

<p>CHAPTER</p> <p>9</p>

DENIAL, REDUCTION, SUSPENSION OR TERMINATION OF WAIVER SERVICES

Any time a waiver service is denied, reduced, suspended or terminated, the participant/legal guardian must be given written notice of the action and must be given written notice of the right to request reconsideration/appeal. Additionally, there is a ten (10) calendar day waiting period (from the date form is completed and sent to the participant/legal guardian) before proceeding with a reduction, suspension or termination (See the list of exceptions below).

The following exceptions do not require a ten (10) calendar day notice before proceeding with the action:

- Denial of waiver service(s), including requests for units beyond established limits
- Client-requested reduction
- Termination due to loss of Medicaid eligibility
- Voluntary withdrawal
- Termination due to death
- Termination due to move out of state
- Termination due to admission to an ICF/ID/Nursing Facility or Jail
- Suspension of services due to Hospital Admission

Denials: If the participant/legal guardian requests a waiver service and is denied (either at the local or state level), the Service Coordinator or Early Interventionist must complete the Notice of Denial of Service (ID/RD Form 16-A) within two (2) working days of notification that the service is denied. The denied service(s) must be indicated on the form along with the reason(s) and any supporting comments. The original Notice of Denial of Services (ID/RD Form 16-A) is sent to the participant/legal guardian along with the written reconsideration/appeals process included/attached. A copy of the denial must be placed in the participant's file.

Terminations: If a waiver service will be terminated, the Service Coordinator/Early Interventionist must complete the Notice of Termination of Service (ID/RD Form 16-B). The terminated service(s) must be indicated on the form along with the reason(s) and any supporting comments. The effective date for termination must be at least ten (10) calendar days from the date that the form is completed and sent to the participant/legal guardian (exceptions previously noted apply). This gives the participant/legal guardian ten (10) calendar day notice prior to termination and the opportunity to request reconsideration/appeal the decision. If the participant requests a timely reconsideration/appeal (within 10 calendar days of the termination notification), then the participant may choose to continue to receive the services uninterrupted while awaiting the decision. If a Reconsideration decision is upheld, then the participant may be liable for payment of those services. Although the participant has a total of thirty (30) calendar days to request reconsideration/appeal the decision, the service will be terminated if the reconsideration is not requested within ten (10) calendar days. The original Notice of

Termination of Service (ID/RD Form 16-B) is sent to the provider of the service. A copy, with the appeals process included/attached, is sent to the participant/legal guardian, and another copy must be placed in the participant's file.

Note: If the participant/legal guardian requests reconsideration/appeal within 10 calendar days of the notice and chooses to continue to receive services while awaiting the outcome of the reconsideration/appeal, the Service Coordinator/Early Interventionist must contact the provider of service and ensure that the service continues uninterrupted. This contact must be documented in the participant's record.

Suspensions: When enrolled in the ID/RD Waiver, there may be circumstances when a participant's service(s) may need to be suspended. One example is when a participant is admitted to a hospital. In these instances, all waiver services must be suspended. Many participants and their providers of Residential Habilitation have made arrangements for prescribed drugs and Assistive Technology supplies to be delivered directly to the residence on a regular schedule. These arrangements must cease while the participant is hospitalized.

If a waiver service is suspended, the Service Coordinator/Early Interventionist must complete the Notice of Suspension of Service (ID/RD Form 16-C). The service(s) must be indicated on the form along with the reason(s) and any supporting comments. The suspension date will be at least ten (10) calendar days from the date the form is completed and sent to the participant/legal guardian (exceptions previously noted apply). This gives the participant ten (10) calendar day notice prior to suspension of the service and the opportunity to request reconsideration/appeal. As a reminder, **if the participant has been admitted to a hospital, then ten (10) calendar days notice is not required**. If the participant requests reconsideration/appeals within 10 calendar days of the notification, then the participant/legal guardian may choose to continue to receive the services uninterrupted while awaiting the outcome of the reconsideration/appeal. If, however, the decision is upheld upon reconsideration/appeal, then the participant/legal guardian may be liable for payment of those services. Although the participant has a total of thirty (30) calendar days to request reconsideration of/appeal the decision, the service will be suspended if the reconsideration/appeal is not requested within ten (10) calendar days. The original Notice of Suspension of Service (ID/RD Form 16-C) is sent to the provider of the service. A copy, with the reconsideration/appeals process included/attached, must be sent to the participant/legal guardian, and another copy must be placed in the participant's file.

