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Assimilated by R. Shawn Majette.

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CHAPTER I

GENERAL INFORMATION

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CHAPTER I
GENERAL INFORMATION

INTRODUCTION

The Virginia Medicaid Provider Manual describes the role of the provider in the Virginia Medical Assistance Program (Medicaid). To provide a better understanding of the Medicaid Program, this manual explains Medicaid rules, regulations, procedures, and reimbursement and contains information to assist the provider in answering inquiries from Medicaid members.

The manual can also be an effective training and reference tool for provider administrative personnel, since it conveys basic information regarding the Medicaid Program, covered and non-covered services, and billing procedures. Proper use of the manual will result in a reduction of errors in claims filing and, consequently, will facilitate accurate and timely payment.

In addition to the Medicaid Program, other programs administered by the Department of Medical Assistance Services (DMAS) include the Family Access to Medical Insurance Security (FAMIS) program, the State and Local Hospitalization (SLH) program, and the Uninsured Medical Catastrophe Fund. If you have any questions concerning the Medicaid Program or any of the other programs listed above, please contact the provider "HELPLINE" at:

804-786-6273	Richmond Area
1-800-552-8627	All other areas

PROGRAM BACKGROUND

In 1965, Congress created the Medical Assistance Program as Title XIX of the Social Security Act, which provides for federal grants to the states for their individual Medical Assistance programs. Originally enacted by the Social Security amendments of 1965 (Public Law 89-97), Title XIX was approved on July 30, 1965. This enactment is popularly called "Medicaid" but is officially entitled "Grants to States for Medical Assistance Programs." The purpose of Title XIX is to enable the states to provide medical assistance to eligible indigent persons and to help these individuals if their income and resources are insufficient to meet the costs of necessary medical services. Such persons include dependent children, the aged, the blind, the disabled, pregnant women, and needy children.

The Medicaid Program is a jointly administered federal/state program that provides payment for necessary medical services to eligible persons who are unable to pay for such services. Funding for the Program comes from both the federal and state governments. The amount of federal funds for each state is determined by the average per capita income of the state as compared to other states.

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Virginia's Medical Assistance Program was authorized by the General Assembly in 1966 and is administered by the Virginia Department of Medical Assistance Services (DMAS). The Code of Federal Regulations allows states flexibility in designing their own medical assistance programs within established guidelines. Virginia Medicaid's goal is to provide health and medical care for the Commonwealth's poor and needy citizens using the health care delivery system already in place within the state. In 2003, the Virginia General Assembly changed the name of the Medicaid program covering most children to FAMIS Plus. The change in name was intended to facilitate a coordinated program for children's health coverage including both the FAMIS (Family Access to Medical Insurance Security Plan) and FAMIS Plus programs. All covered services and administrative processes for children covered by FAMIS Plus remain the same as in Medicaid. While the Virginia Medicaid Program is administered by DMAS, the eligibility determination process is performed by local departments of social services through an interagency agreement with the Virginia Department of Social Services. The *State Plan for Medical Assistance* for administering the Medicaid Program was developed under the guidance of the Advisory Committee on Medicare and Medicaid appointed by the Governor of the Commonwealth of Virginia. The State Plan is maintained through continued guidance from the Board of Medical Assistance Services, which approves amendments to the *State Plan for Medical Assistance* with policy support from the Governor's Advisory Committee on Medicare and Medicaid. Members of the Governor's Advisory Committee and the Board of Medical Assistance Services are appointed by the Governor.

Individuals originally became eligible for Medicaid because of their "categorical" relationship to two federal cash assistance programs: Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI). However, congressional mandates in the late 1980s resulted in dramatic changes in Medicaid eligibility provisions. Now individuals, in additional selected low-income groups, are eligible for Medicaid solely on the relationship of their incomes to the Federal Poverty Guidelines. New Federal Poverty Guidelines are published annually in the *Federal Register* and become effective upon publication.

On June 7, 2018, Governor Northam approved the state budget that expanded eligibility to include the Modified Adjusted Gross Income (MAGI) adult group, also known as the Medicaid Expansion covered group. The MAGI adult group includes adults between the ages of 19 and 64, who are not eligible for or enrolled in Medicare, and who meet income eligibility rules. After receiving the necessary approvals from the Centers for Medicare and Medicaid Services (CMS), DMAS began enrolling individuals in the MAGI adult group on January 1, 2019.

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Medicaid is a means-tested program. Applicants' income and other resources must be within program financial standards, and different standards apply to different population groups, with children and pregnant women, the MAGI adult group, and persons who are aged, blind, or disabled. Reference Chapter III of this manual for detailed information on groups eligible for Medicaid.

GENERAL SCOPE OF THE PROGRAM

The Medical Assistance Program (Medicaid) is designed to assist eligible members in securing medical care within the guidelines of specified State and federal regulations. Medicaid provides access to medically necessary services or procedures for eligible members. The determination of medical necessity may be made by the Utilization Review Committee in certain facilities, a peer review organization, DMAS professional staff or DMAS contractors.

Covered Services

The following services are provided, **with limitations** (certain of these limitations are set forth below), by the Virginia Medicaid Program:

- BabyCare - Prenatal group patient education, nutrition services, and homemaker services for pregnant women and care coordination for high-risk pregnant women and infants up to age two.
- Blood glucose monitors and test strips for pregnant women
- Case management services for high-risk pregnant women and children up to age 1 (as defined in the State Plan and subject to certain limitations)
- Christian Science sanatoria services
- Clinical psychology services
- Clinic services
- Community developmental disability services
- Contraceptive supplies, drugs and devices
- Dental services

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- Diabetic test strips
- Durable medical equipment and supplies
- Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) – For individuals under age 21, EPSDT must include the services listed below:
- Screening services, which encompass all of the following services:
    - Comprehensive health and developmental history
    - Comprehensive, unclothed physical exam
    - Appropriate immunizations according to age and health history
    - Laboratory tests (including blood lead screening)
    - Health education
- Home health services
- Eyeglasses for all members younger than 21 years of age according to medical necessity
- Hearing services
- Inpatient psychiatric services for members under age 21
- Environmental investigations to determine the source of lead contamination for children with elevated blood lead levels
- Other medically necessary diagnostic and treatment services identified in an EPSDT screening exam, not limited to those covered services included above
- Skilled nursing facilities for persons under 21 years of age
- Transplant procedures as defined in the section “transplant services”
- All states are required to offer EPSDT to all Medicaid-eligible individuals under age 21 to determine any physical and mental defects that they may have and to provide health care, treatment, and other measures to correct or ameliorate the defects or chronic conditions discovered. The services available under EPSDT are not limited to those available in the Medicaid State Plan for Medical Assistance. Services requiring preauthorization under the State Plan for Medical Assistance will

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continue to require pre-authorization. DMAS reserves the right to utilize medical necessity criteria for non-State Plan services under EPSDT.

- Commonwealth Coordinated Care Plus (CCC Plus) Waiver services - Individuals who meet the criteria for a nursing facility level of care can be authorized to receive adult day health care, personal care (agency directed or consumer directed) services, Respite Care and Skilled Respite Care services, Personal Emergency Response System (PERS), Services Facilitation services, Transition Coordination, and Transition services

- Emergency hospital services

- Emergency services for aliens

- Enteral nutrition (EN) - Coverage is limited to circumstances in which the nutritional supplement is the sole source of nutrition except for individuals authorized through the CCC Plus Waiver or through EPSDT, is administered orally or through a nasogastric or gastrostomy tube, and is necessary to treat a medical condition. Coverage of oral administration does NOT include the provision of routine infant formula.

- Extended services for pregnant women, pregnancy-related and postpartum services for 60 days after the pregnancy ends (limitations applicable to all covered services apply to this group as to all other member groups)

- Eye refractions

- Plan First (family planning services) – Medicaid fee-for-service program for men and women who meet the eligibility criteria. Plan First includes coverage of those services necessary to prevent or delay a pregnancy. It shall not include services to promote pregnancy such as infertility treatments. Family planning does not include counseling about, recommendations for or performance of abortions, or hysterectomies or procedures performed for medical reasons such as removal of intrauterine devices due to infections.

- Federally Qualified Health Center services

- Home and Community-Based Care Waiver services

- Home health services

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- Hospice services for individuals certified as terminally ill (defined as having a medical prognosis that life expectancy is six months or less)
- Family and Individual Support Waiver
- Gender dysphoria treatment services
- Inpatient care hospital services
- Inpatient Psychiatric Hospital Services for Individuals under 21 years of age (medically needy are not covered)
- Intensive rehabilitation services
- Intermediate care facility – Individuals with Intellectual Disabilities Services (medically needy members are not covered)
- Laboratory and radiograph services
- Legend and Non-legend drugs are covered with some limitations or exclusions. (See the Pharmacy Manual for specific limitations and requirements)
- Mental health, with limitations, covered under mental health and intellectual disability community services listed below:
- Mental Health:
- Crisis stabilization
- Mental health support
- Assertive community treatment
- Intensive in-home services for children and adolescents
- Therapeutic day treatment for children and adolescents
- Partial hospitalization Program
- Intensive Outpatient Program
- Psychosocial rehabilitation
- Crisis intervention
- Case management

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- Substance Use Disorder:

- Residential treatment for pregnant and postpartum women
- Day treatment for pregnant and postpartum women
- Crisis Intervention
- Intensive Outpatient
- Day Treatment
- Case Management
- Opioid Treatment
- Outpatient Treatment

- Community Living Waiver:

- Nurse-midwife services
- Nursing facility services

- Occupational therapy

- "Organ and disease" panel test procedures for blood chemistry tests

- Optometry services

- Outpatient hospital services

- Over-the-counter alternatives to certain classes of legend drugs. Upon a doctor's prescription or order, a pharmacy may provide and Medicaid will cover a drug that no longer requires a prescription to dispense. See the Pharmacy Manual for specific limitations and requirements.

- Papanicolaou smear (Pap) test

- Payment of deductible and coinsurance up to the Medicaid limit less any applicable payments for health care benefits paid in part by Title XVIII (Medicare) for services covered by Medicaid.
- Physician services

- Podiatry services

- Prostate specific antigen (PSA) test (1998)

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- Prostheses limited to artificial arms, legs, and the items necessary for attaching the prostheses, which must be pre-authorized by the DMAS central office. Also breast prostheses for any medically necessary reason and ocular prostheses for reason for loss of eyeball regardless of age of the member or the cause of the loss of the eyeball.

- Psychiatric Hospitals for the Aged (65 Years and Older)

- Psychological testing for persons with intellectual disability as part of the evaluation prior to admission to a nursing facility (January 1, 1989)

- Reconstructive surgery - post-mastectomy (1998)

- Rehabilitation services (physical therapy – effective 1969; other rehabilitation services – effective 1986)

- Renal dialysis clinic services

- Routine preventive medical and dental exams and immunizations, sensory and developmental screenings and immunizations are covered for all eligible members under the age of 21

- Routine preventive and wellness services, including annual wellness exams, immunizations, smoking cessation, and nutritional counseling services for the MAGI Adult (Medicaid Expansion) covered group.

- Rural Health Clinic services

- School-based services

- Services for individuals age 65 and older in institutions for mental diseases

- Specialized nursing facility services

- Speech-language therapy services

- CCC Plus Waiver services - For children and adults who are chronically ill or severely impaired, needing both a medical device to compensate for the loss of a vital body function and require substantial and ongoing skilled nursing care to avert further disability or to sustain their lives. Authorized services include Private Duty

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Nursing, Private Duty Respite Care services, Personal Care (Adults Only), Assistive Technology, Environmental Modifications and Transition services.

- Telemedicine for selected services.
- Tobacco Cessation screening, counseling and pharmacotherapies.
- Transplant services: kidney and corneal transplants, heart, lung, and liver transplants, without age limits; under EPSDT, liver, heart, lung, small bowel and bone marrow transplants and any other medically necessary transplant procedures that are not experimental or investigational, limited to persons under 21 years of age. Coverage of bone marrow transplants for individuals over 21 years of age is allowed for a diagnosis of lymphoma or breast cancer, leukemia, or myeloma.
- Transportation services related to medical care
- Treatment Foster Care Case Management

General Exclusions

Payment cannot be made under the Medicaid Program for certain items and services, and Virginia Medicaid will not reimburse providers for these non-covered services. Members have been advised that they may be responsible for payment to providers for non-covered services. Prior to the provision of the service, the provider must advise the member that he or she may be billed for the non-covered service. The provider may not bill the member for missed or broken appointments, which includes transportation services arranged by the member who is not at the pickup point or declines to get into the vehicle when the provider arrives.

Examples of such non-covered services are as follows:

- Abortions, except when the life or health of the mother is substantially endangered
- Acupuncture
- Artificial insemination or in vitro fertilization
- Autopsy examinations
- Cosmetic surgery

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- Courtesy calls - visits in which no identifiable medical service was rendered
- Custodial care
- DESI drugs (drugs considered to be less than effective by the Food and Drug Administration)
- Domestic services (except for those approved as part of personal care services or homemaker services under BabyCare or EPSDT)
- Experimental medical or surgical procedures
- Eyeglass services for members age 21 and over
- Fertility Services - Services to promote fertility are not covered. However, if there is a disease of the reproductive system that requires treatment to maintain overall health, the medical procedure will be covered
- Free services - Services provided free to the general public cannot be billed to Medicaid; this exclusion does not apply where items and services are furnished to an indigent individual without charge because of his or her inability to pay, provided the provider, physician, or supplier bills other patients to the extent that they are able to pay
- Items or services covered under a workers' compensation law or other payment sources
- Meals-on-Wheels or similar food service arrangements and domestic housekeeping services which are unrelated to patient care
- Medical care provided by mail or telephone (not including telemedicine)
- Medical care provided in freestanding psychiatric hospitals except through EPSDT and SUD waiver, or for individuals aged 65 and over
- Personal comfort items
- Physician hospital services for non-covered hospital stays

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- Private duty nursing services – Other than for children under an appropriate waiver or EPSDT and adults under the appropriate waiver
- Procedures prohibited by State or federal statute or regulations
- Prostheses (other than limbs, and the items necessary for attaching them, and breast prostheses)
- Psychological testing done for purposes of educational diagnosis or school admission or placement
- Routine foot care
- Screening services: Exceptions: Pap smears, mammograms, and PSA tests consistent with the guidelines published by the American Cancer Society.
- Services determined not to be reasonable and/or medically necessary
- Services to persons age 21 to 65 in mental hospitals
- Sterilizations when the patient is under age 21 or legally incompetent
- Supplies and equipment for personal comfort, such as adult diapers except when provided as durable medical equipment, "Lifecall" systems (except under the EDCD, DD, and Intellectual Disability Waivers), and air cleaners
- Unkept or broken appointments
- Unoccupied nursing facility beds except for therapeutic leave days for nursing facility patients
- Weight loss programs

MEMBER COPAYS

COPAYS ARE THE SAME FOR CATEGORICALLY NEEDY MEMBERS, QUALIFIED MEDICARE BENEFICIARIES (QMBS), AND MEDICALLY NEEDY MEMBERS. COPAYS AND THEIR AMOUNTS ARE EXPLAINED IN CHAPTER

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III OF THIS MANUAL. MANAGED CARE PROGRAMS

Coverage for the vast majority of Medicaid enrolled individuals is provided through one of the DMAS managed care programs, Medallion 4.0 or Commonwealth Coordinated Care Plus (CCC Plus). Medallion 4.0 and CCC Plus programs contract with the same six managed care organizations (MCOs), and all MCOs offer coverage statewide. In addition, both CCC Plus and Medallion 4.0 provide services that help keep people healthy as well as services that focus on improving health outcomes. For more information on the current health plans, please visit www.dmas.virginia.gov.

Medallion 4.0 serves as the delivery system for children, pregnant women, and individuals in the MAGI Adult Group who are not determined to be "medically complex." CCC Plus provides a higher acuity of care coordination services and serves as the delivery system that provides coverage for individuals who are aged, blind or disabled, or who are dually eligible for Medicare and Medicaid, or who receive long-term services and supports, or individuals in the MAGI adult group determined to be "medically complex." "Medically complex" is defined as individuals who have complex medical and/or behavioral health condition and a functional impairment, or an intellectual or developmental disability.

Individuals awaiting managed care enrollment will receive coverage through the DMAS feefor-service program for a brief period (approximately 15-45 days) until they are enrolled in managed care. Additionally, some services for managed care enrolled individuals are covered through fee-for-service; these are referred to as managed care carved-out services. Detailed information about managed care-excluded populations and carved out services for Medallion 4.0 and CCC Plus is available on the DMAS website at http://www.dmas.virginia.gov, under Managed Care Benefits.

Once enrolled in managed care, members have up to 90 days to change their plan for any reason. Members also have the ability to change their plan during their annual open enrollment period. Open enrollment varies by population and program. For the MAGI Adult (expansion) population, open enrollment is from November 1 through December 31 each year. For CCC Plus, open enrollment is from October 1through December 18 each year. For Medallion 4.0 open enrollment varies by program region. (See Managed Care Enrollment Broker section below for additional information.)

Managed Care Enrollment Broker (Maximus)

DMAS contracts with an enrollment broker, Maximus, which provides information to help Medallion and CCC Plus members select or change health plans. Members can find out which health plans contract with their primary care provider (PCP) or other provider. Providers should also let their members know which Medicaid health plans they accept.

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Members may use the following Maximus contact information for the Medallion 4.0 and CCC Plus managed care programs.

- **Medallion 4.0**
  Maximus has designed a mobile app for managed care enrollment for the Medallion 4.0 program. The app is available to download in the Apple App Store and Google Play for both iPhone and Android users.

  To get the free mobile app, search for Virginia Managed Care on the Apple App Store or Google Play and download. After downloading the app, members will log in using a two-step identification process, Medicaid ID, and social security number, or social security number and date of birth; non-members can log-in as guests.

  Similar to the website, the main capabilities of the app allow members to view their profile, compare health plans, enroll in a health plan, change health plans, and search for providers and health plan information. For more information, members can also visit the Medallion 4.0 enrollment website at: https://virginiamanagedcare.com/ or call 1-800-643-2273 or TTY: 1-800-817-6608.

- **CCC Plus**
  Members can visit the enrollment website for the CCC Plus managed care program at https://cccplusva.com/ to view the health plan comparison chart and to choose or change their health plan. Members can also call the CCC Plus Helpline at 1-834374-9159 or TTY 1-800-817-6608 for more information.

MCO Provider Reimbursement

In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan. The managed care plan may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for service individuals. For more information, please contact the individual 's managed care plan directly. Providers interested in contracting with the plans should also contact the MCO directly. MCO contact information for contracting and credentialing is available on the DMAS website:

- **Medallion 4.0** The managed care helpline for the Medallion program is 800-6432273 and the web address is https://www.virginiamanagedcare.com/
- **CCC Plus** (http://www.dmas.virginia.gov/#/cccplusinformation See “Medical Provider Update October 2017”)

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DMAS reimburses the health plans a monthly capitated fee for each member. These fees are preset, and are determined by demographics such as patient's age, sex, program designation, and locality of residence. Each MCO is responsible for developing its own network of providers and for ensuring that its delivery system has an adequate number of facilities, locations, and personnel available and accessible to provide covered services for its members. Providers who contract with a MCO must meet the MCO's contracting requirements.

Medicaid-contracted MCOs must provide all the services covered by Medicaid, at least within an equal, amount, duration, and scope as Medicaid, except for certain "carved-out services." "Carved-out" means that the client remains enrolled in the MCO plan but the carved-out services are covered and reimbursed by DMAS within DMAS program guidelines. **DMAS will NOT provide reimbursement for services provided to MCO enrolled members EXCEPT for those services carved-out specifically from the MCO contracts.** Carved-out services vary by program and are listed in the CCC Plus and Medallion 4.0 Contracts, available on the DMAS Website, in the Managed Care Benefits section. The member must present his or her Medicaid plastic ID card when receiving carved-out services.

Eligibility and MCO Enrollment Verification

Medicaid eligibility and managed care enrollment coverage must be verified before treatment is provided. Medallion and CCC Plus members will have a MCO identification card and a Medicaid card. Medallion and CCC Plus MCO providers must adhere to their contract with the MCO regarding referrals, prior authorization, and billing requirements. Service authorization from the member's MCO is required for any out-of-network services, *except for emergency and family planning services.* The provider is responsible for ensuring that proper referrals and service authorizations are obtained. If the MCO denies authorization for a service, the member may exercise his right to appeal to the MCO. Members can also appeal to DMAS after first exhausting the MCO's appeal process. A provider may bill a member only when the provider has provided advanced written notice to the member, prior to rendering services that their MCO/Medicaid will not pay for the service. The notice must also share that the provider is accepting the member as a private pay patient, not as a Medicaid patient and the services being provided are the financial responsibility of the patient. Failure to confirm Medicaid eligibility and MCO coverage can result in a denial of payment.

To verify eligibility, call the MCO's enrollment verification system or the DMAS MediCall line at 1-800-772-9996 or 1-800-884-9730 (outside of Richmond), or (804) 965-9732 or (804) 965-9733 for Richmond and the surrounding counties. Eligibility information is also

available using the web-based Automated Response System (ARS). When using the DMAS MediCall line or the ARS system, MCO information, if applicable, follows Medicaid eligibility information.

Continuity of Care

The Department attempts to make the transition between fee-for-service Medicaid and the MCO seamless whenever possible. As a result there is a process to ensure that the Medicaid information and authorization information is transferred and honored. In order to assure continuity of care for members enrolled in MCOs, the following procedures are used:

- The Member's MCO shall assume responsibility for all managed care contract covered services authorized by either the Department or a previous MCO, which are rendered after the MCO enrollment effective date, in the absence of a written agreement otherwise. For on-going services, such as home health, outpatient mental health, and outpatient rehabilitation therapies, etc., the member's MCO shall continue authorized services without interruption until the Contractor completes its utilization review process to determine medical necessity of continued services or to transition services to a network provider;
- DMAS shall assume responsibility for all covered services authorized by the member's previous MCO which are rendered after the effective date of dis-enrollment to the feefor-service system, if the member otherwise remains eligible for the service(s), and if the provider is a Medicaid provider;
- If the prior authorized service is an inpatient stay, the claim should be handled as follows:
  - If the provider contracts with the MCO under a per diem payment methodology, the financial responsibility shall be allocated between the member's current MCO and either DMAS or the new MCO. In the absence of a written agreement otherwise, the member's current MCO and DMAS or the new MCO shall each pay for the period during which the member is enrolled with the entity.
  - If the provider contracts with the MCO under a DRG payment methodology, the MCO is responsible for the full inpatient hospitalization from admission to discharge, including any outlier charges.
- If services have been authorized using a provider who is out of network, the member's MCO may elect to reauthorize (but not deny) those services using an in-network provider.

FAMILY ACCESS TO MEDICAL INSURANCE SECURITY (FAMIS) PLAN

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP).

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Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner.

Virginia's Title XXI program is known as FAMIS and is a comprehensive health insurance program for Virginia's children from birth through age 18 who are not covered under other health insurance and whose income is over the Medicaid income limit and under 200 percent of the Federal Poverty Level. FAMIS is administered by DMAS and is funded by the state and federal government.

FAMIS Covered Services

FAMIS covered services are somewhat different from Medicaid covered services. One of the key differences is that most children enrolled in the FAMIS Program are not eligible for EPSDT treatment services. Children who are eligible for the FAMIS program must enroll with a Managed Care Organization (MCO). Although FAMIS enrollees receive well child visits, they are not eligible for the full EPSDT treatment benefit.

The following services are covered for FAMIS enrollees:

- Abortion only if necessary to save the life of the mother
- Behavioral therapies including, but not limited to, applied behavior analysis;
  - Assistive technology
  - Blood lead testing
- Chiropractic with benefit limitations
- Clinic services (including health center services) and other ambulatory health care services
- Community Mental Health Rehabilitation Services (CMHRS) including:
  - Intensive in-home services
  - Therapeutic day treatment
- Mental health crisis intervention
- Case management for children at risk of (or with) serious emotional disturbance
- Dental services (includes diagnostic, preventive, primary, orthodontic, prosthetic and complex restorative services)
- Durable medical equipment, prosthetic devices, hearing aids, and eyeglasses with certain limitations
- Disposable medical supplies
- Early Intervention services including targeted case management
- Emergency hospital services
- Family planning services, including coverage for prescription drugs and devices approved by the U.S. Food and Drug Administration for use as contraceptives

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- Gender dysphoria treatment services
- Home and community-based health care services (includes nursing and personal care services, home health aides, physical therapy, occupational therapy, and speech, hearing, and inhalation therapy)
- Hospice care including care related to the treatment of the child's condition with respect to which a diagnosis of terminal illness has been made
- Inpatient substance abuse treatment services, with the following exceptions: services furnished in a state-operated mental hospital, services furnished in IMDs, or residential services or other 24-hour therapeutically planned structural services
- Inpatient services (365 days per confinement; includes ancillary services)
- Inpatient acute mental health services in general acute care hospital only. Does not include those (a) services furnished in a state-operated mental hospital, (b) services furnished by IMDs, or (c) residential services or other 24-hour therapeutically planned structural services
- Maternity services including routine prenatal care
- Medical formula, enteral/medical foods (sole source, specialized formula – not routine infant formula)
- Nurse practitioner services, nurse midwife services, and private duty nursing services are covered. Skilled nursing services provided for special education students are covered with limitations
- Organ transplantation
- Outpatient mental health services, other than services furnished in a state-operated mental hospital
- Outpatient substance abuse treatment services, other than services furnished in a state-operated mental hospital. These include intensive outpatient, partial hospitalization, medication assisted treatment, case management, and peer support services
- Outpatient services, including emergency services, surgical services, clinical services, and professional provider services in a physician's office or outpatient hospital department
- Outpatient diagnostic tests, X-rays, and laboratory services covered in a physician's office, hospital, independent and clinical reference lab (including mammograms);
- Prescription drugs (mandatory generic program) and over-the-counter (optional for managed care)
- Peer support services
- Physician services, including services while admitted in the hospital, or in a physician's office, or outpatient hospital department
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
- School based health services

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- Skilled nursing facility
- Surgical services
- Transportation - professional ambulance services only to medically necessary covered services (fee-for-service members have routine access to and from providers of covered medical services)
- Vision services
- Well-child care, including visits, laboratory services as recommended by the American Academy of Pediatrics Advisory Committee, and any immunizations as recommended by the Advisory Committee on Immunization Practice (ACIP)

Member Copays

FAMIS does not have yearly or monthly premiums. However, children who are enrolled in a MCO must pay co-payments for some covered services. There are no co-payments required for preventative services such as well-child care, immunizations, or dental care. The chart below shows the co-payment amounts for some basic FAMIS services for children who are enrolled in a MCO, based on co-pay status.

NOTE: Native Americans and Alaskan Natives do NOT have any co-payments.

SERVICE*	**Co-pay Status 1**	**Co-pay Status 2**
Outpatient Hospital or Doctor	$2 per visit	$5 per visit
Prescription Drugs	$2 per prescription	$5 per prescription
Inpatient Hospital	$15 per admission	$25 per admission
Non-emergency use of Emergency Room	$10 per visit	$25 per visit
Yearly Co-payment Limit per Family	$180	$350

*Other co-payments may apply to other services.

EMERGENCY MEDICAID SERVICES FOR ALIENS

Section 1903v of the Social Security Act (42 U.S.C. 1396b) requires Medicaid to cover emergency services for specified aliens when these services are provided in a hospital emergency room or inpatient hospital setting. (See Chapter III for details on eligibility.)

The medical conditions subject to this coverage may include, but are not limited to, the following:

- Cerebral vascular attacks

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- Traumatic injuries
- Childbirth
- Acute coronary difficulties
- Emergency surgeries (i.e., appendectomies)
- Episodes of acute pain (etiology unknown)
- Acute infectious processes requiring intravenous antibiotics
- Fractures

To be covered, the services must meet emergency treatment criteria and are limited to:

- Emergency room care
- Physician services
- Inpatient hospitalization not to exceed limits established for other Medicaid members
- Ambulance service to the emergency room or hospital
- Inpatient and outpatient pharmacy services related to the emergency treatment

Hospital outpatient follow-up visits or physician office visits related to the emergency care are not included in the covered services.

CLIENT MEDICAL MANAGEMENT (CMM)

The Client Medical Management Program (CMM) for members and providers is a utilization control and case management program designed to promote proper medical management of essential health care and, at the same time, promote cost efficiency. The basis for CMM member and provider restriction procedures is established through federal regulations in 42 CFR 431.54(e-f) and state regulations as set forth in 12 VAC 30-130-800 through 12 VAC 30-130-820. (See the "Exhibits" section at the end of this chapter for detailed information on the CMM Program.)

Providers may refer Medicaid patients suspected of inappropriately using or abusing Medicaid services to DMAS's Recipient Monitoring Unit. Referred members will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician and/or pharmacy in the Client Medical Management Program.

Referrals may be made by telephone or in writing. The number for the Recipient Monitoring Unit is (804) 786-6548 or toll-free (888) 323-0589. Referrals can also be faxed to (804) 3718891. Office hours are 8:15 a.m. – 5:00 p.m., Monday through Friday except state holidays. Voice mail receives after-hours referrals.

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Written referrals should be mailed to:

Lead Analyst, Recipient Monitoring Unit
Division of Program Integrity
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

When making a referral, provide the member's name and Medicaid number and a brief statement regarding the nature of the utilization problems. Copies of pertinent documentation, such as emergency records, would be helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

SOURCES OF INFORMATION

MediCall Automated Voice Response System

Toll-free numbers are available 24-hours-per-day, seven days a week, to confirm member eligibility status, claim status and check status. The numbers are:

1-800-772-9996	Toll-free throughout the United States
1-800-884-9730	Toll-free throughout the United States
(804) 965-9732	Richmond and Surrounding Counties
(804) 965-9733	Richmond and Surrounding Counties

Providers access the system using their Virginia Medicaid provider number as identification. Specific instructions on the use of the verification systems are included in "Exhibits" at the end of this chapter.

Automated Response System (ARS)

Providers may use the Internet to verify member eligibility and perform other inquiry functions. Inquiries can be submitted in real-time. Specific instructions on the use of the ARS are included in "Exhibits" at the end of this chapter.

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HELPLINE

A toll-free "HELPLINE" is available to assist providers in interpreting Medicaid policy and procedures and in resolving problems with individual claims. The HELPLINE numbers are:

- (804)786-6273 Richmond Area & out-of-state long distance
- 1-800-552-8627 In-state long distance (toll free)

The HELPLINE is available Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays.

The Virginia Medicaid provider number must accompany all provider inquiries (both written and via the HELPLINE). All provider information and data are filed by provider number. This number will expedite recovery of the requested information.

Do not use these HELPLINE numbers for member eligibility verification and eligibility questions. Local departments of social services are responsible for supplying information to members, and members who have questions about the Medicaid Program should be directed to their local departments of social services. If MediCall is not available, the data will also be unavailable to the HELPLINE (when the system is down).

The Medicaid HELPLINE and MediCall numbers are for provider use only and should not be given to members.

ELECTRONIC FILING REQUIREMENTS

The Virginia MMIS is HIPAA-compliant and, therefore, supports all electronic filing requirements and code sets mandated by the legislation.

The Virginia MMIS will accommodate the following Electronic Data Interchange (EDI) transactions according to the specifications published in the ASC X12 Implementation Guides version 4010A1.

- 837P for submission of professional claims
- 837I for submission of institutional claims
- 837D for submission of dental claims
- 276 & 277 for claims status inquiry and response
- 835 for remittance advice information for adjudicated (paid and denied) 270 & 271 for eligibility inquiry and response
- 278 for prior authorization request and response.

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Although not mandated by HIPAA, DMAS has opted to produce an unsolicited 277 transaction to report information on pended claims.

If you are interested in receiving more information about utilizing any of the above electronic transactions, your office or vendor can obtain the necessary information at our fiscal agent's website: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal.

PROVIDER MANUAL UPDATES

This manual is designed to accommodate new pages as further interpretations of the law and changes in policy and procedures are made. Accordingly, revised pages or sections will be issued by the Department of Medical Assistance Services (DMAS) as needed.

NOTICE OF PROVIDER RESPONSIBILITY

The provider is responsible for reading and adhering to the policies and regulations explained in this manual and for ensuring that all employees do likewise. The provider also certifies by his or her personal signature or the signature of an authorized agent on each invoice that

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all information provided to the Department of Medical Assistance Services is true, accurate, and complete. Satisfaction and payment of any claim will be from federal and State funds, and any provider who submits false claims, statements, or documents may be prosecuted under applicable federal or State laws.

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EXHIBITS

THE VIRGINIA MEDICAL ASSISTANCE MEDICALL SYSTEM

GENERAL INFORMATION

The Virginia Medical Assistance MediCall System offers Medicaid providers twenty-fourhour-a-day, seven-day-a-week access to current member eligibility information, check status, claims status, prior authorization information, service limit information, pharmacy prescriber identification number cross reference, and information to access member eligibility and provider payment verification via the Internet. MediCall is an enhancement to the previous Medicaid Audio Verification Response System (AVRS).

Not only does MediCall offer providers flexibility in choosing the time of day for their inquiries, but it also makes efficient use of staff time. A valid provider number and a touchtone telephone are required to access MediCall.

To reach an operator while using the member eligibility verification feature of MediCall, key "0" at any prompt within the Member Eligibility menu. Operator assisted calls are limited to three name searches per call. The operator will not be able to return the caller to MediCall for further inquiries. Operators are available from 8:30 a.m. to 4:30 p.m. Eastern time, Monday through Friday except for state holidays.

MediCall prompts the caller throughout the inquiry, giving and receiving only essential, pertinent information. The data provided is the most up-to-date information available, direct from the Medicaid eligibility, claims and remittance databases. If the caller waits too long to respond to a system prompt, the call will be disconnected.

System downtime will be scheduled during non-peak hours. If the caller dials MediCall during this time, the caller will be informed that the system is unavailable. System downtime is typically scheduled for:

2:00 a.m. to 4:00 a.m. Daily 2:00 a.m. to 6:30 a.m. Thursday
10:00 p.m. Saturday to 6:00 a.m. Sunday

The telephone numbers are:

1-800-772-9996	Toll-free throughout the United States
1-800-884-9730	Toll-free throughout the United States
(804) 965-9732	Richmond and Surrounding Counties
(804) 965-9733	Richmond and Surrounding Counties

If you have any questions regarding the use of MediCall, contact the Medicaid Provider "HELPLINE." The HELPLINE is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except State holidays, to answer questions. The HELPLINE numbers are:

1-804-786-6273 Richmond Area and out of state long distance 1-800-552-8627 In state long distance (toll-free)

HOW TO USE THE SYSTEM

To access MediCall, the provider must have a currently active Medicaid provider number. The provider's number is verified before access to MediCall is authorized.

Responses by the caller to MediCall are required within a specified period of time. If the time limit is exceeded, the call will be disconnected. The caller should have the following information available before calling:

- 10 digit National Provider Identifier (NPI) or Atypical Provider Identifier (API)
- Member Medicaid Number (12 digits) or Social Security Number (9 digits) **and** Date of Birth (8 digits) in month, day, century and year format (mmddyyyy) (necessary for member eligibility verification and claims status)
- From and Thru Date(s) of Service in month, day, century and year format (mmddyyyy) (necessary for member eligibility verification and claims status). The caller will have the following limits when entering dates of service:
- The caller does not have to enter a **Thru** date of service if services were rendered on a single day. Pressing the # key prompts the system to continue.
- Future month information is only available in the last week of the current month.
- Inquiries cannot be on dates of service more than one year prior to the date of inquiry.

After dialing the MediCall number, the system will ask for the NPI or API. Enter the 10 digit number and select from the following options:

- Press “1” for member eligibility verification.
- Press “2” for claims status.
- Press “3” for recent check amounts.
- Press “4” for service authorization information.
- Press “5” for service limit information.

MEMBER ELIGIBILITY VERIFICATION

Enter the From and Thru dates of service. **The service dates for member eligibility verification cannot span more than 31 days.** When the dates of service have been entered, MediCall will verify the information and respond by speaking the first six letters of the last name and the member's Medicaid number for confirmation.

Remain on the line to obtain important member information that might affect payment, such as:

- Special Indicator Codes (Copayment)
- Client Medical Management Information Including Pharmacy/Physician Telephone Number
- Medicare Eligibility
- Other Insurance Coverage
- Special Coverage (QMB, QMB--Extended)
- "MEDALLION" Participation (prior to July, 2012)
- Managed Care Organization provider name and assignment dates

At this point, MediCall will prompt the caller for the next action. The caller may ask for additional dates of service on this member, or may inquire on another member.

The caller may check up to **three** dates of service for each member and inquire on up to **three** members per call.

If the caller is using a Social Security Number instead of the member ID number, the dates of service will relate to the first member ID reported. If multiple open records exist for the same Social Security Number, you will be advised to contact the local department of social services. You will be given a 3-digit city/county code of the appropriate agency and a 5-digit caseworker code. A cross-reference list of the city/county codes is provided as an exhibit to this chapter.

The caller will receive a "not eligible" response if the future dates about which he or she inquires are beyond the information on file.

A response, "not eligible," will be given if the member is not eligible for all days within the time span entered.

PROVIDER CHECK LOG

The most recent check information is presented by invoice type. This inquiry permits the provider to receive check dates and amounts from the most recent three remittances.

CLAIMS STATUS

For claims status information, the MediCall system will prompt the provider to choose the among the following invoice types (additional information in italics).

- For inpatient care, press 01.
- For long-term care, press 02.
- For outpatient hospital, home health or rehabilitation services, press 03.
- For personal care, press 04.
- For practitioner (physician CMS-1500 billing), press 05.
- For pharmacy, press 06.
- For independent labs (outpatient lab services), press 08.
- For Medicare crossover, press 09.
- For dental, press 11.
- For transportation, press 13.

For claims status, the From date cannot be more than 365 days in the past. The Thru date cannot be more than 31 days later than the From date. After keying the member identification number and the From and Thru date(s) of service, MediCall will provide the status of each claim up to and including five claims. MediCall will prompt for any additional claims or return to the main menu.

SERVICE AUTHORIZATION INFORMATION

The From and Thru dates for prior authorization cannot span more than 365 days. When the 12-digit member ID number and the 8-digit from and through dates of service have been entered, you will be prompted to enter the 11-digit prior authorization number, if known. If you do not know the prior authorization number, then press the pound (#) key. MediCall will verify prior authorization data on file. The system will prompt you to return additional prior authorization data for the same member and dates, enter new dates for the

same member, another prior authorization number for the same member or to enter another member ID number to begin a new inquiry.

SERVICE LIMITS INFORMATION

Service limits can be obtained by service type or procedure code:

- For occupational therapy, press 1. For physical therapy, press 2 For speech therapy, press 3.
- For home health aide, press 4.
- For home health skilled nursing, press 5.
- For DME purchases, press 6 and for DME rentals, press 7.

For occupational therapy, speech therapy or physical therapy the MediCall system will return non-school based and school based service limits separately.

PRESCRIBING PROVIDER ID

Only enrolled Pharmacy providers can access this choice. When prompted, the caller should enter the license number of the prescriber. MediCall will return the first six letters of the prescriber's last name and Medical Assistance provider number. If the prescriber is not active in Virginia Medicaid, you will receive a message that the number is not on file.

The Automated Response System (ARS)

GENERAL INFORMATION

The Automated Response System (ARS) offers Medicaid and FAMIS providers twenty-fourhour-a-day, seven-day-a week Internet access to current member eligibility information, service limits, claim status, service authorizations, and provider payment history. This weenabled tool helps provide cost-effective care for members, and allows providers to access current information quickly and conveniently.

The ARS can be accessed through the Virginia Medicaid Web portal at www.virginiamedicaid.dmas.virginia.gov. Please visit the portal for information on registration and use of the ARS.

CITY/COUNTY CODES

(The Three-Digit Numerical Identifier
of the Local Social Services/Welfare Agency Currently Handling the Case)

If two or more member records using the same SSN are active on the same date of service, inquirers are prompted to contact the Social Services agency for resolution.

COUNTIES

001	Accomack	049	Cumberland	097	King and Queen
003	Albermarle	051	Dickenson	099	King George
005	Alleghany	053	Dinwiddie	101	King William
007	Amelia	057	Essex	103	Lancaster
009	Amherst	059	Fairfax	105	Lee
011	Appomattox	061	Fauquier	107	Loudoun
013	Arlington	063	Floyd	109	Louisa
015	Augusta	065	Fluvanna	111	Luneburg
017	Bath	067	Franklin	113	Madison
019	Bedford	069	Frederick	115	Mathews
021	Bland	071	Giles	117	Mecklenburg
023	Botetourt	073	Gloucester	119	Middlesex
025	Brunswick	075	Goochland	121	Montgomery
027	Buchanan	077	Grayson	125	Nelson
029	Buckingham	079	Greene	127	New Kent
031	Campbell	081	Greensville	131	Northampton
033	Caroline	083	Halifax	135	Nottoway
035	Carroll	085	Hanover	137	Orange
037	Charlotte	087	Henrico	139	Page
041	Chesterfield	089	Henry	141	Patrick
043	Clarke	091	Highland	143	Pittsylvania
045	Craig	093	Isle of Wight	145	Powhatan
047	Culpeper	095	James City	147	Prince Edward
149	Prince George	167	Russell	179	Stafford
153	Prince William	169	Scott	181	Surry
155	Pulaski	171	Shenandoah	183	Sussex
157	Rappahannock	173	Smyth	185	Tazewell
159	Richmond	175	Southampton	187	Warren
161	Roanoke	177	Spotsylvania	191	Washington
193	Westmoreland	195	Wise	197	Wythe
199	York				

CITIES

510	Alexandria	620	Franklin	710	Norfolk
515	Bedford	630	Fredericksburg	720	Norton
520	Bristol	640	Galax	730	Petersburg
530	Buena Vista	650	Hampton	735	Poquoson
540	Charlottesville	660	Harrisonburg	740	Portsmouth
550	Chesapeake	670	Hopewell	750	Radford

570	Colonial Heights	678	Lexington	760	Richmond
580	Covington	680	Lynchburg	770	Roanoke
590	Danville	683	Manassas	775	Salem
595	Emporia	685	Manassas Park	780	South Boston
600	Fairfax	690	Martinsville	790	Staunton
610	Falls Church	700	Newport News	800	Suffolk
810	Virginia Beach	820	Waynesboro	830	Williamsburg
840	Winchester				
976	Central Processing Unit for FAMIS				

STATE MENTAL HEALTH FACILITIES

983 Southern Virginia Mental Health Institute
- 985 Southeastern State Hospital
- 986 Northern Virginia Training Center
- 987 Virginia Treatment Center
- 988 Northern Virginia Mental Health Institute
- 990 Central Virginia Training Center
- 991 Western State Hospital
- 992 Southwestern State Hospital
- 993 Piedmont State Hospital
- 994 Eastern State Hospital
- 996 Hiram Davis Hospital
- 997 Catawba State Hospital

CLIENT MEDICAL MANAGEMENT INTRODUCTION

The Client Medical Management Program (CMM) for members and providers is a utilization control and case management program designed to promote proper medical management of essential health care and, at the same time, promote cost efficiency. The basis for CMM member and provider restriction procedures is established through federal regulations in 42 CFR 456.3 and state regulations as set forth in 12 VAC 30-130-800 through 12 VAC 30130-810.

MEMBER RESTRICTION

Utilization Review and Case Management

Federal regulations allow states to restrict members to designated providers when the members have utilized services at a frequency or amount that is not medically necessary. Restricted members are identified and managed by the Recipient Monitoring Unit (RMU) in the Division of Program Integrity.

CMM enrollment is based upon review of the individual member's utilization patterns. All Medicaid members except MCO members and institutionalized long-term care residents are eligible for utilization review by RMU staff. If the member's utilization patterns meet the criteria for enrollment in CMM, the member is notified to select designated primary providers. Examples of inappropriate utilization are:

- Emergency room use for medical problems that could be treated in a physician's office;
- Using more than one physician and/or pharmacy to receive the same or similar medical treatment or prescriptions; and
- A pattern of non-compliance which is inconsistent with sound fiscal or medical practices.

Each CMM member is assigned a case manager in the Recipient Monitoring Unit to assist both members and providers with problems and questions related to CMM. The case manager is available to:

- Resolve case problems related to CMM procedures and provider assignments;
- Counsel the member on the appropriate access to healthcare;
- Approve/deny requests for provider changes; and
- Complete a utilization review prior to the end of the enrollment period to determine if CMM restriction should be extended.

Member Enrollment Procedures

Members identified for CMM enrollment receive a letter explaining the member/provider relationships under medical management. The letter includes the Member/Primary Provider

Agreement forms (see the sample forms at the end of this section) with directions for completing and returning the form to the Recipient Monitoring Unit. Members are given thirty (30) days to select their primary providers by obtaining their signatures on the form. The provider's signature indicates agreement to participate as the CMM provider for the member. DMAS reviews member requests for specific providers for appropriateness and to ensure member accessibility to all required medical services.

Members also have thirty (30) days from the receipt of the restriction notice to appeal enrollment in CMM. Assignment to designated providers is not implemented during the appeal process.

CMM enrollment is for 24 months. Assignment to both a physician and pharmacy is made with few exceptions.

When members do not return choices to the Recipient Monitoring Unit or have difficulty in finding providers, RMU staff will select providers for them. RMU staff contact providers directly to request participation as a CMM provider for the member and follow-up by mailing or faxing the agreement form for the provider's signature.

When completed agreement forms are received, the member is enrolled in CMM effective the first of the next month in which a restricted Medicaid card can be generated. Both members and selected providers are notified by mail of the enrollment date.

Members enrolled in the Client Medical Management can be identified through the process of eligibility verification. A swipe of the Medicaid ID card will return the names and telephone numbers of the primary care physician and designated pharmacy. The dates of assignment to each provider are also included. This information is also available through the MediCall System and the web-based Automated Response System (ARS). Instructions for both resources are provided in this chapter.

Each CMM member also receives an individual Medicaid coverage letter with the name(s) and address of the designated primary health care provider and/or designated pharmacy printed on the front each time there is a change in providers.

Designated Primary Care Physicians (PCP)

Any physician enrolled in Medicaid as an individual practitioner may serve as a designated primary care physician (PCP) except when:

- The physician's practice is limited to the delivery of emergency room services; or
- The physician has been notified by DMAS that he or she may not serve as a designated provider, covering provider, or referral provider for restricted members.

Federally Qualified Community Health Centers (FQHCs) and Rural Health Clinics (RHCs) may serve as PCPs also. Other provider types such as ambulatory care centers may be established as designated providers as needed but only with the approval of DMAS.

Primary care physicians are responsible for coordinating routine medical care and making referrals to specialists as necessary. The PCP must arrange 24-hour coverage when they are not available and explain to their assigned members all procedures to follow when the office is closed or when there is an urgent or emergency situation.

