Individual Summary of Board-Based HASCI Services” (see example on page 10.14 p.5). To request reimbursement, “Monthly Provider Summary of Board-Based HASCI Services” forms should be used (an example of the monthly form can also be seen on page 10.14 p. 5). On-line versions of both these forms are available on the DDSN application portal under Business Tools >Forms. Providers may create their own in-house forms for these purposes as long as the same information is supplied.

Following are instructions for completing both forms. The data submitted is subject to review by DDSN Central Office and/or District Offices for accuracy.

**Individual Summary of Board-Based HASCI Services:**

- Enter the Provider's name.
- Enter the name of the consumer for whom you are reporting services.
- Enter the last four (4) digits of the consumer's social security number in this format: xxx-xx-1234.
- Enter the service invoice code for the first service. (Refer to the HASCI Services list beginning on page 10.14 p.1). Invoice codes should only be listed on the first line of the service being reported. If there are multiple lines to that service, you do not need to enter the invoice code again until the first line of the next service.
- For each service, enter what constitutes a unit (i.e., hour, half-day, day, etc.).
- For each service, enter the date it was provided. List dates in chronological order. Complete the listing of all dates for one service before beginning another service.
- For each date of service, enter the total number of units provided that day.
- Next to the total number of units, enter the approved rate for that service. (Approved rates may be found on the HASCI Waiver Budget Approval form.)
- Calculate the total dollar amount for each line of service by multiplying the number of service units by the rate for the service. Enter the total next to the rate. After the total for each type of service has been calculated and entered, calculate the grand total and enter that on the next line below.
- HASCI waiver case managers must sign the completed form. A signature indicates compliance with the certification statement.

**Monthly Provider Summary of Board-Based HASCI Services**

- Enter the Provider's name.
- Enter the month and year for which the Summary form is being prepared and submitted. (Providers should submit invoices monthly.)
- Number each line sequentially beginning with the number 1.
- Enter the last four (4) digits of the consumer's social security number in the following format (xxx-xx-1234) for each consumer on an accompanying Individual Summary of Board-Based HASCI Service forms. These will be submitted as support to the Monthly Provider Summary form.
- Enter the name of each consumer from the Individual Summary forms.
- Calculate and enter the total for each consumer from the Individual Summary forms. After the last total has been entered, calculate the grand total for the Monthly Provider Summary form by adding all of the totals together.
- The provider executive director and finance director (or other chief financial official) should sign the completed Monthly Provider Summary form. These signatures indicate compliance with the certification statement.

**B. Requesting Reimbursement**

When requesting reimbursement, providers should prepare a Monthly Provider Summary of Board-Based HASCI Services form and attach all supporting Individual Summary of Board-Based HASCI Service forms (and check copies, if applicable). These forms should be mailed to:

SC Department of Disabilities and Special Needs  
Attn: SURB  
PO Box 4706  
Columbia, SC 29240

For providers who prefer to upload billing documents electronically, please contact SURB about obtaining access to the Reporting and Billing Center (RBC). RBC is a secure system on DDSN's application portal for uploading confidential billing documents that go to the SURB area. **If you choose to upload documents through RBC, please do not mail the originals.**

In SURB, the forms are audited to ensure that 1) all services listed were approved, 2) all services listed were provided during the approved time period, 3) the rates billed agree with the rates approved, and 4) the number of services previously paid for (by service) plus the number of services currently invoiced do not exceed the total number of services approved.

After the forms are reviewed and any corrections made (if necessary), payments are processed through DDSN's financial system. Each consumer's name, partial social security number and county are verified and then a routine check is made to ensure that current year budgets are available. After completing the review process, SURB staff records the purchase order number and initials the forms before forwarding to Accounts Payable for processing.

C. Service Billing

SURB uses service reporting documents to create statistical data reports and to initiate Medicaid billings to DHHS.

3. Confidentiality of On-Line Reporting Documents

Title II of HIPAA, known as the Administrative Simplification (AS) provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA; Pub.L. 104–191), required the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans and employers.

All DDSN providers are required to comply with all applicable standards, orders and regulations pursuant to HIPAA concerning the confidentiality of information shown on all on-line reporting documents



Environmental Modifications Checklist Example:

### HASCI WAIVER – Environmental Modifications Checklist

This section is to be completed by the HASCI Waiver Coordinator and forwarded to Cost Analysis.

Individual's Name: \_\_\_\_\_  
SSAN: \_\_\_\_\_  
Provider: \_\_\_\_\_ DSN  
C O File #: \_\_\_\_\_

The Plan of Service for this individual supports the need for the following environmental modifications and the modifications are necessary to prevent institutionalization. The modifications are:

widen an exterior door by KRC Construction, Inc. 1925

Signature \_\_\_\_\_ Date \_\_\_\_\_

This section is to be completed by Cost Analysis and forwarded with supporting documentation (POS and Low Bid) to SURB.