Once the participant is ready to resume the service(s), the Service Coordinator/Early Interventionist must submit a new authorization form to the designated provider(s).

If the Level of Care certification or the Support Plan exceeds three hundred sixty five (365) days, waiver services must be suspended until a current Level of Care certification or Support Plan is completed, at which time a new authorization form must be completed.

Reminder: A waiver service must be received every 30 days in order for the participant to remain enrolled. If all waiver services are suspended for 30 days (for example: a 30 day hospitalization) then the individual must be disenrolled from the waiver (See chapter 7)

Note: If the participant/legal guardian requests reconsideration/appeals within 10 calendar days of the notice of suspension and chooses to continue to receive services while awaiting the outcome of the reconsideration/appeal, the Service Coordinator/Early Interventionist must contact the provider of service and ensure the service continues uninterrupted. This contact must be documented in the participant record.

Reductions: If a waiver service will be reduced, the Service Coordinator/Early Interventionist must complete the Notice of Reduction of Service (ID/RD Form 16-D). The reduced service(s) must be indicated on the form along with the reason(s) and any supporting comments. The reduction effective date must be at least

ten (10) calendar days from the date that the form is completed and sent to the participant/legal guardian. This gives the participant/legal guardian notice prior to reduction of the service and the opportunity to request reconsideration/appeal the decision. If the participant/legal guardian requests reconsideration or appeals within 10 calendar days of the notice, then the participant may choose to continue to receive the services uninterrupted while awaiting the outcome of the reconsideration/appeal. If, however, the decision is upheld upon reconsideration/appeal, then the participant/legal guardian may be liable for payment of those services. Although the participant/legal guardian has a total of thirty (30) calendar days to request reconsideration/appeal, the service will be reduced if the reconsideration is not requested within ten (10) calendar days. The original Notice of Reduction of Service (ID/RD Form 16-D) is sent to the provider of the service. A copy, with the appeals process included/attached, must be sent to the participant/legal guardian, and another copy must be placed in the participant's file. **The Service Coordinator/Early Interventionist must also complete a new authorization, reflecting the reduced units of service, and send the original to the provider.** Copies of the new authorization must also be sent to the participant/legal guardian and placed in the participant's file.

Note: If the participant/legal guardian requests reconsideration or appeals within 10 calendar days of the notice of reduction and chooses to receive services in the authorized amount while awaiting the outcome of the reconsideration/appeal, the Service Coordinator/Early Interventionist must contact the provider of service and ensure that the service continues uninterrupted. This contact must be documented in the participant record.

If a request for reconsideration/notice of appeal is received by SCDDSN Central Office, the Service Coordinator/Early Interventionist will be promptly notified and instructed on how to proceed.

**S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
INTELLECTUAL DISABILITY/RELATED DIABILITIES WAIVER
NOTICE OF DENIAL OF SERVICE**

To: _____ (Please check one: Participant Legal Guardian)

Address: _____

Participant's Name: _____ DOB: _____ Medicaid #: _____

YOU ARE HEREBY NOTIFIED THAT THE REQUEST FOR THE FOLLOWING SERVICE(S) FOR THE PERSON NAMED ABOVE HAS BEEN DENIED PURSUANT TO 42 C.F.R 440.230 (d). EXPLANATION OF APPEAL RIGHTS IS ATTACHED.

