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07.10 Introduction

Service authorization is the process of issuing a written document, which enables enrolled service providers to initiate home and community-based services for participants. The service authorization is based on the finalized service plan for an individual CLTC participant.

The CLTC Participant's Rights and Responsibilities Statement include several expectations that a participant and CLTC should abide by if the participant receives waiver services. These expectations are critical to the effective delivery of services and should be carefully communicated to the participant.

Restrictions on amount of services a waiver participant receives may be necessary. If this is determined to be the situation, such restrictions will be communicated to staff as interim policy and procedures.

07.20 Service Authorization Policy and Procedure

07.21 Waiver Services

The purpose of waiver services is to provide realistic options for participants who need help to remain at home and thus avoid unnecessary or premature nursing home care.

Waiver services are provided by contracted and enrolled Medicaid providers to eligible participants and may include:

- Adult Day Health Care *****
- Adult Day Health Care Nursing
- Adult Day Health Care Transportation *****
- Adult Care Home
- Attendant Care
- Bath Safety Equipment
- Case Management *****
- Companion Services: Individual and Agency (* agency only)
- Environmental Modifications
- Enhanced Environmental Modifications
- Enhanced Pest Control
- Home Delivered Meals *****
- Nursing Home Transition
- Nutritional Supplements
- Personal Care I *****
- Personal Care II *****
- Personal Emergency Response System
- Pest Control
- Respite Care: Institutional *****, Community Residential Care Facility *****
- Telemonitoring

*** indicates a scope of service is available**

A scope of service exists for many of the waiver services and is part of the agreement which defines both provider and CLTC's responsibilities in the provision of waiver services. See the Chapter 7 Service Addendums for more information.

Case management is a waiver service that is provided to all participants who participate in the CLTC program. It is the process of discussing and coordinating services to enable the participant to remain in the home. Case management begins on the date the participant enters the program and continues through the date of application closure. It is a vital part of the long term care service system. Some participants may choose and/or need only case management services. In such situations, the value of case management is in the continued follow-up, coordination and monitoring of services other than CLTC waiver services. On-going case management enables the **Case Manager** to periodically evaluate changes in the participant's service needs.

Waiver services other than case management should not be authorized until all other community resources have been explored and documented. An agency's maintenance of effort is vital in assuring that CLTC can be a cost effective program. Maintenance of effort means that an agency will continue to provide services that the agency has in place once CLTC initiates case management. It is important that state agencies, their affiliates, and other local organizations make every effort to maintain existing services to long term care participants and to provide additional services when appropriate. Cost-shifting to the Medicaid Program must be avoided. In instances where CLTC has requested an agency to provide temporary services while eligibility is being established, maintenance of effort may not be applicable.

Maintenance of effort is considered to be satisfied when those agencies involved in the participant's care continue their services after CLTC becomes involved. If an agency discontinues a service, the **Case Manager** should contact that agency to determine if it is a temporary or permanent interruption and then annotate in the Narrative accordingly.

Moreover, a participant's primary contact and/or other permitted caregiver support should continue their efforts in caring for that person. In most situations, CLTC waiver services should not replace the caregivers' support, but should supplement their efforts.

Waiver services may **not** be provided by the following individuals:

1. The spouse of the Medicaid consumer;
2. A parent, step-parent, or foster parent of a minor Medicaid consumer;
3. Any other legally responsible guardian (court ordered). Power of Attorney (POA) alone does not equate to being the legally responsible guardian.

Note: The primary contact cannot serve as the supervisor of the paid caregiver and be the paid caregiver. This would mean the person was supervising himself/herself. A person who is the primary caregiver cannot be paid to provide respite. The reason for this is these two services are primarily designed to give relief to the primary caregiver. Should there be any question as to whether a paid caregiver falls in any of the above listed categories, contact **Central Office Designee.**

Several factors influence authorization of waiver services. These factors include:

1. The participant’s type of support system and the assistance provided.
2. The degree of assistance required and the time required to complete the care.
3. The participant’s cognitive ability and its impact on the degree of assistance required and the time required to complete the care.
4. The participant’s expressed need for assistance and the value the participant assigns to these needs.
5. The availability of other resources to meet these needs.
6. The most cost-effective way to meet these needs.

In summary, waiver services should only be authorized when there is a lack of available Non-Medicaid services to meet the participant's needs as specified in the CLTC Service Plan.

07.21.10 Waiver Participant Residing in Community Residential Care Facility

A Waiver participant may continue waiver services while residing in a Community Residential Care Facility if that specific facility meets specific requirements. Prior to authorizing waiver services for the participant residing in a Community Residential Care Facility, the following questions must be asked by the Community Residential Care Facility Administrator or designee. This information must be documented in the narrative. If any answer is no, the participant may not be able to remain in the waiver.

1. Can the participant's room be locked and does the participant have a key?

2. Does the participant have the ability to have a private room and/or choose a roommate?

3. Is food available twenty-four (24) hours per day, seven (7) days per week?

4. Can the participant have a guest twenty-four (24) hours per day, seven (7) days per week?

5. Did the participant sign an Agreement and/or Contract with the Community Residential Care Facility?

When a waiver participant resides in an approved Community Residential Care Facility, the participant may routinely receive any of the following services: Case Management, Personal Care II one (1) hour per day up to seven (7) days per week and Nutritional Supplements. The participant that resides in Community Residential Care Facility may not routinely receive any other waiver services. If a waiver service other than Case Management, Personal Care II or Nutritional Supplements is indicated, the **Case Manager** must request an exception from the **Central Office Designee**.

Should relocation of a waiver participant be required in cases where the CRCF Is not in compliance with waiver requirements, the **Case Manager** or **Nurse Consultant** will discuss all options with the participant, primary contact and CRCF.

The **Case Manager** or **Nurse Consultant** will notify the **Area Administrator** and/or **Lead Team** if it is determined that a CLTC waiver participant is residing in a non-compliant CRCF. The **Area Administrator** or **Lead Team** will notify **Central Office Designee.**

The **Case Manager** or **Nurse Consultant** will:

- Provide a list to the participant of complaint CRCF from the Nursing Facility Bed

Locator.

- Explain alternative options for care including other non-waiver community resources or aging services.
- Explain the need to re-locate to an approval facility in order to remain enrolled in waiver.
- Document all decisions.
- Send a CLTC Notification Form 171 to participant and/or primary contact providing a thirty (30) day notice indicating the need to move to a complaint setting.

Refer to Waiver Interactions with Community Residential Care Facility (Refer to 07.31 or Phoenix Help.)

07.22 Choice of Waiver Service Provider(s)

A participant, primary contact, and/or other permitted caregiver support must make a choice of provider for each waiver service. When the initial assessment is completed by in-home visit, the choice of case management provider is documented on the participant's Choice of Provider(s) Form (Service Provider Report), during the **Nurse Consultant's** assessment visit. If the **Nurse Consultant** completes a phone assessment, the choice of case management provider will be obtained by the **Case Manager II** by phone when the case is transferred for enrollment. The **Case Manager II** will document the provider in order of preference in the narrative record. The remaining waiver services may be explained to the participant, primary contact, and/or other permitted caregiver supports during the **Case Manager's initial phone contact or visit** at which time the participant, primary contact, and/or other permitted caregiver supports may make a verbal choice of provider for a needed service or services. The verbal choice must be annotated on the Choice of Provider(s) Form (Service Provider Report) and documented in the narrative record in order of preference. If a verbal choice cannot be obtained, a participant's Choice of Provider(s) Form (Service Provider Report) will be mailed to the participant and/or primary contact.

The participant Choice of Provider(s) Form (Service Provider Report) is discussed with the participant, primary contact, and/or other permitted caregiver supports during the **Case Manager's Initial Visit.** During this visit, the signature is secured for previous verbal choice(s). Subsequent changes or additions of providers are made verbally and documented in the narrative and need not be documented on the participant Choice of Provider(s) Form. It is important that the participant, primary contact, and/or other permitted caregiver supports makes this decision independently. The **Case Manager** shall not influence a participant's choice of providers. If a participant is not physically or mentally able to complete and/or sign the participant Choice of Provider(s) Form (Service Provider Form), the primary contact or other permitted caregiver supports may do so for the participant. The lack of a signature on the form will not preclude the participant from receiving waiver services.

At any time, the participant, primary contact, and/or other permitted caregiver supports requests an additional waiver service or a change in providers, the **Case Manager** will inform the participant, primary contact, and/or other permitted caregiver supports of all available providers of the service(s). The **Case Manager** must narrate this information exchange as well as the choice of provider(s), in order of preference in the narrative record. At any time, the participant, primary contact, and/or other permitted caregiver supports may request a change in any choice of provider including Case Management Provider.

When creating a referral, the **Case Manager** will enter the provider choices in order of preference. Phoenix will automatically refer and notify the next Provider of Choice if an affirmative response has not been received from the first chosen provider within forty-eight (48) hours.

It is the responsibility of each local CLTC Area Office in conjunction with the CLTC Central Office to keep a continuously updated Resource Directory for each waiver service available in that region.

Process:

- **Nurse Consultant** will provide CLTC Brochure and CLTC Choosing a **Case Manager** brochure and secure participant/primary contact signature on the initial Case Management Provider Choice Form if a home visit is completed.

- If the initial assessment is completed by phone, the **Case Manager II** will obtain the Case Management Provider Choice verbally during the enrollment process. These choices must be documented on the Service Provider Report and in the narrative record in order of preference. The **Case Manager** will provide the CLTC Brochure and the CLTC Choosing a Case Manager Brochure at the Initial Visit.

- **Upon transfer, Case Manager II** will contact or visit participant/primary contact for service planning. If service provider choices cannot be made by phone, **Case Manager II** will send appropriate provider choice list (Service Provider Report) for the negotiated services. **Case Manager II** will contact the participant and/or primary contact **within seven (7) business days** from mailing the list regarding choice of providers. A copy of the provider choice form with the choice date should be retained in Phoenix. **Upon Initial Visit** by the **Case Manager**, this form will be signed and dated by participant/primary contact. If contact is by visit, the **Case Manager II** will have the choice form signed when choice is made.

- New cases may be transferred to the on-going **Case Manager** at any time during the month; however, the Initial Visit time frame requirements must be considered. Adequate time must be allowed for the **Case Manager** to complete the Initial Visit within the thirty (30) day timeliness requirement.

  ***Exception:** If the Initial Visit is due within five (5) business days of the Case

Management referral, the **Case Manager** must complete the visit within ten (10) days of accepting the referral. The late visit activity will not be subject to strikes or recoupment for timeliness if the Initial Visit is made with ten (10) business days of the referral acceptance.

- Assigned **Case Manager** will provide follow up for any services provider choices and referrals/authorizations in process.

07.23 Authorization of Waiver Services

Prior to authorization of any waiver services, the **Case Manager** must be familiar with all scopes of services. Waiver services are based on a participant's need as documented in the Service Plan. Prior approval of the authorization by designated State Worker or Medicare - Medicaid Plan (PRIME) designee for PRIME waiver participants is required before issuing the authorization.

Upon receipt of participant's choice of provider, the **Case Manager** must initiate referrals to the chosen provider(s) **within two (2) business days**.

Prior to initiating a service authorization, the **Case Manager** must make the referral to the provider through Phoenix and include any special needs or preferences of the participant. The provider must be given the opportunity to accept or reject the referral. The provider must accept or reject the referral **within two (2) business days.** Once a start date has been negotiated with the Provider, the **Case Manager** has two (2) business days to issue an authorization to initiate the waiver service. (Note: except ADHC and Incontinence Supplies where physician orders are needed prior to authorization). The service authorization must be specific, accurate, and sent to the provider via Phoenix.

It is acceptable to authorize waiver services on the day of admission to or discharge from an institution (i.e., hospital, nursing home, rehabilitation center, psychiatric facility.) The Narrative must clearly document the need for such services.

The authorization period end date may or may not be indicated on the Service Provision Form. The end date will be included when the service is required for a known period of time, if less than thirty (30) days from the start date. The authorized end date on the Service Provision Form is a valid date of service delivery to the participant. Authorizations without an end date will be valid until a new service authorization or termination is issued to the provider.

For specific services see the corresponding chapter addendum.

The **assigned Case Manager:**

- Contacts participant to discuss specific needs, provider choice and schedule of services.

- Obtains prior approval of authorization by designated State Worker or Medicare - Medicaid Plan (PRIME) designee for PRIME waiver participants.

- Notifies provider of a referral, including any special needs or preferences of the participant and possible start date of services using Phoenix.

- If necessary, forwards a copy of the appropriate form or forms to the Physician for completion and signature.

- Upon confirmation of start date of services, contacts participant to inform of start date and confirmed schedule of services.

- Completes Service Provision Form for each waiver service being authorized.

