SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

NURSING FACILITY SERVICES PROVIDER MANUAL

JULY 1, 2019

South Carolina Department of Health and Human Services

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PROGRAM OVERVIEW

NURSING FACILITY

A nursing facility is a health-related facility which fully meets the requirements for state nursing facility licensure and must be surveyed for compliance with the requirements of participation in the Medicaid program by the South Carolina Department of Health and Environmental Control (DHEC) Bureau of Certification and be certified as meeting federal and state requirements of participation for long-term care facilities.

INSTITUTION FOR MENTAL DISEASE

A nursing facility may also meet the criteria to be an Institution for Mental Disease (IMD). An IMD is defined as an institution primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services. Whether a facility is an IMD is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases.

SWING-BED HOSPITALS

Hospitals participating in both the Medicaid and Medicare programs, in addition to providing an inpatient hospital level of care, may also provide nursing facility levels of care and be reimbursed as “swing-bed” hospitals. A swing-bed hospital must:

- Be located in a rural area;
- Have fewer than 100 inpatient beds exclusive of newborn and intensive care type beds; and
- Be surveyed for compliance by DHEC and certified as meeting federal and state requirements of participation for swing-bed hospitals.

INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES

An Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) is an institution licensed and operated primarily for the diagnosis, treatment, or habilitation of persons with intellectual disabilities or related disabilities and which provides, in a protected setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services to help each individual function optimally. The facility must be surveyed for compliance and certified as meeting federal and state requirements of participation for ICF/IID facilities.

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

- Provider Administrative and Billing Manual
- Forms

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COVERED POPULATIONS

ELIGIBILITY/SPECIAL POPULATIONS

Program Service Requirements – Medical

All individuals desiring Medicaid payments for nursing facility care must be certified as meeting the level of care criteria for nursing home placement. The Community Long-Term Care (CLTC) program conducts preadmission review and level of care certification for all eligible residents seeking Medicaid sponsorship of inpatient services in a nursing facility. Criteria for Medicaid- sponsored levels of care are specified in the CLTC Assessment and Level of Care Manual available through the regional CLTC area offices.

CLTC certification is required in the following situations:

- Prior to any Medicaid-sponsored admission to a long-term care facility from any location;

  Exception: If the admission is a same-day transfer of a current Medicaid resident from another nursing facility at the same level of care, a CLTC certification is not required.

- Prior to readmission to a long-term care facility from any location once Medicaid payment has been terminated;

  Note: This includes readmission from the hospital if the stay has exceeded a Medicaid-authorized bed-hold period. Authorized bed-hold periods include the following:

  – Up to 10 days in a hospital; a resident may be in the hospital 10 full days, returning on the 11th day;

  – Up to 18 days per fiscal year for a deinstitutionalization program not to exceed nine days at any one time; and

  – Up to an approved 30 consecutive days for the purpose of participation in an approved rehabilitation program.

- Prior to the date Medicaid payment may begin, when a resident's care in a long-term care facility is being paid for privately, by Medicare, or any other source, and Medicaid sponsorship is being requested;

- When a time-limited certification has expired and Medicaid payment is to continue;

- Prior to the admission of a resident from an IMD facility administered by the Department of Mental Health (DMH) to a non-DMH-administered long-term care facility; and

- Prior to the admission of a resident from an ICF/IID administered by the Department of Disabilities and Special Needs (DDSN) to a non-DDSN long-term care facility

Consent Form
A Consent Form (DHHS Form 121) must be signed by the resident at the time of the initial assessment and submitted along with the Long-Term Care Assessment form (linked below) to the CLTC area office. A responsible relative signs the form if a resident is incompetent or physically impaired. If no responsible relatives exist, a responsible non-relative or appointed guardian signs the form. The Consent Form must be signed in order for the CLTC nurse consultant to take action on the case.

Long Term Care Assessment – DHHS Form 1718
The Long-Term Care Assessment form (DHHS Form 1718) is the instrument used to evaluate residents seeking Medicaid-sponsored long-term care services. The CLTC nurse consultant reviews the assessment prior to certification as follows:

- When a resident is located in a Medicaid-certified long-term care facility, the resident will be assessed by the staff of that facility.

- When a resident is located in a non-Medicaid-certified facility, the assessor will be determined by an agreement between the CLTC area administrator and the nursing facility administrator.

- When a resident is located in the hospital at the time of the initial assessment, the assessor will be determined by agreements between the CLTC area administrator and the hospital administrator.

- When a resident is located in the community at the time of application, CLTC or the staff of the agency actively involved with the resident may complete the assessment.

The assessment form must be completed accurately, obtaining all available information. The assessor should read the South Carolina Assessment and Level of Care Manual for Medicaid-Sponsored Long-Term Care Services thoroughly before completing an assessment.

The assessment must be completed by a registered nurse, social worker, social services worker, and/or physician. A person who is related to the resident may not complete any portion of the assessment.

The CLTC nurse consultant has **14 calendar days** from receipt of the referral to complete the assessment and determine the level of care.

Level of Care Certification Letter – DHHS Form 185
Prior to determining a level of care, the CLTC nurse consultant is required to make a visit to see the resident prior to determining the level of care. After making the level of care determination, the CLTC nurse consultant sends a Level of Care Certification Letter (DHHS Form 185) to all involved

parties. The effective date on the Level of Care Certification Letter corresponds to the date requested by the nursing facility or South Carolina Department of Health and Human Services (SCDHHS). If a date is not requested, certification is issued based on the date the level of care is determined. Retroactive level of care certification will not be routinely authorized for more than 10 days prior to the date of the receipt of the Long-Term Care Assessment form (DHHS Form 1718) by the CLTC area office.

Level of Care Control
Federal and state regulations outline requirements for the control and utilization of Medicaid services in long-term care facilities. The facility interdisciplinary team (IDT) performs and reviews resident assessments. The team is also responsible for determining the resident's level of care.

Level of Care Changes
All changes in the level of care must be certified by the IDT coordinator in accordance with the Resident Case Mix Classification Change form (DHHS Form 210). DHHS Form 210 must be sent on the first working day after the decision is made to all of the following parties:

- Resident and family/responsible party;
- Regional SCDHHS eligibility office;
- Attending physician;
- Facility administrator and financial officer; and
- SCDHHS Division of Community and Facility Services, only when the determination is less than intermediate level of care.

Adverse Changes
All parties must be notified in writing when DHHS Form 210 indicates a resident no longer meets the level of care. When the original decision is made by the facility IDT, Long-Term Living should be notified immediately.

When a resident in a nursing facility or ICF/IID is awaiting placement due to a change in the resident's level of care, and a resident no longer medically or psychiatrically requires long-term care, there will be a limit of up to the 30 administrative days available to make alternate placement. If alternate placement is found within the 30 days and is refused by the resident or responsible party, the Medicaid payment will terminate immediately. Thirty administrative days do not apply to the initial CLTC determinations of less than intermediate level of care.

Referrals
The following individuals should be referred to CLTC for Medicaid certification**:**

- All individuals who are seeking admission under Medicaid sponsorship to a nursing facility. This includes a current resident under another pay source requesting Medicaid sponsorship.

- Any individual who is eligible or potentially eligible for Medicaid benefits, appears to have long-term care needs, and is seeking community-based services.

The nursing facility staff should make referrals to CLTC by completing the Long-Term Care Assessment form (DHHS Form 1718) and forwarding it along with a signed Consent Form (DHHS Form 121) to the appropriate CLTC area office. Providers should refer to the CLTC Assessment and Level of Care Manual for instructions on how to complete DHHS Form 1718.

CLTC has been designated to perform preadmission review of all applicants for Medicaid-sponsored nursing facility care. This function must occur prior to admission to a long-term care facility and before the date for which Medicaid vendor payment can begin. The CLTC review indicates that the resident requires a skilled or intermediate level of care. When the level of care certification is completed by CLTC, the nursing facility is notified via a Level of Care Certification Letter (DHHS Form 185) at the time of admission.

For nursing facility residents being discharged to the community and seeking CLTC services, CLTC must receive a referral prior to the discharge in order to ensure that appropriate community services can be provided to the individual without interruption. The individual must be financially eligible and continue to meet nursing home level of care criteria and the conditions specified in CLTC policy and procedures program. It is crucial for nursing facility staff to coordinate with CLTC regarding eligibility and enrollment in a waiver program prior to discharge.

Out-of-State Referral

If an out-of-state resident desires Medicaid-sponsored payment in South Carolina, a referral must be made to the CLTC area office. CLTC will make arrangements to have an assessment completed and issue a tentative level of care. A final level of care must be determined by CLTC through a visit to the South Carolina nursing facility within 10 working days of the resident's admission to the facility. All Preadmission Screening and Resident Review (PASARR) regulations must also be followed. PASARR information can be found later in this section.

Certification Validity

CLTC certification for a person waiting for placement in a long-term care facility is valid for 30 days. Upon admission to a nursing facility, the certification is valid indefinitely except for the following:

- A resident's Medicaid benefits are terminated for any reason.

  Exception: A Medicaid resident's benefits are terminated for 31 days or less for financial eligibility reasons (*e.g.,* excessive resources).

- CLTC has specified that the resident's certification is time-limited and the time limit has expired.

- A resident enters a private facility under a pay source other than Medicaid. A resident must be certified again before a Medicaid conversion will be allowed.
- A resident's condition changes or location from where he or she was initially certified changes (*e.g.,* home to hospital, hospital to home, or long-term care facility to home).
- A resident exceeds a Medicaid-authorized bed-hold period or was formally discharged because he or she no longer met the bed-hold requirements.
- If a certification becomes invalid, updated information must be obtained and the resident must be re-evaluated before the long-term care facility admission under Medicaid can take place. Any certification letter that has been altered is invalid.

Time-Limited Certifications

A resident's medical condition or other functional factors may sometimes warrant certification and a nursing facility admission for a specific period of time. In these situations, CLTC may determine that a resident can benefit from temporary placement in a long-term care facility and will certify the resident's placement for a specific amount of time.

Such placement will have specified time frames and goals in the care plan developed by the nursing facility staff. The CLTC nurse consultant should notify the nursing facility, in writing, of a resident's disabilities and/or short-term needs. This information will be valuable to the nursing facility in the development of the care plan to meet the resident's short-term needs.