- | | |
|---|---|
| <input type="checkbox"/> Adult Attendant Care Services | <input type="checkbox"/> Environmental Modifications |
| <input type="checkbox"/> Adult Day Health Care | <input checked="" type="checkbox"/> Nursing Services |
| <input type="checkbox"/> Adult Day Health Care Nursing | <input type="checkbox"/> Personal Care Services <input type="checkbox"/> PCI <input type="checkbox"/> PCII |
| <input type="checkbox"/> Adult Day Health Care Transportation | <input type="checkbox"/> Personal Emergency Response System (PERS) |
| <input type="checkbox"/> Adult Companion Services | <input type="checkbox"/> Prescribed Drugs |
| <input type="checkbox"/> Adult Dental Services | <input type="checkbox"/> Private Vehicle Modifications |
| <input type="checkbox"/> Adult Vision Services | <input type="checkbox"/> Psychological Services |
| <input type="checkbox"/> Audiology Services | <input type="checkbox"/> Residential Habilitation |
| <input type="checkbox"/> Behavior Support Services | <input type="checkbox"/> Respite Care |
| <input type="checkbox"/> Career Preparation Services | <input type="checkbox"/> Specialized Medical Equipment, Supplies and
Assistive Technology (* listed below) |
| <input type="checkbox"/> Community Services | <input type="checkbox"/> Employment Services <input type="checkbox"/> Support Center |
| <input type="checkbox"/> Day Activity Services | |

* Assistive Tech: _____

Reason:

- | | |
|---|---|
| <input type="checkbox"/> Need(s) not justified | <input type="checkbox"/> Exceeds service limits |
| <input type="checkbox"/> Service(s) available through State Plan Medicaid | <input type="checkbox"/> Other: _____ |

Comments (required): _____

Service Coordination Provider: _____ Service Coordinator Name: _____

Address: _____

Phone # _____

Signature of Service Coordinator

Date

Original: Participant/legal guardian / Copy: File

S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
INTELLECTUAL DISABILITY/RELATED DIABILITIES WAIVER
NOTICE OF TERMINATION OF SERVICE

To: _____

Address: _____

Participant's Name: _____ DOB: _____ Medicaid #: _____

YOU ARE HEREBY NOTIFIED TO TERMINATE THE PROVISION OF THE FOLLOWING SERVICE(S) TO THE PERSON NAMED ABOVE PURSUANT TO 42 C.F.R 440.230 (d). ONLY THE NUMBER OF UNITS RENDERED PRIOR TO OR ON THE EFFECTIVE DATE OF _____ MAY BE BILLED.

- Adult Attendant Care Services
Adult Day Health Care
Adult Day Health Care Nursing
Adult Day Health Care Transportation
Adult Companion Services
Adult Dental Services
Adult Vision Services
Audiology Services
Behavior Support Services
Career Preparation Services
Community Services
Day Activity
Employment Services
Environmental Modifications
Nursing Services
Personal Care Services
Personal Emergency Response System (PERS)
Prescribed Drugs
Private Vehicle Modifications
Psychological Services
Residential Habilitation
Respite Care
Specialized Medical Equipment, Supplies and Assistive Technology
Support Center Services

Reason:

- Change in need; no longer justifies original request
No longer meets ICF/ID Level of Care
Change in provider availability
Entered an ICF/ID
Voluntary withdrawal
Death (do not send a copy to the family)
Medical condition has improved
Participant/legal guardian requested
Medicaid ineligible
Participant moved out of state
Facility stay exceeded 30 consecutive days
Other (explain in comments below)

Comments (required): _____

Service Coordination Provider: _____ Service Coordinator Name: _____

Address: _____

Phone # _____

Signature of Service Coordinator

Date

Original: Provider / Copy: Participant/legal guardian, File

ID/RD Form 16-B (Revised 12/12)

APPEALS PROCESS MUST BE ATTACHED

INTELLECTUAL DISABILITY/RELATED DIABILITIES WAIVER
NOTICE OF SUSPENSION OF SERVICE

To: _____

Address: _____

Participant's Name: _____ DOB: _____ Medicaid #: _____

YOU ARE HEREBY NOTIFIED TO SUSPEND THE PROVISION OF THE FOLLOWING SERVICE(S) TO THE PERSON NAMED ABOVE PURSUANT TO 42 C.F.R 440.230 (d). ONLY THE NUMBER OF UNITS RENDERED PRIOR TO OR ON THE EFFECTIVE DATE OF _____ MAY BE BILLED.

