

SECTION 2

POLICIES AND PROCEDURES

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PROGRAM DESCRIPTION

PROGRAM OVERVIEW

“Sickle cell disease” as defined by the Sickle Cell Disease Association of America is an inherited blood disorder that affects red blood cells. There are several types of sickle cell diseases. The most common are:

- Sickle cell anemia (SS)
- Sickle-hemoglobin C disease (SC)
- Sickle beta-plus thalassemia
- Sickle beta-zero thalassemia

Private and public sickle cell foundations and agencies participate in the Sickle Cell program under Title XIX of the Social Security Act. The purpose of the program is to improve the beneficiary’s access to community-based services, reduce the need for costly hospitalization, prevent the deterioration of the sickle cell patient’s health, and provide the necessary medical information and training to the beneficiary and his or her family. The program should:

- Conduct interviews with the beneficiary and his or her family and/or guardian to determine needs, risk factors, required interventions, and obtain medical and social history
- Schedule beneficiary follow-up services to discuss testing and assessment results and recommended treatment
- Refer the beneficiary and his or her family to the necessary services in the community
- Develop an Individual Treatment Plan (ITP)/Care Plan (CP) and assist the beneficiary in obtaining needed services
- Coordinate services from multiple agencies that are required to meet the beneficiary’s needs
- Serve as the beneficiary’s advocate in ensuring access to all necessary services, and ensuring the beneficiary’s freedom of choice of providers

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PROGRAM DESCRIPTION

PROGRAM OVERVIEW (CONT'D.)

- Assist the beneficiary in finding a medical home or a primary care physician
- Create an Emergency Care Plan for the beneficiary and his or her family that will assist the family in handling emergency situations
- Provide information about sickle cell disease to the beneficiary and his or her family

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PROGRAM REQUIREMENTS

BENEFICIARY ELIGIBILITY REQUIREMENTS

Beneficiaries must meet specific requirements in order to be eligible for the Sickle Cell program. Eligibility requirements are the following:

- The beneficiary must be eligible for Medicaid.
- The beneficiary must be diagnosed by laboratory testing as having sickle cell disease or must have preliminary laboratory tests showing evidence of sickle cell disease. If further laboratory testing shows that the beneficiary does not have sickle cell disease, he or she will no longer be eligible for sickle cell services.
- The beneficiary must reside in a non-medical institution or home.

PROVIDER REQUIREMENTS

Providers qualify for enrollment by demonstrating the ability to provide Sickle Cell services in accordance with the requirements set forth by Medicaid and by signing an agreement with the South Carolina Department of Health and Human Services (SCDHHS). The agreement may specify additional policies and procedures not covered in this manual.

Quality Assurance

Providers will conduct program evaluations annually that include the following:

- Program's stated goals and objectives
- Beneficiary outcomes via identified needs on the ITP/CP
- Consumer satisfaction survey on 75% of beneficiaries served during the year
- Evidence of the program's compliance with the ITP/CP, training timelines and procedures
- Compliance with staff qualifications and program guidelines under Medicaid standards, policies, and procedures
- Corrective action plans for compliance deficiencies

The results of the evaluations will be used to review

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PROGRAM REQUIREMENTS

Quality Assurance (Cont'd.)

policies and practices and to institute changes when indicated. A copy of each evaluation must be forwarded to SCDHHS no later than 60 days following the end of the fiscal year. Evaluations should be sent to the following address:

Program Manager
Department of Health and Human Services
Division of Family Services
Post Office Box 8206
Columbia, SC 29202-8206

Staff Training

Providers must ensure that newly employed staff members have comprehensive training and adequate supervision prior to managing cases. Training and/or supervision are gained by participating in preservice orientation provided or approved by SCDHHS, and ongoing meetings and training as required by the provider.

Health and Safety

Providers must recognize, report, or correct situations that put the beneficiary and his or her family at risk of health, safety, and/or abuse issues.