Conversion from Other Payment Sources to Medicaid

When a resident exhausts Medicare benefits, private pay, or other resources, he or she may be eligible for conversion to Medicaid sponsorship.

Medicare remains the primary payment source until one of the following situations occur:

- The resident's Medicare benefits are exhausted; or
- The resident is no longer receiving Medicare reimbursable skilled services.

A resident and his or her family must make an application for financial eligibility determination at the local SCDHHS. At the time of this application, the local SCDHHS eligibility staff will send a Request for Assessment form (DHHS Form 1231) to the nursing facility where the applicant resides. The nursing facility staff is responsible for completing a Long-Term Care Assessment form (DHHS Form 1718) and forwarding it to the appropriate CLTC area office within 10 calendar days of receipt of DHHS Form 1231 from SCDHHS eligibility staff.

DHHS Form 1718 should be completed and sent, whenever possible, prior to or on the date of application for Medicaid financial eligibility. Nursing facilities have been advised that, at the very latest, the Long-Term Care Assessment form (DHHS Form 1718) must be received in the CLTC

area office within 10 calendar days of the date on the Request for Assessment form (DHHS Form 1231) sent by SCDHHS.

Sometimes a nursing facility may anticipate the need for conversion from Medicare or another payment source to Medicaid and request a future date of certification. If this is the case, CLTC staff will not issue a Level of Care Certification Letter (DHHS Form 185) assessment on information that is submitted more than two weeks prior to the requested date of certification. The CLTC nurse consultant who is responsible for the level of care decision must be made aware by the nursing facility of any changes that occur in the resident's condition before certifying.

Level I Screening – DHHS Form 234
Nursing facility and/or hospital staff may conduct the PASARR Level I screening, provided that the individual conducting the screening has been trained by the local CLTC office and a Memorandum of Agreement between the nursing facility or the hospital and CLTC has been signed. The screenings must be complete and accurately reflect the resident's condition at the time of the screening. DHHS Form 234 is used to record the results of the screening. DHHS Form 234 is included on the provider portal. Level I screening **must** also be conducted when:

- A resident is admitted to a Medicaid-certified nursing facility;
- A resident has exceeded the 10-day bed hold prior to a nursing facility readmission from a hospital for inpatient treatment of a psychiatric condition;
- A resident transfer from another state to South Carolina; or
- A resident is admitted for respite to a nursing facility. (A respite care stay is defined as 14 days or less.).

Level I screening is **not necessary** when:

- A resident transfer from one certified nursing facility to another certified nursing facility within South Carolina. The transferring facility is responsible for sending all PASARR information to the receiving facility.
- A resident is admitted to a facility that is not Medicaid certified.
- There are intra-facility conversions from one payment source to another.
- A resident is admitted to a nursing facility from a hospital for an acute inpatient treatment of the same condition for which he or she was hospitalized and where the nursing facility stay is anticipated to be less than 30 days, as certified by a physician. If a resident who enters a nursing facility as an exempted hospital discharge is later found to require more than 30 days of nursing facility care, the DMH or the DDSN must conduct the PASARR Level I within 40 calendar days of admission.

- The admissions are swing-bed or administrative days admissions.

Nurses or social workers (to include social work designees or social services workers) within the facility may conduct Level I screening.

Without exception, a Medicaid nursing facility must comply with preadmission screening mandates of PASARR, regardless of payment source.

Level II Determination – DHHS Form 250
CLTC is responsible for Level II referrals on residents entering a nursing facility. The nursing facility is responsible for Level II referrals due to significant changes in a resident's condition within its facility. Residents identified through the Level I process as having an MI or ID are referred through the Level II process to determine the need for services of a lesser intensity (to be provided by the nursing facility) or specialized services (to be provided by the DMH or DDSN, as appropriate). The nursing facility is responsible for notifying and explaining the Level II determinations and advising the resident and responsible party regarding their right to appeal the outcome of any part of the PASARR process. DHHS Form 250 is used to record the results of the review. DHHS Form 250 is included on the provider portal.

Once a resident who has been determined to need treatment for a mental illness or an intellectual disability through the Level II process has been admitted to a nursing facility, an additional Level II PASARR referral will be required when there is a significant change in a resident's condition. A significant change is defined as a major change in a resident's status that is not self-limiting, impacts more than one area of a resident's health status, and requires interdisciplinary review or revision of the plan of care.

The following items should be included in the Level II packet:

- Level I Screening (DHHS Form 234);
- Mini Mental State Exam;
- Psychiatric Evaluation (DHHS Form 250) only for a resident with mental illness;
- Consent Form (DHHS Form 121);
- South Carolina Long-Term Care Assessment (DHHS Form 1718);
- Social History (DHHS Form 247 for residents with MI or DHHS Form 248 for residents with ID);
- Resident's history and physical completed by the physician; and
- Copies of the resident's hospital and/or nursing home records.

Refer to the Forms information on the provider portal for DHHS Form 243, DHHS Form 121, DHHS Form 247, and DHHS Form 248.

Delegated Status Facilities – Certification
DMH has the authority for preadmission review of residents 65 years of age and older admitted to the IMD. Each Medicaid-sponsored resident must be issued a certification by the DMH indicating the level of care and effective date. This certification must be signed by a physician.

DDSN has the authority for preadmission review of residents admitted to an ICF/IID. Each Medicaid-sponsored resident must be issued a certification by DDSN indicating the level of care and the effective date. This certification must be signed by a nurse, social worker and/or physician.

SCDHHS has review and oversight for all admissions to DMH and DDSN facilities. SCDHHS determinations will prevail in all disputed cases.

DMH Responsibilities – DMH retains the function of determining the need for nursing facility care for residents residing within DMH facilities. However, an independent contractor may conduct psychiatric evaluations on residents residing in the DMH facility who meet the criteria established for having a mental illness.

DDSN Responsibilities – DDSN retains the function of conducting evaluation and determination of residents applying to or residing in a nursing facility who are suspected or diagnosed as having intellectual disabilities or related disabilities.

Resident Assessments
A nursing facility furnishing long-term care for either or both the Medicare and Medicaid programs must conduct comprehensive, accurate assessments of each resident's functional capacity using the Minimum Data Set (MDS) Version 3.0. Full assessments must be conducted within 14 days of admission, at least annually, and within 14 days of a significant change in a resident's status. These assessments include the Care Area Assessments (CAAs). Quarterly reviews must be completed at least every three months between full assessments.

Key components of these assessments serve as the basis for developing a plan of care that assists a resident in attaining or maintaining the highest practicable physical, mental, and psychosocial functioning possible. A nursing facility must link the MDS and CAA information in the care planning process. Federal regulations require each individual completing a portion of the assessment to sign and certify its accuracy. The registered nurse assessment coordinator signs to certify that the assessment is complete.

More detailed information regarding resident assessment may be obtained by reviewing the Long-Term Care Resident Assessment Instrument User's Manual, Version 3.0. Copies of the currently specified MDS and Quarterly Review Instruments were initially supplied to all nursing facilities. Providers are responsible for duplicating copies and for obtaining supplies from private printing sources beyond this initial distribution.

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ELIGIBLE PROVIDERS

PROVIDER QUALIFICATIONS

Additional Swing-Bed Services Guidelines

For covered services, swing-bed facilities must adhere to the following additional guidelines:

- The CLTC program will perform preadmission review and level of care certification for all eligible residents seeking Medicaid sponsorship in hospital swing-beds.
- A resident may be admitted from any point (*i.e.,* home, hospital, or another nursing facility).
- A resident transfer to a regular nursing facility is not a requirement of the Medicaid program.
- There is no limit on the number of days a Medicaid resident can occupy a swing-bed.
- Laboratory, X-ray, and therapies can be billed as outpatient hospital ancillary charges. However, dually eligible resident charges should be billed to Medicare Part B.
- Physician visits are billed and reimbursed separately from the hospital swing-bed nursing services. The physician services should follow standard policies for professional reimbursement.
- No bed-hold policy exists during a short-term hospitalization for a resident in the same hospital who transfers from a swing-bed to an acute bed. An administrative discharge and readmission are required for a stay of 10 days or less. The CLTC office must assess and/or certify all residents exceeding a 10-day hospital stay prior to readmission to the hospital swing-bed for nursing facility services.
- The local county SCDHHS office must approve financial eligibility for swing-bed admission. Additionally, Medicaid residents are required to contribute recurring income toward the cost of swing-bed care.

Identifiable Part

A nursing facility can operate as an identifiable part of another facility. The identifiable part must be an identifiable unit such as an entire ward of contiguous rooms, a wing, a floor or a building. The identifiable part consists of all beds and related facilities in the unit, and houses all residents for whom Medicaid payment is being made for nursing services. The identifiable part may share such central services and facilities as management services, building maintenance and laundry.

Federal regulations stipulate that a skilled nursing facility (SNF) certified for participation in Medicare is deemed by the Secretary of the U.S. Department of Health and Humans Services (HHS) to meet

the standards of certification under Medicaid. The contract issued by the state Medicaid agency to an SNF will be coterminous with the Medicare contract issued to the facility.

Distinct Part – ICF/IID State Operations Manual, Section 2134 (Rev. 1, 05-21-04)
According to the CMS ICF/IID State Operations Manual, Section 2134, neither the law nor federal regulations define or require ICF/IID services in terms of distinct parts. However, as a State Medicaid program requirement, States may provide for distinct part ICF/IID approvals. Where the State Medicaid Agency (SCDHHS) elects to define the ICF/IID program in terms of distinct parts, these additional federal provisions must be met:

- The distinct part must be a clearly identified unit, such as an entire ward, wing, floor, building, or a number of designated rooms;
- The distinct part consists of all beds and related facilities in the unit; and
- The institution does not require transfer of patients or individuals to or from the distinct part, where, in the opinion of the attending physician, transfer might be harmful to the physical or mental health of the patient or individual. Otherwise, the unit houses all ICF/IID residents in the institution.

Program Service Requirements – Financial

SCDHHS is responsible for the criteria for Medicaid financial eligibility and sponsorship of nursing facility services. All requests for information and assistance with Medicaid applications should be referred to a local SCDHHS office. The SCDHHS county office listing is located on the website at https://www.scdhhs.gov/site-page/where-go-help.