- | | |
|---|--|
| <input type="checkbox"/> Adult Attendant Care Services | <input type="checkbox"/> Environmental Modifications |
| <input type="checkbox"/> Adult Day Health Care | <input type="checkbox"/> Nursing Services |
| <input type="checkbox"/> Adult Day Health Care Nursing | <input type="checkbox"/> Personal Care Services <input type="checkbox"/> PCI <input type="checkbox"/> PCII |
| <input type="checkbox"/> Adult Day Health Care Transportation | <input type="checkbox"/> Personal Emergency Response System (PERS) |
| <input type="checkbox"/> Adult Companion Services | <input type="checkbox"/> Prescribed Drugs |
| <input type="checkbox"/> Adult Dental Services | <input type="checkbox"/> Private Vehicle Modifications |
| <input type="checkbox"/> Adult Vision Services | <input type="checkbox"/> Psychological Services |
| <input type="checkbox"/> Audiology Services | <input type="checkbox"/> Residential Habilitation |
| <input type="checkbox"/> Behavior Support Services | <input type="checkbox"/> Respite Care |
| <input type="checkbox"/> Career Preparation Services | <input type="checkbox"/> Specialized Medical Equipment, Supplies and Assistive Technology |
| <input type="checkbox"/> Community Services | |
| <input type="checkbox"/> Day Activity | <input type="checkbox"/> Support Center Services |
| <input type="checkbox"/> Employment Services | |

Reason:

- | | |
|--|---|
| <input type="checkbox"/> Entered hospital/rehab (less than 30 calendar days) | <input type="checkbox"/> Entered ICF/ID |
| <input type="checkbox"/> Entered nursing facility (less than 30 calendar days) | <input type="checkbox"/> Entered Jail |
| <input type="checkbox"/> Other: _____ | |

Comments (required): _____

Service Coordination Provider: _____ Service Coordinator Name: _____

Address: _____

Phone # _____

Signature of Service Coordinator

Date

Original: Provider / Copy: Participant/legal guardian, File

**S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
INTELLECTUAL DISABILITY/RELATED DIABILITIES WAIVER
NOTICE OF REDUCTION OF SERVICE**

To: _____

Address: _____

Participant's Name: _____ DOB: _____ Medicaid #: _____

YOU ARE HEREBY NOTIFIED THAT THE SERVICE BELOW IS BEING REDUCED FOR THE PERSON NAMED ABOVE PURSUANT TO 42 C.F.R 440.230 (d). THIS REDUCTION IS EFFECTIVE ON DATE _____ .

- | | |
|---|--|
| <input type="checkbox"/> Adult Attendant Care Services | <input type="checkbox"/> Environmental Modifications |
| <input type="checkbox"/> Adult Day Health Care | <input type="checkbox"/> Nursing Services |
| <input type="checkbox"/> Adult Day Health Care Nursing | <input type="checkbox"/> Personal Care Services <input type="checkbox"/> PCI <input type="checkbox"/> PCII |
| <input type="checkbox"/> Adult Day Health Care Transportation | <input type="checkbox"/> Personal Emergency Response System (PERS) |
| <input type="checkbox"/> Adult Companion Services | <input type="checkbox"/> Prescribed Drugs |
| <input type="checkbox"/> Adult Dental Services | <input type="checkbox"/> Private Vehicle Modifications |
| <input type="checkbox"/> Adult Vision Services | <input type="checkbox"/> Psychological Services |
| <input type="checkbox"/> Audiology Services | <input type="checkbox"/> Residential Habilitation |
| <input type="checkbox"/> Behavior Support Services | <input type="checkbox"/> Respite Care |
| <input type="checkbox"/> Career Preparation Services | <input type="checkbox"/> Specialized Medical Equipment, Supplies and Assistive Technology |
| <input type="checkbox"/> Community Services | |
| <input type="checkbox"/> Day Activity | <input type="checkbox"/> Support Center Services |
| <input type="checkbox"/> Employment Services | |

