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10.10 INTRODUCTION

This Chapter includes policies and procedures for case/application termination and case transfer. Case termination involves all activities associated with closing a CLTC case when an applicant/participant exits the program for specified reasons.

Termination of a case is not to be confused with termination of waivered services or termination of one application when more than one application is open. (See Chapter 7.25 Termination of Waivered Services.)

Individuals may have more than one CLTC program application open at the same time if his/her situation requires and the appropriate criteria are met. It is important for CLTC workers to verify both program application and overall status in Phoenix prior to initiating and ending case actions.

0.20 TERMINATION AND TRANSFER POLICIES

10.21 Termination

An applicant/participant should be terminated for any of the following reasons on the date of action, unless otherwise specified:

- **Aged out of program**

- **AWP-In Nursing Home**
  This closure is only used when updating the Awaiting Placement Report when it is learned that the person is in the nursing facility.

- **Certified and Closed**
  Individual is living in the community, has been determined to meet level of care criteria, and is seeking placement in a Medicaid-sponsored long-term care facility.

- **Certified and Closed-bed available**
  Applicant is seen in the community, and states that NH bed is available.

- **Declined participation in program**
  Individual declines to participate by signing Service Choice or stating verbally that he/she does not want any continued involvement with CLTC. Narrative must include documentation of the contact and reason for the termination.

- **Did not relocate to South Carolina**
  Out-of-state applicant who does not relocate to the state within 60 days (see Chapter 8 Section 08.22.11).

- **Died**
  The date of closure must be the date of death. In Phoenix, this will be a global termination, closing all applications. Narrative entries must be completed prior to closure. If appropriate, services must be terminated prior to closure.

- **Enrolled in another Program**

- **Entered Administrative Days**
  Individual is Certified for Administrative Days coverage in an acute care hospital.

- **Entered DMH/DDSN Program**
  Entered a Department of Mental Health/Department of Disabilities and

Special Needs facility. Follow up should be made to the licensed facility to determine if the admission to the program is to be short or long term prior to terminating. (See Section 05.39)

- **Entered HASCI Waiver**

- **Entered HMO**
  Entered Health Maintenance Organization.

- **Entered ID/RD Waiver**
  Entered Intellectual Disabilities/Related Disabilities Waiver administered by DDSN.

- **Entered Nursing Home**
  Medicaid-sponsored nursing home placement only, including conversion to Medicaid-sponsored nursing home. For waiver participants/applicants, the date of closure must be the date the individual entered the nursing home under Medicaid sponsorship.

- **Entered Nursing Home with Private Pay**

- **Entered PACE (Program For All Inclusive Care for the Elderly)**.
  Only to be used by designated CLTC offices.

- **Entered Residential Care Facility**
  Admitted to Community Residential Care Facility under a payment source other than Optional State Supplement.

- **TEFRA**
  Entered Tax Equity and Fiscal Responsibility Act of 1987 program (also known as "Katie Beckett"), a special Medicaid category for disabled children living at home who are not otherwise Medicaid eligible due to family income.

- **Full Calendar Month Criteria**
  Waiver participant who has met the full calendar month criteria, which is defined as from the first calendar day of the month throughout the last calendar of the month. If the participant remains hospitalized or institutionalized for a full calendar month, the case must be closed to the waiver effective no later than the last day of the full calendar month period. (See Section 05.39)

- **Financial Application not Completed Within 30 days**

- **Financially Ineligible**
  Participant does not meet financial guidelines for Medicaid-sponsored

long term care services. Notification or verification must be available before a participant is terminated. If a participant requires services in the community, referrals should be made for the participant to other community agencies. Using the date of financial ineligibility as determined by County Medicaid Eligibility, the case must be closed the last day of eligibility. For example, if ineligible 9-1-14, the closure date must be 8-31-14. If is learned that financial eligibility will be reinstated within 7 days of the closure, it should be reported in Phoenix as a problem to have the case reopened.

- **PASARR Completed**

- **Inappropriate after Intake**
  Individual was referred for a program without being informed or was referred for a program in error. This termination reason should not be used when the applicant is declining participation, did not meet intake criteria or is financially or medically ineligible for a program.