- Sends Service Provision Form to Provider via Phoenix. Service Provision Form and Service Plan are accessible to the providers of PCI, PCII, ADHC, ADHC – Nursing, and ADHC-Transportation. The Service Plan is not available via Phoenix for Attendant Care or Respite Care. The **Case Manager** must provide the Service Plan via mail, fax, or personal delivery to the Respite Care Provider and Attendant Provider.

- Contacts participant or primary contact at **next scheduled contact** to verify implementation of service. Exception: Environmental Modification must be verified at the contact following the authorized end date.

- If Institutional Respite or Respite in a Community Residential Care Facility is being sought, refer to the corresponding Addendum in this chapter.

- Reviews participant's service plan within two (2) business days of receipt of the Provider's request to modify the service plan.

07.24 Verifying Implementation of Authorized Services

Case Manager must address service delivery with the participant, primary contact, and/or other permitted caregiver supports during the next scheduled contact following the service authorization start date. Care Call claims should be reviewed. Follow-up contact with the provider (s) may be necessary to resolve questions or problems with authorized services.

07.25 Change/Termination of Waiver Services

When an existing service authorization requires a change, other than a change of provider, the **Case Manager** completes a service termination and keys a changed service authorization. Prior approval of the authorization by designated State Worker or Medicare – Medicaid Plan (PRIME) designee for PRIME waiver participants is required before issuing the authorization. The new Service Provision Form must be sent to the provider of services.

When a provider of services changes, the **Case Manager** must terminate the Service Provision Form with the previous provider and initiate a new service authorization for the chosen provider. The terminated Service Provision Form must be sent to the terminated provider and the new

Service Provision Form must be sent to the new provider of service via Phoenix.

When a service is changed for a weekly service, but the provider does not change, the authorization start date must be Sunday.

Services must be terminated if a participant no longer requires the service or if the participant becomes ineligible to receive the service. Waiver services may be terminated at any time during a re-evaluation cycle. Termination of a service will necessitate a revision of the service plan. Services will remain in effect through the date of termination on the Service Provision Form.

When services are involuntarily suspended, reduced or terminated, the participant must be given a written appeal notice as well as a written **ten (10) calendar day notice**. If the participant and/or primary contact decides to appeal and notifies the office within the ten (10) calendar days of the notification, services may continue at the participant's primary contact's request, until the outcome of the hearing. The participant and/or primary contact should be informed that the participant may be responsible for the cost of services received during this period if the hearing decision is not in the participant's favor.

When a participant is determined to be financially ineligible, waiver services must be terminated on the last date of eligibility. This action must be documented in the narrative.

Both the participant and provider must be notified by verbal contact at the time of service termination if the termination is immediate. This verbal notification must be followed with a service termination to the provider and a notification form to the participant and appropriate parties. The Conversation feature in Phoenix may be used in instances where immediate information is not required and when appropriate.

When a medically ineligible decision is final for a waiver participant, waiver services must be terminated in accordance with proper notice to the provider.

When services are voluntarily suspended, reduced or terminated, an appeals notice is not required. A CLTC Notification Form 171 must be sent stating the request.

If a requested service is denied, a CLTC Notification Form 171 must be sent stating what service was denied and the appeals notice must be given. A ten (10) day notice is **not** required.

The notification letter must be mailed within two (2) business days of the date of the letter.

07.26 Rationale for Increased Service Units

For Adult Day Health Care, Personal Care I, Personal Care II, Agency Companion, Individual Companion and/or Attendant Care:

When a participant is determined to need a change in the level of services provided, the **Case Manager/Nurse Consultant** must review all services and strive to meet the needs of the participant. The need for the increase in service units must be justified by the assessment,

narrative and service plan.

If the participant is not authorized for Adult Day Health Care OR the participant is authorized for Adult Day Health Care two (2) days or less per week, the services of Personal Care I, Personal Care II, Agency Companion, Individual Companion and/or Attendant Care can be approved by the State Reviewers in any combination not exceed twenty (20) hours per week. The **Area Administrator or Lead Team** may approve any combination of twenty-one (21) to thirty (30) hours per week. **Central Office Designee** may approve any combination of thirty-one (31) or more hours per week.

It the participant is authorized for Adult Day Health Care three (3) or more days per week, the services of the Personal Care I, Personal Care II, Agency Companion, Individual Companion and/or Attendant Care can be approved by the State Reviewers in any combination not to exceed fifteen (15) hours per week. The **Area Administrator or Lead Team** may approve any combination of sixteen (16) to twenty-five (25) hours per week. **Central Office Designee** may approve any combination of twenty-six (26) or more hours per week.

The **Case Manager** must provide justification of the need for increased service units in the comments section of the approval request section of the Service Plan and submit the request through Phoenix to the **Area Administrator** or **Lead Team** for approval. The **Area Administrator** or **Lead Team** reviewing the request will enter a comment indicating whether or not the need is justified. If the **Area Administrator** or **Lead Team** determine the need is justified, the request is sent to the **Central Office Designee** for review. The **Case Manager** will send an email request to the **Central Office Designee** asking for review of the request after approval from the **Area Administrator** or **Lead Team** is obtained. The **Central Office Designee** will review the request in Phoenix, complete the review column and indicate the decision in the comment section. The **Case Manager** will be notified by email once the request has been reviewed.

When a participant is determined to need a change in the level of services provided, the **Case Manager/Nurse Consultant** must review all services and strive to meet the needs of the participant. The need for the increase in service units must be justified by the assessment, narrative and service plan.

For Nutritional Supplements and Personal Emergency Response System:

If it is determined that a participant does not meet the criteria for Nutritional Supplements or Personal Emergency Response System but needs the service. A request for an exception may be sent to the **Central Office Designee** for review. This request should be sent via an email.

When **Central Office Designee** has granted an exception for Nutritional Supplements or Personal Emergency Response System, an additional review is not required by **Central Office Designee** upon re-evaluation if the following conditions are met:

- The original **Central Office** approval was not time limited.

- There is no change in the condition(s) which justified the need for the original exception approval.

- There has been no change in the participant's level of care.

Note: This does not apply to approvals for increased Personal Care I, Personal Care II, Agency Companion, Individual Companion or Attendant. All of these increased service units are time limited and require approval upon re-evaluation.

When **Central Office** Service Exception is needed for any service, the **Area Office** reviewers will review the request and enter a comment with the recommendation regarding the request. The reviewer will leave the review column blank. The **Case Manager** must email the **Central Office Designee** to request review of the exception following the **Area Office** review. The **Central Office Designee** will either approve or deny the exception request and will notify the **Case Manager** by email.

ADDENDUMS

7A Adult Day Health Care

One (1) unit of service is a participant-day of Adult Day Health Care (ADHC) service, consisting of a minimum of five (5) hours at the ADHC, not including transportation time.

Exceptions: The following are examples of cases where CLTC **may** consider a request for reimbursement even though the participant was not at the center for the entire five (5) hours. In all such cases, the provider must advise the CLTC Area Office. This contact must be documented in Phoenix.

- If the participant has a medical emergency, non-scheduled medical/doctor's visit, or need for urgent care.
- Inclement weather affecting the safe transport of participants, emergency evacuations such as for hurricanes, disasters, or when the Governor declares weather or other emergency.
- If an emergency arises where the staff must accompany the participant to receive medical attention.
- If the ADHC is transporting the participant to a medical appointment, then a four (4) hour stay is acceptable.

These cases must be approved by the CLTC Central Office, and will be addressed on a case-by-case basis upon receipt of a request describing the circumstances.

The **Case Manager** will create the Service Provider Choice Form (Service Provider Report) in Phoenix. The **Case Manager** will obtain the provider choice(s) from the participant and/or primary contact in the order of preference. These choices may be obtained verbally, by mail or during an in-home visit. If the choices are made verbally, the choices are documented on the Service Provider Choice Form (Service Provider Report) and in the narrative. The Service Provider Report will be signed by the participant and/or primary contact at the next in-home visit.

The **Case Manager** will update the Service Plan to include the need for Adult Day Health Care.

Prior approval must be requested via the service request section of the Service Plan in Phoenix.

The **Case Manager** will create a referral to the chosen providers in order of preference in via Phoenix.

If the referral is accepted, the **Case Manager** notifies the ADHC of the pertinent participant information including the contact information for the physician. The ADHC must obtain the physician orders for the participant to attend ADHC utilizing the Adult Day Health Care Form. Once the ADHC has obtained the physician's order, the ADHC must notify the **Case Manager** to negotiate the start date for services to begin.

The **Case Manager** will authorize the amount, frequency and duration of services in accordance with the participant's Service Plan.

The Service Provision Form and the Service Plan must be sent to the provider via Phoenix to initiate services. The initial Service Plan and the new Service Plan created following re-evaluation will be available to the provider via Phoenix.

If a participant transfers from one ADHC provider to another ADHC provider, the participant's existing Physician order for ADHC remains effective.

The ADHC is responsible for providing transportation when the most direct route door to door from the participant's residence to the adult day care is 15 miles or less one way.

If the participant has different locations for pick up and drop off, the authorization must indicate all locations. The comment section of the authorization should be used to indicate any additional locations for pick up/drop off. The additional locations must be within the 15 miles of the ADHC for CLTC to pay for ADHC transportation.

7B Adult Day Health Care-Nursing

One (1) unit of service includes any one or more of the allowed ADHC-Nursing Services during one (1) day's attendance at the ADHC.

This service is provided by a licensed nurse in the ADHC. ADHC-Nursing is limited to the following skilled procedures:

- Ostomy care
- Urinary catheter care
- Decubitus ulcer/wound care
- Tracheostomy care
- Tube feeding
- Nebulizer treatment that requires medication

The **Case Manager** will update the Service Plan to include the need for Adult Day Health Care-Nursing.

Prior approval must be requested via the service request section of the Service Plan in Phoenix.

Note: An intervention for at least one of the skilled procedures must be included on the Service Plan in order to request prior approval.

The **Case Manager** will create a referral to the chosen ADHC provider.

The ADHC provider must obtain the physician orders utilizing DHHS Form 122A for the participant to receive ADHC-Nursing prior to the initiation of the service. The ADHC is responsible for obtaining the initial order as well as the direct care and ongoing orders including changes in frequency. Once the ADHC has obtained the physician's orders, the ADHC must notify the **Case Manager** to negotiate they start date for services to begin.

The **Case Manager** will authorize the amount, frequency and duration of services in accordance with the participant's Service Plan. The authorization is not day specific. There is one (1) procedure code for ADHC-Nursing regardless of the procedure to be completed.

The authorization should include the number of units per week.

An authorization change is not necessary for a change in the days of the week the procedure will be provided unless a change in the frequency is needed.

If there is a change in frequency, the ADHC will obtain updated physician's order and will notify the **Case Manager**. The **Case Manager** will issue a new Service Provision Form, if necessary. For example, the Procedure was ordered to be done two (2) times per week and is now needed five (5) times per week.

If there is a change in the Procedure, the ADHC will notify the **Case Manager**. The **Case Manager** will document the contact with the provider in the narrative or through the Conversation section in Phoenix.

The **Case Manager** will update the Service Plan if indicated. A new Service Provision Form is not needed. For example, the participant was receiving nebulizer treatments and now urinary catheter care was added. The change would require documentation of the contact and an update in the Service Plan but would not require a new Service Provision Form.

The Service Provision Form must be sent to the provider via Phoenix to initiate services. The initial Service Plan and the new Service Plan created following re-evaluation will be available to the provider via Phoenix.

7C Adult Day Health Care-Transportation

One (1) unit of service is one way of ADHC-Transportation or two (2) units maximum per one (1) day of attendance at ADHC for those participants living within fifteen (15) miles (door to door) of ADHC and do not have another source of transportation such as a family member.

The ADHC is responsible for providing transportation when the most direct route door to door from the participant's residence to the ADHC is fifteen (15) miles or less one way.

If the participant has different locations for pick-up and drop-off, the authorization must indicate all locations. The comment section or the authorization should be used to indicate any additional locations for pick-up and drop-off. The additional locations must be within the fifteen (15) miles of the ADHC for CLTC to pay for ADHC transportation.

The **Case Manager** will update the Service Plan to include the need for Adult Day Health Care- Transportation.

Prior approval must be requested via the service request section of the Service Plan in Phoenix.

No Physician Order is required.

The **Case Manager** will authorize the amount, frequency and duration of services in accordance with the participant's Service Plan.

The Service Provision Form and the Service Plan must be sent to the provider via Phoenix to initiate services. The initial Service Plan and the new Service Plan created following Re-evaluation will be available to the provider via Phoenix.

7D Attendant Care

The unit of service is one (1) hour. This service may be authorized in one-half (1/2) hour increments after a minimum of one (1) hour.

The objectives of the Attendant Care Service are to restore, maintain, and promote the health status of Medicaid Home and Community Based waiver participants through home support, medical monitoring, and assistance with activities of daily living.