The local SCDHHS office utilizes the Notice of Admission, Authorization, and Change of Status for Long-Term Care form (DHHS Form 181) to notify providers of all approved or disapproved Medicaid nursing facility eligibility applications. An example of DHHS Form 181 is included on the provider portal. The form includes the authorization date for Medicaid payment and any resident monthly income liability amounts due to the nursing facility. DHHS Form 181 is required to initiate payment by Medicaid, and must accompany the monthly billing or requests for Medicare Part A Skilled Nursing Facility coinsurance payments.

Monthly Recurring Income
When individuals apply for Medicaid to assist with payment of institutional care, the financial eligibility determination is a two-step process. The first step will determine if the resident meets the Medicaid eligibility requirements. If the resident meets the Medicaid eligibility requirements, then the second step will determine the amount of available income the resident must contribute toward the cost of care. The resident's monthly recurring income amount is determined by the SCDHHS Eligibility caseworker and reported to the provider on DHHS Form 181. Recurring income is not applied during the calendar month of admission from or discharge to a non-institutional living setting. It is the provider's responsibility to collect recurring income amounts from the resident and/or responsible party. There is no prohibition on collecting recurring income amounts in advance.

Deductions for Non-Covered Incurred Medical Expenses
Institutionalized individuals with income are allowed limited deductions from their recurring income liability if they incur non-covered medical expenses. Non-covered medical expenses are defined as those that are medically necessary, prescribed by a licensed practitioner, and are not covered by Medicaid or any other third-party payer, including Medicare. Deductions are not allowed for expenses incurred prior to entering a long-term care facility. Both the limitation and the procedures for claiming non-covered medical expenses are included in Section 6 of this manual.

Estate Recovery
In August of 1993, Congress passed a law that requires states to recover amounts that Medicaid has previously paid for certain residents. In South Carolina, the Estate Recovery Program went into effect on July 1, 1994. The state will recover amounts paid by Medicaid for services received on July1, 1994 or later.

Estate recovery applies to the following residents:

- A person who was 55 years of age or older when he or she received medical assistance paid by Medicaid. The medical assistance may have consisted of nursing facility services, home- and community-based services, and hospital and prescription drug services provided to individuals in a nursing facility or receiving home- and community-based services.

- A person of any age who was an inpatient in a nursing facility, intermediate care facility for the intellectually disabled, or other long-term care facility at the time of death, and who was required to pay most of his or her monthly income to the facility toward the cost of care.

When a resident dies, the state files a claim with the probate court against the resident's estate to recover amounts paid by Medicaid for the deceased resident's medical care.

Recovery will not be made as long as there is a surviving spouse, minor child (under age 21), or a disabled child. A disabled child is defined according to Supplemental Security Income (SSI) criteria. Recovery may be waived if it would cause undue hardship to a surviving family member.

Recovery will not be made for residents who died before July 1, 1994.

Questions about this change in the law should be submitted in writing to:

Department of Health and Human Services
Division of Accountability and Collections
Estate Recovery Department
Post Office Box 100127
Columbia, SC 29202-3127

Income Trust

Income trust provisions apply to residents with incomes in excess of the Medicaid Cap who meet one of the following requirements:

- Reside in a nursing facility; or
- Receive home and community-based services through any of the state's waivers, and meet all Medical Assistance Only (MAO) institutional eligibility requirements except for the income limit

An institutionalized individual who meets all eligibility requirements except income may establish an income trust with his or her monthly income. The income placed into the trust each month is not counted as income for purposes of determining Medicaid eligibility.

Assets other than income may not be included in an income trust. If any other assets are included, the trust is subject to the same treatment as other trusts created with assets. The individual may be subject to a transfer of assets penalty if he or she places assets other than his or her own monthly income into the income trust.

Income Trust Exemption – In order for an income trust to be exempt from transfer of assets penalties and the rules that normally govern the treatment of trusts, SCDHHS must be named the secondary beneficiary of the trust. The trust must provide that upon the death of the Medicaid resident, any funds remaining in the trust, up to the amount paid on behalf of the individual by Medicaid, must be paid to the state Medicaid agency.

At the resident's death, the trustee is required to reimburse the Medicaid agency for expenditures paid on behalf of the resident. The applicant/resident is the "primary" beneficiary and the single state Medicaid agency is the "secondary" beneficiary. The trust may also specify additional beneficiaries, as long as these beneficiaries do not receive any distributions until after the Medicaid agency has been repaid in full.

Eligible Trust Income Determination **– All trusts (i.e., income trusts and/or those created with assets) must be reviewed by SCDHHS for a determination of the appropriate treatment of the trust**.

There is no limit on the amount of monthly income that can flow into the trust. Income placed in a trust that meets all the requirements from exemption as a trust is not considered income for the purpose of determining eligibility for Medicaid. Also, income generated by the trust that remains in the trust is not considered income to the individual for the purposes of the Medicaid eligibility determination.

Post-Eligible Trust Income – Although income that goes into the trust each month is not considered income for the purpose of determining eligibility for Medicaid, all of the individual's monthly income is used in the post-eligibility step when determining the amount to be contributed towards the cost of care. The Centers for Medicare and Medicaid Services rules require that all of the individual's income be counted in the post-eligibility step regardless of whether the income

passes through the trust. The individual's gross income must be considered in determining the amount he or she must contribute toward the cost of care in the facility or toward the cost of the home- and community-based services he or she receives. Gross income includes all income deposited in the trust and all income outside the trust. Income is distributed in accordance with the post-eligibility treatment of income.

The steps for post-eligibility treatment of income for institutionalized individuals apply to all income made available from the trust as well as all other income available to the individual. This includes trust income exempted in the eligibility step.

From the individual's gross monthly income (trust income plus non-trust income), the following amounts or items may be deducted in the following order:

Personal needs allowance – The standard personal needs allowance (*i.e.,* $30.00, $90.00 for individuals receiving reduced VA pension, or $100.00 if participating in an ICF/IID work therapy program) applies to all individuals residing in a nursing, swing bed, or ICF/IID facility.

In addition, the following deductions apply only to those individuals who are required to establish an income trust to become eligible for Medicaid:

- A $10.00 monthly fee is deducted for the trustee to manage the income trust. This deduction is made only if the trustee charges the fee. A higher fee not to exceed $50.00 per month is permitted only with the authorization of SCDHHS.

- The actual bank service charges, not to exceed $20.00 per month, owed by the income trust are deductible should the bank charge a fee.

- A deduction may be made once per calendar year (*i.e.,* the month in which the taxes are paid) for the payment of any state or federal income taxes, if the trust owes taxes. The trustee must provide the SCDHHS worker with a copy of the income trust's tax returns submitted to the federal and state governments. The amount due is deducted from the individual's next payment to the facility through an increase in the personal needs allowance for that month.

Applicable family maintenance allowances – Family maintenance allowances are deducted for all eligible members of the household including those allowed under the spousal impoverishment provisions.

Home maintenance allowance – A home maintenance allowance, not to exceed the maximum SSI payment for an individual, is allowed for an institutionalized individual where the physician has certified that he or she will be able to return home within six months.

Medical expenses – Medical expenses that are not subject to a third-party payment are deductible. Regional SCDHHS staff will make the deduction for health insurance premiums for institutionalized

individuals, and the nursing facility will make the deduction for other non-covered medical expenses when a nursing facility files its monthly claim for payment.

Recurring Income as Related to Income Trust – The remainder of the resident's income is the amount by which the state reduces its Medicaid payment to the medical institution (i.e., the resident's recurring income). The recurring income is the amount that the resident is required to apply toward the cost of care in the facility. However, the recurring income reported on DHHS Form 181 cannot exceed the average monthly Medicaid payment rate for that facility.

If the institutionalized resident has recurring income greater than the average monthly Medicaid rate of the nursing facility in which he or she resides, then DHHS Form 181 will reflect slightly less than the facility's average monthly rate. The excess amount must be left to accumulate in the resident's income trust.

The remaining funds in the trust may not be used for any other purpose except for the sole benefit of the non-institutionalized spouse, if one exists. If the funds are used for another purpose, the amount used may be considered a transfer of assets or as countable income to the resident.

During the term of the trust, the trustee may not dissolve or modify the terms of the trust without the concurrence and approval of SCDHHS.

Dual Certification
The state plan requires that if a facility wants to participate in Medicaid and is eligible to participate in Medicare, it must participate in both programs. Providers are encouraged to have all facility beds dually certified for both Medicaid and Medicare. Any decertification actions are applicable and coterminous to both programs. To request certification the provider must contact DHEC.

Documentation of Certification
The documentation of certification originates at DHEC. DHEC determines compliance and sends the documentation to the HHS with recommendations for certification and the period of certification.

Civil Rights Clearance
SCDHHS is responsible for ensuring that all providers are in compliance with civil rights requirements. CMS's Office of Equal Opportunity and Office for Civil Rights conduct the compliance reviews for the Medicare portion; and the Compliance Division of the South Carolina Human Affairs Commission conducts the compliance reviews of the Medicaid portion.

Disclosure of Information
Federal regulations require the disclosure of pertinent findings resulting from surveys of any health care facility, laboratory, agency, clinic, or other organization providing health care services.

The disclosure document must contain a description of the deficiencies as noted by DHEC, as well as comments from the provider concerning its plan for correcting the deficiencies or other comments relating to each deficiency.

Upon request, HHS or DHEC will make the findings of each survey report available to the public. If the survey shows signs of noncompliance, then the information is made available to the SCDHHS Regional Director where the facility is located, the office of the Ombudsman, the attending physician, the Board of Long-Term Health Care Administrators, and the Medicaid Fraud Control Unit.

Nurse Aides

Federal regulations require that all employees used as nurse aides on a temporary, contract, or permanent (part-time or full-time) basis must be listed on the South Carolina Nurse Aide Registry in order to work in a Medicaid-certified nursing facility. (See below for the requirements that pertain to non-certified aides.) It is the responsibility of the Medicaid-certified nursing facility to verify that the nurse aides are listed with the South Carolina Nurse Aide Registry.

South Caroline Nurse Aide Registry – The South Carolina Nurse Aide Registry is a database of all registered nurse aides in South Carolina. The registry is maintained by SCDHHS through a contractual relationship with a designated agent according to federal and state requirements and guidelines. The information stored in the registry includes demographic information for each registered nurse aide, as well as documented findings and convictions of incidents of resident abuse, neglect, or misappropriation of resident property. To access the registry, go to http://www.PearsonVUE.com/.

