

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES



COMMUNITY LONG-TERM CARE PROVIDER MANUAL

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South Carolina Department of Health and Human Services

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PROGRAM OVERVIEW

The mission of Long-Term Living (LTL) is to provide a cost-effective alternative to institutional placement for eligible clients with long term care needs, if they choose, allowing them to remain in a community environment. The South Carolina Department of Health and Human Services (SCDHHS) Division of Long-Term Living operates several waiver programs, as well as three Department of Disabilities and Special Needs (DDSN) waivers. LTL also administers the Palmetto SeniorCare (PSC) program.

Home and Community Based Waiver are programs that allow individuals who meet an institutional level of care to receive items and services not covered through the South Carolina Medicaid State Plan. These items and services are allowed through the waiver programs to assist individuals in remaining in their own home or other community setting and avoiding institutional placement.

WAIVER PROGRAMS

Community Choices Waiver

The LTL Community Choices Waiver is designed to serve Medicaid-eligible individuals who are age 18 or older and have long term care needs. To avoid or delay costly nursing home admission, clients are able to access the services necessary to receive care at home through careful assessment, service planning, care coordination and monitoring.

HIV/AIDS Waiver

The LTL Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Waiver is designed to serve Medicaid-eligible HIV/AIDS clients, regardless of age, who choose to live at home but have long term care needs and are at risk for hospitalization.

Mechanical Ventilator Dependent Program

The Mechanical Ventilator Dependent Program is designed to serve Medicaid-eligible persons' age 21 or older who are dependent on mechanical ventilation and have long term care needs. Clients are able to receive services to supplement care in their home through careful assessment, service planning and service coordination.

Medically Complex Children (MCC) Waiver

MMCs Waiver is designed to serve children with a serious illness or condition expected to last at least twelve (12) months. The waiver participants must meet the following state defined medical criteria, which identify the child as being dependent upon the evaluation of medications, hospitalizations, skilled nursing services, specialists and ancillary services. The MCC Waiver will service children who meet the Hospital Level of Care. The services approved in this waiver are Pediatric Medical Day Care and Care Coordination.

Palmetto SeniorCare (PSC) Program

PSC is a federal Medicaid and Medicare capitated program serving clients in the greater Columbia area (Richland and Lexington counties) who meet all of the following criteria:

- Are age 55 or older;
- Meet nursing home level of care; • Wish to remain in the community; and
- Choose to participate in the program.

Participants in PSC receive all services through PSC either directly from PSC staff, health care professionals or through subcontracted health care entities. Many of the services provided are centered in the PSC Adult Day Health Centers.

Children's Personal Care Aide (PCA) Services

Children's PCA services provide PCA services in the community to Medicaid-eligible children under 21 years of age who meet established medical necessity criteria.

SCDHHS and SCDDSN Waivers

In a joint effort, SCDHHS and DDSN are providing a broad range of home- and community-based waiver services to Medicaid-eligible individuals.

SCDHHS serves as an administrative oversight and monitoring entity to ensure the health, safety, and welfare of the waiver beneficiaries. SCDHHS is responsible for ensuring that a formal system is in place to periodically review clients' services and to ensure that those in place are consistent with identified needs of clients. DDSN has the primary responsibility for the daily operation of the Head and Spinal Cord Injury (HASCI) program.

Head and Spinal Cord Injury (HASCI) Waiver

In a joint effort, SCDHHS and DDSN are providing a broad range of home- and community-based waiver services to Medicaid-eligible individuals with the most severe physical impairments involving head and spinal cord injuries. The HASCI Waiver is designed to help clients who would otherwise require services in a nursing facility or Intermediate Care for Individuals with Intellectual Disabilities (ICF/IID) to remain independent in the community.

Intellectual Disability/Related Disabilities (ID/RD) Waiver

ID/RD waiver services are provided based on identified needs of the participant and the appropriateness of the service to meet the need. Services may be limited due to provider availability. A list of enrolled and qualified providers of ID/RD Waiver services can be located at the DDSN website (www.ddsn.sc.gov) or by contacting the local DDSN Board in the county in which the participant lives or the participant's Waiver Case Manager/Early Intervention provider is located.

Community Supports (CS) Waiver

The CS waiver allows persons ages 3 and older with an ID/RD to choose to receive care at home rather than in an ICF/IID. Although the participants may choose to receive care at home, he/she

must require the degree of care that would be provided in the ICF/IID. The CS Waiver has a cost limit with which services are provided.

LTL SERVICE COORDINATION AND DDSN CASE MANAGEMENT FUNCTIONS

Intake

The intake process identifies persons who may be eligible for the program and serves as an information and referral source for those who do not meet intake criteria. The LTL area office and the local DDSN board ensures that all persons with perceived long term care needs receive every opportunity for exposure to the LTL program. The intake telephone numbers are as follows:

- For all DHHS waiver client referrals, call 1-888-971-1637.
- For all DDSN waiver client referrals, call 1-800-289-7012.

Assessment

Assessment uses a comprehensive standard instrument to determine a client's current long term care needs. Information obtained during the assessment process will assist staff in making a level of care decision and initiating a plan of service for discussion with the client and/or family.

Service Planning

Service planning encompasses a comprehensive review of the client's problems and strengths. Mutually agreed-upon goals are set based on identified needs. This service planning process allows for participation of the client and/or family, physician, service providers, the service coordinator and/or the LTL case management team. Service planning provides involved persons with information necessary to make an informed choice regarding the location of care and services to be utilized. The outcome of this process is a written plan of service.

Case Management

LTL case management is a vital part of the long term care program that is provided for all waiver clients. (Case management for HASCI, CS and ID/RD waiver clients is provided by DDSN.)

Case management ensures continued access to the long term care program. It also enables case managers to advise, support and assist clients and their families in coping with changing needs and in making decisions regarding long term care.

Case management includes the following five activities: service counseling, service planning, service coordination, monitoring and re-evaluating.

DDSN Case Management

Case Management is a vital part of the DDSN programs and is provided for all participants. This process ensures continued access to DDSN programs and enables Case Managers to continue advising, supporting and assisting clients and their families in coping with changing needs and in making decisions regarding DDSN programs.

Case Management includes the following five activities: service planning, coordinating service, service authorization, monitoring and re-evaluating.

NOTE: References to supporting documents and information are included throughout the manual. This information is found at the following locations:

- [Provider Administrative and Billing Manual](#)
- [Forms](#)
- [Section 4 - Procedure Codes](#)

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COVERED POPULATIONS

ELIGIBILITY/SPECIAL POPULATIONS

Level of Care Determination

Level of care determination is the process of identifying the extent of a person's medical, psycho-behavioral, and functional disability in keeping with the South Carolina Level of Care Criteria for Medicaid-Sponsored Long-Term Care. To be eligible for LTL services, a person must be determined to meet either skilled or intermediate level of care criteria, or, in the case of persons with HIV/AIDS, be at risk for hospitalization. These criteria help determine a client's requirement for care.

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ELIGIBLE PROVIDERS

PROVIDER QUALIFICATIONS

All LTL services have prerequisites for participation and require enrollment/contracts with SCDHHS. Certain licensing requirements may also exist. Please see the Provider Administrative and Billing Manual for general Medicaid enrollment and licensing requirements.

LTL Waiver Supply Providers

Home and Community Based Waiver Programs

South Carolina currently administers seven waivers that allow for the provision of supplies. The Community Choices, HIV/AIDS, Mechanical Ventilation and MCC waivers are operated by the Department of Health and Human Services. Authorizations for these waivers will be made through the SCDHHS Phoenix web-based case management and authorization system. This system notifies the provider with an email directing the provider to a secure website. The provider will accept authorizations at this website. All providers requesting enrollment as a LTL provider to distribute waiver supplies must be trained and utilize the Phoenix web-based case management and authorization system.

For waivers operated by DDSN, which include ID/RD, HASCI and CS waivers, all authorizations are currently faxed to the provider.

Providers of waiver supplies must verify Medicaid eligibility of each participant prior to rendering services and at least one business day prior to transmitting the order. To verify Medicaid eligibility, the provider can utilize the South Carolina Medicaid Web-Based Claim Submission Tool or by utilizing other point of sale devices.