- **Participant Incarcerated**
  Incarcerated Waiver participant must be terminated by the last day of the month of incarceration.

- **Intake Criteria not met**
  Intake criteria not met for program application.

- **Medically Ineligible for program**
  Individual does not meet level of care criteria for Medicaid-sponsored long term care services. Medically Ineligible Policy (see Section 03.22) must be followed prior to terminating the individual as medically ineligible.

  Note: The waiver or children's services participant who is determined to be medically ineligible must receive a **ten (10) calendar day** notice prior to termination of the case. Services can continue through the date of termination. If appealed **within 10 calendar days**, the application/case may remain open if requested by the participant and/or primary contact. The participant and provider must be notified of this determination through the CLTC Notification Form 171 and the date of termination, ten (10) calendar days from notification, must be indicated on the form. Once the **ten (10) calendar days period** has expired, the application/case must be closed in Phoenix and termination policies and procedures followed.

- **Merged Case**

- **Moved outside of South Carolina**

- **Participant is Non-Compliant**
  Participant closed due to non-compliance. (Refer to Section 05.39.30)

- **Referred to HASCI**
  DDSN is the agency designated for Head and Spinal Cord Injury (HASCI) waiver. CLTC **Nurse Consultants** are responsible for the initial pre-admission screening and nursing facility level of care determination. If the individual meets the level of care criteria for nursing home, terminates as Referred HASCI Waiver.

- **Terminated and Referred to Medicare**
  Admission to a nursing home with Medicare as the payment source with or without CLTC involvement in the referral process (unless a planned temporary stay for Case Management case. Refer to Section 05.39). The date of closure must be the date the individual entered the nursing home.

- **Unable to Locate the Participant**

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

- Receives information which indicates the individual should be terminated.
- Notifies involved agencies and/or providers of individual's termination, when appropriate.
- Notifies the individual, primary contact, or other permitted caregiver support verbally of reason for termination and discusses referrals to other agencies when appropriate.
- Completes CLTC Notification Form 171 to notify participant, primary contact, or other permitted caregiver support of the reason for termination.
- Completes Status Changes section of Phoenix **within five (5) business days** of CLTC Notification.

The following must also be completed for waiver participants:

- Completes service(s) termination when appropriate. This must be done prior to case closure.
- Terminates the application in Phoenix.
- E-mails the **designated CLTC Support Staff** for RSP indicator entry so that entry is made **within four (4) calendar days** of waiver termination date.

The designated Support Staff:

- Enters termination date from program on RSP updated screen **within 4 calendar days** of termination in Phoenix.
- Makes copies of correspondence for mailing to designated persons.
- Places copies of correspondence in the file.
- Files correspondence file.

10.21.10 Transition to/from Another Waiver

In cases in which a participant is changing enrollment from one waiver to another waiver, coordination between involved agencies must occur to ensure continuity of care and continued Medicaid eligibility. The participant must be terminated from the original waiver, and then be enrolled in the receiving waiver effective the following calendar day. Once the termination and enrollment dates have been coordinated between the two involved waivers, CLTC must make an entry into RSP, terminating/entering the participant from the waiver, and send the CLTC Notification Form 171 to the participant, primary contact, and/or other permitted caregiver support giving the reason for termination. Advance notice must be given to all involved providers. A copy of the CLTC Notification Form 171 must be sent to the receiving agency and to providers.

If the transfer is to a waiver that requires a different level of care, i.e. nursing facility level of care to at risk for hospitalization, an assessment and level of care must be completed by a **Nurse Consultant** prior to the transfer.

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

- Coordinates with receiving waiver and participant to ensure continuity of care and continued Medicaid eligibility.
- Notifies involved providers in advance of planned termination.
- Terminates all waivered service authorizations.
- Terminates participant from CLTC waiver once appropriate written notification is obtained from receiving waiver.
- Completes CLTC Notification Form 171 to notify the receiving waiver and participant of the reason for termination.
- Routes to the **designated Support Staff** for mailing of any appropriate correspondence and for keying RSP as appropriate.

10.22 Transfer of Waiver Participant to Another CLTC Region

When a waiver participant relocates to another CLTC region, the case can be transferred to another CLTC Area Office for continued case management and

other waivered services.

Note: Transfer of a **pending** waiver participant is addressed in Section 02.29.10.