Conditions for Employment – Permanent part-time or full-time nurse aides must meet one of the following conditions to work in a Medicaid-certified nursing facility:

- A nurse aide must be certified through the South Carolina Nurse Aide Registry. The nursing facility must contact the South Carolina Registry to confirm each applicant's status. Possession of a card alone is not an indicator of current certification.
- A non-certified nurse aide may work up to four months in a Medicaid-certified nursing facility if he or she is enrolled in a state-approved training program or has successfully completed a state-approved training program. A non-certified nurse aide may not have resident contact until he or she has documentation on file at the nursing facility that he or she has completed at least 16 hours of state-approved training in the following areas:
  - Communication and interpersonal skills;
  - Infection control;
  - Safety/emergency procedures;
  - Promoting residents' rights; and
  - Respecting residents' rights.

These non-certified nurse aides may only perform skills that are marked on a checklist on file at the nursing facility and signed by the instructor. In order to continue working beyond four months, a nurse aide must successfully complete testing, and the results must be received by the registry prior to the end of the four-month period.

Note: Any nurse aide candidates seeking certification must attend training at a state-approved program prior to testing.

Facility Sponsorship – A nursing facility may sponsor nurse aide candidates in training and/or testing. To sponsor a candidate, a nursing facility must employ a nurse aide or give a written offer of employment and have a signed acceptance of that offer. A nursing facility that does not sponsor candidates should refer all uncertified applicants to a SCDHHS-designated testing entity. Information will be mailed to the candidates on how to be self-sponsored and be reimbursed for training and/or testing costs.

A nursing facility choosing to sponsor nurse aide candidates is responsible for paying all costs associated with the training, testing, certification, and recertification of their aides. Medicaid reimbursement will be provided to the nursing facility through annual cost settlements beginning with the fiscal year ending September 30, 2003 cost reports. The facility should download a listing of the state-approved nurse aide training programs at http://www.PearsonVUE.com/.

The nursing facility should refer to the sponsor handbook distributed by SCDHHS' testing agent for instructions on applying for testing. To receive additional handbooks and applications, a nursing facility may call the testing agent, its subcontractor, or go to the SCDHHS Division of Long-Term Living Web site at http://www.scdhhs.gov/.

Reciprocity – A nursing facility wanting to hire nurse aides who are certified in a state other than South Carolina should refer those nurse aides to the South Carolina Nurse Aide Registry for consideration of reciprocity. These nurse aides may not have resident contact until reciprocity is granted or the nurse aide has successfully completed the written and skilled parts of the Nurse Aide Competency Evaluation Program.

PROVIDER MEDICAID ENROLLMENT AND LICENSING

Survey, Certification, and Licensing

DHEC is the licensing and survey authority for all nursing, IMD, swing bed, and ICF/IID facilities. DHEC is responsible for establishing and maintaining the health standards for private and public institutions in which Medicaid residents receive services.

DHEC surveys facilities to determine whether they meet the requirements to participate in the Medicaid program. This standard survey includes a case mix stratified sample of residents and measures the quality of care furnished to them.

The following indicators are used to measure the quality of care:

- Medical, nursing and rehabilitative care;
- Dietary and nutrition services;
- Activities and social participation; and
- Sanitation, infection control, and the physical environment.

An audit is conducted to determine the accuracy of the resident assessments and the written plans of care. A review for compliance with resident rights issues is also performed.

Compliance with Long-Term Care Facility Requirements

DHEC also surveys all facilities for compliance or noncompliance with long-term care facility requirements. In certain circumstances, the federal regulatory agency may conduct its own surveys of long-term care facilities. Surveys are unannounced and are conducted no more than once every 15 months. Additional surveys may be necessary under certain circumstances. All surveys are subject to review and oversight by the federal survey entity, the Centers for Medicare and Medicaid Services (CMS).

The South Carolina Department of Health and Human Services (SCDHHS) certifies the compliance or non-compliance of non-state-operated nursing facilities, and with the exception of a complaint survey or validation survey conducted by CMS or federal survey, its decision is final.

CMS certifies the compliance or noncompliance of all state-operated facilities. SCDHHS may not execute a provider agreement or make Medicaid payments unless the Secretary of HHS has certified the facility to provide the services.

Certification – Full Compliance

If a facility is found to be in substantial compliance with all state and federal requirements for participation as a nursing facility, a Medicaid contract is issued. The effective date may not be earlier than the date of the survey. SCDHHS may elect not to issue a contract or to cancel the contract based on documentation showing good cause.

Facilities with Health and Safety Deficiencies – Not Certified

A facility that is not certified will not be issued a Medicaid contract.

Contract

Any certified nursing facility requesting participation in the Medicaid program must contract with SCDHHS to become a provider of services. A Medicaid contract is issued to a nursing facility in full compliance with all state and federal requirements. The effective date of the contract may not be earlier than the date of the survey. SCDHHS may elect not to issue a contract or to cancel a contract based on documentation showing good cause. A Medicaid contract will not be issued to a non-certified nursing facility.

Contract Termination

SCDHHS may terminate a Medicaid contract prior to the specified term if any of the following occurs:

- The facility is not complying with contract provisions or participation requirements.
- The facility fails to provide information necessary for determining whether Medicaid payments are due and the amounts thereof.
- The facility refuses to allow the examination of records to verify the required documentation for payment under the Medicaid program.

If a nursing facility's Medicaid contract is terminated, it may not be reinstated unless SCDHHS finds that the reason for termination has been resolved and there is reasonable assurance it will not recur.

Sanctions

A nursing facility that does not comply with the requirements of participation for Medicaid certification is subject to the imposition of sanctions by the Centers for Medicare and Medicaid Services.

Sanctions that may be imposed upon the facility, in addition to termination of a provider agreement, may include one or more of the following:

- Denial of payment for new admissions;
- Denial of payment for all residents;
- Temporary management;
- Civil money penalties;
- State monitoring;
- Directed plan of correction;
- Directed in-service training;
- Transfer of residents; and
- Decertification of the facility.

DHEC recommends appropriate sanction remedies to CMS after considering the scope and severity of the survey findings. Upon acceptance of DHEC's recommendations, CMS will impose the remedies. SCDHHS is notified of such remedies and subsequently notifies the facility if the remedy

includes necessary action by SCDHHS. Otherwise, CMS imposes the remedy and notifies the facility.

Facility-based Training Program

A nursing facility may develop and implement its own facility-based training program. Such programs must meet the training requirements of 42 CFR 483.15 and any additional state requirements. The program must also be approved by SCDHHS.

If the nursing facility is approved for training and subsequently falls under one of the following exclusions, its training authority will be rescinded for a 24-month period:

- An extended survey or a partial extended survey;
- Civil money penalties in excess of $5,000; or
- Denial of payment for new admissions or temporary management.

4
COVERED SERVICES & DEFINITIONS

COVERED SERVICES AND DEFINITIONS

Covered Services Guidelines

Resident Care

The provider accepts responsibility to provide the care needed to any person who is admitted to that facility. The provider further agrees that care shall be provided under the direction of the attending physician in accordance with state licensing regulations and, when appropriate, in accordance with applicable federal and state regulations. Responsibility for care cannot be ended until the attending physician discharges the resident from the facility or needed care is arranged through alternate placement. SCDHHS may assist in arranging alternate placement when requested by the provider.

Skilled Nursing Services

All nursing care facilities must be able to provide skilled nursing services to all residents certified as skilled level of care residents.

Intermediate Nursing Services

All nursing care facilities must be able to provide nursing and personal care services to all residents certified as intermediate level of care residents.

Subacute Care

Subacute care is care provided to the totally ventilator-dependent Medicaid resident in need of less than acute hospital services and who meets level of care criteria for nursing facility services. A CLTC certification of subacute level of care and a provider contract amendment to provide such care are required for the provider to be reimbursed at the enhanced subacute rate for this service.

Note: The Certification Letter (DHHS Form 185) from CLTC must indicate subacute care.

Complex Care Service

South Carolina Medicaid Complex Care is a program that targets Medicaid-eligible hospital patients who no longer require hospitalization but meet the nursing facility level of care. The program is intended to provide financial incentives to enrolled nursing facilities who admit Medicaid beneficiaries with complex care needs.

Potential outcomes of this program include:

- To provide financial incentives to nursing facilities for admission of beneficiaries with complex care needs;

- To reduce the difficulties that hospitals experience in placing beneficiaries with Medicaid coverage, who require nursing facilities services;
- To facilitate access to nursing facility services to provide the appropriate level of care in the most appropriate setting; and
- To provide cost savings that nursing facility placement would generate.

Eligibility – Beneficiaries who qualify for the Complex Care program must meet the South Carolina Level of Care Criteria (Skilled or Intermediate) for Long-Term Care. Beneficiaries must also have multiple needs, which fall within the higher ranges of disabilities in the criteria. The beneficiary must have been admitted as inpatient in an acute hospital for at least 10 consecutive days.

A beneficiary receiving hospice services cannot be approved for Complex Care. If a beneficiary has been approved for Complex Care and later elects Hospice services, Complex Care must be terminated.

Level of Care Criteria – All Complex Care individuals must meet the level of care criteria for long-term care and also have two or more of the following requirements:

- Decubitus care – Stage 4.
- Tracheostomy Tube/cannula – Sinus alone does not qualify a beneficiary for long-term care. The beneficiary must have a tube/cannula need for aseptic care and tracheal aspiration.
- Oral suctioning by respiratory care unit or nursing facility staff.
- Extended duration of parenteral fluids of two weeks or more (PPN or TPN) given by IV-Intravenous access only; No Antibiotics – The anticipated duration of use parental fluids must be included in the documentation.
- Disruptive behavior(s) at least 60% of the time requiring 1:1 assistance or restraints 24 hours a day/7 days a week resulting often from head trauma accidents, neuro-deficits, bi-polar affective disorder and/or other chronic mental illnesses. Documentation should include the PASARR II.
- Diagnosis of HIV – Beneficiary must take at least three medications for the treatment of HIV/AIDS and CD4 level equal to or less than 500.
- A Medicaid-only beneficiary who requires goal directed therapies (occupational therapy, speech therapy, or physical therapy) receiving therapist totaling 5 days per week for 2 of 3 disciplines that addresses a recently diagnosed medical condition, within the last six (6) months.
- Dialysis
- Ventilator dependent (on life sustaining ventilator, six or more hours a day).