Reason:

- | | |
|---|---|
| <input type="checkbox"/> Change in need; no longer justifies original request | <input type="checkbox"/> Medical condition has improved |
| <input type="checkbox"/> Participant/legal guardian requested | |
| <input type="checkbox"/> Other: _____ | |

Comments (required): _____

Service Coordination Provider: _____ Service Coordinator Name: _____

Address: _____

Phone # _____

Signature of Service Coordinator

Date

Original: Provider / Copy: Participant/legal guardian, File

ID/RDSCDDSN RECONSIDERATION PROCESS

The South Carolina Department of Disabilities and Special Needs (SCDDSN) is responsible for the day-to-day operations of the Intellectual Disability-Related Disabilities (ID-RD) Waiver, the Community Supports (CS) Waiver, the Head and Spinal Cord Injury (HASCI) Waiver, and the Pervasive Developmental Disorder (PDD) Waiver. If a Waiver participant disagrees with a decision made and/or action taken by SCDDSN, reconsideration and reversal of the adverse decision/action may be requested.

The SCDDSN reconsideration process must be completed in its entirety before seeking an appeal with the South Carolina Department of Health and Human Services (SCDHHS), which is the State Medicaid Agency.

A request for a SCDDSN reconsideration of an adverse decision/action must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision/action. The request must clearly state the basis of the complaint, previous efforts to resolve the complaint, and relief sought. If necessary, a Case Manager or other staff may assist the participant, legal guardian or representative in requesting reconsideration. The request must be dated and signed by the participant, legal guardian or representative assisting the participant. The request for reconsideration must be mailed to:

**State Director
SC Department of Disabilities and Special Needs
P.O. Box 4706
Columbia, SC 29240**

The State Director or a designee will issue a written decision within ten (10) working days of receipt of the written reconsideration request and mail it to the participant, legal guardian or representative. If the State Director upholds the original adverse action/decision, the reason(s) shall be specifically identified in the written notification.

Note: In order for affected Waiver services to continue during the SCDDSN reconsideration process and the SCDHHS Medicaid appeal process, the participant, legal guardian or representative's request for SCDDSN reconsideration must be submitted within ten (10) calendar days of receipt of written notification of the adverse decision/action. Continuation of the affected Waiver services must be specifically requested in the request for SCDDSN reconsideration. If the adverse decision/action is upheld, the participant or legal guardian may be required to repay the cost of affected Waiver services received during the time of the reconsideration/appeal processes.

SCDHHS MEDICAID APPEAL PROCESS

If the participant, legal guardian or representative fully completes the SCDDSN reconsideration process above and is dissatisfied with the result, the participant, legal guardian or representative has the right to request an appeal with the State Medicaid Agency, which is the South Carolina Department of Health and Human Services (SCDHHS). The appeal request may be made electronically using the SCDHHS website indicated below or it may be mailed to SCDHHS. This must be done no later than thirty (30) calendar days after receipt of the SCDDSN notification.

The purpose of a SCDHHS administrative appeal is to prove error(s) in fact or law pertaining to a decision made and/or action taken by SCDDSN that adversely affects a Waiver participant. The appeal must clearly state the specific issue(s) that are disputed and what action is requested. A copy of the reconsideration notification received from SCDDSN must be uploaded using the SCDHHS website indicated below or included with the mailed appeal.

The participant, legal guardian or representative is encouraged to file the appeal electronically at www.scdhhs.gov/appeals.
OR

The appeal request may be mailed to:

**SC Department of Health and Human Services
Division of Appeals and Hearings
P.O. Box 8206
Columbia, SC 29202-8206**

An appeal request to SCDHHS is valid if filed electronically or mailed to the above address and postmarked no later than the thirtieth (30th) calendar day following receipt of the SCDDSN reconsideration notification. Unless a valid appeal request is made to SCDHHS, the SCDDSN reconsideration decision will be final and binding. If a valid appeal request is made, the participant, legal guardian or representative will be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request, which may include a scheduled hearing.