Attendant Care is a service to assist with ADL and IADL care. This service is self-directed by the participant, or directed by someone who is able and willing to be the Employer of Record (EOR) for Attendant services.

No Physician Order is required for this service.

1. Participants must be present when Activities are being provided. Attendant Care activities include:

    a. Support of activities of daily living, e.g. assistance with bathing, dressing, feeding, personal grooming, personal hygiene, transferring and mobility;

    b. Meal or snack preparation, planning and serving, cleaning up afterwards, following specially prescribed diets as necessary and encouraging participants to adhere to any specially prescribed diets;

    c. General housekeeping includes cleaning (such as sweeping, vacuuming, mopping, dusting, taking out the trash, changing bed linens, defrosting and cleaning the refrigerator, cleaning the stove or oven, cleaning bathrooms) and activities as needed to maintain the participant in a safe and sanitary environment. Housekeeping only includes areas specific to the participant such as the participant's bedroom, bathroom, etc.

    d. Shopping assistance, essential errands, and escorting participant to medical services. **Attendants are not allowed to provide transportation.**

    e. Assistance with communication, which includes, but is not limited to placing a phone within participant's reach and physically assisting participant with the use of the phone, and orientation to daily events.

    f. Monitoring medication, e.g. the type that would consist of informing the participant it is time to take medication as prescribed by the physician and as written directions on the box or bottle indicate. It does not mean that the attendant is responsible for giving the medicine; however, it does not preclude the attendant from handing the medicine container or medicines already set up in daily containers to the participant.

The waiver service definition for "Attendant" allows a participant or the designee to self-direct "skilled service activities" performed by the Attendant with approval from the participant's physician. These activities are considered "health maintenance activities" which could be performed by the participant if the individual were physically and mentally capable. With Physician approval, Attendants may provide skilled services which are

considered health maintenance activities for participants in all Community Long Term Care Home and Community Based Services Waivers.

When a referral is being made to UAP for Attendant Care and it is being requested the Attendant provide Skilled Service Activities, the **Case Manager** will include a comment on the referral stating "*Participant/representative has requested a skilled service to be provided."* For existing referrals, already in process with UAP, where a skilled service need has been identified, the **Case Manager** will note in the comment section on the referral, *"Participant/representative has requested a skilled service to be provided."* The **Case Manager** will email UAP to notify them of the change in the referral.

UAP will send the "MEDICAID HOME COMMUNITY BASED WAIVERS PHYSICIAN STATEMENT FOR PARTIICAPNT DIRECTED ATTENDANT CARE" and a copy of the legislation to the assigned **Case Manager**, who will provide the form and a copy of the legislation to the Participant or Attendant's Employer of Record. The **Participant or Employer of Record or Designee** is responsible for obtaining the physician approval/signature.

Once the signed Physician's Statement has been received, the **Case Manager** will scan the form into Phoenix scans under the Attendant scan tag and email UAP to notify the form has been returned and scanned. UAP will complete the Attendant match visit once this notification is received by email.

If the Attendant is unable to or fails to check-in or check-out via Care Call when providing service, the Attendant must complete a resolution Log acknowledging the service was provided and the reason the Care Call System was not used.

Discussion & Selection of an Employer of Record (EOR) for Attendant Care Services

If the **Case Manager** and participant and/or primary contact identify Attendant Care is a need, the **Case Manager** will discuss the need to identify an Employer of Record (EOR). In order for the participant to be approved for Attendant Care services, the participant or designee will serve as the Employer of Record (EOR). The EOR for attendant service must be knowledgeable and involved in the participant's day to day care.

The Primary Contact cannot serve as the Attendant unless there is an approved designated Employer of Record who assumes the responsibility of all attendant care related contacts with the Case Manager.

The EOR should reside within a 50-mile radius of the participant's home. Any exceptions must be approved by UAP and CLTC Central Office.

The Employer of Record (EOR)

- Must be willing and able to interview prospective Attendants;
- Meet with UAP in the home for all match visits and when follow-up visits are necessary;
- Discuss the participant's attendant care needs by telephone with CLTC staff or **Case Manager**;
- Meet with the **Case Manager** in the participant's home for the Initial Visit if available;
- Meet with the **Case Manager** in the participant's home for quarterly visits if available;
- Meet with the **Case Manager** in the participant's home for annual re-evaluation visits;
- Attend the initial Attendant/EOR Care Call training if available. Must provide weekly supervision of

the Attendant;

- Must provide guidance, direction and assistance with problems related to the participant's care to the Attendant;
- Is responsible to review and sign the Attendant logs weekly, acknowledging that services were or were not provided by the attendant on the days notated on the logs;
- ***Note:*** *When a blind participant self-directs Attendant Care, UAP reads related forms to the Participant and instructs Attendants or other permitted caregivers in the home to read the Daily Logs to the Participant, prior to signing.*
- Must be present to observe the care provided by the Attendant at least monthly;
- Must review and sign the Resolution Form completed by Attendant, acknowledging that the service was provided if the Attendant is unable to or fails to check-in or check-out on the designated phone; The signed Resolution Log must be received by the CLTC Area Office within thirty (30) days of the date of the Attendant Care service or a strike will be issued.

Referrals to University Affiliated Program (UAP) for Attendant Care

Once a prospective EOR is identified, and the prospective EOR has identified a prospective Attendant, the prospective EOR will discuss the choice of provider with the participant and **Case Manager**. If the **Case Manager** agrees that this is a reasonable option for participant care, the **Case Manager** will:

- Obtain a Choice of Provider

- Complete a referral to UAP in Phoenix. Choose "Approval Request" on the carrousel to complete the appropriate sections of "Participant Directed Care" or "Representative Directed Care". The **Case Manager** should alert UAP of any concerns when sending the form to UAP, such as APS involvement, etc. in the comment section.

- UAP sends an information packet to the EOR and an enrollment packet to the Attendant and a UAP Nurse makes contact with the participant's prospective EOR to discuss Attendant Care service.

- UAP will make arrangements to visit the participant and the prospective EOR & Attendant in the participant's home after the Attendant meets the requirements to enroll. Match Visits by UAP must include observation of the ADL care as outlined in the service plan.

- Upon completion of a match visit, UAP will notify the **Case Manager** by approving the match via Phoenix.

- **Case Manager** will review any comments provided by UAP at the Match Visit.

- After receiving notification of approval in Phoenix from UAP, the **Case Manager** will notify the **Support Staff** to check the resource directory to verify the Attendant's enrollment and review the first and/or second light(s) are green in Phoenix. If enrolled and the appropriate lights are green in Phoenix, the **Support Staff** determines if the Care Call training box has been completed.

- If the Attendant has not been enrolled, an enrollment notification will be sent from Central Office when the provider has been enrolled and is in the Resource Directory

- When the provider has been enrolled, **Support Staff** sends an e-mail to the **Case Manager** to notify of the status of the Attendant's enrollment.

- UAP instructs the Attendant to contact the **Case Manager** to schedule Care Call Training after the Attendant receives a provider number.

- If Phoenix shows the red stop light under "ok to authorize" Attendant services, **do not authorize the service**. View status screen to determine the enrollment information that is missing.

- **Case Manager** reviews the specific attendant information in the Participant's Phoenix case in the Attendant Care Request section.

- If Phoenix shows the green light under "ok to authorize" Attendant services, and Care Call training is needed; arrange Attendant/EOR Care Call Training in the CLTC Area Office for the Attendant provider by the **Care Call Specialist**. The **Case Manager** reviews the service plan and duties with the Attendant during the Care Call Training. The **Case Manager** reviews the authorization with the Attendant. Unless otherwise approved by the Area Administrator or Lead Team, Attendant Care services will be started with the following Sunday's date. The Service Provision Form designates the units per week, not specific days.

- The **Case Manager** provides the attendant with a Service Provision Form.

- The **Case Manager** provides the attendant with a copy of the Service Plan.

- **Note: If Care Call training has been attended by the chosen provider within the past 6 months, it is not necessary to repeat the training unless a refresher session is requested.**

When Attendant Care service is terminated, the Case Manager:

- Sends a copy of the service termination form to the Attendant provider.
- Contacts the Attendant provider by phone if the termination is effective immediately.
- Notifies UAP of the termination of the service**.**
- Updates the Service Plan to reflect the change in service.
- Completes a Notice of Discontinued Employment Form and faxes to Public Partnerships, LLC (PPL).

When the Attendant Care Provider changes to another Attendant Care Provider, the Case Manager:

- Receives and discusses the selection of the new prospective Attendant with the EOR.
- Complete a new pre-screen under the Approval Request tab in Phoenix.

- Awaits UAP approval of the match with the new Attendant in Phoenix prior to authorizing service.
- Works with the **Care Call Specialist** to schedule training, if needed.
- Authorizes the total number of hours per week. The EOR and Attendant will negotiate the appropriate days and times of service to meet the participant's needs as outlined by the Participant's Service Plan.
- Instructs the EOR and Attendant Provider that billing for hours over the number of hours authorized will result in non-payment. Billing for hours that were not provided will result in recoupment. Billing for hours when the Participant is in the hospital, rehabilitation facility, nursing facility, outpatient surgery center, incarcerated or any otherwise inappropriate billing, such as transporting Participant or providing service to a Participant in an unapproved location may result in termination of the service and the Attendant provider. The EOR may also be terminated if he/she fails to properly monitor and/or prevent fraudulent or improper billing by the Attendant.

When more than one Attendant is authorized for a participant

When more than one Attendant provides services on a regular basis, all Attendants will be authorized the total amount of Attendant Care hours approved to provide services on an ongoing basis. A comment is included on the authorization stating the total combined Attendant hours cannot exceed the total hours approved. For example: If fifteen (15) units authorized between two (2) Attendants and primary Attendant provided twelve (12) hours, this leaves only three (3) units for the second (2^{nd}) Attendant. The EOR must closely work with the two (2) Attendants regarding the specific times that each will provide service since the total hours cannot exceed fifteen (15). The **Case Manager** must monitor hours closely to ensure the fifteen (15) hour total is not exceeded.

Exception: If both attendants provide a specific number of units each week, the hours can be divided and authorized specific to the EOR's designation of the break-out of hours by narrating the break-out of hours in the comment section on the authorization.

If only a one-time/temporary backup Attendant is necessary, the service is authorized at the time of the usage. The EOR or Attendant should notify the **Case Manager** in advance, if possible. If the one-time/temporary backup Attendant is necessary when the CLTC Area Office is closed and unable to provide prior approval, the EOR must call as soon as the CLTC office reopens. The authorization must specify the number of hours worked and have a start and end date. The primary authorization is left open. The Attendant should check-in and check-out in Care Call. It is the **Case Manager's** responsibility to assure the approved number of hours are not exceeded.

Case Manager On-going Responsibilities:

1. **Daily Logs**

    - The Daily Attendant Log is an important documentation tool used by all Attendants to record services provided.

    - The log is to be completed daily by the Attendant outlining only the specific tasks performed on the noted date as part of the participant's care. The log is to be signed weekly

by the EOR and to be received in the CLTC Area Office that serves the participant by the fifteenth (15th) of the following month. The CLTC **Support Staff** will receive and date stamp the attendant logs and forward to the assigned **Case Manager**.

- The assigned **Case Manager** will review all information on the log to ensure that the Attendant Care services notated as provided to the Participant are in compliance with the Participant's Service Plan and match the Care Call information through Phoenix. The **Case Manager** should also make sure the logs have the required signature of the Attendant and the EOR and that they are not copies of previously submitted logs.

- Receipt and review of the logs, as well as any Attendant comments showing problems or changes in the condition of the participant, should be narrated in Phoenix **no later than the twenty-second (22nd) day of the month.** The completed logs will be scanned into Phoenix scans under the "Attendant" scan tag. If the logs are not received with appropriate signatures by both the Attendant and Employer of Record by the fifteenth (15th) of the month, the **Case Manager** will complete and mail a CLTC Notification Form to the Participant/Primary Contact and EOR no later than the twenty-second (22nd) of that month. The termination date (often (10) calendar days from the date mailed) and reason for the termination is to be included in the CLTC Notification Form. If the logs are received by the deadline, the Service Provision Form remain open.

- Should the Attendant fail to properly submit the logs within the time frame a second time, the Attendant service for that Participant will be terminated and not reinstated for that participant/attendant match. The **Case Manager** should offer other services to the participant/primary contact to meet the participant's service needs.

- If the logs are not received with proper signature by the end of the ten (10) calendar day notice, no further extension is required by the **Case Manager**. The attendant service is immediately terminated.

- If the Attendant is serving another participant, and is timely for that Participant, services for the second Participant may continue.

- Discrepancies or differences in services provided and those indicated on the service plan, Attendant Care Logs, or in Care Call should be investigated and resolved by the **Case Manager**.

2. If participant or EOR is suspected of no longer being capable of supervision, UAP will be informed by the **Case Manager**.