To ensure the beneficiary's health and safety, providers must perform the following:

- Report signs and symptoms of illness to family and medical professionals when appropriate
- Assist families in taking measures to ensure that the environment is free of fire and safety hazards
- Assist families in deriving the best benefits from all aspects of the ITP/CP, including assistive devices, technologies and waiver supports, nutrition services, and therapies
- Train and assist families in acquiring and maintaining medical support and resources in their community
- Assist families in maintaining up-to-date immunizations and well-beneficiary screenings

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PROGRAM REQUIREMENTS

PROGRAM STAFF

Case Manager (CM)

The case manager shall be a registered nurse (RN) or a social worker (SW). Case managers must meet the following requirements:

Registered Nurse

The registered nurse must be licensed in South Carolina and meet one of the following requirements:

- At least one year of adult medical and/or surgical clinical experience and one of the following:
 - An additional six months of pediatric experience
 - Completion of a pediatric assessment course within the last six months
- At least one year of pediatric experience and one of the following:
 - An additional six months of adult medical and/or surgical experience
 - Completion of an adult assessment course within the last six months.

Registered nurses must attend an SCDHHS-approved in-service training related to sickle cell disease annually and documentation must be maintained in the staff records.

Social Worker (SW)

The social worker must be licensed by the South Carolina Board of Social Examiners as one of the following:

- Licensed Master Social Worker (LMSW)
- Licensed Independent Social Worker (LISW) Advanced Practice (AP) and/or Clinical Practice (CP)
- Licensed Baccalaureate Social Worker (LBSW)

The LBSW must be under the supervision of a master's level social worker (an LMSW or an LISW).

The social worker must have at least one year of experience working with individuals in a health and/or

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PROGRAM REQUIREMENTS

**Case Manager (CM)
(Cont'd.)**

human service environment, and must attend an SCDHHS-approved in-service training related to sickle cell diseases annually and documentation must be maintained in the staff records.

Case Manager Assistant

A case manager assistant must have, at a minimum, a high school diploma or GED, and skills and/or competencies sufficient to perform assigned tasks or the capacity to acquire those skills and/or competencies. The case manager assistant must be under the supervision of a case manager.

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PROGRAM DOCUMENTATION

As a condition of participation in the Medicaid program, providers are required to maintain and allow appropriate access to clinical records that fully disclose the extent of services provided to the Medicaid-eligible beneficiary. The maintenance of adequate records is regarded as essential for the delivery of appropriate services and quality medical care. Providers must be aware that these records are key documents for post-payment review. In the absence of appropriately completed clinical records, previous payments may be recovered by SCDHHS.

It is essential that providers conduct an internal records review. The internal records review ensures that services are medically necessary and that the service delivery, documentation, and billing comply with Medicaid policies and procedures.

Providers are required to maintain a clinical record on each Medicaid-eligible beneficiary that includes the documentation of all Medicaid-reimbursable services. Clinical records must be current, meet documentation requirements, and provide a clear descriptive narrative of services and progress toward goals and objectives listed in the ITP/CP. Clinical records should be in chronological order so that the information may be easily reviewed, copied, and audited.

CLINICAL RECORDS REQUIREMENTS

Clinical records must include the following:

- A Release of Information form signed by the beneficiary and/or the beneficiary's parent or guardian authorizing the release of any medical information necessary to process Medicaid claims and requesting payment of government benefits on behalf of the beneficiary. (This may be incorporated in a Consent for Treatment form.)
- Test results and evaluation reports
- A current and valid ITP or CP
- Emergency Care Plan
- Progress Summary Notes

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PROGRAM DOCUMENTATION

CLINICAL RECORDS REQUIREMENTS (CONT'D.)

- Clinical service notes
- A signature sheet that identifies all staff by name, signature, and initials

INDIVIDUAL TREATMENT PLAN (ITP) / CARE PLAN (CP)

Each beneficiary receiving services must have an Individual Treatment Plan/Care Plan developed by a multi-disciplinary team that outlines the strengths and needs of the beneficiary and his or her family.