- Total care – This individual is totally dependent in all activities of daily living: incapable of locomotion; unable to transfer; totally incontinent of urinary or bowel function; must be totally bathed and dressed and toileted and need extensive assistance to eat.

- Morbid obesity/bariatric – The beneficiary must have a BMI of at least 40 and exceed ideal body weight by at least 100 pound must include other D/X and need assistance with 1 activity of daily living. In addition, the beneficiary must require special equipment such as beds, lifts, and/or additional staff or have at least one associated comorbidity such as diabetes, heart disease, stroke, and/or osteoarthritis. The special equipment that is required and comorbidities must be documented.

  Exception: If the beneficiary meets the criteria for morbid obesity as outlined above, a second Complex Care medical need is not required.

Initial Certification – The initial assessment must be completed by the hospital staff using the Complex Care Supplemental Assessment, SCDHHS Form 185S. SCDHHS Form 185S must be submitted to the SCDHHS state office for review prior to the initial admission of the individual into the nursing facility. Current progress notes and/or a history and physical must be included with SCDHHS Form 185S in order for a complex care decision to be made. SCDHHS will determine if the beneficiary meets the Complex Care criteria. SCDHHS State Office will return the approved or denied SCDHHS Form 185S within five business days from the date the completed 185S form and medical documentation was received.

The certification issued for a beneficiary indicates whether he or she meets the complex care criteria and is time limited for no more than six months.

Nursing Facility Complex Care Recertification – The nursing facility is responsible for obtaining a copy of the approved and signed Complex Care Supplemental Assessment (SCDHHS Form 185S) prior to admission into the nursing facility. SCDHHS Form 185S will indicate the dates for which the beneficiary is approved for Complex Care. Initial Complex Care determinations will not be made for beneficiaries who were admitted into the nursing facility prior to submission of Complex Care referral.

Re certifications for Complex Care must be completed by the nursing facility 10 days prior to the end of the certification period. The nursing facility must submit SCDHHS Form 185S and current progress notes to the agency to determine if the beneficiary continues to meet complex care criteria. If the beneficiary continues to meet Complex Care criteria, SCDHHS Form 185S will be approved for 90 days.

An individual who is certified to meet complex care criteria may transfer to another nursing facility. In order for the receiving nursing facility to receive the complex care rate, the facility must be enrolled as a Complex Care provider. It is the responsibility of the receiving nursing facility to obtain a current copy of the approved Complex Care Assessment (SCDHHS Form, 185S). A new SCDHHS Form 185S is not required prior to admission if the certification is current.

While a Complex Care resident is in an acute care hospital, SCDHHS will reserve his or her bed up to 10 calendar days under the following conditions:

- The hospital stay is expected to be short term.
- It is expected that the Medicaid resident will return to the same nursing facility.

SCDHHS cannot provide payment to the facility to reserve the bed if the above criteria are not met. If the resident exceeds the 10-calendar day bed hold the resident's eligibility must be terminated.

Complex Care Resident Transfer to Another Nursing Facility – An initial Complex Care referral cannot be made for an individual who is on a Medicaid bed hold. An initial request for Complex Care must be submitted by an acute hospital prior to the initial admission into the nursing facility.

An individual who is certified to meet complex care criteria may transfer to another nursing facility. In order for the receiving nursing facility to receive the complex care rate, the facility must be enrolled as a Complex Care provider. It is the responsibility of the receiving nursing facility to obtain a current copy of the approved Complex Care Assessment (SCDHHS Form, 185S). A new SCDHHS Form 185S is not required prior to admission if the certification is current.

Bed Hold – While a Complex Care resident is in an acute care hospital, SCDHHS will reserve his or her bed up to 10 calendar days under the following conditions:

- The hospital stay is expected to be short term.
- It is expected that the Medicaid resident will return to the same nursing facility.

SCDHHS cannot provide payment to the facility to reserve the bed if the above criteria are not met. If the resident exceeds the 10-calendar day bed hold the resident's eligibility must be terminated.

An initial Complex Care referral cannot be made for an individual who is on a Medicaid bed hold. An initial request for Complex Care must be submitted by an acute hospital prior to the initial admission into the nursing facility.

Termination – At the point that a beneficiary no longer meets the Complex Care criteria, the beneficiary must be terminated from the Complex Care program. The determination that a beneficiary no longer meets Complex Care criteria can be made by either the Nursing Facility provider or SCDHHS. In addition, if the nursing facility fails to submit the recertification (SCDHHS Form 185S) prior to the expiration date, the beneficiary must be terminated from Complex Care. In order to terminate the Complex Care reimbursement, the Nursing Facility provider must submit a terminating SCDHHS Form 181 with Complex Care provider ID number. In addition, to the terminating SCDHHS Form 181, the Nursing Facility provider must also provide an admitting SCDHHS Form 181 with the facility non-Complex Care provider id number.

All SCDHHS Form 181s related to the termination of a Complex Care beneficiary must be sent to SCDHHS State Office by:

- Email at Complexcare@scdhhs.gov; or
- Fax to (803) 255-8209.

Complex Care and Managed Care – The nursing facility is responsible for verifying the nursing facility applicant's Medicaid eligibility prior to admission. Providers may verify a beneficiary's eligibility for Medicaid benefits by utilizing a Point of Sale (POS) Device, the South Carolina Medicaid Web-based Claims Submission Tool (Web Tool), or an eligibility verification vendor. Current Medicaid MCO members will also receive a membership card from their MCO. Either source will provide a toll-free contact number for the resident's MCO plan.

MCO providers will be responsible for reimbursing the nursing facility for up to the first 90 days of nursing facility care. If the nursing facility stay is anticipated to be greater than 90 days, the nursing facility should immediately begin working with the MCO to remove the resident from the MCO plan. For questions regarding the Managed Care program, please visit the SCDHHS Web site at http://scdhhs.gov to view the MCO Policy and Procedure Guide.

Complex Care Nursing Facility Requirements – To be eligible to participate in the Complex Care program, a nursing facility must enroll with SCDHHS as a Complex Care provider and meet the following qualifications:

- Be in substantial compliance with conditions for participation in the Medicaid and Medicare programs;
- Have an adequate number of trained staff to address the needs of higher acuity beneficiaries;
- Possess a written agreement with the local hospital(s) to facilitate a successful transition;
- Be capable of providing 24-hour lab support;
- Have a at least one physician visit per week;
- Have Level of Care IV capability 24 hours a day/7 days a week;
- Have a registered nurse and/or nurse practitioner available, especially during the physician's visit with each patient; and
- Coordinate the resident's care with the facility's Medical Director.

Program Policy and Administration

Over-the-Counter (OTC) Drugs

OTC drugs (with the exception of insulin) are reimbursed in the per diem rate for all facilities in accordance with procedures established by SCDHHS, the Bureau of Reimbursement Methodology, and published in the Medicaid Cost Reporting Manual. OTC products may not be billed to a resident or any other entity.

Prescription Drugs

The traditional fee-for-service Medicaid pharmacy services program sponsors reimbursement for a maximum of four prescriptions per resident per month for residents over the age of 21. Certain products and product categories are exempt from the monthly prescription limitation. If an adult resident needs more than four prescriptions or refills within a given month, then a prescription limit override process is available for those prescriptions that meet the override criteria. This prescription limit override is reserved for those prescriptions that, in the clinical judgment of the pharmacist, meet the override criteria.

Pharmacists should submit the fee-for-service claim using the prescription limit override process if any of the following apply:

- The monthly prescription limit has been met.
- The prescription or refill is for an essential drug used in the resident's treatment plan for one of the following conditions: acute sickle cell disease, diabetes, hypertension, behavioral health disorder, end stage lung disease, life-threatening illness, cancer, end stage renal disease, organ transplant, cardiac disease, HIV/AIDS or the terminal stage of an illness.

Certain pharmaceuticals (*e.g.,* anti-ulcer drugs, etc.) require prior authorization, meaning that coverage is determined through the Department of Pharmacy Services' clinical prior authorization process. Approval for Medicaid coverage of products requiring prior authorization is resident-specific and is determined according to certain established criteria. Prior authorization is required if a resident requests a specific brand name product and/or drug and a generic equivalent is available.

Other Services

Hospice Services

A certified hospice agency may provide routine home care, continuous home care, or inpatient respite care to a resident who resides in a nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) if the resident elects the Medicaid hospice benefit and if he or she meets the hospice eligibility criteria.

A certified hospice agency assumes full responsibility for professional management of the individual's hospice care in accordance with the Hospice Conditions of Participation (42 CFR 418.00). The agency makes any arrangements necessary for routine care in a participating Medicare or Medicaid facility.

Written Agreement

A nursing facility must have a written agreement with the Medicaid hospice provider specifying that the Skilled Nursing Facility/Nursing Facility (SNF/NF) Conditions of Participation are applicable to all residents in the nursing facility. Hospice residents are no exception. A hospice resident must be assessed using the information contained in the Resident Assessment Instrument, have a plan of care (POC), and receive all services contained in the POC.

When a resident of a nursing facility elects the Medicaid hospice benefit, the hospice and the nursing facility must communicate, establish, and agree upon one coordinated POC for both providers. The POC must also reflect the hospice philosophy of care and be based on an assessment of the resident's needs and unique living situation in the nursing facility. The POC must include the resident's current medical, physical, psychosocial, and spiritual needs. The hospice provider must designate a registered nurse from the hospice agency to coordinate the implementation of the POC. An emergency plan must be left with the nursing facility by the hospice agency. This emergency plan may be used in cases of hospice resident emergencies and must include emergency telephone numbers.

The nursing facility and the certified hospice agency are responsible for performing their respective functions, which have been agreed upon and included in the POC. The certified hospice agency retains the overall professional management responsibilities for directing the implementation of the POC. All of the covered hospice services must be available as necessary to meet the needs of the resident. All core services must be routinely provided directly by hospice employees and cannot be delegated to the nursing facility. Nursing care, physicians' services, medical social work, and counseling are considered core hospice services.

Drugs and medical supplies must be routinely provided as needed for the palliation and management of the terminal illness and related conditions. Drugs must be furnished in accordance with accepted professional standards of practice.

The POC should reflect the participation of the hospice agency, the nursing facility, and the resident to the greatest extent possible. The certified hospice agency and the nursing facility must communicate with each other when changes are made to the POC. Evidence of this coordinated POC must be present in the clinical records of both providers.