Estimated total cost (low bid attached): \$925.00  
Date Provider notified of approval: 8/21/13  
Estimated date of completion (suspense date): 10/21/13

Signature \_\_\_\_\_ Date \_\_\_\_\_

This section is to be completed by SURB.

Invoice received: \_\_\_\_\_  
\* Is work consistent with modification budgeted:  Yes  No  
Date of completion: \_\_\_\_\_  
Date paid: \_\_\_\_\_  
Cost of modification (amount paid): \$ \_\_\_\_\_  
Check or PO Number: \_\_\_\_\_  
Date billed to SCHHSFC: \_\_\_\_\_

\* Contact Cost Analysis if no or amount is not consistent with low bid.

ENVMOD XLS 2/21/96

Private Vehicle Modification (T2039) Form Example:

**HASCI WAIVER - Van Modifications  
Private Vehicle Modification (T2039)  
VR Participation With State Match**

- 1) This Section to be Completed by the HASCI Waiver Coordinator and forward to Cost Analysis. Attach copy of VR letter indicating mutual agreement to participate with State Match.

Individual's Name: [REDACTED]  
SSAN: [REDACTED]  
Provider: Rich/Lex DSN  
Estimated Cost: 40,584.36  
Comments: \_\_\_\_\_

[Signature] 2/13/06  
Signature

- 2) This section is to be completed by Cost Analysis and forward with attached VR letter to SURB.

Verification That Budget is in Place: 2/13/06  
Verification That Comments in Place: RET

- 3) This section to be completed by SURB and forward to General Ledger Control along with the VR letter and a copy of the "Individual Summary of Board Based HASCI Services Provided" form.

Date received Individual Summary: 1/13/06  
Cost of Assistive Tech from Summary: \$ 30,000.00  
Date Billed DHHS: 1/19/06

- 4) This section to be completed by General Ledger Control. General Ledger Control will attach a copy of the invoice to this form and maintain all documentation under scheduled retention schedule.

Current State Match Rate: 69.32 %  
Amount To Bill VR: \$ 9204.00  
Date Billed VR: 2/27/06

Section 10.15: HASCI Waiver Rehabilitation Supports Reporting and Billing Procedures

Rehabilitation Supports (RS) are interventions and assistance to improve a condition or to promote/sustain optimal functioning for a person with a behavioral health disorder and functional deficits. Rehabilitation supports are not a form of therapy or counseling, but rather a focus on restoration or strengthening the skills necessary for increased independence and stability in living, learning, social and working environments. For more detailed information on Rehabilitation Supports, please refer to the Rehabilitation Supports Manual located at [www.ddsn.sc.gov](http://www.ddsn.sc.gov) under the Service Providers area.

1. HASCI Rehabilitation Supports Definitions

DDSN Contract Provider - The organization or entity DDSN contracts with to provide services.

Unit of Service - A time period of a least one hour and up to three hours with a minimum of one hour face-to-face service with a consumer. In order to report two units of service, the first three hours of service must have at least one hour of face to face with the fourth hour being face to face or one hour within the second 3 hour session must be face to face.

In rare situations, more than two units in one day may be provided, but DDSN Central Office HASCI Division approval is required before payment can be processed for any units of service in excess of two units per day.

Direct Service Provider - The person or entity that provides HASCI Rehabilitation Support Services to an eligible consumer.

Lead Clinical Staff – The person or persons that provide initial and ongoing monitoring to ensure compliance, as outlined in the HASCI Rehabilitation Supports Manual, and supervises the direct support staff.

2. Reporting and Billing Procedures

The DDSN contract provider is responsible for reporting all units of HASCI RS services to DDSN Central Office Finance (SURB). When the direct service provider is not a DDSN contract provider or an employee of the contract provider, the DDSN contract provider is responsible for collecting reportable units of service information from the direct service provider and submitting that information to SURB.

The DDSN contract provider should obtain all HASCI RS services documentation from the Lead Clinical Staff (LCS) and summarize the individual units of service on a Rehabilitation Supports Report of Service (RS Form 6). The contract provider should also summarize the units of service collectively on a Summary Invoice for Rehabilitation Supports Provided (RS Form 6 Summary). Examples of these forms may be found on pages 10.15 p.3-4 of this section. Fill-in versions of these forms are available on the DDSN application portal under Business Tools >Forms. For service reporting purposes, these forms must be submitted to SURB once a month at a minimum or as frequently as weekly.

