ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS PROVIDER PROVISIONS

A 1.1 PURPOSE: The South Dakota Department of Human Services ("State" or "DHS"), Division of Long Term Services and Supports (LTSS), provides home and community-based service options to individuals 60 and older and to individuals 18 years of age and older with disabilities. State services enable these South Dakotans to live independent, meaningful lives while maintaining close family and community ties. The State provides home and community-based services, as specified in the Individual Support Plan (ISP), to prevent or delay premature or inappropriate nursing facility placement.

The purpose of the Environmental Accessibility Adaptations is to improve accessibility to areas of the living environment, promote safety and reduce risk as demonstrated by an identified need in the individual's needs assessment. Environmental Accessibility Adaptations services enable individuals to remain living at home by maintaining and/or improving functional capacity to perform activities of daily living.

A 1.2 PROVISION: In addition to the requirements outlined in the SD Medicaid Provider Agreement, the Provider agrees to comply with all the requirements in this document.

STANDARD PROGRAM DEFINITIONS

B 2.1 "Eligible Consumer" is an any person in need of services who is determined eligible for by DHS.

B 2.2 "Environmental Accessibility Adaptations (EAA)" are those physical adaptations to the private residence of the consumer, or the consumer's family, required by the consumer's ISP, that are necessary to ensure the health, welfare, and safety of the consumer or that enable the consumer to function with greater independence in the home. Such adaptations include the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric or plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the consumer.

Adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the consumer are excluded. Adaptations or improvements that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (i.e. in order to improve entrance/egress to a residence or to widen a bathroom to accommodate a wheelchair).

This service does not include general repair or maintenance to the residence, which are standard housing obligations of the owner or tenant.

B 2.3 "Individual Support Plan (ISP)" is an electronic document within each consumer's record in the Therap case management system. The ISP is developed by the LTSS Case Management Specialist with the consumer, as well as any individuals the consumer chooses. The ISP must be finalized with the agreement and informed consent of the consumer in writing and signed by all individuals and providers responsible for its implementation.

The ISP reflects the services and supports that are important for the individual to meet the needs identified through an assessment of need, as well as what is important to the individual with regards to preferences for the delivery of such services and supports.

B 2.4 "**Therap**" is the online case management documenting and billing software

B 2.5 "Therap Service Auth" is the electronic document in Therap which details the services authorized for the consumer. The "Therap Service Auth" must be acknowledged by the Provider within 7 business days of receipt. Failure to acknowledge the " Therap Service Auth" within the designated time frame may negatively affect reimbursement for services provided. Any permanent change to the "Therap Service Auth" must be reviewed and authorized by the State.

If a Provider is concerned that there is an error on the 'Therap Services Auth', the Provider should not acknowledge the 'Therap Service Auth'. The Provider should contact the LTSS Case Management Specialist assigned as the consumer's case manager to resolve any potential discrepancies.

STANDARD PROGRAM REQUIREMENTS

C 3.1 RULES AND REGULATIONS: The Provider shall comply with all South Dakota Codified Laws and Administrative Rules of South Dakota applicable to the services provided. The Provider also agrees to comply in full with all licensing requirements and other standards required by federal, state, county, city or tribal statute, regulation or ordinance in which the service and/or care is provided. Liability resulting from noncompliance with regulations, licensing, and/or other standards required by federal, state, county, city or tribal statute, regulation or ordinance or through the Provider's failure to ensure the safety of all consumers served is assumed entirely by the Provider.

C 3.2 VERIFICATION AND DOCUMENTATION: The Provider is required to maintain documentation and verification demonstrating compliance with these Provider Provisions. This documentation must be readily available upon request.

C 3.3 REFERRALS AND GEOGRAPHIC AREA: Any LTSS consumer living within the Provider's identified geographic area may be referred to the Provider. The Provider is expected to consider all referrals but may turn down a referral due to safety concerns, unavailability of staff, or inability to serve consumer need. The consumer will be offered the choice of available Providers and select the Provider of his/her choice.

C 3.4 INTERPRETERS: If Interpreter services are necessary, Providers must utilize DHS approved interpreters. Interpreter services must be authorized by the LTSS Case Management Specialist prior to Interpreter services being utilized. The LTSS Case Management Specialist and Provider will cooperatively arrange for interpreter services as necessary for service provision.

C 3.5 REIMBURSEMENT: The rate(s) for services are specified in HOPE Waiver Fee Schedule. All services authorized and delivered by the Provider to eligible consumers will be reimbursed at the stated rates.

Approved claim forms, including all required information (e.g. Provider's National Provider Identifier, consumer's primary diagnosis code (etc.) will be submitted by the Provider to the State for payment of services authorized and provided.

The Provider must only bill for services authorized and acknowledged in Therap and delivered by the Provider. Units authorized are a maximum. The Provider must contact the LTSS Case Management Specialist if additional services are determined to be necessary or requested by the consumer.

The consumer must be present when services are being performed unless an exception is specified in the Therap Service Auth. If the Provider encounters a situation where an exception is needed, the Provider must contact the State for authorization.

The State's reimbursement for services rendered shall be considered payment in full. Except for the cost-share for waiver services, the Provider may not bill the consumer for any additional fees. The Provider will be advised of the consumer's cost-share, if any, and will be responsible for collecting the cost-share from the consumer.

The State will not reimburse or otherwise be made liable for purchases or transactions made by the Provider on behalf of the consumer.