For the transferring waiver case, the transferring and receiving CLTC Area Offices must coordinate activities as outlined:

- If there is prior knowledge of the participant's move, the transferring Area Office must notify the receiving Area Office of the pending transfer and give the new location of the participant.

- The transferring Area Office will review the open authorizations with the receiving Area Office.

- The **assigned Case Manager** in the transferring Area Office will contact the **Case Manager II** in the receiving Area Office to make the transfer referral official when the participant's move has occurred or the imminent date is known.

- The receiving Area Office will advise the participant/primary contact of the available provider options in the prospective new location.

- If a participant moves to another county and there is an open APS case or a referral has been made on a participant, **the transferring Provider Case Manager, Case Manager, Case Manager II or Nurse Consultant** should notify the assigned APS worker of the participant's move to a new location.

- If a participant moves to another county and there is an open APS case or a referral has been made on the participant, the transferring Provider Case Manager, Case Manager, Case Manager II or Nurse Consultant will notify the receiving Area Office.

- **The receiving Area Office will review** all of the service authorizations and will contact the provider to determine if the authorized service may continue in the receiving area. The receiving Area Office will confirm that the provider number is correct for the receiving Area Office. If upon review the provider number is found to be incorrect, the receiving Area Office will complete the authorization using the correct provider number.

- The transferring Area Office should ensure all forms or documents not available in Phoenix are scanned to the Participant's Phoenix file.

- Do not terminate the application and do not close in RSP.

- Once the transferring Area Office cues Phoenix to transfer the case, the transferring Area Office will no longer be able to enter information in Phoenix. The **transferring CLTC Worker** must have all their actions completed before cuing the transfer.

- A Re-evaluation is not required upon transfer, unless the re-evaluation was not completed timely in the transferring Area Office. The case is accepted "as is" and the receiving **Case Manager** will be responsible for completing the re-evaluation.

- The **Case Manager II o**f the receiving Area Office conducts a telephone contact at the time of transfer to update any pertinent information.

- The **Case Manager II** of the receiving Area Office should obtain the case management choice if the current choice of Case Management is not available in the receiving Area Office.

- The ongoing C**ase Manager** should complete a new "Home Assessment" at the next scheduled home visit after the transfer.

- The ongoing **Case Manager** should maintain the original re-evaluation cycle.

  Note: An initial Case Manager visit is not required.

- A signed provider choice and new Participant's Rights and Responsibilities Statement will be obtained on the first visit to the participant in the new Area Office.

- If after transfer a case is found by the receiving Area Office to be medically ineligible, the receiving **Case Manager** should seek input from the primary physician. If the applicant is determined medically ineligible after receiving information from the physician, the case should be reviewed by the **Lead Team Case Manager** and/or **Area Administrator**. If the Area Office is unable to make a level of care determination, **Central Office** should be notified.

- If after transfer a case is found to have a re-evaluation to be past due, the re-evaluation should be completed within seven (7) business days and the **Lead Team Case Manager and Area Administrator** should be notified.

- The receiving **Case Manager II** routes the information to the **designated Support Staff** for correspondence file setup and any items to be sent to

the participant/primary contact and providers if indicated.

Applications involving more than one CLTC Area Office:

When a waiver case from a CLTC Area Office requires a different program (for example nursing home application) in another Area Office, the area with the open waiver case will give access to the other CLTC office to complete the necessary work in Phoenix. Once the work has been completed, that Area Office must notify the "home" CLTC Area Office of completion and the access will be closed.

If a CLTC office receives a referral for Nursing Home or PASARR on an applicant on the processing list in another area, the office where the person is on the processing list will give access to Phoenix to the office receiving the referral. Once the work has been completed, that Area Office must notify the "home" CLTC Area Office of completion and the access will be closed.

If an Area Office has an open nursing home application and the applicant is moved to a hospital in another area, the case should be transferred to the Area Office where the nursing home application is being made from the hospital.

If an Area Office has a pending nursing home conversion case and an application is received for nursing home in another CLTC Area Office, the Area Office with the pending application will give access to the other CLTC Area Office. Once the work has been completed, that Area Office must notify the "home" CLTC Area Office of completion and the access will be closed.