DDSN Central Office approval is required for units of service in excess of two units per day. If reporting more than two units in one day, the Report of Service and Summary Invoice forms must be sent to DDSN Central Office HASCI Division for approval. If approval is given, the HASCI Division Director will forward the approved forms to SURB for payment processing. **No payment for units in excess of 2 will be processed without HASCI Division approval.**

3. Submission of Forms

The DDSN contract provider should forward the completed Rehabilitation Supports Report of Service (RS Form 6) and Summary Invoice for Rehabilitation Support Provided forms (RS Form 6 Summary) to:

**SC Department of Disabilities and Special Needs**  
**ATTN: SURB**  
**PO Box 4706**  
**Columbia, SC 29240**

For providers who prefer to upload these documents electronically, please contact SURB about obtaining access to the Reporting and Billing Center (RBC). RBC is a secure system on DDSN's application portal for uploading confidential billing documents that go to the SURB area. **If you choose to upload documents through RBC, please do not mail the originals.**

Once received, the forms are reviewed to ensure that (1) the cumulative units by consumer do not exceed the maximum stated in the contract, (2) the cumulative number of consumers does not exceed the maximum stated in the contract, and (3) the cumulative total units of service for all consumers does not exceed the total contracted units of service.

4. Confidentiality of Reporting Documents

Title II of HIPAA, known as the Administrative Simplification (AS) provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA; Pub.L. 104-191), required the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans and employers.

All DDSN providers are required to comply with all applicable standards, orders and regulations pursuant to HIPAA concerning the confidentiality of information shown on all on-line reporting documents.



Summary Invoice for Rehabilitation Support Provided Example:

**SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS  
REHABILITATION SUPPORTS**

**SUMMARY INVOICE FOR REHABILITATION SUPPORTS PROVIDED**

DSN Board: \_\_\_\_\_

Invoice Number: \_\_\_\_\_

Contract Number: \_\_\_\_\_

Month and Year Services Delivered: \_\_\_\_\_

Units of Service Delivered: \_\_\_\_\_

Contract Rate: \_\_\_\_\_ \$

Total Amount Due (Units x Contract Rate): \_\_\_\_\_ \$

Example

**PROVIDER CERTIFICATION:** All units of service billed above have been provided in accordance with DDSN's contractual guidelines for Rehabilitation Supports and with my specific authorization. All units billed above are documented on a completed Rehabilitation Supports Report(s) of Services, which are attached.

\_\_\_\_\_  
DSN Board Signature

\_\_\_\_\_  
Date

-----

**For Central Office Finance use:**

The Units billed above are supported by properly completed Rehabilitation Supports Report(s) of Service, and the Units have been received against the applicable contract.

\_\_\_\_\_  
Central Office Signature

\_\_\_\_\_  
Date

Section 10.16: Financial Managers and Reporting Documents Procedures

DDSN distributes funding for a majority of its services through the use of Financial Managers. Funding for services is sent to a consumer's financial manager regardless of what entity will actually be providing services. It is the Financial Manager's responsibility to utilize available funds to meet the needs of consumers based on their assessed needs, appropriately justified in their approved plans. Also, Financial Managers are required to inform DDSN when funds are not available to address consumers' identified needs. All expenditures of DDSN funds should be done in accordance with DDSN Departmental Directive 250-10-DD: Funding for Services.

1. Definitions

A. Financial Manager

A financial manager is a DSN Board, Qualified Provider or a Self-Directed Support Corporation (SDSC) designated to receive funding for a consumer and the reporting documents used to report delivered services back to DDSN. Babcock Center, Charles Lea Center and Berkeley Citizens, Inc. are contracted entities and are considered DSN Boards for the purpose of assigning Financial Managers.

B. Service Provider

A service provider is the entity that delivers services to consumers. Service providers are grouped into three categories based on the type of contract under which they provide services:

- (1) Regular/Contract: The service provider is the Financial Manager. Services are provided under a capitated services contract agreement between the provider and DDSN.
- (2) Other DSN Board/Subcontract: The service provider is a DSN Board that is not the Financial Manager. Services are provided under a subcontract agreement between the Financial Manager and the service provider.
- (3) Qualified Provider/Subcontract: The service provider is a Qualified Provider that is a private entity approved through the State Medicaid Agency's Service Provider Enrollment process. Services are provided through a subcontract agreement between the Financial Manager and the Qualified Provider.

### C. DSN Boards

#### 1. Capitated Services

Capitated services are person-centered services and supports funded through a budgeting model that assigns one of nine different funding levels to consumers based on their documented needs. Capitated services requiring the submission of reporting documentation include:

- a. Residential Habilitation (RESLOGS-Census Logs) or SLP I (Paper Logs)
- b. Day Services including Job Coach (DSAL-Roll Books)
- c. Case Management for consumers with a Funding Band (Service Notes Module of CDSS)
- d. Respite Services (Paper Log-Individual Service Reports/ISRs)
- e. Companion Services (Paper Log-Individual Service Reports/ISRs)

#### 2. Non-Capitated Services

Non-capitated services are person-centered specific services not provided under capitated services for which a Financial Manager is paid directly as opposed to being paid for as a group of services (i.e. band payment). Non-capitated services requiring reporting documentation include:

- a. Early Intervention (Service Notes Module of CDSS)
- b. Case Management for consumers without a funding band (Service Notes Module of CDSS)