The ITP/CP validates the necessity and appropriateness of services. It outlines the service delivery needed to meet the identified needs of the beneficiary, reduce problems and costly behavior, and improve the overall functioning of the beneficiary. The ITP/CP serves as a guide for the staff to assist the beneficiary and his or her family or guardian in accessing the appropriate services, and to move them through the service delivery system.

The ITP/CP is developed through a coordinated team effort (physician, nurse, social worker, targeted case manager, etc.), and is based on the needs determined during the assessment process. The ITP/CP must be updated according to the beneficiary's level of functioning, with new goals added as needed, or at least annually.

In order for Medicaid reimbursement to be claimed, all beneficiaries must have an up-to-date and completed ITP/CP in the clinical record within one month of the first date of service. Payment may be recouped for each date of service a record was out of compliance.

The maximum duration of an ITP/CP is 12 months from the date of the case manager's signature on the ITP/CP. If the ITP/CP is reformulated prior to its expiration date, the maximum duration is 12 months from the reviewing case manager's signature.

ITPs/CPs must be in writing or print and include the following:

- Beneficiary's name and Medicaid ID number written on a cover sheet
- Current medical and developmental status on the beneficiary and/or his or her family
- Genetic counseling information for the beneficiary and/or his or her family members

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PROGRAM DOCUMENTATION

INDIVIDUAL TREATMENT PLAN (ITP)/ CARE PLAN (CONT'D.)

- Current social history on the beneficiary and/or his or her family
- Emergency Care Plan
- Strategies to promote the family and/or caregiver as the primary treatment agent in the delivery of the service
- Annual evaluations and assessments on the beneficiary
- Objectives and goals with defined frequency limits
- Evaluations and assessments
- Appointments for genetic counseling for the beneficiary and his or her family member (if not already completed)
- Staff signature, title, and date
- Signature of beneficiary and/or his or her parent or guardian

Any changes in the beneficiary's program, services, medical status, needs, or progress must have a corresponding entry in the ITP/CP. Entries must be dated, initialed, and signed by the case manager. Entries must be arranged in chronological order so that the information may be easily reviewed, copied, and audited. Reassessment of needs should be ongoing throughout the period of service delivery.

EMERGENCY CARE PLAN

Each beneficiary must have an Emergency Care Plan to assist the family in dealing with emergency situations. A copy of the plan must be given to the beneficiary and/or his or her family to post near the telephone or entryway. An additional copy must be placed in the beneficiary's record. The Emergency Care Plan will be considered part of the ITP/CP. If the establishment of an Emergency Care Plan takes more than one encounter, the plan must be listed in the ITP/CP as a concern. (The Emergency Care Plan must be listed as a goal in the ITP/CP.)

The Emergency Care Plan must include all of the following:

- The name and telephone number of the beneficiary's primary care physician and a list of

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PROGRAM DOCUMENTATION

EMERGENCY CARE PLAN (CONT'D.)

symptoms that need to be reported immediately to the physician

- The telephone number of the ambulance or emergency medical transportation and indications as to when to seek immediate intervention
- The name and telephone number of the case manager and a list of events that need to be reported to the case manager

If possible, the name and telephone number of a friend or family member who may be called to come to the aid of or serve as the caregiver should be included.

PROGRESS SUMMARIES

Progress summaries are periodic reviews to evaluate the beneficiary's progress toward treatment goals, the appropriateness of the services being furnished, and the need for the beneficiary's continued participation in the Sickle Cell Services program. A review of the beneficiary's participation in all services will be conducted at least every 90 calendar days from the date the beneficiary begin receiving services and must be summarized by the CM and documented in the ITP/CP Progress Summary Report. The CM will review the following areas:

- The beneficiary's progress toward treatment objectives and goals
- The appropriateness of the services provided and their frequency
- The need for continued treatment
- Recommendations for continued services

Upon termination or expiration of the treatment period, the CM must review the ITP/CP with the beneficiary and evaluate the beneficiary's progress in reference to each of the treatment goals. The signature of the CM responsible for the review is required. The CM should also assess the need for continued services and the specific services needed based on the progress of the beneficiary.