Authorizations for Incontinence Products

Providers must deliver products based on authorizations received from Case Managers, Nurses, Early Interventionists working with participants. SCDHHS/DDSN will not authorize or pay for incontinence products for children under age 4.

The authorizations will provide the frequency of delivery and the participant information necessary to provide the incontinence products. Authorizations may provide for monthly, bi-monthly or other frequency arrangements. However, incontinence products will not be delivered more frequently than monthly for each authorized participant. For authorizations that indicate an amount on a per case basis, please refer to the procedure code information on the provider portal.

All authorizations for incontinence products must utilize the codes as outlined in the procedure code information on the provider portal. The provider is expected to package these items in accordance with the quantity authorized in the table above, even if repackaging is required. After the initial

delivery to the participant, future deliveries of the product to the participant must be at the same time of the month as the first delivery and at the frequency established by the authorization.

For any new initial authorizations, the supplies must be shipped within three business days of the provider receiving the authorization and must be received by the participant within one week of the provider's receipt of the authorization.

The provider shall not charge participants additional fees or surcharges; the unit rate reflected in the table above is the price reimbursed to Medicaid providers for incontinence products.

If the provider is unable to provide products as scheduled, the provider must contact the participant by telephone no less than five business days before the scheduled delivery date to inform him/her of the delay in shipment. The provider must offer the participant the option to wait on the product or choose another product that may be delivered on schedule.

- If the provider has made three unsuccessful attempts to contact the participant by telephone, the provider shall send a backorder notification to the participant. The backorder notification must give the participant the option to wait on the product or to choose an alternate product.
- If the provider attempts a delivery and the participant refuses to accept delivery, the provider will provide instructions to the participant on how to obtain the package. The provider must notify the Case Manager/Nurses/Service Coordinator/Early Interventionists if this becomes an issue.

Providers are allowed to ship more than a single months' worth of product to a participant. Providers electing to ship product in advance to a participant's place of residence may not ship more than a full quarters worth of product on any single delivery. Providers opting to ship in this manner accept the risk that the participant may lose Medicaid eligibility prior to the provider being able to bill for a second or third month of product. Authorizations from case managers and service coordinators will still reflect the normal shipment pattern that was originally authorized. The case manager and/or service coordinator will not add comments approving this shipment method. Providers must bill each month of product separately on the first day of the month if they elect to deliver multiple months of product in one shipment.

Incontinence products will be shipped or delivered to participants residing in community residential care facilities, community training homes, supervised living placements and individual homes (houses, apartments, trailers, rental properties, etc.).

Incontinence Product Quality

All products distributed to Home and Community Based Waiver (HCBW) participants must be latexfree and hypoallergenic. Products will not be kept in inventory long enough for the quality to degrade, i.e. adhesives drying out. No damaged or rejected products will be provided to (HCBW) participants. All products must not be shipped beyond their expiration date.

- All diapers/briefs must have a closure system, a wetness indicator that is visible to change, a polymer absorbent core in the middle of the product, a hydrophilic top sheet and a waterproof backing. See the chart entitled, "Adult Briefs," for additional specifications. The provider's

products must meet or exceed the requirements of the Standard Product and Universal Requirements.

- Protective underwear must have banding to indicate front and back, contain an absorbent polymer core, have elastic leg gatherings and tear away sides, and be embossed to help with the wicking of liquids away from the skin. See the chart entitled, “Protective Underwear,” for additional specifications. The provider’s products must meet or exceed the requirements of the Standard Product and Universal Requirements.
- All underpads must have a hydrophilic top sheet that allows fluid to pass quickly into an absorbent core and a polypropylene backsheet that protects against leakage. The underpads should help with wicking of liquid away from the skin.
- A case of medium size underpads must have a minimum count of 200 (minimum size 22”-23”), and a case of large size underpads must have a minimum count of 150 (minimum size 22”-35”). See the chart entitled, “Underpads,” for additional specifications. The provider’s products must meet or exceed the requirements of the Standard Product and Universal Requirements.
- Incontinence pads, inserts, shields, or liners must have a hydrophilic top sheet, absorbent core and a waterproof polypropylene backing. The incontinence pad, insert, shield, or liner must be embossed to wick liquids away from the skin. See the chart entitled, “Pads, Inserts, Shields,” for additional specifications. The provider’s products must meet or exceed the requirements of the Category 2 product in this chart.
- Disposable wipes must be at a minimum size of six inches by six inches, provided in at least a seventy-count tub, have a pre-moistened, alcohol-free formula and be safe for use on the skin.
- All pediatric diapers/briefs and protective underwear must be quality premium brands by nationally recognized manufacturers Covidien (Kendall), First Quality, Kimberly Clark, Medline or Proctor and Gamble.

In addition to the other requirements stated above, the provider must:

- Maintain products in inventory for no longer than two months before being delivered to customers.
- Maintain climate control measures in its storage facilities to ensure product quality.

SCDHHS may perform an audit at any time. The audit may also include, but is not limited to, pricing and distribution of product adherence, responses to complaints, grievances or inquiries. SCDHHS reserves the right to audit the provider’s performance at any time.

Adult Briefs

Recommendation:		Two protection levels - Standard and Premium, differentiated by lab performance.	
Product Specification	Size	Overall Length and Width; waist range is for reference only.	
	Performance	Use standard lab measurements as detailed in Attachment A and B	
		Rate of Acquisition (ROA) & Rewet	100 ml fluid add-on for Youth and Small
		Capacity	200 ml for all others
Product Preparation:		Trim waist elastic and leg gathers, if present; fold under the front and back wing flaps	

Standard Brief				Product Performance ⁽¹⁾		
Size	Minimum Length⁽²⁾	Minimum Width⁽³⁾	Waist Range	ROA	Rewet	Capacity
	inches	inches	inches	≤	≤	≥
				seconds	grams	grams
Youth	21.0	15.0	15 - 22"	65.0	4.0	900
Small	26.0	17.5	20 - 31"	65.0	4.0	1,100
Medium	31.0	24.0	32 - 44"	65.0	6.0	1,400
Regular	33.0	27.0	40 - 48"	65.0	6.0	1,400
Large	36.5	29.5	45 - 58"	65.0	6.0	1,700
Extra Large	38.0	31.0	56 - 64"	65.0	6.0	1,700
Extra Extra Large	38.0	33.5	62 - 67"	65.0	6.0	1,700

Premium Brief				Product Performance ⁽¹⁾		
Size	Minimum Length⁽²⁾	Minimum Width⁽³⁾	Waist Range	ROA	Rewet	Capacity
	inches	inches	Inches	≤	≤	≥
				seconds	grams	grams
Youth	21.0	15.0	15 - 22"	60.0	2.0	1,100
Small	26.0	17.5	20 - 31"	60.0	2.0	1,300
Medium	31.0	24.0	32 - 44"	60.0	2.5	1,800
Regular	33.0	27.0	40 - 48"	60.0	2.5	1,800
Large	36.5	29.5	45 - 58"	60.0	2.5	2,100
Extra Large	38.0	31.0	56 - 64"	60.0	2.5	2,100
Extra Extra Large	38.0	33.5	62 - 67"	60.0	2.5	2,100

Notes

⁽¹⁾ To qualify for inclusion on the formulary, products need to meet or exceed two of the three performance standards and be within 15% of the third standard

⁽²⁾ Measured by cutting leg elastic and stretching flat

⁽³⁾ Measured at non-tape end

Universal Requirements

1. Designed with wetness indicator visible on the outside of the brief
2. Designed with a side closure system (if tape tab, minimum of 2 per side and width ≥ 5/8")
3. Designed with multi-elastic leg gathers
4. Backing is waterproof

PROTECTIVE UNDERWEAR

Recommendation		One protection level	
Product Specification	Dimension	Waist	Measure inside width fully stretched out under tension
		Length	Cut product at side seams
	Measure length fully stretched out under tension		
	Performance	Rate of Acquisition & Rewet	100 ml fluid add-on for all products
		Total Capacity	As per ISO Method
Product Preparation	Cut product at side seams Pin the product down so it lies flat		

Size	Minimum Inside Width ⁽²⁾ inches	Minimum Length ⁽³⁾ inches	Product Performance ⁽¹⁾		
			ROA	Rewet	Capacity
			≤ seconds	≤ grams	≥ grams
Small	18	23	60.0	2.0	900
Medium	22	28	60.0	2.0	1,000
Large	27	31	60.0	2.0	1,100
Extra Large	31	32	60.0	2.0	1,200

Universal Requirements

1. Designed with a continuous elasticized waistband and side panels.
2. Designed with multi-elastic leg gathers
3. Backing is waterproof

Notes

⁽¹⁾ To qualify for inclusion on the formulary, products need to meet or exceed two of the three performance standards and be within 15% of the third standard

⁽²⁾ Measure inside width stretched out under full tension

⁽³⁾ Measured by cutting product at side seams and fully stretching flat under tension.