The hospice resident residing in a nursing facility should not experience any lack of nursing facility services or personal care because of his or her status as a hospice resident. A nursing facility must offer the same services to its residents who have elected the hospice benefit as it furnishes to its residents who have not elected the hospice benefit. The resident has the right to refuse any service.

The certified hospice agency may involve the nursing facility's nursing personnel in assisting with the administration of prescribed therapies included in the POC only to the extent that the hospice agency would routinely utilize the services of a hospice resident's family or caregiver in implementing the POC.

Non-Core Service
The certified hospice agency may arrange to have non-core hospice services provided by a nursing facility if the certified hospice agency assumes professional management responsibility for these services and ensures that these services are performed in accordance with the policies of the certified hospice agency and the resident's POC. Non-core services include provision of medical appliances and supplies (including drugs and biologicals), home health aide services, and physical therapy, occupational therapy, and speech-language pathology services.

Payment for Services
When a Medicaid beneficiary who is a nursing facility to ICF/IID resident and is also Medicare eligible (referred to as dually eligible) chooses to elect the hospice benefit, Medicare becomes the primary payer of the hospice benefit. For either a Medicaid only or a dually eligible resident, the state Medicaid agency must pay the hospice agency for the facility room and board payment.

For dates of service July 11, 2011 and forward, when presented with a reimbursement claim, SCDHHS will directly reimburse the hospice agency an amount no less than 95% of the daily Medicaid rate of reimbursement for the room and board of the patient receiving hospice. The hospice must reimburse the facility according to the terms specified in their contract arrangements.

Room and board include:

- Prescribed nutritious meals as directed in the POC;
- Performance of personal care services;
- Assistance in the activities of daily living;
- Administration of medication;
- Maintenance regarding the cleanliness of the resident's environment; and
- Supervision and assistance in the use of durable medical equipment and prescribed therapies.

Palmetto SeniorCare
Palmetto SeniorCare (PSC) is a state plan program of comprehensive care that allows the frail elderly to live in their communities. A special community-based program of Palmetto Health Alliance, PSC serves residents who are age 55 and older and who meet a nursing home level of care. PSC is provided at five centers in Richland and Lexington counties.

Palmetto SeniorCare is part of the national Program of All-Inclusive Care for the Elderly (PACE), an optional benefit under Medicare and Medicaid that focuses entirely on elderly people who are frail enough to meet their state's standards for nursing home care. The program brings together all the medical and social services needed for someone who otherwise might be in a nursing home.

A team, including a physician, registered nurse, therapists, and other health professionals, assesses the resident's needs, develops a comprehensive plan of care, and provides for total care. Generally, services are provided in an adult day health center, but they may also be given in a resident's home, a hospital, a long-term care facility, or a nursing home.

Enrollment in the PSC is voluntary. Once a resident is enrolled, PACE becomes the sole source of all Medicare and Medicaid-covered services, as well as any other items or medical, social, or rehabilitation services the PACE interdisciplinary team determines an enrollee needs. If a resident requires placement in a nursing home, PACE is responsible and accountable for the care and services provided to the resident and regularly evaluates the resident's condition.

A PACE organization receives a fixed monthly payment from Medicare and Medicaid for each participating resident, depending on their Medicare and Medicaid eligibility. The payments remain the same during the contract year, regardless of the services a resident may need.

For information and enrollment, contact Palmetto SeniorCare at (803) 931-8175.

Paid Feeding Assistants (PFAs) Program

Federal regulations for long-term care facilities were updated on September 26, 2003 to permit the use of paid feeding assistants (PFAs) to supplement the services of certified nursing assistants under certain conditions. The intent of this change is to provide more residents with help in eating and drinking and to reduce the incidence of unplanned weight loss and dehydration.

Effective January 1, 2004, South Carolina nursing facilities may employ PFAs. SCDHHS is responsible for developing and implementing policies for the PFAs program.

Training ─ PFAs must successfully complete an eight-hour state-approved feeding assistant training program and work under the supervision of a registered nurse or licensed practical nurse. The core curriculum of the training program encompasses the minimum federal standard. A nursing facility may use existing curricula if they adhere to the SCDHHS core curriculum. A nursing facility is encouraged to establish or require programs that exceed the minimum federal standards.

Oversight ─ DHEC will provide oversight for the PFA program through the annual survey process. During surveys, surveyors will observe the meal or snack service and note any concerns related to the residents receiving feeding assistance. If concerns are noted, the surveyors will investigate to determine if this constitutes a deficient practice and if the PFAs have successfully completed the eight-hour training program. Surveyors will also determine if a resident receiving the feeding assistance is one who does not have complicated feeding problems. This will be done by a review of medical charts and discussion with the professional nursing staff. Surveyors will also note concerns about the supervision of PFAs and investigate how the nursing facility provides the supervision by interviewing and observing staff during meal or snack times. Deficiencies will be cited, if appropriate. Facilities will retain training and employment records of PFAs. This will document the facility's compliance with federal regulations and provide a record for surveyors to review.

Requirements — The requirements of a Paid Feeding Assistants program are as follows:

- PFAs must have a minimum of eight hours of training.
- The program must be approved by SCDHHS.
- The nursing facility must maintain a record of all individuals used as feeding assistants who have successfully completed the training program for PFAs. The nursing facility must also have on file evidence that the individual has successfully completed a state-approved program and has the necessary competency to feed a resident.
- The program must be coordinated and performed under the general supervision of a registered nurse or licensed practical nurse.
- PFAs must work under the supervision of a registered nurse or a licensed practical nurse who is readily available.
- The nursing facility must ensure that PFAs feed only residents who do not have complicated feeding problems. Complicated feeding problems include but are not limited to difficulty swallowing, recurrent lung aspirations and tube or parenteral/IV feedings.
- PFAs must be based on the charge nurse's assessment and the resident's latest assessment and plan of care.

State Approval Guidelines — State approval is initiated by obtaining or requesting the South Carolina Core Curriculum for Paid Feeding Assistants, Requirements and Guidelines from SCDHHS. This can be done by mail, fax, or visiting the SCDHHS Web site at http://www.scdhhs.gov/. The PFA guidelines must be read, signed, and maintained on record by the administrator/program coordinator of the PFA program and the SCDHHS Division of Long Term Living Services representative. This agreement shall remain in effect as long as the facility has a PFA program.

Contact Information — For more information on the Paid Feeding Assistants program and a copy of the required core curriculum, visit the SCDHHS Web site at http://www.scdhhs.gov/.

5
BENEFIT ADMINISTRATION

PROGRAM POLICY AND ADMINISTRATION

Computing Resident Days

In computing the number of days of service rendered to a resident, the date of admission will be counted, but not the date of discharge. One day will be allowed for a resident admitted and discharged on the same day.

Accommodations

Private rooms are not a covered service under Medicaid. The cost difference between a private and a semi-private room may not be billed to Medicaid. There is not a regulation that prohibits a resident or responsible party from paying the cost difference when the family requests a private room. The cost difference charged to a Medicaid resident cannot be more than the amount charged any other resident, which is usually the difference between the customary private and semi-private room rates.

Bed Holds

Nursing Facility Responsibilities

At the time of admission, a nursing facility must provide written information to a resident, a family member, or legal representative before the following situations occur:

- Transfer to a hospital; and
- Utilization of therapeutic deinstitutionalization leave.

This written information must specify the following:

- The duration of the Medicaid bed-hold policy during which the resident is permitted to return and resume residence in the nursing facility.
- The nursing facility's policies regarding bed-hold periods. These policies must be consistent with federal and state policies.

A nursing facility must establish and follow a written policy under which a resident whose hospitalization or therapeutic leave exceeds the bed-hold period is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if both of the following apply:

- The resident requires the services provided by the facility.
- The resident is eligible for Medicaid nursing facility services.

Short-Term Hospitalization
While a resident is in an acute care hospital, SCDHHS will reserve his or her bed up to 10 calendar days under the following conditions:

- The hospital stay is expected to be short term.
- It is expected that the Medicaid resident will return to the same nursing facility.

SCDHHS cannot provide payment to the facility to reserve the bed if the above criteria are not met.

Medicaid will sponsor the 10-day bed hold for residents with dual Medicare/Medicaid eligibility when the above criteria are met.

Bed holds will be monitored on a continuing random sample basis and verified on regular nursing facility audits.

Exception: The bed-hold policy for short-term hospitalization is not applicable when a swing-bed hospital resident is discharged to acute care status in the same hospital. The hospital must adjust the monthly swing-bed billing to exclude short-term acute days. The Notice of Admission, Authorization, and Change of Status for Long-Term Care form (DHHS Form 181) must include an explanation in Section II, last line, i.e., “Resident discharged to and/or readmitted from acute care status — same facility.” Items II F and G must reflect the dates of hospitalization. A new CLTC Certification form (DHHS Form 185) and a county DHHS eligibility office authorization (DHHS Form 181) are required when a resident is readmitted to swing-bed status after the 11th day.

Therapeutic Deinstitutionalization
Bed holds for therapeutic deinstitutionalization are authorized for 18 days each state fiscal year that runs from July 1 through June 30. Each period of leave may be for a maximum of nine days, and periods of leave may not be consecutive. A resident’s plan of care must include the attending physician’s authorization for home leave. Chart entries should include:

- The length of time for which the leave was approved;
- The goal of the leave; and
- The results of the leave in relation to the goal upon the resident’s return.

Approved Rehabilitation
Bed holds for the purpose of a Medicaid resident’s participation in an approved training program, such as a program sponsored through the South Carolina Department of Vocational Rehabilitation, are authorized for 30 days. For a leave of absence to be granted under this policy, approval must be requested in writing from the Director of the Division of Long-Term Living Services at the following address:

Director
Division of Long Term Living
Post Office Box 8206
Columbia, SC 29202-8206

The following conditions must be met for a leave of absence:

- A resident must have been formally accepted into an approved program.
- The program must be prescribed by the attending physician.
- Upon completion of the program, the results of the evaluation must be fully documented in the resident's chart.
- The approved leave of absence cannot exceed 30 days.

Intermediate Care Facilities for the Intellectually Delayed
Bed hold is authorized for 96 days each state fiscal year (July 1 through June 30). Each period of leave may be for a maximum of eight days per month. However, two 16-consecutive-day therapeutic leaves may be authorized as an integral part of the 96 aggregate days if prescribed by the attending physician with medical justification documented in the resident's clinical record.