CLINICAL SERVICE NOTES

Clinical service notes are written summaries of each service or activity provided to or on behalf of the beneficiary. Interventions detailed in clinical service notes must be clearly linked to the goals and objectives listed in the ITP/CP.

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PROGRAM DOCUMENTATION

CLINICAL SERVICE NOTE (CONT'D.)

Clinical service notes must:

- Provide a pertinent clinical description of the activities that took place during the session, treatment as related to stated goals, and objectives listed in the ITP/CP
- Document that the services rendered correspond to billing in regard to the date of service, the type of service, and the length of time of the service(s)
- Be signed by the staff member delivering the service. The staff member must sign his or her name/initials, title, and date the entry.

Providers should ensure that the following general requirements are adhered to when recording clinical service notes:

- Each entry must be individualized and beneficiary-specific.
- Each entry must stand alone and may not include arrows, ditto marks, “same as above,” etc.
- All entries must be signed by the staff delivering the service and should be accurate. If initials are used, a signature sheet must be maintained in the provider’s office.
- All entries must be typed or legibly handwritten in black or blue ink. Copies are acceptable, but must be completely legible. The originals must be available if needed.
- All clinical service notes must be placed in the record within five calendar days. Providers may not bill Medicaid for services before the notes are placed in the chart.
- All entries must be filed in the beneficiary’s clinical record in chronological order.
- If an abbreviation or a symbol is used in a given record, one of the following conditions must be met:
 - The full title must be written out with the abbreviation beside it the first time it is used.
 - The provider must keep a key of accepted

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CLINICAL SERVICE NOTE (CONT'D.)

abbreviations, and this list must be made available upon request.

- All entries made by the case manager assistant must be co-signed by the case manager before being placed in the record.

ERROR CORRECTION PROCEDURES

The beneficiary's clinical record is a legal document. Therefore, extreme caution should be used when altering any part of the record. The appropriate procedure for the correction of errors in legal documents must be followed when correcting an error in a clinical record. An error in the documentation should never be totally marked out and correction fluid should never be used. Draw one line through the error, enter the correction, initial, and date.

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PROCEDURAL AND DIAGNOSTIC CODING

South Carolina Medicaid requires that claims be submitted using codes from the current editions of the Healthcare Common Procedure Coding System (HCPCS) and/or the Current Procedural Terminology (CPT) as allowed by each provider agreement.

In 1996, the Centers for Medicare and Medicaid Services (CMS) implemented the National Correct Coding Initiative (CCI) to control improper coding that leads to inappropriate increased payment for health care services. The South Carolina Medicaid program utilizes Medicare reimbursement principles. Therefore, the agency will use CCI edits to evaluate billing of CPT codes and Healthcare Common Procedure Coding System codes by Medicaid providers in post-payment review of providers' records. For assistance with billing, providers may access the CCI Edit information online at the CMS Web site, <http://www.scdhhs.gov/>.

Medicaid reimburses the services listed below. To determine which codes a provider may use, please refer to the individual provider agreement. All services are contracted, but not all codes are used by each provider.

TARGETED CASE MANAGEMENT

Targeted Case Management providers are responsible for locating, coordinating, and monitoring necessary and appropriate services for beneficiaries. Additionally, TCM providers encourage the use of cost-effective medical care by referrals to the appropriate providers, by offering the following components:

The **assessment** component includes activities that focus on needs identification. Activities under this component include assessment of a Medicaid beneficiary to determine the need for any medical, educational, social, and/or other services. Specific assessment activities include taking the beneficiary's history, identifying the needs of the beneficiary, and completing related documentation. It also includes gathering information, if necessary, from other sources such as family members, medical providers, and educators to form a complete assessment of the beneficiary. This comprehensive assessment can minimize the need for an individual to be covered under multiple case management plans and have

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PROGRAM SERVICES

TARGETED CASE MANAGEMENT (CONT'D.)

multiple case managers, and can reduce the likelihood of service duplication and inefficiencies.