The provider's *NPI number* is used for billing and referral purposes.

Designated Pharmacies

Any pharmacy enrolled as a community pharmacy billing on the Pharmacy Claim Form or other acceptable media may serve as a designated pharmacy unless the pharmacy has been notified by DMAS that it may not serve as a designated provider.

Designated pharmacies must monitor the member's drug regimen. The pharmacist should fill prescriptions from the PCP, referred physicians, and emergency prescriptions. Referrals can be confirmed by reviewing the member's copy of the referral form or by contacting the PCP's office. Close coordination between the PCP and the pharmacist, particularly if a medication problem has been identified, is a very important component of the program.

Changing Designated CMM Providers

The member or designated provider may initiate a request for a change of a designated provider by contacting the Recipient Monitoring Unit. Designated providers requesting a change must notify the member in addition to contacting RMU. If the designated provider requests the change and the member does not select a new provider by the established deadline, RMU shall select for them.

All changes must be preauthorized by DMAS RMU staff. The member's RMU case manager may contact the provider before making a final decision on the change request to try to resolve questions or issues and avoid unnecessary changes. If DMAS denies a member's request, the member shall be notified in writing and given the right to appeal the decision. Changes are allowed for:

1. Relocation of the member or provider;
2. Inability of the designated provider to meet the routine medical/pharmaceutical needs of the member; or
3. Breakdown of the relationship between the provider and member.

Provider changes can occur any time of the month because the effective date is the date the new provider signs the Member/Primary Provider Agreement form. When a new provider is assigned, RMU mails a letter to the member confirming the effective date of the change. The letter instructs the member *to show the letter with the Medicaid identification card.*

Letters go to the affected providers also. All verification inquiries will return the new primary provider from the date it is entered into the computer system.

A PCP No Longer in Practice

If a provider leaves the practice or retires, he or she must notify CMM so that the restricted member can be reassigned to a new PCP.

Covered Services and Limitations

Under CMM, DMAS will pay for covered outpatient medical and/or pharmaceutical services only when they are provided (1) by the designated providers, (2) by physicians seen on written referral from the PCP, (3) by covering providers linked with the designated provider in a CMM Affiliation Group, or (4) in a medical emergency. A medical emergency means that a delay in obtaining treatment may cause death or serious impairment of the health of the member. Payment for covered outpatient services will be denied in all other instances (unless the covered services are excluded from Client Medical Management Program requirements), and the member may be billed for the services.

All services should be coordinated with the designated provider. The CMM PCP referral does not override Medicaid service limitations. All DMAS requirements for reimbursement, such as pre-authorization, still apply as indicated in each provider manual.

Physician Services

A Medicaid-enrolled physician who is not the PCP may provide and be paid for outpatient services to these members only:

- In a medical emergency situation in which a delay in the treatment may cause death or result in lasting injury or harm to the member.
- On written referral from the PCP using the Practitioner Referral Form (DMAS-70). This also applies to covering physicians who have not been affiliated with the PCP.
- When they are a part of a CMM provider affiliation group that includes the PCP.
- For other services covered by DMAS which are excluded from the Client Medical Management Program requirements.

Services Excluded from PCP Referral

These services should be coordinated with the primary health care provider whose name appears on the member's eligibility card, but they are excluded from special billing instructions for the Client Medical Management Program.

Covered services that do not need a referral include:

- Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) wellchild exams and screenings (members under age 21);
- Immunizations (member under age 21);
- Family planning services;
- Expanded prenatal services, including prenatal group education, nutrition services, and homemaker services for pregnant women and care coordination for high-risk pregnant women and infants;
- Dental services (members under age 21);
- Services provided under Home and Community-Based Care Waivered Services;
- Hospice services;
- Renal dialysis services;
- Routine vision care services (routine diagnostic exams for members of all ages and eyeglasses for members under age 21). Medical treatment for diseases of the eye and its appendages still requires a written referral;
- Audiology services;
- Podiatry services;
- Prosthetic services;
- MH/ID community rehabilitative services;
- Psychiatric diagnostic and therapeutic services (limited sessions of outpatient treatment);
- Inpatient hospital services;
- Life-threatening medical emergencies; and
- School-based services.

CMM Provider Affiliation Groups

Physician affiliation groups allow covering physicians to see each other's patients without a written referral. CMM affiliations may be set up for physicians within a practice or for the single practitioner who arranges coverage by a physician not sharing office space.

Affiliations can be open-ended or for a specified period of time (such as when the PCP is away from the office for days or weeks). CMM affiliations may include physicians, Rural Health Clinics, Federally Qualified Health Clinics (FQHC), and nurse practitioners.

Affiliations are not member-specific. This means that once provider numbers are affiliated, claims will pay for all CMM members who receive services from a member of an affiliation group that includes the member's PCP on the date of service.

The PCP requests affiliation by completing the CMM Provider Affiliation Form (see sample form at the end of this section) and returning it to the Recipient Monitoring Unit (RMU). The form is used to set up a new affiliation group or to update a group. Providers are responsible for notifying DMAS when a new provider joins the group or a provider leaves the group to ensure claims are processed correctly. Contact the Recipient Monitoring Unit at (804) 786-6548 in Richmond, or toll-free at 1-888-323-0589, to request a form.

Emergency Room Services

Outpatient hospital emergency room services for restricted members are limited to reimbursement for medical emergencies. Emergency hospital services means that the threat to the life or health of the member necessitates the use of the most accessible hospital facility available that is equipped to furnish the services. Reimbursement may be conditional upon the review of the emergency-related diagnosis or trauma ICD diagnosis codes and the necessary documentation supporting the need for emergency services. Additional guidelines for payment of medical services provided in the outpatient hospital emergency room setting are listed in Chapter IV "Covered Services" in this manual.

CMM clients must have a written PCP referral in order for non-emergency services provided in the emergency room to be reimbursed at an all-inclusive rate. The PCP must use the Practitioner Referral Form, DMAS-70. Payment will be denied without a referral unless there is a life-threatening emergency. Non-emergency services provided without a PCP referral become non-covered services, and the member is responsible for the full cost of the emergency room visit.

CMM also requires a PCP referral form for:

- Reimbursement to CONSULTING physicians who treat a CMM client in the emergency room setting, and
- Reimbursement for any follow-up outpatient or office consultations resulting from an ER visit.

Emergency Pharmacy Services

Prescriptions may be filled by a non-designated pharmacy only in emergency situations (e.g., insulin or cardiac medications) when the designated pharmacy is closed or the designated pharmacy does not stock or is unable to obtain the drug.

<u>Provider Reimbursement and Billing Instructions</u>

Management Fees

Each physician, FQHC, or Rural Health Clinic that serves as a CMM primary care provider (PCP) receives a monthly case management fee of $5.00 for each assigned CMM member. Payment is made through a monthly remittance process. PCPs receive a monthly report listing the CMM members assigned the previous month for whom payment is made.

PCP and Designated Pharmacy Providers

DMAS pays for services rendered to CMM members through the existing fee-for-service methodology. Designated providers (PCP's and pharmacies) bill Medicaid in the usual manner, but non-designated providers who are not affiliated with the CMM provider must follow special billing instructions. Complete instructions for the CMS 1500 (08-05) and UB-04 billing invoices as well as Point-of-Sale (POS) billing can be found in the billing instruction chapter of this manual.

Affiliated Providers

Providers who are affiliated with a designated CMM provider in the Medicaid system bill Medicaid in the usual manner with no special billing instructions. Claims process with a look-up to the CMM Affiliation Groups in the system.

Referral Providers

To receive payment for their services, referral providers authorized by the client's PCP to provide treatment to that client must place the Provider Identification Number of the PCP in Locator 17a (1D qualifier followed by the API number) or 17b (National Provider Identifier number of referring physician – 17B requirement effective 5/23/08) of the CMS-1500 (0805) and attach the Practitioner Referral Form.

Physicians Billing Emergency Room Services

When billing for emergency room services on the CMS-1500, the attending physician bills evaluation and management services with CPT codes 99281-99285 and enters "Y" in Block 24-C. When the PCP has referred the client to the emergency room, place the PCP's NPI number in Block 17b on the CMS -1500 and attach the Practitioner Referral form.

Facilities Billing Emergency Room Services with a Referral

When billing for emergency room services on the on the UB-04 CMS 14-50, place the PCP's provider number in space 78, and attach the Practitioner Referral Form.

Non-designated Pharmacy Providers

When billing on the Pharmacy Claim Form or as a Point-Of-Sale (POS) provider, enter code

"03" in the "Level of Service" field to indicate emergency.

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT PROGRAM

DMAS providers may refer Medicaid patients suspected of inappropriate use or abuse of Medicaid services to the Recipient Monitoring Unit (RMU) of the Department of Medical Assistance Services. Referred members will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician or pharmacy in the Client Medical Management (CMM) Program. See "Exhibits" at the end of Chapter I for detailed information on the CMM Program. If CMM enrollment is not indicated, RMU staff may educate members on the appropriate use of medical services, particularly emergency room services.

Referrals may be made by telephone, FAX, or in writing. A toll-free helpline is available for callers outside the Richmond area. Voice mail receives after-hours referrals. Written referrals should be mailed to:

Lead Analyst, Recipient Monitoring Unit
Division of Program Integrity
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Telephone: (804) 786-6548
CMM Helpline: 1-888-323-0589

When making a referral, provide the name and Medicaid number of the member and a brief statement about the nature of the utilization problems. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

PROVIDER RESTRICTION

Restricted providers are identified and managed by the DMAS Provider Review Unit. States may restrict providers from participation in the Medicaid Program when the provider has provided items or services at a frequency or amount not medically necessary or has provided items or services of a quality that does not meet professionally recognized standards of health care. State regulations allow DMAS to restrict providers' participation as designated providers, referral providers, or covering providers for CMM restricted members when a provider has billed services at a frequency or level exceeding that which is medically necessary or when a provider's license to practice has been revoked or suspended in Virginia by the appropriate licensing board.

Provider restriction is for 24 months. Providers may appeal any proposed restriction in accordance with the *Code of Virginia*, Section 2.2-4000 et seq., as discussed in the chapter

containing utilization review and control information in this manual. Restriction is not implemented pending the result of a timely appeal request.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
CLIENT MEDICAL MANAGEMENT PROGRAM

PRACTITIONER REFERRAL FORM

Recipient's Name: _____ DMAS#: _____

Referred to: _____ Date: _____

Purpose of Referral (check one):

____ Physician covering in absence of primary health care provider for (specify period of absence for up to 90 days) _____

_____

____ See one time only for _____

____ See as needed for on-going treatment of _____

_____

(Referral for on-going treatment must be renewed at 90 day intervals.)

This recipient is restricted to me as his/her primary health care provider. Please refer to the billing chapter in your Medicaid Provider Manual for billing information. **This form must be part of your medical record. For reimbursement, a copy must be attached to every claim submitted on behalf of this recipient.**

If you wish to refer this patient to another source who will be billing Medicaid, you must obtain another referral form for that physician from me.

These referral provisions do not apply while the recipient is an inpatient in a hospital.

_____
Signature of Primary Health Care Provider

_____
Name of Primary Health Care Provider

Provider ID#: _____

Address: _____

_____

_____

Telephone #: (____) _____

(Instructions on Back)

DMAS-70 4/89

REFERRAL PHYSICIAN'S COPY

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES CLIENT MEDICAL MANAGEMENT PROGRAM

RECIPIENT/PRIMARY PROVIDER AGREEMENT PHYSICIAN

DATE: _____

RECIPIENT NAME:_____**DMAS#**: _____

I. My choice for primary physician is given below. I understand that Medicaid will pay for covered outpatient physician services provided by my primary physician. Other physicians will be paid only when my primary physician makes a medical referral or is unable to provide services in a medical emergency requiring immediate treatment.

RECIPIENT SIGNATURE: _____ **DATE**: _____

TELEPHONE NUMBER: _(___)_____

II. PRINT NAME AND ADDRESS OF PHYSICIAN: _____

_____

_____

I agree to undertake primary health care and make appropriate referrals to specialists for the recipient named above.

PHYSICIAN'S SIGNATURE: _____
DATE: _____

PHYSICIAN'S DMAS ID#: _____ **TELEPHONE NUMBER**: _(___)_____
(Use Virginia Medicaid Provider Billing Number)

MAIL/FAX BY _____ **TO:** _____

RECIPIENT MONITORING UNIT
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES RICHMOND, VIRGINIA 23219
600 EAST BROAD STREET, SUITE 1300

INSTRUCTIONS

1. You must sign the form in Section I. If the form is for a child, the parent or guardian must sign.

2. The physician you select must be enrolled as an individual physician with Medicaid and bill on the HCFA 1500 invoice or other acceptable media using his/her own Medicaid provider number. The physician can tell you if these requirements are met.

3. If the physician agrees to be your primary physician, ask him/her to **sign and date the form and write in the Medicaid provider number.**

4. Be sure the physician's name and the office address are **PRINTED** clearly in Section II.

5. When Sections I and II are completed, return the form to our office in the enclosed postage paid envelope. The form may also be **FAXED** to **(804) 371-8891.**

6. Any questions can be directed to the Recipient Monitoring Unit in Richmond, **(804) 786-6548** or toll free **1-888-323-0589**.

(03/03)

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES CLIENT MEDICAL MANAGEMENT PROGRAM

RECIPIENT/PRIMARY PROVIDER AGREEMENT PHARMACY

DATE: _____

RECIPIENT NAME:_____DMAS#: _____

I. My choice for designated pharmacy is given below. I understand that Medicaid will pay for covered outpatient pharmacy services from my designated pharmacy. Other pharmacies will be paid only when my designated pharmacy does not stock or cannot supply medications in a medical emergency requiring immediate treatment.

RECIPIENT SIGNATURE: _____ DATE: **_____**

TELEPHONE NUMBER: (___)

II. PRINT NAME AND ADDRESS OF PHARMACY:_____

_____

I agree to monitor the drug utilization and provide all outpatient pharmaceutical needs for the recipient named above.

PHARMACY REPRESENTATIVE'S SIGNATURE: _____DATE: _____

PHARMACY'S DMAS ID#: _____ TELEPHONE NUMBER: **_____**

(Use Virginia Medicaid Provider Billing Number)

MAIL/FAX BY _____ TO: _____ RECIPIENT MONITORING UNIT

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES RICHMOND, VIRGINIA 23219
600 EAST BROAD STREET, SUITE 1300

INSTRUCTIONS

1. You must sign the form in Section I. If the form is for a child, the parent or guardian must sign.

2. The community pharmacy you select must be a Medicaid provider that bills on the Pharmacy Claim Form or other acceptable media. The pharmacist can tell you if the pharmacy meets these requirements.

3. If the pharmacist agrees to be your designated provider, ask him/her to **sign and date the form and write in the pharmacy's National Provider Identifier.**

4. Be sure the name and address of the pharmacy is **PRINTED** clearly in Section II.

5. When Section I and II are completed, return the form to our office in the enclosed postage paid envelope. The form may also be **FAXED** to **(804) 371-8891.**

03/03

6. Any questions can be directed to the Recipient Monitoring Unit in Richmond. Call toll-free to the CMM Helpline **(1-888-323-0589)** or call **(804) 786-6548** in the Richmond Metro area**.**

SECTION I: General Information

Provider Name:		**Provider Number:**	
Business Name:		**IRS ID number**	
Street Address*:**		**Contact Person:**	
Telephone Numbers:		**Contact Phone**:	
24-hour Access:	**(Required)**	**Email:**	
Office Hours:		**FAX:**	

(*****The address *must* be a physical street address.)**

SECTION II: Service Locations

Please list all Medicaid provider identification numbers issued to you.

Medicaid Number **Medicaid Number**

SECTION III: Affiliations

Please list the names and Medicaid numbers of those associated physicians or nurse practitioners at the location listed in Section I who are to be affiliated for business and billing purposes. Use the back of this form if more space is needed.

Name	**Medicaid Number**

DO NOT WRITE BELOW THIS SPACE

03/03

RETURN FORM TO:

Recipient Monitoring Unit
Department of Medical Assistance Services
Richmond, Virginia 23219

600 E. Broad Street, Suite 1300

OFFICE USE ONLY

Affiliation Group number assigned by system

FIPS Code _____
Affiliation Group Number assigned by RMU

_____

RMU
Signature_____
___ Date
_____

_____

_ Affiliation group to include provider numbers listed in Sections II and III.

Manual Title	Chapter	Page
Developmental Disabilities Waivers (BI, FIS, CL) Services	2	
Chapter Subject	Page Revision Date	
Provider Participation Requirements	2/10/2022	

Manual Title	Chapter	Page
Developmental Disabilities Waivers (BI, FIS, CL) Services	2	
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CHAPTER 2

PROVIDER PARTICIPATION REQUIREMENTS

Manual Title	Chapter	Page
Developmental Disabilities Waivers (BI, FIS, CL) Services	2	i
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CHAPTER II
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Note: Should manual user find hyperlinks in this chapter do not work, please copy the hyperlink to clipboard and paste into browser.

MEDICAID PROGRAM INFORMATION

Federal regulations governing program operations require Virginia Medicaid to supply program information to all providers. The current system for distributing information is associated with the provider number on the enrollment file, which assures that each assigned provider receives program information. Providers enrolled at multiple locations or who are individuals of a group using one central office may receive multiple copies of updates, and other publications sent by DMAS. Individual providers may request that publications not be mailed to them by completing a written request to the Contractor – Provider Enrollment Services at the address provided in "Requests for Participation" earlier in this chapter.

All Medicaid provider manuals are available on-line on the DMAS website at http://www.virginiamedicaid.dmas.virginia.gov/ (Provider Risk table – see page 18)

PARTICIPATING PROVIDER

A participating provider is an agency or program that meets the standards and requirements set forth by the Department of Medical Assistance Services (DMAS) and has a current signed participation agreement with DMAS.

All providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their participation agreements. Providers approved for participation in the Medicaid Program must perform the following activities, as well as any others specified by DMAS:

- On a monthly basis, screen and document the names of all new and existing employees and contractors to determine whether any are excluded from eligibility for payment from federal health care programs, including Medicaid (i.e., via the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals and Entities (LEIE) website). Immediately upon learning of an exclusion, report in writing to DMAS such exclusion information to: DMAS, ATTN: Program Integrity/Exclusions, 600 East Broad Street, Suite 1300, Richmond, VA 23219 or email to providerexclusion@dmas.virginia.gov. See Provider Responsibilities to Identify Excluded Individuals and Entities section below.

- Perform criminal history record checks for barrier crimes in accordance with applicable licensure requirements at §§ 37.2-416, 37.2-506, and 37.2-600 37.2-607 of the Code of Virginia, as applicable. If the individual enrolled in the waiver is a minor child, also perform a search of the VDSS Child Protective Services Central Registry. The provider will not be compensated for services provided to the individual enrolled in the waiver effective on the date and afterwards that any of these records checks verifies that the staff person providing services was ineligible to do so pursuant to the applicable statute.

- In order to ensure compliance with CMS requirements as well as protect the privacy of those who are providing services to individuals enrolled and receiving services through the Developmental Disabilities Waivers during Quality Management Reviews, the provider must retain the following documentation and make it available upon request:
  - Verification that fingerprints were obtained and sent (copy of what was sent to include a date)
  - Verification that the results were received (letter from company indicating the results)
  - Verification, if there was evidence of a conviction, that the results were reviewed and there is a statement indicating the results were reviewed to determine if barrier crimes were or were not noted. The statement should be signed and dated with the printed name and title included)

- For consumer-directed (CD) services, the CD attendant must submit to a criminal history records check obtained by the fiscal employer agent within 30 days of employment. If the individual enrolled in the waiver is a minor child, the CD attendant must also submit to a search within the same 30 days of employment of the VDSS Child Protective Services Central Registry. The CD attendant will not be compensated for services provided to the waiver individual effective the date on which the employer of record learned, or should have learned, that the record check verifies that the CD attendant has been convicted of barrier crimes pursuant to § 37.2-416 of the Code of Virginia or if the CD attendant has a founded complaint confirmed by the VDSS Child Protective Services Central Registry (if applicable).

- The DMAS-designated fiscal employer agent will require the CD employee to notify the employer of record of all convictions occurring subsequent to the initial record check. CD employees who refuse to consent to criminal background checks and VDSS Child Protective Services Central Registry checks will not be eligible for Medicaid reimbursement. The CD employer of record will require CD employees to notify the employer of record of all convictions occurring subsequent to the initial record check.

- The CD employer of record will require CD employees to notify the employer of record of all convictions occurring subsequent to the initial record check.

- Immediately notify DMAS in writing, whenever there is a change in the information which the provider previously submitted to the Provider Enrollment Unit. For a change of address, notify –DMAS Provider Enrollment Services prior to the change and include the effective date of the change; providers must send in a letter by fax to the Provider enrollment unit at the contractor (Conduent) 804-270-7027 or 888-335-8476. Providers must include the provider NPI, Name, and have the authorized administrator sign the letter on company letterhead.

- Assure freedom of choice to individuals in seeking medical care from any institution, pharmacy, practitioner, or other provider qualified to perform the service(s) required and participating in the Medicaid Program at the time the service is performed;

- Assure the individual's freedom to refuse medical care, treatment, and services and document that potential adverse outcomes that may result from refusal of services were discussed with the individual;
- Accept referrals for services only when staff is available to initiate services within 30 calendar days of the referral and perform such services on an ongoing basis;

- Accept training on Crisis Education and Prevention Plans (CEPPs) by DBHDS, or its contractor, based on individual needs.

- For those providers licensed by DBHDS, follow DBHDS procedures to identify and report to DBHDS those individuals who are at high risk due to medical or behavioral needs or other factors that lead to a supports need level of 6 or 7. (See p. 22 "**CORRECTION TO 12VAC30-122-180 as it relates to tier four (4)")**

- Participate in the completion of Quality Service Reviews conducted by DBHDS or its contractor.

- Provide services and supports for individuals in accordance with the Individual Support Plan (ISP) and in full compliance with 42 CFR 441.301, which provides for person-centered planning and other requirements for home and community-based settings including the additional requirements for provider-owned and controlled residential settings (see "Home and Community Based Settings Requirements" later in this chapter); Title VI of the Civil Rights Act of 1964, as amended (42 USC § 2000d et seq.), which prohibits discrimination on the grounds of race, color, or national origin; the Virginians with Disabilities Act (Title 51.5 (§ 51.5-1 et seq.) of the Code of Virginia); § 504 of the Rehabilitation Act of 1973, as amended (29 USC § 794), which prohibits discrimination on the basis of a disability; and the Americans with Disabilities Act, as amended (42 USC § 12101 et seq.), which provides comprehensive civil rights protections to individuals with disabilities in the areas of employment, public accommodations, state and local government services, and telecommunications. In the event a discrimination complaint is lodged, DMAS is required to provide the Office of Civil Rights (OCR) with any evidence regarding compliance with these requirements;

- In addition to compliance with the general conditions and requirements, all providers enrolled by DMAS must adhere to the requirements outlined in federal and state laws, regulations, DMAS provider manuals, and their individual provider participation agreements;

- Provide services and supports to Medicaid individuals of the same quality and in the same mode of delivery as provided to the general public;

- Submit reimbursement claims to DMAS for the provision of covered services and supports to individuals in amounts not to exceed the provider's usual and customary charges to the general public and accept as payment in full the amount established by the DMAS payment methodology from the individual's authorization date for that waiver service.

- Providers may not bill DMAS or individuals for broken or missed appointments;
- Accept assignment of Medicare benefits for eligible Medicaid individuals;
- Use Medicaid program-designated billing forms as per chapter 5 (DD manual provider billing) for submission of claims for reimbursement;
- Maintain and retain business records (e.g., licensing or certification records as appropriate) and professional records (e.g., staff training and criminal record check documentation). All providers, including services facilitation providers, must also document fully and accurately the nature, scope, and details of the services provided to support claims for reimbursement. Provider documentation that fails to fully and accurately document the nature, scope, and details of the services provided may be subject to recovery actions by DMAS or its designee. Provider documentation responsibilities include the following:
    - Retain records for at least six years from the last date of service or as provided by applicable state and federal laws, whichever period is longer. Records of minors must be kept for at least six years after such minor has reached the age of 18 years.
    - If an audit is initiated of the provider's records within the required retention period, the records must be retained until the audit is completed and every exception resolved. No business or professional records that are subject to the audit may be created or modified by providers, employees, or any other interested parties, either with or without the provider's knowledge, once an audit has been initiated.
    - Policies regarding retention of records will apply even if the provider discontinues operation. Providers must notify DMAS in writing of storage, location, and procedures for obtaining records for review should the need arise. The location, agent, or trustee of the provider's records must be within the Commonwealth of Virginia.
    - Develop a plan for supports that includes at a minimum for each individual they support:
        - The individual's desired outcomes that describe what is important to and for the individual in observable terms;
        - Support activities and support instructions that are inclusive of skill-building as may be required by the service provided and that are designed to assist in achieving the individual's desired outcomes;
        - The services to be rendered and the schedule for such services to accomplish the desired outcomes and support activities, a timetable for the accomplishment of the individual's desired outcomes and support activities, the estimated duration of the individual's need for services, and the provider staff responsible for overall coordination and integration of the services specified in the plan for supports; and

- Documentation regarding any restrictions on the freedoms of everyday life in accordance with human rights regulations (12VAC35-115) and the requirements of 42 CFR 441.301.

- Furnish to authorized state and federal personnel, in the form and manner requested, access to provider records and facilities;

- Make available, as may be requested, specific, relevant information about the individual enrolled in the waiver;

- Follow the following documentation requirements:

  - Prepare and maintain unique person-centered progress note written documentation in each individual's record about the individual's responses to services and rendered supports and of specific circumstances that prevented provision of the scheduled service, should that occur. Such documentation should be written, signed, and dated on the day the described supports were provided. However, documentation that occurs after the date services were provided must be dated for the date the entry is recorded and the date of actual supports delivery is to be noted in the body of the note. In instances when the individual does not communicate through words, the provider must note his observations about the individual's condition and observable responses, if any, at the time of service delivery.

  - Examples of unacceptable person-centered progress note written documentation include:

    - Standardized or formulaic notes;
    - Notes copied from previous service dates and simply re-dated;
    - Notes that are not signed and dated by staff who deliver the service, with the date services were rendered; and
    - Notes that do not document the individual's unique opinions or observed responses to supports;

  - Maintain an attendance log or similar document that indicates the date services were rendered, type of services rendered, and number of hours or units provided (including specific timeframe for services with a unit of service shorter than one day) for each service type except for one-time services such as assistive technology, environmental modifications, transition services, individual and family caregiver training, electronic home-based supports, services facilitation, and personal emergency response system support, where initial documentation to support claims will suffice.

- Document and maintain written semi-annual supervision notes for each Direct Support Professional (DSP) that are signed by the supervisor. Additionally,

  - For DBHDS-licensed entities, the provider must provide ongoing supervision of all companions and/or DSP staff consistent with the requirements of 12VAC35-105.
  - For providers who are licensed by VDH or have accreditation from a CMS-recognized organization to be a personal care or respite care provider, they must provide ongoing supervision of companion or DSP staff consistent with those regulatory requirements.

- Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to individuals enrolled in Medicaid;
- Agree to furnish information and record documentation on request and in the form requested to DMAS, DBHDS, the Attorney General of Virginia or his authorized representatives, federal personnel (e.g., Office of the Inspector General), and the State Medicaid Fraud Control Unit. The Commonwealth's right of access to provider premises and records survives any termination of the provider participation agreement.

- Hold information regarding individuals confidential. A provider must disclose information in his or her possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of DMAS or DBHDS. DMAS and DBHDS will not disclose medical information to the public, except as required by applicable law;

- Change of Ownership. When ownership of the provider agency changes, notify DMAS at least 15 calendar days before the date of change;

- All facilities covered by § 1616(e) of the *Social Security Act* in which home- and community-based services will be provided must comply with applicable standards that meet the requirements for board and care facilities. Health and safety standards will be monitored through the DBHDS' licensure standards, 12 VAC 35-102-10 et seq. or through DSS approved standards for adult foster care providers and licensure standards 22 VAC 40-70-10 et seq.;

- Refrain from engaging in any type of direct marketing activities to Medicaid individuals or their families/caregivers. "Direct marketing" means (i) conducting directly or indirectly door-to-door, telephonic, or other cold call marketing of services at residences and provider sites; (ii) mailing directly; (iii) paying finder's fees; (iv) offering financial incentives, rewards, gifts, or special opportunities to eligible individuals and the individual's family/caregivers, as appropriate, as inducements to use the provider's services; (v) continuous, periodic marketing activities to the same prospective individual and the individual's family/caregiver, for example, monthly, quarterly, or annual giveaways, as inducements to use the provider's services; or (vi) engaging in marketing activities that offer potential customers rebates or discounts in conjunction with the use of the provider's services or other benefits as a means of influencing the individual and the individual's family/caregivers use of the provider's services;

- Providers must ensure that staff providing waiver services read and write English to the degree required to create and maintain the required documentation;

- Report suspected abuse or neglect immediately at first knowledge to the local Department for Aging and Rehabilitative Services, adult protective services agency or the local department of social services, child protective services agency; to DMAS or its designee; and to the DBHDS Office of Human Rights, if applicable pursuant to §§ 63.2-1509 and 63.2-1606 of the Code of Virginia when the participating provider knows or suspects that an individual receiving home and community-based waiver services is being abused, neglected, or exploited;

- Adhere to provider contract and the DMAS provider service manual. In addition to compliance with the general conditions and requirements, all providers enrolled by DMAS must adhere to the conditions of participation outlined in their individual provider contracts and in the DMAS provider manual;

- In Accordance with 12VAC30-122-120 providers of services under any of the DD Waivers may not be parents or guardians of individuals enrolled in the waiver who are minor children, or in the case of an adult enrolled in the waiver, the adult individual's spouse. Payment will not be made for services furnished by other family members who are living under the same roof as the individual receiving services unless there is objective, written documentation, as defined in this subsection, as to why there are no other providers available to provide the care. Such other family members, if approved to provide services for the purpose of receiving Medicaid reimbursement, must meet the same provider requirements as all other licensed provider staff or consumer-directed employees. "Objective, written documentation" means documentation that demonstrates there are no persons available to provide supports to the individual other than the unpaid family/caregiver who lives in the home with the individual.

- Examples of such documentation may be (i) copies of advertisements showing efforts to hire; (ii) copies of interview notes; (iii) documentation indicating high turnover in consumer-directed assistants who provide, via the consumer-directed model of services, personal assistance services, companion services, respite services, or any combination of these three services; (iv) documentation supporting special medical or behavioral needs; or (v) documentation indicating that language is a factor in service delivery. The service provider must provide such documentation as is necessary or requested by DBDHS for service authorization;

- Providers will not be reimbursed while the individual enrolled in a waiver is receiving inpatient services in an acute care hospital, nursing facility, rehabilitation facility, ICF/IID, or any other type of facility;

- Providers with a history of noncompliance, which may include (i) multiple records with citations of failure to comply with regulations or multiple citations related to health and welfare for one support plan, or (ii) citation by either DMAS or DBHDS in key identified areas, resulting in a corrective action plan or citation will be required to undergo mandatory training and technical

assistance in the specific areas of noncompliance as part of a corrective action plan. These areas of noncompliance may include but are not limited to health, safety, or failure to address the identified needs of the individual. Failure to comply with any areas in the corrective action plan will result in referral to DMAS Program Integrity and initiation of proceedings related to termination of the provider Medicaid participation agreement.

- Providers must ensure that all employees or contractors without clinical licenses who will be responsible for medication administration demonstrate competency of this set of skills under direct observation prior to performing this task without direct supervision.

- DBHDS-licensed providers must ensure all employees or contractors who will be responsible for performing de-escalation and/or behavioral interventions demonstrate competency of this set of skills under direct observation prior to performing these tasks with any individual receiving services

PROVIDER QUALIFICATIONS

To qualify as a DMAS provider of selected DD waiver services, the provider of the services must meet the following criteria:

- The provider must demonstrate the ability to serve individuals in need of comprehensive services regardless of the individual's ability to pay or eligibility for Medicaid reimbursement;

- The provider must have the administrative and financial management capacity to meet state and federal requirements; and

- The provider must have the ability to document and maintain individual records in accordance with State and federal requirements.

In addition to Targeted ID or DD Case Management that is provided to all DD Waivers individuals, the DD Waivers offer the following services:

- Assistive Technology;
- Benefits Planning;
- Center-based Crisis;
- Community-based Crisis;
- Community Coaching;
- Community Engagement;
- Community Guide;
- Companion (agency-directed and consumer-directed);
- Crisis Support Services;
- Group Day;
- Electronic Home-Based Supports;

- Environmental Modifications;
- Group Home Residential;
- Independent Living Supports;
- Individual and Family/Caregiver Training;
- In-home Supports;
- Peer Mentor Supports
- Personal Assistance (agency-directed and consumer-directed);
- Personal Emergency Response Systems (PERS);
- Private Duty Nursing
- Respite (agency-directed and consumer-directed);
- Service Facilitation;
- Shared Living;
- Skilled Nursing;
- Sponsored Residential;
- Supported Employment - Group and Individual;
- Supported Living Residential;
- Therapeutic Consultation;
- Transition Services; and
- Workplace Assistance.

INDIVIDUAL RIGHTS/RESPONSIBILITIES

The provider must have a written statement of individual rights, which clearly states the responsibilities of both the provider and the individual in the provision of services. This statement of individual rights must be signed by the individual and the provider representative at the time services are initiated. This statement must be maintained in the individual's file, and a copy must be given to the individual. The statement of individual rights must include the following:

- The provider's responsibility to notify the individual in writing of any action taken which affects the individual's services;

- The provider's responsibility to render supports according to acceptable standards of care;

- The provider's procedures for patient pay collection;

- The individual's obligation for patient pay, if applicable;

- The provider's responsibility to make a good faith effort to provide supports according to the Individual Support Plan and to notify the individual when unable to provide supports;

- The provider, or Services Facilitator in the case of consumer-directed (CD) services, of Personal Assistance (agency-directed (AD) & CD), Respite (AD & CD), Companion (AD & CD), In-home Supports, and Shared Living must inform the individual of his or her responsibility to have a back-up plan for times when the provider is unable to secure coverage and to identify which staff the individual should contact regarding schedule changes;

- The provider's responsibility to treat the individual with respect, to respond to any questions or concerns about the supports rendered, and to routinely check with the individual about his or her satisfaction with the supports being rendered; and

- The individual's responsibility to treat provider staff with respect and to communicate problems immediately to the appropriate provider staff.

PROVIDER RESPONSIBILITIES TO IDENTIFY EXCLUDED INDIVIDUALS AND ENTITIES

In order to comply with Federal Regulations and Virginia Medicaid policy, providers are required to ensure that Medicaid is not paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities.

Medicaid payments cannot be made for items or services furnished, ordered, or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known about the exclusion. This provision applies even when the Medicaid payment itself is made to another provider, practitioner, or supplier that is not excluded, yet affiliated with an excluded provider. A provider who employs or contracts with an excluded individual or entity for the provision of items or services reimbursable by Medicaid may be subject to overpayment liability as well as civil monetary penalties.

All providers are required to take the following three steps to ensure Federal and State program integrity:

- Screen all new and existing employees and contractors to determine whether any of them have been excluded.

- Search the HHS-OIG List of Excluded Individuals and Entities (LEIE) website monthly by name for employees, contractors and/or entities to validate their eligibility for Federal programs. See below for information on how to search the LEIE database.

- Immediately report to DMAS any exclusion information discovered. Such information should be sent in writing and should include the individual or business name, provider identification number (if applicable), and what, if any, action has been taken to date. The information should be sent to:

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DMAS
Attn: Program Integrity/Exclusions
600 E. Broad St, Ste 1300
Richmond, VA 23219
-or-
E-mailed to: **providerexclusions@dmas.virginia.gov**

PROVIDER ENROLLMENT

Any provider of services must be enrolled in the Medicaid Program prior to billing for any services provided to Medicaid individuals. Providers must sign the Developmental Disability (DD) Waiver Services Participation Agreement to provide Targeted Intellectual Disability (ID) or DD Case Management or the Developmental Disability (DD) Waiver Participation Agreement to provide any of the DD Waiver services. The Contractor - Provider Enrollment Services is the DMAS contractor responsible for provider enrollment. The Contractor - Provider Enrollment Services will review the documentation from the provider that verifies provider qualifications. If the provider meets the qualifications as outlined in this chapter, Contractor - Provider Enrollment Services will send the provider notification that the application has been approved. The provider must maintain documentation (including relevant license, vendor agreement, letter of approval, personnel records, etc.) that verifies the provider's qualifications for review by DMAS and Department of Behavioral Health and Developmental Services (DBHDS) staff.

Upon the receipt of the signed contract, and the approval with signature by DMAS, a ten-digit Atypical Provider Identifier (API) as appropriate – or National Provider Identifier (NPI) number will be assigned as the provider identification number to each provider category (e.g., case management, private duty nursing, personal assistance, respite). **DMAS will not reimburse the provider for any services rendered prior to the assigning of this provider identification number to your file.** This number must be used on all billing invoices and correspondence submitted to DMAS or DMAS contractor – Provider Enrollment Services.

This manual contains instructions for billing and specific details concerning the Medicaid Program. Providers must comply with all sections of this manual to maintain continuous participation in the Medicaid Program.

REQUESTS FOR ENROLLMENT

All providers who wish to participate with Virginia Medicaid are directed to complete their request via the online enrollment through our Virginia Medicaid web-portal. If a provider is unable to enroll electronically through the web, they can download a paper application from the Virginia Medicaid web-portal and follow the instructions for submission. Please go to www.virginiamedicaid.dmas.virginia.gov to access the online enrollment system or to download a paper application.

DMAS strongly encourages providers to enroll or make updates electronically via our web portal. An application for participation submitted on paper will add additional time to the processing of your enrollment and to your request to update your provider file.

Please note: If you are planning to enroll via the paper enrollment process, DMAS will only accept the provider enrollment applications that have the provider screening questions listed. Previous versions of the provider enrollment applications that do not have the provider screening regulation questions will not be accepted and will be rejected with a request to submit the version that is currently posted on the Virginia Medicaid Web Portal at www.virginiamedicaid.dmas.virginia.gov**.**

If you have any questions regarding the online or paper enrollment process, please contact the contractor of Provider Enrollment Services at 1-888-829-5373 (toll free) or 1-804-270-5105 (local).

UTILIZATION OF INSURANCE BENEFITS

The Virginia Medical Assistance Program is a "last pay" program. Benefits available under Medical Assistance must be reduced to the extent that they are available through other federal, State, or local programs; coverage provided under federal or State law; other insurance; or third party liability. Health, hospital, Workers' Compensation, or accident insurance benefits must be used to the fullest extent in meeting the medical needs of the covered person. Supplementation of available benefits will be as follows:

- **Title XVIII (Medicare) -** Virginia Medicaid will pay the amount of any deductible or coinsurance for covered health care benefits under Title XVIII of the Social Security Act for all eligible persons covered by Medicare and Medicaid.

- **Workers' Compensation -** No Medicaid Program payments will be made for a patient covered by Workers' Compensation.

- **Other Health Insurance -** When an individual has other health insurance (such as CHAMPUS/TRICARE, Blue Cross-Blue Shield, or Medicare), Medicaid requires that these benefits be used first. Supplementation will be made by the Medicaid Program when necessary, but the combined total payment from all insurance must not exceed the amount payable under Medicaid had there been no other insurance.

- **Liability Insurance for Accidental Injuries -** DMAS will seek repayment from any settlements or judgments in favor of Medicaid individuals who receive medical care as the result of the negligence of another. If an individual is treated as the result of an accident and DMAS is billed for this treatment, Medicaid should be notified promptly so action can be initiated by Medicaid to establish a lien as set forth in the Code of Virginia § 8.01-66.9. In liability cases, providers may choose to bill the third-party carrier or file a lien in lieu of billing Medicaid.

- In the case of an accident in which there is a possibility of third-party liability or if the individual reports a third-party responsibility (other than those cited on his or her Medical Assistance Identification Card), and whether or not Medicaid is billed by the provider for rendered services related to the accident, the provider must forward the DMAS-1000 to:

Third-Party Liability Casualty Unit
Virginia Medical Assistance Program
600 East Broad Street
Richmond, Virginia 23219

TERMINATION OF PROVIDER PARTICIPATION

A participating provider may voluntarily terminate participation in Medicaid (either a termination of all Medicaid services or any one or more of several services being provided by the agency) at any time; however, written notification must be provided to the DMAS Director and contractor -PES thirty (30) days prior to the effective date. The addresses are:

Director, Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Virginia Medicaid -PES
PO Box 26803
Richmond, Virginia 23261-6803

Except as otherwise provided by applicable federal or state law, DMAS may terminate a provider from participating in the Medicaid program (i) pursuant to § 32.1-325 of the Code of Virginia, (ii) as may be required by federal law for federal financial participation, and (iii) in accordance with the provider participation agreement, including termination at will on 30 days written notice. The agreement may be terminated if DMAS determines that the provider poses a threat to the health, safety, or welfare of any individual enrolled in a DMAS administered program. DMAS may also terminate a provider's participation agreement if the provider does not fulfill its obligations as described in the provider participation agreement. Such provider agreement terminations must be in accordance with § 32.1-325 of the Code of Virginia, 12VAC30-10-690, and Part XII (12VAC30-20-500 et seq.) of 12VAC30-20. Such action precludes further payment by DMAS for services provided to individuals subsequent to the date specified in the termination notice.

Appeals of Provider Termination or Enrollment Denial: Such a request must be in writing and must be filed with the DMAS Appeals Division **within 15 calendar days** of the receipt of the notice of termination or denial. The provider has the right to appeal in any case in which a Medicaid agreement or contract is terminated or denied to a provider pursuant to Virginia Code §32.1-325D and E. The provider may appeal the decision in accordance with the Administrative Process Act (Virginia Code § 2.2-4000 et seq.).

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TERMINATION OF A PROVIDER CONTRACT UPON CONVICTION OF A FELONY

Subsection (c) of § 32.1-325 of the Code of Virginia mandates that, "Any such Medicaid agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony, or who has otherwise pled guilty to a felony, in Virginia or in any other state, the District of Columbia, or the United States territories must, within 30 days of such conviction, notify DMAS of this conviction and relinquish his participation agreement. Such provider agreement terminations must be effective immediately and conform to § 32.1-325 of the Code of Virginia and 12VAC30-10-690. Providers will not be reimbursed for services that may be rendered between the conviction of a felony and the provider's notification to DMAS of the conviction. Reinstatement will be contingent upon applicable provisions of state law.

PROVIDER SCREENING REQUIREMENTS

All providers must now undergo a federally mandated comprehensive screening before their application for participation is approved by DMAS. Screening is also performed on a monthly basis for any provider who participates with Virginia Medicaid. A full screening is also conducted at time of revalidation, in which every provider will be required to revalidate at least every 5 years.

The required screening measures are in response to directives in the standards established by Section 6401(a) of the Affordable Care Act in which CMS requires all state Medicaid agencies to implement the provider enrollment and screening provisions of the Affordable Care Act (42 CFR 455 Subpart E). These regulations were published in the Federal Register, Vol. 76, February 2, 2011, and were effective March 25, 2011. The required screening measures vary based on a federally mandated categorical risk level. Providers categorical risk levels are defined as "limited," "moderate," or "high." Please refer to the table listed below for a complete mapping of the provider risk categories and application fee requirements by provider class type.

Application	Rule Risk Category	App Fee Requirement Yes(Y) or No(N)
Comprehensive Outpatient Rehab Facility (CORF)	Moderate	Y
Hospital	Limited	Y
Hospital Medical Surgery Mental Health and Mental Retarded	Limited	Y
Hospital Medical Surgery Mental Retarded	Limited	Y
Hospital TB	Limited	Y
Long Stay Hospital	Limited	Y
Long Stay Inpatient Hospital	Limited	Y
Private Mental Hospital(inpatient psych)	Limited	Y
Rehab Outpatient	Limited	Y
Rehabilitation Hospital	Limited	Y
Rehabilitation Hospital	Limited	Y
State Mental Hospital(Aged)	Limited	Y
State Mental Hospital(less than age 21)	Limited	Y
State Mental Hospital(Med-Surg)	Limited	Y

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Audiologist	Limited	N
Baby Care	Limited	N
Certified Professional Midwife	Limited	N
Chiropractor	Limited	N
Clinical Nurse Specialist - Psychiatric Only	Limited	N
Clinical Psychologist	Limited	N
Licensed Clinical Social Worker	Limited	N
Licensed Marriage and Family Therapist	Limited	N
Licensed Professional Counselor	Limited	N
Licensed School Psychologist	Limited	N
Nurse Practitioner	Limited	N
Optician	Limited	N
Optometrist	Limited	N
Physician	Limited	N
Physician	Limited	N
Physician	Limited	N
Podiatrist	Limited	N
Psychiatrist	Limited	N
Psychiatrist	Limited	N
Substance Abuse Practitioner	Limited	N
Ambulance	Moderate	Y
Ambulance	Moderate	Y
Durable Medical Equipment (DME)	Moderate –Revalidating High – Newly enrolling	Y
Emergency Air Ambulance	Moderate	Y
Emergency Air Ambulance	Moderate	Y
Hearing Aid	Limited	N
Home Health Agency - State Owned	Moderate –Revalidating High – Newly enrolling	Y
Home Health Agency - Private Owned	Moderate –Revalidating High – Newly enrolling	Y
Hospice	Moderate	Y
Independent Laboratory	Moderate	Y
Local Education Agency	Limited	N
Pharmacy	Limited	N
Prosthetic Services	Moderate –Revalidating High – Newly enrolling	Y
Renal Unit	Limited	Y
Adult Day Health Care	Limited	N

Application	Rule Risk Category	App Fee Requirement Yes(Y) or No(N)
Private Duty Nursing	Limited	N
Federally Qualified Health Center	Limited	Y
Health Department Clinic	Limited	N
Rural Health Clinic	Limited	Y
Developmental Disability Waiver	Limited	N
Alzheimer's Assisted Living Waiver	Limited	N

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Treatment Foster Care Program	Limited	N
Qualified Medicare Beneficiary (QMB)	Limited	N
ICF-Mental Health	Limited	Y
ICF-MR Community Owned	Limited	Y
ICF-MR State Owned	Limited	Y
Intensive Care Facility	Limited	Y
Skilled Nursing Home	Limited	Y
SNF-Mental Health	Limited	Y
SNF-MR	Limited	Y
Psych Residential Inpatient Facility	Limited	Y
Consumer Directed Service Coordination	Limited	N
Personal Care	Limited	N
Respite Care	Limited	N
Personal Emergency Response System	Moderate –Revalidating	Y
	High – Newly enrolling	
Case Management DD Waiver	Limited	N
CMHP Transition Coordinator	Limited	N
Transition Coordinator	Limited	N
PACE	Limited	N
Family Caregiver Training	Limited	N
Mental Retardation Waiver	Limited	N
Mental Health Services	Limited - all others	Y - only for Mental Health Clinics
	Moderate -- Community Mental Health Centers	
Early Intervention	Limited	N
Group Enrollment	Limited	N
Group Enrollment	Limited	N
Ambulatory Surgical Center	Limited	Y
Ordering, Referring, or Prescribing Provider	Limited	N

Limited Risk Screening Requirements

The following screening requirements will apply to limited risk providers: (1) Verification that a provider or supplier meets any applicable Federal regulations, or State requirements for the provider or supplier type prior to making an enrollment determination; (2) verification that a provider or supplier meets applicable licensure requirements; and (3) federal and state database checks on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type and that they are not excluded from providing services in federally funded programs.