3. If the EOR dies, or is no longer able or willing to provide weekly supervision, the Attendant Service must be immediately terminated. In this situation, the participant/primary contact and the Attendant are to be notified by phone of the termination. A copy of the termination form is mailed to the Attendant.

4. Any changes in the EOR must be referred as a new match visit to determine the prospective EOR's ability to direct care and to establish the Attendant as the Employee of the EOR with the fiscal agent.

5. **Case Manager** will notify UAP of any changes in the participant's condition or situation that may impact the Attendant Care services.

6. The **Care Call Specialist** will receive written Care Call Resolution Forms and will contact the **Case Manager** for confirmation that the service was provided. All requests for confirmation of resolutions should be reviewed and investigated, and the **Case Manager** must respond to the **Care Call Specialist** for approval/denial within seven (7) calendar days. Any delay in response back to **the Care Call Specialist** should be narrated; giving reason for the delay. Prompt action to finalize the resolution is expected.

7. If UAP inactivates a match and the attendant is suspended or terminated, UAP will inform the assigned **Case Manager**. The **Case Manager** will notify the participant, attendant and EOR of the suspension or termination. The **Case Manager** will terminate the authorization. UAP will confirm the termination and will contact the **Lead Team Case Manager** or **Area Administrator**, if needed.

Monitoring of Service by UAP

Problem resolution visits by the **UAP Nurse** may be requested by the participant, primary contact, EOR, Attendant, **Case Manager**, Lead Team **Case Manager** or **Area Administrator**. All appropriate parties will be consulted for problem resolution.

7E Bath Safety Equipment

One (1) unit of service includes any one of the allowed Bath Safety Equipment items.

For participants with an identified need, the following Bath Safety Equipment may be authorized:

- Transfer shower bench
- Shower chair
- Raised toilet seat
- Hand held shower

Bath Safety Equipment		Frequency	Quantity Authorized/Limit
Transfer shower bench		One per Participant	1 every 2 years
Shower chair		One per Participant	1 every 2 years
Raised toilet seat		One per Participant	1 every 2 years
Hand held shower		One per Participant	1 each year

The need for this equipment must be evaluated in the home prior to authorizing the service. The need for this service must be documented in the Home Assessment section of Phoenix.

The participant must choose between a transfer bench and a shower chair based on the ability to transfer in and out of the tub. Only one (1) of these items will be authorized every two (2) years.

The **Case Manager** will create the Service Provider Choice Form (Service Provider Report) in Phoenix. The **Case Manager** will obtain the provider choice(s) from the participant and/or primary contact in order of preference. These choices may be obtained verbally, by mail or during an in-home visit. If the choices are made verbally, the choices are documented on the Service Provider Report and in the narrative. The Service Provider Choice Form (Service Provider Report) will be signed by the participant and/or contact at the next in-home visit.

The **Case Manager** will update the Service Plan to include the need for Bath Safety Equipment.

Prior approval must be requested via the service request section of the Service Plan in Phoenix.

The **Case Manager** will create a referral to the chosen provider in order of preference via Phoenix.

No Physician Order is required for this service.

The **Case Manager** will authorize the amount, frequency and duration of services in accordance with the participant's Service Plan. This Service Provision Form will include a start date and an end date which will be thirty (30) days later.

The Service Provision Form must be sent to the provider via Phoenix to initiate services. The Service Plan is not required to be sent to the provider for this service.

CLTC STANDARDS FOR BATHROOM SAFTEY PRODUCTS

Specs for Raised Toilet Seat with Steel Legs (3-in-1 Folding Steel Commode with Standard Seat Depth)
Reimbursement - $100.00
Maximum weight capacity – 350 pounds
Seat width – 13.75" - 15"
Seat depth – 13" - 14.5"
Seat height – 15.5" - 18"
Overall width – 22.25"
Locking Installation
Primary Material is steel and Lifetime Warranty

Specs for Transfer Benches:
Reimbursement - $150.00
Adjustable height from 17" to 23"
Backrest
Arm rail
Seat depth – 18"
Seat width – 33" minimum
Maximum weight capacity – 350 pounds
Installation, assembly and adjustment

Specs for Shower Chair with Back:
Reimbursement - $60.00
Back rest
Maximum weight capacity – 300 pounds
Adjustable
Seat height- 17" to 21"
Seat width – 20"
Seat depth – 18"
Installation

Specs for Hand Held Shower:
Reimbursement - $50.00
Minimum 6' hose
Pause/ shut off function
Installation with Teflon tape

Specs for Bariatric Raised Toilet Seat (Heavy Duty, Bariatric Folding Commode):
Reimbursement - $195.00
Minimum weight capacity – 650 pounds
Seat width – 13.75" - 15"
Seat depth – 16.5"

Seat height – 15.5" - 22"
Width between arms – 24"
Overall width – 31.75"
Locking
Includes installation
Primary Material is Steel
Lifetime Limited Warranty

Specs for Bariatric Shower Transfer Bench with Back:
Reimbursement - $170.00
Minimum weight capacity – 500 pounds
Seat width - 28"
Seat depth – 16"
Seat height – 16" minimum
Installation

Specs for Bariatric Shower Seat with Back:
Reimbursement - $126.00
Minimum weight capacity – 500 pounds
Seat width - 17"
Seat depth – 16"
Seat height – 16" minimum
Installation

7F Case Management

A unit is service is fifteen (15) minutes of either **Case Manager** Contact or Case Management Visit.

The Service Provider Choice Form (Service Provider Report) for Case Management generated from Phoenix is used for the participant and/or primary contact to indicate choices(s) of Case Management Provider in order of preference. If the initial waiver assessment is completed by in-home visit, the **Nurse Consultant** will obtain the choices. If the initial waiver assessment is completed by phone, the enrolling **Case Manager II** will obtain the choices and document the choices in order of preference on the Service Provider Report. The **on-going Case Manger** will obtain the participant's and/or the primary contact's signature on the Service Report during the Initial Visit.

The intensity of Case Management services provided to each participant is dependent upon the individual participant's needs as set forth in the participant's Service Plan. All waiver participants will receive Case Management Service.

The Service Plan will include the Case Management Service.

Prior approval must be requested via the service request section of the Service Plan in Phoenix. A written justification reason is not required. Prior approval will be obtained for twenty-four (24) units of Case Management Contact and twenty-four (24) units of Case Management Visit initially.

A referral is created and sent to the chosen providers in order of preference via Phoenix.

If the referral is accepted, the **on-going Case Manager** has two (2) business days to contact the **Case Manager II** to receive the case. The case will be discussed with the **on-going Case Manager**. The **Case Manager II** will complete the Service Provision Forms for both Case Management Contact and Case Management Visit.

If the **on-going Case Manager** uses all of the authorized units, the **on-going Case Manager** must request additional units in advance. This prior approval request must be sent to the **Area Administrator** or **Lead Team** and approval or denial of the request must be documented in the narrative.

Case Management Services must be provided Monday through Friday between the hours of 7:00am-7:00pm.

Case Management shall include the following activities:

A. Service Planning
B. Service Coordination
C. Monitoring
D. Re-evaluation
E. Service Plan Evaluation
F. Service Counseling
G. Initial Authorization of Waiver Service
H. Changes in Services within an Authorization Period
I. Termination of Waiver Services

J. Case Termination and/or Transfer
K. Documentation of each activity reflecting date of occurrence.

Note: Case Management providers should refer to other related chapters as well as the requirements of the Community Long Term Care Case Management Contract and the Case Management Scope of Services at:

https://www.scdhhs.gov/provider-type/cltc-provider-manual-020105-edition-posted1142005

7G Companion Services

The unit of service is one (1) hour (not including time for transportation to and from participant's residence, breaks or meals). This service may be authorized in one-half (½) hour increments after a minimum of one (1) hour.

Companion services are provided in the participant's residence intended to provide short-term relief for caregivers with needed supervision of participants. **The service does not include hands-on care.**

Participants must be present when this service is being provided.

Companion activities include:

1. Socialization – reading , conversation, assistance with participant's mail or newspaper;

2. Assistance with meal or snack preparations, serving and cleaning up afterwards;

3. Incidental housekeeping including sweeping, dusting, assistance with or supervision of the participant's laundry or linens, and other light chores needed to maintain the participant in a safe and sanitary environment. Housekeeping is only for the areas specific to the participant such as the participant's bedroom, bathroom, etc.

4. Shopping assistance, essential errands and escorting participant to medical services. **Companions are not allowed to provide transportation.**

5. Sitting service focusing on the participant including supervision, orientation and observation for basic safety to include making emergency contact if needed.

Companion services can be provided by an agency provider or Medicaid enrolled individual companion provider.

A person who is the primary caregiver cannot be paid to provide companion services. The reason for this is the service is primarily designed to give relief to the primary caregiver.

The **Case Manager** will create the Service Provider Choice Form (Service Provider Report) in Phoenix. The **Case Manager** will obtain the provider choice(s) from the participant and/or primary contact in the order of preference. These choices may be obtained verbally, by mail or during an in-home visit. If the choices are made verbally, the choices are documented in the Service Provider Choice Form (Service Provider Report) and in the narrative. The Service Provider Report will be signed by the participant and/or primary contact at the next in-home visit.

The **Case Manager** will update the Service Plan to include the need for Companion Service.

Prior approval must be requested via the service request section of the Service Plan in Phoenix.

The **Case Manager** will create a referral to the chosen providers in order of preference via Phoenix.

If the referral is accepted, the **Case Manager** will negotiate the start date for services to begin.

No Physician Order is required.

The **Case Manager** will authorize the amount, frequency and duration of services in accordance with the participant's Service Plan. The Companion Individual Service is authorized by the week. The Companion Agency Service is authorized by the day.

The Service Provision Form must be completed. The duties of the Companion service must be listed in the Comments section of the Service Provision Form. The Service Provision Form must be given to the Companion Individual by mail or hand delivery. The Service Provision Form must be sent to the Companion Agency via Phoenix. The Service Plan is available to the provider in Phoenix.

Companion Services Provided by Individual Companion Providers

If the **Case Manager** and participant/primary contact identify Companion (Individual) as a need, then the **Case Manager** will:

- Complete the Pre-screening in Phoenix for Participant Directed Care (UAP Form 1) OR Pre-screening for Assessment for Representative Directed Care (UAP Form 2)
- Obtain a Choice of Provider.
- Make a referral if the pre-screening is passed, to UAP by emailing UAP with the participant's name and CLTC number.
- UAP conducts the enrollment review process (PPD, SLED check, Fiscal Agent paperwork) and notifies the **Case Manager** of the findings.
- UAP notifies the participant and/or primary contact of the SLED check results.
- If approved by UAP, monitor Phoenix for approval and for the CLTC Central Office notification of enrollment.

The **CLTC Area Office Support Staff** will:

- Check the Resource Directory to verify companion's enrollment as a provider after receiving email from UAP.
- Verify if the training box has been completed if the companion is enrolled. If the companion has not been enrolled, an enrollment notification will be sent from Central Office when the provider has been enrolled and is on the Resource Directory.
- Send an email notification to the **Case Manager** when the companion is enrolled.

The **Case Manager** will then review the specific Individual Companion information in the Participant's Phoenix record under the Attendant Care Request section.

- If the light under "ok to authorize" for companion services in Phoenix is red, **do not** authorize the individual companion services. View status screen to determine what enrollment information is missing.
- When the light under "ok to authorize" companion services in Phoenix is green, proceed to arrange billing training for the provider in the CLTC Area Office with the **CLTC Area Office Support Staff.** During training, the **Case Manager** to review the activities to be performed by the Companion.

  Note: If billing training has already been attended by the chosen provider, it is not

necessary to repeat the training. The service authorization including the activities to be completed in the comments section, may be mailed to the companion provider.

- Completes Service Provision Form in Phoenix and sends a copy to the provider and UAP.
- The Companion does NOT complete Daily Logs.
- Completes a service termination in Phoenix when the service is terminated and sends a service termination to the companion provider. Also, UAP must be notified of the termination date of the companion service. The Service Plan must be updated accordingly.
- Completes a Notice of Discontinued Employment Form and faxes to Public Partnerships, LLC (PPL).

After the Companion service starts: the **Case Manager** should make every effort to schedule the next quarterly home visit during a time when the companion provider is available. The **Case Manager** should review the service expectations with the companion and participant and/or primary contact, and monitor for quality and appropriateness.

Companion Services Provided Through an Agency

Service Provision Form must be sent to the provider designating the units per day. It is important that the **Case Manager** coordinate this service with other services going into the home as well as with the companion's supervisor.

7H Environmental Modifications

This service must be participant specific and for the benefit of the participant. Environmental Modification must be necessary to ensure health, welfare and safety and enable the participant to function with greater independence in the home without which, the participant would require institutionalization.