### D. Qualified Providers

Qualified Provider services are person-centered services and supports funded through payments to Qualified Providers acting as Financial Managers. These services are reported after they have been performed and the Qualified Provider is reimbursed for the services according to published rate schedules in place at the time the service is provided. Qualified Providers services requiring the submission of reporting documentation include:

1. Residential Habilitation (RESLOGS-Census Logs) or SLP I (Paper Log – Individual Service Reports (ISRs).
2. Day Services including Supported Employment (DSAL)
3. Early Intervention/Case Management for Consumers (Therap)
4. Respite Services (Paper Log – Individual Service Reports (ISRs)
5. Companion Services (Paper Log – Individual Service Reports (ISRs)

## 2. Assignment of a Financial Manager

### A. General Guidelines

At initial intake, the Financial Manager for a consumer is established along with his or her Home-Board, which is generally in the consumer's county of residence.

1. For Consumers receiving Capitated Services (i.e. Services in a Funding Band): the DSN Board designated to receive the funding band payment for a consumer is assigned as the Financial Manager. Generally, consumers receiving capitated services include those living in residences operated by a DSN Board and consumers receiving Day Supports (up to the number of approved contract slots).
2. For Consumers receiving Non-Capitated Services (i.e. Specific Services not in a Funding Band): the DSN Board in the consumer's county of residence is initially assigned as both the Home-Board and the Financial Manager.
3. For Consumers receiving Services through a Qualified Provider Financial Manager: Consumers may choose a Qualified Provider to act as their Financial Manager. The DSN Board in the consumer's county of residence will be assigned as their Home-Board.

#### B. Change in Assignment of Financial Manager

If a consumer moves to another county, the Home-Board and Financial Manager automatically change in CDSS to the DSN Board in his/her new county of residence. However, the Financial Manager will not change if (1) the consumer's Home-Board and Financial Manager were not the same when the move occurred or (2) if the beginning dates for the current Home-Board and Financial Manager were not the same.

If the Financial Manager designation is not correct, the Case Manager/Early Interventionist must request a correction unless one of the following has occurred: (1) a consumer specifically chose another DSN Board to be his or her Financial Manager or (2) the consumer receives HASCI services (HASCI Case Managers are assigned to regions and consequently are not based in every county provider office). Corrections to CDSS may be initiated through contact with the Cost Analysis Division. Aside from the above mentioned instances, generally the Home-Board and Financial Manager will be the consumer's county of residence.

Example: Joe is moving from Acorn County to Beet County. His Home-Board at the time of his move is Acorn. After his transfer to Beet County, his Home-Board and his Financial Manager are shown as Beet County, but Joe chooses Grain County to be his Financial Manager instead. In that case, Grain County would be Joe's Financial Manager and Beet County would be his Home-Board.

### 3. Financial Manager Responsibilities

#### A. Reporting Services

The Financial Manager is responsible for reporting all services that are provided to a consumer. That means completing the necessary reporting documents and submitting them to DDSN. The Financial Manager is responsible for reporting both services provided by them and the services provided by a subcontracted DSN Board or Qualified Provider. The Financial Manager must maintain an accounting system (and the supporting fiscal records

by service) that is adequate enough to ensure that claims are in accordance with all applicable laws, regulations, and policies.

#### B. Contracting for Services

Consumers may receive services from their Financial Manager or they may request to receive services from another DSN Board or other Qualified Provider. Consumers have a choice of providers that includes: 1) another DSN Board, 2) a DDSN contracted entity which operates as a DSN Board or 3) a Qualified Provider from the Qualified Provider List (QPL). When a consumer selects a provider other than his or her own Home Board/Financial Manager, arrangements should be made through a sub-contractual agreement between the Financial Manager and the service provider (i.e., another DSN Board or Qualified Provider).

### 4. Service Reporting Documents

#### A. Submission of Reporting Documents

It is the responsibility of the rendering service provider to complete all necessary reporting documents and submit them to DDSN according to the stated schedule. Hard copy documents should be mailed to: **DDSN, Attn: SURB, PO Box 4706, Columbia, SC, 29240.**

For providers who prefer to upload billing documents electronically, please contact SURB about obtaining access to the Reporting and Billing Center (RBC). RBC is a secure system on DDSN's application portal for uploading confidential billing documents that go to the SURB area. **If you choose to upload documents through RBC, please do not mail the originals.**

1. Regular/Contract – The Financial Manager is providing the service. All reporting documents should be submitted on-line by the 5<sup>th</sup> business day of the month.
2. Other DSN Boards/Subcontract – The Financial Manager has a subcontract with another DSN Board to provide service. All reporting documents for services delivered must be postmarked by the 20<sup>th</sup> of the month.
3. Qualified Providers/Subcontract – The Financial Manager has a subcontract with a Qualified Provider to provide service. All reporting documents must be postmarked by the 20<sup>th</sup> of the month.