Underpads

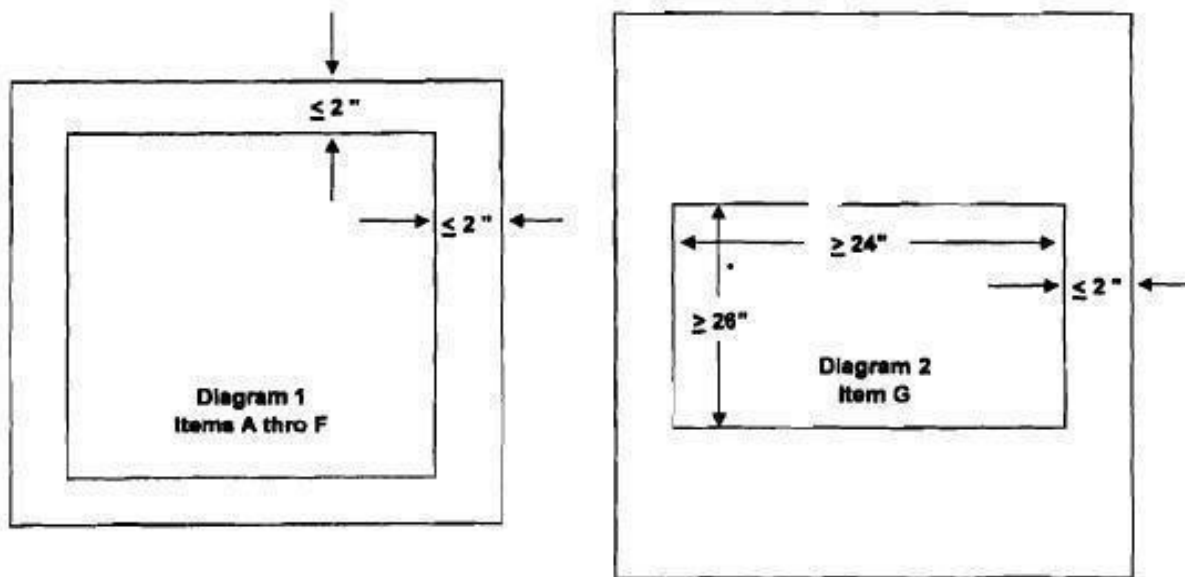
Recommendation: Seven sizes of Underpads in two protection levels
 To ensure acceptable performance levels, minimum absorbent core area is also specified.

Performance: Determined by ISO Capacity Method.

	Size +/- 2 " inches	Minimum Mat Size inches	Product Performance	
			Standard	Premium
			≥ grams	≥ grams
A	17 x 24	See Diagram 1 below	200	500
B	23 x 23			
C	23 x 36		300	1,200
D	30 x 30			
E	30 x 36			
F	36 x 36		700	1,700
G	28 x 70	24 X 26		

Universal Requirements

1. Mat size should be large enough that the border (non absorbent area) is ≤ 2.0" (see diagrams)



PADS, INSERTS, SHIELDS

Recommendation:		Three categories; based on capacity.	
Product Specification	Size	One size	
	Performance	Use standard lab measurements as detailed in Attachment A and B	
		Rate of Acquisition (ROA) & Rewet	100 ml fluid add-on
		Capacity	As per ISO Method
Product Preparation		Unfold; trim waist elastic and leg gathers, if present	

		Product Performance ⁽¹⁾				
		Width	Length	ROA	Rewet	Capacity
		inches	inches	≤	≤	≥
Category 1	Light	- na -	- na -	NA	NA	250
Category 2	Moderate	- na -	- na -	NA	NA	500
Category 3	Heavy	≥ 8.0	≥ 22.0	60	2.0	1,000

The products must have one of the following attributes:

1. Embossed or channeled absorbent mat
2. Elastic gathers
3. Super absorbent polymer
4. Waterproof backing

Notes:

⁽¹⁾ For category 3 only, to qualify for inclusion on the formulary, products need to meet or exceed two of the three performance standards and be within 15% of the third standard

Authorizations for Oral Nutritional Supplements

Providers must deliver products based on authorizations received from Case Managers, Nurses and Early Interventionists working with participants. The authorizations will provide the frequency of delivery and the participant information necessary to provide the oral nutritional supplements, including the correct procedure code and amount to bill for DDSN participants. Each can of nutrient must have a minimum of 225 cal/250 ml and come in a 24-count case in order to qualify for Medicaid reimbursement.

For SCDHHS waivers, a Physician’s Order is required for this service. The SCDHHS Physician’s Order Form must be completed by the participant’s physician in order for this service to be authorized. The physician must indicate the needs for the supplement, recommend the quantity and indicate at least one of the qualifying conditions:

- Wasting (loss of ten percent (10%)) body mass in the last sixty (60) days;
- Severe dental or gum problems that prevent the participant from chewing;
- Has a condition that requires a protein supplement;
- Has a swallowing problem that prevents the participant from achieving adequate weight; or
- Due to a medical condition, the participant cannot maintain adequate weight.

Note: Nutritional Supplements must not be authorized for those with adequate weight unless the participant has dental or swallowing problems.

For DDSN waiver policy, please refer to the policy manuals listed on their website at <https://www.ddsn.sc.gov>.

Authorizations for Miscellaneous Supplies and Equipment

Providers must deliver products based on authorizations received from Case Managers, Nurses and Early Interventionists working with participants. The authorizations will provide the frequency of delivery and the participant information necessary to provide the supplies and equipment, including the correct procedure code and amount authorized to bill for DDSN participants. When billing for DDSN participants, all supplies and equipment delivered on the same date of service, using the same miscellaneous procedure code, should be combined and billed as a single line item when filing the claim for payment.

Staffing and Operating Procedures

The provider shall employ staff to receive authorizations electronically via secure website, fax, or mail. The provider must maintain all authorizations for products on file for audit purposes. The provider must have adequate staff to:

- Contact participants to coordinate service delivery;
- Package or repackage products to coordinate precisely with authorizations;
- Handle complaints and grievances received from participants, case managers/nurses and service coordinators/early interventionists;
- Obtain authorizations from the secure website, fax or mail;
- Input product shipment and billing information into SCDHHS' Electronic Visit Verification (EVV) system for the waivers operated by SCDHHS. For those waivers operated by SCDDSN product information and billing

will be done via the South Carolina Medicaid Web-Based Submission Tool, tape, diskette or hard copy.

Providers must fill orders from its own inventory or must contract with other companies for the purchase of items necessary to fill the order. A provider must not contract with any entity currently excluded from any state or federal health care programs.

Providers must notify beneficiaries of warranty coverage and honor all warranties under applicable state law, and repair or replace free of charge Medicaid-covered items that are under warranty.

Providers cannot initiate telephone contact with participants, LTL staff, or case management providers in order to solicit new business. The provider shall not market directly to potential or current Medicaid waiver participants (including direct mail advertising, door-to-door, telephonic or other "cold-call" marketing).

Cold-call marketing is any unsolicited personal contact by the provider with a potential or current Medicaid waiver participant.

Solicitation is defined as any communication from the provider to a potential or current participant that can reasonably be interpreted as intended to influence the participant to choose to receive services from the provider or to not receive services from another provider. The provider may be suspended or terminated for violating this policy.