The service must be cost effective. The **Case Manager** must exercise professional judgment regarding the appropriateness of the service. The service is not intended for major home improvement, remodeling, or cosmetic improvements. The **Case Manager** explore other available community resources prior to requesting approval for this service.

The need for Environmental Modifications must be evaluated in the home prior to authorization. The need for this service must be documented in the Home Assessment section of Phoenix. During the home visit, the **Case Manager** must explain and obtain appropriate signatures on the Participant or Landowner Consent Form for all the environmental modification services.

Exception: Authorization of heaters, fans or air conditioners does not require a Participant or Landowner Consent Form.

The **Case Manager** will update the Service Plan to include the need for Environmental Modification.

Prior approval must be requested via the service request section of the Service Plan in Phoenix. This service may only be approved or denied by the **Area Administrator** or **Lead Team**. The service prior approval is required prior to sending the request to the Environmental Modification Specialist.

Note: There is a lifetime cap of $7,500. This includes the costs for ramps, heaters, fans, air conditioners, and enhanced environmental modifications. Requests to exceed this amount must be sent to **Central Office** for consideration and approval.

7I Heaters/Fans/Air Conditioners

One (1) unit of service includes any one of the allowed items of Heater/Fans/Air Conditioners.

The need for this equipment must be evaluated in the home prior to authorizing the service. The need for this service must be documented in the Home Assessment section of Phoenix.

One (1) Heater, One (1) Fan and one (1) Air Conditioner can be authorized every three (3) years, if needed. No exception shall be granted.

The Participant or Landowner Consent Form is not required for this service.

The **Case Manager** will update the Service Plan to include the need for Heater/Fan/Air Conditioner Equipment.

Prior approval must be requested via the service request section of the Service Plan in Phoenix.

The **Case Manager** will create the Service Provider Choice Form (Service Provider Report) in Phoenix. The **Case Manager** will obtain the provider choice(s) from the participant and/or primary contact in order of preference. These choices may be obtained verbally, by mail or during an in-home visit. If the choices are made verbally, the choices are documented on the Service Provider Choice Form (Service Provider Report) and in the narrative. The Service Provider Choice Form (Service Provider Report) will be signed by the participant and/or primary contact at the next in-home visit.

The **Case Manager** will create a referral to the chosen providers in order of preference via Phoenix.

No Physician's Order is required for this service.

The **Case Manager** will authorize the amount, frequency and duration of service in accordance with the participant Service Plan. This Service Provision Form will include a start date and an end date which will be thirty (30) days later.

The modification specifics must be clearly stated:

- Air conditioners must be 10,000 BTU and will be reimbursed at a rate of $415.00 This rate includes installation and a one year in-home warranty. During this one year warranty period, it is the responsibility of the provider to replace and/or repair the unit.

- Box fans will be reimbursed at a rate of $40.00 each and must have three (3) speeds.

- Heaters will be reimbursed at a rate of $65.00. Heaters must have a minimum of a one year warranty and must have a safety shut off feature. This includes delivery and set up. The following heater alternatives are allowed: Lasko2 Heat Tower electric space heater Model 6251 Item# 142570 and Warmwave 1500 watt ceramic portable tower heater Model HPQ15M. Heaters may be shipped to the participant.

The **Case Manager** must verify service and satisfaction with the work completed by the provider, as appropriate, on the next scheduled contact after the authorization end date. If there are problems, the **Case Manager** shall negotiate resolution of the problems and/or complaint with the provider.

7J Ramps

This policy is to be used when a ramp is needed and no other Environmental Modifications are needed.

The need for this service must be evaluated in the home prior to authorizing the service. The **Case Manager** will visit participant's home to assess the need for a ramp. This visit may be completed at the next regularly scheduled home visit or the **Case Manager** may request permission for a Special Visit if it is deemed the service is needed as soon as possible.

The need for this service must be documented in the Home Assessment section of Phoenix.

During the home visit, the **Case Manager** must explain and obtain appropriate signatures or the Participant or Landowner Consent Form.

The **Case Manager** will create the Service Provider Choice Form (Service Provider Report) in Phoenix. The **Case Manager** will obtain provider choice(s) from the participant and/or primary contact in order of preference. These choices may be obtained verbally, by mail or during an in-home visit. If the choices are made verbally, the choices are documented on the Service Provider Choice Form (Service Provider Report) and in the narrative. The Service Provider Choice Form (Service Provider Report) will be signed by the participant and/or primary contact at the next in-home visit. The participant and/or primary contact should be encouraged to contact chosen provider(s) to determine if the provider is willing to accept the referral and to determine how long it will take the provider to complete the work.

Under no circumstances shall a **Case Manager** assist the participant in choosing a provider.

The **Case Manager** will update the Service Plan to include the need for a ramp.

Prior approval must be requested via the service request section of the Service Plan in Phoenix. This service may only be approved or denied by the **Area Administrator** and **Lead Team**. The service prior approval is required prior to sending the request to the Environmental Modification Specialist.

The **Case Manager** will complete the ramp form in the Home Assessment section on Phoenix while in web mode. Click on "Refer to Providers". Notate if the Environmental Modifications Specialist should review "difficult situation" such as homes that are elevated and high off the ground, homes with small yards and when there is a discrepancy about which door is to be used.

The **Case Manager** will create a referral to the chosen provider in the order of preferences via Phoenix.

Note: Do not put an end date on this referral. Send the referral from the laptop while in web mode from the Home Assessment section in Phoenix. Complete all fields of the referral. If the referral is sent by cell phone remotely or from the laptop in tablet mode or not sent through the Home Assessment, the provider will not receive the Ramp Completion Form. Do not create a ramp referral in Waiver Supports.

If the referral is accepted, the **Case Manager** will receive notification in the Notification section in Phoenix. No further action is needed by the **Case Manager** until the provider submits the Ramp Completion Form via Phoenix.

When the ramp is completed, the provider must submit the Ramp Completion Form in Phoenix. Upon notification of receipt of the Ramp Notification Form via Phoenix, the **Case Manager** must complete the Service Provision Form. The start date is the date the Service Provision Form in created and the end date is thirty (30) days later. The dollar amount to be entered on the Service Provision Form is the dollar amount indicated by the provider via the Ramp Completion Form.

If a ramp and an Enhanced Environmental Modification and being requested at the same time for the same participant, see Chapter 7, Section 7L.

If the participant and/or primary contact is dissatisfied or complains about the ramp and an inspection by the Environmental Modification Specialist is needed, the **Case Manager** will indicate this in Phoenix by using the checkbox to request a review. The **Case Manager** will proceed with creating and sending the Service Provision Form to the provider while the Environmental Modification Specialist is reviewing the complaint. Provider payment should not be delayed pending review by the Environmental Modification Specialist.

Reimbursements for ramps and landings are as follows:

Ramps - $45.00 per linear foot
Landings - $15.00 per square foot clear space
Wedges - $12.00 per square foot
Deck raising - $4.00 per square foot
Adding a layer of 2 x 6 or 5/4 x 6 to existing structure - $5.00 per square foot
Adding railings to existing structure - $13.00 per linear foot

All charges in the "other" category must be pre-approved by the Environmental Modification Specialist.

It is the responsibility of the provider to construct all jobs to the required code of the Americans with Disabilities Act (ADA), as well as meeting specific requirements stipulated by CLTC. In addition, all required permits are the responsibility of the provider.

7K Enhanced Environmental Modifications

Enhanced Environmental Modifications needs may be requested for participants who own their own home/property or the home is owned by a family member where no rent is paid to the family member. Rent to own is considered renting.

The need for this service must be evaluated in the home prior to authorizing the service. The **Case Manager** will visit participant's home to assess the need for the Enhanced Environmental Modifications. This visit may be completed at the next regularly scheduled home visit or the **Case Manager** may request permission for a Special Visit if it is deemed the service is needed as soon as possible. The need for this service must be documented in the Home Assessment section of Phoenix.

During the home visit, the **Case Manager** must explain and obtain appropriate signatures on the Participant or Landowner Consent Form.

Prior approval must be requested via the service request section of the Service Plan in Phoenix. This service may only be approved or denied by the **Area Administrator** or **Lead Team**. The service prior approval is required prior to sending the request to the Environmental Modification Specialist.

The **Case Manager** will complete the Environmental Needs Tab of the Home Assessment section in Phoenix. The **Case Manager** will indicate the type of Enhanced Environmental Modification needed from the list in Phoenix and will send the request to the Environmental Modification Specialist via Phoenix.

The Environmental Modification Specialist will assess the request and indicate via Phoenix when the request is ready for bidding.

The providers serving the geographical area of the participant will receive an email and a Phoenix Notification inviting them to bid on the Enhanced Environmental Modification. Providers will have access to details of the job including location and pictures in Phoenix. Providers are given one (1) week to submit a bid via Phoenix.

Once the bid period is closed, the Environmental Modification Specialist will award the job by notifying the winning bidder and the **Case Manager** via Phoenix.

The Enhanced Environmental Modification provider indicates via Phoenix that the Enhanced Environmental Modification project has been completed. The **Case Manager** will be notified of the awarded bid dollar amount and the provider information upon the project completion. The **Case Manager** will be able to see this information both at the point of bid award and at the point of job completion. The **Case Manager** must click on the notification to see the Enhanced Environmental Modification project screen where the awarded bid dollar amount is shown. The **Case Manager** will click "Create Authorization."

The **Case Manager** will create a Service Provision Form via Phoenix. The start date will be the date the Service Provision Form is created and the end date will be thirty (30) days later.

The Enhanced Environmental Modification provider will bill through Care Call.

If the participant and/or primary contact is dissatisfied or complains about the Enhanced Environmental Modification and an inspection by the Environmental Modification Specialist is needed, the **Case Manager** will indicate this in Phoenix by using the checkbox to request a review. The **Case Manager** will proceed with creating and sending the Service Provision Form to the provider while the Environmental Modification Specialist is reviewing the complaint. Provider payment should not be delayed pending review by the Environmental Modification Specialist.

7L Enhanced Environmental Modifications and a Ramp

Enhanced Environmental Modification needs may be requested for participants who own their own home/property or the home is owned by a family member where no rent is paid to the family member and a ramp is needed. The provider who is awarded the bid will provide both items.

The need for this service must be evaluated in the home prior to authorizing the service. The **Case Manager** will visit participant's home to assess the need for the Enhanced Environmental Modification and a ramp. This may be completed at the next regularly scheduled home visit if it is deemed the service is needed as soon as possible. The need for this service must be documented in the Home Assessment section of Phoenix.

During the home visit, the **Case Manager** must explain and obtain appropriate signatures on the Participant or Landowner Consent Form.

Prior approval must be requested via the service request section of the Service Plan in Phoenix. This service may only be approved or denied by the Area Administrator or Lead Team. The service prior approval is required prior to sending the request to the Environmental Modification Specialist.

The **Case Manager** will complete the Environmental Needs Tab of the Home Assessment section in Phoenix. The **Case Manager** will indicate the type of Enhanced Environmental Modification needed from the list is Phoenix and will send the request to the Environmental Modification Specialist via Phoenix.

The **Case Manager** will complete the ramp form in the Home Assessment section in Phoenix.

The **Case Manager** must wait for a response from the Environmental Modification Specialist through Phoenix before proceeding.

The Environmental Modification Specialist will assess the request and indicate via Phoenix when the request is ready for bidding.

The providers serving the geographical area of the participant will receive an email and a Phoenix notification inviting them to bid on the Enhanced Environmental Modification and ramp. Providers will have access to details of the job including location and pictures in Phoenix. Providers are given one (1) week to submit a bid via Phoenix.

Once the bid period is closed, the Environmental Modification Specialist will award the job by notifying the winning bidder and the **Case Manager** via Phoenix.

The Enhanced Environmental Modification provider indicates via Phoenix that the Enhanced Environmental Modification project has been completed. The **Case Manager** and Environmental Modification Specialist will be notified of the awarded bid dollar amount and the provider information upon the completion. The **Case Manager** will be able to see this information upon the point of bid award and at the point of job completion.

The **Case Manager** must click on the notification to see the Enhanced Environmental Modification project screen where the awarded bid dollar amount is shown. The **Case Manager** will click "Create Authorization."

The **Case Manager** will create a Service Provision Form via Phoenix. The start date will be the date of the Service Provision Form is created and the end date will be thirty (30) days later.

When the ramp is completed, the provider must submit the Ramp Completion Form in Phoenix. Upon notification of receipt of the Ramp Completion Form via Phoenix, the **Case Manager** must complete the Service Provision Form. The start date is the date the Service Provision Form is created and the end date is thirty (30) days later. The dollar amount to be entered on the Service Provision Form is the dollar amount indicated by the provider via the Ramp Completion Form.

The provider will bill through Care Call.

Note: If there is a critical need for the ramp and the **Case Manager** determines the participant cannot wait for the bid process for the Enhanced Environmental Modification, the **Case Manager** should authorize the ramp in accordance with the participant's choice of provider and follow the process for the ramp service.