A one-time 30-day consecutive leave per admission will be allowed for discharge planning and permanent placement to a home environment. The attending physician must prescribe this leave as a vital part of the discharge planning activity. Leaves of absence exceeding the allowable days will require a discharge from the facility.

Resident Personal Needs Allowance

A resident has the right to manage his or her own financial affairs. A nursing facility may not require a resident to deposit his or her personal funds with the facility. However, upon written authorization from a resident, the nursing facility must hold, safeguard, manage, and account for the resident's personal funds deposited with that facility. The resident's funds are managed in accordance with federal regulations as specified in the Resident Rights in Section 4.

The residents' personal funds will be reviewed by the state auditor and by DHEC as part of normal survey and certification procedures. Discrepancies will be reported to SCDHHS for necessary action. Since Medicaid reimbursement provides for the management of these funds, a resident should not be charged.

During the course of a Medicare or Medicaid stay, a nursing facility may not charge a resident for the following categories of items and services:

- Nursing services as required;
- Dietary services as required;

- Activities program as required;
- Room/bed maintenance services;
- Routine personal hygiene items and services as required to meet the needs of the residents, including but not limited to hair hygiene supplies, comb, brush, bath soap, disinfecting soaps, specialized cleaning agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over-the-counter drugs, hair and nail hygiene services, bathing and basic personal laundry; and
- Medically related social services as required.

A nursing facility may charge a resident for the following items, if requested, and must inform a resident that there will be a charge for these items if payment is not made by Medicare or Medicaid:

- Telephone;
- Television and/or radio for personal use;
- Personal comfort items, including smoking materials, notions, novelties and confections;
- Cosmetic and grooming items and services in excess of those for which payment is made under Medicare or Medicaid;
- Personal clothing;
- Personal reading matter;
- Gifts purchased on behalf of a resident;
- Flowers and plants;
- Social events and entertainment outside the scope of the activities program, as required by federal regulations;
- Non-covered special care services such as privately hired nurses or aides;
- Private rooms, except when therapeutically required (*e.g.,* isolation for infection control); or
- Specially prepared or alternative food requested instead of food generally prepared by the facility.

A nursing facility may not charge a resident or his or her representative for any items or services not requested by the resident. A nursing facility may not require a resident or his or her representative

to request any item or service as a condition of admission or continued stay. A nursing facility must inform a resident or his or her representative when an item or service is requested that requires an additional charge and must specify the amount of the charge.

Transfer to Another Facility

When a Medicaid resident is transferred from one facility to another facility, the transferring facility must ensure that all records needed for continuity of care and all funds and personal property of each resident are transferred with the resident to the accepting facility. The transferring facility is responsible for the resident's care until the transfer is completed.

Solicitation

Direct solicitation is defined as an appeal for funds from persons who are known to be either applying for admission to or residing in a long-term care facility or from relatives or guardians of such persons. Medicaid policy prohibits direct solicitation from Medicaid long-term care residents or their relatives. Federal regulations provide that participation in the Medicaid program will be limited to providers of service who accept, as payment in full, the amounts paid in accordance with the fee structure. Providers who have an agreement with SCDHHS and who solicit contributions, donations, or gifts directly from Medicaid residents or family members will be deemed to be in noncompliance with this federal requirement. These solicitations will be construed as supplementation of the state's payment for services in long-term care facilities. General public appeals for contributions are not considered direct solicitation of Medicaid residents or families.

When a resident (where deemed competent; if not, then the family member or guardian) makes a free-will contribution, the provider is required to execute a statement. The contributor and the facility administrator must sign the statement. The statement should state that the services provided in the facility are not predicated upon contributions or donations made by the resident or his or her relatives or guardians, and the gifts are "free-will" contributions.

Sitters

Residents may have sitters who provide services that are not reimbursable under the Medicaid program. A facility will be in violation of the policy and its Medicaid contract with the agency if it permits a "sitter" or non-employee to render all or part of the total nursing needs as defined by federal regulations and agency policy to a Medicaid resident. This may result in refusal to reimburse the facility for care of the resident and/or subject the facility to other penalties including termination of the contract. This information is not applicable to volunteer personnel providing non-medically necessary services to all residents on a nondiscriminatory basis without compensation from any source.

Other Services

Medicaid Managed Care Organization (MCO) Program

Limited interaction is anticipated between MCO residents and a nursing facility, as nursing facility residents are ineligible for participation in the Managed Care program (MCO or Medical Home Network – Medically Complex Children's Waiver). However, the following guidelines and procedures

have been developed to clarify Medicaid policies relative to Medicaid MCO enrollees placed in a Medicaid-certified nursing facility, including IMDs.

The nursing facility is responsible for verifying the nursing facility applicant's Medicaid eligibility prior to admission. Current Medicaid providers may call the South Carolina Medicaid Interactive Voice Response System at (888) 809-3040 to verify a resident's Medicaid eligibility. To access this system, providers will need their provider PIN number and the resident's Medicaid number. Nursing facility providers should listen to the entire message to determine if the resident is currently participating. Medicaid MCO members will also receive a membership card from their MCO. Either source will provide a toll-free contact number for the resident's MCO plan.

MCO providers will be responsible for reimbursing the nursing facility for up to the first 90 days of nursing facility care. This includes an intervening hospital stay in which the MCO reimburses for bed-hold days. If the nursing facility stay is anticipated to be greater than 90 days, the nursing facility should immediately begin working with the MCO to remove the resident from the MCO plan. The Medicaid program will not sponsor bed holds during the 90 days of MCO-sponsored nursing home placement; however, there are no prohibitions against the sponsorship of bed holds by the MCO provider.

If a resident enters the hospital without the payment of bed-hold days in a nursing facility, then a new episode of care will commence when the resident returns to the nursing facility. If the resident is discharged from a nursing facility prior to completion of a 90-day episode of care and later enters a nursing facility again, a new episode of care will commence for the purpose of counting the 90 days of care. MCO liability during the 90 days of nursing home placement encompasses payment for all Medicaid MCO core benefit services (institutional, professional, and ancillary).

A nursing facility should contact the MCO prior to admitting an MCO-sponsored resident to determine the MCO's prior authorization protocols. Providers are responsible for following the MCO's procedures for referral, prior authorization, and provision of all services included in the MCO core benefits. Claims from Medicaid providers for MCO core benefit services will be rejected unless both the MCO and the provider have met their responsibilities for the services. Codes used to reject nursing facility claims will be 974 or 989. Providers should refer to the Web Tool for the resident's managed care provider and submit a new claim to resolve claim edits.

Arrangements concerning MCO payments for nursing facility services during any 90-day period or any part of a 90-day period should be made between and at the discretion of the MCO provider and the nursing facility. MCO-sponsored residents should also be counted in the Medicaid census for survey and certification.

Medicaid MCO program members admitted to nursing facilities and requiring institutionalization for more than 90 days in a given episode of care will be removed from the Medicaid MCO program. Medicaid will continue to pay for the resident's nursing home care beyond the 90-day episode if the resident is certified as financially and medically eligible for nursing facility care and is residing in a

Medicaid-certified bed. In order to ensure all Medicaid requirements of participation are met and to ensure the availability of a Medicaid bed in the event the MCO-sponsored resident needs nursing facility care beyond 30 days, Medicaid MCO-sponsored residents may only be placed in a bed in a portion of a nursing facility certified for participation in Medicaid.

Except for Medicaid non-payment of bed holds, all other Medicaid requirements of participation for nursing facilities apply, including level of care certification, preadmission screening and resident review (PASARR), resident assessment, residents' rights, etc. The MCO must obtain a level of care certification from CLTC for Medicaid MCO program members prior to admission to a nursing facility. Therefore, a nursing facility must not admit a Medicaid MCO program member to the facility without a level of care certification. PASARR requirements apply and are mandatory for all nursing facility admissions, regardless of pay source; therefore, the PASARR process must also be completed for MCO participants prior to admission. Resident assessment completion requirements and deadlines will be identical to requirements for individuals under Medicaid sponsorship.

Upon exhaustion of MCO-sponsored coverage, a resident must meet all Medicaid eligibility standards (both medical and financial) for Medicaid to continue sponsorship and payments. Applications to the local SCDHHS eligibility office should be made at the earliest possible date, preferably before or on the initial date of admission under MCO coverage. Because the MCO is only responsible for the first 90 days in any episode of care and residents remaining in a nursing facility beyond 90 days will be removed from the MCO, it is essential that a nursing facility carefully clarify at admission that the resident will be responsible for payment beyond the first 90 days if they are not eligible for the Medicaid nursing home payment at the time of removal from the MCO. Residents who do not qualify for Medicaid nursing home payment will be considered private pay and could be left without a payment source if their stay in the nursing home exceeds 90 days.

6
SPECIAL CONSIDERATIONS

RESIDENT RIGHTS

The Omnibus Budget Reconciliation Act (OBRA) of 1987 provides for PASARR requirements to screen residents prior to a nursing facility placement. Residents identified at the Level I screening process with a serious MI or an ID are then referred through the Level II review process to determine the need for services of a lesser intensity or specialized rehabilitation services. A Medicaid-certified nursing facility is prohibited from admitting any new resident who has a serious mental illness or an intellectual disability unless it has been determined that the resident requires the level of services provided by the nursing facility and the resident is in need of specialized services or specialized rehabilitation services for a serious mental illness or an intellectual disability.

Appeals

A resident may appeal the level of care decision made by CLTC. The resident (or designated representative) must write a letter requesting an appeal within 30 days of the date of the official written notification issued by CLTC. The letter must be addressed to:

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

This information is printed on the back of the written notification (DHHS Form 185) sent to the resident.

Note: Failure to adhere to the guidelines above may result in a denial of Medicaid certification. Also, the 30 administrative days for alternate placement provision do not apply to CLTC adverse decisions prior to the start of Medicaid provider payment.

Any nursing facility applicant or resident has the right to request an appeal of any action relate PASARR requirement which, in the opinion of the individual applicant or resident, adversely affects his or her eligibility status, receipt of service, locus of service, and/or assistance. The formal process of review and adjudication of action and/or determinations is done under the authority of Section 1-23-310 et seq., Code of laws, State of South Carolina, 1976, as amended, and the South Carolina Department of Health and Human Services regulations Section 126-150 et seq.