Moderate Risk Screening Requirements

The following screening requirements will apply to moderate risk providers: Unannounced pre-and/or post-enrollment site visits in addition to those screening requirements applicable to the limited risk provider category listed above. The screening requirements listed in this section are to be performed at the time of initial enrollment and at the time of revalidation, which is at least every 5 years.

High Risk Screening Requirements

In addition to those screening requirements applicable to the limited and moderate risk provider categories listed above, providers in the high risk category may be required to undergo criminal background check(s) and submission of fingerprints. These requirements apply to owners, authorized or delegated officials or managing employees of any provider or supplier assigned to the "high" level of screening. Providers should reference § 19.2-392.02. (National criminal background checks by businesses and organizations regarding employees or volunteers providing care to children or the elderly or disabled using the following link: https://law.lis.virginia.gov/vacode/title19.2/chapter23/section19.2-392.02/

Application Fees

All newly enrolling (including new locations), re-enrolling, and reactivating institutional providers are required to pay an application fee. If a provider class type is required to pay an application fee, it will be outlined in the Virginia Medicaid web portal provider enrollment paper applications, online enrollment tool, and revalidation process. **The application fee requirements are also outlined in Appendix section of this provider manual.**

The Centers for Medicare and Medicaid Services (CMS) determine what the application fee is each year. This fee is not required to be paid to Virginia Medicaid if the provider has already paid the fee to another state Medicaid program or Medicare, or has been granted a hardship approval by Medicare.

Providers may submit a hardship exception request to CMS. CMS has 60 days in which to approve or disapprove a hardship exception request. If CMS does not approve the hardship request, then providers have 30 days from the date of the CMS notification to pay the application fee or the application for enrollment will be denied.

An appeal of a hardship exception determination must be made to CMS as described in 42 CFR 424.514.

Out-of-State Provider Enrollment Requests

Providers that are located outside of the Virginia border and require a site visit as part of the Affordable Care Act are required to have their screening to include the passing of a site visit previously completed by CMS or their State's Medicaid program prior to enrollment in Virginia Medicaid. If your application is received prior to the completion of the site visit as required in the screening provisions of the Affordable Care Act (42 CFR 455 Subpart E) by the entities previously mentioned above, then the application will be rejected.

REVALIDATION REQUIREMENTS

All providers will be required to revalidate at least every 5 years. The revalidation of all existing providers will take place on an incremental basis and will be completed via Virginia Medicaid web portal.

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Registration into the Web Portal will be required to access and use the online enrollment and revalidation system.

All enrolled providers in the Virginia Medicaid program will be notified in writing of a revalidation date and informed of the new provider screening requirements in the revalidation notice. If a provider is currently enrolled as a Medicare provider, DMAS may rely on the enrollment and screening facilitated by CMS to satisfy our provider screening requirements.

ORDERING, REFERRING AND PRESCRIBING (ORP) PROVIDERS

Code of Federal Regulations 455:410(b) states that State Medicaid agencies must require all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers.

The ACA requires ordering, referring, and prescribing providers to enroll only to meet new ACA program integrity requirements designed to ensure all orders, prescriptions or referrals for items or services for Medicaid beneficiaries originate from appropriately licensed practitioners who have not been excluded from Medicare or Medicaid. The only exception to this requirement is if a physician is ordering or referring services for a Medicaid beneficiary in a risk-based managed care plan, the provider enrollment requirements are not applicable to that ordering or referring physician. If a provider does not participate with Virginia Medicaid currently but may order, refer or prescribe to Medicaid members they must now be enrolled to ensure claims will be paid to the servicing provider who is billing for the service. As a servicing provider, it is essential to include the National Provider Identifier (NPI) of any ORP on all claims to ensure the timely adjudication of claims.

CORE COMPETENCY REQUIREMENTS

Direct Support Professionals (DSPs) and their supervisors who provide services and supports for people with developmental disabilities (DD) are required to complete an orientation training process. This process is designed to increase the quality services, to build skills and confidence among workers, and to enhance the supervisor-DSP relationship.

Any agency employee, regardless of credentials, who provides Medicaid Waiver reimbursable support as a DSP (as defined under 12VAC30-122-20), must complete the DSP orientation training process. **Inclusion of any such support in a job description or similar agency expectation, establishes a role that is subject to these requirements.** This process also applies to supervisors who oversee the work of DSPs. Providers may elect to employ agency trainers in delivering training content, but the use of a trainer does not supplant conversations between DSPs and supervisors about the content of the training or the application of that content within the provider setting.

This process does not apply to professional staff who provide consultative or specialized medical and behavioral support, such as Therapeutic Consultation, Skilled Nursing, and Private Duty Nursing unless

these staff are acting in the capacity of a DSP or DSP Supervisor. This process is not required for Consumer-Directed Services or Services Facilitators.

AGENCY TYPES AND SERVICES

Agencies providing direct support to individuals on the Developmental Disabilities' waivers are required to complete the DSP Orientation training. This includes both non-DBHDS licensed providers (such as Home Care Organizations licensed by the Virginia Department of Health and Employment Services Organizations providing DD Waiver services) in addition to DBHDS-licensed providers.

These requirements apply to all providers of the following services:

- Agency-Directed Personal Assistance
- Agency-Directed Companion
- Agency-Directed Respite
- Center-based Crisis Services
- Community-based Crisis Services
- Crisis Support Services
- Community Engagement
- Community Coaching
- Group Day Services
- Group Home Residential
- Independent Living Support Services
- Individual and Group Supported Employment
- In-Home Support Services
- Sponsored Residential
- Supported Living Residential
- Workplace Assistance

TRAINING, TESTING, AND ASSURANCES REQUIREMENTS

Providers of the services listed above must assure that DSPs and their supervisors have received training in:

- The characteristics of developmental disabilities and Virginia’s DD Waivers,
- Person-centeredness, positive behavioral supports, effective communication,
- Health risks and the appropriate interventions, and
- Best practices in the support of individuals with developmental disabilities.

Health risks include at a minimum: choking, skin care (pressure sores, skin breakdown), aspiration pneumonia, falls, urinary tract infections, dehydration, constipation and bowel obstruction, change of mental status, sepsis, seizures, and early warning signs of such risks, and how to avoid such risks. Best

practices include at a minimum: the concepts of dignity of risk, self-determination, community integration and social inclusion (*e.g.*, building and maintaining positive relationships, being active and productive in society, empowerment, advocacy, rights and choice, and safety in the home and community).

This training requirement can be accomplished through the *DBHDS 2016 Orientation Training Materials* available online through the following website: http://www.partnership.vcu.edu/DSP_orientation/.

Direct Support Professionals (DSPs) and DSP supervisors must pass a DBHDS-approved objective, standardized test covering the topics referenced above prior to providing direct, reimbursable services in the absence of other qualified staff who have passed the knowledge-based test and who document the provision of supports for reimbursement purposes. DSPs and supervisors must pass the written test with a score of at least 80%. All supervisors/trainers who will be preparing DSPs to pass the test and/or meet competencies, must complete the supervisors' training online and pass the accompanying test with a score of at least 80% prior to orienting new DSPs to provide services under the DD Waivers.

DSP supervisors in both DBHDS-licensed and non-DBHDS-licensed agencies must complete online training and testing through the Commonwealth of Virginia Learning Center (COVLC), which can be accessed online by following this guide: http://www.dbhds.virginia.gov/assets/doc/DS/pd/5.-dbhds-external-entities-domain-guide.pdf. The supervisory training can be located in the COVLC by searching with the key word "DSP".

A signed assurance document confirms the receipt of instruction in the required training topics. Assurance documents are specific to DSP/DSP Supervisor role. There are two versions and DSPs and DSP supervisors complete the version that matches their role within the organization. These assurance documents are available online at: https://law.lis.virginia.gov/admincode/title12/agency30/chapter122/section9998/

Evidence of completed core competency training, a copy of the DSP completed test, the DBHDS-issued certificate of completion for supervisors, and documentation of assurances (DMAS Form P242a and P245a as applicable), must be retained in the provider's record of each applicable staff member and subject to review by DBHDS for licensing compliance and by DMAS for quality management review and financial audit purposes. In accordance with 12VAC30-122-180, the following waiver providers must ensure that DSPs and DSP supervisors, including relief and contracted staff, complete competency observation and the competency checklist within 180 days from date of hire:

- Agency-directed personal assistance service,
- Agency-directed companion service,
- Agency-directed respite service,
- Center-based crisis support service,
- Community-based crisis support service,
- Community engagement service,

- Community coaching service,
- Crisis support service,
- Group day service,
- Group home residential service,
- Independent living service,
- In-home support service,
- Sponsored residential service,
- Support living residential service, and
- Workplace assistance service.

From the 180 days of date of hire, DMAS will not reimburse for those services provided by DSPs or DSP supervisors who have failed to pass the orientation test.

DSPs who move employment from one agency to another and have documentation of having completed training and passed the DSP Orientation Manual Test at their prior employer do not have to be retrained, although the new agency should still discuss the values and concepts as they pertain to their agency's policies with the new employee. The new provider should obtain a copy of the DSP's scored test or supervisor's VLC certificate and assurance and keep it on file.

Observed Competency Requirements

Please refer to instructions as per DMAS form P241a. If at any time a DSP or DSP Supervisor is found to be deficient in any competency area, the provider must document actions taken and the date that restoration of ability is confirmed pursuant to 12VAC30-122-180. Agencies with DSPs or DSP supervisors who have failed to pass the orientation test or demonstrate competencies as required will be referred to DMAS Program Integrity for consideration of additional actions.

Advanced Competency Requirements for DBHDS-Licensed Providers Supporting People with Complex Health Needs, Behavioral Support Needs, and/or Autism at SIS® Tier Four

DBHDS-licensed providers must also ensure that DSPs and DSPs supervisors supporting individuals identified as having the most intensive needs, as determined by assignment to SIS® tier four based on a completed Supports Intensity Scale® assessment, must receive training specific to the individuals' needs and levels.

CORRECTION TO 12VAC30-122-180 as it relates to tier four (4) – regulation does not indicate Level 5 as being included in the advanced competency requirements. This section should acknowledge Tier 4 to include **Level 5**, in addition to Level 6, or Level 7 support needs.

Advanced competencies are required for DSPs and DSP supervisors who support individuals at SIS® tier four who have intensive health needs, behavioral support needs, and/or a diagnosis of autism. Individuals who require a higher level of support due to risk in one or more of these areas must only be supported by DSPs and DSP supervisors who demonstrate these competencies within 180 days of hire

or within 180 days of initiating services to an individual with related support needs. **It is required that all staff within a single service setting meet the required competencies within the required timeframes based on the needs of all individuals supported in that setting.** The need for advanced competencies is established through the identification of one or more of these factors in a current assessment and/or the Individual Support Plan (ISP):

Criteria for Requiring Advanced Competencies at SIS® Tier Four	
Health	The presence of a complex health condition that necessitates specific supports and instructions indicates that Health Competencies (DMAS P244a) must be met
Autism	A diagnosis of autism indicates that Autism Competencies (DMAS P201a) must be met
Behavioral	The need for behavioral supports either in the ISP or in a formal behavioral plan indicates that Behavioral Supports Competencies (DMAS P240a) must be met

Providers must identify and implement or attend training that relates to all three advanced competency areas as applicable. Advanced competency training may be accessed through a variety of means as long as it is nationally recognized or developed or approved by a qualified professional in each competency area. Qualified professionals who can develop or approve training include:

Qualified Professionals for Advanced Competency Training Content	
Health	A physician, nurse practitioner, psychiatric nurse practitioner, or registered nurse (RN)
Autism	A psychiatrist; a psychologist; psychiatric nurse practitioner; a Licensed Professional Counselor (LPC); a Licensed Clinical Social Worker (LCSW); a Psychiatric Clinical Nurse Specialist, or a Certified Autism Specialist (CAS), an Occupational Therapist (OL), a Speech-Language Pathologist (SLP), a Licensed Behavior Analyst (LBA), or a Licensed Assistant Behavior Analyst (LABA)
Behavioral	A psychiatrist; a psychologist; psychiatric nurse practitioner; a Licensed Professional Counselor (LPC); a Licensed Clinical Social Worker (LCSW); a Psychiatric Clinical Nurse Specialist, Positive Behavioral Support Facilitator (PBSF), a Licensed Behavior Analyst (LBA), or a Licensed Assistant Behavior Analyst (LABA)

The following topics must be included in training provided to DSPs and their supervisors when supporting individuals at SIS® tier four, where applicable:

Required Topics for Advanced Competency Training Content	
Health	Confidentiality; professional collaboration; communicating health information; documenting health information; relationship between physical and mental health; common risk factors for DD-related health conditions; universal precaution procedures; performing delegated tasks; supporting Virginia's identified risks for people with DD including: skin care (pressure sores; skin breakdown), aspiration pneumonia, falls, urinary tract infections, dehydration, constipation & bowel obstruction, sepsis, and seizures; providing direct care to individuals with complex health care needs (e.g. ADL's, positioning, care of Durable Medical Equipment, and specialized supervision with appropriate responses to health parameters set by the health professional
Autism	General characteristics of autism; dual diagnosis; environmental modifications/assessments; communication supports and strategies; social skills, peer interactions, and friendship; sensory integration; life span supports

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Behavioral	Ethical practices (practicing within scope); function and purpose of behavior; replacement behavior training; positive behavior support; behavioral prevention; dual diagnosis; data collection (goal and purpose); ruling out medical concerns for behavior

Evidence of completed advanced core competency training is documented on the assurance forms (DMAS Form P242a or P245a) completed by DSPs and DSP supervisors. The director of the provider agency or designee must complete the advanced core competencies checklist(s) for supervisors and DSP supervisors must complete checklists for DSPs they supervise. In instances where the director is also a supervisor or providing direct support, it is recommended that another supervisor not directly supervised by the director observe for competencies and sign the competencies checklist along with the director.

Any DSP or DSP supervisor who does not demonstrate proficiency with the required competencies within the initial 180 days from hire (or within 180 days of beginning to support a person with related needs, as applicable), must only provide support under direct supervision, observation and guidance of qualified staff who document the provision of these supports in the person's record until proficiency is confirmed and documented by the provider. If at any time a DSP or DSP Supervisor is found to be deficient in any competency area, the provider must document actions taken and the date that restoration of ability is confirmed pursuant to 12VAC30-122-180. Agencies with DSPs or DSP supervisors who have failed to pass the orientation test or demonstrate competencies as required will be referred to DMAS Program Integrity for consideration of additional actions. "Deficient" is defined as an established pattern of inability to demonstrate one or more competency skills.

- Upon discovery of a staff person's inability to demonstrate proficiency, the provider has seven calendar days to begin remediation of the identified skills and document the issue and the actions taken by the agency to confirm proficiency.

- If proficiency is not reconfirmed within seven days following discovery of a second episode, occurring within three months of the staff person's inability to demonstrate proficiency, the skills being remediated must only be performed under direct supervision, observation and guidance of qualified staff who document the provision of these supports in the person's record.

- Once proficiency with these skills have been demonstrated, the provider must maintain a signed confirmation which describes the actions taken and is completed by the DSP Supervisor for DSPs and the Agency Director or designee for DSP Supervisors and may resume billing for these related supports provided by the DSP or DSP Supervisor from that date forward.

Requirements for Annual Recertification of Training Competencies:
Providers must initiate a review of these competencies, at least annually, with sufficient time to identify and remediate any concerns. Competencies are not portable across agencies and must be confirmed at each agency within 180 days of hire and reconfirmed at least annually. Providers may align the competency process with an established employee evaluation processes to ensure ongoing requirements and performance standards are met.

A new checklist must be completed every fifth year and annual documentation must include confirmation that the DSP or supervisor continues to meet standards by demonstrating the skills and behaviors as applicable in the competency checklist(s) (P240a, P244a, p201a, as applicable). The checklist(s) must be retained in the provider record and subject to review by DBHDS for licensing compliance. These checklists are available online at: https://law.lis.virginia.gov/admincode/title12/agency30/chapter122/section9998/

Documentation requirements are detailed in the following chart:

Role	Supervisor's training certificate	Copy of Written Test with 80%+ score	Assurances Document	Basic DSP Competencies	Advanced competencies based on individual needs at SIS® tier four
Supervisors in non-DBHDS-licensed agencies	✓	n/a	DMAS P245a	DMAS P241a	n/a
DSPs in non-DBHDS-licensed agencies	n/a	✓	DMAS P242a	DMAS P241a	n/a
Supervisors in DBHDS-licensed agencies	✓	n/a	DMAS P245a	DMAS P241a	DMAS P240a, P244a and P201a (as applicable)
DSPs in DBHDS-licensed agencies	n/a	✓	DMAS P242a	DMAS P241a	DMAS P240a, P244a and P201a (as applicable)
n/a = not applicable; These documents must be retained in the provider record and subject to review by DBHDS for licensing compliance and by DMAS for quality management review and financial audit purposes.					
Documentation related to identified deficiencies in any competency area and restoration of ability must be maintained pursuant to 12VAC30-122-180.					

HOME AND COMMUNITY-BASED SETTINGS REQUIREMENTS

Introduction

In June 2009, the Centers for Medicare and Medicaid Services (CMS) first announced the intent to publish regulations defining the character of home and community-based settings. CMS acknowledged that some individuals who receive Home and Community Based Services (HCBS) in a residential setting managed or operated by a service provider have experienced a provider-centered and institution-like living arrangement, instead of a person-centered and home-like environment with the freedoms that should be characteristic of any home and community-based setting. CMS stated that using such settings to provide home and community-based services are contrary to the purpose of the 1915(c) waiver program.

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On March 17, 2014 (CMS) issued the Home and Community Based Services (HCBS) Final Rule 42 CFR 441.301. The final rule extends to the following settings in Virginia's DD waivers: group day services, group supported employment settings, group home residential, sponsored residential settings, and supported living services.

CMS defines home and community-based settings by the nature and quality of individuals' experiences. The home and community-based settings provisions establish a more outcome-oriented definition of home and community-based settings, rather than one based solely on a setting's location, geography, or physical characteristics. The changes related to clarification of home and community-based settings are intended to maximize the opportunities for participants in HCBS programs to have access to the benefits of community living and to receive services in the most integrated setting and effectuate the law's intention for Medicaid HCBS to provide alternatives to services provided in institutions.

Person-Centered Planning

The HCBS settings regulations specify that service planning for participants in Medicaid HCBS programs under section 1915(c) of the Social Security Act must be developed through a person-centered planning process that addresses health and long-term services and support needs in a manner that reflects individual preferences and goals. The regulations require that the person-centered planning process is directed by the individual with long-term support needs and may include a representative that the individual has freely chosen, as well as others chosen by the individual to contribute to the process.

Minimum elements of the person-centered ISP include that it:

- Reflects that the setting was the individual's choice and is integrated in and supportive of full access of the individual to the greater community,
- Reflects the individual's strengths and preferences,
- Reflects that clinical and support needs that have been identified through a functional needs assessment,
- Includes individually identified desired outcomes and support activities,
- Reflects the (paid/unpaid) services/supports and providers of such services/supports that will assist the individual to achieve identified goals,
- Reflects risk assessment, mitigation, and backup planning,
- Is understandable (e.g., linguistically, culturally, and disability considerate) to both the individual receiving HCBS and the individual's support system,

- Identifies the individual and/or entity responsible for monitoring the PC ISP,
- With the written, informed consent of the individual, is finalized, agreed to, and signed by all individuals/providers responsible for implementation of the PC ISP,
- Is distributed to the individual and others involved in the PC ISP,
- Includes services that afford the individual the option to self-direct,
- Prevents service duplication and/or the provision of unnecessary services/supports.

Specific Settings and Protections:

The Developmental Disabilities (DD) Home and Community-Based Services (HCBS) Waivers provide Virginians eligible for DD Waiver services the choice to receive services and supports in the community versus an institutional setting. Per federal regulations (42 CFR 441.301), individuals enrolled in an HCBS waiver are permitted specific rights. For individuals enrolled in a DD waiver and receiving one of the following DD waiver services: **group day, group supported employment, group home, sponsored residential and supportive living**, the setting must:

- Be integrated in and support full access to the greater community.

  Intent: Individuals who receive HCBS have equal access to the same community resources and activities available to the greater community. Rules and practices that facilitate community access should be established. When providing HCBS, individuals should not be isolated from individuals who do not have disabilities. Providers must ensure that practices do not create an environment that is institutional in nature as outlined in federal regulation (42 CFR 441.301). Providers must support individuals in their desires to participate in the community providing opportunities for new experiences using the philosophy and practice of person-centered thinking.

  - For provider owned/or operated residential settings, access to the greater community is also inclusive of having access to come and go from the home. As such, each individual must be assessed for their ability to manage an entrance door and/or a room door key. If an individual in the home wants an entrance key and there are no barriers, a key must be provided. Serval types of keys are permissible, including a “Smart Lock” that has a key pad where individuals are provided the access code.

- Ensure an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

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Intent: People receiving HCBS have a right to be treated with respect and dignity in all aspects of life. This includes respecting people's likes and dislikes, talking with people in a way that makes them feel respected and heard, and assisting people with personal supports in a compassionate manner that preserves their privacy and dignity.

- Optimize, but not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

  Intent: People retain the ability to make choices about how they spend their time in any given setting and have opportunities to participate in age-appropriate activities. Providers must engage with the individual and the team using person-centered thinking to ensure that:

  - Individuals are supported in life-informed "real" choices and autonomy;
  - Individuals are offered actual experiences on which they can base future choices;
  - Plans are created with the appropriate balance between autonomy and safety;
  - Individuals' personal preferences are made a priority. When there is a difference of opinion with a guardian or provider preference (unless for a documented health and safety reason), there should be open dialogue in order to come to agreement;
  - Individuals are supported and inspired to work toward their goals, dreams and priorities.
  - Individuals' choices regarding services and supports, and who provides them are facilitated.

- In **addition** to the rights and qualities specified above, in provider operated settings where group home, sponsored residential and supportive living services are provided, the following conditions must be met:

- The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of Virginia. For settings in which landlord tenant laws do not apply, there will be a lease, residency agreement, or other form of written agreement in place for each HCBS

participant, and the document provides protections that address eviction processes and appeals comparable to those provided under the landlord tenant law.

Intent: Individuals have the right to know their legal protections as renters. This includes a lease or residency agreement that include language that provides protections to address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant laws. This should be a time-limited document that is renewed in a significant and understandable way with the individual. This will also include specific information regarding leaving housing and when an individual could be required to relocate. This eviction process should be explained to the individual and follow the Virginia Landlord Tenant Act.

- Each individual has privacy in their sleeping or living unit:
  - Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
  - Individuals sharing units have a choice of roommates in that setting.
  - Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

Intent: Individuals have the same rights as all other citizens in their homes. This requirement is intended to ensure individuals have the privacy they desire and can lock their bedroom doors if they choose. Rather than requiring an individual to share a room with a stranger, providers must have a process for individuals to choose their own roommates. This requirement is also intended to ensure that the individual's living space feels like a home to them and can be furnished or decorated as they choose.

- Individuals have the freedom and support to control their own schedules and activities and have access to food at any time.

  Intent: Individuals control their day-to-day lives the same way other community members do. This includes control over planning their own daily schedules and activities and choosing when and what they eat.

- Individuals are able to have visitors of their choosing at any time.

  Intent: Individuals have the opportunity to develop close, private, and personal relationships without having unnecessary barriers or obstacles imposed on them. HCBS federal rules require that individuals be able to have visitors at any time, without restriction, just as anyone would have in their own home or rental unit. Providers should not be screening who the individual elects to have as a visitor. This does not mean that individuals can be inconsiderate of others' rights or the need for quiet and safety in the residence. It is intended to ensure that individuals

who live in residential settings have the same freedoms as other community members in relationships with visitors in their own homes.

- The setting is physically accessible to the individual

  Intent: For those individuals who need supports to move about the setting as they choose, providers of HCBS services must provide for adaptations for physical accessibility. These adaptations may include, but are not limited to:

  - grab bars,
  - seats in the bathroom,
  - ramps for wheel chairs,
  - viable exits for emergencies,
  - accessible appliances to individuals (e.g., the washer/dryer are front loading for individuals in wheelchairs),
  - tables and chairs at a convenient height and location so that individuals can access and use the furniture comfortably.

Modification to Residential Rights

If an individual requires a modification to any residential specific right, the provider must document the following in the ISP. In addition, the provider is responsible for all supplemental documentation as it relates to data collection.

- Identify a specific and individualized assessed need for the modification to the right.
- Document the positive interventions and supports used prior to any modifications to the person-centered ISP.
- Document less intrusive methods of meeting the need that have been tried but did not work.
- Include a clear description of the condition that is directly proportionate to the specific assessed need.
- Include regular collection and review of data to measure the ongoing effectiveness of the modification.
- Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
- Include the informed consent of the individual.
- Include an assurance that interventions and supports will cause no harm to the individual.

Provider Documentation Requirements

- Providers of services in any of the HCBS affected settings must develop a Home and Community Based Services Rights Policy. This policy must be inclusive of the following:

  - Specifically outlining the rights afforded to people receiving HCBS services (including a value on community and personal interests);
  - A person-centered planning policy; and
  - Modification of rights (in residential settings).

- Documentation (via a disclosure form) that a provider has reviewed, in a significant and understandable manner, the HCBS afforded rights to each individual receiving services upon admission into a program and annually thereafter.

- Agency policy and appropriate documentation that new employees, contractors, students, and volunteers are trained in HCBS rights upon orientation to an agency and annually thereafter.

- All documentation related to residential specific modifications including informed consent forms, data collection forms, regular modification reviews, and all less-intrusive attempts to support an individual rather than modify a right.

Provider resources

Additional information, reference material, and further guidance on HCBS settings provider requirements is located in the HCBS Toolkit at https://www.dmas.virginia.gov/for-providers/long-term-care/waivers/home-and-community-based-services-toolkit/

SUPPORT COORDINATION/CASE MANAGEMENT

Support Coordination for Persons with Intellectual Disability

Providers of support coordination for individuals with intellectual disability must be limited to the Community Services Boards. All CSB/BHA providers must have a current, signed provider agreement with DMAS and must directly bill DMAS for reimbursement.

The provider must meet the following criteria:

- The provider must guarantee that individuals have access to emergency services on a 24-hour basis. "Emergency services" are defined in DBHDS Licensing regulations as "unscheduled and sometimes scheduled crisis intervention, stabilization, and referral assistance provided over the telephone or face-to-face, if indicated, available 24 hours a day and seven days per week;"

- The provider must demonstrate the ability to serve individuals in need of comprehensive services regardless of the individual's ability to pay or eligibility for Medicaid reimbursement;

- The provider must have the administrative and financial management capacity to meet state and federal requirements;

- The provider must document and maintain individual records in accordance with state and federal requirements;

- The provider must submit the Individual Support Plan in an electronic format in the state DD Home and Community-Based Services (HCBS) waiver management system for service authorization and data management for individuals enrolled in any DD HCBS waiver. The provider must submit evidence of follow-up and monitoring to assess ongoing progress of the ISP, ensuring services are delivered, and health and safety is maintained to DMAS and/or DBHDS in the format specific;
- The provider must participate in activities designed to safeguard individuals' health and safety in accordance with approved DD HCBS waiver requirements and/or DBHDS licensing standards;

- The provider must participate in activities designed to assure ongoing compliance by DD HCBS waiver participants' providers of service subject to the Final Rule Settings Requirements found at 42 CFR 441.301(4) and as described in the approved Statewide Transition Plan;

- The services must be in accordance with the Virginia State Plan; and

- The provider must be licensed as a developmental disability support coordination agency by the Department of Behavioral Health and Developmental Services.

Providers may bill for intellectual disability support coordination only when the services are provided by qualified support coordinators. The support coordinator must possess a combination of intellectual disability work experience and relevant education that indicates that the incumbent, at entry level, possesses the knowledge, skills, and abilities listed in this subdivision. These must be documented in the application form or supporting documentation or observable and documented during the interview (with appropriate supporting documentation).

Knowledge of:

- The definition, and causes of intellectual disability and best practices in supporting individuals who have intellectual disability;

- Treatment modalities and intervention techniques, such as positive behavior supports, person-centered practices, independent living skills training, community inclusion/employment skills, supportive guidance, family education, crisis intervention, discharge planning, and support coordination;

- Different types of assessments and their uses in service planning;

- Individuals' civil and human rights;
- Local community resources and service delivery systems, including support services, eligibility criteria and intake process, termination criteria and procedures, and generic community resources;
- Types of intellectual disability programs and services;
- Effective oral, written, and interpersonal communication principles and techniques;
- General principles of documentation; and
- The service planning process and the major components of an ISP.

Skills in:

- Interviewing;
- Negotiating with individuals and service providers;
- Observing and documenting an individual's behaviors;
- Identifying and documenting an individual's needs for resources, services, and other assistance;
- Identifying services within the established service system to meet the individual's needs and preferences;
- Coordinating the provision of services by diverse public and private providers, generic and natural supports;
- Using information from assessments, evaluations, observations, and interviews to develop and revise as needed individual support plans;
- Formulating, writing, and implementing individualized individual support plans to promote goal attainment and community integration for individuals with intellectual disability;
- Using information from assessment tools evaluations, observations, and interviews to develop and revise as needed individual support plans (for example to ensure the ISP is implemented appropriately, identify change in status or to determine risk of crisis/hospitalization); and
- Identifying community resources and organizations and coordinating resources and activities.

Abilities to:

- Demonstrate a positive regard for individuals and their families (e.g., treating people as individuals, allowing risk taking, avoiding stereotypes of people with intellectual disability, respecting individual and family privacy, and believing individuals can grow and contribute to their community);
- Be persistent and remain objective;
- Work as team member, maintaining effective interagency and intra-agency working relationships;
- Work independently, performing position duties under general supervision;
- Communicate effectively, verbally and in writing; and
- Establish and maintain ongoing supportive relationships.

Support Coordination for Individuals with Developmental Disabilities Other than Intellectual Disability

Providers of support coordination to individuals with developmental disabilities other than ID must be CSBs or BHAs that have current, signed provider agreements with the Department of Medical Assistance Services (DMAS) and directly bill DMAS for reimbursement. CSBs or BHAs must contract with other entities to provide support coordination.

The provider must meet the following criteria:

- The provider must guarantee that individuals have access to emergency services on a 24-hour basis. "Emergency services" are defined in DBHDS Licensing regulations as "unscheduled and sometimes scheduled crisis intervention, stabilization, and referral assistance provided over the telephone or face-to-face, if indicated, available 24 hours a day and seven days per week;"
- The provider must demonstrate the ability to serve individuals in need of comprehensive services regardless of the individual's ability to pay or eligibility for Medicaid;
- The provider must have the administrative and financial management capacity to meet state and federal requirements;
- The provider must document and maintain individual records in accordance with state and federal requirements; and

- The provider must submit the Individual Support Plan in an electronic format in the state DD Home and Community-Based Services (HCBS) waiver management system for service authorization and data management for individuals enrolled in any DD HCBS waiver. The provider must submit evidence of follow-up and monitoring to assess ongoing progress of the ISP, ensuring services are delivered, and health and safety is maintained to DMAS and/or DBHDS in the format specific;

- The provider must participate in activities designed to safeguard participants' health and safety in accordance with approved DD HCBS waiver requirements and/or DBHDS licensing standards; and

- The provider must participate in activities designed to assure ongoing compliance by DD HCBS waiver participants' providers of service subject to the Final Rule Settings Requirements found at 42 CFS 441.301(4) and as described in the approved Statewide Transition Plan

- The provider must be licensed as a developmental disability support coordination agency by the Department of Behavioral Health and Developmental Services.

Support coordinators who provide developmental disability support coordination services and were hired after September 1, 2016, must possess a minimum of a bachelor's degree in a human services field or be a registered nurse. Support coordinators hired before September 1, 2016, who do not possess a minimum of a bachelor's degree in a human services field or are not a registered nurse may continue to provide support coordination if they are employed by or contracting with an entity that had a Medicaid provider participation agreement to provide developmental disability support coordination prior to February 1, 2005, and the support coordinator has maintained employment with the provider without interruption, which must be documented in the personnel record.

Support coordinators must possess developmental disability work experience or relevant education that indicates that at entry level he/she possesses the following knowledge, skills, and abilities that are documented in the employment application form or supporting documentation or during the job interview:

Knowledge of:

- The definition and causes of developmental disability and best practices in supporting individuals who have developmental disabilities;

- Treatment modalities and intervention techniques, such as positive behavioral supports, person-centered practices, independent living skills, training, community inclusion/employment training, supportive guidance, family education, crisis intervention, discharge planning, and service coordination;

- Different types of assessments and their uses in determining the specific needs of the individual with respect to his ISP;
- Individuals' human and civil rights;
- Local service delivery systems, including support services;
- Types of programs and services that support individuals with developmental disabilities;
- Effective oral, written, and interpersonal communication principles and techniques;
- General principles of documentation; and
- The service planning process and the major components of the ISP.

Skills in:

- Interviewing;
- Negotiating with individuals and service providers;
- Observing and documenting an individual's behaviors;
- Identifying and documenting an individual's needs for resources, services, and other assistance;
- Identifying services within the established service system to meet the individual's needs and preferences;
- Coordinating the provision of services by diverse public and private providers, generic and natural supports;
- Analyzing and planning for the service needs of individuals with developmental disability;
- Formulating, writing, and implementing individual-specific support plans designed to facilitate attainment of the individual's unique goals for a meaningful, quality life; and
- Using information from assessments, evaluations, observations, and interviews to develop and revise as needed individual support plans (for example to ensure the ISP is implemented appropriately, identify change in status or to determine risk of crisis/hospitalization).

Abilities to:

- Demonstrate a positive regard for individuals and their families (e.g., allowing risk taking, avoiding stereotypes of people with developmental disabilities, respecting individual and family privacy, believing individuals can grow and contribute to their community);
- Be persistent and remain objective;
- Work as a team member, maintaining effective interagency and intra-agency working relationships;
- Work independently, performing position duties under general supervision;
- Communicate effectively, orally and in writing; and
- Establish and maintain ongoing supportive relationships.

Support coordinators must not be:

- The direct care staff person or "DSP," defined as a staff member identified by a waiver services provider that has the primary role of assisting the individual on a day-to-day basis with routine personal care needs, social support, and physical assistance in a wide range of daily living activities so that the individual can lead a self-directed life in his own community,
- The immediate supervisor of the direct care staff person,
- Otherwise related by business or organization to the direct care staff person, or
- An immediate family member of the direct care staff person.

Support coordination services must not be provided to the individual by

- Parents, guardians, spouses, or any family living with the individual, or
- Parents, guardians, spouses, or any family employed by an organization that provides support coordination for the individual except in cases where the family member was employed by the support coordination entity prior to implementation of the DD waivers regulations effective 5/01/2021.

Support coordinators must receive supervision within the employing organization. The supervisor of the support coordinator must have one of the following:

- A master's degree in a human services field and one year of required documented experience working with individuals who have developmental disabilities;

- A registered nurse licensed in the Commonwealth, or who holds a multistate licensure privilege, and one year of documented experience working with individuals who have developmental disabilities;

- A bachelor's degree and two years of experience working with individuals who have developmental disabilities;

- A high school diploma or GED and five years of paid experience in developing, conducting, and approving assessments and ISPs as well as working with individuals who have developmental disabilities;
- A license to practice medicine or osteopathic medicine in the Commonwealth and one year of required documented experience working with individuals who have developmental disabilities; or

- Meets other requirements as set out in the Department of Behavioral Health and Developmental Disabilities licensing regulations.

Support coordinators must obtain at least one hour of documented supervision at least every 90 calendar days.

Support coordinators must complete a minimum of eight hours of training annually in one or more of a combination of areas described in the knowledge, skills, and abilities described above and must provide documentation to his/her supervisor that demonstrates that training is completed. The documentation must be maintained by the supervisor of the support coordinator in the employee's personnel file for the purposes of utilization review. This documentation must be provided to the Department of Medical Assistance Services and the Department of Behavioral Health and Developmental Services upon request.

Freedom of Choice for ID and DD Support Coordination

The provision of support coordination services must not restrict an individual’s free choice of providers.

- Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in the plan.

- Eligible individuals will have free choice of any qualified Medicaid provider of other medical care under the plan.

- Individuals who are eligible for or who have received the Building Independence, Community Living, and Family and Individual Supports waivers must have free choice of support

coordinator as well as the providers of support coordination services within the parameters described above and as follows. At any time, an individual may make a request to change his support coordinator. For those individuals who receive ID support coordination, choice of a neighboring CSB must be given if the individual does not desire support coordination from the CSB in whose catchment area he/she resides. For those individuals who receive DD support coordination services:

- The CSB that serves the individual will be the provider of support coordination.
- If the individual or family decides that no choice is desired in that CSB, the CSB must afford a choice of another CSB with whom the responsible CSB has a memorandum of agreement.
- If the individual or family decides that no choice is desired in that CSB, or with another CSB, the CSB must afford a choice of a private entity with whom they have a contract that was procured through the RFP process.

- When the required support coordination services are contracted out to a private entity, the CSB/BHA must remain the responsible provider and only the CSB/BHA may bill DMAS for Medicaid reimbursement.

PROVIDER RECONSIDERATION OF ADVERSE ACTIONS

Service providers seeking to contest an adverse action issued by a DMAS Contractor must follow the DMAS Contractor's policies and procedures for requesting reconsideration. For information regarding the reconsideration process, providers should consult their agreement with the DMAS Contractor. The provider's exhaustion of the DMAS Contractor's reconsideration process is a mandatory pre-requisite to filing an appeal with DMAS. If no reconsideration process exists, then the provider may appeal directly to DMAS.

APPEALS OF ADVERSE ACTIONS

Definitions:

Administrative Dismissal – means:

1) A DMAS provider appeal dismissal that requires only the issuance of an informal appeal decision with appeal rights but does not require the submission of a case summary or any further informal appeal proceedings; or
2) The dismissal of a member appeal on various grounds, such as lack of a signed authorized representative form or the lack of a final adverse action from the MCO or other DMAS Contractor.

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Adverse Action – means the termination, suspension, or reduction in covered benefits or the denial, in whole or in part, of payment for a service.

Adverse Benefit Determination – Pursuant to 42 C.F. R. § 438.400, means, in the case of an MCO, any of the following: (i) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (ii) The reduction, suspension, or termination of a previously authorized service; (iii) The denial, in whole or in part, of payment for a service; (iv) The failure to provide services in a timely manner, as defined by the State; (v) The failure of an MCO to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances an appeals; (vi) For a resident of a rural area with only one MCO, the denial of a member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network; (vii) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities. The denial, in whole or in part, of payment for a service solely because the claim does not meet the definition of a "clean claim" at § 447.45(b) is not an adverse benefit determination.

Appeal – means:

1) A member appeal is:

    a. For members enrolled in an MCO, in accordance with 42 C.F.R. § 438.400, defined as a request for review of an MCO's internal appeal decision to uphold the MCO's adverse benefit determination. For members, an appeal may only be requested after exhaustion of the MCO's one-step internal appeal process. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or

    b. For members receiving FFS services, defined as a request for review of a DMAS adverse action or DMAS Contractor's decision to uphold the Contractor's adverse action. If an internal appeal is required by the DMAS Contractor, an appeal to DMAS may only be requested after the Contractor's internal appeal process is exhausted. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or

2) For services that have already been rendered, a provider appeal is:

    a. A request made by an MCO's provider (in-network or out-of-network) to review the MCO's reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. After a provider exhausts the MCO's reconsideration process, Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq*. and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq*.; or

    b. For FFS services, a request made by a provider to review DMAS' adverse action or the DMAS Contractor's reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. If an adverse action requires reconsideration before appealing to DMAS, the provider must exhaust the Contractor's reconsideration process, after which Virginia Medicaid affords the provider

the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq*. and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq*.

Internal Appeal – means a request to the MCO or other DMAS Contractor by a member, a member's authorized representative or provider, acting on behalf of the member and with the member's written consent, for review of the MCO's adverse benefit determination or DMAS Contractor's adverse action. The internal appeal is the only level of appeal with the MCO or other DMAS Contractor and must be exhausted by a member or deemed exhausted according to 42 C.F.R. § 438.408(c)(3) before the member may initiate a State fair hearing.

Reconsideration – means a provider's request for review of an adverse action. The MCO's or DMAS Contractor's reconsideration decision is a pre-requisite to a provider filing an appeal to the DMAS Appeals Division.

State Fair Hearing – means the Department's *de novo* evidentiary hearing process for member appeals. Any internal appeal decision rendered by the MCO or DMAS Contractor may be appealed by the member to the Department's Appeals Division. The Department conducts *de novo* evidentiary hearings in accordance with regulations at 42 C.F.R. § 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370.

Transmit – means to send by means of the United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission.

MEMBER APPEALS

Information for providers seeking to represent a member in the member's appeal of an adverse benefit determination is located in Chapter III.

PROVIDER APPEALS

Non-State Operated Provider

The following procedures will be available to all non-state operated providers when an adverse action is taken that affords appeal rights to providers.

If the provider chooses to exercise available appeal rights, a request for reconsideration must be submitted if the action involves a DMAS claim under the EAPG payment methodology or involves a ClaimCheck denial. The request for reconsideration and all supporting documentation must be submitted within 30 days of the receipt of written notification of the underpayment, overpayment, and/or denial to the attention of the Program Operations Division at the following address:

Program Operations Division
Department of Medical Assistance Services
600 East Broad Street,
Richmond, Virginia 23219

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DMAS will review the documentation submitted and issue a written response to the provider's request for reconsideration. If the adverse decision is upheld, in whole or part, as a result of the reconsideration process, the provider may then appeal that decision to the DMAS Appeals Division, as set forth below.

Internal appeal rights with a managed care organization ("MCO") must also be exhausted prior to appealing to DMAS if the individual is enrolled with DMAS through a Virginia Medicaid MCO.

For services that have been rendered and applicable reconsideration or MCO internal appeal rights have been exhausted, providers have the right to appeal adverse actions to DMAS.

Provider appeals to DMAS will be conducted in accordance with the requirements set forth in the Code of Virginia § 2.2-4000 *et. seq.* and the Virginia Administrative Code 12 VAC 30-20-500 *et. seq.*

Provider appeals to DMAS must be submitted in writing and **within 30 calendar days** of the provider's receipt of the DMAS adverse action or final reconsideration/MCO internal appeal decision. However, provider appeals of a termination of the DMAS provider agreement that was based on the provider's conviction of a felony must be appealed **within 15 calendar days** of the provider's receipt of the DMAS adverse action. The provider's notice of informal appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues from the action being appealed. Failure to file a written notice of informal appeal within the prescribed timeframe will result in an administrative dismissal of the appeal.

The appeal must be filed with the DMAS Appeals Division through one of the following methods:

- Through the Appeals Information Management System ("AIMS") at https://www.dmas.virginia.gov/appeals/. From there you can fill out an informal appeal request, submit documentation, and follow the process of your appeal.
- Through mail, email, or fax. You can download a Medicaid Provider Appeal Request form at https://www.dmas.virginia.gov/appeals/. You can use that form or a letter to file the informal appeal. The appeal request must identify the issues being appealed. The request can be submitted by:
    - Mail or delivery to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;
    - Email to appeals@dmas.virginia.gov; or
    - Fax to (804) 452-5454.

The Department of Medical Assistance Services normal business hours are from 8:00 a.m. to 5:00 p.m. Eastern time. Any documentation or correspondence submitted to the DMAS Appeals Division after 5:00 p.m. will be date stamped on the next day the Department is officially open. Any document that is filed with the DMAS Appeals Division after 5:00 p.m. on the deadline date will be untimely.

Any provider appealing a DMAS informal appeal decision must file a written notice of formal appeal with the DMAS Appeals Division **within 30 calendar days** of the provider's receipt of the DMAS informal appeal decision. The notice of formal appeal must identify each adjustment, patient, service date, or other disputed matter that the provider is appealing. Failure to file a written notice of formal appeal within 30 calendar days of receipt of the informal appeal decision will result in dismissal of the appeal. The notice of appeal must be transmitted through the same methods listed above for informal appeals.

The provider may appeal the formal appeal decision to the appropriate circuit court in accordance with

the APA at the Code of Virginia § 2.2-4025, *et. seq*. and the Rules of Court.

The provider may not bill the member for covered services that have been provided and subsequently denied by DMAS.

Repayment of Identified Overpayments
Pursuant to § 32.1-325.1 of the *Code of Virginia*, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When lump sum cash payment is not made, interest shall be added on the declining balance at the statutory rate, pursuant to the *Code of Virginia*, § 32.1-313.1. Repayment and interest will not apply pending the administrative appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates, to the satisfaction of DMAS, a financial hardship warranting extended repayment terms.

State-Operated Provider

The following procedures will be available to state-operated providers when DMAS takes adverse action which includes termination or suspension of the provider agreement or denial of payment for services rendered. State-operated provider means a provider of Medicaid services that is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration of any issue that would be otherwise administratively appealable under the State Plan by a non-state operated provider. This is the sole procedure available to state-operated providers.

The reconsideration process will consist of three phases: an informal review by the Division Director, a further review by the DMAS Agency Director, and a Secretarial review. First, the state-operated provider must submit to the appropriate DMAS Division Director written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives a Notice of Program Reimbursement (NPR), notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought, the amount of the adjustment sought and the reason(s) for seeking the adjustment. The Division Director or his/her designee will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution.

Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable laws and regulations. The Division Director shall consider any recommendation of his/her designee and render a decision.

The second step permits a state-operated provider to request, within 30 days after receipt of the Division Director's decision, that the DMAS Agency Director or his/her designee review the Decision of the Division Director. The DMAS Agency Director has the authority to take whatever measures he/she deems appropriate to resolve the dispute.

The third step, where the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, permits the provider to request, within 30 days after receipt of the DMAS Agency Director's Decision, that the DMAS Agency Director refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary, as appropriate. Any determination by such Secretary or Secretaries shall be final.