The provider is prohibited from giving anything of value to a state employee or contract employee associated with the LTL program. Providers may be suspended or terminated for violating this requirement.

Providers must answer questions, respond to complaints from participants and maintain documentation of contacts in response to complaints. Complaint records must include the name, address, telephone number, and Medicaid number of the participant, a summary of the complaint and any actions taken to resolve it.

Providers are responsible for delivery and must instruct beneficiaries on use of Medicaid-covered items and maintain proof of delivery. Please see the documentation requirements set forth in this manual for more information regarding proof of delivery.

Providers must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the participant at the time it was fitted or sold) from participants.

Providers must disclose to SCDHHS any person having ownership, financial or control interest in the agency. A provider must not convey or reassign a provider number (i.e., the provider may not sell or allow another entity to use its Medicaid billing number).

LTL Environmental Modification Providers

Environmental modification services provide pest control and physical adaptations or modifications to the home that are necessary to ensure the health, welfare and safety of the client. Environmental modifications enable clients to function with greater independence in the home. An example of such a modification is the construction of a ramp. All environmental modification providers must have and maintain a residential or general contractor's license to provide services. In addition to this

requirement, providers must have and maintain general liability and worker's compensation insurance. Environmental modifications must meet certain standards and specifications as detailed under *LTL Environmental Modification Standards and Specifications* of this manual.

PROVIDER MEDICAID ENROLLMENT AND LICENSING

LTL providers are required to complete and sign an individual enrollment form (DHHS 219-LTLIC or LTLI-NC) before submitting claims to Medicaid. Group providers must complete a separate form (DHHS 219-LTLGC or LTLG-NC).

Compliance Review

Compliance reviews are completed approximately 180 days after initiation of services with LTL. Unannounced reviews are conducted thereafter. At the sole discretion of SCDHHS/LTL, special reviews may be conducted at any time.

Field Service Representatives

After enrollment, visits are made to providers periodically and upon request. The purpose of each visit is to coordinate information concerning the Medicaid program and provide technical assistance as required.

Workshops are conducted on a periodic basis to acquaint providers with current Medicaid policy and regulations, changes or amendments.

Requests for Field Service assistance and questions regarding manuals, bulletins, or workshops should be directed to the SCDHHS Medicaid Provider Service Center at 1-888-289-0709 or submit an online inquiry at <http://www.scdhhs.gov/contact-us>.

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COVERED SERVICES & DEFINITIONS

A table displaying the waiver program to which the LTL covered services are associated with is included here with their associated definitions to follow.

	Children's PCA Services	Community Choices Waiver	CS Waiver	HASCI Waiver	HIV/AIDS Waiver	ID/RD Waiver	Mechanical Ventilator Dependent Program	MCC Waiver
Adult Day Health Care (ADHC) Nursing		X	X			X		
ADHC Services		X	X			X		
ADHC Transportation		X	X			X		
Adult Dental						X		
Adult Vision						X		
Assistive Technology and Appliances			X					
Assistive Technology and Appliances Assessment/ Consultation			X					
Attendant Care Services		X		X	X	X	X	
Audiology Services				X		X		
Behavior Support Services			X	X		X		
Care Coordination								X
Career Preparation Services			X	X		X		
Case Management		X	X	X	X	X	X	
Community Services (Individual and/or Group)			X			X		
Companion Services		X			X	X		
Day Activity			X	X		X		
Employment Services			X	X		X		
Environmental Modifications		X	X	X	X	X	X	

Environmental Modification, Specialized Supplies, and Adaptations		X			X		X	
Habilitation Services (Day)					X			
Habilitation Services (Prevocational)								
Habilitation Services (Residential)				X		X		

	Children's PCA Services	Community Choices Waiver	CS Waiver	HASCI Waiver	HIV/AIDS Waiver	ID/RD Waiver	Mechanical Ventilator Dependent Program	MCC Waiver
Health Education for Consumer-Directed Care				X				
Home Delivered Meals		X			X		X	
In-Home Supports			X					
Incontinence Supplies			X	X		X		
Nursing Services				X	X	X	X	
Occupational Therapy				X				
Pediatric Medical Day Care								X
Peer Guidance for Consumer-Directed Care				X				
Personal Care I (PC I) Services		X	X		X	X	X	
Personal Care II (PC II) Services	X	X	X		X	X	X	
Personal Emergency Response System (PERS)		X	X	X		X		
Pest Control Bed Bugs and Pest Control Treatment		X		X	X		X	
Physical Therapy				X		X		
Private Vehicle Modification			X	X		X		
Private Vehicle Modification Assessment/Consultation			X	X		X		
Psychological Services				X				
Respite (In-Home)			X	X		X	X	

Respite (Institutional/NF)		X		X		X	x	
Respite Care		X					X	
Respite Care in a Community Residential Care Facility		X						
Specialized Medical Supplies, Equipment and Assistive Technology						X		
Specialized Medical Supplies, Equipment and Assistive Technology Assessment/Consultation					X	X		
Speech and Hearing Services				X				
Support Center Services			X			X		

Adult Day Health Care Services

ADHC Services is care furnished to someone 18 or older, a minimal of 5 hours per day for one or more days per week, in an outpatient setting, encompassing both health and social services.

Based on the client’s identified needs, ADHC centers provide a range of health care and support services. The center provides planned therapeutic activities to stimulate mental activity, communication and self-expression. The center staff provides meals and supervision of personal care. The center also transports clients to and from home, if they live within fifteen miles of the center. With special approval, the center may also provide additional services.

A limited number of skilled procedures are available to persons receiving ADHC. A licensed nurse, as ordered by a physician, provides the skilled procedures in the ADHC center. Nursing care is provided to:

- Monitor the client’s vital signs and ability to function;
- Supervise intake of medication and possible reactions;
- Teach health care and self-care; and
- Oversee treatment in conjunction with a client’s physician and case manager.

The South Carolina Department of Health and Environmental Control (DHEC), or the equivalent licensing agency for out-of-state facilities, must license all adult day care centers. Furthermore, centers must have adequate procedures for medical emergencies and must meet the minimum staffing requirements as specified by the contract.

Adult Day Health Care-Nursing Services

ADHC-Nursing Services is provided in ADHC center; limited to ostomy care, urinary catheter care, decubitus/wound care, tracheostomy care, tube feedings and nebulizer treatment.

Adult Day Health Care-Transportation

ADHC-Transportation service is prior-authorized for individuals receiving the ADHC service, who reside within fifteen (15) miles of the ADHC center.

Assistive Technology and Appliances

Assistive Technology and Appliances is a device, an item, piece of equipment, or product system that is used to increase or improve functional capabilities of participants thereby resulting in a decrease or avoidance of need for other waiver services.

Assistive Technology and Appliances Assessment/Consultation

Assistive Technology and Appliances Assessment/Consultation may be provided (if not covered by State Plan Medicaid) to determine specific needs related to the participant's disability for which specialized medical equipment and assistive technology will assist the participant to function more independently.

Attendant Care Services

Attendant care services assist with the performance of activities of daily living and personal care, which may include hands-on care, of both a medical and non-medical supportive nature, specific to the needs of a medically stable, physically handicapped individual. These services may include skilled medical care to the extent permitted by state law. Housekeeping and community access activities that are incidental to the performance of the client-based care may also be furnished as part of this activity. The kinds of activities that an attendant provider performs include the following:

- Assistance with personal hygiene, feeding, bathing, and meal preparation;
- Encouraging clients to adhere to specially prescribed diets;
- General housekeeping duties;
- Shopping assistance;
- Assistance with communication; and
- Monitoring medication.

The client may directly supervise the attendant when the client has been trained to perform this function, and when the safety and efficacy of client-provided supervision has been certified in writing by an RN or otherwise as provided within state law. This certification must be based on actual observation of the client and the specific attendant care provider during the actual provision of care. Documentation of the certification will be maintained in the client's individual plan of service.

Transportation may be provided as a component of the service when it is related to the performance of daily living skills. The cost of this transportation is included in the rate paid to the providers of attendant care services. These services may be conducted in a variety of settings as outlined in the DDSN plan of service. These services shall not duplicate any other service. An RN licensed to practice in the state must provide supervision. The frequency and intensity of supervision will be specified in the client's written plan of service by the DDSN service coordinator.