7M Enhanced Pest Control

A unit of service is one (1).

Enhanced Pest Control service is exclusively for the treatment of bed bug infestation.

Enhanced Pest Control cannot be authorized for a participant residing in an apartment complex. However, authorization may be considered for a participant residing in a single dwelling rental house or a duplex dwelling rental house that is not managed by a governmental entity such as the Housing Authority.

In the case of a rental single house or rental duplex and the landlord does not provide Enhanced Pest Control (bed bug infestation treatment) the **Case Manager** must obtain permission from the participant and/or primary contact to speak to the landlord about Enhanced Pest Control treatment. If the participant and/or primary contact refuses to allow the **Case Manager** to contact the landlord, the **Case Manger** will deny the Enhanced Pest Control request. This information must be clearly documented in the narrative including the participant and/or primary contact's permission to contact the landlord, the landlord's full name, the contact with the landlord and the landlord's response. A CLTC Notification Form 171 will be sent stating the reason the service is denied.

If the landlord refuses to provide the Enhanced Pest Control for the participant, the **Case Manager** will proceed with the approval and authorization process.

If the landlord refuses to allow Enhanced Pest Control treatment to be provided, Enhanced Pest Control should not be authorized and the **Case Manager** will send CLTC Notification Form 171 stating the reason the service is denied.

The need for Enhanced Pest Control must be documented in the Home Assessment section in Phoenix.

The **Case Manager** will update the Service Plan to include the need for Enhanced Pest Control.

Prior approval must be requested via the service request section of the Service Plan in Phoenix. The Reviewer makes a comment in the justification field but leaves the review field blank. The Reviewer notifies the **Case Manager** by phone or email whether or not to continue the process. After the **Case Manager** receives Reviewer's notification prior approval the **Case Manager** explains to the participant and/or primary contact that if a Pest Control provider is already in place and if that particular Pest Control provider is also an Enhanced Pest Control provider, the same provider will provide the Enhanced Pest Control (bedbug infestation treatment) if the treatment is approved.

No Physician's Order is required for this service.

If the participant does not currently receive Pest Control service or the current Pest Control provider does not also provide Enhanced Pest Control, the **Case Manager** will create the Service Provider Choice Form (Service Provider Report) in Phoenix. The **Case Manager** will obtain the provider choice(s) from the participant and/or primary contact in order of preference. The choices may be obtained verbally, by mail or during an in-home visit if the choices are made verbally, the choices are documented on the Service Provider Choice Form (Service Provider Report) and in the narrative. The Service Provider Choice Form (Service Provider Report) will be signed by the participant and/or primary contact at the next home visit.

The **Case Manager** will create a referral to the chosen providers for Enhanced Pest Control in order of preference in Phoenix.

Note: The **Case Manager** should note in comment section of the referral that the services is not to be provided until the rate is approved by Central Office Designee.

The Enhanced Pest Control provider visits the participant's home to verify bed bug infestation.
If bedbug infestation is confirmed, Enhanced Pest Control provider sends the following information to the **Case Manager**:

- Confirms bedbug infestation;
- Informs the specific type of treatment to be used;
- Provides photo or photos of bedbugs found;
- States the total cost of treatment;
- Provides photo(s) of bedbugs found;
- Describes the steps that must be taken by the participant in preparation for successful treatment;
- Describes the likelihood of successful eradication;
- Agrees to provide fitted mattress covers for affected areas;
- Provides a one year written warranty of service.

When the Enhanced Pest Control provider provides the **Case Manager** with all of the above required documentation, the **Case Manager** will complete the following:

- Requests review by sending all of the received information to **Central Office Designee** at PROVIDER-Distribution@scdhhs.gov.
- Scans the Enhanced Pest Control required information including photos to the participant's Phoenix file under the "Provider" scan tag.
- Receives notification from **Central Office Designee** via email whether or not the provider may proceed with treatment by approving or denying the request.
- Notifies the Reviewer of Services that **Central Office** approval has been received so the Reviewer may provide prior approval.
- Notifies the Enhanced Pest Control provider verbally of **Central Office Designee's** decision.
- CLTC Notification Form 171 to the Enhanced Pest Control Provider if treatment is appropriate.
- Sends with the participant and/or primary contact the option of authorizing Personal Care I service if help is needed to prepare the home for successful treatment.

Note: The Enhanced Pest Control Provider must make a minimum of two (2) treatment visits and notifies the **Case Manager** when eradication is complete.

- Creates the Service Provision Form in Phoenix. The start date is the date the notification of completed treatment and eradication was received and the end date is thirty (30) days from the start date. The dollar amount entered is the dollar amount that was approved by Central Office Designee.

The cost of Enhanced Pest Control is not included in the $7,550.00 lifetime cap for Environmental Modification Service.

The Enhanced Pest Control provider must return to the home and provide re-treatment as necessary within the one (1) year warranty timeframe which begins on the start date of the authorization.

7N Home Delivered Meals

A unit of service is one (1) meal delivered to a participant's residence. Each meal provides a minimum of one-third the current recommended dietary allowance (RDA) for the age group as adopted by the United States Department of Agriculture.

The **Case Manager** will create the Service Provider Report in Phoenix. The **Case Manager** will obtain the provider choice(s) from the participant and/or primary contact in the order of preference. The choice may be obtained verbally, by mail or during an in-home visit. If the choices are made verbally, the choices and documented on the Service Provider Choice Form (Service Provider Report) and in the narrative. The Service Report will be signed in the narrative. The Service Provider Choice Form (Service Provider Report) will be signed by the participant and/or primary contact at the next in-home visit.

The **Case Manager** will update the Service Plan to include the need for Home Delivered Meals.

Prior approval must be requested via the service request section of the Service Plan in Phoenix.

The **Case Manager** will create a referral to the chosen providers in order of preference via Phoenix.

No Physician's Order is required for this service.

If the referral is accepted, **Case Manager** negotiates the start date for services to begin.

The **Case Manager** will authorize the amount, frequency and duration of the services in accordance with the participant's Service Plan.

The Service Provision Form must be sent to the provider via Phoenix to initiate services. This service does not require a Service Plan be sent to the provider.

7O Nursing Home Transition

Applicants currently under Medicaid payment in a nursing home and wanting to enter the Community Choices waiver who are transitioning from the nursing home or who have been discharged home from the nursing home within the last 10 days may be eligible for the Nursing Home Transition service.

Nursing Home Transition services are available **once in a lifetime** and are limited to a **$1,000 lifetime cap** on services. Funds should be used to only meet needs that are barriers to transition. The **Case Manager II** should use sound judgment when approving services to ensure purchases are modest and reasonable. Funds cannot be used to pay existing bills, past due balances, rent or groceries.

The Nursing Home Transition Service may include authorizations for the items listed below when a specific need has been identified:

Deposits:
- Security
- Utility (land-line phone, water, electricity, and gas)

2. Appliances (basic, most economical item):
   - Washing Machine
   - Dryer
   - Refrigerator
   - Microwave

3. Furniture (basic, most economical item):
   - Dinette (table and four chairs)
   - Bed (twin or double (full))
   - Dresser/chest of drawers
   - Night stand
   - Couch
   - Chair

At Intake

If the Nursing Home Transition Service is being requested, the **Intake Nurse Consultant** must review Phoenix for a history of previous nursing home transition budget or Phoenix Application choice of Nursing Home Transition Service", indicating previous receipt of nursing home transition services. **If a previous history exists**, the applicant is not eligible for the Nursing Home Transition Service and the referral process should proceed as a regular Community Choices referral.

If there is no previous Nursing Home Transition Service history, an Application for Nursing Home Transition may be completed.

Note: If the referral is received after discharge from the nursing home but within 10 days of applicant's discharge from a nursing facility, transition meeting will not be held. Instead, the **assigned Nurse**

Consultant will complete a Level of Care. If Level of Care is met and financial eligibility confirmed, the case will then be transferred to **Case Manager II** who will determine if transition services are indicated.

After Intake

Nursing Home Transition service cases will be assigned to appropriate **Nurse Consultant** based on the nursing home location.

The **assigned Nurse Consultant** will complete an assessment and Level of Care. This may be completed at any time prior to the required transition team meeting. (**At discharge**, **the assigned Nurse Consultant** will perform an assessment update or reevaluation as indicated to ensure assessment is current for waiver enrollment. If Medicaid conversion is needed prior to discharge, an Application for Nursing Home Placement may be made.

The **assigned Nurse Consultant** will contact participant, primary contact, nursing facility social worker and **Case Manager II** to schedule a transition team meeting to be held at the nursing facility.

At the Transition Team Meeting

The **assigned Nurse Consultant** facilitates the transition team meeting and ensures the nursing home social worker coordinates home health services and any indicated DME available from Medicare/Medicaid sources prior to discharge from the facility. (If Level of Care is met and financial eligibility confirmed, the case will then be transferred to CMII who will determine if transition services are indicated.)

The **Case Manager II** explains the nursing home transition services based on needs identified by participant/primary contact.

The **Case Manager II** offers a current Provider Choice List for the nursing home transition services needed and explains process for identifying additional transition service providers if desired by participant/primary contact.

- Advises participant/primary contact that they may choose additional providers not currently enrolled. However, provision of service depends upon provider's willingness to accept terms of enrollment.

- If a provider not currently listed is desired, **Case Manager II** instructs participant/primary contact to provide contact information for selected provider(s) to **Case Manager II**.

Case Manager II explains additional waiver services/options and offers provider lists for any of these services where need is identified.

Following the Transition Team Meeting

The **assigned Nurse Consultant** documents transition meeting in Phoenix and transfers case to **Case Manager II** as "assigned worker" and keys the change in Phoenix.
Case Manager II receives case assignment from the assigned Nurse Consultant following the transition team meeting and documents **Case Manager II** portion of Transition Team Meeting.

Case Manager II keys RSP to Nursing Home Transition and completes Nursing Home Transition Services

Budget in Phoenix.

Case Manager II initiates Nursing Home Transition service planning per participant provider choices and Completes Nursing Home Transition Services authorizations. (Note: Service codes are W6XX. A pop-up warning message will appear when the $1,000 limit is approached. Entries exceeding this limit will be allowed by Phoenix, but must have prior approval of CLTC Central Office and must be documented in the Narrative.)

- **If participant chooses a non-enrolled provider** for a transition service, **Case Manager II** contacts provider to explain program and obtains a signed Medicaid Provider Enrollment form. If provider declines participation, **Case Manager II** notifies participant to obtain alternate provider choice.

- **When an eligible provider has been chosen**, the **Case Manager II** instructs the participant/Phoenix to obtain a written quote using the Price Quote Form for the requested transition service(s). Price Quote form should include all applicable taxes and delivery fees. Completed quote is returned to **Case Manager II**.

- **If transition service is needed prior to discharge**, **Case Manager II** obtains agreement from provider to accept "Letter of Intent", with payment to follow after discharge and waiver enrollment. The signature date of the "Letter of Intent" should be the Authorization Start Date. The provider does not get a copy of the authorization. If provider will not accept "Letter of Intent" to provide services prior to payment, **and transition service is needed before discharge can take place**, **Case Manager II** will advise participant to make discharge plans based on projected date for delivery of services.

- **If participant does not discharge from the nursing facility after 30 days** following completion of services provided by "Letter of Intent", designated staff will ensure Nursing Home Transition RSP has been opened and authorizes payment, using same date for start and end. Claim is keyed following normal office procedure. Nursing Home Transition RSP is closed prior to waiver enrollment. **If participant is not discharged by 90 days following date of referral**, and no discharge date is imminent, case is closed as entered nursing home.

- **Following discharge from the nursing home**, **Case Manager II** enrolls participant in the Community Choice waiver and changes status in Phoenix to "Enrolled", accordingly, and Community Choice Waiver RSP is opened per office policy.

- **After Phoenix Outcome and RSP are changed to "1- Community Choices"**, the **Case Manager II** notifies designated staff to key claims for Nursing Home Transition service authorizations to Care Call.

- Nursing Home Transition Service authorization end dates (and claims) will be entered **after the date of service AND after outcome changes to "1"**. The end date will be the day after the claim is keyed to Care Call.

- **Once transition services are concluded**, **Case Manager II** can transfer case to an ongoing **Case Manager** per existing office policy.

  Note: In cases involving a transfer between local CLTC offices, the case will first be assigned to the

Nurse Consultant in the local CLTC office receiving the Nursing Home Transition Service referral based on the nursing home location.

a. The **Nurse Consultant** in the "originating" office will conduct the transition team meeting and the **Case Manager II** of that same office will also attend. After the applicant's discharge from the facility, the case will be transferred per existing policy and the **Case Manager II** in the "receiving" office will complete the provision of the transition services.

b. **Case Manager II** from the "originating" office will contact the **Case Manager II** in the office the participant is transferring to for appropriate provider lists.

c. Provision of services prior to discharge will be coordinated between **Case Manager IIs** in both offices.