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CLIENT/INDIVIDUAL MEMBER APPEALS

Individual/Member Appeals

The Code of Federal Regulations at 42 C.F.R. § 431, Subpart E, and the Virginia Administrative Code at 12 VAC 30-110-10 through 370, require that written notification be provided to individuals when DMAS or any of its contractors takes an action that affects the individual's receipt of services. Most adverse actions may be appealed by the Medicaid Individual or by an authorized representative on behalf of the individual. Adverse actions include partial approvals, denials, and reductions in service, suspensions, and terminations. Also, failure to act on a request for services within required timeframes may be appealed. For individuals who do not understand English, a translation of appeal rights that can be understood by the individual must be provided.

If an appeal is filed before the effective date of the action, or within 10 days of the date the notice of action was mailed, services may continue during the appeal process. However, if the adverse action is upheld by the hearing officer, the individual will be expected to repay DMAS or the DMAS Contractor for all services received during the appeal period. For this reason, the individual may choose not to receive continued services. The DMAS Contractor will be notified by DMAS to reinstate services if continuation of services is applicable. If coverage is continued or reinstated due to an appeal, DMAS or the DMAS Contractor may not terminate or reduce services until a decision is rendered by the hearing officer.

Appeals may be requested orally or in writing. Appeals filed orally or electronically must be received within 30 days of receipt of the notice of adverse action. Appeals sent by mail must be postmarked within 30 days of receipt of the notice of adverse action.

Appeal requests may be sent in the following ways:

- Electronically through the Appeals Information Management System at: www.dmas.virginia.gov/#/appealsresources or email to https://www.dmas.virginia.gov/appeals**.** From there you can fill out an appeal request, submit documentation, and follow the process of your appeal. Or a letter can be written. Include a full copy of DMAS' final denial letter and any documents for DMAS to review during the appeal.

- By faxing the appeal request to DMAS at (804) 452-5454
- By mail or in person by **s**ending or bringing the appeal request to Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219

- By phone**.** Call DMAS at (804) 371-8488 (TTY: 1-800-828-1120)

ADDITIONAL OPTIONS

Assistive Technology (AT)

Assistive Technology must be provided by DMAS enrolled Durable Medical Equipment (DME) providers or DMAS enrolled Community Services Boards or Behavioral Health Authorities (CSBs/BHAs) with a signed, current waiver provider agreement with DMAS to provide the AT service.

Independent assessments for the AT service must be conducted by independent professional consultants. Independent, professional consultants include, for example, speech-language therapists, physical therapists, occupational therapists, physicians, behavioral therapists, certified rehabilitation specialists, or rehabilitation engineers. The type of professional providing the assessment must be appropriate to the device or equipment.

Providers that supply AT service for an individual must not perform the assessment or consultation or write the specifications. Any request for a change in cost, either an increase or a decrease, requires justification and supporting documentation of medical need necessity and service authorization by DMAS or its designee. The provider must receive a copy of the professional evaluation to purchase the items recommended by the professional. If a change is necessary, then the provider must notify the assessor to ensure the changed items meet the individual's needs.

If a rehabilitation engineer or certified rehabilitation specialist is needed to combine systems not typically designed to be compatible, modify an existing device, or design/fabricate a specialized device, the plan for supports and service authorization request must include appropriate justification and explanation.

Providers may not be the spouse, parents (natural, adoptive, foster or step-parent/caregivers) or guardian of the individual receiving service.

Community Guide

Providers must have a current, signed provider participation agreement with DMAS in order to provide this service. The provider designated in the participation agreement must directly provide the service and bill DMAS for reimbursement.

General Community Guide services must be provided by persons who have successfully completed and received a certificate of completion for both The Learning Community's:

- Person-Centered Thinking training; and
- Community Connections training.

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The Community Housing Guide services must be provided by persons who have successfully completed:

- The Learning Community's Person-Centered Thinking training; and
- DBHDS Independent Housing Curriculum Modules 1-3.

Electronic Home-Based Supports (EHBS)

Providers of this service must have a current, signed participation agreement with DMAS. Providers as designated on this agreement must render this service directly and must bill DMAS for Medicaid reimbursement.

An EHBS service provider must be one of the following:

- A Medicaid-enrolled licensed personal care agency;
- A Medicaid-enrolled durable medical equipment provider;
- A CSB or BHA;
- A center for independent living;
- A licensed and Medicaid-enrolled home health provider;
- An EHBS manufacturer/company that has the ability to provide electronic home-based equipment, direct services (i.e., installation, equipment maintenance, and service calls), and monitoring; or
- A PERS manufacturer/company that is Medicaid-enrolled and has the ability to provide electronic home-based equipment, direct services (i.e., installation, equipment maintenance, and service calls), and monitoring services.

The provider of ongoing monitoring systems must provide an emergency response center with fully trained operators who are capable of

- Receiving signals for help from an individual's equipment 24 hours a day, 365 or 366 days per year as appropriate;
- Determining whether an emergency exists; and
- Notifying the appropriate responding organization or an emergency responder that the individual needs help.

The EHBS service provider must have the primary responsibility to furnish, install, maintain, test, and service the equipment, as required, to keep it fully operational. The provider must replace or repair the device within 24 hours of the individual's notification of a malfunction of the unit or device.

The EHBS service provider must properly install all equipment and must furnish all supplies necessary to ensure that the system is installed and working properly.
The EHBS service provider must install, test, and demonstrate to the individual and family/caregiver, as appropriate, the unit or device before submitting a claim to DMAS. The provider responsible for installation of devices must document the date of installation and training in use of the devices.

The provider of off-site monitoring must document each instance of action being taken on behalf of the individual. This documentation must be maintained in this provider's record for the individual and must be provided to either DMAS or DBHDS upon demand. The record must document all of the following:

- Delivery date and installation date of the EHBS;
- The signature of the individual or his family/caregiver, as appropriate, verifying receipt of the EHBS device;
- Verification by a test that the EHBS device is operational, monthly or more frequently as needed;
- Updated and current individual responder and contact information, as provided by the individual or the individual's care provider or support coordinator/case manager; and
- A case log documenting the individual's utilization of the system and contacts and communications with the individual or his family/caregiver, as appropriate, support coordinator, or responder.

Environmental Modifications (EM)

Providers of this service must have a current, signed participation agreement with DMAS. Providers as designated on this agreement must render this service directly and must bill DMAS for Medicaid reimbursement.

An EM service provider must be one of the following:

- A Medicaid-enrolled durable medical equipment provider; or
- A CSB or BHS.

The contractor must:

- Comply with all applicable state and local building codes;
- If used previously by the provider, have satisfactorily completed previous environmental modifications; and
- Be available for any service or repair of the environmental modifications.

As described in Chapter IV, it is possible that the services of any or all of the following four professions may be required to complete one modification:

- A Rehabilitation Engineer;
- A Certified Rehabilitation Specialist;
- A building contractor; or
- A vendor who supplies the necessary materials.

Providers may not be the spouse or parent or legal guardian of the individual receiving service.

Individual and Family/Caregiver Training (IFCT)

Providers of this service must have a current, signed participation agreement with DMAS. Providers as designated on this agreement must render this service directly and must bill DMAS for Medicaid reimbursement.

Individuals who provide Individual and Family/Caregiver Training must have the appropriate licensure or certification as required for the specific professional field associated with the training area, and have expertise in, experience in, or demonstrated knowledge of the training topic set out in the plan for supports.

Individual and family/caregiver training service may be provided through seminars and conferences organized by the enrolled provider entities. The service may also be provided by individual practitioners who have experience in or demonstrated knowledge of the training topics. Individual practitioners may include psychologists, teachers or educators, social workers, medical personnel, personal care providers, therapists, and providers of other services such as day and residential support services.

Qualified provider types include:

- Staff of home health agencies, community developmental disabilities service agencies, developmental disabilities residential providers, community mental health centers, public health agencies, hospitals, clinics, or other agencies or organizations; and

- Individual practitioners, including licensed or certified personnel such as RNs, LPNs, psychologists, speech-language therapists, occupational therapists, physical therapists, licensed clinical social workers, licensed behavior analysts, and persons with other education, training, or experience directly related to the specified needs of the individual as set out in the ISP.

Peer Mentor Supports

The administering agency for this service must have a current, signed participation agreement with DMAS. Providers as designated on this agreement must render this service directly and must bill DMAS for Medicaid reimbursement.

The administering agency must be a DBHDS licensed provider of DD services, Employment Service Organization, or Center for Independent Living. The administering agency must serve as the enrolled provider and maintain the documentation of the peer mentor's qualifications, criminal background and Child Protective Registry (if service recipient is under age 18) checks, and other required documentation.

Peer Mentor Supports must be provided by an individual with a developmental disability who has lived independently in the community for at least one year and is or has been a recipient of services, including but not limited to publicly-funded housing, Medicaid waiver services, work incentives, and supported employment. "Living independently" can mean living in his/her own home or apartment, inclusive of receiving waiver supports such as In-home Supports, Independent Living Supports, Supported Living or Shared Living. Residents of group homes or sponsored residential homes and those residing in their family homes may not be Peer Mentors.

The peer mentor must have completed DBHDS's DD Peer Mentor training curriculum and passed the accompanying test.

Transition Services

Providers must be enrolled as a Medicaid Provider for Case Management services and work with the DMAS designated agent – Consumer Directed Care Network (CDCN) to receive reimbursement for the purchase of appropriate transition goods or services on behalf of the individual.

CRISIS SUPPORT OPTIONS

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Center-Based Crisis Support

Providers must have current signed participation agreements with DMAS and are required to directly provide the services and bill DMAS for Medicaid reimbursement.

Providers for adults shall be licensed by DBHDS as providers of Group Home Service-REACH (Regional Education Assessment Crisis Services Habilitation) or, for children, a residential group home-REACH for children and adolescents with co-occurring diagnosis of developmental disability and behavioral health needs.

Center-based crisis support service must be provided by a licensed mental health professional (LMHP), LMHP-supervisee, LMHP-resident, LMHP-RP, certified pre-screener, QMHP, QDDP, or, for skill-building and supervising the individual in crisis, a DSP under the supervision of one of these professionals.

Providers must ensure that DSP staff meet provider training and competency training requirements as specified earlier in this chapter.

Supervision of DSPs must be provided by a supervisor meeting DBHDS Licensing regulatory requirements. Providers must document the provision of supervision and make it available for inspection by DBHDS and DMAS representatives. Documentation of supervision must be signed by the staff person designated to perform the supervision and oversight and must include, at a minimum, the following:

- Date of contact or observation;
- Person contacted or observed;
- A summary about the DSP's performance and service delivery; and
- Any action planned or taken to correct problems identified during supervision and oversight.

Community-Based Crisis Support

Providers of community-based crisis support service must have current signed participation agreements with DMAS and directly provide the service and bill DMAS for Medicaid reimbursement.

Providers must be licensed by DBHDS as providers of crisis stabilization service-REACH (Regional Education Assessment Crisis Services Habilitation). Community-based crisis support service must be provided by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a certified pre-screener, QMHP, or QDDP.

Crisis Support Service

Providers of crisis support service must have current signed participation agreements with DMAS and must directly provide the service and bill DMAS for Medicaid reimbursement.

Crisis support service must be provided by entities licensed by DBHDS as providers of residential crisis stabilization service, or nonresidential crisis stabilization service. Providers must employ or utilize QDDPs, licensed mental health professionals, or other qualified personnel credentialed to provide clinical or behavioral interventions. For the purposes of services delivery and billing, those individuals that do not have a license or degree are considered non-professionals. Those that meet QDDP requirements or are licensed are considered professionals.

Providers must ensure that DSP staff meet provider training and competency training requirements as specified earlier in this chapter.
Supervision of DSPs must be provided by a supervisor meeting DBHDS Licensing regulatory requirements. Providers must document the provision of supervision and make it available for inspection by DBHDS and DMAS representatives. Documentation of supervision must be signed by the staff person designated to perform the supervision and oversight and must include, at a minimum, the following:

- Date of contact or observation;
- Person contacted or observed;
- A summary about the DSP's performance and service delivery; and
- Any action planned or taken to correct problems identified during supervision and oversight.

EMPLOYMENT AND DAY OPTIONS

Benefits Planning

All providers of Benefits Planning services must maintain and adhere to current, signed participation agreements with DMAS. Providers as designated on this agreement must render this service directly and must bill DMAS for Medicaid reimbursement.

Eligible providers for Benefits Planning services must possess written verification that they are one of the following:

- A nationally certified SSA Community Work Incentive Coordinators (CWIC); or
- A DARS certified Work Incentive Specialist Advocate (WISA) approved vendor.

Only providers that have completed required Community Financial Empowerment and Financial Literacy training from the Consumer Financial Protection Bureau (CFPB) and Your Money, Your Goals are eligible to provide and receive payment for a completed Financial Health Assessment.

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Community Coaching

Providers must be licensed by DBHDS as providers of non-center-based day support services.

Providers must have a current, signed provider participation agreement with DMAS to provide this service and directly provide the service and bill DMAS for Medicaid reimbursement.

Providers must ensure that DSP staff meet provider training and competency training requirements as specified earlier in this chapter.

The DSP providing community coaching service must not be an immediate family member of an individual receiving the community coaching service. For an individual receiving sponsored residential services, the DSP providing community coaching must not be a member of the sponsored family residing in the sponsored residential home.

Supervision of DSPs must be provided by a supervisor meeting DBHDS Licensing regulatory requirements. Providers must document the provision of supervision and make it available for inspection by DBHDS and DMAS representatives. Documentation of supervision must be signed by the staff person designated to perform the supervision and oversight and must include, at a minimum, the following:

- Date of contact or observation;
- Person contacted or observed;
- A summary about the DSP's performance and service delivery; and
- Any action planned or taken to correct problems identified during supervision and oversight.

Community Engagement

Providers must be licensed by DBHDS as providers of non-center-based day support services.

Providers must have a current, signed provider participation agreement with DMAS in order to provide this service. The provider designated in the participation agreement must directly provide the service and bill DMAS for reimbursement.

Providers must ensure that DSP staff meet provider training and competency training requirements as specified earlier in this chapter.
The DSP providing community engagement service must not be an immediate family member of an individual receiving community engagement services. For an individual receiving sponsored residential

service, the DSP providing community engagement services must not be a member of the sponsored family residing in the sponsored residential home.

Supervision of DSPs must be provided by a supervisor meeting DBHDS Licensing regulatory requirements. Providers must document the provision of supervision and make it available for inspection by DBHDS and DMAS representatives. Documentation of supervision must be signed by the staff person designated to perform the supervision and oversight and must include, at a minimum, the following:

- Date of contact or observation;
- Person contacted or observed;
- A summary about the DSP's performance and service delivery; and
- Any action planned or taken to correct problems identified during supervision and oversight.

Employment and Community Transportation (ECT)

The service will be offered through an administering agency that possesses any DBHDS license to provide services to individuals with developmental disabilities, an Employment Service Organization, or a Center for Independent Living. Administering agencies must have a current, signed participation agreement with DMAS to provide these services. Providers as designated on this agreement are responsible for billing DMAS for Medicaid reimbursement.

The service may be provided by the individual's family member or legally responsible person, but may not be the guardian, parent, step-parent of an individual under the age of 18 or spouse of an adult who is receiving the service.

In the case of private transportation, the administering agency is responsible for screening community persons to drive the individual to the designated location(s) according to the ISP.

The private driver must:

- Be 18 years of age or older;
- Possess a valid driver's license;
- Possess and maintain at a minimum:
    - A satisfactory driving record defined as no reckless driving charges within the past 24 months, and

- Proof of general liability insurance coverage in compliance with federal and/or state statutory requirements The insurance must insure the driver or the passengers:

    - Against loss from any liability imposed by law for damages;
    - Against damages for care and loss of services, because of bodily injury to or death of any person;
    - Against injury to or destruction of property caused by accident and arising out of the ownership, use, or operation of such motor vehicle(s) within the Commonwealth, any other state in the United States, or Canada;
    - Subject to a limit or exclusive of interest and costs, with respect to each motor vehicle of $25,000 because of bodily injury to or death of one person in any one accident and, subject to the limit for one person, to a limit of $50,000 because of bodily injury to or death of two or more persons in any one accident; and
    - Subject to a limit of $20,000 because of injury to or destruction of property of others in any one accident.

The administering agency is responsible for screening community persons to drive the individual to the designated location(s) according to the ISP. This includes verification of the private driver's:

- Possession of a current, valid driver's license and no reckless driving charges within the past 24 months,
- Possession of car insurance,
- Ensuring that the driver meets the minimum age requirement of age 18, and
- Completion of an attestation signed by the private driver, the individual, and the individual's guardian or authorized representative, as appropriate, that the driver has disclosed any relevant felonies and if listed on any registry. The administering agency must ensure that the driver is not listed on the Virginia Sex Offender Registry.

Initially and annually the administering provider must verify and document that each private driver possesses a current, valid driver's license and car insurance.

Group Day Services

Providers of this service must have a current, signed participation agreement with DMAS. Providers as designated on this agreement must render this service directly and must bill DMAS for Medicaid reimbursement.

Providers of the group day service must hold either a current day support or community-based day support license issued by DBHDS.

Providers of group day service must comply with HCBS setting requirements per 42 CFR 441.301 and as described earlier in this chapter.

Supervision of DSPs must be provided by a supervisor meeting DBHDS Licensing regulatory requirements. Providers must document the provision of supervision and make it available for inspection by DBHDS and DMAS representatives. Documentation of supervision must be signed by the staff person designated to perform the supervision and oversight and must include, at a minimum, the following:

- Date of contact or observation;
- Person contacted or observed;
- A summary about the DSP's performance and service delivery; and
- Any action planned or taken to correct problems identified during supervision and oversight.

Providers must ensure that staff providing group day service meet provider training and competency requirements as specified earlier in this chapter.

Group and Individual Supported Employment

Providers of this service must have a current, signed participation agreement with DMAS. Providers as designated on this agreement must render this service directly and must bill DMAS for Medicaid reimbursement.

Providers must be DARS-contracted providers of supported employment service. DARS must verify that these providers meet criteria to be providers through a DARS-recognized accrediting body. DARS must provide the documentation of this accreditation verification to DMAS and DBHDS upon request.

Providers must maintain their accreditation in order to continue to receive Medicaid reimbursement. Providers that lose their accreditation, regardless of the reason, are not eligible to receive Medicaid reimbursement and will have their provider agreements terminated by DMAS effective the same date as the date of the loss of accreditation. Reimbursements made to such providers after the date of the loss of the accreditation will be subject to recovery by DMAS. Providers whose accreditation is restored will be permitted to re-enroll with DMAS upon presentation of accreditation documentation and a new signed provider participation agreement.

Providers of group supported employment services must comply with HCBS setting requirements per 42 CFR 441.301 and as described earlier in this chapter.

Workplace Assistance

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Providers of this service must have a current, signed participation agreement with DMAS. Providers as designated on this agreement must render this service directly and must bill DMAS for Medicaid reimbursement.

Providers must be either:

- Licensed by DBHDS as a provider of non-center-based day support service, or
- Providers of supported employment services with DARS. DARS must verify that these providers meet criteria to be providers through a DARS-recognized accrediting body. DARS must provide the documentation of this accreditation verification to DMAS and DBHDS upon request.
    - DARS-contracted providers must maintain their accreditation in order to continue to receive Medicaid reimbursement.
    - DARS-contracted providers that lose their accreditation, regardless of the reason, must not be eligible to receive Medicaid reimbursement and must have their provider agreement terminated by DMAS. Reimbursements made to such providers after the date of the loss of the accreditation must be subject to recovery by DMAS.

Providers must ensure that staff providing these services meet provider training and competency requirements as specified earlier in this chapter. In addition, prior to seeking reimbursement for this service from DMAS, these providers must ensure that staff providing workplace assistance service have completed training regarding the principles of supported employment. The documentation of the completion of this training must be maintained by the provider and must be provided to DMAS and DBHDS upon request.

The DSP providing workplace assistance service must coordinate his service provision with the job coach, if there is one providing individual supported employment service to the individual being supported.

Supervision of DSPs must be provided by a supervisor meeting DBHDS Licensing regulatory requirements. Providers must document the provision of supervision and make it available for inspection by DBHDS and DMAS representatives. Documentation of supervision must be signed by the staff person designated to perform the supervision and oversight and must include, at a minimum, the following:

- Date of contact or observation;
- Person contacted or observed;
- A summary about the DSP's performance and service delivery; and
- Any action planned or taken to correct problems identified during supervision and oversight.

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MEDICAL AND BEHAVIORAL SUPPORT OPTIONS

Personal Emergency Response System (PERS)

Providers of this service must have a current, signed participation agreement with DMAS. Providers as designated on this agreement must render this service directly and must bill DMAS for Medicaid reimbursement.

- Providers must be one of the following:
- A licensed home health or personal care agency,
- A durable medical equipment provider,
- A hospital, or
- A PERS manufacturer that has the ability to provide PERS equipment, direct services (i.e., installation, equipment maintenance, and service calls), and PERS monitoring.

Providers must comply with all applicable federal and state laws and regulations, all applicable regulations of DMAS, and all other governmental agencies having jurisdiction over the service to be performed.

Private Duty Nursing

Providers of this service must have a current, signed participation agreement with DMAS. Providers as designated on this agreement must render this service directly and must bill DMAS for Medicaid reimbursement.

Private duty nursing service may be provided by either

- A licensed RN or
- A licensed LPN who is under the supervision of a licensed RN.

The licensed RN or LPN shall be employed by a DMAS-enrolled home health provider or contracted with or employed by a DBHDS-licensed day support service, respite service, or residential service provider.

Both RNs and LPNs providing private duty nursing service must have current licenses issued by the Virginia Board of Nursing or hold current multistate licensure privileges to practice nursing in the Commonwealth.

Skilled Nursing

Providers of RNs or LPNs for this service must have a current, signed participation agreement with DMAS to provide Skilled Nursing services. Providers that have a DMAS Participation Agreement to

provide private duty nursing or home health services may provide DD Waivers skilled nursing services under this agreement. Providers as designated on this agreement must render this service directly and must bill DMAS for Medicaid reimbursement.

Providers must either employ or subcontract with nurses who are currently licensed as either RNs or LPNs per the Code of Virginia or who hold a current multistate licensure privilege to practice nursing in the Commonwealth.

The following types of providers can provide skilled nursing services:

- A licensed RN or LPN, who is under the supervision of a licensed RN, employed by a DMAS-enrolled home health provider, or

- A licensed RN or LPN, who is under the supervision of a licensed RN, contracted with or employed by a DBHDS-licensed day support, respite, or residential services provider – which includes Independent Living Supports, Shared Living, Supported Living, In-Home Support Services, Sponsored Residential and Group Home Residential Services.

Providers (the licensed entity) must maintain documentation of required licenses in the appropriate employee personnel records. Such documentation must be provided to either DMAS or DBHDS upon request.

Foster care providers may not act as skilled nursing service providers for individuals for whom they provide foster care.

Therapeutic Consultation

The following types of therapeutic consultation are reimbursable as DD waiver services when the individual consultant or the employee of an agency with a valid Participation
Agreement meets the required provider standard:

- Psychology Consultation may only be provided by a professional who is:
    - A Psychiatrist who is licensed in the Commonwealth of Virginia;
    - A Psychologist who is licensed by the Commonwealth of Virginia;
    - A Licensed Professional Counselor (LPC) who is licensed by the Commonwealth of Virginia;
    - A Licensed Clinical Social Worker (LCSW) who is licensed by the Commonwealth of Virginia;

- A Psychiatric Clinical Nurse Specialist who is licensed by the Commonwealth of Virginia; or
- A Psychiatric Nurse Practitioner licensed by the Commonwealth of Virginia.

- Behavior Consultation may only be provided by a professional who:
  - Meets the above criteria to provide a psychology consultation; or
  - Is a Positive Behavioral Supports Facilitator endorsed by a recognized positive behavior supports organization; or
  - Is a licensed Behavior Analyst or a licensed Assistant Behavior Analyst.
- Speech Consultation: This service must be provided by a speech-language pathologist who is licensed by the Commonwealth of Virginia.
- Occupational Therapy Consultation: This service must be provided by an Occupational therapist who is licensed by the Commonwealth of Virginia.
- Physical Therapy Consultation: This service must be provided by a physical therapist who is licensed by the Commonwealth of Virginia.
- Therapeutic Recreation Consultation: This service must be provided by a therapeutic recreational specialist who is certified by the National Council for Therapeutic Recreation Certification
- Rehabilitation Consultation: This service must be provided by a rehabilitation engineer or certified rehabilitation specialist.

RESIDENTIAL OPTIONS

Group Home Residential

Providers of this service must have a current, signed participation agreement with DMAS. Providers as designated on this agreement must render this service directly and must bill DMAS for Medicaid reimbursement.

The provider of group home residential service for adults who are 18 years of age or older must be licensed by DBHDS as a provider of group home residential services or a provider approved by the local department of social services as an adult foster care provider. Providers of the group home residential service for children (up to the child's 18th birthday) must be licensed by DBHDS as a children's residential provider.

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Providers of group home residential services must comply with HCBS setting requirements per 42 CFR 441.301 and as described earlier in this chapter. In these settings, lease or residency agreements must comply with and support individual choice of service and setting.

Supervision of DSPs must be provided by a supervisor meeting DBHDS Licensing regulatory requirements. Providers must document the provision of supervision and make it available for inspection by DBHDS and DMAS representatives. Documentation of supervision must be signed by the staff person designated to perform the supervision and oversight and must include, at a minimum, the following:

- Date of contact or observation;
- Person contacted or observed;
- A summary about the DSP's performance and service delivery; and
- Any action planned or taken to correct problems identified during supervision and oversight.

Providers must ensure that staff providing group home residential services meet provider training and competency requirements as specified earlier in this chapter.

Independent Living Support

Providers of this service must have a current, signed participation agreement with DMAS. Providers as designated on this agreement must render this service directly and must bill DMAS for Medicaid reimbursement.

Providers of independent living support services must be licensed by DBHDS as providers of supportive in-home residential services.
Supervision of DSPs must be provided by a supervisor meeting DBHDS Licensing regulatory requirements. Providers must document the provision of supervision and make it available for inspection by DBHDS and DMAS representatives. Documentation of supervision must be signed by the staff person designated to perform the supervision and oversight and must include, at a minimum, the following:

- Date of contact or observation;
- Person contacted or observed;
- A summary about the DSP's performance and service delivery; and
- Any action planned or taken to correct problems identified during supervision and oversight.

Providers must ensure that staff providing independent living support services meet provider training and competency requirements as specified earlier in this chapter.

In Home Support Services

Providers of this service must have a current, signed participation agreement with DMAS. Providers as designated on this agreement must render this service directly and must bill DMAS for Medicaid reimbursement.

Providers of in-home support services must be licensed by DBHDS as providers of supportive in-home services.

Supervision of DSPs must be provided by a supervisor meeting DBHDS Licensing regulatory requirements. Providers must document the provision of supervision and make it available for inspection by DBHDS and DMAS representatives. Documentation of supervision must be signed by the staff person designated to perform the supervision and oversight and must include, at a minimum, the following:

- Date of contact or observation;
- Person contacted or observed;
- A summary about the DSP's performance and service delivery; and
- Any action planned or taken to correct problems identified during supervision and oversight.

Providers must ensure that staff providing in-home support services meet provider training and competency requirements as specified earlier in this chapter.

Shared Living

Providers of this service must have a current, signed participation agreement with DMAS. Providers as designated on this agreement must render this service directly and must bill DMAS for Medicaid reimbursement.

Shared living service administrative providers must be licensed by DBHDS to provide at least one service to individuals with developmental disabilities and must manage the administrative aspects of this service, including roommate matching as needed, background checks, training, periodic onsite monitoring, and disbursing funds to the individual. The shared living administrative provider will be reimbursed a flat fee payment for the completion of these duties following submission of monthly claims for shared living service for reimbursement based upon the amount determined through the service authorization process.

Sponsored Residential

Providers of this service must have a current, signed participation agreement with DMAS. Providers as designated on this agreement must render this service directly and must bill DMAS for Medicaid reimbursement.

Sponsored residential services must be provided by agencies licensed by DBHDS as a provider of sponsored residential service.

Providers must ensure that sponsors providing sponsored residential services meet provider training and competency requirements as specified earlier in this chapter.

Supervision of DSPs who are hired by the Sponsor to supplement their hours of support or to provide support during such time as the Sponsor is not present, must be provided by a supervisor meeting DBHDS Licensing regulatory requirements. Providers must document the provision of supervision and make it available for inspection by DBHDS and DMAS representatives. Documentation of supervision must be signed by the staff person designated to perform the supervision and oversight and must include, at a minimum, the following:

- Date of contact or observation;
- Person contacted or observed;
- A summary about the DSP's performance and service delivery; and
- Any action planned or taken to correct problems identified during supervision and oversight.

Sponsored residential settings must comply with the HCBS setting requirements per 42 CFR 441.301. In these settings, lease or residency agreements must comply with and support individual choice of service and setting.

Supported Living

Providers of this service must have a current, signed participation agreement with DMAS. Providers as designated on this agreement must render this service directly and must bill DMAS for Medicaid reimbursement.

The provider must be licensed by DBHDS as a provider of supervised residential service or supportive in-home service.

Providers must ensure that staff providing supported living residential services meet provider training and competency requirements as specified earlier in this chapter.

Supervision of DSPs must be provided by a supervisor meeting DBHDS Licensing regulatory requirements. Providers must document the provision of supervision and make it available for inspection by DBHDS and DMAS representatives. Documentation of supervision must be signed by the staff person designated to perform the supervision and oversight and must include, at a minimum, the following:

- Date of contact or observation;
- Person contacted or observed;
- A summary about the DSP's performance and service delivery; and
- Any action planned or taken to correct problems identified during supervision and oversight.

Supported living residential service must comply with the HCBS settings requirements when provided in DBHDS licensed settings per 42 CFR 441.301 and as described earlier in this chapter. In these settings, lease or residency agreements must comply with and support individual choice of service and setting.

Self Directed and Agency Directed Services

- Perform criminal history record checks for barrier crimes in accordance with applicable licensure requirements at §§ 37.2-416, 37.2-506, and 37.2-600 37.2-607 of the Code of Virginia, as applicable. If the individual enrolled in the waiver is a minor child, also perform a search of the VDSS Child Protective Services Central Registry. The provider will not be compensated for services provided to the individual enrolled in the waiver effective on the date and afterwards that any of these records checks verifies that the staff person providing services was ineligible to do so pursuant to the applicable statute.

    - For consumer-directed (CD) services, the CD employee must submit to a criminal history records check obtained by the fiscal employer agent within 30 days of employment. If the individual enrolled in the waiver is a minor child, the CD employee must also submit to a search within the same 30 days of employment of the VDSS Child Protective Services Central Registry. The CD employee will not be compensated for services provided to the waiver individual effective the date on which the employer of record learned, or should have learned, that the record check verifies that the CD employee has been convicted of barrier crimes pursuant to § 37.2-416 of the Code of Virginia or if the CD employee has a founded complaint confirmed by the VDSS Child Protective Services Central Registry (if applicable).

    - The DMAS-designated fiscal employer agent will require the CD employee to notify the employer of record of all convictions occurring subsequent to the initial record check. CD employees who refuse to consent to criminal background checks and VDSS Child Protective Services Central Registry checks will not be eligible for Medicaid reimbursement.

    - The CD employer of record will require CD employees to notify the employer of record of all convictions occurring subsequent to the initial record check. CD employees who refuse to consent to criminal background checks and VDSS Child Protective Services registry checks will not be eligible for Medicaid reimbursement.

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Individual Rights/Responsibilities

- The provider must have a written statement of individual rights, which clearly states the responsibilities of both the provider and the individual in the provision of services. This statement of individual rights must be signed by the individual and the provider representative at the time services are initiated. This statement must be maintained in the individual's file, and a copy must be given to the individual. The statement of individual rights must include the following:

- The provider, or Services Facilitator in the case of consumer-directed (CD) services, of Personal Assistance (agency-directed (AD) & CD), Respite (AD & CD), Companion (AD & CD), In-home Supports, and Shared Living must inform the individual of his or her responsibility to have some planned back-up for times when the provider is unable to secure coverage and to identify which staff the individual should contact regarding schedule changes.

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CHAPTER III

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DETERMINING ELIGIBILITY

The Department of Medical Assistance Services (DMAS) administers Virginia's medical assistance programs: Medicaid (called FAMIS Plus for children), FAMIS for children under age 19 years, and FAMIS MOMS for pregnant women. FAMIS and FAMIS MOMS offer coverage similar to Medicaid but have higher income thresholds. Per state regulations, eligibility determinations for the medical assistance programs are made by the local departments of social services (LDSS) and by the Cover Virginia Central Processing Unit (CPU).

Inquiries from persons who wish to apply for medical assistance should be referred to the LDSS in the locality in which the applicant resides, to the Cover Virginia Call Center at 1-855-242-8282, or the Cover Virginia website at www.CoverVA.org. DMAS will not pay providers for services, supplies, or equipment until the applicant's eligibility has been determined. (See "Assistance to Patients Possibly Eligible for Benefits.") Once an applicant has been found eligible, coverage for Medicaid can be retroactive for up to three months before the month in which the application was filed. A member's eligibility must be reviewed when a change in the member's circumstances occurs, and all members are subject to an annual renewal (redetermination) of eligibility.

Groups Covered by Medical Assistance

Individuals who apply for Medicaid are evaluated under the covered group or groups they meet. Each covered group has a prescribed income limit, and some covered groups also have an asset or resource limit. . Individuals may be eligible for full medical assistance coverage, including the payment of Medicare premiums for Medicaid members with Medicare, if they fall into one of the following covered groups and meet the nonfinancial and financial requirements for the group:

- Auxiliary Grants (AG) recipients
- Aged, blind or disabled (ABD) recipients of Supplemental Security Income (SSI) and certain former SSI recipients with "protected" status
- ABD individuals with income less than or equal to 80% of the Federal Poverty Level (FPL) who are age 65 or older and/or who are eligible for or enrolled in Medicare.
- Low-Income Families with Children (parents with a dependent child under age 18 years in the home)
- Pregnant women, and postpartum women through the end of the 60-day postpartum period (Medicaid, FAMIS MOMS)

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- Newborns up to age one year born to mothers who were eligible for Medicaid or covered by FAMIS or FAMIS MOMS at the time of the birth
- Children in foster care or subsidized adoptions, and individuals under age 26 who were formerly in foster care until their discharge from foster care at age 18 or older.
- Children under age 19 years (FAMIS Plus, FAMIS)
- Adults between the ages of 19 and 64 who are not eligible for or enrolled in Medicare. These individuals are referred to as Modified Adjusted Gross Income (MAGI) Adults.
- Individuals under age 21 in institutional care
- Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)—women and men who were certified through the Breast and Cervical Cancer Early Detection Program.
- Individuals who are in long-term care institutions or receiving services under a home and community-based care waiver, or who have elected hospice care

The following individuals may be eligible for limited Medicaid coverage if they meet the nonfinancial and financial requirements for their covered group:

- Qualified Medicare Beneficiaries (QMBs) with income over 80% of the FPL but within 100% of the FPL. This group is eligible for Medicaid coverage of **Medicare premiums, deductibles, and coinsurance only**.
- Special Low-Income Medicare Beneficiaries (SLMB) with income less than 120% of the FPL. This group is eligible for Medicaid coverage of **Medicare Part B premiums only**.
- Qualified Individuals (QI) with income equal to or greater than 120% but less than 135% of the FPL. This group is eligible for Medicaid coverage of the **Medicare Part B premiums** only.
- Qualified Disabled and Working Individuals (QDWI) with income up to 200% of the FPL. This group is eligible for Medicaid payment of **Medicare Part A premiums only**.
- Plan First – any individual with income equal to or less than 200% of FPL. This group is eligible for limited Medicaid coverage of family planning services only and not covered for full Medicaid benefits. If a member does not wish to be enrolled in Plan First, he or she should contact the local DSS to be disenrolled.

Medically Needy Covered Groups and Spenddown

Through a process known as "spenddown," Medicaid provides a limited period of full coverage for certain groups of "Medically Needy" individuals who meet all of the Medicaid

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eligibility requirements but have excess income for full benefit Medicaid. Individuals to which spenddown may apply include:

- ABD individuals
- Pregnant women and their newborn children
- Children under age 18
- Individuals under Age 21 in institutional care, under supervision of the Department of Juvenile Justice, foster care, or subsidized adoptions
- Individuals in long-term care institutions and those receiving services under a home and community-based care waiver or who have elected hospice care.

To be eligible for Medicaid, the individual must have incurred medical expenses that at least equal the spenddown liability. If the individual's allowable medical expenses equal the spenddown liability amount before the end of a budget period (six-month period for non-institutionalized individuals or a one month period for institutionalized individuals), the applicant may receive a limited period of Medicaid coverage which will stop at the end of the budget period. The spenddown liability is the difference between the individual's income and the Medically Needy income limit for the individual's locality, multiplied by the number of months in the individual's spenddown period. Eligibility must be re-determined in order to establish eligibility in subsequent budget periods.

An individual placed on a spenddown does **not** have full Medicaid coverage until the spenddown is met, however they may be eligible for limited Medicaid coverage, Plan First, during the spenddown period. Medicaid cannot pay medical expenses incurred prior to the date the spenddown is met.

Emergency Medicaid Services for Aliens

To be eligible for full Medicaid benefits, FAMIS or FAMIS MOMS, an individual must be a resident of Virginia and a U.S. citizen or an alien qualified for full benefits. Individuals who do not qualify for full Medicaid benefits due to their alien status may be eligible for Medicaid coverage of emergency services if they meet all other nonfinancial and financial eligibility requirements for full Medicaid coverage.. The FAMIS and FAMIS MOMS programs do not cover emergency services for undocumented immigrants.

LDSS staff determine eligibility for receipt of emergency Medicaid coverage based on regular eligibility criteria and documentation from the provider of services that emergency services were provided. The provider may refer the individual to the LDSS or Cover Virginia (see Chapter I for information on the covered services and the coverage criteria.) For the purposes of this section, labor and delivery are considered emergency services.

Receipt of the emergency treatment will be verified by the LDSS through the member's medical record obtained from the provider. The LDSS will send a written request to the provider for the necessary documentation of the emergency service. This documentation must include all required Medicaid forms and a copy of the member's complete medical

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record. For inpatient hospital stays, this documentation will be the medical record for the entire hospitalization up to the 21-day limit for those over age 20.

The LDSS is authorized to approve labor and delivery services of up to three days for a vaginal delivery and five days for a cesarean section. All other services will be referred to DMAS for approval of the coverage of treatment and for establishment of the time for which this coverage will be valid.

If the member is found eligible and the emergency coverage is approved by DMAS, each provider rendering emergency care will be notified via the Emergency Medical Certification Form (#032-03-628) of the member's temporary eligibility number for coverage of the treatment of the conditions during the time stated on this form. This form will also be used to notify providers if an alien is not eligible for emergency care (See "Exhibits" at the end of this chapter for a sample of this form.).

Medicaid Eligibility for Institutionalized Individuals

An institutionalized individual is defined as one who is receiving long-term services and supports (LTSS) as an inpatient in a medical institution or nursing facility or in the home or community setting. Home and community based services (HCBS) include waiver services such as personal care, adult day health care, respite care, and the Program for All Inclusive Care for the Elderly (PACE).

To be approved for Medicaid-covered LTSS, the individual must be institutionalized in a nursing or other medical facility or have been screened and approved for HCBS. and be eligible for Medicaid in a full-benefit covered group.

If an individual is not eligible for Medicaid in any other full-benefit covered group, the individual's eligibility in the one of the special income covered groups is determined. The policy for these groups allows a different method of determining income and resource eligibility, a higher income limit of 300% of the SSI payment for one person.,
An married institutionalized individual's spouse at home is referred to as the community spouse. The community spouse is able to retain a specified amount of resources in order to continue to meet maintenance needs in the community. Some of the institutionalized spouse's monthly income may also be allocated to the community spouse if certain criteria are met. Atthe time of application for Medicaid, the LDSS completes the resource assessment document, which produces a compilation of a couple's combined countable resources at the time one spouse became institutionalized and a calculation of a spousal share (the amount of shared resources that can be allocated to the community spouse). An institutionalized spouse with a community spouse may also request a resource assessment without submitting a Medicaid application to assist with financial planning.

Most individuals receiving LTSS have an obligation toward the cost of their care, known as the patient pay. MAGI adults do not have a patent pay responsibility.

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FAMILY ACCESS TO MEDICAL INSURANCE SECURITY (FAMIS) PLAN

FAMIS is Virginia's Title XXI Children's Health Insurance Program (CHIP) and is a comprehensive health insurance program for children from birth through age 18 who are not covered under other health insurance and whose income is over the Medicaid income limit but no more than 200% of the FPL.

FAMIS provides twelve months of continuous coverage (beginning with the month the child was enrolled), unless:

- The family's gross monthly income goes over the income limit for the family size,
- The child moves out of Virginia,
- The child is found eligible for FAMIS Plus (children's Medicaid)
- The child turns age 19 during the 12 month enrollment period, or
- The family requests, that the FAMIS coverage be stopped.

FAMIS coverage is administered as two benefit packages through two delivery systems. One is a modified Medicaid look-alike component offered through a fee-for-service (FFS) program. The other package is delivered by contracted managed care organizations (MCOs). When children are initially enrolled in FAMIS they will have brief coverage in FFS before transitioning to a managed care organization (MCO). Children found eligible under FAMIS are eligible for benefits similar to those covered under the State Plan for Medical Assistance except for inpatient mental hospital services, some community mental health rehabilitation services, routine services, transportation, and some cost-sharing limitations.

The FAMIS MOMS program covers pregnant women and postpartum women through the end of the 60-day postpartum period whose income is over the Medicaid income limit but no more than 200% of the FPL. FAMIS MOMS provides the same benefits to pregnant women as Medicaid, including dental services. There are no copayments for pregnancy related services.

MEMBER ELIGIBILITY CARD

A blue and white plastic eligibility card is issued to members to present to participating providers. Plan First members receive a green and white identification card. **The provider is obligated to determine that the person to whom care or service is being rendered is the same individual listed on the eligibility card.** The provider has the responsibility to request such identification as he or she deems necessary. Presentation of a plastic ID card is not proof of coverage nor guarantee of payment. A sample of an eligibility card is included under "Exhibits" at the end of this chapter.

Eligibility must be confirmed each time service is rendered. Verification can occur through a verification vendor, the voice response system or the web-based verification system. LDSS do not provide verification of eligibility to providers.

Some individuals have coverage under a Virginia Medicaid/FAMIS contracted managed care organization (MCO) and should not receive services outside their network without a referral

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and authorization from the MCO. These members will have an MCO card in addition to the Medicaid/FAMIS card. The verification response will advise if the member has restrictions such as a contracted MCO enrollment, or a primary payer.

The provider must determine if the service is within the dates of eligibility. These dates must be checked prior to rendering any service. Benefits are available only for services performed during the indicated period of eligibility; Medicaid/FAMIS will not pay for care or services rendered before the beginning date or after the end date of eligibility.

Bank Identifier

The top six numbers on the plastic card represent the Bank Identifier Number (BIN), which is required for pharmacy benefit cards under the National Council of Prescription Drug Programs (NCPDP).

Name of Eligible Person

An eligibility card is issued to each person eligible for full Medicaid/FAMIS benefits and QMBs. Members enrolled in Plan First receive a green and white identification card. Check the name against another proof of identification if there is any question that the card does not belong to the member.

Member's Eligibility Number

The **member's** complete eligibility number is embossed on the front of the eligibility card. Eligibility numbers are distinct and permanent. When a member relocates or moves into another case, or has a break in eligibility, he keeps the same number and the same card. When members are enrolled in Plan First, they will receive a green and white identification card. This number serves as a "key" in verifying current eligibility status.

All 12 digits must be entered on Medicaid forms for billing purposes.

Date of Birth

The date of birth indicates the member's age and identifies eligibility for those services with age restrictions, such as dental care for members under age 21 and pregnant women. The date of birth should be checked prior to rendering any services. The provider should verify the age of the member. If the provider has a question as to the age of the member, means of identification other than the Medicaid/FAMIS card should be examined.

Sex

The member's gender is indicated on the card.

Card #

The sequential number of the member's card is given. If a card is lost or stolen and another

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is issued, the prior card will be de-activated and will not confirm eligibility using the magnetic "swipe" mechanism.

Cardholder's Signature (signature line on back)

The signature line provides another element of verification to confirm identity.

VERIFICATION OF MEMBER ELIGIBILITY

It is the obligation of the provider of care to determine the identity of the person named on the eligibility card and the current eligibility status, to include program type or MCO enrollment. It is in the best interest of the provider to review the card each time services are rendered. Possession of a card does not mean the holder is currently eligible for benefits. **The member does not relinquish the card when coverage is cancelled.** Replacement cards must be requested.

Program/Benefit Package Information

Members' benefits vary depending upon the program in which they are enrolled. The eligibility verification will provide information on which program the member is participating in. Examples of these programs include Medallion 3.0, Medicaid fee-for-services, FAMIS MCO, CCC Plus, FAMIS fee-for-service and Medicare premium payment.

Limited Benefit Programs for Which Members Receive Eligibility Cards

The Medicare Catastrophic Coverage Act of 1988 and other legislation require State Medicaid Programs to expand the coverage of services to QMBs. There are two levels of coverage for QMBs, based on financial eligibility.

QMB Coverage Only—Members in this group are eligible for Medicaid coverage of Medicare premiums and of deductible and coinsurance up to the Medicaid payment limit, less the member's copayment on allowed charges for all Medicare-covered services. Their Medicaid verification will provide the message "QUALIFIED MEDICARE BENEFICIARY--QMB." The Medicare coinsurance is limited to the Medicaid fee when combined with the Medicare payment.

QMB Extended Coverage—Members in this group are dually-eligible for full Medicaid coverage and Medicare. They are eligible for Medicaid coverage of Medicare premiums and of deductible and coinsurance up to the Medicaid payment limit on allowed charges for all Medicare-covered services plus coverage of all other Medicaid-covered services listed in Chapter I of this manual. This group's Medicaid verification provides the message, "QUALIFIED MEDICARE BENEFICIARY--QMB EXTENDED." These members are responsible for copays for pharmacy services, health department clinic visits, and vision services.

SLMBs and QIs do not receive member eligibility cards because they are not eligible for the payment of medical services rendered.

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Plan First—Men and women enrolled in Plan First can receive limited Medicaid covered family planning services only, and they receive a green and white plastic Plan First identification card. This group's Medicaid verification provides the message, "PLAN FIRST - FAMILY PLANNING SERVICES ONLY." See the Plan First Manual for more information.