Environmental Accessibility Adaptations (EAA) and modifications must be done in compliance with community building code requirements by contractors properly licensed and experienced in performing the remodeling work. The Provider must assure the contractor's work is completed before payment is made to the contractor.

For assistance with claim denials and billing issues, Providers must notify the State within the 6-month time limits outlined in ARSD 67:16:35:04. For all claims inquiries, Providers must submit a Claims Resolution Template to ltsstherap@state.sd.us for further review and technical assistance. Providers are encouraged to resubmit all

previously denied claims every 90 days for SD Medicaid and SD DHS/LTSS claims compliance. Claims inquiries will be reviewed by appropriate LTSS staff in the order in which they are received.

LTSS will not address or review SD Medicaid or LTSS State-funded claims issues that are not in alignment with ARSD 67:16:35:04. LTSS staff will not review and research claims if there is not a claim submitted to Medicaid or LTSS within 6 months of the date of service and every 3 months thereafter per Medicaid billing requirements. It is ultimately the responsibility of the Provider to submit a request for reimbursement for services provided within established guidelines.

LTSS will assist Providers with claims resolution if there is a Claims Resolution Template submitted within 3 months of the date of service. This will ensure there is still time to resolve the issue prior to the timely filing deadline.

SERVICE-SPECIFIC PROGRAM REQUIREMENTS

D 4.1 ELIGIBILITY: The State shall complete a needs assessment and determine the consumer's eligibility for services. The State shall provide case management regarding a consumer's on-going eligibility; authorize services; approve or disapprove changes in services; and seek resolution of consumer concerns and other consumer related issues. Once eligibility has been determined, an eligible consumer will be referred to the Provider of his/her choice for EAA services.

D 4.2 REFERRAL: The LTSS Case Management Specialist shall make a referral to the chosen Provider when the need for an EAA is identified. The Provider must accept or deny the referral. If the Provider accepts the referral, a "Therap Service Auth" will be sent to the Provider by the LTSS Case Management Specialist authorizing the Initial Assessment.

D 4.3 SCOPE OF WORK: The Provider must coordinate and supervise the project to completion.

1. The Provider must complete an Initial Assessment which includes the following:
    a. Visit the site to determine the scope of work involved;
    b. Locate and obtain EAA bids from a minimum of two contractors to complete the project; and
    c. Submit two EAA bids to the LTSS Case Management Specialist and acknowledge the "Therap Service Auth" prior to starting the project.
2. The Provider must monitor completion of the EAA project. Monitoring tasks include:
    a. Writing a contract with the contractor;
    b. Monitoring the progress of the contractor with telephone calls or onsite visits;

c. Monitoring the contractor to ensure work is being completed as authorized; and
d. Contacting the LTSS Case Management Specialist if the cost of the project is expected to exceed the initial authorized amount. The Provider must receive an Therap Service Auth from the LTSS Case Management Specialist to ensure reimbursement for the full cost of the project.

3. The Provider must conduct a Final Assessment of the completed EAA project. A Final Assessment requires:
    a. Going onsite to confirm completion of the project; and
    b. Submitting a copy of the Final Assessment Report to the LTSS Case Management Specialist (including the amount of face-to-face staff time spent on the project and the final cost of the EAA project)
4. The Provider must bill Medicaid for the EAA project, which requires:
    a. Obtaining written (e.g. fax, e-mail) confirmation from the LTSS Case Management Specialist for approval to bill for services once the Final Assessment Report is accepted.

D 4.4 REQUEST FOR REIMBURSEMENT:

1. Initial Assessment (Service Code T1028):
    a. Provider's in-home initial face-to-face staff time to obtain project specifics in order to obtain bids and secure a contract, and
    b. must be submitted and shall be paid regardless of whether the EAA was completed or not.
2. Monitoring of the Project (Services Code S5165):
    a. Units spent securing a contract and writing a contract, units spent monitoring the progress of the project to ensure successful completion
3. Cost of the Project (Service Code S5165):
    a. Materials necessary to complete the project.
    b. Labor required for completion of the project.
    c. Provider must complete Final Assessment and receive approval from LTSS Case Management Specialist prior to billing for the Cost of the Project.
4. Final Assessment (Service Code T1028):
    a. Provider's in-home face-to-face staff time to assess completion of the project for compliance and safety and ensure the project meets the needs of the consumer.
    b. Provider must submit a Final Assessment Report to the LTSS Case Management Specialist (including the amount of face-to-face staff time spent on the project) to receive approval to bill for the EAA project.

The LTSS Case Management Specialist will review the report and will authorize the Final Assessment. Following approval, the Provider may bill both Cost of the Project (S5165) and the Final Assessment (T1028)

D 4.5 DISCONTINUATION OF AUTHORIZATION: The Department of Human Services' Division of Long Term Services and Supports may discontinue services if DHS exhausts its resources for providing the services, the consumer can no longer benefit from the services provided, or the consumer's or the Provider's health or safety would be jeopardized if the services were continued. Specific reasons for discontinuing services include the following:

1. The consumer's needs have surpassed the scope of the HOPE waiver;
2. The consumer poses a safety risk;
3. The consumer is not in compliance with the Individual Support Plan (ISP);
4. The consumer is not capable of self-preservation in an emergency;
5. The consumer's condition has improved and no longer meets level of care requirements;
6. The consumer failed to participate in the cost of service as required; or
7. The need for the EAA has been met through completion of the project.