7P Nutritional Supplements

A unit of service is one (1) case of Nutritional Supplements per month.

Waiver participants who have a need for nutritional supplements, may be authorized for up to two (2) cases per month. Two case per month is the maximum amount allowed. No exceptions may be made.

The Nutritional Supplement must contain at least two hundred twenty (220) calories per two hundred fifty (250) milliliters.

The **Case Manager** will update the Service Plan to include the need for Nutritional Supplements.

Prior approval must be requested via the service request section of the Service Plan in Phoenix.

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 lone of the qualifying conditions:

1. Wasting (loss of ten percent (10%)) body mass in the last sixty (60) days.

2. Severe dental or gum problems that prevent the participant from chewing.

3. Has a condition that requires a protein supplement.

4. Has a swallowing problem that prevents the participant from achieving adequate weight.

5. Due to a medical condition, the participant cannot maintain adequate weight.

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

If the participant is receiving tube feedings, Nutritional Supplements may not be authorized. Tube feeding supplies should be obtained through Medicaid State Health Plan.

Any exceptions to this must be approved by Central Office.

The **Case Manager** will create the Service Provider Choice Form (Service Provider Report) in Phoenix. The **Case Manager** will obtain the provider choice(s) from the participant and/or primary contact in the order of preference. The choice may be obtained verbally, by mail or during an in-home visit. If the choices are made verbally, the choices are documented on the Service Provider Choice Form (Service Plan Report) and in the narrative. The Service Provider Choice Form (Service Provider Report) will be signed by the participant and/or primary contact at the next in-home visit.

The **Case Manager** will create a referral to the chosen provider in order of preference in Phoenix.

The **Case Manager** will authorize the amount, frequency and duration of the service in accordance with the

participant's service plan.

The Service Provision Form must be sent to the provider via Phoenix to initiate service. A copy of the signed Physician's Order must be faxed or mailed to the provider.

This service does not require a Service Plan be sent to the provider.

A new Physician's Order is not required at the re-evaluation. However if the participant's condition changes and the change impacts the need for Nutritional Supplement (type or amount), a new Physician Order must be obtained.

If the participant's waiver application is terminated and then re-enrolled and the need for Nutritional Supplements continues, a new Physician's Order must be obtained. If the service for Nutritional Supplements is terminated for any reason, a new Physician Order must be obtained to re-start the service.

Diabetic Nutritional Supplements are authorized at the rate of $45.00 per case.

All other Nutritional Supplements are authorized at the rate of $33.00 per case.

7Q Personal Care I

A unit of service is one (1) hour. This service can be authorized in ½ hour increments above a one (1) hour minimum.

Personal Care I Service is provided in the participant's residence (except when shopping, laundry services, etc., must be done off-site or escort services are provided.)

The Personal Care I is not allowed to provide any skilled medical service at any time under any circumstance.

The **Case Manager** will update the Service Plan to include the need for Personal Care I.

Prior approval must be requested via the service request section of the Service Plan in Phoenix.

No Physician's Order is required for this service.

The **Case Manager** will create the Service Provider Choice Form (Service Provider Report) in Phoenix. The **Case Manager** will obtain the provider choices from the participant and/or primary contact in the order of preference. The choices may be obtained verbally, by mail, or during an in-home visit. If the choices are made verbally, the choices are documented on the Service Provider Choice Form (Service Provider Report) and in the narrative. The Service Provider Choice Form (Service Provider Report) will be signed by the participant and/or primary contact at the next in-home visit.

The **Case Manager** will create a referral to the chosen provider in order of preference in Phoenix.

The **Case Manager** will authorize the amount, frequency and duration of the service in accordance with the participant's Service Plan.

The authorization for this service is day specific. The PCI Service authorization must be specific regarding the preferred time of day – morning, afternoon or evening – that the service is needed. These times are defined as:

Morning 3:00am – 12:00noon
Afternoon 12:01pm – 6:00pm
Evening 6:01pm – 2:59am

The time of day is negotiated with the provider and participant as necessary and the agreed upon time of day must be indicated on the Service Provision Form. The specific time of day for the service (such as 10:00am to 12:00pm) should appear on the Service Provision Form ONLY if and when it is essential in meeting the participant's service needs.

If the participant receives the service more than one (1) time per day, each appropriate time should be indicated

on the Service Provision Form and a comment must be made in the comment section.

It is acceptable to authorize Personal Care I service for a participant on the date of admission to or discharge from an institution such as a hospital, nursing home, rehabilitation center or psychiatry facility. The record must clearly document the need for such services.

The Service Provision Form must be sent to the provider via Phoenix to initiate service. The initial Service Plan and the new Service Plan created following re-evaluation will be available to the provider via Phoenix. If a revision is made to the service plan that affects the provider's service delivery, the provider must be notified of the change via phone or conversation feature.

7R Personal Care II

A unit of service is one (1) hour. This service can be authorized in one-half (1/2) hour in increments above a one (1) hour minimum.

Personal Care II service is provided in the participant residence (except when shopping, laundry service, etc. must be done off-site or escort services are provided.)

Personal Care II is not allowed to provide any skilled service at any time under any circumstances.

The **Case Manager** will update the Service Plan to include the need for Personal Care II.

Prior approval must be requested via the service request section of the Service Plan in Phoenix.

No Physician's Order is required for this service.

The **Case Manager** will create the Service Provider Choice Form (Service Provider Report) in Phoenix. The **Case Manager** will obtain the provider choices) from the participant and/or primary contact in the order of preference. The choices may be obtained verbally, by mail, or during an in-home visit. If the choices are made verbally, the choices are documented on the Service Provider Choice Form (Service Provider Report) and in the narrative. The Service Provider Choice Form (Service Provider Report) will be signed by the participant and/or primary contact at the next home visit.

The **Case Manager** will create a referral to the chosen provider in order of preference in Phoenix.
The **Case Manager** will authorize the amount, frequency, and duration of the service in accordance with the participant's Service Plan.

The authorization for this service is day specific. The PCII service authorization must be specific regarding the preferred time of day – morning, afternoon, or evening - that the service is need. These times are defined as:

Morning 3:00am – 12:00 noon
Afternoon 12:01pm – 6:00pm
Evening 6:01pm – 2:59pm

The time of day is negotiated with the provider and participant as necessary and the agreed upon time of day must be indicated on the Service Provision Form. The specific time of day for the service (such as 10:00am to 12:00pm) should appear on the Service Provision Form ONLY if and when it is essential in meeting the participant's service needs.

If the participant receives the service more than one (1) time per day, each appropriate time should be indicated on the Service Provision Form and a comment must be made in the comment section. The participant whose needs are such that the absence of the Personal Care II would have a substantial impact

on the participant's health and safety is identified as being "At Risk for Missed PCII Visit." The **Case Manager** must discuss any special needs or preferences of the participant with the PCII provider prior to authorization. In these cases, the Service Provision Form will state that the participant is "At Risk for Missed PCII Visit."

It is acceptable to authorize Personal Care II service for a participant on the date of admission to or discharge from an institutional such as a hospital, nursing home, rehabilitation center, or psychiatry facility. The record must clearly document the need for such service.

The Service Provision Form must be sent to the provider via Phoenix to initiate service. The initial Service Plan and the new Service Plan created following re-evaluation will be available to the provider via Phoenix. If a revision is made to the Service Plan that affects the provider's service delivery, the provider must be notified of the change via phone or conversation feature.

7S Personal Emergency Response System

A unit of service is one (1) month.

A Personal Emergency Response System (PERS) is an electronic device which enables a participant to secure help in the event of an emergency.

PERS may be authorized for those participants with an identified need who lives alone or who are alone for a substantial period of time. A substantial period of time is defined as being alone six (6) or more consecutive hours three (3) or more days per week. Any deviation from this criteria requires **Central Office Designee** approval.

The **Case Manager** will update the Service Plan to include the need for Personal Emergency Response System.

Prior approval must be requested via the service request section of the Service Plan in Phoenix.

The **Case Manager** will create a referral to the chosen provider for PERS installation and PERS on going in order of preference in Phoenix.

The **Case Manager** will authorize the amount, frequency, and duration of the service in accordance with the participant's Service Plan.

The PERS Installation Service Provision Form will be completed with a start date and an end date. The start date and the end date for PERS installation authorization must be in the same month. The **Case Manager** should negotiate with the provider to make sure the installation occurs within the same month. Depending on the time of the month when prior approval is given for the service, the provider may not be able to install the PERS during the current month. In this case, authorization would need to be completed for the next month. The Service Plan is not sent to the provider for this service.

The PERS on-going Service Provision Form start date will be the same day as the PERS installment start date and will not have an end date.

The **Case Manager** will create the Service Provider Choice Form (Service Provider Report) in Phoenix. The **Case Manager** will obtain the provider choices(s) from the participant and/or primary contact in the order of preferences. The choices may be obtained verbally, by mail, or during an in-home visit. If the choices are made verbally. The choices are documented on the Service Provider Choice Form (Service Provider Report) and in the narrative. The Service Provider Choice Form (Service Provider Report) will be signed by the participant and/or primary contact at the next home visit.

Note: If an exception needs to be approved by **Central Office Designee**, the **Area Office** reviewer will review the request and enter a comment regarding the service justification in the comment section. The assigned **Case Manager** will send an email requesting the **Central Office Designee** review of the approval request.

7T Pest Control

A unit of service is one (1) every other month.

Pest Control cannot be authorized for a participant residing in an apartment complex. However, authorization may be considered for a participant residing in a single dwelling rental house or a duplex dwelling rental house that is not managed by a governmental entity such as the Housing Authority.

In the case of a rental single house or rental duplex, and the landlord does not provide Pest Control, the **Case Manager** must obtain permission from the participant and/or primary contact to speak to the landlord about Pest Control treatment. If the participant and/or primary contact refuses to allow the **Case Manager** to contact the landlord, the **Case Manager** will deny the Pest Control request. This information must be clearly documented in the narrative including the participant and/or primary contact's permission to contact the landlord, full name, the contact with the landlord and the landlord's response. A CLTC Notification Form 171 will be sent stating the reason the service is denied.

If the landlord refuses to provide the Pest Control for the participant, the **Case Manager** will proceed with the approval and authorization process.

If the landlord refuses to allow Pest Control to be provided, Pest Control should not be authorized and the **Case Manager** will send CLTC Notification Form 171 stating the reason the service is denied.

The need for Pest Control must be documented in the Home Assessment section in Phoenix.

The **Case Manager** will update the Service Plan to include the need for Pest Control.

Prior approval must be requested via the service request section of the Service Plan in Phoenix.

No Physician's Order is required for this service.

The **Case Manager** will create the Service Provider Choice Form (Service Provider Report) in Phoenix. The **Case Manager** will obtain the provider choices from the participant and/or primary contact in the order of preference. The choices may be obtained verbally, by mail or during and in-home visit. If the choices are made verbally, the choices are documented on the Service Provider Choice Form (Service Provider Report) and in the narrative. This Service Provider Choice Form (Service Provider Report) will be signed by the participant and/or primary contact at the next home visit.

The **Case Manager** will create a referral to the chosen providers for Pest Control in order of preference in Phoenix.

The **Case Manager** will authorize the amount, frequency and duration of the service in accordance with the participant's service plan.

The Service Provision Form must be sent to the provider via Phoenix to initiate the service. This authorization will be completed with a start date and will not have an end date.

Exception: If a one (1) time treatment is authorized the **Case Manager** will indicate a start date and an end date.

A maximum of six (6) treatments can be authorized within a twelve (12) month period. Pest Control may be authorized with a frequency of every other month at a maximum. Pest Control treatment must be completed by the provider within fourteen (14) days of the acceptance of the authorization. This service does not require a Service Plan be sent to the provider.

In the event more than one participant resides in the same residence, Pest Control must only be authorized for one of the participants.

The cost of Pest Control service is not included in the $7500.00 lifetime cap for Environmental Modification services.

7U Respite - Community Residential Care Facility

A unit of service is a patient day. A patient day is defined as a twenty-four (24) hour period including the day of admission and excluding the day of discharge. A participant may use twenty-eight (28) days of respite-Community Residential Care Facility per fiscal year July 1st through June 30th.

Participants may receive respite services in Community Residential Care Facility (CRCF) that are enrolled with the Division of CLTC as respite providers.

Participants not eligible for respite in the CRCF:

1. Participants who are dependent on oxygen or mechanical ventilation.
2. Participants who require tube feedings.
3. Participants who are diagnosed with dementia and have a history of wandering, unless prior approved by Central Office.
4. Participants who are at skilled level of care, unless prior approved by Central Office.

The **Case Manager** will update the Service Plan to include the need for Community Residential Care Facility Respite.