An applicant or resident of a nursing facility who is dissatisfied with an action taken or proposed by any entity involved in the PASARR process which, in their opinion, adversely affects his or her eligibility status, receipt of service, locus of service and/or assistance may appeal that decision.

These decisions are subject to appeal whether at preadmission or at annual resident review and include (but are not limited to) the following decisions:

1. Classification of the individual under any of the advance categorical determination groups.

2. Failure to classify the individual under any of the advance categorical determination groups.

3. Referral of the individual to Level II for individualized determination by the State Mental Health or Disabilities and Special Needs Authority.

4. Failure to refer the individual to Level II for individualized determination by the State Mental Health or Disabilities and Special Needs Authority.

5. Determination by the State Disabilities and Special Needs Authority regarding the need (or the lack of need) for specialized services and/or the locus to receive the care.

6. Determination by the State Mental Health Authority regarding the need (or lack of need) for specialized services and/or the locus to receive the care.

7. Nursing facility decisions to discharge or to transfer a resident to another facility due to the need for treatment services identified by the State Mental Health Authority, or due to lack of need for nursing facility or specialized services.

The nursing facility, applicant, resident, or designated representative must make written request for an appeal within 30 days of the date of the official notification issued to him or her and must specify the decision being appealed and the basis for the appeal. The letter should be addressed to:

Appeals and Hearings
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

Resident Appeals to Reduction of Benefits

A Medicaid resident has the right to a hearing regarding any decision that results in a reduction of services or benefits. The hearing is initiated by filing a notice of appeal within 60 days of the initial decision that caused the appeal. The notice of appeal should state with specificity the action being appealed and must be addressed to:

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

In the case of adverse decisions affecting benefits, the notice must be filed within 10 days to continue payment of Medicaid benefits until the hearing decision is rendered.

The notice of appeal must include a request to stop benefits if the petitioner does not want benefits to continue past 30 administrative days. If the hearing decision is not in the resident's favor, then action may be initiated to recoup Medicaid payments made in excess of 30 days beyond the initial adverse decision. Staff from the Division of Appeals and Hearings will provide information to nursing facilities concerning the administrative appeals process. All inquiries pertaining to appeals and hearings should be discussed with the Appeals Division staff at (800) 763-9087.

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NON-COVERED MEDICAL EXPENSE DEDUCTIONS

GENERAL INFORMATION

Institutionalized individuals who have monthly recurring income are allowed deductions from their income for medical expenses not covered by Medicaid or a third-party payer. The following terms are used in explaining this policy:

DEFINITIONS

Monthly Recurring Income

The amount of income the individual is required to contribute toward the cost of care. This amount is determined by the county SCDHHS and is provided to the facility on DHHS Form 181. It is the resident's gross income minus:

- The $30 personal needs allowance;
- Income allocated to a spouse or family member living at resident's residence, if applicable;
- Home maintenance expenses, if applicable; and
- Health insurance premiums (other than Medicare), if applicable.

Non-Covered Medical Expenses

Expenses recognized by state law as medical expenses, but not covered by the Medicaid program or a third-party payer. Non-covered medical expenses also include those items and/or services that exceed the Medicaid maximum allowable. Examples of non-covered medical expenses and/or services include, but are not limited to:

- Maximum physician visits per year exceeded;
- Dentures, denture repair, and restorative and preventive dental care;
- Prescription drugs above the four per month limit;
- Eyeglasses; and
- Hearing aids.

Non-covered medical expenses **DO NOT** include any items and/or services recognized as allowable costs for Medicaid rate-setting purposes.

Incurred Monthly Expenses

The allowable costs of the resident's non-covered medical expenses that can be deducted from their monthly recurring income. No deductions can be made if the resident has no reported monthly recurring income.

Allowable Deductions

The resident or responsible party provides the nursing facility with a statement of medical necessity from a licensed practitioner.

Non-covered expenses allowed as deductions from monthly recurring income include:

- Prescription drug above the four prescriptions per month limit, not to exceed $54 per additional prescription per month.
- Eyeglasses not covered by the Medicaid program, not to exceed a total of $108 per occurrence for lenses, frames, and dispensing fee. A licensed optometrist or ophthalmologist must certify the necessity for eyeglasses.
- Dentures — a one-time expense, not to exceed $651 per plate or $1,320 for one full pair of dentures. A licensed dental practitioner must certify the necessity for dentures. An expense for more than one pair of dentures must be prior approved.
- Denture repair deemed necessary by a licensed dental practitioner, not to exceed $77 per occurrence.
- Physician and other medical practitioner visit above the limit visit per year, not to exceed $69 per visit.
- Hearing aids — a one-time expense, not to exceed $1,000 for one or $2,000 for both. A licensed practitioner must certify the necessity for hearing aids. An expense for more than one hearing aid must be prior approved by SCDHHS.
- The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty is limited to zero.
- Other non-covered medical expenses that are recognized by state law but not covered by Medicaid, not to exceed $20 per item and/or service. These non-covered medical expenses must be prescribed by a licensed practitioner and must be prior approval from SCDHHS.

DHHS FORM 235

Non-covered medical expenses not listed under the allowable deductions must have prior approval. DHHS Form 235 is the Request for Approval of Non-Covered Medical Expenses. (Refer to the Forms section for an example of DHHS Form 235.) Part 1 of the form must be fully completed by

the nursing facility. Please include a description of the item or service, the reason for prior approval, and cost of the item or service. Submit DHHS Form 235 to the following address for approval:

SC Department of Health and Human Services
Division of Medicaid Policy and Planning
Post Office Box 8206
Columbia, SC 29202-8206

Explanation of Data Fields

From:

Enter the name and address of the nursing facility.

To:

Enter the resident's name and Medicaid ID number.

Part I
Completed by the nursing facility.

Description of Item(s)/Service Received — Enter a description of the non-covered items and/or services received by the resident.

Reason Item(s)/Service is a Questionable Deduction or Needs Prior Approval — Explain why these non-covered items and/or services need prior approval.

Cost of Item(s)/Service — List the actual cost for all non-covered items and/or services that need prior approval.

Part II
Completed by SCDHHS.

Item(s)/Service Approved for Deduction — This section is completed by the SCDHHS county office and indicates approval or disapproval of items and/or service.

Instructions for Making the Deduction

Providers should use the following instructions to make deductions:

- The resident or responsible party provides a bill for the non-covered medical expense to the nursing facility. The resident or responsible party must also provide a statement from a licensed practitioner to certify that the item is medically necessary.
- The nursing facility makes a copy of the bill and the practitioner's certification and enters the amount of the bill on the monthly log sheet, Log of Incurred Medical Expenses (DHHS Form 236). (Refer to the Forms section for an example of DHHS Form 236.)

- The copy of the bill and the practitioner's certification must be attached to the log sheet and maintained by the facility for audit purposes. DHHS Form 236 will be maintained for each resident who requests and is allowed a deduction. Dollar limits have been established for most items and/or services. If the limit is less than the actual cost of the item and/or service, the limit must be used rather than the actual costs.

- At the end of each month, the nursing facility totals the allowable non-covered medical expenses found in the "Lesser of Cost or Allowable Deduction" column of DHHS Form 236. This is the amount to be deducted from that resident's monthly recurring income. If the resident's non-covered medical expenses are greater than his or her recurring income, the difference is carried over into the following month(s).

- Calculations for reported medical expenses will be made automatically during the claims payment process. The payment system subtracts the incurred monthly expenses from the monthly recurring income to arrive at a new monthly recurring income for that month only and calculates accordingly. Deductions must not exceed the resident's monthly recurring income. Allowed amounts in excess of the monthly income may be carried forward and reported the next month(s). Deductions cannot be made if the resident has no reported monthly income.

- The resident is given credit for the deduction in one of the following ways:

  – If the nursing facility collects monthly recurring income from the resident at the beginning of the month, the nursing facility will credit the amount deducted by one of the following transactions:

    › Refund the amount of the incurred monthly expenses to the resident or the responsible party; or

    › Pay the amount of the allowable incurred monthly expenses to each provider from the resident's monthly recurring income.

  – If the nursing facility collects monthly recurring income from residents at the end of the month, the nursing facility will:

    › Subtract the amount of allowable incurred monthly expense from the resident's monthly recurring income; and

    › Collect the difference from the resident or responsible party.

Special Notes

Providers should consider the following before submitting non-covered expenses for deduction:

- Deductions **cannot** exceed a resident's monthly recurring income. Amounts in excess of monthly income may be carried forward and reported the next month.

- Deductions **cannot** be made if the resident has no reported monthly income.
- A DHHS Form 181 must be attached to the DHHS Form 236. A level of care box must be checked.
- Accurate records for each resident must be maintained for all non-covered medical expense deductions to include bills for services, certification of medical necessity from a licensed practitioner, and monthly log sheets (DHHS Form 236). There is no requirement to submit the records with the monthly turn around document, but they are subject to an audit by the State Auditor's Office.

DHHS FORM 236

Explanation of Data Fields

The following items on the DHHS Form 236, Log of Incurred Medical Expenses, are completed each month by providers for each resident with allowable non-covered expense deductions.

For the Month of:

At the top of the form, enter the month for non-covered incurred expenses.

Recipient's Name:

Enter the name of the resident.

Medicaid ID Number:

Enter the resident's ten-digit Medicaid number.

Month:

Enter the month for non-covered incurred expenses.

Item/Service:

Enter the items and/or services submitted by the resident or responsible party for deduction.

Date Rendered:

Enter the date of service from the bill.

Date Bill Provided to Facility:

Enter the date the bill was received from the resident by the nursing facility.

Amount Billed for Item/Service:

Enter the total charges for the item and/or services billed to the resident.

Lesser of Cost or Allowable Deduction:

Enter the lesser of A or B:

A. Allowable deductible amount or item and/or service; or

B. Total charges billed to resident.

Total:

Enter the sum of all allowable non-covered medical expense in Lesser of Cost or Allowable Deduction column.

Monthly Recurring Income (DHHS Form 181):

Enter the approved amount from DHHS Form 181 Section III Item 12C.

Incurred Monthly:

Enter the amount from the Total field. This is the amount to be deducted from the resident's monthly recurring income. (This amount should not exceed the monthly recurring income.)

Amount Carried Over to Next Month:

If the incurred monthly expenses are greater than the monthly recurring income, enter the difference carried over to the next month.