All Others—Members without ANY of these messages at time of verification will be eligible for those covered services listed in Chapter I of this manual.

Special Indicator Code (Copayment Code)

The Special Indicator Code indicates the status of copayments or eligibility for certain additional services. These codes are:

Code	Message
A	Under 21 - No copay exists.
B	Individuals Receiving Long-Term Care Services, Home or Community-Based Waiver Services, or Hospice Care - No copay is required for any service.
C	All Other Members - Copays apply for inpatient hospital admissions, outpatient hospital clinic visits, clinic visits, physician office visits, other physician visits, eye examinations, prescriptions, home health visits, and rehabilitation service visits. (Some verification methods may return a yes/no response. Yes = copays apply. No = copays do not apply)

The following copay exemptions apply:

- Members in managed care organizations may not have to pay copays.
- Pregnancy-related services or family planning clinic visits, drugs, and supplies are exempt from copays for all members.
- No copayments apply for any emergency services for any member, with one exception for members in Client Medical Management with a pharmacy restriction. Please refer to the Client Medical Management exhibit in Chapter I for more information on this exception.

The Medicaid member co-pays are located in Chapter IV.

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The FAMIS member co-pays are:

Service*	**Co-pay Status 1**	**Co-pay Status 2**
Outpatient Hospital or Doctor	$2 per visit	$5 per visit
Prescription Drugs	$2 per prescription	$5 per prescription
Inpatient Hospital	$15 per admission	$25 per admission
Non-emergency use of Emergency Room	$10 per visit	$25 per visit
Yearly Co-payment Limit per Family	$180	$350

*Other co-payments may apply to other services.

Insurance Information

The "Insurance Information" in the verification response indicates any type of insurance coverage the member has in addition to Medicaid. This information includes specific insurance companies, dates of coverage, policy numbers, and a code that specifies the particular type of coverage of the policy. These items are:

Carrier Code	A three-digit code indicating the name of the insurance carrier, e.g. 001 for Medicare (See Insurance Company Code List for these code numbers in "EXHIBITS" at the end of this chapter.) If the carrier code is 003 (not listed), call the member's local eligibility worker for assistance in obtaining the name of the insurance carrier.
Begin Date	The first date on which this insurance policy was effective
Type Code	An alpha character describing the type of coverage provided by the policy, such as a "D" for dental coverage. (See the Type of Coverage Code List under "EXHIBITS" at the end of this chapter for a list of these codes.)
Policy Number/ Medicare Code	The specific policy or Medicare number for the insurance identified by the Carrier Code

Only insurance information for active policies during the period for which eligibility is requested is provided at verification. If the member reports insurance information different from what is on the card, refer the member to his or her LDSS eligibility worker to correct the data so bills will be processed correctly.

Under the assignment of benefits regulations, DMAS can act on behalf of the member (subscriber) and recover third-party payment from the primary carrier. Workers' Compensation and other liability insurances (e.g., automobile liability insurance or home

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accident insurance) **are always considered as primary carriers** for cases where coverage is applicable to the injury being treated. Because the member's eligibility card cannot indicate this coverage, it is necessary that cause-of-injury information be obtained from the member.

Primary Care Providers (PCPs) for the Client Medical Management Program

A primary care designation or restriction is imposed by the Member Monitoring Unit of DMAS as a result of high utilization of services by the member causing unnecessary or duplicate services. Eligibility verification will list the names of designated primary care providers (physician and/or pharmacy). The designated providers must agree to the relationship prior to the designation appearing on the member's card. Unless it is an emergency, do not provide services without contacting the primary care provider first for authorization.

Managed Care Programs

Most Medicaid members are enrolled in one of the Department's managed care programs (Medallion 3.0, Medallion 4.0, CCC Plus, PACE). Each program has specific eligibility requirements and health plan assignment criteria for its members. For more information, please contact the individual's managed care plan/PACE provider directly.

Contact and/or eligibility and assignment information for managed care plans can be found on the DMAS website for each program as follows:

- Medallion 3.0:
  http://www.dmas.virginia.gov/#/med3
- Medallion 4.0:
  http://www.dmas.virginia.gov/#/med4
- Commonwealth Coordinated Care Plus (CCC Plus):
  http://www.dmas.virginia.gov/#/cccplus
- Program of All-Inclusive Care for the Elderly (PACE)
  http://www.dmas.virginia.gov/#/longtermprograms

MEMBER WITHOUT AN ELIGIBILITY CARD

A member who seeks services without a current eligibility card should be considered responsible for all charges incurred unless eligibility is verified. The provider can verify eligibility without the card using two other identification keys, including name, Social Security Number, and date of birth. These can be used to access the MediCall automated System, the verification vendors, and the web verification system (ARS). See Chapter I for further information about verification methods. LDSS do not provide verification of eligibility to providers.

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ASSISTANCE TO PATIENTS POSSIBLY ELIGIBLE FOR BENEFITS

If a patient is unable to pay for services rendered, the provider may refer the patient or the patient's authorized representative to the LDSS in the locality in which the applicant resides or to the Cover Virginia Call Center at 1-855-242-8282 for an application for health care coverage. The LDSS or Cover Virginia will notify the patient of eligibility or ineligibility. Medicaid assumes no financial responsibility for services rendered prior to the effective date of a member's eligibility. The effective date of Medicaid eligibility may be retroactive up to three months prior to the month in which the application was filed, if the patient was eligible during the retroactive period. Once a patient is found eligible, providers may bill Medicaid for covered services, and upon receipt of payment from Medicaid, must reimburse the patient for the out-of-pocket expenses; Medicaid does not reimburse members for out-of-pocket expenses.

MEDICAID APPLICATIONS--AUTHORIZED REPRESENTATIVE POLICY

Medicaid eligibility requirements are strict and require an applicant or someone conducting business on his or her behalf to attest to citizenship or alien status, declare all income and assets, and make assignment of insurance and medical support benefits. In order to accurately determine eligibility, LDSS must ensure that an individual who files an application or someone conducting business on behalf of the applicant has full knowledge of the applicant's situation and can provide correct information.

A Medicaid applicant must sign the application form unless the application is filed and signed by the applicant's legal guardian or conservator, attorney-in-fact, or other person who is authorized to apply on the applicant's behalf. If the applicant is unable to sign his or her name but can make a mark, the mark must be designated "his/her mark" and witnessed by one person.

A child under age 18 cannot legally sign a Medicaid application for himself or herself unless he or she is legally emancipated from his or her parents. If a child is not legally emancipated, his or her parent or legal guardian**,** an authorized representative designated by the parent or legal guardian, or a caretaker relative with whom the child lives must sign the application. Exception: A minor child under 18 years of age may apply for Medicaid on behalf of his or her own child.

A legally competent individual age 18 or older may authorize anyone age 18 or older to file a Medicaid application on his or her behalf provided that the authorization is in writing, identifies the individual or organization authorized to conduct business on his or her behalf, and is signed by the individual giving the authorization.

When an individual has been determined by a court to be legally incompetent or legally incapacitated, the individual's legally appointed guardian or conservator is the individual's authorized representative and can apply for Medicaid on the individual's behalf. If an individual does not have a legal guardian or authorized representative and is mentally unable to sign an application or designate a representative, the individual's spouse will be considered the authorized representative for Medicaid purposes. In situations where the individual is not married, is estranged from his or her spouse, or the spouse is unable to represent him or her, a relative of the individual who is willing to take responsibility for the

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individual's Medicaid business may be considered his or her authorized representative. Relatives who may be considered authorized representatives in this situation are, in the following order of preference: the individual's adult child; parent; adult sibling; adult niece or nephew; or adult aunt or uncle.

If it is determined that an individual cannot sign an application and does not have an attorney-in-fact or authorized representative, a Medicaid application may be filed by someone other than an authorized person provided the individual's inability to sign the Medicaid application is verified by a written statement from the individual's doctor. The statement must indicate that the individual is unable to sign and file a Medicaid application because of his or her diagnosis or condition. The LDSS will pend the application until it can be appropriately signed if it is determined that court action has been initiated to have a guardian or committee appointed for the individual or until an Adult Protective Services investigation concludes that guardianship proceedings will not be initiated. Under no circumstances can an employee of, or an entity hired by, a medical service provider who stands to obtain Medicaid payment file a Medicaid application on behalf of an individual who cannot designate an authorized representative.

An application may be filed on behalf of a deceased person by his or her guardian or conservator, attorney-in-fact, executor or administrator of his or her estate, surviving spouse, or a surviving family member, in the following order of preference: adult child, parent, adult sibling, adult niece or nephew, or adult aunt or uncle. The application must be filed within a three-month period subsequent to the month of the individual's death. Medicaid coverage can be effective no earlier than three months prior to the application month. Under no circumstances can an employee of, or an entity hired by, a medical service provider who stands to obtain Medicaid payment file a Medicaid application on behalf of a deceased individual.

NON-MEDICAID PATIENT RELATIONSHIP

Medicaid-eligible members who elect to be treated as private patients or who decline to verify their Medicaid eligibility with providers will be treated as private pay patients by the provider and by DMAS. Providers are required to furnish supporting documentation whenever patients fall into either of these categories.

NEWBORN INFANT ELIGIBILITY

All newborn days, including claims for "well babies," must be submitted separately. "Well baby" days cannot be processed as part of the mother's per diem, and no information related to the newborn must appear on the mother's claim.

A newborn is automatically considered eligible for Medicaid or FAMIS through age 1 year if the newborn's mother was eligible for full coverage Medicaid or enrolled in FAMIS or FAMIS MOMS at the time she gave birth. A medical assistance application must be filed for any child whose mother was not eligible for Medicaid or enrolled in FAMIS/FAMIS MOMS at the time of the child's birth.

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An easy, streamlined way for hospitals to report the birth of the newborn is through the Medicaid Web Provider Portal www.virginiamedicaid.dmas.virginia.gov under the link "E-213". Any hospital staff that have approval from their hospital and have access to the portal may report the newborn's birth and receive the newborn's Member ID within 2 business days via email.

The provider can verify newborn eligibility from the card using two other identification keys, including name, social security number, and the date of birth. These can be used to access MediCall, the verification vendors, and the web-based system, ARS.

See Chapter I for more information on eligibility verification.

MEDICAID ELIGIBILITY FOR HOSPICE SERVICES

To be eligible to elect hospice as a Medicaid benefit, an individual must be entitled to Medicaid benefits and be certified as terminally ill. "Terminally ill" is defined as having a medical prognosis that life expectancy is six months or less. If the individual is eligible for Medicare as well as Medicaid, the hospice benefit must be elected or revoked concurrently under both programs.

GUIDELINES ON INSTITUTIONAL STATUS

Federal regulations in 42 CFR 435.1009 prohibit federal financial participation in Medicaid services provided to two groups of individuals in institutions; these individuals are NOT eligible for Medicaid:

- individuals who are inmates of a public institution, and
- individuals under age 65 years who are patients in an institution for the treatment of mental diseases (IMD), unless they are under age 22 and are receiving inpatient psychiatric services. An IMD is a hospital, nursing facility or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment or care, including medical attention, nursing care and related services, to persons with mental diseases. A psychiatric residential treatment facility for children and adolescents is an IMD. An Intermediate Care Facility for the Intellectually Disabled (ICF-ID) is not an IMD.

Inmates of a Public Institution

Inmates of public institutions fall into three groups:

- individuals living in ineligible public institutions;
- incarcerated adults; and
- juveniles in detention.

An individual is an inmate of a public institution from the date of admission to the public institution until discharge, or from the date of actual incarceration in a prison, county or city

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jail or juvenile detention facility until permanent release, bail, probation or parole. An individual is considered incarcerated until permanent release, bail, probation or parole.

An individual who lives in a public residential facility that serves more than 16 residents is NOT eligible for Medicaid. The following are ineligible public institutions:

- public residential institutions with more than 16 beds
- residential facilities located on the grounds of, or adjacent to, a public institution with more than 16 beds.

Incarcerated Individuals

Incarcerated individuals (adults and juveniles) who are hospitalized can be eligible for Medicaid payment limited to services received during an inpatient hospitalization of 24 hours or longer, provided they meet all other Medicaid eligibility requirements.

Incarcerated individuals include:

- individuals under the authority of the Virginia Department of Corrections (DOC) or Virginia Department of Juvenile Justice (DJJ), and
- individuals held in regional and local jails, including those on work release.

Individuals are not eligible for full benefit Medicaid coverage while they are living in a correctional facility, regional or local jail or juvenile facility.

An individual in prison or jail who transfers temporarily to a halfway house or residential treatment facility prior to a formal probation release order is still an inmate of a public institution and can only be eligible for Medicaid payment limited to services received during an inpatient hospitalization.

An individual released from jail under a court probation order due to a medical emergency is NOT an inmate of a public institution because he is no longer incarcerated.

Once an individual is released from the correctional facility, he can be enrolled in full benefit Medicaid, provided he meets all Medicaid eligibility requirements.

Juveniles

In determining whether a juvenile (individual under age 21 years) is incarcerated, the federal Medicaid regulations distinguish between the nature of the detention, pre- and post-disposition situations, and types of facilities.

a. Prior to Court Disposition

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The following juveniles can be eligible for Medicaid payment limited to services received during an inpatient hospitalization.

- juvenile who is in a detention center due to criminal activity
- juvenile who has criminal charges pending (no court disposition has been made) who is ordered by the judge to go to a treatment facility, then come back to court for disposition when the treatment is completed

b. After Court Disposition

Juveniles who are on probation with a plan of release which includes residence in a detention center are inmates of a public institution. If they go to any of the secure juvenile correctional facilities, they are inmates of a public institution and can only be eligible for Medicaid payment limited to inpatient hospitalization. A list of secure detention facilities in Virginia is available on the Department of Juvenile Justice's web site: http://www.djj.virginia.gov/Residential_Programs/Secure_Detention/pdf/Detention_Home_Contacts_02242011rev.pdf.

If they go to a non-secure group home, they can be eligible for Medicaid or FAMIS because a non-secure group home is not a detention center.
A juvenile who is in a detention center due to care, protection or in the best interest of the child can be eligible for full benefit Medicaid or Family Access to Medical Insurance Security (FAMIS) coverage.

c. Type of Facility

The type of facility, whether it is residential or medical and whether it is public or private must be determined. A juvenile is not eligible for full-benefit Medicaid if he/she is a resident of an ineligible public residential facility. He can be eligible for Medicaid coverage limited to inpatient hospitalization if he is admitted to a medical facility for inpatient services.

Who is Not an Inmate of a Public Institution

An individual is NOT an inmate of a public institution if:

- the individual is in a public educational or vocational training institution for purposes of securing education or vocational training OR
- the individual is in a public institution for a temporary period pending other arrangements appropriate to his needs. Individuals in public institutions for a temporary period include:

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- individuals admitted under a TDO
- individuals arrested then admitted to a medical facility
- inmates out on bail
- individuals on probation (including a juvenile on conditional probation or probation in a secure treatment center), parole, or conditional release
- juveniles in a detention center due to care, protection or in their best interest.

MEMBER APPEALS

The Code of Federal Regulations at 42 CFR §431, Subpart E, and the Virginia Administrative Code at 12VAC30-110-10 through 12VAC30-110-370, require that written notification be provided to individuals when DMAS or any of its contractors takes an action that affects the individual's receipt of services. Most adverse actions may be appealed by the Medicaid member or by an authorized representative on behalf of the member. Adverse actions include partial approvals, denials, reductions in service, suspensions, and terminations. Also, failure to act on a request for services within required timeframes may be appealed. Members who are enrolled in an MCO may appeal to the MCO or directly to DMAS. For individuals who do not understand English, a translation of appeal rights that can be understood by the individual must be provided.

If an appeal is filed before the effective date of the action, or within 10 days of the date the notice of action was sent, services may continue during the appeal process. However, if the agency's action is upheld by the hearing officer, the member may be expected to repay DMAS for all services received during the appeal period. For this reason, the member may choose not to receive continued services. The provider will be notified by DMAS to reinstate services if continuation of services is applicable. If services are continued or reinstated due to an appeal, the provider may not terminate or reduce services until a decision is rendered by the hearing officer.

Member appeals must be requested in writing and postmarked or submitted within 30 days of receipt of the notice of adverse action. The member or his authorized representative may complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov, or by calling (804) 371-8488.

If the member is not able to get the form, he may write a letter. The letter must include the name of the person whose request for benefits was denied, reduced, or cancelled. Also, the letter must include the person's date of birth, social security number, case number, the agency that took the action, and the date of the action.

A copy of the notice or letter about the adverse action should be included with the appeal request. The appeal request must be sent to the:

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Appeals Division
Department of Medical Assistance Services
600 E. Broad Street, 6th Floor
Richmond, Virginia 23219
Appeal requests may also be faxed to: (804) 452-5454

The Appeals Division will notify members of the date, time and location of the hearing if the appeal is valid and a hearing is granted. The hearing will be conducted by a DMAS Hearing Officer. Most hearings will be done by telephone.

The Hearing Officer's decision is the final administrative decision by DMAS. If the member does not agree with the Hearing Officer's decision, he/she may appeal it directly to the circuit court in the city or county of residence.

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EXHIBITS

Commonwealth of Virginia
Department of Social Services

EMERGENCY MEDICAL CERTIFICATION

TO: DIVISION OF PROGRAM OPERATIONS
DEPT. OF MEDICAL ASSISTANCE SERVICES
600 EAST BROAD STREET, SUITE 1300
RICHMOND, VA 23219

APPLICANT'S NAME:

CASE NUMBER:

I. LDSS REFERRAL SECTION

THE ABOVE-NAMED INDIVIDUAL APPLIED FOR MEDICAID ON _____. RETROACTIVE COVERAGE FOR _____IS ALSO REQUESTED.
(DATE)
INDIVIDUAL'S STATUS: ☐ A ☐ B ☐ C DIALYSIS PATIENT: YES ☐ NO ☐

ATTACHED IS INFORMATION ON THE EMERGENCY SERVICES MEDICAL TREATMENT.

SIGNED: _____WORKER #:_____TELEPHONE #:_____DATE: _____

AGENCY NAME:_____

AGENCY ADDRESS:_____

II. DMAS CERTIFICATION SECTION

I HAVE REVIEWED THE MEDICAL EVIDENCE AND DETERMINED THAT THE MEDICAL CONDITION
☐ IS AN EMERGENCY ☐ IS NOT AN EMERGENCY

THE REASON FOR DETERMINATION, OR SPECIFICS OF COVERED SERVICES AND DURATION OF COVERAGE ARE DETAILED BELOW.

SIGNED:_____TITLE:_____TELEPHONE #_____DATE:_____

III. PROVIDER NOTIFICATION SECTION

TO: MEDICAID SERVICE PROVIDERS

☐ THE ABOVE-NAMED INDIVIDUAL IS ELIGIBLE FOR MEDICAID TO COVER EMERGENCY SERVICES. ONLY SERVICES DIRECTLY RELATED TO THE EMERGENCY ARE COVERED FOR THE TIME PERIOD SPECIFIED BELOW. IF APPROVAL IS FOR DIALYSIS, THE ONLY COVERED SERVICES ARE THOSE FOR OUTPATIENT DAILYSIS. ANY OTHER SERVICES REQUIRE A SEPARATE CERTIFICATION. THIS FORM SERVES AS YOUR NOTIFICATION OF ELIGIBILITY IN LIEU OF A MEDICAID CARD. IF YOU HAVE ANY QUESTIONS, CALL THE PROVIDER HELPLINE AT 1-800-552-8627. **PLEASE NOTE: THIS NUMBER IS FOR PHYSICIANS/PROVIDERS ONLY.**

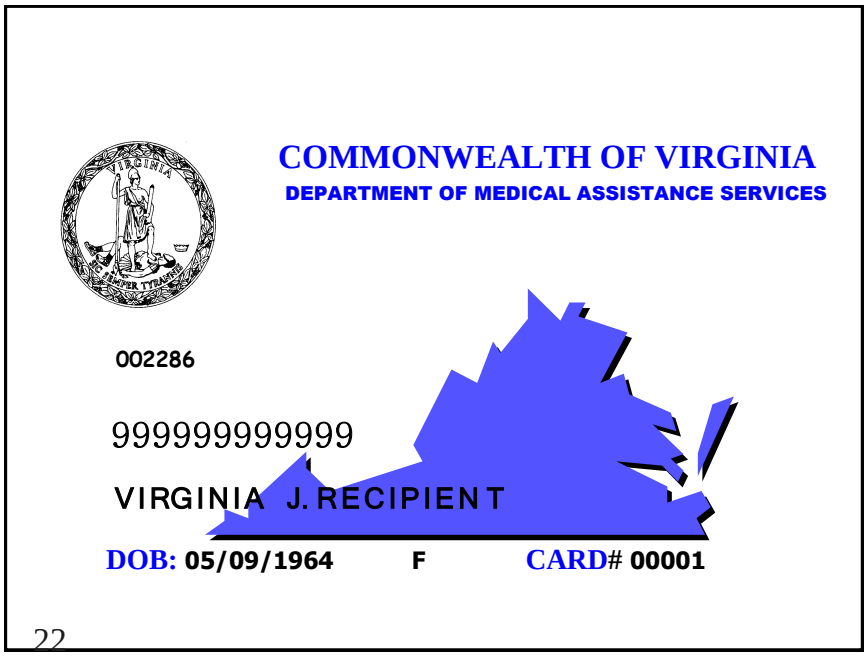
PERIOD OF COVERAGE: _____
MEDICAID NUMBER: _____
OTHER INSURANCE: _____

☐ THE ABOVE-NAMED INDIVIDUAL HAS BEEN DETERMINED INELIGIBLE FOR MEDICAID COVERAGE FOR EMERGENCY SERVICES.

REASON: _____

SIGNED: _____TITLE: _____DATE:_____
032-03-0628-07-eng (6/13)

SAMPLE MEDICAID CARD



SAMPLE PLAN FIRST CARD

Department of Medical Assistance Services

MEDICAID/FAMIS NEWBORN ELIGIBILITY NOTIFICATION HOSPITAL USE ONLY

This document is the official notification of the child's birth for Medicaid or FAMIS enrollment. For children born to a Medicaid/FAMIS/FAMIS MOMS eligible mother, the Medicaid/FAMIS eligibility for the newborn begins on the date of birth.

ALL QUESTIONS MUST BE ANSWERED IN ORDER TO BE PROCESSED (Please Type or Print Clearly)

Mother's Name _____ (Last) _____ (First) _____ (M.I.)

Mother's SSN ___ - ___ - _____ **Mother's Date of Birth** ___/___/_____ (MM/DD/YY)

Mother's Address _____ (Street)

_____ (City) _____ (State) _____ (Zip)

Mother's Medicaid/FAMIS/FAMIS MOMS ID Number (12 digits) ___ - ___ - ___

Mother's Telephone Number *(if known)* ( ) -

Full Name of Newborn(s)			**Birth Date**	**Sex**	**Race**
Last	First	MI	MM/DD/YY		
Last	First	MI	MM/DD/YY		
Last	First	MI	MM/DD/YY		

Submitted by _____ (Name and Title) **Signature** _____

Hospital Name _____ Telephone # ( ) -

Hospital Address _____

ONLINE REPORTING OF DEEMED NEWBORNS: Hospital staff can access the "Newborn E-213" link via DMAS provider web portal and log in utilizing their user name and password: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal
Within two business days, the hospital staff will receive secure email with the 12 digit enrollee ID and infant's MCO name.
Or
CALL COVER VIRGINIA AT 1-855-242-8282 TO REPORT THE BIRTH OF THE BABY. *You will be asked to provide your information and the baby's name, date of birth, race, gender, the baby's mother's name and her Medicaid/FAMIS ID number.*

If using the manual process, please fax or mail form immediately to the local DSS office for the mother's case.

DSS Use Only

Date Received ___/___/___ MM/DD/YY

Date Processed ___/___/___ MM/DD/YY

Note: Medicaid/FAMIS newborns must be linked to their mother's case when enrolled in MMIS.

DMAS-213 Hospital **COMMONWEALTH OF VIRGINIA** RVSD0915

Department of Medical Assistance Services

MEDICAID/FAMIS NEWBORN ELIGIBILITY NOTIFICATION MCO USE ONLY

This document is the official notification of the child's birth for Medicaid or FAMIS enrollment.
For children born to a Medicaid/FAMIS/FAMIS MOMS eligible mother, the Medicaid/FAMIS eligibility for the newborn begins on the date of birth.

ALL QUESTIONS MUST BE ANSWERED IN ORDER TO BE PROCESSED (Please Type or Print Clearly)

Mother's Name _____ (Last) _____ (First) _____ (M.I.)

Mother's SSN ___ - ___ - _____ **Mother's Date of Birth** ___/___/_____ (MM/DD/YY)

Mother's Address _____ (Street)

_____ (City) _____ (State) _____ (Zip)

Mother's Medicaid/FAMIS/FAMIS MOMS ID Number (12 digits) ___ - _____ - _____

Mother's Telephone Number *(if known)* ( ) -

Full Name of Newborn(s)			Birth Date	Sex	Race
Last	First	MI	MM/DD/YY		
Last	First	MI	MM/DD/YY		
Last	First	MI	MM/DD/YY		

Submitted by _____ (Name and Title) **Signature** _____

MCO Name _____ Telephone # ( ) -

MCO Address _____

FAX OR MAIL FORM IMMEDIATELY:
Local DSS Office for the Mother's Case
Current listing of local DSS agencies:
www.dss.virginia.gov/localagency

OR

CALL COVER VIRGINIA AT 1-855-242-8282 TO REPORT THE BIRTH OF THE BABY. You will be asked to provide your information and the baby's name, date of birth, race, gender, the baby's mother's name and her Medicaid/FAMIS ID number.

DSS Use Only
Date Received ___/___/___ (MM/DD/YY)
Date Processed ___/___/___ (MM/DD/YY)
Note: Medicaid/FAMIS newborns must be linked to their mother's case when enrolled in MMIS.

DMAS-213 MCO **COMMONWEALTH OF VIRGINIA** RVSD0915

INSURANCE COMPANY CODES

CARRIER CODE	CARRIER NAME
00001	MEDICARE
00002	ABSENT PARENT
00003	NOT LISTED
00004	AMERICAN COMM MUT LIFE INS CO
00005	ACADEMY LIFE INS CO
00006	AETNA US HEALTHCARE
00007	ALLSTATE INSURANCE CO
00008	AMERICAN DEFENDER LIFE INS CO
00009	AMERICAN FIDELITY ASSUR CO
00010	AMERICAN HERITAGE LIFE INS CO
00011	AMERICAN MUT LIABILITY INS CO
00012	AMERICAN RESERVE LIFE INS CO
00013	APPALACHIAN LIFE INS CO
00014	WILSET ASOCIATES INS
00015	WALMART ASSOC HLTH PLAN
00016	AMERICAN INCOME LIFE INS CO
00017	AMERICAN SENIOR CITIZENS
00018	AMERICAN CANCER
00019	AMERICAN INTEGRITY INS CO
00020	BANKERS FIDELITY LIFE INS CO
00021	BANKERS LIFE AND CASUA INS CO
00022	BANKERS LIFE INS CO OF NE
00023	BENEFICIAL NATIONAL
00024	BLUE RIDGE INSURANCE CO
00025	BUILDERS LIFE
00026	AMERICAN FAMILY LIFE ASSUR CO
00027	ATLANTIC LIFE INSURANCE CO
00028	AMERICAN MOTORISTS INS CO
00029	BENEFICAL MULTIPLE INS
00030	TRIGON BC/BS OF VA
00031	BLUE CROSS BLUE SHIELD SW VA
00032	BC/BS OF THE NAT'L CAP'TL AREA
00033	BLUE CROSS BLUE SHIELD MD
00034	ANTHEM BC/BS OF CHATTANOOGA TN
00035	BLUE CROSS BLUE SHIELD OF KY
00036	OTHER BC BS
00037	COMMONWEALTH LIFE INS CO OF KY
00038	CONSTITUTION LIFE INS CO
00039	COLUMBIA MUTUAL
00040	CHAMPUS
00041	CHAMPVA
00042	CHARTER SECURITY
00043	CHESAPEAKE LIFE INS CO
00044	THE CITADEL LIFE INS CO
00045	CITIZENS HOME
00046	COASTAL STATES LIFE INS CO
00047	COLONIAL LIFE ACCIDENT INS CO
00048	COLONIAL PENN INSURANCE CO
00049	COMBINED INS CO OF AMERICA
00050	CIGNA
00051	CONTINENTAL CASUALTY COMPANY
00052	CENTRL ST HLTH LIF INS OMAHA
00053	DEER

00054	FOUNDERS LIFE ASSURANCE CO
00055	KLAIS & COMPANY
00056	BENEFIT ADMIN OF AMERICA INC
00057	DURHAM LIFE INSURANCE CO
00058	GROUP HEALTH ASSOCIATION INC
00059	GUARANTEE TRUST LIFE INS CO
00060	EASTERN INSURANCE COMPANY
00061	EMMCO INSURANCE COMPANY
00062	EMPLOYERS LIFE INS CO WAUSAU
00063	EQUITABLE LIFE ASSURANCE
00064	EQUITY NATIONAL LIFE INS CO
00065	DARDEN RESTAURANTS
00066	GROUP HEALTH ASSOCIATION INC
00067	GUARDIAN LIFE INS CO OF AMER
00068	HEALTH BENEFIT ADMINISTRATORS
00069	AETNA INS CO FORT WAYNE
00070	FEDERAL HOME LIFE INS CO
00071	NAT'L CLAIM ADMIN SERV (NCAS)
00072	FEDERATED LIFE INS CO
00073	FIDELITY BANKERS LIFE INS CO
00074	FIREMANS FUND INS CO
00075	METRO MACHINE CORP
00076	HUNT TAYLOR
00077	FIRST VIRGINIA LIFE INS CO
00078	THE FRANKLIN LIFE INS CO
00079	IDEAL MUTUAL
00080	ITT LIFE INSURANCE CO
00081	INA BENFIT SER
00082	GEN FIDELITY
00083	GLOBE LIFE INSURANCE COMPANY
00084	GEOTWN COM HTH PLAN
00085	GOV EMP LIFE INS
00086	GULF LIFE INSURANCE CO
00087	BEVERLY ENTERPRISES
00088	INDEPENDENT LIFE ACCID INS CO
00089	THE LINCOLN NATL LIFE INS CO
00090	HARTFORD LIFE INSURANCE CO
00091	HERALD LIFE INSURANCE CO
00092	HOME BENEFICIAL LIFE INS CO
00093	HOME LIFE GROUP BENE SERV INC
00094	PEOPLE SECURITY INSURANCE CO
00095	LABORERS DIST COU VA HLTH WELF
00096	LIFE INVESTORS INS CO OF AMER
00097	MEDICO LIFE INSURANCE CO
00098	MONTGOMERY WARD LIFE INS CO
00099	INDEPENDENCE
00100	INTEGON LIFE INSURANCE CORP
00101	INTEGRITY NATL LIFE INS CO
00102	INTER STATE ASSURANCE COMPANY
00103	INVESTORS
00104	NATL ASSOC GOVER EMPLOY
00105	NATL SENIOR CITIZENS GROUP
00106	NATIONAL TRAVELERS LIFE CO
00107	JOHN HANCOCK MUTUAL LIF INS CO
00108	NATIONAL BENEFIT LIFE INS CO
00109	GREAT WEST LIFE ASSUR.CO-MD
00110	KENTUCKY CENTRAL LIFE INS CO

00111	KEY LIFE
00112	NATL ACCIDENT AND HLTH
00113	NATL LIFE AND ACCID INS CO
00114	NATIONAL CASUALTY CO
00115	LIBERTY LIFE INS CO
00116	LIBERTY NATIONAL LIFE INS CO
00117	LIFE AND CASUALTY INS CO TN
00118	LIFE INS CO OF GEORGIA
00119	LIFE INS CO OF NORTH AMERICA
00120	THE LIFE INSURANCE CO OF VA
00121	LINCOLN INCOME LIFE INS CO
00122	LONE STAR LIFE INSURANCE CO
00123	LUMBERMENS
00124	ORANGE STATE LIFE HLTH INS CO
00125	PEOPLES SECURITY LIFE INS CO
00126	PROTECTIVE LIFE INS CO
00127	THE PYRAMID LIFE INSURANCE CO
00128	MARYLAND LIFE
00129	MASSACHUSETTS GEN LIFE INS CO
00130	MASSACHUSETTS MUT LIFE INS CO
00131	MAYFLOWER NATIONAL LIFE INS CO
00132	MED INDEMNITY CO
00133	METROPOLITAN CASUALTY INS CO
00134	MIDLAND MUTUAL LIFE INS CO
00135	MID SOUTH INS CO
00136	MID STATES
00137	MIDWEST SECURITY INS CO
00138	MUTUAL OF OMAHA INS CO
00139	MUTUAL LIFE
00140	BENEFIT PLAN STRATEGIES
00141	NYHART (WYNN'S PRECISION)
00142	SOUTHEAST LIFE
00143	NATL AMER LIF INS CO OF PA
00144	BUSINESS ADMIN & CONSULTANTS
00145	NATIONAL HOME LIF ASSURANCE C
00146	INTERCARE BENEFIT SYSTEMS
00147	NATIONAL LIFE INSURANCE CO
00148	NATIONAL SAVINGS LIFE INS CO
00149	NATL UN FIRE INS PITTSBURG PA
00150	NATIONWIDE LIFE INSURANCE CO
00151	NEW YORK LIFE INSURANCE CO
00152	NORTH AMERICAN INS CO
00153	NORTHWESTERN NATL LIFE INS CO
00154	UFCW HLTH AND WELFARE FUND
00155	SOUTHWESTERN LIFE INS CO
00156	OCCIDENTAL
00157	OPTOMETRIC SERV CORP
00158	SENTRY LIFE INS CO
00159	STANDARD LIFE SEC INS CO OF NY
00160	PAUL REVERE LIFE INS CO THE
00161	PENN MUTUAL LIFE INS CO
00162	STONEBRIDGE INSURANCE COMPANY
00163	PENSION LIFE INS CO OF AMERICA
00164	PHYSICIANS LIFE IN CO
00165	JEFFERSON PILOT LIFE INS CO
00166	PIONEER LIFE INS CO OF IL
00167	PROVIDEN LIFE & ACCIDENT INS C

00168	PRUDENTIAL INS CO OF AMERICA
00169	CONFED ADMIN SERVICES INC
00170	C & O RAILROAD
00171	SENIOR AMER
00172	RELIANCE
00173	REPUBLIC AMERICAN LIFE INS CO
00174	NATIONAL FINANCIAL
00175	ROYAL GLOBE
00176	TRUST
00177	UNION LABOR LIFE INS CO
00178	UNION BANKERS INS CO
00179	UNITED EQUITABLE INS CO
00180	SAFECO
00181	SCHOLASTIC
00182	TRIGON ADMINISTRATORS - VA
00183	SHENANDOAH LIFE INS CO
00184	SOUTHERN AID LIFE INS CO INC
00185	SOUTHLAND LIFE INS CO
00186	SOUTHWEST GENERAL
00187	STATE FARM FIRE & CASUALTY CO
00188	SUN LIFE ASSURANCE CO OF CANAD
00189	ITPE-NMU
00190	NETWORK HEALTH PLAN CORP
00191	UNITED CHAMBER ASSUR PLN
00192	TRANS-GENERAL LIFE INS CO
00193	TRAVELERS
00194	TWENTIETH CENTURY LIFE INS CO
00195	AETNA-FMC CORPORATION
00196	UNION CENTRAL LIFE INS CO THE
00197	USAF DEPT OF DEFENSE
00198	UNITED FAMILY LIFE INS CO
00199	USAA LIFE INS CO
00200	UNION SECURITY LIFE INS CO
00201	UNITED AMERICAN INS CO
00202	UNITED FIRE INSURANCE COMPANY
00203	UNITED MIN WORK OF AMER HLTH
00204	UNIVERSAL LIFE INS CO
00205	CENTRAL RESERVE LIF OF N AMER
00206	UNITED INS CO OF AMERICAL
00207	NATIONAL FOUNDATION LIFE INS C
00208	WESTERN AND SOUTHERN LIFE INS
00209	ZEBA TRUST
00210	ALUMINUM WKRS
00211	AMALGAMATED CLOTHING & TEXTILE
00212	AMAL MEATCUTTERS
00213	AMERICAN FED OF GOVT EMP
00214	POSTAL WKRS UNION
00215	ASBESTOS WKRS
00216	BAKERY AND CONFECTIONERY BENE
00217	BRICKLAYERS UNION
00218	BRHD RAILWAY CLERKS
00219	CARPENTERS UNION
00220	COMM WKRS OF AMER
00221	CONST GEN LAB UNION
00222	INT ASSO MACHINSTS
00223	INT BRHD ELECT WKRS
00224	INT UN OP ENGINEERS

00225	IRON WORKERS TRUST FUND
00226	MILLWRIGHTS UNION
00227	NATIONAL ASSOC OF LTR CARRIERS
00228	MAIL HANDLERS BENEFIT PLAN
00229	PLAST & CEMENT
00230	PLUMBERS & STEAMFITTERS
00231	SHEET METAL WORKERS' LOCAL 100
00232	TEAMSTERS JOINT COUNCIL NO 83
00233	FOOD & COMM WKRS
00234	UNITED PAPERWKRS
00235	UNITED STEELWKRS
00236	WAREHOUSE EMP
00237	BENEFIT PLAN SERVICES
00238	GREAT AMERICAN INS CO
00239	BANKERS MULTIPLE LINE INS CO
00240	VA DENTAL PLAN
00241	VA FARM BUR MUT
00242	VA MUT BENEFIT
00243	VA SURETY CO
00244	VOLUNTEER ST
00245	EMERSON ELEC BENE PLAN T
00246	EASTERN MED SUPPLY POLIC
00247	HARDEN & CO
00248	WAUSAU INSURANCE COMPANY
00249	WESTERN NAT LIFE INS CO
00250	WORLD INS CO
00251	HEALTH CARE ADINISTRATORS INC
00252	CROWN LIFE INS CO
00253	KEYSTONE INS CO
00254	YOUTHGUARD
00255	UNITED BENEFIT LIFE INS CO
00256	VA HLTH AND ACCIDENT ASSOC
00257	GUARANTEE RESERVE LIF INS CO
00258	NATIONAL LIBERTY LIFE
00259	GEORGE WASHINGTON LIFE INS CO
00260	PENNSYLVANIA LIFE INS CO
00261	OLD AMERICAN INS CO
00262	MONUMENTAL LIFE INS CO
00263	CENTRAL VA UFCW
00264	NEWPORT NEWS SHIPYARD
00265	PHYSICIAN MUTUAL INS CO
00266	REINSURED LEX GROUP INS
00267	EMPLOYEE BENEFIT CLAIMS
00268	VETERANS LIFE INS CO
00269	WASHINGTON AREA CORP CAR
00270	WAYNE ADMIN GROUP INS
00271	NEW ENGLAND GEN LIFE INS CO
00272	FIRST CONTINENTAL LIFE & ACCID
00273	MOUNTAIN TRAIL INSURANCE
00274	NAT'L HOME HEALTH
00275	WILLIS CORROON ADMIN SERV
00276	VA INDEPENDENT COAL CORP
00277	UNITED OF OMAHA LIFE INS CO
00278	NAT'L LEAGUE OF POSTMAST
00279	BENEFITS PLAN SERVICES INC
00280	CONTRACT DRIVERS INS TRUST
00281	TRANS AMER ACCIDENTAL LF

00282	FOOD HEALTH CARE
00283	RICHMOND BENEFICAL LIFE
00284	UNION FIDELITY LIFE INS CO
00285	SOUTHERN LUMBER MANF SPE
00286	UNION PLAN ADMINSTRATIO
00287	WOODMEN OF THE WORLD LIF INS
00288	WASHINGTON NATIONAL INS CO
00289	NORTH CAROLINA MUT LIF INS CO
00290	SPERRY MARINE SYSTEM
00291	DEPARTMENT OF LABOR
00292	CIF SERVICE CENTER
00293	VIRGINIA PLAN
00294	THE MINISTERS & MISSIONARIES B
00295	KISER INSURANCE CO
00296	CENTRAL VA RETAIL CLERK
00297	COSTAL PLAIN INS
00298	N N INVESTORS LIFE INS
00299	STUDENT ACCIDENT PROTECT
00300	VA DENTAL SERVICE PLAN
00301	WEAVER ASSOCIATES
00302	HORSEMEN BEN & PROT ASSOC
00303	PACIFIC MUTUAL LIFE INS CO
00304	THE OHIO STATE LIFE INS CO
00305	DELTA DENTAL PLAN OF VA
00306	POSTMASTERS BENEFIT PLAN
00307	EQUICOR
00308	ESMARK
00309	OPTIMA HEALTH PLAN
00310	SMITHFIELD FOOD HEALTH PLAN
00311	J P KENNEDY INS CO
00312	HUMANA INSURANCE
00313	ALLIANCE HLTH BENE PLAN
00314	HRSA/ILA
00315	ROLLINS INS CO
00316	AARP
00317	TIME INSURANCE COMPANY
00318	COSTAL HEALTH CARE PLAN
00319	HMO PLUS
00320	HEALTH AMERICA
00321	QUAKER CITY
00322	MONUMENTAL GENERAL INS CO
00323	UNION LIFE/HOSP INDEMNIT
00324	UNION FEDERAL NATIONAL
00325	COLONIAL BENEFIT ADMINISTRATOR
00326	AETNA
00327	NORTHEAST DELTA INSURANCE
00328	H J WILLIAMS COMPANY INS
00329	BENEFICIAL STANDARD LFE INS CO
00330	FEDERAL LIFE INS CO
00331	BAYLY MARTIN & FAY INS
00332	HMO OF PENNSYLVANIA
00333	BOILERMAKER NAT HLTH & WEL FND
00334	ENGINEERS UNION 106
00335	U S FIDELITY & GUARANTY
00336	AVTEX FIBERS INC
00337	STOUFERS CONCOURSE HOTEL
00338	LOYAL AMERICAN LIFE INS CO

00339	PRUDENTIAL AUTO DEALER
00340	SECURITY TRST LFE INS CO OF GA
00341	STATE MUTUAL INS CO OF AMERICA
00342	NAT'L CAPITAL ADMIN SERVC
00343	KISER GEORGETOWN INS
00344	PRIVATE HEALTH CARE SYS
00345	SECARE 65
00346	TEACHERS PROTECTIVE MUT LFE IN
00347	CCEB TRUST
00348	SEA FARERS
00349	CNS WHOLESALE GROCERY
00350	WEYERHAEUSER GROUP INS
00351	MAIL HANDLERS BENEFIT PLAN
00352	CHOICE INS HEALTH PLAN
00353	MWH MEDICORP MEDICAL PLN
00354	GOVERNMNT EMPLOYEES HOSP ASSOC
00355	VULCAN LIFE INS CO
00356	JOHN ALDEN LIFE INS CO
00357	PROVIDERS ALLCARE ADMINISTRATO
00358	LIFE & HLTH INS CO OF AMERICA
00359	CENTRAL LIFE ASSURANCE CO
00360	IBEX BENEFITS
00361	GREAT WESTERN
00362	CONFEDERATION LIFE
00363	BLUE CROSS/BLUE SHIELD OF MASS
00364	AMERICAN REPUBLIC INS CO
00365	HLTH CARE PLAN ADMIN
00366	HORACE MANN INS CO
00367	GENERAL AMERICAN INS CO
00368	OXFORD LIFE INSURANCE CO
00369	GENERAL AMERICAN INS CO
00370	NORTH BROOK INSURANCE
00371	HERITAGE NAT'L HLTH PLAN
00372	GLOBAL INS MANAGEMENT
00373	FLORIDA ROCK INDUSTRIES
00374	VETERANS OF FOREIGN WARS
00375	HUDSON GROUP ADMINIS
00376	KAISER PERMANENTE
00377	HARVEST LIFE INS CO
00378	TENNESSEE COMPANY GROUP
00379	TRANSPORT LIFE INSURANCE CO
00380	CONTROL DATA SYSTEMS INC.
00381	GREAT WEST LIFE ASSURANCE CO
00382	HECHINGER
00383	HOME BLDS ASSOC OF VA HLTH BNF
00384	GREAT WEST LIFE ASSURANCE CO
00385	CHESTERFIELD RESORCE INC
00386	SECURITY TRST LFE INS OF GA
00387	HILTON NEVADA CORP GRP HLTH BN
00388	DAYSTORM LADD FURNITURE
00389	SENTARA HEALTH PLAN
00390	CAPITOL AMERICAN LIFE INS CO
00391	PRINCIPAL MUTUAL LIFE INS CO
00392	FIELDCREST MILLS
00393	HUDSON GROUP ADMINISTRATOR
00394	GOLDEN RULE LIFE INS CO
00395	CONSUMERS UNITED LIFE INS CO

00396	COMPREHENSIVE BENEFITS SERV CO
00397	DEAN COMPANY EMPLOYEE
00398	PLANNED ADMINISTRATOR INC.
00399	AWANA CLUBS INT'L GROUP INS
00400	DAN RIVER MILLS INC
00401	LINCOLN NATIONAL LIFE INS CO
00402	BOOKE AND COMPANY
00403	MEDICAL DOCTORS INDIV PRACTICE
00404	CORPORATE SYSTEMS ADMIN
00405	TRANSPORT LIFE INS COMPANY
00406	C AND A INSURANCE COMPANY
00407	FEDERAL EXPRESS CORP GRP HLTH
00408	ROSES INTERACTIVE MEDICAL SER
00409	CHARLES CO EMPLOYEE BENEFIT TR
00410	PROVIDERS ALLCARE ADM
00411	SETTLERS LIFE INS CO
00412	NORTHERN GROUP SERVICES INC
00413	AID ASSOCIATION FOR LUTHERANS
00414	OLD SURETY LIFE OF TEXAS
00415	PACIFIC FIDELITY LIFE INS CO
00416	LANE CO IN HLTH CARE PLAN
00417	REYNOLDS METALS INSURANCE
00418	C AND O EMPLOYEES HOSP ASSOC
00419	CAMPBELL TAGGART INC
00420	COBRA SERVICE
00421	BASSETT WALKER
00422	ATLANTA GROUP BENEFIT CENTER
00423	LONG - AIR DOX CO
00424	ALTA
00425	UNITED FURNITURE WORKERS INS
00426	ATLANTA LIFE INSURANCE CO
00427	GROUP HEALTH ADMINISTRATORS
00428	MEDICAL FACILITIES OF AMERICA
00429	CIGNA
00430	ADVANCED INSURANCE SERVICE
00431	ITT HARTFORD LIFE & ANNUITY
00432	HEALTH CLAIM SERVICES
00433	FRINGE BENEFIT REVIEW
00434	NGS AMERICAN
00435	JEFFERSON PILOT C/O AMPRO FISH
00436	CRUM & FOSTER INS COMPANIES
00437	T P A OF GEORGIA
00438	SECURITY LIFE INS CO OF AMER
00439	MCDONOUGH-CAPERTON BENEFIT SER
00440	PCS HEALTH SYSTEM CLAIMS
00441	LAWRENCE MUSGROVE ASSOC
00442	WASHINGTON POST - SELF INSURER
00443	OPTIMUM CHOICE INC
00444	BLUE CROSS BLUE SHIELD(EMPIRE)
00445	G H I
00446	BENEFIT PLAN ADMINISTRATORS
00447	B/C - B/S OF ILLINOIS
00448	JOHN DEERE LIFE INS COMPANY
00449	NRECA NAT'L ROYAL ELECTRIC COR
00450	H. L. DUKE & COMPANY
00451	AMERICAN NATIONAL INS CO
00452	THE MUTUAL GROUP