- Assessments include a periodic reassessment to determine whether a beneficiary's needs and/or preferences have changed. SCDHHS recommends that a face-to-face reassessment be conducted at least annually or more frequently if changes occur in a beneficiary's condition.
- The **care planning** component builds on the information collected through the assessment phase. Activities under this component include ensuring the active participation of beneficiaries, working with beneficiaries and others to develop goals, and identifying a course of action to respond to the assessed needs of beneficiaries. The goals and actions in the ITP/CP should address medical, social, educational, and other services needed by the beneficiary. However, while the assessment and care plan must be comprehensive and address all of the beneficiary's needs, the beneficiary may decline to receive services outlined in the care plan. The beneficiary shall not be required to receive services from a particular provider or from any provider if the beneficiary chooses. If a beneficiary declines services listed in the care plan, this must be documented in the beneficiary's case record.
- The **referral and linkage** component includes activities that help link beneficiaries with medical, social, educational, and/or other providers, programs, and services that are capable of providing the assessed needed services. For example, making referrals to providers for needed services and scheduling appointments may be considered case management.
- The **monitoring or follow-up** component includes activities and contacts that are necessary to ensure the ITP/CP is implemented effectively and is adequately addressing the needs of the beneficiary. The activities and contacts may be with the beneficiary, family members, outside service providers, or other entities. These may be as frequent as necessary, but must be within a 90-day period, to help determine whether services are being furnished

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PROGRAM SERVICES

TARGETED CASE MANAGEMENT (CONT'D.)

in accordance with the beneficiary's ITP/CP, the adequacy of the services in the ITP/CP, and changes in the needs or status of the beneficiary. This function includes making necessary adjustments in the ITP/CP and service arrangements with outside service providers. Quarterly monitoring or a follow-up activity must be documented in the CSNs or progress summaries for each beneficiary.

CASE MANAGEMENT

Some beneficiaries who have complex social and/or medical problems may require services from more than one case management provider or agency to be successfully managed and/or integrated into the community. Sickle Cell Services providers may render Case Management services to those beneficiaries receiving Targeted Case Management from another case management provider.

Concurrent care shall be rendered to a beneficiary for whom another provider has been designated the primary case manager. When concurrent care is provided, the service is documented as Case Management. The concurrent care provider renders different, distinctive types of services from the primary case manager.

The concurrent care provider shall notify the primary case manager in a timely manner regarding the following:

- Changes in the beneficiary's and/or his or her family situation
- Needs, problems, or progress
- Required referrals
- Program planning meetings

The needs and resources of each beneficiary may change over time, as well as the need for TCM services from another provider. To ensure that a beneficiary's needs are adequately met and that there is no duplication of services and Medicaid payments, TCM providers must work closely and cooperatively. A system must exist within each case management program to ensure that service providers are communicating, coordinating care and services, and adequately meeting the needs of the beneficiary.

When a primary case manager, as well as a secondary provider, for each overlapping situation has been determined, the primary case manager shall:

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CASE MANAGEMENT (CONT'D.)

- Ensure access to services
- Arrange needed care and services
- Monitor the case on an ongoing basis
- Provide crisis assessment and referral services
- Provide needed follow-up
- Communicate telephonically or face-to-face with other involved agencies and/or providers on a regular basis

The primary case manager has the primary responsibility of integrating information and recommendations from other providers for beneficiaries so that beneficiaries can develop an integrated, person-centered plan for addressing their multiple needs. Providers must ensure that a conflict of interest does not exist resulting in the case manager making self-referrals.

In addition, providers cannot condition receipt of case management services on the receipt of other services since this also serves as a restriction on the beneficiary's access to case management services.