Behavior Support Services

Behavior Support Services is to assist people who exhibit problem behaviors learn why the behavior occurs and to teach new appropriate behaviors which are effective and improve their quality of life.

Career Preparation Services

Career Preparation Services are services aimed at preparing participants for careers through exposure to and experience with various careers and through teaching such concepts as compliance, attendance, task completion, problem solving, safety, self-determination and self-advocacy.

Case Management

A qualified case manager provides LTL case management for all waiver clients. The objective of case management is to counsel clients regarding services and support. Case managers assist participants in gaining access to needed waiver and other State plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services to which access is gained. The case manager also assists clients in coping with changing needs and in making decisions regarding long term care. He or she also ensures continued access to appropriate and available services.

Companion

Companion services provide short-term relief for caregivers and supervision of clients.

Community Services (Individual and Group)

Community Services aimed at developing one's awareness of, interaction with and/or participation in his/her community through exposure to and experience in the community and through teaching such concepts as self-determination, self-advocacy, socialization and the accrual of social capital.

Day Activity

Day Activity supports and services provided in therapeutic settings to enable individuals to achieve, maintain, improve, or decelerate the loss of personal care, social or adaptive skills.

Environmental Modification, Specialized Supplies and Adaptations

Environmental modification services provide physical adaptations to the home required by a client's plan of service necessary to ensure the health, welfare and safety of the client. Environmental modifications are changes that enable clients to function with greater independence in the home and without which the client would require institutionalization.

Included is the installation of specialized electric and plumbing systems required to accommodate the medical equipment and supplies necessary for the welfare of clients.

Excluded are those adaptations or improvements to the home that are of general utility and have no direct medical or remedial benefit to the client. Services must be provided for the client's benefit, not for the convenience of other occupants. Environmental modifications shall meet all applicable state and local building codes. In those counties without local building codes, all services shall be provided in accordance with standard building codes as set forth in the South Carolina Code of Laws § 6-9-10 et seq.

Habilitation Services (Day)

Day habilitation services provide assistance with the acquisition, retention, or improvement of self-help, socialization, and adaptive skills that take place in a non-residential setting, separate from the home or facility in which the client resides. Normally, these services are furnished four or more hours a day, on a regularly scheduled basis, for one or more days a week unless provided as an adjunct to another day activity included in the beneficiary's plan of service. Day habilitation services focus on enabling clients to attain or maintain their maximum functional level. They shall also be coordinated with any physical, occupational or speech therapies listed in the plan of service. Additionally, day habilitation services reinforce skills or lessons taught in school, therapy or other settings.

Habilitation Services (Prevocational)

Prevocational habilitation services are not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or Section 602 (16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Activities included in this service are not directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the client's plan of service as directed to habilitation rather than explicit employment objectives. These services teach concepts such as compliance, attendance, task completion, problem solving, and safety, to prepare clients for paid and unpaid employment.

Excluding supported employment programs, prevocational habilitation services are provided to clients not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year. When compensated, individuals are paid less than 50 percent of minimum wage.

Documentation will be maintained in each client's file that the service is not otherwise available under the program funded under the Rehabilitation Act of 1973 or P.L. 94-142.

Habilitation Services (Residential)

Residential habilitation services include the care, skills training, and supervision provided to clients in a non-institutional setting. The degree and type of care, supervision, skills training, and support of clients will be based on the plan of service and the client's individual needs. Services include assistance with the following:

- The acquisition, retention, or improvement of skills related to activities of daily living, such as personal grooming and cleanliness;
- Household chores and bed-making;

- Eating and preparation of food; and
- Social and adaptive skills necessary to enable the individual to reside in a non-institutional setting.

Other than costs that are for modifications or adaptations to a facility required to assure the health and safety of residents or meet the requirements of the applicable life safety codes, payments for residential habilitation are not made for the following:

- Room and board;
- Costs of facility maintenance;
- Upkeep; and
- Improvement.

Payments for residential habilitation do not include those made, directly or indirectly, to members of the client's immediate family. Payments will not be made for the routine care and supervision provided by a family or group home provider or for activities or supervision covered by a source other than Medicaid.

Health Education for Participant-Directed Care

Health Education for Participant-Directed Care is instruction by a registered nurse to assist an individual to manage own personal care provided by another individual.

Home Delivered Meals

Nutritionally sound meals are delivered to clients at their homes. Based on a physician's orders, meals may include standard diets or therapeutic and/or modified diets. All menus must be reviewed and approved by a registered dietitian and meals must be prepared and delivered according to the standards developed by LTL.

In-Home Support

In-Home Support is care, supervision, teaching and/or assistance provided directly to or in support of the individual and provided in the individual's home, family home, the home of others and/or in community settings. This service is self-directed.

Incontinence Supplies

Incontinence Supplies include diapers, under-pads, wipes, liners and disposable gloves provided to participants who are at least 21 years old and who are incontinent of bowel and/or bladder according to established medical criteria.

Nursing Services

Nursing services provide skilled medical monitoring, direct care and interventions that meet the medical needs of clients at home. Nursing services prevent institutionalization.

HIV/AIDS Waiver Note: The client's condition may require 24-hour continuous care for a short duration due to an episodic condition.

Occupational Therapy

Occupational Therapy is treatment used to restore or improve fine motor functioning.

Pediatric Medical Day Care

Pediatric Medical Day Care is a medical day care center for medically fragile children.

Peer Guidance for Participant-Directed Care

Peer Guidance for Participant-Directed Care is information, advice, and encouragement provided by a peer to an individual with SCI/severe physical impairment to recruit, train, and supervise own caregivers.

Personal Care I (PC I) Services

PC I services are designed to help preserve a safe and sanitary home environment, provide shortterm relief for caregivers and assist clients with personal care. These services supplement, but do not replace, the care provided to clients. The kinds of services performed by the PC I aide include the following:

- Meal planning and preparation;
- General housekeeping;
- Assistance with shopping;
- Companion or sitter services;
- Assistance with financial matters, such as delivering payments to designated recipients on behalf of the client;
- Assistance with communication; and
- Observing and reporting on the client's condition.

Personal Care II (PC II) Services

PC II services are designed to help clients with normal daily activities and to monitor the medical conditions of functionally impaired/disabled clients. The kinds of activities that the PC II aide performs are comparable to those that family members would perform for the person in need. PC II aides provide assistance with walking, bathing, dressing, toileting, grooming, preparing meals and feeding. The aide also helps to maintain the home environment, including light cleaning, laundry, shopping and keeping the home safe. The client's vital signs, such as respiratory rate, pulse rate, and temperature are observed. The aide may also remind the client to take prescribed medication(s) and, when necessary, transport and/or escort the client.

PC II aides work under the supervision of an RN or LPN in the client's home. Under no circumstances may a PC II aide perform any type of skilled medical service.

HIV/AIDS Waiver Note: PC II aides who provide services to HIV/AIDS clients should be trained in infection control. The Centers for Disease Control and Prevention (CDC) precautions must be followed when rendering care to protect the client and the PC II aide.

Personal Emergency Response System (PERS)

PERS is an electronic device that enables participants at high risk of institutionalization to secure help in an emergency; limited to those participants who live alone or who are alone in their own home for significant parts of the day or night and who would otherwise require extensive routine supervision.

Pest Control Treatment and Pest Control Bed Bugs

Pest Control Treatment and Pest Control Bed Bugs aid in maintaining an environment free of insects such as roaches and other potential disease carriers to enhance safety, sanitation and cleanliness of the participant's home/or residence.

Physical Therapy

Physical Therapy is treatment used to improve or compensate for mobility and movement dysfunction and related functional impairments.

Private Vehicle Modifications

Private Vehicle Modifications to a privately-owned vehicle is used to transport the participant (e.g. installation of a lift, tie downs, lowering the floor of the vehicle, raising the roof, etc.); limit of \$7,500 per vehicle with a lifetime cap of 2 vehicles.