00453	ACORDIA LOCAL GOV'MNT BENEFITS
00454	AM FOREIGN SERV PROT ASSOC
00455	E B SERVICES INC
00456	SELF FUNDED PLANS INC
00457	PHYSICIANS ASSOC
00458	FLEETWOOD INDUSTRIES
00459	PAID PRESCRIPTION PROGRAM
00460	SOUTHERN HEALTH INSURANCE
00461	HEALTH PLUS
00462	B/C - B/S OF NORTH CAROLINA
00463	CAPITAL CARE BC BS
00464	NATIONAL HEALTH INS CO
00465	E D S ELECTRONIC DATA SYSTEM
00466	INSUREX BENEFITS
00467	BENEFIT CONSULTANT SERVICES
00468	MAMSOVA
00469	AETNA LIFE INS CO NC
00470	TOWER LIFE INSURANCE CO
00471	SERV BEN PLAN RETAIL PHARM PRO
00472	UNITED STATES LIFE INS CO
00473	NATIONAL BENEFIT PLANS
00474	CHESAPEAKE BAY FISHING CO
00475	JOHN HANCOCK INS CO
00476	GROUP HEALTH COOPERATIVE
00477	AMALGATED LIFE INS CO
00478	SAVERS LIFE INS CO
00479	METLIFE (METROPOLITAN)
00480	CIGNA HEALTHCARE
00481	ROSES INC
00482	BLUE CROSS/BLUE SHIELD-MI
00483	BLUE CROSS BLUE SHIELD OF WV
00484	BMA BUSINESS MEN'S ASSURANCE
00485	HEALTH STRATEGIES
00486	CORPORATE BENEFITS SERVICE INC
00487	HEALTHKEEPERS
00488	BLUE CROSS BLUE SHIELD OF AL
00489	BC/BS OF PA (INDEPENDENCE)
00491	AETNA LIFE INS CO INDIANA
00492	KANAWHA INSURANCE CO
00493	AMERICAN MEDICAL SECURITY
00494	AMER POSTAL WORKERS UNION PLAN
00495	TRAVELERS
00496	PRIORITY HLTH CARE-HLTHKEEPERS
00497	NATL ASSOC OF HOME BUILDERS
00498	EMPLOYERS HEALTH INS CO
00499	BORDEN INC
00500	PAN AMERICAN LIFE INS CO
00501	THE GUARDIAN
00502	NOBLE LOUNDES AND JOHNSON
00503	CONTINENTAL GENERAL INS CO
00504	SOUTHERN BENEFIT SERVICE
00505	AMER BANKERS LIFE ASSUR OF FL
00506	NATIONWIDE LIFE INS CO
00507	GUARANTEE MUTUAL LIFE INS CO
00508	PIECE GOOD SHOPS INC SELF INSU
00509	WASHINGTON WHOLESALERS INS CO
00510	STATE FUND WORKERS COMPENS INS

00511	ADMINISTRATIVE CONSULTANTS
00512	BLUE CROSS BLUE SHIELD OF FL
00513	GROUP BENEFITS SERVICES
00514	PHOENIX MUTUAL LIFE INS
00515	DUKE AND CO EMPLOYEE BEN MANAG
00516	THE PRINCIPAL FINANCIAL GROUP
00517	PLUMBERS PIPEFITTERS MED FUND
00518	EMPLOYEE BENEFIT MANAGEMENT CO
00519	CENTRAL BENE NATL LIFE INS CO
00520	FORTIS BENEFITS INS CO
00521	BLUE CROSS BLUE SHIELD OF MO
00522	ALICARE INC
00523	RURAL ELECTRIC GRP INS ADMINIS
00524	METROPOLITAN LIFE INS CO
00525	BLUE CROSS BLUE SHIELD OF TX
00526	CLAIMSWARE INC
00527	HEALTH RISK MANAGEMENT
00528	THE MEGA LIFE & HEALTH INS CO
00529	BC/BS OF MAINE
00530	TPA OF FORT WORTH
00531	ACORDIA NATIONAL
00532	BC/BS OF CENTRAL NEW YORK
00533	DIVERSIFIED GROUP ADMIN. INC.
00534	AFF TEAMS HLTH/WEL MD-LOCAL311
00535	PIEDMONT ADMINISTRATORS
00536	FIRST HEALTH - UTAH
00537	GLOBE LIFE & ACCIDENT INS. CO.
00538	COMMUNITY MUTUAL INS CO
00539	BLUE CROSS-BLUE SHIELD-HIGHMRK
00540	CIGNA
00541	THE GUARDIAN
00542	ALLIANCE ASSURANCE CO
00543	TRAVELERS-NEW YORK
00544	UNITED MEDICAL RESOURCES INC
00545	HEALTH SOURCE INS GROUP
00546	AMERICAN CONT LIFE INS CO
00547	TRAVELERS-DENTAL-NEW YORK
00548	HMO OF VIRGINIA
00549	A CONSULTING SERVICES
00550	AETNA HEALTH PLAN-OHIO
00551	FCE BENEFIT ADMINISTRATORS
00552	FIRST HLTH ADVANTAGE-PROVIDIAN
00553	PRO CLAIM ADMIN INC (PROCLAIM)
00554	CORESOURCE INC (NC)
00555	METRAHEALTH
00556	CORESOURCE INC
00557	DUKE BENEFITS SERVICES
00558	PHARMACY NETWORK NAT CORP
00559	BANKERS UNITED LIFE ASSURANCE
00560	SOUTHERN HEALTH SERVICES
00561	GRGE WASHINGTON UNIV HLTH PLAN
00562	METRO LIFE INS CO (DE)
00563	BA MULLICAN LUMBER/MANUF CO
00564	HOME LIFE GP BEN & SERV INC
00565	CONTINENTAL ASSURANCE CO
00566	AETNA LIFE INS CO - TX
00567	BC/BS OF WI

00568	NAT TELE COOP ASSOC/GRP HLTH
00569	AMPRO FISHERIES COMPANY
00570	EXPRESS SCRIPTS
00571	HARRINGTON BENEFIT SERVICES
00572	PARTNERS NAT HLTH PLANS NC
00573	GROUP INSURANCES SERVICES
00574	ASSOCIATED BENEFITS CORP OF TN
00575	FOUNTAINHEAD ADMIN INC
00576	SINGER FURNITURE - ROANOKE
00577	HUMANA HEALTH PLAN
00578	BLUE CROSS AND BLUE SHIELD TN
00579	CHUBB LIFEAMERICA INS. CO
00580	SPECTRUM ADMINISTRATORS
00581	GENERAL HEALTH BENEFITS
00582	BLUE CROSS AND BLUE SHIELD NJ
00583	HEALTHTRUST
00584	BLUE CROSS AND BLUE SHIELD MS
00585	AMINITRON
00586	TRAVELERS PLAN ADMIN OF TENN
00587	GALLAGHER BASSETT
00588	ALEXANDRIA HOSPITAL PLAN
00589	PROVIDENT LIEF AND ACCID
00590	HEALTHSOURCE PROVIDENT-MEDICAL
00591	NASI WELFARE FUND
00592	WILLSE & ASSOCIATES INC
00593	CLAIM MANAGEMENT SERVICE
00594	PENN WESTERN BENEFITS INC
00595	PHILADELPHIA AMERICAN LIFE INS
00596	JONBIL INC
00597	ELECTRO-MECHANICAL CORP
00598	COLUMBIA FOREST PRODUCTS
00599	FEDERAL BLACK LUNG ASSOC
00600	JEFFERSON PILOT LIFE INS CO TN
00601	GENERAL ELECTRIC MED BENEFITS
00602	E.B.C. MID-AMERICAL
00603	HELATH NETWORK AMERICA
00604	MENNONITE MUTUAL AID
00605	THE TRAVELERS-MANAGED CARE SYS
00606	LIFE INSURANCE CO OF N AMER
00607	MEDICAL CLAIMS MANAGEMENT CORP
00608	METRA HLTH/RAILROAD ACCOUNTS
00609	MAMSI
00610	CAREMARK PRESCRIPTION SERV DIV
00611	MID-ATLANTIC MED SERV
00612	NEW YORK LIFE/HEALTH PLUS
00613	WEIMAN UPHOLSTERY
00614	ACORDIA NATIONAL-BC/BS OF KY
00615	POWELL MOUNTAIN COAL CO INC
00616	NOBEL GROUP BENEFITS
00617	BLUE CROSS/BLUE SHIELD OF NJ
00618	U S HEALTHCARE
00619	MCKEE FOODS GROUP BENEFITS
00620	STATE FARM INSURANCE
00621	BLUE CROSS/BLUE SHIELD OF IOWA
00622	BASSETT FURNITURE
00623	BRENCO INC
00624	BLUE CROSS/BLUE SHIELD OF SC

00625	NEW RIVER INDUSTRIES INC
00626	BLUE CROSS/BLUE SHIELD KANSAS
00627	COST MANAGEMENT TECHNOLOGIES
00628	BLAIR MILL ADMINISTRATORS
00629	CENTRA HEALTH BENEFITS
00630	MAN-U SER CONTRACT TRUST FUND
00631	WILLIAM TALLEY SIGN CO
00632	B.P.S. INC
00633	CELTIC LIFE INS CO
00634	LADD MEDICAL CLAIMS DEPT
00635	SELF INSURED SERV CO
00636	SHOOSMITH BROTHERSINC HLTH PLN
00637	MANCHESTER GROUP HEALTH PLAN
00638	DOANE PRODUCTS CO GROUP BENE
00639	EDUCATORS MUTUAL LIFE
00640	CENTRAL CAROLINA WAREHOUSE GRP
00641	MANGE-MEDICAL-CLAIMSWARE
00642	ELECTRICAL WELFARE TRUST FUND
00643	PRUDENTIAL INSURANCE COMPANY
00644	MET LIFE DENTAL
00645	GREAT WEST LIFE & ANNUITY INS
00646	BASSETT EMPLOYEE BENEFITS
00647	ANTHEM LIFE
00648	CIGNA HEALTHCARE OF VA
00649	JOHN HANCOCK
00650	JOHN DEERE HLTH CARE
00651	HILSTON VALLEY MED CTR
00652	THE GUARDIAN
00653	SOTHERN HEALTH TPA
00654	NETWORK INSURANCE INC
00655	ROCCO BENEFITS
00656	MANPOWER
00657	LAB DIST CO HL & WEL TRST FD#2
00658	MASS MUTUAL UNICARE
00659	JONES HILL & MERCER EMPL BENE
00660	BLUE CROSS AND BLUE SHIELD
00661	AETNA LIFE INS CO-PENNSYLVANIA
00662	CARILION HEALTH PLANS
00663	AETNA LIFE INS CO-FLORIDA
00664	CIGNA-DELEWARE
00665	STARMARK
00666	MEDICARE PART B-RAILROAD
00667	AETNA HEALTH PLAN-OKLAHOMA
00668	FIRST HEALTH-MARYLAND
00669	GREAT WEST LFE ASSUR CO PITTSB
00670	CONTINENTAL LIFE AND ACCIDENT
00671	TYSON FOODS INC
00672	STRATEGIC RESOURCE COMPANY
00673	WASHINGTON GAS & LIGHT CO
00674	AETNA LIFE INS CO -MASS
00675	DENTAL HLTH ADMIN & CONSLT SR
00676	FAISON INSURANCE ASSOCIATES
00677	TEACHER'S STATE EMPLOYEES'
00678	HEALTH PLANS INC
00679	FEDERATED MUTUAL INS.
00680	ACORDIA BENEFITS OF THE SOUTH
00681	ADMINITRON INC.

00682	ACORDIA BENEFITS
00683	HEATAC INC.
00684	VIRGINIA SPRINKLERS
00685	MANAGED PRESCRIPTION SERVICES
00686	PULASKI FURNITURE CORPORATION
00687	PIEDMONT COMMUNITY HEALTH PLAN
00688	CONSUMER DENTAL CARE
00689	ALTA HEALTH STRATEGIES INC
00690	METRAHEATLH
00691	AETNA LIFE INS CO-TYLER TX
00692	EMPLOYESS PLAN INC
00693	FEDERAL EMP BENE-TRIGON BCBS
00694	DONOVAN BENEFIT SYSTEMS INC
00695	EXPRESS SCRIPTS INC
00696	NATIONAL PRESCRIPTION ADM-NPA
00697	KIRK VAN ORSDEL INC
00698	BLUE CROSS & BLUE SHIELD OHIO
00699	GOODYEAR GROUP INS.
00700	INDIANAPOLIS NEWPAPERS INC
00701	VIRGINIA HEALTH NETWORK
00702	EPOCH GROUP
00703	UNITED HEALTHCARE CORPORATION
00704	THE NEW ENGLAND CARE HLTH PLAN
00705	COLUMBIA HOSP CORP OF AMERICA
00706	PROVANTAGE
00707	MEDIPLUS
00708	FIRST ALLMERICA FINAN LIFE
00709	BC/BS OF CT
00710	CENTRAL UNITED INSURANCE CO
00711	AETNA LIFE INS CO - CALIF
00712	DONNKENNY APPAREL INC.
00713	ALLMERICA FINANCIAL
00714	SRX PHARMACY SPECIALISTS
00715	HEALTHSOURCE PROVIDENT
00716	BC/BS OF PA (CAPITAL)
00717	L & H ADMINISTRATORS
00718	GRAPHIC COMM & NAT'L H & W FND
00719	RELIASTAR(PRESTO PROD-#187119)
00720	METROPOLITAN LIFE INS CO-ILL
00721	QUALCHOICE OF NORTH CAROLINA
00722	AETNA HEALTH PLAN-MID-ATLANTIC
00723	WISCONSIN PHYS SERV/INSUR-TEC
00724	GATEWAY HEALTH ALLIANCE
00725	CORPORATE HEALTH ADMINISTRATOR
00726	AETNA LIFE INS CO - MICHIGAN
00727	PRUDENTIAL INS CO (ALBANY)
00728	TRIGON ADMINISTRATORS - NC
00729	AETNA LIFE INS CO - READING
00730	BC/BS OF PUERTO RICO
00731	AETNA LIFE INS CO - FRESNO CA
00732	STANDARD INSURANCE COMPANY
00733	YOUNG LIFE BENEFIT PLAN
00734	BLUE CROSS/BLUE SHIELD-CALIF
00735	BC/BS OF ARKANSAS
00736	AETNA INS CO.- KENTUCKY
00737	AETNA HEALTH PLAN - ILLINOIS
00738	BLUE CROSS/BLUE SHIELD

00739	ANTHEM BLUE CROSS/BLUE SHIELD
00740	PRUDENTIAL HEALTHCARE GROUP
00741	POSITIVE CARE ADMINISTRATORS
00742	TYSON FOODSINC-TEMPERANCEVILL
00743	EMPLOYEE BENEFIT SERVICES INC
00744	ALLIED ADMINISTRATORS
00745	PRINCIPAL HLTH CARE OF MID-ATL
00746	CENTRA
00747	THE DARBY CHOICE PROGRAM
00748	PRUDENTIAL HEALTHCARE
00749	PENINSULA HEALTHCARE
00750	INTERACTIVE MEDICAL SYSTEMS
00751	VALUE BEHAVIORAL HEALTH
00752	HEWITT COLEMAN AND ASSOCIATES
00753	USA HEALTH NETWORK
00754	ONE HEALTH PLAN
00755	MEDIPLAN
00756	CNA INSURANCE CO
00757	SOUTHAMPTON MEM HOSP-VICARE AD
00758	AETNA LIFE INS CO-DELAWARE
00759	HEALTH PLAN SERVICES INC.
00760	UNITED HLTHCARE ADMINISTRATORS
00761	NYL CARE
00762	MCELROY METAL MILL INC
00763	ALLIANCE
00764	UNITED HEALTH CARE
00765	OPTIMUM CHOICE
00766	UNICARE GROUP CLAIMS
00767	CHA HEALTH
00768	UNITED HEALTHCARE
00769	LITTLE CAESAR FRANCHISE BEN PL
00770	STARBRIDGE/STAR HUMAN RES GRP
00771	BC/BS OF ROCHESTER AREA
00772	EMPHESIS
00773	KENTUCKY UTILITIES COMPANY
00774	THE GUARDIAN (WASHINGTON)
00775	LINE CONSTRUCTION BENEFIT FUND
00776	NEW YORK LIFE
00777	UNICARE
00778	BC/BS OF MINNESOTA
00779	CRAWFORD & COMPANY
00780	BLUE CROSS BLUE SHIELD OF LA
00781	PROVIDENT LFE & ACC-S.CAROLINA
00781	PROVIDENT LFE & ACC-S.CAROLINA
00782	BUNKER HILL FOODS INC
00783	CIGNA - NEW MEXICO
00784	BENEFIT CONCEPTS INSURANCE
00785	HUMANA EMPLOYERS HEALTH
00786	BC/BS OF UTICA (NEW YORK)
00787	THE CENTENNIAL LIFE INS. CO.
00788	PREFERRED HEALTH PLAN INC.
00789	BENEFIX/OLAN MILLS GR MED PLAN
00790	JEFFERSON-PILOT (BLUE RDG ADM)
00791	CUNA MUTUAL INS CO-CREDIT UNIO
00792	AMERITAS DENTAL CARE DIVISION
00793	PITTMAN AND ASSOCIATES
00794	COMMONWEALTH HEALTH ALLIANCE

00795	BENEFIT ASSISTANCE CORP
00796	COASTAL LUMBER HEALTH CARE
00797	ARAMARK
00798	VICARE
00799	PRIMARY HEALTH SERVICES
00800	ABC-ASSOC BLDRS & CONTRACTORS
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GENERAL INFORMATION

A code that identifies the type of coverage an enrollee has with the third party. Allowed values in this report are 'A' = Part A, 'B' = Part B and 'RD' = Part D.

Subsystem: Financial
Business Name: N/A
Reference Name: C_CVRG_CVAL
Cobol Picture: X(02)
DB2 Data Type: CHAR(02)
Range: N/A

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BUSINESS RULES

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VALID VALUES	DESCRIPTION
A	Medicare Part A
B	Medicare Part B
C	Cancer
D	Dental
E	Not assigned
F	Home Health/Personal Care
G	Mental Health
H	Hospitalization

I	Indemnity/Accident
J	Dependent Pregnancy
K	Medicare Extended
L	Managed Care (HMO/PPO)
M	Major/Medical-Comprehensive
N	Intermediate Care Nursing Facility
O	Optical/Vision
P	Physician
Q	Chiropractor
R	Pharmacy
RD	Medicare Part D
S	Skilled Nursing
T	Transportation
U	Uninsured Absent Parent
V	Rehabilitation/Physical Medicine
W	Worker's Compensation
X	Preventive Care
Y	Medicare Part A-HMO (no longer used)
Z	Medicare Part B-HMO (no longer used)

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ELIGIBILITY

DD waivers services are available to eligible individuals, including children, with a developmental disability (DD) who have been determined to require the level of support provided in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID). These services must be determined to be an appropriate service alternative to exit from, delay or avoid placement in an ICF-IID and necessary to ensure community integration.

Only individuals residing within the physical boundaries of the Commonwealth are eligible to be authorized and have their services reimbursed through the waiver.

While individuals who are inpatients of a hospital, nursing facility, ICF-IID, or inpatient rehabilitation facility may be on the waiting list and may receive limited support coordination, they are not eligible to be authorized to receive waiver services (with the exception of Transition Services) until exiting the institution and being enrolled in the waiver.

In order to be approved for a DD waiver, an individual must meet the following criteria:

- Have a developmental disability;
- Have significant functional limitations in major life activities, as documented on the age appropriate version of the Virginia Individual Developmental Disabilities Eligibility Survey (VIDES) form;
- Meet Medicaid financial eligibility criteria; and
- Indicate willingness to accept waiver services within 30 days of slot assignment.

Diagnostic Eligibility

For the purposes of these waivers, **"intellectual disability"** is defined as follows (according to the Code of Virginia - § 37.2-100. Definitions.

Intellectual disability" means a disability, originating before the age of 18 years, characterized concurrently by (i) significant sub-average intellectual functioning as demonstrated by performance on a standardized measure of intellectual functioning, administered in conformity with accepted professional practice, that is at least two standard deviations below the mean and

(ii) significant limitations in adaptive behavior as expressed in conceptual, social, and practical adaptive skills.

For the purposes of these waivers, **"developmental disability"** is defined as follows (according to the Code of Virginia):

"Developmental disability" means a severe, chronic disability of an individual that:

- Is attributable to a mental or physical impairment, or a combination of mental and physical impairments, other than a sole diagnosis of mental illness;
- Is manifested before the individual reaches 22 years of age;
- Is likely to continue indefinitely;
- Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and
- Reflects the individual's need for a combination and sequence of special interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

An individual from birth to age nine, inclusive, who has a substantial developmental delay or specific congenital or acquired condition may be considered to have a developmental disability without meeting three or more of the criteria described in bullets listed directly above if the individual, without services and supports, has a high probability of meeting those criteria later in life.

"Age of Onset" clarification - For some individuals who come to the attention of waiver screeners later in life, school records no longer exist, the individual did not complete their education, or special education services were not even in existence at the time. In order to meet the second component of the definition of developmental disability, it is acceptable for the professional who completes the testing/evaluation to affirm the other required components of the definition also to include a written attestation regarding age of onset. This attestation must indicate that, based on familial report or other evidence (such as that gleaned from past hospitalizations or institutional stays), the developmental disability has existed since the developmental period.

Documentation of the above may include one or more of the following, as may be appropriate for the diagnosis. This documentation must address the above criteria and reflect the individual's current functioning:

- Psychological evaluation
- School testing/records
- Part C assessments
- Occupational Therapy/Physical Therapy/Speech and Language Therapy assessments
- Adaptive assessments
- Social history
- Medical records
- Social Security Administration determination.

The diagnosis may originate from a medical doctor, Occupational Therapist, Physical Therapist, Speech and Language Therapist, psychologist, or other professional acting within his scope of practice. An updated evaluation confirming diagnosis may be required if an individual's functioning changes significantly while receiving waiver services.

Functional Eligibility

Functional eligibility for the waiver is determined through the use of the Virginia Intellectual Developmental Disabilities Eligibility Survey (VIDES) appropriate to the individual according to his/her age, completed no more than six months prior to waiver enrollment and annually, prior to the ISP meeting, once waiver services have begun.

The VIDES must be conducted by a qualified Support Coordinator in person (face-to-face) with the individual and, as applicable, another person who knows the individual well. The results of the VIDES must be recorded in the Waiver Management System (WaMS).

If the individual to be screened resides out of state, the VIDES may be completed through the use of remote technology that allows the Support Coordinator to view the individual and converse with him/her and any other person who knows the individual well, as appropriate. The interactive audio/video connection must be of sufficient audio quality and visual clarity so as to be functionally equivalent to a face-to-face encounter, conducted in a confidential manner and any information sharing consistent with applicable federal and state laws and regulations and DMAS policy. Health Information Portability and Accountability Act of 1996 (HIPAA) confidentiality requirements are applicable.

The three versions of the VIDES are as follows:

- VIDES for infants must be used for the evaluation of individuals who are younger than three years of age (DMAS-P235). Two or more of five categories must be met.
- VIDES for children must be used for the evaluation of individuals who are three years of age through 17 years of age (DMAS-P-236). Two or more of seven categories must be met.
- VIDES for adults must be used for the evaluation of individuals who are 18 years of age and older (DMAS-P237). Three or more of eight categories must be met.

The VIDES may not be completed in its entirety by either the individual's family or service providers.

Financial Eligibility

Once assigned a waiver slot, the individual must be found to be financially eligible for Medicaid services in order to receive DD waiver services. Local departments of social services (LDSS) determine an individual's financial eligibility for Medicaid. Some individuals not otherwise financially eligible for Medicaid may be eligible to receive DD waiver services.

Patient Pay

Some individuals who are approved for Medicaid under eligibility rules unique to waiver recipients may have a patient pay responsibility. Patient pay refers to an individual's obligation to pay towards the cost of long term services and supports if the individual's income exceeds certain thresholds. This means that Virginia reduces its payment for DD waiver services by the amount of the individual's income remaining after all allowable deductions are made for "personal maintenance needs."

Patient pay is determined by the LDSS using the following methodology:

- The allowable income level used for waivers is 300% of the current supplemental security income (SSI) payment standard for one person.

- Under the DD Waivers, the coverage groups authorized under the Social Security Act is considered as if the individual were institutionalized for the purpose of applying institutional deeming rules. All individuals under the waivers must meet the financial and nonfinancial Medicaid eligibility criteria and meet the level-of-care criteria for an ICF/IID. The deeming rules are applied to waiver eligible individuals as if the individuals were residing in an ICF/IID or would require that level of care.

- The Commonwealth will reduce its payment for DD waiver services provided to an individual by that amount of the individual's total income, including amounts disregarded in determining eligibility, that remains after allowable deductions for personal maintenance needs, other dependents, and medical needs have been made according to federal guidelines. DMAS will reduce its payment for DD waiver services by the amount that remains after the following deductions:

    - For individuals to whom § 1924(d) of the Social Security Act applies and for whom the Commonwealth waives the requirement for comparability pursuant to § 1902(a)(10)(B), DMAS will deduct the following in the respective order:

- The basic maintenance needs for an individual under the DD Waivers, which is equal to 165% of the SSI payment for one person. Due to expenses of employment, a working individual will have an additional income allowance. For an individual employed 20 hours or more per week, earned income will be disregarded up to a maximum of both earned and unearned income up to 300% of SSI; for an individual employed at least four hours but less than 20 hours per week, earned income will be disregarded up to a maximum of both earned and unearned income up to 200% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5% of the individual's total monthly income, will be added to the maintenance needs allowance. However, in no case will the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI.

- For an individual with only a spouse at home, the community spousal income allowance determined in accordance with the Social Security Act.

- For an individual with a family at home, an additional amount for the maintenance needs of the family determined in accordance with the Social Security Act.

- Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including Medicare and other health insurance premiums, deductibles, or coinsurance charges, and necessary medical or remedial care recognized under state law but not covered under the State Plan for Medical Assistance.

- For individuals to whom § 1924(d) does not apply and for whom the Commonwealth waives the requirement for comparability pursuant to § 1902(a)(10)(B), DMAS will deduct the following in the respective order:

    - The basic maintenance needs for an individual under the DD Waivers, which is equal to 165% of the SSI payment for one person. Due to expenses of employment, a working individual will have an additional income allowance. For an individual employed 20 hours or more per week, earned income will be disregarded up to a maximum of both earned and unearned income up to 300% of SSI; for an individual employed at least four but less than 20 hours per week, earned income will be disregarded up to a maximum of both earned and unearned income up to 200% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5% of the individual's total monthly income, will be added to the maintenance needs allowance. However, in no case will the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI.

- For an individual with a dependent child, an additional amount for the maintenance needs of the child, which is equal to the Title XIX medically needy income standard based on the number of dependent children.

- Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including Medicare and other health insurance premiums, deductibles, or coinsurance charges, and necessary medical or remedial care recognized under state law but not covered under the State Plan for Medical Assistance.

DMAS will reimburse the providers only for services that are not covered by the patient pay.

The patient pay determination is initiated when an individual's Support Coordinator notifies the LDSS via the DMAS-225 that the individual has been approved for DD Waiver services or the individual receiving DD waiver services experiences a change in circumstances, income, or assets.

The LDSS will determine an individual's patient pay amount obligation into the Medicaid Management Information System (MMIS) or other Medicaid informational system adopted by the administering Medicaid agency at the time action is taken as a result of an application for waiver services, redetermination of eligibility, or reported change in an individual's situation. That amount is transmitted electronically to the Medicaid Enrollment and Claims system.

If an individual receiving DD Waiver services has a patient-pay amount, a provider is designated to collect the patient pay. Providers designated to collect patient pay are responsible for collecting the patient pay amount and reducing the claim for Medicaid payment of DD Waiver services by that amount.

Verification of an individual's patient pay obligation will be available through the web-based Automated Response System (ARS) and telephone-based MediCall system. Responsible providers, as designated by the Support Coordinator, must monitor the ARS/MediCall systems in order to determine the appropriate amount of patient pay to collect. These verification systems allow the provider to access information regarding Medicaid eligibility, claims status, check status, service limits, service authorization, and pharmacy prescriber identification.

The website to enroll for access to this system is https://rb.gy/76e7sn The MediCall voice response system will provide the same information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider. Information regarding how to access these systems is included in Chapter 1 of each provider manual.

The DMAS-generated Notice of Approval of Pre- Authorized Services serves as the provider's confirmation of individual eligibility and authorization to bill for waiver services. Only the cost of

medically necessary, individual-specific, customized, non-covered items or services may be deducted from patient pay by the eligibility worker.

The assigned provider should include the patient pay on the claim. Providers must submit claims for all services, even if the provider does not expect reimbursement for a claim due to patient pay. MMIS is only able to track patient pay when a claim is submitted. Providers are responsible for collecting only the amount of patient pay that is deducted from their claim.

PATIENT PAY CONSUMER DIRECTED SERVICES

The only exception to application of patient pay rules stated above is for those choosing to self-direct their consumer-directed services.

Agency providers need to document how the actual patient pay amount was obtained. The F/EA is responsible for ensuring the patient pay amount is withheld from CD reimbursement.

MEDICAID LTC COMMUNICATION DOCUMENT (DMAS-225)

It is the responsibility of the Support Coordinator to complete the DMAS-225 form. The form is sent to the LDSS for review by an eligibility worker and determination on patient pay responsibility. The DMAS-225 is then sent back to the Support Coordinator. The Support Coordinator will review the DMAS-225 and, for individuals who have a patient pay obligation, identify the provider with the highest potential billing amount and inform the provider in writing that they must collect the patient pay.

The DMAS-225 will be used to advise the LDSS staff which provider is responsible for collecting the individual's patient pay obligation. The Support Coordinator, should complete the Provider NPI# (or API) data field on the DMAS-225. The DMAS-225, when completed by the LDSS, will then be used to inform the Support Coordinator of the individual's eligibility status.

Once a responsible provider is identified, the Support Coordinator forwards a computer generated confirmation of level of care eligibility and the DMAS-225 (with the top portion completed) to the LDSS indicating that the individual has met the level of care requirements and providers have been selected.

Following verification that the individual has been screened and approved to receive DD Waiver services, the LDSS eligibility worker will determine the individual's Medicaid eligibility, complete the LDSS portion of the DMAS-225 and return it to the Support Coordinator with the bottom section completed, showing confirmation of the individual's Medicaid identification number and the date on which the individual's Medicaid eligibility was effective.

The Support Coordinator must maintain a copy of the DSS-completed DMAS-225 in the individual's support coordination file.

The Support Coordinator may monitor the ARS/MediCall systems for financial eligibility and patient pay obligations. DSS is responsible for notifying the Support Coordinator if the individual no longer meets eligibility requirements and for updating the Support Coordinator of changes to an individual's eligibility.

The DMAS-225 is also used by the Support Coordinator and the LDSS to exchange information that may affect the eligibility status of an individual. The Support Coordinator must complete an updated DMAS-225 and forward it to the LDSS eligibility worker whenever an individual experiences any of the following:

- A change in address;
- A change in provider of support coordination services;
- An increase or decrease in monthly income;
- A change in collector of patient pay;
- Discharge from all DD Waiver services;
- An interruption in all DD Waiver services for more than 30 consecutive days; and
- Death.

The Support Coordinator must update the DMAS-225 and submit it to the LDSS within 5 business days following any of these changes. The exact change in circumstances and reason for the change must be clearly noted on the DMAS-225.

DD WAIVERS ENROLLMENT AND WAITING LIST

The individual who has been found to be eligible for the DD waivers will be given, by the Support Coordinator, his choice of either institutional placement or receipt of home and community-based waiver services. The "Documentation of Recipient Choice between Institutional Care or Home and Community-Based Services" (DMAS 459-C) form is used by the Support Coordinator to give eligible individuals their choice of either institutional placement or receipt of home and community-based waiver services. If the individual selects home and community-based waiver services, electronic confirmation by DBHDS is received that a slot is available, and an Individual Support Plan that ensures the individual's safety can be developed, then the Support Coordinator may enroll the individual in the waiver.

When an individual has been found eligible for and desires services through the DD waivers, but there is not a slot available, the individual may be added to the DD waivers waiting list by the Support Coordinator. To be placed on the waiting list for the DD Waivers (referred to as the waiting list) both diagnostic eligibility and functional eligibility (determined through completion of the VIDES) must be met. The following is also needed:

- Documentation of the date of need,
- The types of services sought, and

- The "Documentation of Recipient Choice between Institutional Care or Home, and Community-Based Services" (DMAS 459-C) form.

Within 10 business days of placement on the waiting list, the Support Coordinator must notify the individual in writing that:

- He or she has been placed on the waiting list,
- His or her priority level status, and
- Offer appeal rights (see the "Individual's Right to Appeal and Fair Hearing" section of Chapter VI for details).

Placement on the waiting list occurs in WaMS.

While an individual must not be simultaneously enrolled in more than one waiver, an individual who has a diagnosis of DD may be on the waiting list for the DD Waivers while simultaneously being enrolled in the Commonwealth Coordinated Care Plus Waiver (CCC+ waiver) if the individual meets applicable criteria for either. Individuals who reside in NFs or other institutions who qualify for the DD Waivers may also be on the waiting list.

Individuals who accompany parents or guardians deployed overseas for active duty U.S. military or Foreign Service assignment but retain Virginia residency may, if they so choose, remain on the statewide DD waivers waiting list and be considered for DD waivers slot assignment when they are within three months of returning to Virginia.

There must be annual documentation of contact with each individual on the waiting list to provide the choice between waiver and institutional placement through completion of the Attestation Documentation of Individual Choice for Home and Community-Based Services" (DMAS 459-C) form and updating of the types of services sought/needed. During the month in which the individual was added to the waiting list DBHDS sends, via postal mail to the adult individual or identified representative, the two forms mentioned above. These forms may also be completed online via the WaMS Waitlist Portal. If the forms are not completed in the WaMS portal or received back within 30 days, DBHDS will attempt a second mailing of the forms, plus the Notice of Action letter informing the individual that he/she will be removed from the waiting list if the second set of forms are not completed in the WaMS portal or received within 60 days. At the end of the 60 days, if no forms are received or appeal filed, the individual's name will be removed from the waiting list. Quarterly, CSBs will receive completed Choice forms for individuals on their portion of the waiting list for inclusion in their files and a report of the names of individuals whose names have been removed from the waiting list.

Waiting List Priority Status and Criteria

In order to ensure waiver services are provided to those with the most urgent need, the Support Coordinator/case manager will identify, after discussion with the individual and family/caregiver,

as appropriate, the priority status that best reflects the situation of the individual seeking waiver services. The waiting list includes Priority One, Priority Two and Priority Three categories. The individual will be assigned the priority level that best describes his/her need for waiver services by meeting at least one criterion in the category. This decision will be documented using the DD Waivers' Priority Criteria Checklist form. Also documented on this form is confirmation that the individual, the individual's spouse, or the parent of an individual who is a minor child would accept DD waiver services within 30 days of slot assignment.

Only those individuals who meet Priority One criteria and are willing to accept services within 30 days of slot assignment are eligible to be reviewed for a CL or FIS slot, until such time as all individuals in the Priority One group have received slots.

Priority One:
This designation will be given to individuals who will require a waiver service *within one year* and are determined to meet at least one of the following criteria:

- An immediate jeopardy exists to the health and safety of the individual due to the unpaid primary caregiver having a chronic or long-term physical or psychiatric condition that currently significantly limits the ability of the primary caregiver to care for the individual; or there are no other unpaid caregivers available to provide supports.

- There is immediate risk to the health or safety of the individual, primary caregiver, or other person living in the home due to either of the following conditions:

    - The individual's behavior, presenting a risk to himself or others, cannot be effectively managed even with Support Coordinator-arranged generic or specialized supports; or

    - There are physical care needs or medical needs that cannot be managed even with Support Coordinator-arranged generic or specialized supports

- The individual lives in an institutional setting and has a viable discharge plan; OR

- The individual is a young adult who is no longer eligible for IDEA services and has expressed a desire to live independently. After individuals attain 27 years of age, this criterion will no longer apply.

Priority Two:
This designation will be given to individuals who will need a waiver service in *one to five years* and are determined to meet at least one of the following criteria:

- The health and safety of the individual is likely to be in future jeopardy due to:

- The unpaid primary caregiver having a declining chronic or long-term physical or psychiatric condition that currently significantly limits his/her ability to care for the individual,

- There are currently no other unpaid caregivers available to provide supports, or

- The individual's skills are declining as a result of lack of supports.

- The individual is at risk of losing employment supports,

- The individual is at risk of losing current housing due to a lack of adequate supports and services, or

- The individual has needs or desired outcomes that with adequate supports will result in a significantly improved quality of life.

Priority Three:
This designation will be given to individuals who will need a waiver slot in *five years or longer* as long as the current supports and services remain and have been determined to meet at least one of the following criteria:

- The individual is receiving a service through another funding source that meets current needs,

- The individual is not currently receiving a service but is likely to need a service in five or more years**,** or

- The individual has needs or desired outcomes that with adequate supports will result in a significantly improved quality of life.

Individuals and family/caregivers, as appropriate, have the right to appeal the determination of the individual's priority level.

If an individual determines at any time that he or she no longer wishes to be on the waiting list, the individual may contact his Support Coordinator and request removal from the waiting list. The Support Coordinator will notify DBHDS and the individual's name will be removed from the waiting list. The Notice of Action form generated by the Virginia Waiver Management System is generated and sent by the Support Coordinator to the individual informing the individual of their right to appeal this decision.

A review of the individual's status and a new Priority Criteria Checklist will be completed by the Support Coordinator when the needs of the individual change, but ideally no less than once every

three years. Any changes to an individual's priority status or removal from the waiting list due to change in status are communicated to DBHDS via WaMS. When an individual's priority level decreases or change in waiting list status is made, the individual and family member/caregiver, as appropriate, must be notified in writing of his or her appeal rights. Changes in status that require notification of appeal rights are indicated on the Notice of Action form.

***Critical Needs Summary** Step 1 Review*

All individuals meeting the Priority One criteria must have a Critical Needs Summary – Step 1 Review form completed by their Support Coordinator in WaMS as soon as possible after the determination is made that they meet the criteria. This form should be based on documented information in the individual's record (family report, intake summary, reports by professionals, etc., as appropriate). The Critical Needs Summary form will generate a Critical Needs Summary score that is maintained in WaMS.

The Critical Needs Summary form for each individual on the waiting list must be reviewed and updated annually after the first CNS, and whenever the individual's "critical needs" change.

DD WAIVERS SLOT MANAGEMENT

Slot Allocation

When the General Assembly has approved less than 40 new slots for a given waiver, the available slots will be allocated by DBHDS to regions or sub-regions of the state for distribution to the individuals in that region or sub-region who are determined to have the most urgent needs. If there are BI slots to be allocated, the BI slots will be allocated by region.

When at least 40 new Community Living or Family and Individual Supports waiver slots are funded by the General Assembly, one slot will be allocated by DBHDS to each CSB. Additional slots up to the total number of available slots for a given waiver will be allocated to CSBs for individuals living within that CSB's catchment area based upon a formula combining the following objective factors and criteria:

- The region's population,
- The percentage of Medicaid eligible individuals in the catchment area, and
- Each CSB's percentage of individuals on the "Priority One" portion of the statewide waiting list.

Individuals are enrolled into a DD Waiver when a slot becomes available to their local CSB or region. This may occur through attrition or through the allocation of new slots to the CSB or region.

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Slot Assignment – Community Living and Family and Individual Supports Waivers

When it is anticipated that a vacant slot or slots will become available for assignment, the Support Coordinators for the individuals with the highest Critical Needs Summary scores will prepare written summaries of the individuals' needs on the "Slot Assignment Review" form in WaMS. Completed forms will be distributed to Waiver Slot Assignment Committee (WSAC) members in advance of the meeting to permit sufficient time for a thorough reading. This may include individuals new to the system who have not yet been placed on the Statewide Waiting List.

A Waiver Slot Assignment Committee (WSAC) is the impartial body of trained volunteers established for each locality or region with responsibility for recommending to DBHDS individuals eligible for a waiver slot according to their urgency of need at the time a slot becomes available. All WSACs must be composed of community members who are not employees of a CSB or a private provider of either support coordination or waiver services and are knowledgeable of and have experience in the developmental disabilities service system. When a slot is available, the CSB will contact the WSAC facilitator, who will coordinate with DBHDS staff to call a meeting of the committee as soon as possible.

The determination of the number of individuals to be reviewed by the WSAC follows the following procedures:

- If the number of available slots is 5 or less, the 10 top-ranking Critical Needs Summary (CNS)-Step 1 individuals will be considered for review;

- If there is more than one individual ranked at number 10, all equally scoring individuals at the cut-off point will be considered for review. For example, if three individuals in the "number 10 spot" have the same score all three will be reviewed, making the total to be reviewed 12 instead of 10;

- If a CSB has more than 5 slots available, the number of top-ranking individuals reviewed will be double the number of available slots. For example, if 7 slots are available, the number of top ranking CNS-Step 1 individuals moving to WSAC review will be 14. In this example, if there is more than one individual ranked at number 14, all equally scoring individuals at the cut-off point will be included for consideration in the Step 2 review.

The Support Coordinator, Support Coordinator Supervisor, or designee will be available to provide information to the WSAC about the person being considered, but may not be a voting member of the committee. Slots are assigned by DBHDS based on the recommendations from WSACs on who should be served first due to urgency of need at the time a slot becomes available.

WSAC members will discuss their impressions based on the information contained in the Slot Assignment Review form. Without knowledge of the type of slots that are available, committee members will rank those in the review pool for urgency based on their need for services, from

highest to lowest. Using the "Slot Assignment Scoring Summary-Step 2 Review" form, each committee member will assign a numeric score in each of five categories for each individual. These scores will be totaled, thereby arriving at a total score for the committee member. All WSAC members' scores will be totaled and divided by the number of WSAC members, resulting in a final, decimal-based score. The WSAC will recommend individual(s) with the highest score(s) to DBHDS to receive the available slot(s).

Should there be a tie, WSAC members will re-review and discuss the Support Coordinators' summaries for those individuals and rescore until one individual emerges with a higher score.

To assure statewide consistency, DBHDS staff will participate in each WSAC meeting as an observer and monitor of the slot assignment process. Following the WSAC meeting, DBHDS staff will pair WSAC recommended individuals with the type of waiver slot that will best meet each individual's needs (e.g., individuals with documented needs for a residential service only available in the CL waiver, such as group home or sponsored residential, will be assigned a CL slot, while individuals seeking supports in the family or individual's own home will be assigned a FIS slot). DBHDS staff will maintain documentation of the names of individuals reviewed for the slot(s), their respective Step 2 scores from the WSAC meeting, and the name of the individuals who received the available slot(s).

If there are no individuals on the waiting list at a given CSB who required group home or sponsored residential services, vacant CL waiver slots may be held for 90 days in case an individual presents who does need those services. If no one presents, a regional WSAC will be held to assign the vacant CL waiver slot(s).

Following the WSAC meeting, DBHDS staff will assign an individual receiving a slot "projected enrollment" status in WaMS. The Support Coordinator is notified that a slot is available when the Regional Supports Specialist (RSS) moves the individual to projected enrollment status in WaMS. The Support Coordinator must notify the individual and family/caregiver of slot availability and available services within the offered waiver within 7 calendar days of the waiver slot assignment date. This contact must be documented in the individual's record.

The individual or family caregiver, as applicable, will confirm acceptance or declination of the slot within 15 calendar days of notification of slot availability. If the individual or family caregiver, as applicable, has not relayed their decision to the SC within 7 calendar days, the SC shall make and document a second contact. If no decision is forthcoming after 15 calendar days, the SC shall notify DBHDS staff who will remove the individual from projected enrollment status, return him to the waiting list, and take steps to assign the slot to the next highest scoring individual from the review pool.

After the individual has accepted the waiver slot offered by the CSB, the Support Coordinator will provide a print screen of the projected slot enrollment page from WaMS, along with the DMAS-225 (Medicaid Long-Term Care Communication Form) to the LDSS office so that financial

eligibility for Medicaid and the waiver can be confirmed and any patient pay responsibilities can be determined. After the Support Coordinator has received written notification of Medicaid eligibility from the local department of social services, the Support Coordinator will inform the individual, submit information to DMAS or its designee to enroll the individual in the waiver, and develop the person-centered individual support plan (ISP). A Confirmation of Slot letter will be available in WaMS and should be provided to the individual and his/her caregiver by the Support Coordinator.

In the event that a CSB has a vacant slot but does not have an individual who meets the Priority One criteria, the slot may be held by the CSB for 90 days from the date it is identified as vacant in case someone in that area is identified as meeting Priority One criteria. If no one meeting the Priority One criteria is identified within 90 days, the slot will be made available for allocation to another CSB in the region through a regional WSAC as described below for the BI slot assignment process. If no one meeting in Priority One criteria has been identified within that region, DBHDS will, within 30 days, reallocate the slot to another region where there is unmet Priority One need.

Slot Assignment - Building Independence Waiver

Each of five regional WSACs, composed of one representative from each existing WSAC within the region, will make assignment recommendations for BI waiver slots. If the number of individuals interested in a BI waiver slot with Priority One status for all CSBs in a region is less than the number of available slots, those individuals are assigned a slot without a regional WSAC session occurring. A regional WSAC session will then be held for the remainder of available slots, reviewing those individuals meeting criteria for Priority Two and then Priority Three.

When a waiver slot becomes available through attrition, DBHDS will work with the region to determine if there is an individual appropriate for the slot in the region. If not, DBHDS will reassign the slot to a region with individuals who have requested access to a more integrated, independent living arrangement that can be supported through the provision of a minimal level of supports (i.e., through the BI waiver).

Facility Slots

DBHDS may maintain a separate pool of waiver slots for individuals who choose discharge from state-operated facilities and other institutional settings. The Division of Developmental Services (DDS) at DBHDS will track individuals discharged from these settings into waiver slots.