Staff Responsibilities

Providers are responsible for providing the following TCM services:

- Assisting a beneficiary in obtaining the required educational, treatment, residential, medical, social, or other support services by accessing available services or advocating for service provision
- Contacting social, health, and rehabilitative service providers, by telephone or face-to-face, to promote access to and appropriate the use of services by beneficiaries. Additionally, services by multiple providers may be coordinated.
- Monitoring the beneficiary's progress through the services and performing periodic reviews and reassessments of treatment when the following occurs:
 - When assessing a beneficiary's need for services includes a physical, a psychological, or a mental status examination or evaluation; billing for the examination or evaluation must be under the appropriate medical service category. Referrals for

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PROGRAM SERVICES

Staff Responsibilities (Cont'd.)

such services may be considered a component of TCM services, but the actual provision of the service does not constitute TCM.

- When an assessment indicates the need for medical treatment, referral, or arrangements, these activities may be included, but actual treatment may not.
- Arranging and monitoring the beneficiary's access to primary health care providers including a written correspondence sent to a primary health care provider that gives a synopsis of the treatment the beneficiary is receiving, as needed
- Coordinating and monitoring other health care needs of a beneficiary by arranging appointments for other needed services with follow-up and documentation
- Staffing meetings related to receiving consultation and supervision on a specific case to facilitate optimal case management. This includes recommending and facilitating the beneficiary's movement from one provider to another.
- Contacting the beneficiary to deal with specific and identifiable problems of service access that require the case manager to guide or advise the beneficiary in the solution of the problem. (Interventions to monitor the beneficiary's general condition must be face-to-face.)
- Contacting the beneficiary's family members, representatives of the beneficiary's human service agencies, and other service providers to form a multidisciplinary team to develop a comprehensive and individualized service plan which describes a beneficiary's problems and corresponding needs, and details services to be accessed or procured to meet those needs
- Preparing a written report that details the beneficiary's health status, history, treatment, or progress (other than for legal or consultative purposes) for physicians or other service providers or agencies

Telephone contacts are Medicaid reimbursable when:

- The contact is necessary to assist beneficiaries in accessing care from health care providers or community agencies, and/or informing beneficiaries of actions they must take to successfully access these

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PROGRAM SERVICES

Staff Responsibilities (Cont'd.)

services. In these situations, the case manager must document the specific service-access actions beneficiaries were instructed to take, as well as any actions taken by the case manager to ensure this service access. This contact includes brief communication directing beneficiaries to other medical care.

- The contact is necessary to follow up on specific service-access needs of beneficiaries. The access arrangements must have been previously planned for beneficiaries, and the contact must be designed to monitor the completion of the service by the disabled or otherwise non-compliant beneficiary.

Medicaid reimbursement for telephone contacts with beneficiaries is restricted to a maximum of two units per day.

Medicaid does not reimburse brief conversations to apprise the beneficiary of appointment times, or contacts for the purpose of monitoring his or her general condition.

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Case Management Hierarchy

If overlap occurs, the guidelines in the following table should be used:

Providers	Primary Case Manager	Concurrent Care
CCEDC and Sickle Cell	CCEDC	Sickle Cell
DDSN and Sickle Cell	DDSN	Sickle Cell
DDSN Early Intervention and Sickle Cell	DDSN	Sickle Cell
DMH and Sickle Cell	Sickle Cell	DMH
DAODAS and Sickle Cell	Sickle Cell	DAODAS
Sickle Cell and SCSDB – Commission for the Blind	SCSDB – Commission for the Blind	Sickle Cell
Sickle Cell and CLTC	CLTC	Sickle Cell
Sickle Cell and DJJ	DJJ	Sickle Cell

KEY:

CCEDC = Continuum of Care for Emotionally Disturbed Children

CLTC = Community Long-Term Care

DAODAS = Department of Alcohol and Other Drug Abuse Services

DDSN = Department of Disabilities and Special Needs

DJJ = Department of Juvenile Justice

DMH = Department of Mental Health

SCSDB = South Carolina School for the Deaf and Blind

Billing/Frequency Limits

TCM is billed in unit increments of 15 minutes for a maximum of eight units per day. Concurrent care shall be rendered to a beneficiary for whom another provider has been designated the primary case manager. Concurrent care is billed in unit increments of 15 minutes for a maximum of eight units per day.