#### B. Exceptions for Case Management and Early Intervention

Case Management and Early Intervention services are entered on-line through a CDSS Module called "Service Notes." Each DSN Board or Qualified Provider providing these services is responsible for completion and submission of service notes. (See Section 10.8: Service Notes Reporting and Billing Procedures for Case Management and Early Intervention.)

C. Service Reporting Documents Cross-Reference

Detailed procedures for completing DDSN's service reporting documentation may be found in the Finance Manual sections as listed below:

<b>Finance Manual Chapter 10</b>	
Section 10.1 – Residential Services Reporting and Billing Procedures for RESLOG (formerly Census Tracking)	Residential Habilitation
Section 10.2 – Day Services Reporting and Billing Procedures for DSAL	Day Supports to include Supported Employment Services
Section 10.6 – HCB Waiver Respite Care Reporting and Billing Procedures	Respite Care
Section 10.7 – Supervised Living Program (SLP) I Reporting and Billing Procedures	Supervised Living Program I (SLP I)
Section 10.8 – Service Notes Reporting and Billing Procedures for Case Management and Early Intervention Services	Case Management and Early Intervention
Section 10.10 – HCB Waiver Caregiver Services Reporting and Billing Procedures	HCB Waiver Caregivers

Section 10.18: Waiver Credit Report Procedures

Payments to providers are based on capitated funding. Full waiver budgets, including direct-billed and board-based services, are used to calculate funding levels. Because funding bands are calculated using full services, DDSN avoids paying for the same services twice (once to the Boards and again through MMIS) by recovering from the Boards the amount actually processed through the Medicaid Management Information System (MMIS). MMIS is the entity that processes South Carolina Medicaid payments.

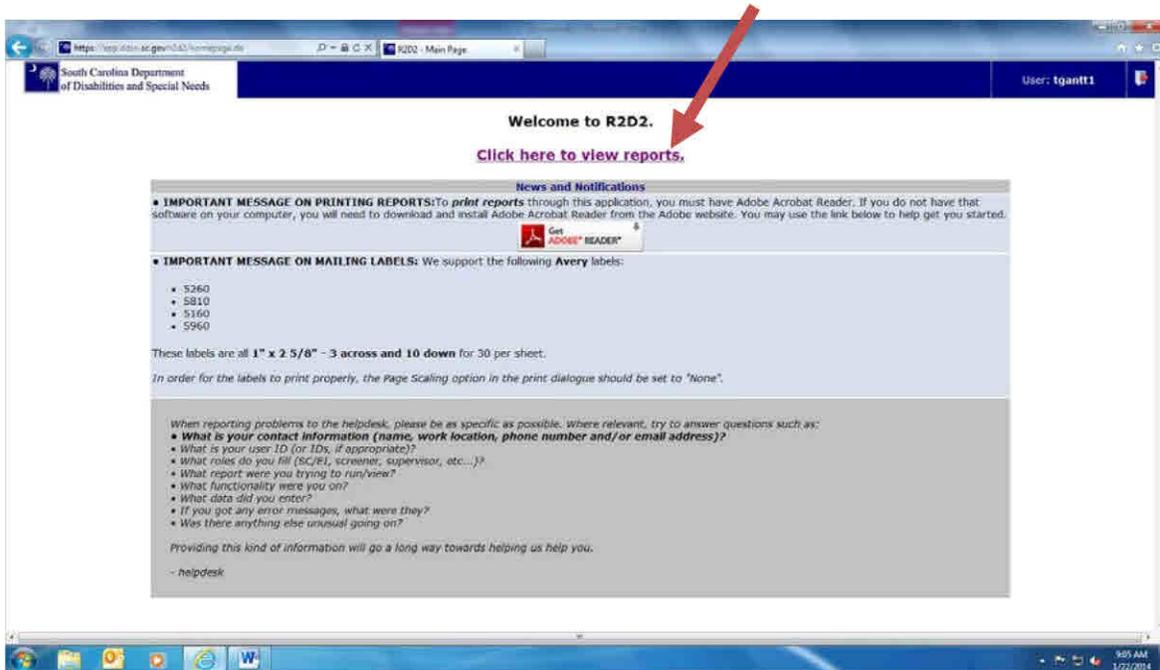
1. The Waiver Credit Report Process

DDSN receives a file monthly from the South Carolina Department of Health and Human Services (DHHS) containing all services paid by Medicaid during the prior month for consumers enrolled in the IR/RD and CS Waivers. From this file, a report of direct-billed services is extracted showing the calculated total credit for each Board. A credit adjustment is processed through DDSN Accounts Payable for each board-based service accordingly.

Providers have access to the DDSN application portal and may run Waiver Credit Reports using the Actuate Reporting Application (R2D2). The parameters needed to run these reports (Julian Date and Year) are posted at the top of the page in R2D2 immediately after users sign-in. Instructions for running a Waiver Credit Report for your Board follow on pages 10.18 p.2 through 10.18 p.5.