If an individual is readmitted to an institution within 12 months of discharge, and the admission is a long-term admission, the waiver slot will revert to the statewide pool for facility discharges. If the discharged individual resides in the community for 12 consecutive months following discharge, the waiver slot will remain with the CSB providing support coordination services during the 12th month of community residence.

Emergency Slots

If there are no available slots in the DD waivers and an eligible individual, either on the waiting list or newly known to the CSB, is encountering an emergency situation which may be remedied by a DD waiver slot, the Support Coordinator may apply to DBHDS for consideration for an emergency slot through submission of the "Complex Case Consult for Emergency Access to Waiver Services" form to DBHDS after careful exploration of all other alternatives for the individual by the CSB, Regional Support Team, as appropriate, and DBHDS staff.

Individuals must meet at least one of the emergency criteria below to be eligible for immediate access to waiver services without consideration to the length of time they have been waiting to access services.

- Child protective services has substantiated abuse/neglect against the primary caregiver and has removed the individual from the home, or

- For adults where (i) adult protective services has found that the individual needs and accepts protective services or (ii) abuse/neglect has not been founded, but corroborating information from other sources (agencies) indicate that there is an inherent risk present and there are no other caregivers available to provide support services to the individual,

- Death of primary caregiver or lack of alternative caregiver coupled with the individual's inability to care for himself and danger to self or others without supports.

The information will be reviewed by the Complex Case Consultation Team (C3T) within 2 business days. DBHDS will consider the individual's circumstances and determine if he meets at least one of the emergency access criteria. Should the C3T affirm that all community options have been considered and explored, an emergency slot will be assigned to the individual, subject to available funding and a finding of eligibility, by the end of the 2nd business day after receipt of the complete request.

If the C3T identifies other alternatives, these will be recommended to include a referral to the Regional Support Team as appropriate.

Emergency slots may be assigned by DBHDS to individuals found to meet emergency criteria for whom no other resources can be identified until the total number of available emergency slots statewide reaches 10% of the emergency slots funded for a given fiscal year, or a minimum of three slots. At that point, the next nonemergency waiver slot that becomes available at the CSB in receipt of an emergency slot must be reassigned to the emergency slot pool in order to ensure the availability of emergency slots for future emergencies within the Commonwealth's fiscal year.

Individuals not previously identified but newly known as needing supports resulting from an emergent situation are also eligible for an emergency slot.

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Reserve Slots

Reserve slots may be used to transition an individual from the DD waiver in which he is presently enrolled into another of the DD waivers. To be considered for a reserve slot there must be a documented change in the individual's assessed support needs that requires a move to another waiver in order to access a needed service(s). Consideration will also be given to whether the individual has attempted to fully utilize the services available in the present waiver.

An individual who needs to transition between the DD waivers will not be placed on the waiting list.

The Support Coordinator will document in writing the change in an individual's assessed needs, which requires a service (or services) that is not available in the DD waiver in which the individual is presently enrolled. The Support Coordinator will submit to DBHDS a "Request for a Reserve Slot" form when an individual meets the above criteria within three business days of knowledge of need.

The assignment of reserve slots will be managed by DBHDS, which will maintain a chronological list of individuals in need of a reserve slot in the event that the reserve slot supply is exhausted. Within three business days of adding an individual's name to the reserve slot list, DBHDS will advise the individual in writing that his name is on the reserve slot list and inform him of his chronological placement on the list. Within three business days of receiving a request from an individual for a status update regarding his placement on the list, DBHDS will advise the individual of his current chronological list number.

When a slot is vacated in one of the DD Waivers (e.g., due to the death of an individual), the slot must be assigned to the next individual in that CSB's chronological queue for a reserve slot in that waiver. When an individual transitions to a new DD waiver using a reserve slot, the waiver slot vacated by that individual will be offered to the next individual in that CSB's chronological queue for a reserve slot in that waiver. If the individual chooses to accept the slot, DBHDS will assign. If there is not an individual in that CSB's chronological queue for a reserve slot in that waiver, the vacated slot will be assigned to an individual on the statewide waiting list who resides in the CSB's catchment area by DBHDS after review and recommendations from the local WSAC.

When a reserve slot becomes available and an individual is identified from the chronological list to access the slot, the Support Coordinator will assure to DBHDS that the service that warranted the transfer to the new waiver (e.g., group home residential) is (i) identified and (ii) a targeted date of service initiation is in place prior to the reserve slot assignment to the new waiver.

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DEVELOPING THE INDIVIDUAL SUPPORT PLAN (ISP)

After the Support Coordinator has received written notification of Medicaid eligibility from the local department of social services, the Support Coordinator will inform the individual, submit information in WaMS to enroll the individual in the waiver, and develop the person-centered individual support plan (ISP).

The Support Coordinator will meet with the individual projected to receive waiver services and the individual's family/caregiver, as appropriate, within 30 calendar days of waiver assignment date to:

- Discuss the individual's assessed needs, existing supports, and preferences;
- Obtain a medical examination, which was completed no earlier than 12 months prior to the initiation of waiver services;
- Update the VIDES as needed so that it is dated no more than six months prior to the start of waiver services;
- Begin to develop the personal profile; and
- Discuss that a Supports Intensity Scale® (SIS) or other developmentally appropriate assessment (for individuals under the age of five years) will need to be scheduled.

Prior to or at the meeting to discuss the individual's assessed needs, the Support Coordinator will provide the individual with a choice of services identified as needed and available in the assigned waiver, alternative settings, and providers. The individual's choices will be documented on the Virginia Informed Choice form (DMAS-460/459A). Once the providers are chosen, the Support Coordinator will schedule a planning meeting with the members of the support team to develop the unique person-centered ISP based on the individual's assessed needs, preferences, and the individual's family/caregiver preferences, as appropriate. The ISP sets out the supports and actions to be taken during the year by each provider, as detailed in each provider's Plan for Supports to achieve desired outcomes, goals, and dreams.

Persons invited by the individual to participate in the person-centered planning meeting may include the individual's family members, planning partner, service providers, and others as desired by the individual. The Support Coordinator must also participate. During the person-centered planning meeting, the services to be rendered to the individual, the frequency of services, the type of service provider or providers, and a description of the services to be offered are identified and included in the ISP. At a minimum, the individual enrolled in the waiver, or the family/caregiver as appropriate, and Support Coordinator must sign and date the ISP. All Plans for Support, including the Support Coordination PFS, must be signed by the individual, or the family/caregiver, as appropriate. If the signature of the individual receiving services or the family/caregiver, as

appropriate, cannot be obtained, the provider must document attempts to obtain the necessary signature and the barrier to obtaining it.

Each service provider must submit a copy of his plan for supports to the Support Coordinator. The plan for supports from each service provider will be incorporated into the ISP.

The Support Coordinator will review and ensure all plans for supports meet the established service criteria for the identified needs prior to electronically submitting these along with the results of the comprehensive assessment and a recommendation for the final determination of the need for ICF/IID level of care for service authorization.

The ISP must contain the following components:

- Part I: Personal Profile;
- Part II: Essential Information;
- Part III: Shared Planning;
- Part IV: Agreements; and
- Part V: Plans for Support.

During the person-centered planning meeting, the services to be rendered to the individual, the frequency of services, the type of provider, and a description of the services to be offered are identified and included in the ISP. The Support Coordinator must complete a risk assessment as part of the planning process. The risk assessment is an assessment used to determine areas of high risk of danger to the individual or others based on the individual's serious medical or behavioral factors. The ISP must then contain the steps and supports needed to mitigate any identified risks.

At a minimum, the individual enrolled in the waiver, the family/caregiver, as appropriate, and Support Coordinator will sign and date the ISP. The Support Coordinator determines the effective date of the ISP. Any services that are added after the initial date of the ISP will be required to be reauthorized upon the ISP's annual date, if not before. Support Coordinators will provide individuals and the family/caregiver, as appropriate, with a copy of the individual's ISP.

The individual, family/caregiver, or Support Coordinator will contact chosen providers so that services can be initiated within 30 calendar days of receipt of written confirmation of waiver enrollment.

DMAS will not reimburse providers for services in ISPs that duplicate payments made to public agencies or private entities under other program authorities for this same purpose, nor reimburse for services that are duplicative of each other. DMAS will only reimburse for services as set out in the individual's ISP. Any payments determined to have been made contrary to these limitations will be recovered by either DMAS or its designee.

INDIVIDUAL PLANNING CALENDAR (IPC)

Also during the person-centered planning meeting, the Support Coordinator will engage the individual and family/caregiver, as appropriate, in a conversation about how paid services and natural supports are arranged during the week currently and how the individual would like to see those arranged in the future in order to achieve the life he/she wants. This will be recorded on the Individual Planning Calendar (IPC). The IPC is made up of two parts:

- A **current calendar**, which shows how the individual generally spends his/her week right now; and
- An **aspiration calendar**, which shows how the individual might want to spend his/her week in the future, such as spending more time with family and friends, working in the community, living in his/her own apartment, or other goals.

These tools are located in WaMS.

The IPC tools and process are designed to assist the individual and Support Coordinator in charting a path that moves the individual closer to his/her important goals as reflected in the aspiration calendar by examining the person's current calendar and planning together. The use of the IPC is also related to supports packages, which are a set of assumptions regarding the types and amounts of supports that an individual needs to be adequately supported in the community.

It is a model that reflects reasonable services levels based on common expectations for persons who share similar characteristics. Supports packages and the IPC process are designed to ensure that the individual receives enough support based on what he or she needs.

The IPC is completed by the Support Coordinator once a year at the annual ISP meeting.

PLANS FOR SUPPORTS

Each waiver service provider, in conjunction with the individual, the individual's family/caregiver, as appropriate, and the Support Coordinator, will develop a Plan for Supports for that particular service. The Plan for Supports is that provider's plan for supporting the individual enrolled in the waiver in achieving his or her desired outcomes and facilitating his or her health and safety. The provider Plan for Supports is one component of the individual support plan.

At a minimum, the Plan for Supports must contain:

- The individual's desired outcomes that describe what is important to and for the individual in observable terms;

- Support activities and support instructions that are inclusive of skill-building if required by the service provided and that are designed to assist in achieving the individual's desired outcomes;

- The services to be rendered and the schedule for these services so as to accomplish the desired outcomes and support activities, a timetable for the accomplishment of the individual's desired outcomes and support activities, the estimated duration of the individual's need for services, and the provider staff responsible for overall coordination and integration of the services specified in the plan for supports; and

- Documentation regarding any restrictions on the freedoms of everyday life in accordance with human rights regulations (12VAC35-115) and the requirements of the HCBS settings regulations (42 CFR 441.301).

Each provider submits a copy of his Plan for Supports to the Support Coordinator so that it may be incorporated into the ISP. Providers are responsible for updating the Plan for Supports when an individual's needs change significantly enough so that the existing Plan for Supports no longer reflect the individual's needs and the supports required to meet those needs (e.g., the individual's medical condition deteriorates necessitating increased supports, new risk factors have been identified necessitating the addition of risk management plans/procedures, etc.).

SERVICE AUTHORIZATION

The Support Coordinator is responsible for reviewing and ensuring that the provider-specific Plan for Supports includes allowable activities for the service, reflects the needs and desires of the individual and is in agreement with the discussion at the ISP meeting before electronically submitting the Plan for Supports in WaMS, along with the results of the comprehensive assessment (i.e., relevant social, psychological, and medical information that are used as basis for the development of the ISP), other required ISP elements, and a recommendation for the final determination of the need for ICF/IID level of care to DBHDS for service authorization. All DD waiver services must be authorized before the provider may bill Medicaid.

Waiver services will be approved and authorized by DBHDS only if:

- The individual is Medicaid eligible as determined by the local department of social services,

- The individual has a diagnosis of developmental disability and would, in the absence of waiver services, require the level of care provided in an ICF/IID,

- The individual's ISP can be safely rendered in the community, and

- The contents of providers' plans for supports are consistent with the ISP requirements, limitations, units, documentation requirements of each service, and the individual's documented needs.

DD waiver services may not be authorized or reimbursed by DMAS for an individual who:

- Has his permanent residence outside of the physical boundaries of the Commonwealth, or
- Is an inpatient of a hospital, nursing facility, ICF/IID, or inpatient rehabilitation facility.

The Support Coordinator may recommend waiver services that would promote the individual's exiting from an institutional placement. However, with the exception of Transition Services, waiver services may only be provided when the individual has exited the institution and has been enrolled in the waiver.

DMAS will not reimburse providers for the costs of room and board, education, services covered by other payers, or expenses associated with social or recreational activities.

It is the responsibility of the provider to submit service authorization requests to the Support Coordinator for review, approval, and submission to DBHDS via the Waiver Management System (WaMS) to begin services, to modify the amount or type of services, or to end services. The service authorization request must clearly describe the reason for the action. All requests will be reviewed under the health and safety standard. This standard means that an individual needs the service, based on appropriate assessment criteria and a written Plan for Supports, and that services can safely be provided in the community. A justification describing the individual's need for the service and required documentation for the service will be submitted along with the service authorization request. DBHDS is responsible for assuring that the documentation received supports the request. Final recommendation for authorization of DD waiver services is the responsibility of DBHDS. DMAS has the final authority regarding all service authorizations.

The authorized start date of services will not be prior to the date of receipt by DBHDS of a correct, complete authorization request for an eligible individual except for crisis services. To assure the provider that the individual is eligible and that services are authorized as requested, it is recommended that the required documents be submitted at least 30 working days prior to the requested start of services. Requests for EPSDT Private Duty Nursing services for individuals on the DD waivers should be submitted at least 10 days, but no more than 30 days prior to the requested service start or renewal date. All authorization requests will be acted upon (i.e., review of the documentation to determine individual eligibility and the need for and appropriateness of the service being requested, followed by approval, denial, rejection, or pend for additional information) within 10 working days following receipt by DBHDS. (See definition for Approval, denial, rejection or pend in Appendix A of this manual).

When services are approved by DBHDS, the provider and Support Coordinator will be notified via WaMS. At this point, the individual's waiver status becomes "active." For all services a DMAS-generated Notice of Approval of Pre-Authorized Services will be sent to the individual and the specified service provider notifying them of the action taken by DBHDS and the approved hours/units and authorized start date of services. Only waiver services authorized in the Individual

Support Plan by DBHDS according to DMAS policies and commencing on or after the start date on the Notice of Approval of Pre-Authorized Services will be reimbursed by DMAS.

If the requested services are denied, the provider and Support Coordinator will be notified by DBHDS via WaMS and a DMAS notification letter will be sent to the individual and provider notifying them of the reason for the denial and explaining the individual's appeal rights. Any requests for services that are denied may be resubmitted at a later date if additional justification is obtained.

If DBHDS pends approval of services, notification will be sent to the provider and Support Coordinator explaining the reason for this action and any additional information or action that is required of the provider or Support Coordinator. The Support Coordinator is responsible for submitting the requested information to DBHDS within 30 calendar days. No more than two pends per service authorization request will be permitted. If criteria is not met after receipt of information following the second pend, the request will be rejected or denied. There are no appeal rights with rejected requests and the provider must resubmit the request with a new start date in order to obtain service authorization.

Pending Medicaid Eligibility

DBHDS will notify the provider and Support Coordinator via WaMS if a service authorization request cannot be processed due to a pending Medicaid number. Once the Medicaid number has been issued by the LDSS, the Support Coordinator must save the Medicaid number in the "overview" section of "Person's Information" in WaMS, mark the Medicaid number as "current" by checking the box, and resubmit the request to complete the authorization process. Providers cannot be paid until the Medicaid number has been given to DBHDS.

60-Day Assessment Service Authorization Requests

A 60-day assessment service authorization request may be submitted for group home residential, sponsored residential, supported living residential, in-home supports, independent living supports, agency-directed personal assistance, individual supported employment, group supported employment, group day, community engagement or community coaching. The 60-day assessment service authorization request is authorized only for the assessment period. To continue services after the 60 day assessment, an annual Plan for Supports, developed with the involvement of the individual, must be forwarded by the provider to the Support Coordinator for review and approval. The Support Coordinator must submit the request to DBHDS review prior to the end of the 60 days.

Modifications to Services

To change the amount or type of service previously authorized, a revised Plan for Supports and schedule must be developed with the individual and approved by the Support Coordinator. The

provider must submit a new service authorization request for review and approval by the Support Coordinator and final authorization by DBHDS.

Multiple Providers

If the individual will be receiving the same service from more than one provider, the Support Coordinator should clearly describe the circumstances to DBHDS in the service authorization request. If changes occur during the Individual Support Plan year, the circumstances should be clearly described on the service authorization request. The second provider will submit a claim with **77 modifier** (Concurrent Care). The modifier alerts DMAS to allow two providers to be paid for the same procedure code on or within the same or overlapping time periods.

Changing Providers

To change a provider for an approved service, the Support Coordinator must submit to DBHDS a service authorization request to terminate the services of the existing provider and a service authorization request to begin services with the new provider.

Ending Services

When services from a waiver provider cease, the service authorization in WaMS should be ended with the last date of service delivery, and the detailed reason for terminating the service should be provided. When all DD waiver services end, this constitutes either an interruption or a discharge from the DD waiver. The Support Coordinator should go to the WaMS "Enrollment" and change the status from active/hold to terminated, pending appeal rights. When the appeal timeframe is completed the Support Coordinator will complete a final release of the waiver slot in WaMS. If the individual is deceased, the waiver slot will automatically be released.

Provider Discontinuation of Services

If, at any time, a provider determines that the health, safety, or welfare of the individual enrolled in the waiver, other individuals in that setting, or provider personnel are endangered, the Support Coordinator and DBHDS must be notified by the provider prior to discontinuing services. In a nonemergency situation, when a provider determines that his provision of supports to an individual enrolled in the waiver will be discontinued, the provider must give the individual and the individual's family/caregiver, as appropriate, and Support Coordinator written notification of the provider's intent to discontinue services. The notification letter must provide the reasons for the planned discontinuation and the effective date the provider will be discontinuing services. The effective date of the service discontinuation must be at least 10 business days after the date of the notification letter. The individual enrolled in the waiver may seek services from another enrolled provider. When an individual is transitioning to a different provider, the former provider that served the individual must, at the request of the new provider, provide all medical records and documentation of services to the new provider (consistent with confidentiality requirements,

including the Health Insurance Portability and Accountability Act and the DBHDS Human Rights regulations) to ensure high quality continuity of care and service provision.

In emergency situations, the above mentioned 10-business-day prior written notification period will not be required. The local department of social services adult protective services unit or child protective services unit, as appropriate, and the DBHDS Offices of Licensing and Human Rights and DMAS are to be notified immediately of the emergency discontinuation of services by the Support Coordinator and the provider when the individual's health, safety, or welfare may be in danger.

In both emergency and nonemergency situations requiring discontinuation of services, providers of group home residential services, supported living residential services, and sponsored residential services must comply with the terms set forth in an individual's home and community-based settings residency or lease agreement as described in 42 CFR 441.301.

Delay in Initial Service Initiation/Requests to Retain Slots

If the services are not initiated by the provider within 30 calendar days of the Support Coordinator moving the individual to active enrollment status in WaMS or confirmation of Medicaid eligibility, whichever comes first, the Support Coordinator must notify the local department of social services so that reevaluation of the individual's financial eligibility can be made.

When an individual is referred back to a local department of social services for a redetermination of eligibility and the individual wants to retain the designated slot, the Support Coordinator must, at the same time as submission of notification to the local department of social services, submit a Request to Retain Slot to DBHDS through WaMS requesting retention of the designated slot pending the initiation of services. A copy of the request must be provided to the individual and the individual's family/caregiver, as appropriate.

DBHDS may approve the slot-retention request in 30-day extensions, up to a maximum of four consecutive extensions, or deny the request to retain the waiver slot for the individual when, at the end of this extension time period, there is no evidence of the individual's efforts to utilize waiver services. DBHDS will provide an electronic response to the Support Coordinator indicating denial or approval of the slot extension request within 10 working days of the receipt of the request for extension. The Support Coordinator will notify the individual and family/caregiver, as appropriate, in writing of any denial of the slot extension request and the individual's right to appeal.

Waiver Required Assessment

Each individual who receives DD waiver services is required to have an assessment that gathers information about the individual’s patterns and intensity of needed supports across life activities. The results of this assessment are used in the person-centered planning process, along with other

assessment information from doctors, psychologists and other professionals to develop each individual's ISP.

The SIS® is one such assessment tool. It identifies the practical supports required by individuals who are enrolled in a waiver to live successfully in their communities, specifically assessing individuals' support needs in regards to:

- Home living activities;
- Community living activities;
- Lifelong learning;
- Employment;
- Health, safety, social activities, and self-advocacy;
- Medical and behavioral support needs; and
- What is important to and important for individuals.

The Supports Intensity Scale-Children's Version™ (SIS-C) ™ may be used for individuals who are five years through 15 years of age. The Supports Intensity Scale-Adult Version™ (SIS-A) ™ is used for individuals who are 16 years of age and older. Individuals who are younger than five years of age are assessed using an age-appropriate standardized living skills assessment. The SIS is administered and analyzed by qualified, trained vendors designated by DBHDS.

A SIS assessment and the Virginia Supplemental Questions (VSQ), as appropriate, will be completed with the individual and others, such as family members and staff, who have known the person for at least 3 months and have knowledge of the individual's circumstances and needs for support.

The SIS or other developmentally appropriate assessment is completed according to the following regular schedule:

- At least every four years for those individuals who are 22 years of age and older;
- At least every three years for those individuals who are 16 years of age through 21 years of age;
- Every two years for individuals five years through 15 years of age when the individual is using a tiered service, such as group home residential, sponsored residential, supported living residential, group day, or community engagement. Another developmentally appropriate standardized living skills assessment approved by DBHDS, such as the Brigance Inventory, Vineland, or Choosing Outcomes and

Accommodations for Children will be obtained every two years for service planning purposes for those in this age grouping who are not using a tiered service; or

- For children younger than five years of age, an alternative industry assessment instrument approved by DBHDS, such as the Early Learning Assessment Profile, will be completed by the appropriate professional every two years for service planning purposes.

When there is documentation that an individual's support needs have changed significantly for a sustained period of at least six months, the Support Coordinator may request a SIS reassessment outside of the above regular cycle by completing the Virginia SIS Reassessment Request form and submitting it along with documentation of the need for reassessment to the DBHDS Regional Supports Specialist.

Approved requests will result in the scheduling of a new SIS assessment. Scores from SIS-A™ and SIS-C™ Section 1 (Medical, Behavioral), Section 2, Subsections A, B, and E, and responses to Supplemental Questions will be used to assign levels of supports (levels 1 – 7) to each individual.

The Virginia Supplemental Questions will also be used to identify individuals who have unique needs falling outside of the needs identifiable by the SIS instrument. The VSQ will also be administered and analyzed by the same qualified, trained vendors designated by DBHDS.
The Virginia Supplemental Questions addresses the following topics:

- Severe medical risk,
- Severe community safety risk for people with a related legal conviction,
- Severe community safety risk for people with no related legal conviction,
- Severe risk of harm to self, and
- Fall risk.

Specified affirmative responses to the items in the bullets directly above require a review of the individual's record for verification. After such review, the individual may be assigned to Level 6 (Intense and Significant Medical) or Level 7 (Intense and Significant Behavioral) regardless of scoring on other sections of the SIS.

LEVELS OF SUPPORT AND REIMBURSEMENT TIERS

The results of the SIS, Virginia Supplemental Questions, and, as needed, the document review verification process determine the individual's required level of supports. Levels of supports are described as:

- Level 1 indicates low support needs;
- Level 2 indicates low to moderate support needs;
- Level 3 indicates moderate support needs plus some behavior challenges;
- Level 4 indicates moderate to high support needs;

- Level 5 indicates maximum support needs;
- Level 6 indicates intense and significant support needs due to medical challenges, and;
- Level 7 indicates intense and significant support needs due to behavioral challenges.

An individual's level of support determines his reimbursement tier for certain services so that providers are reimbursed for services provided to individuals consistent with that level of support as follows:

- Tier 1 is used for individuals having Level 1 support needs.
- Tier 2 is used for individuals having Level 2 support needs.
- Tier 3 is used for individuals having Level 3 or Level 4 support needs.
- Tier 4 is used for individuals having Level 5, Level 6, or Level 7 support needs.

REEVALUATION OF SERVICE NEED AND ONGOING SUPPORT COORDINATOR MONITORING

The Support Coordinator is responsible for continuously monitoring the appropriateness of the individual's services and making timely revisions to the ISP as indicated by the changing needs of the individual. Any modification to the amount or type of services in the ISP must be authorized by DBHDS.

The Support Coordinator must monitor the providers' Plans for Supports to ensure that all providers are working toward the desired outcomes with the individual being supported.

Support Coordinators are required to conduct and document evidence of monthly onsite visits for all individuals enrolled in the DD Waivers who are residing in VDSS-licensed assisted living facilities or approved adult foster care homes.

Support Coordinators must conduct and document a minimum of quarterly face-to-face visits with all other individuals with at least one visit annually occurring in the home.

All requests for an individual to receive increased DD waiver services must be reviewed by the Support Coordinator to ensure that the increase is needed to assure the individual's health, safety, and welfare in the community, based on appropriate assessment criteria as supported by the Plan for Supports, and that those services can be safely and cost effectively provided in the community.

QUARTERLY REVIEWS AND ANNUAL REEVALUATION OF SERVICE NEED

The Support Coordinator must review the ISP at least quarterly to determine whether the individual's desired outcomes and support activities are being met and whether any modifications to the ISP are necessary. The person-centered quarterly review must also include documentation regarding the individual's and the individual's family's/caregiver's, as appropriate, satisfaction with services. The results of such reviews must be documented, signed, and dated in the

individual's record even if no change occurred during the review period. This documentation will be provided to DMAS and DBHDS upon request.

The Support Coordinator must complete a reassessment at least annually, in coordination with the individual and the individual's family/caregiver, as appropriate, providers, and others as desired by the individual. The reassessment must be signed and dated by the Support Coordinator and include an update of the level of care (VIDES), personal profile, risk assessment, and any other appropriate assessment information. The VIDES must be updated within a year of the last completed VIDES, with an allowance of completion by the end of the month in which it is due or up to two weeks into the next month, if the due date is at the end of a month. The updated VIDES must be completed prior to or during the ISP meeting in order to confirm continued functional eligibility. If the updated VIDES demonstrates that the individual no longer meets waiver requirements, the Support Coordinator must inform DMAS and DBHDS via WaMS that the individual must be terminated from waiver services, following notification of appeal rights.

The ISP will be revised at this annual juncture in the context of a person-centered planning meeting for consistency with all updated reassessment information. There must be no more than 365 days between ISP dates (366 in a leap year).

Other updated assessments may include:

- A medical examination as needed for adults and according to the recommended frequency and periodicity of the EPSDT program (12VAC30-50-130) for children ages birth to 21 years,

- A new psychological or other diagnostic evaluation completed by a qualified examiner as previously described whenever the individual's functioning has undergone significant change (meaning a change in an individual's condition that is expected to last longer than 30 calendar days but does not include short-term changes that resolve with or without intervention, a short-term acute illness or episodic event, or a well-established, predictive, cyclical pattern of clinical signs and symptoms associated with a previously diagnosed condition where an appropriate course of treatment is in progress, such as deterioration of abilities that is expected to last longer than 30 days, and is no longer reflective of the past evaluation).

CUSTOMIZED RATE

Individual-specific support needs, such as the extraordinary medical or behavioral supports needs, may warrant customized rates for additional supports delivered by the provider. Customized rates are available for qualifying individuals receiving any of the following waiver services:

- Community Coaching,
- Group Day,
- In-home Support,
- Group Home Residential,

- Sponsored Residential,
- Supported Living Residential.

To request a customized rate, providers and Support Coordinators must submit to DBHDS a written request for a customized reimbursement rate via the appropriate Customized Rate Initial Application form (available at http://www.dbhds.virginia.gov/developmental-services/waiver-services) and accompanying documentation of individual need.

The request will be reviewed by the DBHDS Customized Rate Review Team, made up of clinical and administrative staff to determine that the documentation substantiates the intense needs of the individual, whether medical, behavioral, or both, and that the provider has employed staff with higher qualifications (e.g., direct support professionals with four-year degrees) or increased the ratio of staff-to-individual support of one staff person to one individual (1:1) or, in the case of services already required to be provided at a 1:1 ratio, a two staff persons to one individual (2:1) ratio.

This level of staff intervention allows for appropriate supervision both in the home, as well as in the community to prevent and/or reduce social isolation. Shared staffing ratios in these more unique cases (as typically occur in group homes and day services) often do not provide adequate oversight as staff is required to work directly with such individuals to prevent, mitigate, or respond immediately to behavioral incidents, while another staff protects others in the area to ensure all individuals in the setting are safe. In addition, the supervision and oversight required by more experienced/highly trained direct support staff requires clinical professionals who are themselves more highly trained and experienced than is routinely expected/present in these service settings.

The customized rate methodology will modify the existing rate methodology assumptions for the following components in the existing rate methodologies: additional hours related to increased or specialized staffing supports and program costs.

Customized reimbursement rate determinations may be appealed.

For those individuals approved for customized rates, providers and Support Coordinators must resubmit to DBHDS at least annually the appropriate Customized Rate Annual Application form (available at http://www.dbhds.virginia.gov/developmental-services/waiver-services), if continuation of the customized reimbursement rate is sought. The request must include documentation of continued need for a reimbursement rate exceeding the reimbursement rate for the assessed level of support of the individual. The Customized Rate Review Team will review the request to determine whether documentation supports the provider's ongoing receipt of the customized rate. After the review, adjustment determinations for the customized rate may be made. All such adjustment determinations may be appealed.

INDIVIDUALS ELIGIBLE FOR THE CUSTOMIZED RATE:

These extremely medically fragile and/or behaviorally challenged individuals are those whose support needs place them in levels six or seven but who have a higher level of need than will be accommodated by the tier four rates, as well as any individual for whom it is determined that the only other resource is to be served out of state, in a state operated mental health or DD facility, or in a more restrictive environment.
They are identified as those who require greater support in order to find in-state providers willing to serve them. These individuals' needs outweigh the resources provided within the current waiver rate structure. Their needs may warrant:

- Increased staffing ratios, and/or
- Higher credentialed staff, and/or
- Increased programmatic oversight.

Individuals with extraordinary behavioral needs are defined as individuals who threaten the safety of staff and others around them, require increased staffing to immediately address behavioral incidents, require direct 1:1 or 2:1 intervention to mitigate harm to themselves, others, property, or prevent serious incidents in the community to preclude police involvement and/or arrest. Often, these individuals' challenging behaviors are triggered spontaneously, necessitating providers to staff individuals at 1:1 or 2:1 (depending on the severity of the behavior) for some or all of the day. Other individuals require constant supervision to mitigate the frequency of these very challenging behaviors. Individuals who have a high frequency of such behaviors will routinely require additional hours of 1:1 or 2:1 supports.

Behavioral criteria may include, but is not limited to the following:

- The person has a significant behavioral history and/or current behavioral presentation;
- There is a documented high frequency of challenging behavior over the past 6 months;
- The individual has required medical attention due to challenging behavior(s) within the last 90-days;
- The individual is on a restrictive plan because of challenging behavior(s);
- The individual frequently receives PRN medication as a result of challenging behavior(s);
- The challenging behavior(s) in question poses a threat of incarceration, physical injury, or hospitalization;

- The individual requires 1:1 or 2:1 staffing ratios to actively treat/intervene on challenging behaviors;

- The individual requires staff who have some level of behavioral expertise to work with them- i.e. staff who are able to run more complex training programs, take the lead on implementing token economies or other programs that require a structured schedule of reinforcement based upon contingencies in a behavior support plan;

- There are tangible reinforces or other materials that are anticipated to have a short shelf life;

- The individual has medical problems that are made worse when the person engages in challenging behaviors such that immediate redirection or blocking is frequently needed; and/or

- The individual targets other individuals such that he/she frequently needs to be separated from group activities and supervised in an alternative area.

Medically, an individual may require 1:1 or 2:1 staff support when he has a health history or recent health complication that puts him at risk for acute medical complications resulting in hospitalization or death. For example, an individual may require 1:1 during meal time due to severe risk of aspiration; another may require 2:1 during transfers due to a combination of illnesses such as dementia and osteoporosis, resulting in an increased risk of falling that is so high that he may sustain a fracture or head injury. In an effort to fully integrate individuals with severe medical conditions into the community, increased staff are provided during transition periods to prevent emergency medical activities. Staff may require more frequent or intensive training to have the skills needed to perform more challenging health supports such as total personal care and the implementation of nursing delegated tasks. Licensed professionals may need to provide additional supports outside of waiver funding to protect a person's health and safety such as facilitating hospital admissions and discharges, interfacing with the hospital team and providing generalized staff training on skills not covered by typical staff training programs.

Medical criteria may include, but is not limited to the following:

- The individual has a medical diagnosis that requires a specialized plan of care;

- High level staffing supports, specialized training and/or certifications are required to meet the individual's needs or to monitor and report information to health care providers;

- The individual has multiple medical protocols in place with oversight provided by nursing;

- The individual currently has nursing services in place but the need for increased support is still required to institute medical protocols;
- The individual requires increased supervision and monitoring due to active high risk medical concerns;
- The individual has a history of chronic health support needs that without close monitoring pose a risk to their overall wellbeing;
- The individual's medical condition is expected to worsen/progress with increasing need for support; and/or
- The individual has a history or frequent hospitalizations and/or use of ancillary support such as support provided by a wound care specialist, or Hospice care.

INTERRUPTION OF SERVICES

Temporary Interruption with Continued Eligibility

Whenever all waiver services are interrupted on a temporary basis (e.g., temporary loss of financial eligibility, health and safety at risk in current situation, temporary placement in a rehabilitation hospital, NF, or ICF/IID), for more than 90 consecutive days, the Support Coordinator must notify DBHDS, DMAS and LDSS via a DMAS-225 within 5 business days of service interruption. DSS determines if the individual continues to meet all eligibility requirements for Medicaid. See also the "Delay in Initial Service Initiation/Requests to Retain Slots" section above.

Temporary Interruption with Loss of Financial Eligibility

When DSS determines that the individual is no longer eligible, the Support Coordinator must forward the DMAS-225 to DBHDS. DBHDS will discharge the individual from the DD Waiver and end all active service authorizations. If it is a temporary discharge (no more than 60 days), the Support Coordinator must indicate such on the DMAS-225. Individuals who are not financially eligible for Medicaid will not receive Medicaid funding for DD or ID Targeted Case Management.

Individual Enters an ICF/IID, NF, or Rehabilitation Hospital

When services are interrupted due to an individual entering an ICF/IID, NF, or rehabilitation hospital for temporary services, the Support Coordinator must immediately notify the LDSS eligibility worker by telephone and forward a DMAS-225 to the LDSS and DBHDS explaining the reason for the temporary discharge. The slot must be retained using the Retain Slot function in WaMS if this interruption continues for more than 30 days.

To return to DD Waiver services, the Support Coordinator forwards a copy of the revised DMAS-225 to the LDSS and DBHDS, indicating the start date. The DMAS-225 is then returned to the

Support Coordinator. In the event that the DMAS-225 is not received by the Support Coordinator in a timely manner, the Support Coordinator may monitor the ARS/MediCall systems for financial eligibility and patient pay obligations. New service authorization requests are required only if there has been a change in waiver, service, service level, or provider.

DISCHARGING AN INDIVIDUAL FROM DD WAIVER SERVICES

DMAS and DBHDS will ensure only eligible individuals receive DD waiver services and will remove the individual from the waiver and close all services when the individual is no longer eligible for the waiver. Discharge from the DD Waivers must occur when:

- The individual's health, safety, and welfare and medical needs can no longer be safely met in the community;
- The individual is no longer eligible for either Medicaid or no longer meets the ICF/IID level of care or diagnostic eligibility;
- The individual was eligible for one of the waivers and accepted a waiver slot but did not start services for five months;
- The individual moves to another state;
- The individual declines DD waiver services;
- The individual enters an ICF/IID, NF, or rehabilitation hospital;
- The local department of social services determines that the individual is no longer financially eligible;
- HCBS are not the critical alternative to prevent or delay ICF/IID placement;
- An appropriate and cost-effective ISP cannot be developed; or
- The individual is deceased.

To discharge an individual from a DD Waiver the Support Coordinator must complete a DMAS-225, which terminates all DD Waiver services, and must notify all providers. The DMAS-225 is sent to the LDSS clearly noting the date of discharge and the reason for the discharge. The Support Coordinator must notify DBHDS, DMAS and DSS within 5 business days when an individual is discharged from DD waiver services. The Support Coordinator is responsible for ending all active service authorization lines in WaMS and clearly noting the reason for discharge in the “note” section of WaMS. Once all active lines have been ended by DBHDS, the individual’s assignment

to the slot will be promptly terminated in WaMS by the Support Coordinator (following offering appeal rights to the individual and family/caregiver, as appropriate). The CSB will then contact the DBHDS Regional Supports Specialist to request reassignment of the slot via the Waiver Slot Assignment Committee (WSAC) process.

Once an individual is discharged from a DD Waiver, should he/she wish to again receive DD waiver services, the individual must reapply for a DD Waiver.

Transferring Support Coordination/DD Waiver Slots

If an individual receiving waiver services moves or intends to move into a new catchment area, the CSB/BHA of origin must, as soon as practical, contact the receiving CSB/BHA in the new catchment area to inform them. This can be completed via a secure email, phone call, or voicemail. This initial contact is considered a courtesy and is not considered an official request to transfer. However, this initial communication leads to a smooth transition and is recommended. Once the CSB/BHA of origin believes an individual's services are stable, this CSB/BHA must begin the transfer process unless one of the following conditions is met:

- The individual and family/caregiver, as appropriate, has expressed a choice to continue support coordination/case management services with the current CSB/BHA, and the current CSB/BHA is willing and able to provide or contract for support coordination/case management and can demonstrate the capacity to handle emergency situations. If the CSB/BHA of the individual's residence must provide DD emergency/crisis services (vs. mandated mental health emergency/crisis services) at any time, support coordination/case management and the waiver slot will be transferred within 30 days to the CSB/BHA in which the individual resides. In this instance, the current CSB/BHA will be deemed unable to provide support coordination/case management services; or

- The placement in another CSB/BHA service area is temporary (90 days or less).

The formal support coordination transfer process is initiated by a letter that is sent from the DD Director (or designee) from the CSB/BHA of origin to the receiving DD Director (or designee) of the receiving CSB/BHA. This letter is typically accompanied by the most recent versions of the following supplemental documentation, as appropriate for the individual:

- DMAS 225 and information to indicate case has been transferred to the new CSB;
- Patient Pay letter designating collecting provider;
- Individual Support Plan (Parts I-V);
- Quarterly reports from current ISP year;
- Six months of progress notes;
- All provider Plans for Supports and related schedules (Part V);

- Virginia Informed Choice Form;
- Confirmation of diagnosis of developmental disability that comports with the definition of DD at § 37.2-100;
- VIDES;
- SIS;
- Recipient Choice form;
- Risk Awareness Tool (RAT);
- Crisis Risk Assessment Tool (CAT or CRAT);
- On-site Visit Tool (OSVT);
- RST referral (if criteria is met);
- Guardianship/POA documents, recent capacity evaluations; and
- Initial DARS letter or progress note documenting unavailability of DARS funding.

Not all transfers will require each document to be submitted. It is incumbent on the receiving CSB/BHA to review documentation and ensure all necessary documentation has been received. Once the receiving CSB/BHA has reviewed the documents and accepted the transfer, the receiving CSB/BHA will send a letter back to the CSB of origin accepting the transfer and confirming the date of transfer.

On the date of transfer, the CSB/BHA of origin is responsible for transferring the individual's records in all electronic systems (such as WaMS or SIS Online).

If support coordination for an individual receiving waiver services is transferred from one CSB/BHA to another, the waiver slot for that individual will also be transferred to the new CSB/BHA and becomes part of its pool of available waiver slots.

DD and ID SUPPORT COORDINATION / CASE MANAGEMENT SERVICES

There are two different forms of Support Coordination for individuals with developmental disabilities: Support Coordination for individuals with intellectual disability and support coordination for individuals with developmental disabilities other than intellectual disability. Both are State Plan Option Targeted Case Management services and may be provided to individuals who receive DD waiver supports and, in some circumstances to individuals who are not DD waiver recipients.

INDIVIDUAL ELIGIBILITY FOR ID/DD TARGETED CASE MANAGEMENT (SUPPORT COORDINATION)

Individuals are eligible for **ID support coordination** if they are Medicaid eligible and have an intellectual disability as defined in § 37.2-100 of the Code of Virginia. This states:

"Intellectual disability means a disability, originating before the age of 18 years, characterized concurrently by (i) significant sub-average intellectual functioning as demonstrated by performance on a standardized measure of intellectual functioning, administered in conformity with accepted professional practice, that is at least two standard deviations below the mean and (ii) significant limitations in adaptive behavior as expressed in conceptual, social, and practical adaptive skills.

Any individual who meets the above diagnostic and general Medicaid eligibility criteria and there is an individual support plan (ISP) in effect that requires direct or individual-related contacts or communication or activity with the individual, the individual's family or caregiver, service providers, significant others, and others including at least one face-to-face contact with the individual every 90 days is eligible for ID support coordination. Billing can be submitted for such an “active” individual only for months in which direct or individual-related contacts, activity, or communications occur, consistent with the ISP. The individual may be receiving DD waiver services, be on the DD waiver waiting list, or require only active support coordination services.

Individuals are eligible for **DD support coordination** if they are Medicaid eligible, have a developmental disability as defined in § 37.2-100 of the Code of Virginia below and are enrolled in one of the DD waivers or are on the DD waiver waiting list and have a “special service need.”

"Developmental disability means a severe, chronic disability of an individual that (i) is attributable to a mental or physical impairment, or a combination of mental and physical impairments, other than a sole diagnosis of mental illness; (ii) is manifested before the individual reaches 22 years of age; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (v) reflects the individual's need for a combination and sequence of special interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. An individual from birth to age nine, inclusive, who has a substantial developmental delay or specific congenital or acquired condition may be considered to have a developmental disability without meeting three or more of the criteria described in clauses (i) through (v) if the individual, without services and supports, has a high probability of meeting those criteria later in life.”

If a *special service need* is identified for an individual on the DD waiver waiting list, an ISP must be developed to address that need. A special service need is one that requires linkage to and temporary monitoring of those supports and services identified in the ISP to address an individual's mental health, behavioral, and medical needs or provide assistance related to an acute need that coincides with support coordination allowable activities (see below). Support coordinators must make face-to-face contact with the individual at least every 90 calendar days to monitor the special service need, and documentation is required to support such contact. If an activity related to the special service need is provided in a given month, then the support coordinator would be eligible

for reimbursement. Once the special service need is addressed related to the specific activity identified, billing for the service may not continue until a special service need presents again. Examples of special service needs for people with DD who are waiting for waiver services could include:

- A child with autism on the waiting list needs to access behavioral services;
- An adult experiences the loss of a family caregiver and needs to look for alternate housing;
- Following a stroke an adult needs to locate specialized medical services to transition back to their home;
- A family member reports a child on the waiting list has experienced changes in his health, status and needs to explore options to avoid placement in an institutional setting;
- A young person is transitioning out of school and needs to access vocational rehabilitation or employment services;
- A young woman who has limited contact with family begins experiencing seizures and needs to support to locate a neurologist;
- New neighbors move into a person's neighborhood resulting in escalating conflict between the person with DD and the neighbors.

An individual who is receiving active DD support coordination is a person for whom there is an individual support plan (ISP) that requires direct or individual-related contacts or communication or activity with the individual, the individual's family/caregiver, service providers, and significant others. Billing can be submitted for an active individual only for months in which direct or individual-related contacts, activity, or communications occur, consistent with the desired outcomes in the individual's ISP. Face-to-face contact between the support coordinator and the individual must occur at least every 90 calendar days in which there is an activity submitted for billing.

In the following sections, areas of distinction between ID support coordination and DD support coordination will be highlighted. Areas of commonality will be presented as such.

Service Definition/Description:

Support coordination services are activities designed to assist an individual with DD in accessing and maintaining needed medical, psychiatric, social, educational, employment, residential, and other supports essential for living in the community and in developing his or her desired lifestyle. While support coordination is available to some individuals who do not receive DD waiver

services, as detailed above, all individuals receiving DD Waiver services must receive either DD or ID support coordination services.

Support coordination services covered under the Medicaid Program do not require service authorization. The support coordination provider must meet all applicable standards and policies. It is the responsibility of the CSB/BHA to assure individuals' ongoing eligibility and need for support coordination services.

Criteria/Allowable Activities:

A person who receives support coordination services must have a person-centered Individual Support Plan (ISP) in effect which requires at least a monthly direct or individual-related contact, communication or activity with the individual, family / caregiver, service provider(s), or significant others, including at least one face-to-face contact with the individual every 90 days. A 10 day grace period is permitted for the face-to-face contact; however, if the grace period is used, it does not change the original 90 day due date.

The assigned support coordinator must provide support coordination services as frequently and timely as the person needs assistance. There must be at least one documented contact, activity, or communication, as designated above, and relevant to the ISP, during any calendar month for which support coordination services are billed.

The activity of writing the ISP, person-centered review, or case note is not considered a billable support coordination activity. Developing the ISP through a team meeting or reviewing other providers' written materials in order to prepare the support coordination person-centered reviews are billable activities. Accompanying individuals to appointments or transporting them is not covered. While transportation may be a naturally occurring event to facilitate another, billable, activity, transportation alone cannot be used for billing purposes.

Support coordination services allowable activities provided to eligible individuals include:

- Assessment and planning services to include a comprehensive initial assessment and periodic reassessment (at least annually) that is completed face to face with the individual, to determine the need for any medical, behavioral health, educational, social or other services/supports. This does not include performing medical and psychiatric assessment, but does include referral for such assessments when indicated to determine the individual's medical and behavioral needs. These assessment activities include:
    - Taking the individual's history;
    - Identifying the individual's needs, including known and potential risks;

- Gathering information from other sources such as family members; medical, behavioral health and other service providers; social workers; and educators (if applicable), to form a complete assessment and ongoing reassessment of the individual within the individual's cultural context;
- Completing related documentation, and
- Providing all required respondent information to the SIS vendor within 10 business days of the date it is requested or scheduling another developmentally appropriate assessment for children under the age of five or for five through 15 year olds who do not receive tiered services.