Prior approval must be requested via the service request section of the Service Plan.

A Physician's Order is required for this service.

The **Case Manager** will create the Service Provider Choice Form (Service Provider Report) in Phoenix. The **Case Manager** will obtain the provider choice(s) from the participant and/or primary contact in the order of preference. The choices may be obtain verbally, by mail, or during an in-home visit. If the choices are made verbally, the choices are documented on the Service Provider Choice Form (Service Provider Report) and in the narrative. The Service Provider Choice Form (Service Provider Report) will be signed by the participant and/or primary contact at the next in-home visit.

A 2-step PPD is required prior to authorization of the service. The first step of the PPD must be completed prior to admission and the second step may be completed after admission.

The **Case Manager** must obtain the completed Respite Form, which includes the participant's medical history, physical examination report and Physician's Order. The Respite Form must be completed no more than thirty (30) days prior to respite admission date.

Note: If it is not possible to obtain the Respite Form prior to admission, the provider may accept the medical information from the CLTC Assessment in lieu of the Respite Form. In such cases, the provider must obtain the Respite Form with forty-eight (48) hours of the respite admission.

The **Case Manager** will create a referral to the chosen providers in order of preference in Phoenix.

The **Case Manager** will authorize the amount, frequency and duration of the services in accordance with the participant's Service Plan.

The authorization for this service is day specific. The start date is the date of admission and the end date is the day before the discharge date. The comment section of the authorization should specify the number of days the participant will be in respite as well as the discharge date.

The Service Provision Form must be completed and sent to the provider via fax or mailing. The Service Plan and Respite Form must also be sent to the provider via fax or mail.

The reimbursement will include all those items and supplies associated with patient care except prescribed medications and personal items. These items cannot be billed by the provider to Medicaid or the participant.

Examples of items to be supplied by the provider include Durable Medical Equipment, nonprescription medications, med pads, suctioning equipment and supplies, tube feeding equipment and feeding supplies, dressing change supplies, ostomy supplies, catheters and tracheostomy supplies.

Participant and/or primary contact will be responsible for supplying prescribed medications and personal care items such as soap, mouthwash, deodorant, shampoo and clothing during the participant's respite stay.

Participants are allowed a total of twenty-eight (28) days of Community Residential Care Facility Respite during a fiscal year, but no more than fourteen (14) of those days can be respite in a nursing home or hospital during a fiscal year.

7V Respite Care - Institutional (Nursing Home or Hospital)

A unit of service is a patient day. A patient day is defined as a twenty-four (24) hour period including the day of admission and excluding the day of discharge. A participant may use fourteen (14) days of Respite-Institutional (Nursing Home or hospital) per fiscal year July 1st through June 30th.

Participants may receive respite services in nursing homes or hospitals that are enrolled with the Division of CLTC as respite providers.

The **Case Manager** will update the Service Plan to include the need for Respite Care-Institutional.

Prior approval must be requested via the service request section in the Service Plan in Phoenix.

A Physician's Order is required for this service.

The **Case Manager** will create the Service Provider Choice Form (Service Provider Report) in Phoenix. The **Case Manager** will obtain the provider choices from the participant and/or primary contact in the order of preference. The choices may be obtained verbally by mail, or during and in-home visit. If the choices are made verbally, the choices are documented on the Service Provider Choice Form (Service Provider Report) and in the narrative. The Service Provider Choice Form (Service Provider Report) will be signed by the participant and/or primary contact at the next home visit.

A 2-step PPD is required prior to authorization of the service. The first step of the PPD must be completed prior to admission and the second step may be completed after admission.

The **Case Manager** must obtain the completed Respite Form which includes the participant's medical history, physical examination report and Physician's Order. The Respite Form must be completed no more than five (5) days prior to the Institutional (nursing home or hospital) Respite admission.

Note: If it is not possible to obtain the Respite Form prior to admission, the provider may accept the medical information from the CLTC Assessment in lieu of the Respite Form. In such cases, the provider must obtain the Respite Form within forty-eight (48) hours of the respite admission.

The **Case Manager** must request a PASRR be completed by the **Nurse Consultant** prior to admission for the Respite – Institutional service for a participant who will be receiving Respite service in a nursing home.

The **Case Manager** will create a referral to the chosen providers in order of preference in Phoenix.

The **Case Manager** will authorize the amount, frequency and duration of the service in accordance with the participant's Service Plan.

The authorization for this service is day specific. The start date is the date of admission and the end date is the day before the discharge date. The comment section of the authorization should specify the number of days the

participant will be in respite as well as the discharge date.

The Service Provision Form must be completed and sent to the provider via fax and mailing. The Service Plan, Respite Form and PASRR must also be sent to the provider via fax or mail.

The reimbursement will include all those items and supplies associated with patient care except prescribed medications and personal items. These items cannot be billed by the provider to Medicaid or the participant.

Examples of items to be supplied by the provider include Durable Medical Equipment, nonprescription medications, med pads, suctioning equipment and supplies, tube feeding equipment and feeding supplies, dressing change supplies, ostomy supplies, catheters and tracheostomy supplies.

Participant and/or primary contact will be responsible for supplying prescribed medication and personal care items such as soap, mouthwash, deodorant, shampoo and clothing during the participant's respite stay.

Participants are allowed a total of twenty-eight (28) days of respite during a fiscal year, but no more than fourteen (14) of these days can be Institutional Respite in a nursing home or hospital.

7W Telemonitoring

A unit of service is a participant day of Telemonitoring.

Telemonitoring is a service to monitor body weight, blood pressure, blood glucose level, oxygen saturation, and basic heart rhythm information, for Community Choices participants who meet specific criteria.

Community Choices Waiver participants must meet the following criteria in order to be considered for the Telemonitoring service:

1. Have a primary diagnosis of Insulin Dependent Diabetes Mellitus, Hypertension, Chronic Obstructive Pulmonary Disease, and/or Congestive Heart Failure; and

2. Have a history of at least two hospitalizations and/or emergency room visits in the past twelve (12) months; and

3. Be capable of using the Telemonitoring equipment and transmitting the necessary data or have an individual available that is capable of utilizing the Telemonitoring equipment and transmitting the necessary data to the Telemonitoring provider; and

4. Have a primary care physician that approves the use of the Telemonitoring service and who is solely responsible for receiving and acting upon the information via the Telemonitoring service.

The **Case Manager** must complete the Community Choices Pre-Screening for Telemonitoring Form to assure the participant meets the criteria.

If the participant meets the criteria and chooses to receive the service, the **Case Manager** will update the Service Plan to include the need for Telemonitoring.

The **Case Manager** will update the Service Plan to include the need for Telemonitoring.

Prior approval must be requested via the service request section of the Service Plan in Phoenix.

A Physician Order is required for this service.

The **Case Manager** will contact the participant's choice of provider for availability. The **Case Manager** will send a copy of the Community Choices Pre-Screening for Telemonitoring Form to the chosen provider when the referral is accepted.

The Telemonitoring provider must contact the participant's physician to obtain the orders to participate utilizing the approved SCDDHS Form. Upon receipt of the orders, the Telemonitoring provider must notify the **Case Manager** and negotiate a start date. If notification by the provider has not been received within ninety (90)

days of the referral, the **Case Manager** must email PROVIDER-Distribution@scdhhd.gov.

The **Case Manager** will authorize the amount, frequency and duration of services in accordance with the participant's Service Plan.

The Service Provision Form must be sent to the provider by fax or mail. The initial Service Plan and the new Service Plan created following re-evaluation will be sent to the provider by fax or mail.

If upon Re-evaluation the participant no longer meets the initial criteria due to no hospitalization or no Emergency Department visits, the Telemonitoring service may continue.

07.30 CLTC Waiver Interactions with Medicaid State Plan Incontinence Supplies

Note: Please refer to the State Plan Medicaid Incontinence Supplies Policy and Procedure Manual for complete information regarding this service.

The information below is specific to CLTC waiver/Medicaid State Plan Incontinence Supplies interactions.

If there is an open waiver case assigned to a Case Manager and the participant needs incontinence supplies, the **Case Manager** needs to **create an Incontinence Supplies Application in Phoenix**. An e-Referral or Centralized Intake referral should not be made.

Any identified needs for incontinence supplies for PRIME/ waiver participants should be referred to the PRIME Care Coordinator. The Case Manager will not create an IS application in Phoenix. This contact with the PRIME Care Coordinator will be documented in the participant's phoenix narrative.

Creating an IS Application for a current waiver participant:

- Create an Incontinence Supplies application under "Applications: in Phoenix. The worker will indicate the participant is Medicaid eligible.
- Assign the application to the same CLTC worker assigned to the waiver application.
- The Assigned **Case Manager** will complete the Incontinence Supplies assessment.
- Do not complete the separate Incontinence Supplies assessment.
- Do not complete the separate Incontinence Supplies Service Plan.
- Add Incontinence Supplies to the Waiver Service Plan.
- Request prior approval via the service request section of the Service Plan in Phoenix.
- Create the Incontinence Supplies referral. The worker will include a comment on the Incontinence Supplies referral notifying the IS provider when there is a 30 day wait.
- The provider will obtain the Physician's Certification of Incontinence after receiving the referral.
- The CM will create the Service Provision Form (authorization) after receiving notification of acknowledgment from the provider that the Physician's Certification of Incontinence has been obtained under Forms in Phoenix.
- **The Physician Certification of Incontinence Statement must be obtained by the IS provider prior to the Case Manager creating and sending the Initial Service Provision Form (authorization) for Incontinence Supplies.** It is the responsibility of the **Case Manager** to

make sure the provider acknowledgement in Phoenix states the initial Physician Certification of Incontinence Statement has been obtained by the provider prior to authorizing IS. The assigned **Case Manager** will receive a Phoenix notification when the provider indicates the certification has been received. The **Case Manager** may view the acknowledgement in Phoenix Forms.

- The initial Physician Certification of Incontinence Statement is valid for 12 months for waiver participants. The provider is responsible for obtaining an updated Physician Certification of Incontinence Statement and notifying the **Case Manager** through Phoenix when the updated form is received. It is the provider's responsibility to request termination of Incontinence Supplies if the Physician Certification of Incontinence Statement expires and is not renewed by the Physician Certification of Incontinence Statements.

- A waiver participant may receive Incontinence Supplies in a Community Residential Care Facility.

- When Incontinence Supplies are being terminated the **Case Manager** will send a CLTC Notification Form 171 with a ten (10) day notice to the participant/primary contact prior to termination of IS. The notice must indicate the reason the supplies are being terminated and reference the Medicaid State Plan Incontinence Supplies Policy Manual.

When waiver applications are terminated but the participant remains Medicaid Eligible and continues to need Incontinence Supplies.

- The Incontinence Supplies Application and Incontinence Supplies Service Provision Forms will remain open in Phoenix.

- The Waiver **Case Manager** will ensure an Initial Incontinence Supplies Assessment has been completed in Phoenix. If not present, the assessment must be completed prior to re-assigning the Incontinence Supplies Application.

- Any hard copy documents must be scanned into Phoenix Scans.

- The incontinence Supplies Application will be re-assigned to the Community and Facility Services designee.

- The newly assigned worker will receive a Phoenix Notification of assignment.

- The Waiver **Case Manager** will create and send a CLTC Notification informing the participant/primary contact of the change in Incontinence Supplies workers assigned for ongoing monitoring.

- The **Case Manager** will communicate the change to the provider via the Phoenix Conversation Feature or by phone.

Community Residential Care Facility Interactions With Home and Community Based Waiver Programs July 1, 2015

Please see updated chart below regarding Community Residential Care Facilities interactions with CLTC's waiver services

Incontinence Supplies can be authorized for participants residing in a residential care facility.

Waiver services that **may** be routinely authorized by CLTC, if appropriate:

Community Choices	HIV/AIDS
Case Management	Case Management
Personal Care II up to 1 hour/day, 7 days/week	Personal Care II up to 1 hour/day, 7 days/week
Nutritional Supplements	Nutritional Supplements

Waiver services that **may not** be routinely authorized by CLTC, but may be given special consideration on a case by case basis and require Central Office approval:

Community Choices	HIV/AIDS
Adult Day Health Care	----------
----------	Medicaid Nursing
Adult Day Health Care-Nursing	----------

Waiver services that **will not** be authorized by CLTC:

Community Choices	HIV/AIDS
Personal Care I	Personal Care I
Attendant Care	Attendant Care
Home Delivered Meals	Home Delivered Meals
Pest Control/Enhanced Pest Control	Pest Control/Enhanced Pest Control
PERS	----------
Environmental Modification/Enhanced Environmental Modification	Environmental Modification/Enhanced Environmental Modification
Companion	Companion
Bath Safety Equipment	Bath Safety Equipment
Telemonitoring	----------

Two additional prescriptions allowed per month for HIV Waiver Participants residing in a CRCF