Running a Waiver Credit Report:

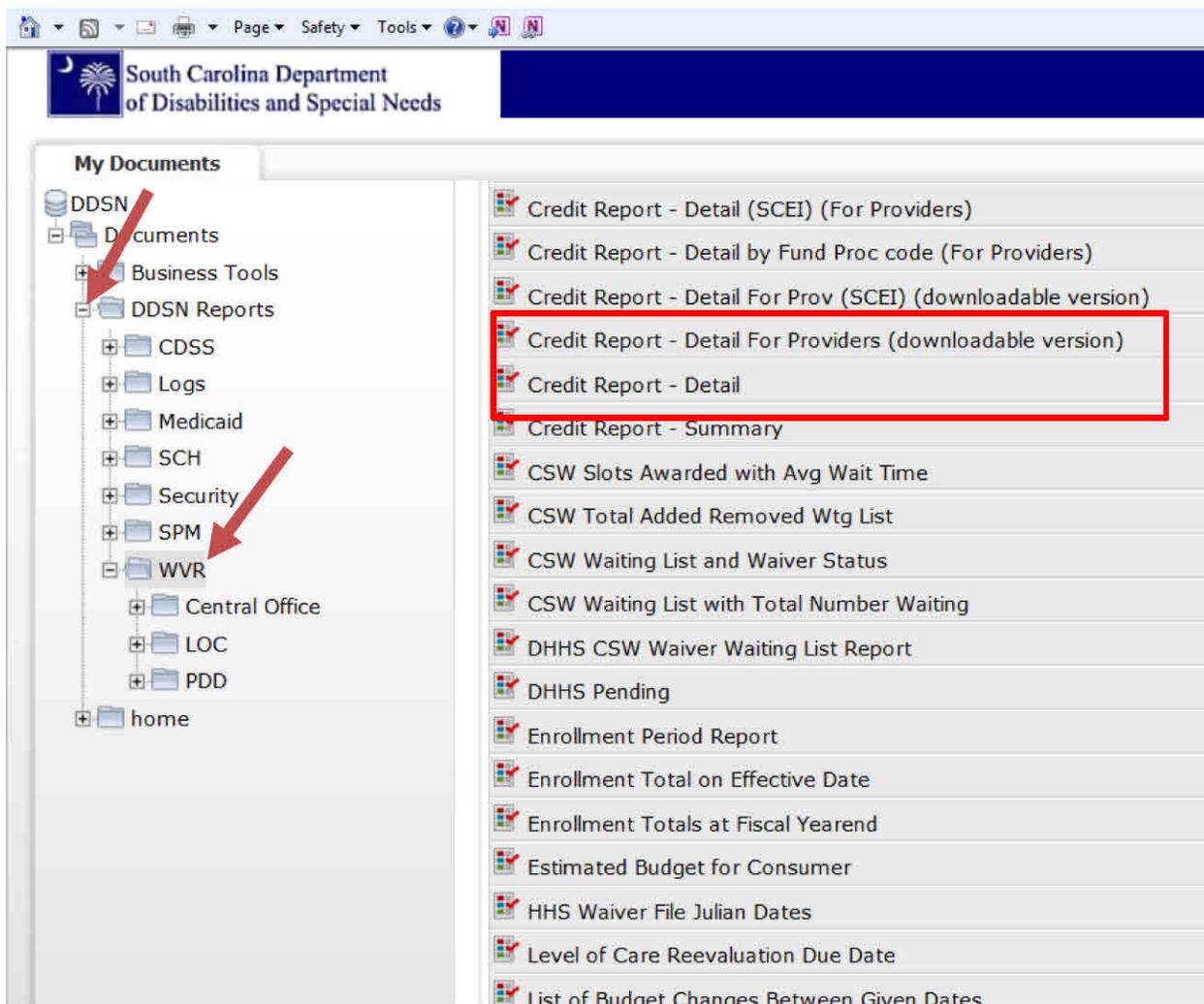
Access the DDSN application portal and select the R2D2 Actuate Reporting Application. When the welcome screen appears (like the one below), click on “[Click here to view reports](#)” near the top of the page. (If you are unable to see R2D2 on the Application Portal, please contact the DDSN Help Desk at 803-898-9767.)



After clicking to expand the DDSN Reports folder on the left side of the screen, click on the WVR folder and a list of available reports will appear on the right side of your screen. (Users will need to scroll down to see all available reports.)

The two main reports providers need for Waiver Credit purposes are:

- Credit Report – Detail for Providers (downloadable version)
- Credit Report – Detail



After clicking on “Credit Report – Detail,” a fill-in box like the one shown below will open. Enter the required parameters. (Julian date information may be found at the top of the page after signing into the application portal.) After all fields have been filled in, click “finish” to generate the report.