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PROGRAM SERVICES

Special Restrictions

No beneficiaries participating in any waiver program that includes case management services will be case-managed under this program.

Case managers will have caseloads that will facilitate assessment of and quick response to situations that need immediate attention. Targeted Case Management/Case Management activities may be rendered to a beneficiary on the date of the beneficiary's discharge from a hospital, Skilled Nursed Facility (SNF), Intermediate Care Facility (ICF), or ICF/Mentally Retarded (MR) facility.

A case management benefit includes only those services to beneficiaries who reside in a community setting or who are transitioning into a community setting following an institutional stay.

Targeted Case Management/Case Management services may be used to transition beneficiaries from an institutional stay into the community. For a covered, long-term institutional stay (greater than 180 consecutive day); beneficiaries are considered to be in transition into the community during the last 60 consecutive days of the stay. Beneficiaries between the ages of 22 and 64 who reside in an Institution for Mental Diseases (IMD) or beneficiaries who are incarcerated are not covered for Targeted Case Management/Case Management services.

For a covered, short-term, institutional stay (less than 180 consecutive days) a beneficiary is considered to be in transition into the community during the last 14 days before discharge.

These time requirements are used to distinguish Targeted Case Management/Case Management services that are not within the scope of discharge planning activities from Targeted Case Management/Case Management services required to transition beneficiaries with complex, chronic medical needs into the community.

Medicaid reimbursement for Targeted Case Management/Case Management services rendered to children, from birth to age 21, residing in a Residential Treatment Facility (RTF) or Institution for Mental Disease, also known as a "psychiatric hospital," is limited to the following:

- Assuring that placement continues to be necessary

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PROGRAM SERVICES

Special Restrictions (Cont'd.)

and appropriate to meet a beneficiary's needs

- Planning for future placement(s)

PATIENT EDUCATION

Patient Education is intended to inform sickle cell patients and their families of the essential facts about sickle cell disease, its treatment, the unique medical, physical and emotional needs of persons with sickle cell, and how to best manage the disease. The service may include instruction on how to recognize signs and symptoms of specific beneficiary complications and should stress the importance of health care maintenance. Patient Education will improve the understanding and access to necessary community treatment resources that are intended to reduce or prevent the deterioration of the sickle cell patient's health.

Staff Responsibilities

Patient Education includes instruction designed to assist in decision making by providing objective information about the natural history of the type of sickle cell disease that may affect offspring. Instruction should employ strategies and techniques designed to help the beneficiary fully understand all the factors that are personally meaningful regarding sickle cell-related family planning decisions.

Patient Education addresses the psychosocial and socioeconomic factors that can affect the beneficiary's ability to function within the home, community, and educational environment. Patient Education services are designed to:

- Advise the beneficiary and his or her family or guardian of the sickle cell disease risk factors, required interventions, and other medical and social issues
- Schedule patient follow-up services to discuss testing and assessment results and the recommended treatment
- Provide information to the beneficiary and his or her family or guardian of genetic risk factors of sickle cell disease
- Discuss the Emergency Care Plan

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Billing/Frequency Limits

Patient Education is billed in unit increments of 15 minutes for a maximum of eight units per day.

NON-COVERED SERVICES

Sickle cell services are not reimbursed under the following conditions:

- When beneficiaries are receiving Community Long-Term Care (CLTC) services
- When beneficiaries are receiving CLTC AIDS waiver services
- When TCM services are provided on the day of a community transitional/discharge planning for an inpatient general hospital stay

If a beneficiary has a primary case manager with another South Carolina Medicaid program and the beneficiary is eligible for Sickle Cell Case Management services, then the sickle cell case manager may choose to co-case manage that program within the Case Management program for concurrent care.