Private Vehicle Assessment/Consultation

Private Vehicle assessment/Consultation is used to determine the specific modifications/equipment, any follow-up inspection after modifications are completed, and training in use of equipment for a Private Vehicle Modification.

Psychological Services

Psychological Services is a treatment to address affective, cognitive and substance abuse issues.

Respite (In-Home)

In-home respite services provide temporary care in the home for Mechanical Ventilator Dependent and DDSN waiver clients living at home and cared for by their families or other informal support systems. These services maintain clients and provide temporary relief for the primary caregivers.

Respite Care

Many clients with long term care needs are cared for at home by family members or other caregivers. Respite care services are intended to provide temporary around-the-clock relief for caregivers by placing the client in an institutional setting for up to fourteen days per state fiscal year. The provider of respite care services must be licensed and certified by DHEC as a hospital, nursing

home, or ICF/IID. Out-of-state providers must be licensed by an equivalent agency of that state. They must also have a valid Medicaid contract with the SCDHHS.

Respite Care in a Community Residential Care Facility

Respite care services may be provided for caregivers by placing the client in a community residential care facility for up to 28 days per state fiscal year. The facility must be licensed by DHEC and have a valid Medicaid contract with SCDHHS for these services.

RN Care Coordination

RN Care Coordination is all of the participant's complete coordination. It includes monthly contact by calls and quarterly face to face assessments.

Specialized Medical Equipment, Supplies and Assistive Technology

Specialized Medical Equipment, Supplies and Assistive Technology are devices, controls, appliances, items necessary for life support, ancillary supplies, equipment, and durable and nondurable equipment not available through State Plan Medicaid that provides medical or remedial benefit to the participant.

Specialized Medical Equipment, Supplies and Assistive Technology Assessment/Consultation

Specialized Medical Equipment, Supplies, and Assistive Technology Assessment/Consultation may be provided (if not covered by State Plan Medicaid) to determine specific needs related to the participant's disability for which specialized medical equipment and assistive technology will assist the participant to function more independently.

Speech and Hearing Services

Speech and Hearing Services is the use of speech therapy, audiology services and augmentative communication.

Support Center

Support Center is non-medical care, supervision and assistance provided in a non-institutional, group setting outside of the participant's home to people who, because of their disability, are unable to care for and supervise themselves.

Supported Employment Services

Supported employment services consist of paid employment for clients for whom competitive employment at or above minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly work sites in which people without disabilities are employed. These services include activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment services are provided at a work site where there are employees without disabilities, payment will be made only for the adaptation, supervision, and training required by clients receiving waiver services because of their disabilities. Payment for supervisory activities rendered as a normal part of the business setting are not included.

Supported employment services furnished under the waiver are not available under any programs funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in each client's file that it is not otherwise available under a program funded under the Rehabilitation Act of 1973 or P.L. 94-142.

Federal financial payments will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

- Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program.
- Payments that are passed through to users of supported employment programs.
- Payments for vocational training that is not directly related to an individual's supported employment program.

5

UTILIZATION MANAGEMENT

PRIOR AUTHORIZATION

Prior Authorization of DDSN Services

Based on the client's plan of service, services will be authorized by DDSN's Case Manager and transmitted/faxed to the provider on an authorization form.

Client Choice of Providers

LTL clients are required to choose a service provider from a Client Choice of Provider(s) Form, which lists available providers of each service for the client's waiver of participation. The Client Choice of Provider(s) Form will identify the referring entity and LTL provider(s) already involved in the care of the client. Any service requiring a referred provider to participate in a bid process is excluded from this policy. For bid process services, the provider submitting the lowest bid will be awarded the referral. If the provider submitting the lowest bid cannot provide the service, the referral will be awarded to the next lowest bidder.

Authorization of Services

Services must be pre-authorized by the LTL/DDSN case manager based on the client's plan of service. With the exception of case management, prior authorizations are required for all LTL/DDSN waiver services. Authorization will be transmitted to the provider by the completion of an LTL Service Provision Form (DHHS Form 175). (For an example of this form, please see the Forms information located on the provider portal.) Accompanying the authorization will be a copy of the plan of service and, if appropriate, a copy of the physician's order.

Authorization Periods

Authorizations will be issued for all LTL and DDSN services indicating the beginning date of the service, the days of the week that the service will be provided, and the number of units of service to be provided. The hours of service will be indicated only if specific times are essential to meeting the client's service needs. For some services, the authorization will designate that the service is to be provided during the morning, afternoon or evening. The authorization period ending date may or may not be indicated on the service provision form. Authorizations without an ending date will be valid until a revised service provision form is issued to the provider.

Changes in Services Within an Authorization Period

Should the client's needs change during an authorization period, a revised service provision form will be sent to the provider. Changes in frequency of a particular service do not require a new physician's order.

Interruption of Services

Previously authorized PCA services will be interrupted if the client enters a hospital or institution for a temporary stay or temporarily chooses not to receive services. The interruption of PCA services

does not require a revised service provision Form, unless the service is to be interrupted for an extended time.

Termination of Authorized Services

Service must be officially terminated whenever it is determined that the client no longer requires an authorized service, becomes either medically or financially ineligible or has not received a service within thirty (30) days. Both the client and the provider must be notified of the termination of services. This verbal notification must be followed with a written confirmation of termination of the service.

Prior Authorization for Hospice Participants

In certain situations, Medicaid beneficiaries receiving the State Plan hospice benefit may receive some waiver services. Prior authorization by the hospice provider is required in cases where waiver services are authorized for Medicaid hospice beneficiaries. The prior authorization number must be placed on the claim in order for the provider to receive reimbursement. The case manager obtains the prior authorization number from the hospice provider and gives it to the provider of the authorized service. Providers submitting hard copy CMS-1500 claims must place the prior authorization number in field 19. Providers submitting claims electronically by diskette or magnetic tapes will place the prior authorization number in field 10. Providers who receive the 976 edit (hospice beneficiary/service requires prior approval) may resolve the edit by submitting a new claim with the corrected information.

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REPORTING/DOCUMENTATION

COST REPORTS

With the exception of respite care, all contracted providers are required to submit a final cost report for each service. The final cost report must cover the entire contract period and be filed no later than 90 days after the end of the reporting period. The cost report shall include the actual cost and service delivery information for the reporting period. If the provider fails to file the cost report within the specified time, all funds due the provider shall be withheld by SCDHHS until the report is filed. All cost reports should be mailed to:

Department of Health and Human Services
Division of Ancillary Reimbursements
Post Office Box 8206
Columbia, SC 29202-8206

If you have any questions regarding cost reports, contact the SCDHHS Medicaid Provider Service Center at 1-888-289-0709 or submit an online inquiry at <http://www.scdhhs.gov/contact-us>.

LTL WAIVER SUPPLY PROVIDERS

Providers of waiver supplies are responsible for delivery. The provider may deliver directly to the participant or a designee. Note the relationship of the designee to the beneficiary on the delivery slip and the signature should be legible. Providers, their employees, and others with a financial interest in the delivery of the item are prohibited from signing and accepting an item on behalf of the participant (i.e., acting as a designee on behalf of the participant).

Providers must maintain proof of the delivery of supplies (i.e., return receipt to include the participant's name, quantity delivered, detailed description of the delivered item, brand name, serial number) in their place of business for a minimum of five years. Proof of delivery documentation must be made available to Medicaid upon request. Any claims for services that do not have a documented proof of delivery from the supplier shall be denied and payments recovered.

Delivery confirmation slips must show ship dates, mailing dates, delivered dates, and addresses to which deliveries were made. The delivery confirmation slip must document if someone signed for the package, or if it was delivered without a signature, and where it was left for the participant.

Medical supply providers can access the delivery confirmation information maintained by the delivery companies online. Providers must keep delivery confirmation records for five years. Medicaid will not accept a tracking number without the follow-up delivery confirmation data.

7

LTL ENVIRONMENTAL MODIFICATION STANDARDS AND SPECIFICATIONS

GENERAL RAMP SPECIFICATIONS

These specifications are to be used as a guide to our providers. They will not be used to diminish in any way local, state and national codes. These specifications are a summary of information gathered using the International Building Code (2010 Edition), ICC, ANSI A117.1 1998 and ADA Standards for Accessible Design.