The screenshot shows a web-based form titled "Parameters" with the following fields and values:

Assistive Technology > \$1000	Include
Consumer Type:	Excl PCA for under 21 & All Nursing Srv
Report Month:	June
Type Waiver:	ID/RD
Julian Day:	179
Financial Manager Number:	340
Report Year:	2017

At the bottom of the form are four buttons: "Cancel", "Back", "Next", and "Finish". A red arrow points to the "Finish" button.

The requested report will open on your screen. Click print for a hard copy.

 <b>SC Department of Disabilities and Special Needs</b>												
Waiver Credit Report for the Month of June Year 2017 Client Detail by Provider for Non-DDSN Providers Type Waiver: ID/RD Excludes Assistive Technology > \$1000 (x1916) (Excludes All Nursing Services for all Ages and PCA srvs-proc code T1019 for Consumers < 21 years old)											Type Waiver: 1 Julian Day: 179 Report Year: 2017	
S.S.#	Fund Type	Service	Part D	21	Last Name	EI	Proc	Modifier	Units	Line Paid Amt	IndivProv	Group Prov
340												
	EI	5/22/2017				E			0.000	143.63	790391	790391
	EI	5/22/2017				E			0.000	7.99	790391	790391
		<b>Fund Total</b>							<b>0.000</b>	<b>151.62</b>		
		<b>Client Total for</b>			<b>EUGENE</b>				<b>0.000</b>	<b>151.62</b>		
	VF	4/3/2017	M			W	T1019	000	16.000	64.00	EX0627	EX0627
	VF	4/4/2017	M			W	T1019	000	16.000	64.00	EX0627	EX0627
	VF	4/5/2017	M			W	T1019	000	16.000	64.00	EX0627	EX0627
	VF	4/6/2017	M			W	T1019	000	16.000	64.00	EX0627	EX0627
	VF	4/7/2017	M			W	T1019	000	16.000	64.00	EX0627	EX0627
	VF	4/10/2017	M			W	T1019	000	16.000	64.00	EX0627	EX0627
	VF	4/11/2017	M			W	T1019	000	16.000	64.00	EX0627	EX0627
	VF	4/12/2017	M			W	T1019	000	16.000	64.00	EX0627	EX0627
	VF	4/13/2017	M			W	T1019	000	16.000	64.00	EX0627	EX0627
	VF	4/14/2017	M			W	T1019	000	16.000	64.00	EX0627	EX0627
	VF	4/17/2017	M			W	T1019	000	16.000	64.00	EX0627	EX0627
	VF	4/18/2017	M			W	T1019	000	16.000	64.00	EX0627	EX0627
	VF	4/19/2017	M			W	T1019	000	16.000	64.00	EX0627	EX0627
	VF	4/20/2017	M			W	T1019	000	16.000	64.00	EX0627	EX0627
	VF	4/21/2017	M			W	T1019	000	16.000	64.00	EX0627	EX0627
	VF	4/24/2017	M			W	T1019	000	16.000	64.00	EX0627	EX0627
	VF	4/25/2017	M			W	T1019	000	16.000	64.00	EX0627	EX0627
	VF	4/26/2017	M			W	T1019	000	16.000	64.00	EX0627	EX0627
	VF	4/27/2017	M			W	T1019	000	16.000	64.00	EX0627	EX0627
	VF	4/28/2017	M			W	T1019	000	16.000	64.00	EX0627	EX0627
		<b>Fund Total</b>							<b>320.000</b>	<b>1,280.00</b>		
		<b>Client Total for</b>							<b>320.000</b>	<b>1,280.00</b>		

The data shown in these reports are amounts paid by Medicaid for each consumer by social security number, fund code, service date, consumer's name, procedure code, units, amount paid, provider number and group provider number.

**Special Notes:**

- ✦ Fund Codes are two-digit alphanumeric numbers that identify a collective group of similar services provided to consumers.

Examples: Durable Medical Equipment, Physician or Hospital Services, etc.

- ✦ Procedure Codes are 5-digit alpha-numeric numbers that represent a systematic listing of services and procedures performed by a provider of service. These codes are based on national standards passed by Congress establishing the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Examples: Respite, Day Habilitation, Early Intervention, Etc.

- ✦ Other codes such as dental (prefix D) or vision (prefix V) may also appear on the Waiver Credit Reports. All of the codes are not listed in this section due to the extremely large number of Level II codes and copyright constraints. These codes are part of the Healthcare Common Procedure Coding System, called "HCPCS" for short. It is available for purchase through merchants like the American Medical Association. However, SURB does have the HCPCS Manual and will answer questions pertaining to these codes. For more information contact the SURB Division by calling (803) 898-9626.

2. Medicaid Payments

Medicaid pays for services as a provider bills for them. Medicaid will not pay for services that are over 365 days old. The timing of payment for services is dependent on the service provider's billing process, which can vary greatly from one provider to another.

**Special Notes:**

- ✦ Service providers have only 365 days from date of service to bill Medicaid.
- ✦ The Waiver Credit Report lists services that are paid in a given month by Medicaid regardless of the date of service.
- ✦ Services may be paid in a 12-month period that could, possibly, represent services over a 24-month period.