General Notes

- Permits are the responsibility of the provider.
- Ramps are to be firm, stable, slip resistant and safe.
- Ramps and landings with drop offs will have a minimum 4" curb and railings.
- Ramps will be built using pressure (weather) treated lumber.
- Please advise clients that ramps need to be treated/weatherproofed annually.
- Ramps and landings are measured by the clear space provided, 56"x56" landings will not be counted as 5'x5' landings and will be re-built.
- No toenailing of railings between posts is permitted.
- All screws will be predrilled with pilot holes to prevent splitting.
- There is only one type/size of ramp, no heavier duty.

General Materials

- 4x4 posts
- 2x6 (min.) joists
- 2x6 or 5/4x6 decking
- 2x4 (min.) curbing, top, and top support rail
- 2x2 pickets

- 1 ¼" galvanized pipes (fence top rails) are to be used as handrails with galvanized "C" clamps and PVC caps.
- 2x4x4" or 2x4x6 handrail spacers
- 3" ring-shanked exterior nails and 3" and 2½" decking screws
- 2500 PSI cement

Foundations

- Posts must be a minimum 4x4 CCA lumber.
- Posts must be sunk a minimum 12" into the ground and set in concrete (min. 25lbs).
- Exception – if post is set on cement walkway or driveway, post may be anchored with a post base attached to the cement and/or cross- braced for stability.
- Foundation posts are to be set no more than 8' apart.
- Set the final post back 8" from the end of the ramp.

Floor Framing

- Outside joists shall consist of 2x6 (min) lumber connected to the foundation posts.
- Inside joists shall be 2x6 (min) and shall be connected to the foundation posts using a header board and proper joist hangers.
- There shall be no more than 16" between joists.
- There shall be four total joists: (2) inside and (2) outside.
- All framing will be attached with 3" ring-shanked nails or 3" decking screws.
- The 1st three decking boards at either end of the ramp must be attached with screws.

Slopes

- All landings must be level (slope no greater than 1:50).
- All cross slopes must not exceed 1:50.
- Ramps will have a maximum slope of 1:12 with few exceptions.
- In the RARE case a steeper slope is needed, the following will apply:
 - A 1:10 slope is permitted for no more than a 6" rise.

- A 1:8 slope is permitted for no more than a 3” rise.

Ramps

- Shall not rise more than 30” between landings.
- Shall lead to a firm stable landing, provider is responsible for the area at the end of a ramp.
- The ramp will be finished with concrete a minimum of 1” deep, 12” long, and the width of the ramp to aid in transition to the ground.
- Shall be level with a cross slope of no more than 1:50.
- Shall have a clear width of 41”.
- With a drop off of more than 2” shall have a minimum 4” curb.
- Shall allow for water to run off and not collect.
- Must be slip resistant (floor areas painted with a non- slip paint).
- Must use 2’x6” or 5/4”x6” as decking.
- Ramps are not to be built attached to the house unless necessary (2’ spacing).
- Ramps for clients using stretchers should avoid turns and be angled if possible.

Note: The end of the ramp will be finished with concrete.

Landings (General)

- Must be level – slope less than 1:50, must be stable and slip resistant.
- Landing will have pickets.
- Landings must have top rail, top support rail and curbing.
- Must be at least 60”x60” clear space if the ramp changes direction.
- “Straight through” landings must be the width of the ramp and 5’ long.
- “Switchback landings” will be at least 60”x96” clear space.
- Joists will be no more than 16” apart.

Landings at Doorways

- Shall have no more than a ½” beveled threshold between landing and interior floor.

- Must have a minimum 18"+ of clear space past the latch side of the door (24" preferred).
- Will minimum have 60"x60" clear space.
- Railings are required for drop offs of more than 2".
- Must not be positioned in such a way as to expose people to the danger of falling, (i.e., railings blocking exposed steps).

Handrails

- Will be made from 1¼" galvanized pipes (fence top rail) with support blocking every 5'. Poles come in 10' lengths and are tapered to fit together.
- Blocking will be screwed into the top rail.
- Shall be attached to blocking with galvanized "C" clamps and glued on PVC caps.
- Shall run parallel to the floor of the landing or ramp.
- Shall be continuous on both sides.
- Shall extend 6" past the end of the last block, but not past the end of the ramp.
- Shall have a 1½" clearance between handrail and top rail and any wall.
- Shall be between 34" and 38" high.
- Shall not rotate within its fittings, drill a screw into galvanized pipes at every block.
- Must be able to withstand 350 lbs. of pressure.

Top rails, side rails and curbing

- All lumber above the floor level is to be attached using decking screws.
- Top rail must have a side support rail on the inside of the ramp.
- All rails shall be attached on the inside of the ramp to the 4x4 posts (no toe- nailing between posts).
- 2x2 pickets will be placed no more than 4" apart, will be pre-drilled and installed with a 2½" decking screw, a 2x4 will be substituted for the last picket at the end of the ramp.
- Pickets will be screwed into the top rail, curbing and the ramp frame. Brad nailing pickets into place before screwing can save time.

- Curbing shall be attached on the inside of the ramp to the 4x4 posts (no toe- nailing between posts) and be 2” off the ramp.

Heavy Duty Ramps and Landings

- Ramps and landings for clients above 250 lbs. shall be built to accommodate the extra weight.
- These ramps shall use: 2x6 decking boards; 2x8 joists every 16”; and be a minimum of 44” wide clear space.

LTL STANDARDS FOR BATHROOM SAFETY PRODUCTS

Specs for Raised Toilet Seat with Steel Legs (3-in-1 Folding Steel Commode with Standard Seat Depth)

- Reimbursement – \$100.00
- Minimum weight capacity – 350 lbs.
- Seat width – 13.75”- 15”
- Seat depth – 13”- 14.5”
- Seat height – 15.5”- 21.5”
- Width between arms – 18”
- Overall width – 22.25”
- Locking
- Installation

Note: Materials – Primary material is steel. Warranty – Lifetime Limited Warranty.

Specs for Bariatric Raised Toilet Seat with Steel Legs (Heavy Duty, Bariatric, Folding Commode – 650 lbs.)

- Reimbursement – \$195.00
- Minimum weight capacity – 650 lbs.
- Seat width – 13.75”- 15”
- Seat depth – 16.5”
- Seat height – 15.5”- 22”

- Width between arms – 24”
- Overall width – 31.75”
- Locking
- Installation

Note: Materials – Primary material is steel. Warranty – Lifetime Limited Warranty.

Specs for Transfer Benches

- Adjustable height from 17” to 23”
- Backrest
- Arm rail
- Seat depth – 18”
- Seat width – 33” minimum
- Maximum weight capacity – 350 lbs.
- Installation, assembly and adjustment

Specs for Bariatric Shower Transfer Benches

- Minimum weight capacity – 500 lbs.
- Backrest
- Seat depth – 16”
- Seat width – 28”
- Seat height – 16” minimum
- Installation

Specs for Shower Chair with Back

- Back rest
- Maximum weight capacity – 300 lbs.
- Adjustable

- Seat height- 17” to 21”
- Seat width – 20”
- Seat depth – 18”
- Installation

Specs for Bariatric Shower Seat

- Back rest
- Minimum weight capacity – 500 lbs.
- Seat height – 16” minimum
- Seat width – 17”
- Seat depth – 16”
- Installation

Specs for Hand-Held Showers

- Minimum 6’ hose
- Pause/shut off function
- Installation with Teflon tape

Specs for Oil Filled Space Heaters

- Reimbursement – \$61.75
- Minimum 1-year warranty
- Wheels/Casters
- 3 heat settings
- The oil filled space heaters must be delivered and set up.
- Accepted brands for oil filled space heaters: Honeywell (Walmart), Pelonis (Home Depot), DeLonghi (Lowe’s).

Alternative Space Heaters that may be Shipped

- Lasko 2 heat tower electric space heater Model 6251 Item # 142570 (Available at Lowes)
- Warmwave 1500-watt ceramic portable tower heater Model HPQ15M (Available at Home Depot)

Note: These products can be shipped to participants. No substitutions are allowed unless prior approval is given in writing.

SANCTION PROCESS

LTL will review provider compliance with environmental modification program requirements on an ongoing basis. The department's environmental modification specialist will complete reviews. Failure to comply with the environmental modification requirements will result in the application of sanctions, either suspension and/or termination.

Suspension

The environmental modification provider is removed from the provider choice list. The provider will not be allowed to bid or be listed on the participant's choice list for the duration of the sanction. The minimum period of suspension is 1 month. Providers who are suspended must complete all outstanding jobs to the specifications indicated by the environmental modification specialist before being allowed to perform new work with LTL.

Termination

The cancellation of your enrollment in the Medicaid (LTL) program resulting in denial of Medicaid participation for a period of three (3) years. After two suspensions for any reason, a third suspension in a two (2) year period from July-June will lead to termination from Medicaid participation.

Compliance Issues Resulting in Suspension and/or Termination

Refusing to complete jobs that the provider has bid on and won

Providers are expected to complete any job where they are the winning bidder. If the winning bidder accepts the job, then refuses to complete the project the provider will be subject to the following sanctioning process.

First offense – Suspend one (1) month

Second offense – Suspend two (2) months (within 1 year of first offense)

Third offense – Termination (within 1 year of first offense)

Example: The provider bids and accepts jobs in several different areas. He or she gets to the jobsite and decides he or she has underbid the project and/or does not have the time or manpower to complete the job and refuses to honor his bid. This action will result in sanctioning of the provider.

Failure to complete jobs timely as defined by the date on the environmental modification specialists bid notification in Phoenix

Providers are expected to complete work in a timely manner. If it is identified that there are three (3) occurrences of this type within a six (6) month time period of January through June and/or July through December, the following sanctions will apply:

Suspension for two (2) months

- Each subsequent occurrence – Suspension for two (2) months

Example: The provider accepts a project through Phoenix which has an expected date of completion on it; if the provider accepts the job he is accepting the completion time frame. If the environmental modification specialist discovers that the provider is not completing this project in the allotted time frame indicated on the bid in Phoenix this action will result in sanctioning of the provider indicated above.

SCDHHS environmental modification Inspector returning to jobsite due to poor workmanship

Providers are expected to comply with the standards set forth by the environmental modification inspector. If the SCDHHS inspector must return to the jobsite due to poor workmanship the following sanctioning process will occur.

- Three (3) substantiated returns in any quarter – Suspend two (2) months
- Six (6) substantiated returns in any quarter – Terminate

Example: The provider accepts a project through Phoenix and completes the job. The environmental modification specialist will then review the work done. If the environmental modification specialist determines the project was not done to general contracting standards a letter will be sent to the provider indicating the corrections that need to be completed on the job. If this occurs, sanctioning of the provider will occur based on the schedule mentioned above.

Documenting in Phoenix that a job is complete and/or billing for services through the Electronic Visit Verification (EVV) system prior to completion of job

Providers cannot bill Medicaid prior to the completion of an environmental modification project. If providers are found to have billed Medicaid or documented in Phoenix that the job was completed prior to job completion the following sanctioning process will apply:

- Recoupment of inappropriate payment, if found job is not completed plus
- First offense – Suspend for one (1) month
- Second offense – Suspend two (2) months
- Third offense – Termination

Example: The provider accepts a project through Phoenix and goes to work on the job. The crew tells the provider they have completed the job and the provider indicates this in the Phoenix system and/or bills for the job through the Electronic Visit Verification (EVV) system . The environmental modification specialist and/or participant determine the project was not complete prior to indicating it in phoenix and/or billing through the Electronic Visit Verification (EVV) system will result in the sanctioning of the provider will occur based on the schedule mentioned above.

Refusal or inability to complete job to the specifications set forth by the Environmental Modification inspector

Providers are expected to complete jobs within the standards set forth by the environmental modification specialist. Any job not completed to general contracting specifications will receive a corrective action letter that must be followed. If the provider does not follow the corrective action letter and the deficiencies are not corrected within two (2) weeks all funds will be recouped and the provider will be automatically suspended from providing services to Medicaid participants until the job has been completed. The provider will be reinstated one month after the date of completion of the job.

A second offense of the type described above will result in being suspended for two months after the correction of the deficiencies and a third offense will result in automatic termination as a Medicaid provider.

Example: The provider accepts a project through Phoenix and completes the job. The environmental modification specialist will then review the work that was done. If the environmental modification specialist determines that the project was not done to general contracting standards a letter will be sent to the provider indicating the corrections that need to be completed on the job. If the provider does not correct the deficiencies within two weeks this will lead to the sanctioning process mentioned above.

PEST CONTROL STANDARDS FOR LTL PARTICIPANTS

Conditions of Participation

All providers must verify participant's Medicaid eligibility upon acceptance of an authorization for pest control and any time services are rendered thereafter to ensure continued eligibility.

Agencies must utilize the automated systems mandated by LTL to document and bill for the provision of services.

Providers must accept or decline referrals from LTL or SCDDSN within two (2) working days. Failure to respond will result in the loss of the referral.

Conduct of Service

The Provider must obtain an authorization for pest control services from LTL. The authorization will designate the amount, frequency and duration of service for participants. Pest control authorizations are for a maximum of once every other month. The Provider will receive new authorizations only when there is a change to the authorized service amount, frequency or duration.

All instructions on the authorization for service must be followed in order to be reimbursed for the pest control service. Pest control services must be completed by the provider within 14 days of acceptance of the LTL authorization for service.

Pest Control treatments need to include both in-home and exterior treatment. All providers must go into the participant's home to inspect and treat the residence and call in the service to the Electronic Visit Verification (EVV) system . If a participant is not at the residence at the time of the treatment the provider will need to reschedule for a time when the participant will be present in the home.

Providers can only utilize a cell phone to call in claims if the participant does not have a home phone.

If for any reason a provider is not able to make the call for pest control the day of the treatment, then the claim will need to be submitted via the Electronic Visit Verification (EVV) system website. Providers who are not routinely calling in claims for this service through the Electronic Visit Verification (EVV) system phone system will be terminated from South Carolina Medicaid.

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BILLING GUIDANCE

LTL WAIVER SUPPLY PROVIDERS

Billing Procedures and Service Monitoring

The provider must agree to participate in all components of SCDHHS' Electronic Visit Verification (EVV) system or Phoenix monitoring and payment system when providing services for participants of the Community Choices, HIV/AIDS, Mechanical Ventilation and MCC waivers. The Electronic Visit Verification (EVV) system is an automated system used for service documentation and Medicaid Management Information System (MMIS) billing. Phoenix is a system that is used for service monitoring, web-based reporting and billing to MMIS. The provider will document its provision of incontinence products for all SCDHHS-operated waivers in the Phoenix system via a web-based claims submission process. Providers will be required to bill claims on this website in a timely manner. Claims, at a minimum, must be entered into the website within the quarter after the date of service. In all cases, services documented are compared with prior authorizations in the system to determine if the services were provided appropriately. Claims rejected for payment must be resubmitted through the local LTL area office.

For monitoring of service delivery and reporting, real-time reports allow providers, case managers, and/or nurses to monitor participants more closely to ensure receipt of services. On a bi-weekly basis, the Electronic Visit Verification (EVV) system generates electronic billing to MMIS for services provided. Only authorized services and the total units provided (up to the maximum authorization) are submitted to MMIS for payment. This billing ensures accuracy of claim processing.

For all instances in which a participant did not receive an authorized shipment for waivers operated by SCDHHS, the provider must indicate the reason why the shipment was not delivered on the Electronic Visit Verification (EVV) system website. For each month in which the delivery of the product was not provided, the provider must indicate the reason on the website by the close of business the following week.

The ID/RD, CS and HASCI waivers currently do not require the use of the Electronic Visit Verification (EVV) billing system and claims may be submitted electronically via the South Carolina Medicaid Web-based Claim Submission Tool, tape, diskette or hard copy.

SCDHHS reserves the right to perform onsite reviews during normal business hours to ensure compliance with policies and procedures.