3. Processing Credits

Due to the time lag between payment by MMIS and DDSN's receipt of the monthly report, and because Board payments are generally processed two weeks before they are due, credits to the Boards are processed during the third month, after the MMIS payment.

The following is an example of what this schedule looks like:

Contract Payment Number	Contract Payment due to Board on or before	Credit Reflects Payments made by MMIS during the month of
1	1-Jul	April
2	1-Aug	May
3	1-Sep	June
4	1-Oct	July
5	1-Nov	August
6	1-Dec	September
7	1-Jan	October
8	1-Feb	November
9	1-Mar	December
10	1-Apr	January
11	1-May	February
12	1-Jun	March

**Special Note:**

- ✦ The last month for any given fiscal year is March, which is credited against June payments.

4. Review Process and Submission of Reimbursement Request

Monitorship is important for many reasons but part of the purpose of monitorship is to prevent a service provider from delivering services in excess of the units authorized or not providing services that are authorized. Occasionally, these types of errors do occur. They may be the result of a variety of circumstances but regardless, action must be taken by the Case Manager to communicate with the service provider and determine the source of the problem and initiate the necessary corrective action.

- A. After running a Waiver Credit Report, **please review it carefully for errors. Requests for corrective action must be made directly to the service provider.** Per HIPAA requirements, service providers must reimburse Medicaid for overpayments, use of wrong procedure codes, duplicate payments, etc. For instructions on how to refund Medicaid, please refer to the SCDHHS website: <https://www.scdhhs.gov/provider>.

Once the original claim has been reversed, the service provider should issue a new replacement claim, if applicable. For claims that have been reversed, the amount of the claim will appear on the Waiver Credit Report as a negative number.

If necessary, DDSN can assist Boards with unresolved issues involving service providers and DHHS. However, before this step is taken – all efforts must be made with the service provider to correct the billing error(s) before asking DDSN for assistance. A written record of the attempts to resolve the issue will be required before DDSN contacts DHHS on a DDSN Provider's behalf.

**Special Note:**

Before contacting the service provider regarding an error, ask yourself the following questions:

- Is the authorization correct? Does the authorization need to be modified to reflect any added or deleted services?
  - Is the budget correct? Does the budget need to be modified to reflect any added or deleted services?
- B. PCA services delivered to consumers under the age of 21, along with nursing services and incontinence supplies are considered State Plan services and therefore are not part of Band payments.
- C. For consumers charged to your Waiver Credit Report that are not your responsibility:
- (1). Photocopy the page from the Waiver Credit Report pertaining to the consumer.
  - (2). Write on the copy that the consumer belongs to another provider and supply effective dates for any transfers or terminations. Forward the copy to SURB with a cover memo explaining the details.

- D. Environmental Modifications charged to Waiver Credit Reports may be reimbursed after review and verification. To facilitate your request, send a letter to DDSN Attn: SURB requesting reimbursement. In the letter, please include the consumer's name and social security number. Also, attach the following documents:
  - (1). A copy of the page from the Waiver Credit Report pertaining to the consumer, and
  - (2). A copy of the authorization pertaining to the consumer.
- E. If a service provider is not cooperative and you suspect Medicaid Fraud, please contact SURB immediately by calling (803) 898-9626.

5. **Submission of Correspondence**

Please direct all correspondence pertaining to adjustment requests (along with any attachments) to **DDSN, ATTN: SURB, P.O. Box 4706, Columbia, SC 29240**.

For providers who prefer to upload these documents electronically, please contact SURB about obtaining access to the Reporting and Billing Center (RBC). RBC is a secure system on DDSN's application portal for uploading confidential billing documents that go to the SURB area. **If you choose to upload documents through RBC, please do not mail the originals.**

6. **DDSN Response to Reviews/Questions**

DDSN will review all reimbursement requests along with any attachments. If in agreement with a submitter's assessment, a "Waiver Credit Report Reimbursement Memo" will be completed and emailed to you, and you will see a payment adjustment on a future payment schedule referencing the Memo you received. For each reimbursement request submitted, you will receive an approval memo or a phone call requesting additional information. If DDSN disagrees with the request, contact will be made directly either by phone or email.

7. **Time Limits on Reviews and Adjustments**

DSN Boards have six (6) months to report possible errors discovered in Waiver Credit Reports. For example, a November 2016 report processed against payments on February 2017 would have to be reviewed and errors reported back to DDSN by August 1, 2017. Once a possible error is reported, there is no time limit placed on a resolution.

8. **Confidentiality of On-Line Documentation**

Title II of HIPAA, known as the Administrative Simplification (AS) provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA; Pub.L. 104-191), required the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans and employers. All DDSN providers are required to comply with all applicable standards, orders and regulations pursuant to HIPAA concerning the confidentiality of information shown on all on-line reporting documents.