- Person-centered service planning that includes development of a shared ISP in accordance with the requirements of the HCBS settings regulations (42 CFR 441.725) and periodic revision of the ISP that is based on the changing needs of the individual, transitions in the individual's life, and information collected through ongoing assessment that:
  - Working with the individual and family / caregiver / representative or guardian and others, specifies measurable outcomes and actions to address the known and potential medical, health and behavioral risks, social, educational, and other services and supports needed by the individual, and addresses risk mitigation to pursue the life the individual wants; and
  - Includes provider-specific (including the support coordinator) plans for support activities that ensure the individual's active participation to and identify a course of action to respond to the assessed needs, including medical, health and behavioral risks, and preferences of the individual.

- Linking individuals to medical, social, educational providers, or other supports and services, including referral and related activities (such as scheduling appointments for the individual, facilitating communication) that are indicated to address identified needs and preferences and achieve outcomes specified in the ISP;

- Monitoring and follow-up to assess ongoing progress and ensure that services are being delivered as outlined in the ISP, as well as to address any change of status:
  - Conducting necessary activities and contacts to ensure the ISP is implemented and adequately addresses the individual's needs. These contacts may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, but at least monthly, to assess the quality of supports delivered and satisfaction of the individual and to determine whether the following conditions are met:

- The individual's health status, any medical conditions, medications and potential side effects are known and monitored and the individual is assisted in accessing primary care and other medical services;

- Services and supports are being furnished at the level and frequency described in the individual's ISP; and

- Services and supports identified in the ISP are adequate to meet the individual's needs.

- Making necessary adjustments to the ISP and service arrangements with providers in response to the individual's needs or status;

- Conducting face to face meetings, at least once every 90 days (with a 10 day grace period) and at least one time per year in the individual's home, and additionally as dictated by the individual's needs to:

  - Observe and assess for any previously unidentified risks, injuries, needs, or other changes in status;

  - Assess whether the individual's ISP is being implemented appropriately and remains appropriate for the individual; and

  - Assess whether supports and services are being implemented consistent with the individual's strengths and preferences and in the most integrated setting appropriate to the individual's needs.

- Convening an annual face to face person-centered planning meeting to review the status of the current ISP, including all provider plans for support. As needed outside the annual review, the support coordinator may convene a meeting(s) to re-evaluate the appropriateness of the plan if the individual's needs have changed significantly; and

- Conducting quarterly reviews of the ISP and evaluating its effectiveness to determine if progress is being made in meeting the individual's outcomes, if it remains appropriate, and if modifications are needed.

- Coordinating services and service planning with other agencies and providers involved with the individual to include discharge planning and support for other transitions in the individual's life;

- Assisting the individual directly for the purpose of locating, developing, or obtaining needed services and resources; coordinating services with other agencies and service providers involved with the individual; navigating the health care system and enhancing community integration by contacting other entities and coordinating services and supports to help the individual develop relationships in the community and participate in vocational, civic, and recreational activities;

- Providing education and counseling which guides the individual and his/her/their family and significant others and develops a supportive relationship that promotes the individual's achievement of outcomes included in the ISP.

Service Limitations

Payments for support coordination services under the State Plan must not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Support coordination services which solely include assistance in which the only function is maintaining service waiting lists or periodically contacting or tracking individuals to determine potential service needs are not Medicaid billable.

Both ID and DD Support Coordination may be billed for services provided to Medicaid-eligible individuals who reside in institutions (including those in acute care hospitals, intermediate care facilities for individuals with intellectual disabilities (ICFs/ID), nursing facilities (NF), and psychiatric hospitals that are not institutions for mental diseases (IMDs) for individuals aged 22-64) during the 30 calendar days immediately preceding discharge. The activities of the support coordinator may not duplicate the activities of the institutional discharge planner and may be billed for no more than two 30-day pre-discharge periods within a 12-month period.

DD Waiver and Support Coordination Screening

Upon an individual's presentation to the CSB requesting a Medicaid-covered service (either one available through the DD waivers or support coordination itself), the support coordinator or designated intake staff must meet with the individual and family/caregiver, as appropriate within 60 days of application, to complete an initial assessment prior to or at admission to include:

- Obtaining evidence of a developmental disability;

- Conducting a Virginia Intellectual and Developmental Disability Eligibility Survey (VIDES), if waiver services are being sought; and

- Inquiring if the individual currently has Medicaid.

The SC uses the above information to determine whether the individual meets admission criteria, assesses the individual's immediate service, health, and safety needs, determines services to meet the individual's identified needs and preferences to the maximum extent possible, explores the use of local community resources available to the general public to meet those needs, and determines whether the CSB has the capability and staffing to provide ongoing support coordination if the individual meets criteria.

Screening for Individuals with ID

If the individual presenting for screening has or likely has a diagnosis of intellectual disability and is Medicaid eligible, the CSB should initiate 90-day assessment ID Targeted Case Management (TCM) to determine eligibility and receive reimbursement for up to 90 days (until eligibility is fully determined). An abbreviated, Plan for Supports may be written and utilized up to the maximum of 90 days for individuals who have not previously received support coordination from any CSB and who do not have diagnostic information necessary to determine eligibility for DD Waiver services. This abbreviated SC Plan for Supports (PFS) should contain:

- Referral information;
- The reason for suspecting the presence of ID; and
- Support activities related to obtaining diagnostic and other assessment information, as well as those related to the need for any ongoing services to include active ID support coordination.

The 90-day SC PFS does not require a person-centered review; however, a final progress note must indicate the results of the 90-day service.

If the individual is or becomes Medicaid eligible and is determined to meet either ID active support coordination service criteria, and is requesting support coordination services, the SC may open the individual to Medicaid ID Targeted Case Management services after developing an annual ISP in compliance with DBHDS Licensure Regulations that address the service need(s).

Screening for Individuals with DD Other than ID

If the individual presenting for screening has or likely has a diagnosis of a non-ID developmental disability (i.e., CP or spinal bifida) or should the diagnosis be unclear, Medicaid reimbursement may be sought directly by the CSB for the screening. CSBs are paid for the screenings at either the state rate or the NOVA rate as set by DMAS. The CSB forwards an invoice on CSB agency letterhead to DMAS which includes:

- The individual’s name;
- Social security number;

- Date of screening; and
- Screening rate (NOVA or ROS).

On a monthly basis, DMAS will collect invoices from CSBs via fax, email or US mail, and determine if the individual identified on the invoices has Medicaid or not. If the individual had Medicaid at the date of the screening, DMAS does not pay for the screening. In such cases, DMAS will contact the CSB to inform them of the individual's Medicaid eligibility. If the individual does NOT have Medicaid at the date of screening, DMAS will forward to internal DMAS reimbursement.

Upon completion of the screening, the CSB makes the determination as to whether the individual is eligible for DD waiver services. Individuals with developmental disabilities, other than intellectual disability, may not receive routine, ongoing support coordination services unless there is a documented special service need, as described earlier in this section.

For both individuals with ID or a DD other than ID, if the individual is determined to be eligible for DD Waiver services, the SC provides choice of either institutional placement or receipt of home and community based waiver services, determines waitlist Priority, places the individual on the DD Waiver waitlist, and provides the individual with appeal rights.

A CSB cannot bill for a DD screening and 90-day TCM in the same month. Upon completion of the screening/eligibility process, the CSB makes the determination if the individual is eligible for Waiver services and/or DD or ID Targeted Case Management (TCM) services, if applicable.

Service Units

The unit of service is one month. Billing for the service may begin with the first face-to-face contact and can be submitted only for months in which at least one direct or individual-related contact, activity, or communication occurs and is documented. Reimbursement is provided only for individuals receiving active support coordination as previously described. There is no maximum number of months that may be billed per year except for those individuals who reside in institutions or medical facilities.

Documentation Requirements

Providers maintain records that document for all individuals receiving support coordination services as follows:

- The name of the individual;

- The dates, times and location of the support coordination;

- The name of the provider agency (if relevant) and the person providing the support coordination service;

- The nature, content, units of the support coordination services received and whether outcomes specified in the ISP have been achieved;

- Whether the individual has declined services in the ISP;

- The need for, and occurrences of, coordination with other support coordinators and care coordinators;

- A timeline for obtaining needed services; and

- A timeline for reevaluation of the ISP.

The following documentation is required to be completed by the support coordinator:

- An ISP which addresses the individual's support needs and desired outcomes, must be developed, reviewed and updated whenever changes in services are required and at least annually. The ISP and any updates must be retained in the record, document the need for support coordination and be approved, dated, and signed by the individual, authorized representative/guardian, other service providers and the support coordinator.

- The support coordinator must annually coordinate the completion of the Personal Profile (Part I of the ISP), which is a person-centered assessment designed to help the team determine and respond to what works in the person's life and thus needs to be maintained or improved and what does not work and thus needs to be stopped or changed. The Personal Profile may be initiated by the individual's chosen planning partner and completed at the person-centered planning meeting, with the final version distributed to all team members following the meeting. The Personal Profile, along with other relevant social, psychological, psychiatric, medical, and level of care information serves as the basis for development of the ISP and Plans for Supports for all services received by the individual, including support coordination. The Personal Profile summarizes the individual's vision of a good life, their talents and contributions, what is working/what is not working, and what is important to the person in the following life areas:

    - Employment;
    - Meaningful Day;
    - Community Living;
    - Safety and Security;

- Healthy Living;
- Social and Spirituality; and/or
- Citizenship and Advocacy.

Additionally, the support coordinator annually updates, as needed, the Essential Information (Part II of the ISP), which includes:

- Legal Representation;
- Disability Determination;
- Health Information;
- Behavioral and Crisis Supports;
- Medications;
- Physical and Health Conditions;
- Last Exam Dates;
- Allergies;
- Social, Developmental, Behavioral and Family History;
- Communication, Assistive Technology and Modifications;
- Education; and
- Employment,
  - Future Plans,
  - Review of Most Integrated Settings.

- The support coordination Plan for Supports (Part V of the ISP) outlines the support coordination support activities and instructions necessary to carry out the ISP. The support coordination Plan for Supports must contain, at a minimum, the following elements:

  - The individual's desired outcomes that describe what is important to and for the individual in observable and measurable terms;

  - Support activities and support instructions that are designed to assist in achieving the individual's desired outcomes;

  - The support coordination services to be rendered;

  - A timetable for the accomplishment of the individual's desired outcomes and support activities;

  - The estimated duration of the individual's needs for services;

  - The support coordinator responsible for the overall coordination and integration of the services specified in the Plan for Supports;

- Documentation regarding any restrictions on the freedoms of everyday life in accordance with human rights regulations and the requirements of the Home and Community-based Services settings regulations (as found in 42 CFR 441.301).

- Documentation, in the form of unique, person-centered progress notes, must indicate the dates and nature of support coordination services rendered. Documentation of a face-to-face contact every 90 days (with a 10-day grace period permitted) must be in the record. This documentation must clearly state that the support coordinator was in the presence of the individual, assessed and documented his or her satisfaction with services, determined any unmet needs, evaluated the individual's status, and assisted with adjustments in the services and supports, including updating the ISP, as indicated.

  In conducting face-to-face meetings, support coordinators meet with each individual as dictated by the individual's needs and documentation should reflect:

  - Observation and assessment for any potential risks, injuries, needs, or other changes in status;

  - Assessment of the status of previously identified risks, injuries, or needs, or other changes in status;

  - Assessment of whether the individual's ISP is being implemented appropriately and remains appropriate for the individual; and

  - Assessment of whether supports and services are being implemented consistent with the individual's strengths and preferences and in the most integrated setting appropriate to the individual's needs.

- Support coordinators must complete the On-Site Visit Tool at face-to-face meetings with individuals, no less than one time per quarter. The On-Site Visit tool is used to observe the person and the environment to assess for risks, to document that the person's ISP is implemented appropriately, and to determine if the person has had a change in status that may necessitate an ISP update.

- Support coordinators must complete the Risk Awareness Tool at or prior to the initial ISP meeting and annually thereafter. The Risk Awareness Tool is designed to increase awareness of the potential for a harmful event (e.g., bowel obstruction, sepsis, fall with injury, self-harm, elopement, etc.) to occur and to facilitate the process of taking action to reduce and prevent the risk. Any risks identified must be addressed in the ISP.

- Support coordinators must complete the Crisis Risk Assessment Tool at intake and at every face-to-face meeting thereafter to capture information that may put an individual at risk for crisis or hospitalization and to foster proactive referrals to the REACH programs if such a risk is determined.

- The ISP must be reviewed via the Person-Centered Review at least every three months beginning from the date of the implementation of the comprehensive ISP. These reviews must evaluate the individual's progress toward meeting the ISP's outcomes and support activities, and the continued relevance of the ISP's strategies and support instructions. As such the review should include relevant information from service providers' person-centered reviews. The support coordinator must update the ISP, if indicated, and implement any updates made. Support coordination quarterly reviews must be added to the individual's record no later than 30 calendar days from the end date of the previous quarter. Each quarterly person-centered review must contain the following elements:

    - A description of the status of each outcome in the plan for supports. Possible statuses include whether the outcome has been achieved, if progress is being made as expected, or if there has been limited or no progress. Any actions needed or that will be taken to resolve barriers or improve progress is noted;

    - Information about any newly identified safety risks;

    - Any changes desired by the individual or family member/caregiver, as applicable and his/her/their satisfaction with services;

    - Confirmation that all approved services were delivered according to the amount detailed in the plan, or, if not, the reason; and

    - Any significant events.

- A new or revised ISP must be developed no more than 365 days (366 in a leap year) from the effective date of the previous ISP.

- The support coordinator must send a "Notice of Action" letter to the individual notifying him/her/them of appeal rights if the individual is denied or found ineligible for support coordination, DD Waiver services or ICF/ID services, placed on the Statewide Waiting List, moved from a higher priority to a lower priority status on the Statewide Waiting List, or services are decreased or terminated.

- All progress note entries must be signed (first initial and last name minimum) and dated with month, day, and year the described supports were provided. Documentation that occurs after date services were provided must be dated with date the documentation was completed and also include the date the services were provided within the body of the note.

- All relevant communication with the individual, the individual's family/caregiver, as appropriate, providers, DBHDS, DMAS, Department of Social Services (DSS), Department of Aging and Rehabilitative Services (DARS), or other related parties must be documented in the record. This should also include written documentation of contacts made with the individual's physicians, informal service providers, and all professionals concerning the individual.

In addition to the above, for individuals receiving DD Waiver services, the support coordinator is responsible for the following:

- Placing the individual who applies for the DD Waivers and is found to meet the eligibility criteria as defined earlier in this chapter on the DD waiver waitlist if there is no available slot until a slot becomes available.

- Coordinating and maintaining the individual's required medical, diagnostic, psychiatric information, as well as the annual Virginia Individual Developmental Disability Eligibility Survey (VIDES) to document the individual's initial and continued eligibility for DD Waiver services. The annual VIDES must be completed prior to the ISP meeting, but no earlier than 11 months, nor later than 13 months after the previous year's VIDES.

  For example, for a 10/1/20 and 10/1/21 ISP:

Previous VIDES	Annual VIDES	Compliant?
8/10/20	8/29/21	Yes – same month
8/10/20	9/7/21	Yes – crosses over a month, but still in 30 day window
8/10/20	9/12/21	No – more than 13 months
8/10/20	7/25/21	No – more than 30 days before annual ISP.

  Additionally, if it is completed in the same month as the previous year's VIDES, it will be considered to meet compliance (e.g., 2020 VIDES was completed on August 10th and 2021 VIDES is completed on August 29th). Similarly, if the VIDES is completed no more than two weeks after last year's VIDES and the time frame crosses over from one month to the next (e.g., 2020 VIDES was completed on September 25th and 2021 VIDES is completed on October 7th), that will also be considered acceptable.

- Maintaining a completed copy of the age-appropriate, DBHDS-approved SIS® or other developmentally appropriate assessment form (depending on the individual's age) and sharing this with waiver services providers.

- For individuals who have a diagnosis of ID (or in rare circumstances - someone who is no longer classified as DD), a new diagnostic assessment must be obtained at such time as the existing assessment fails to reflect the individual's current status, abilities, and adaptive functioning.

- Obtaining medical reassessments as needed for adults according to their health needs and routinely for children less than age 21, in accordance with the Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.

- Maintaining signed and up-to-date Consent to Exchange Information or Release of Information forms (developed by the support coordination provider) for the individual to permit sharing/exchanging information for service coordination.

- Maintaining a current signed copy of the Documentation of Individual Choice between Institutional Care or Home and Community-Based Services **(DMAS 459-C)**, indicating the individual's desire for DD Waiver services over institutional services. The completion of this form is initially the responsibility of the support coordinator and is then received annually from DBHDS for each individual on the wait list.

- Maintaining documentation that the choice of provider(s) has been offered on the "Virginia Informed Choice" **(DMAS-460)** form when DD Waiver services are initiated and:

    - Annually;
    - At enrollment into the DD Waiver;
    - When there is a request for a change in waiver provider(s);
    - When new services are requested;
    - When the individual wants to move to a new location and/or is dissatisfied with the current provider;
    - When making a Regional Support Team (RST) referral for individuals with a DD Waiver.

  The completion of above form is documentation that the individual was given option of selecting the provider of choice from among those agency and consumer-directed providers meeting the individual's needs. The support coordinator must inform the individual and

family member/caregiver, as appropriate, of all available enrolled waiver service providers in the community in which he/she/they desires services, and he/she/they will have the option of selecting the provider of choice from the list of enrolled service providers.

- Reviewing all providers' Plans for Supports to assure that they fulfill all requirements for the particular service offered and address the identified outcomes and support needs before being approved and maintained by the support coordinator. Maintaining an up-to-date copy of the Medicaid LTSS Communication Form (DMAS-225), in the individual's file. See the "Patient Pay" section of this chapter for more details about support coordinator responsibilities related to the DMAS-225.

- Making monthly onsite visits to individuals receiving any DD Waiver services who reside in assisted living facilities (ALFs) or adult foster care (AFC) homes. Quarterly visits to individuals receiving DD Waiver services who reside in DBHDS-licensed sponsored residential homes are recommended. The visits are to occur when the individual is present. For each individual, the following must be documented in the progress notes:

    - Any issues related to the individual's health and safety;
    - Individual satisfaction with service delivery and place of residence; and
    - Staff interactions and types of services the individual is receiving while the support coordinator is present.

  Reporting unresolved health and safety concerns about ALFs to the DSS Division of Licensing and reporting concerns about AFC homes to the local DSS where the home is located.

- Reporting suspicions of abuse, neglect, or exploitation immediately to the DARS Adult Protective Services (APS) 24-hour toll-free hotline (888-832-3858) or DSS Child Protective Services (CPS) Child Abuse and Neglect hotline (800-552-7096).

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	CORRESPONDING REGULATION(S)	BI	FIS	CL
ADDITIONAL OPTIONS				
Assistive Technology	12VAC30-122-270	✓	✓	✓
Community Guide Services	12VAC30-122-330	✓	✓	✓
Electronic Home-Based Services (EHBS)	12VAC30-122-360	✓	✓	✓
Environmental Modifications	12VAC30-122-370	✓	✓	✓
Individual and Family/Caregiver Training	12VAC30-122-430		✓	
Peer Mentor Services	12VAC30-122-450	✓	✓	✓
Transition Services	12VAC30-122-560	✓	✓	✓

ASSISTIVE TECHNOLOGY (AT)

Service Definition

Assistive Technology is the provision of specialized medical equipment, supplies, devices, controls, or appliances that are not available under the Virginia State Plan for Medical Assistance, which;

- Enable individuals to increase their abilities to perform activities of daily living (ADLs);
- Enable individuals to perceive, control, or communicate with their environment;
- Enable individuals to actively participate in other waiver services that are part of their plan for supports; or
- Are necessary for the life support, including the ancillary supplies and equipment necessary to the proper functioning of such items.

Assistive technology devices are portable and authorized per calendar year.

AT service is available to individuals in the Community Living, Family and Individual Support, and Building Independence Waivers who are receiving at least one other waiver service.

Service Requirements & Criteria

In order to be eligible for AT, an individual must have a demonstrated need for a device/equipment that provides remedial or direct medical benefit in the individual's primary residence, primary vehicle, community setting or day program to increase his ability to control his environment, support ISP outcomes as identified, and live safely and independently in the least restrictive community setting.

Allowable equipment and activities may include:

- Specialized medical equipment and ancillary equipment;
- Durable or nondurable medical equipment and supplies that are not otherwise available through the State Plan for Medical Assistance;
- Adaptive devices, appliances, and controls that enable an individual to be independent in areas of personal care and ADLs; and
- Equipment and devices that enable an individual to communicate more effectively.

Equipment, supplies, or technology not available as durable medical equipment through the State Plan for Medical Assistance may be purchased and billed as the AT service as long as the request for the item is documented and justified in the individual's ISP, recommended by the support coordinator, service authorized, and provided in the least expensive, most cost-effective manner possible.

For each AT request and prior to DMAS designated SA contractor approval:

- An independent, professional consultation/evaluation to determine the needs of the individual must be obtained from a qualified professional who is knowledgeable of that item;
- A prescription alone does not meet the standard of an evaluation;
- All evaluations must be signed by the qualified professional;
- Individual professional consultants include speech/language therapists, physical therapists, occupational therapists, physicians, certified rehabilitation engineers or rehabilitation specialists.

Examples Assistive Tech. Devices/Equipment (not a comprehensive list)	Professional Evaluation Required
Organizational Devices	Occupational Therapist, Psychologist, or Psychiatrist
Computer/software or Communication Device	Speech Language Pathologist or Occupational Therapist
Orthotics, such as braces	Physical Therapist or Physician
Writing Orthotics	Occupational Therapist or Speech Language Pathologist
Support Chairs	Physical Therapist or Occupational Therapist
Specialized Toilets	Occupational Therapist or Physical Therapist

Other Specialized Devices/Equipment	Physician, Speech Language Pathologist, Behavioral Consultant, Psychologist, Psychiatrist, Physical Therapist, or Occ. Therapist; depending on device or equipment
Weighted Blankets/Vests	Physical Therapist, Occupational Therapist, Psychologist or Behavioral Consultant

If needed, contact DMAS or its service authorization contractor for assistance with determining the appropriate professional making the recommendation. Items such as furniture shall not be approved if they are of general utility and are not of direct medical benefit.

The AT provider's quote must be compatible with the evaluation completed by the qualified professional. A Rehabilitation Engineer or Certified Rehabilitation Specialist may be utilized if, for example:

- The Assistive Technology will be initiated in combination with Environmental Modifications involving systems which are not designed to go together; or

- An existing device must be modified or a specialized device must be designed and fabricated.

Service Units and Service Limitations

- The service unit is always one, for the total cost of all AT requested for a specific timeframe. The service unit is the total cost of the item and any supplies, or hourly Rehabilitation Engineering costs;

- Providers of AT may not be the spouse, parent (natural, step, adoptive, or foster) or legal guardian of the individual who is receiving waiver services;

- Providers that supply AT for the individual may not perform the professional evaluation or write specifications for that individual;

- Medicaid will not reimburse for any AT devices or services which may have been rendered prior to authorization from the DMAS designated SA contractor;

- An AT provider's written cost estimate for specific materials related to the AT device must be submitted to the Service Authorization contractor. Any request for a change in cost for any increase in cost requires justification and supporting documentation of need and service authorization by the DMAS designated SA contractor;

- The AT provider must receive a copy of the professional evaluation in order to purchase the items recommended by the professional**.** If a change is necessary, then the AT provider must notify the assessor to ensure the changed items meet the individual's needs;

- The maximum Medicaid-funded expenditure per individual for all AT covered procedure codes combined is $5,000 per calendar year and the delivery of the service must be completed within the calendar year. Unexpended portions of the maximum amount may not be carried over from one calendar year to the next;

- Each item must be authorized by the Service Authorization contractor prior to providing the service and cannot be authorized retroactively. The service authorization will not be modified to accommodate delays in product deliveries. In such situations, new service authorizations must be sought by the provider;

- Computer software purchased for an individual must be owned by the individual and accessible by the individual and/or caregiver, as appropriate, to make changes, download updates, etc.;

- All products must be delivered, demonstrated, installed and in working order prior to submitting any claim to Medicaid. The date of service on the claim must be within the service authorization approval dates, which may be prior to the delivery date as long as the initiation of services commenced during the approved dates;

- When two or more individuals receiving waiver services live in the same home, the AT must be shared to the extent practicable consistent with the type of AT;

- AT for individuals younger than 21 years of age must be accessed through the EPSDT benefit;

- All AT service items to be covered must meet applicable standards of manufacture, design, and installation;

- The provider must provide all warranties or guarantees from the AT manufacturer to the individual and family/caregiver, as appropriate.

Service Exclusions

- AT is not covered for purposes of convenience of the caregiver or paid staff, restraint of the individual receiving the waiver, or for recreational or leisure purposes. Such items not covered include, but are not limited to, swing sets, playhouses, bowling balls, tricycles/bicycles, trampolines, television sets, video equipment/games, computer games, playing cards, printers, scanners, sporting equipment, general exercise equipment.

- AT equipment and supplies may not be rented but must be purchased through an AT provider,

- DMAS will not repurchase items purchased with AT funds unless those items have specific time-limited usefulness (e.g., computer/electronic tablets - 5 years),

- Only the actual cost of material attributed to the provider of the AT is reimbursed. Shipping, freight and delivery are not billable to DMAS or to the waiver individual, as such charges are considered all-inclusive in a provider's charge for the item(s),

- Equipment or supplies already covered by the *State Plan for Medical Assistance* may not be purchased under Assistive Technology. DME and Supplies information can be found on the DMAS Web Portal by accessing the *DME Provider Manual, Appendix B.* at: www.virginiamedicaid.dmas.virginia.gov/wps/portal.

- No duplication of payment for the AT service is permitted between the waiver and services covered for adults that are reasonable accommodation requirements of the Americans with Disabilities Act (42 USC § 12101 et seq.), the Virginians with Disabilities Act (Title 51.5 (§ 51.5-1 et seq.) of the Code of Virginia), and the Rehabilitation Act (29 USC § 701 et seq.).

AT maintenance entails the upkeep or installation of an item in order to make or keep the item operational. Some examples, not an all-inclusive list, are the cost of, Smartwatch fees, AT&T Monitoring System, repairing a ceiling lift, "PIE" (bowel management device) machine repairs, replacement screens for IPads with cracked screens or battery changes, repairs and/or the maintenance fee for "Project Life Saver" or "Angel Sense" GPS tracking devices.

Provider Documentation Requirements

The documentation requirements are:

- Documentation of the recommendation for the item by the independent professional consultant.

- The service authorization to be completed by the support coordinator may serve as the plan for supports for the provision of AT service. The service authorization request must be submitted to the SA contractor in order for service authorization to occur. Information to be submitted includes:

    - The need for the service,

  - The process to obtain this service (contacts with potential AT providers or contractors, or both, of service, costs, etc.),
  - The time frame during which the service is to be provided. This includes separate notations of design, supplies, and materials,
  - The Plan for Supports must include the reason that a Rehabilitation Engineer or Certified Rehabilitation Specialist is needed, if one is to be involved.

- Written documentation ensuring that the item is not covered by the *State Plan for Medical Assistance* as Durable Medical Equipment and Supplies,
- Documentation of the date services are rendered and the cost of service needed,
- Any other relevant information regarding the device or modification,
- Documentation of the individual/PCG's receipt of and satisfaction with the AT provided as well as any training provided to the individual/PCG on the usage of the AT,
- Documentation in the Support Coordination record of notification by the individual or individual's representative family/caregiver of satisfactory completion or receipt of the service or item,
- Instructions provided to the individual or individual's representative family/caregiver regarding warranty coverage, repairs, servicing, and complaint resolution,
- Support Coordinators, upon delivery and or installation of AT, must perform and document the results of a face-to-face visit to assure that the individual can use the AT safely and appropriately.

The following accompanying information, as applicable and conducive to the given situation and/or individual's needs:

- Drawings or pictures of items being requested,
- An itemized invoice or estimate,
- The DME denial letter for AT items otherwise covered by DME,
- A description of the individual requiring the item or modification to include age and pertinent disability(ies),

- Any other relevant information regarding the device or modification.

COMMUNITY GUIDE SERVICES

Service Definition/Description

Community Guide services include direct assistance to promote individuals' self-determination. This service involves coordinating community-based resources that provide a connection to and independent participation in integrated, independent housing and/or community activities to avoid isolation. This means that Community Guides investigate and, as necessary, coordinate, the available, naturally occurring supports and community resources to facilitate the individual's participation in those activities of interest to him/her. Community Guides provide information and direct assistance to help the individual develop supportive community relationships and explore, apply for and maintain community resources that are critical to the implementation of the person-centered plan.

This service primarily involves face-to-face contact with the individual to determine his/her specific interests in community resources and to explore these community resources. Community Guides assist the individual to identify the type of community resources which maximize opportunities for meaningful engagement and growth in independence. The aim is to connect the individual to typical community activities or settings in which the individual will engage or reside and facilitate initial participation in these activities or settings. In addition, there is a component of supporting the individual that may occur without him/her present.

The Community Guide will provide the in-depth assistance needed to connect with community resources, activities, and foster engagement distinct from the generic activities provided through routine support coordination. This service is designed to be short-term and periodic in nature.

Criteria/Allowable Activities

There are two different types of Community Guide services:

- General Community Guide:

  This service type involves utilizing existing assessment information regarding the individual's general interests to determine specific preferred activities and venues available in the community to which the person desires to be connected to promote inclusion and independent participation in the life of his/her community. Examples of activities include clubs, special interest groups, physical activities/sports teams, etc. The desired result is an increase in daily or weekly natural supports, as opposed to increasing hours of paid supports.

Allowable activities are listed below. These activities must be in the individual's Plan for Supports.

- Utilize assessment and other information provided by the Support Coordinator along with an in-depth discussion with the individual and family/friends to develop a plan, separate from the Plan for Supports, which:
  - Outlines the individual's interests,
  - Contains a step by step strategy to reduce barriers and challenges in accessing community resources/activities to support those interests,
  - Identifies targeted actions that will build upon these interests to promote community integration and independent or naturally supported involvement.
- Assist the individual with connecting to the identified, non-Medicaid funded community resources by researching and contacting the parties responsible for the identified integrated activities, supports, services, and/or resources delineated in the individual's plan,
- Provide advocacy and informal counseling to help guide the individual in problem solving and decision making and enhance his/her ability to interact with and contribute to the local community,
  - Escort the individual and/or demonstrate on site how to access the identified integrated community activities, supports, services, and/or resources,
  - Follow up with the individual to assess and document his/her participation in or utilization of the activities, supports, services and/or resources to which the Community Guide assisted in connecting.

- Community Housing Guide:
  - This service involves supporting an individual's move to independent housing by helping with transition and tenancy sustaining activities. The Community Housing Guide will work in collaboration with the Support Coordinator, DBHDS Regional Housing Coordinator, landlords and others to support the individual with accessing and sustaining integrated, independent housing. Independent, integrated housing means that the individual has a mortgage or lease in his/her own name (e.g., the person is a tenant); the individual does not live with his/her parent, grandparent or

guardian; and the individual's housing is separate from services (e.g., the individual does not live in a licensed or provider-controlled setting).

Allowable activities are listed below. These activities must be in the individual's Plan for Support.

Conduct a tenant screening using the Community Housing Guide Tenant Screening form (DMAS-P-263) that identifies the individual's housing needs and preferences, and barriers related to successful tenancy;

Develop a plan, which is separate from the Plan for Supports and called a Housing Road Map (DMAS-P262) that outlines the activities the Community Housing Guide and others who support the individual will perform to identify and secure safe, affordable housing. Activities will include assisting the individual with plan implementation and making recommendations to the Support Coordinator for waiver support services and community resources needed in the Individual Support Plan;

- Assist with the housing search process by contacting the identified resources that meet the individual's needs and preferences outlined in the Tenant Screening including administrators of rental assistance, public housing agencies, housing providers, and other entities with housing resources,

- Assist the individual with applying for rent assistance and/or housing by contacting housing providers, attending appointments with housing providers to view apartments, and assisting the individual to complete applications for rental housing,

- Help identify and facilitate the individual's request for resources to cover expenses such as security deposit, moving costs, furnishings, adaptive aids, environmental modifications, and other one-time expenses needed to obtain housing,

- Assist in arranging for and coordinating the details of the move to independent housing (e.g., arranging for a moving company, securing help to pack/unpack, setting up utility services, obtaining renter's insurance, changing address at the post office, etc.),

- Provide education and training on the role, rights and responsibilities of the tenant and landlord during the transition from home or congregate setting as needed during the tenancy,

- As part of the transitional support activities, provide training in responsible tenant behavior and lease compliance; and provide support with activities related to household management

(e.g., operating and maintaining appliances and heating/cooling systems, using the mailbox, submitting requests for repairs, paying rent and utilities),

- Assist in resolving disputes with landlords and/or neighbors to reduce the risk of eviction or other adverse action such as lease violation during the period of time that community guide services are authorized,

- Assist with the housing program's recertification process, if or when requested by the Support Coordinator or the individual's support team, and

- Assist in arranging for and supporting the details of a subsequent move to another independent housing setting.

Service Limitations

No more than twenty-five percent of authorized Plan for Supports hours may consist of Community Guide activities conducted without the individual present, such as researching and contacting potential sites, housing properties, supports, services and resources.

The Community Guide will not supplant, replace, or duplicate activities that the Support Coordinator is required to provide. Prior to accessing funding for this waiver service, all other available and appropriate funding sources, including those offered by Virginia Medicaid State Plan, DARS, and DOE, will be explored and exhausted. It is the provider's responsibility to ensure adequate documentation that service is unavailable through other means.

Service Units

Community Guide is expected to be a short, periodic, intermittent, intense service associated with a specific outcome. An individual may receive one or both types of Community Guide services in an ISP year. The cumulative total across both types of Community Guide services may be no more than 120 hours in an ISP year. In general, each type of Community Guide service may be authorized for up to six consecutive months; however, if after six months, the 120 hour ISP year limit has not been reached and further supports are still required, a request for additional months of Community Guide services may be submitted for service authorization.

If it becomes apparent mid-month that a Community Guide provider is likely to exceed the monthly authorized amount of services, yet still has not reached the annual limit, the provider may request an increase in hours for that month. The provider is still limited to the annual 120 hour per ISP year maximum.

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Service Documentation Requirements

Providers will include in each individual's record:

- A completed copy of the age-appropriate DBHDS-approved SIS® assessment form,
- The provider's Plan for Supports containing, at a minimum, the following elements:
    - The individual's desired outcomes that describe what is important to and for the individual in observable and measurable terms,
    - Support activities and support instructions that are inclusive of skill-building as may be required by the service provided and that are designed to assist in achieving the individual's desired outcomes,
    - The services to be rendered and the schedule of such services to accomplish the desired outcomes and support activities,
    - A timetable for the accomplishment of the individual's desired outcomes and support activities,
    - The estimated duration of the individual's need for services,
    - The provider staff responsible for overall coordination and integration of the services specified in the plan for supports, and
    - Documentation regarding any restrictions on the freedoms of everyday life in accordance with human rights regulations.
- Documentation must correspond with billing. Providers must maintain separate documentation for both face-to face and collateral activities, for each type of service rendered for an individual. Providers' claims that are not adequately supported by corresponding documentation may be subject to recovery of expenditures made.
- Written documentation in the form of unique, person-centered, progress notes or data collected in a supports checklist as appropriate, per the plan for supports. This documentation must confirm the individual's days in service to support units of service delivered and provide specific information regarding the individual's responses to various settings and supports, as well as specific circumstances that prevented provision of the scheduled service, should that occur. Observations of the individual's responses to the service must be available in at least a daily note or if service is provided less than daily, observations of individual responses to the service must be available for each specific

service date. Data must be collected as described in the ISP, analyzed to determine if the strategies are effective, summarized, then clearly documented in the progress notes or supports checklist. Documentation should be written, signed, and dated on the day the described supports were provided. Documentation that occurs after the date services were provided must be dated with the date the documentation was completed and also include the date the services were provided within the body of the note.

- For Community Housing Guide, the provider should retain:
    - A copy of any rent assistance eligibility (e.g., voucher, certificate),
    - A copy of the rent assistance participation agreement,
    - A copy of the individual's lease,
    - Copies of lease violation notices and rent assistance program violation notices,
    - A copy of the Community Housing Guide Tenant Screening and Tenant Roadmap forms (DMAS-P262).
- In a situation whereby the individual's needs have changed significantly, the plan for supports must be reviewed by the provider. A written review must be completed and supported by documentation in the individual's record for submission to the support coordinator at least quarterly with the plan for supports, if modified. Each quarterly person-centered review must contain the following elements:
    - Description of the status of each outcome in the plan for supports. Possible statuses include whether the outcome has been achieved, if progress is being made as expected, or if there has been limited or no progress. Any actions needed or that will be taken to resolve barriers or improve progress is noted:
        - Information about any newly identified safety risks,
        - Any changes desired by the individual or family member/caregiver, as applicable and his/their satisfaction with services.
    - Confirmation that all approved services were delivered according to the amount detailed in the plan, or, if not, the reason, and
    - Any significant events.

  The content of each review must be discussed with the individual and family member/caregiver, as applicable and submitted to the Support Coordinator within 10 calendar days following the end of each quarter. The discussion must be documented either

by the individual and family member/caregiver's signature on the review or a progress note describing the discussion. The due date for the person-centered review is determined by the effective date of the Individual Support Plan and communicated to the provider by the support coordinator. Four written reviews span the entire ISP year. For the annual updates to the plan for supports and every time supporting documentation is updated, the update must be reviewed with the individual and family member/caregiver, as appropriate, and such review must be documented, either by the individual and family member/caregiver's signature on the review, or a progress note describing the discussion,

- Documentation that all other available and appropriate funding sources, including those offered by Virginia Medicaid State Plan, DARS, and DOE, as appropriate, have been explored and exhausted,

- All correspondence to the individual and the individual's family/caregiver, as appropriate, the Support Coordinator, DMAS, DBHDS, and, for Community Housing Guide, relevant housing providers,

- Written documentation of all contacts with family/caregiver, physicians, formal and informal service providers, and all professionals regarding the individual,

- For the annual review (should the service span across two ISP years) and in cases where the Plan for Supports is modified, the team must work collaboratively to implement changes needed or desired by the individual. Changes in the Plan for Supports should be shared with the support coordinator and other participating providers, as appropriate,

- Provider documentation must support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by supporting documentation are subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

ELECTRONIC HOME-BASED SUPPORTS (EHBS)

Service Definition

Electronic Home-Based Supports or "EHBS" provides technology solutions that allow individuals to more safely live in the home environment, and/or achieve greater independence, self-determination, and community inclusion, and/or decrease the need for other Medicaid services, such as reducing the need for staff supports. EHBS may include current SMART Home technologies, purchasing of electronic devices, software, services, equipment, and supplies not covered through the Waiver or through the State Plan for Medical Assistance. EHBS includes portable hand held devices used at home or while in the community. EHBS items and services should be designed to support:

- Increased safety in the home environment;
- Increased independence, self-determination, or community inclusion; and
- Decreased need for other Medicaid services, such as reliance on staff supports.

The EHBS is a covered service in the Community Living, Family and Individual Supports and Building Independence waivers.

Criteria

Individuals who qualify for this service must be at least 18 years of age and capable of using the equipment provided through this service.

A preliminary needs assessment must be completed by an independent professional consultant to determine the best type and use of technology and overall cost effectiveness of various options to include consideration of how the designs will optimize the outcomes for individuals. The results of the assessment should be submitted with the service authorization request prior to the delivery of any goods and services and prior to the submission of any claims for Medicaid reimbursement.

The independent professional consultant conducting the preliminary assessment may be an Occupational Therapist, Behavior Specialist or similarly credentialed specialist, who is licensed or certified by the Commonwealth and specializes in assistive technologies, mobile technologies and current accommodations for individuals with developmental disabilities.

EHBS service will support training in the use of these goods and services, ongoing maintenance, and monitoring to address an identified need in the individual's ISP, including improving and maintaining the individual's opportunities for full participation in the community.

Items or services purchased through EHBS service should be designed to decrease the need for other Medicaid services, such as reliance on staff supports, promote inclusion in the community, or increase the individual's safety in the home environment.

Service Units and Service Limitations

- The ISP year limit for this service is $5,000. No unspent funds from one plan year may be accumulated and carried over to subsequent plan years,

- Receipt of EHBS service may not be tied to the receipt of any other covered waiver or Medicaid service,

- Equipment /supplies already covered by any other Medicaid covered service must be excluded from coverage by this waiver service,

- EHBS service must be provided in the least expensive manner possible that will meet the identified need of the individual enrolled in the waiver and must be completed within the individual's ISP year,

- This service is not covered for those individuals receiving residential supports reimbursed on a daily basis, such as group home, sponsored residential, or supported living services.

- The EHBS provider must receive a copy of the assessment in order to purchase the equipment/supplies recommended by the professional consultant**.** If a change is necessary then the EHBS provider must notify the professional consultant to ensure the changed items meet the individual's needs.

Service Documentation Requirements

- Required service documentation in each individual's record must include signed and dated documentation of the following:

    - The appropriate service authorization to be completed by the support coordinator may serve as the plan for supports for the provision of EHBS service. A rehabilitation engineer may be involved for EHBS service if disability expertise is required that a general contractor may not have. The service authorization request documentation must include justification and explanation if a rehabilitation engineer is needed. The service authorization request must be submitted to the state-designated agency or its designee in order for service authorization to occur,

    - Written documentation regarding the process and results of ensuring that the item is not covered by the State Plan for Medical Assistance as durable medical equipment (DME) and supplies, and that the item is not available from a DME provider,

    - Documentation of the recommendation for the item by an independent professional consultant,

    - Documentation of the date service is rendered and the amount of service that is needed,

    - Any other relevant information regarding the device or modification such as product details,

- Documentation in the support coordination record of notification by the designated individual or individual's representative family/caregiver of satisfactory completion or receipt of the service or item, and

- Instructions regarding any warranty, repairs, complaints, or servicing that may be needed.

ENVIRONMENTAL MODIFICATIONS (EM)

Service Definition

Environmental modifications or "EM" means physical adaptations to an individual's home or primary vehicle which are necessary to ensure the individual's health, safety, or welfare or which enable the individual to function with greater independence. The purpose of Environmental Modifications is to modify, not make general improvements to the home. Environmental Modifications are for pre-existing structures.

EM service is available to individuals in the Community Living, Family and Individual Support, and Building Independence Waivers who are receiving at least one other waiver service.

Criteria

To qualify for EM services the individual must have a demonstrated need for modifications to their primary residence or automotive vehicle that specifically improve the individual's personal functioning and level of independence.

Allowable Activities

- Physical adaptations to the individual's primary residence that enable an individual to live in the community and to function with greater independence that do not involve additions that increase the square footage of the structure, or

- Modifications to the primary vehicle in which the individual is transported that is owned by the individual, a family member with whom the individual lives or has consistent and ongoing contact, or a nonrelative who provides primary long-term support to the individual and is not a paid provider of environmental modifications. This service does not include the purchase or lease of vehicles or general repair of vehicles. Repairs of modifications that have been reimbursed by DMAS may be covered.

Examples of Environmental Modifications

Such modifications may include, but are not necessarily limited to, the following:

- The installation of non-portable ramps and grab-bars, widening of doorways to accommodate wheelchairs,

- Modification of bathroom facilities to accommodate wheelchairs (but not for strictly cosmetic purposes), or

- Installation of specialized electrical and plumbing systems required to accommodate the medical equipment and supplies that are necessary for the individual's welfare.

All services provided in the individual's primary residence must be done so in accordance with applicable state or local building codes and appropriate permits or building inspections which must be provided to the DMAS contractor. Medicaid reimbursement may not occur before service authorization of EM services is completed by the DMAS designated SA contractor.

An EM provider and individual might work with multiple providers in order to complete one modification, for example:

- A building contractor may design and complete the structural modification,

- A vendor who supplies the necessary materials may be separately reimbursed or supplies may be included in the bill of the building contractor, or

- A durable medical equipment provider enrolled with DMAS may be used to bill for modifications.

Service Units and Service Limitations

- The maximum Medicaid funded expenditure per individual for all EM covered procedure codes (i.e., combined total of EM service items and labor related to these items) combined may not exceed $5,000 per calendar year for individuals regardless of the waiver for which EM service is approved and regardless of whether or not the individual changes waivers over the course of the calendar year. The service unit will be one for the total cost of all EM being requested for a specific timeframe,

- Costs for EM may not be carried over from one calendar year to the next. Each item must be service authorized by the DMAS-designated agent for each calendar year. Unexpended portions of this maximum amount may not be accumulated across one or more years,

- Only the actual cost of material and labor is reimbursed. There may not be an additional markup,

- EM must be provided in the least expensive manner possible that will accomplish the modification required by the individual enrolled in the waiver and must be completed within the calendar year,

- Proposed modifications to rental properties must have prior written approval of the property's owner. Modifications to rental properties will only be valid if it is an independently operated rental facility with no direct or indirect ties to any other Medicaid service provider,

- Modifications may be made to a vehicle if it is the primary vehicle used by the individual. This service may not include the purchase of, or the routine maintenance of, vehicles (repairs of modifications which have been reimbursed by DMAS may be covered),

- The EM provider will ensure that all work and products are delivered, installed and in good working order prior to seeking reimbursement from DMAS. The date of service on this provider's claim must be within the service authorization approval dates, which may be prior to the completion date as long as the work commenced,

- The service authorization may not be modified to accommodate installation delays. All requests for cost changes (either increases or decreases) must be submitted to the DMAS designated SA contractor for revision to the previously issued service authorization and must include justification and supporting documentation of medical needs,

- A copy of the provider's cost estimate (quote) for labor and materials for an environmental modification must be submitted to DMAS designated SA contractor, however, should the cost of the item ultimately reflect a total which is less than the original quote, this will not impede the payment to the contracted entity,

- EM maintenance entails the upkeep or installation of an item in order to make or keep the items operational. Some examples, not an all-inclusive list, are maintenance of the tracks for the chair lift to keep it functional, repairs and/or maintenance to stair lifts, ceiling lifts, and/or lifts in vehicles, repairs to "sesame door," transfers of EM items to new placements (i.e., lifts, bidets), or replacement of the boards on the ramp outside the home to ensure the individual can access the community or home.

EM Exclusions

EM service will encompass those items not otherwise covered in the State Plan for Medical Assistance or through another program, for example, if the Fair Housing Act (42 USC §3601 et seq.), the Virginia Fair Housing Law (§39-96.1 et seq. of the Code of Virginia) or the Americans with Disabilities Act (42 USC § 12101 et seq.), the Virginians with Disabilities Act (Title 51.5 (§ 51.5-1 et seq.) of the Code of Virginia), or the Rehabilitation Act (29 USC § 701 et seq.) which requires the modification.

- There may be no duplication of EM services within the same residence such as multiple wheelchair ramps or previous modifications to the same room. (There may be no duplication of EM within the same ISP year),

- Modifications must not be used to bring a substandard dwelling up to minimum habitation standards. Adaptations or improvements to the primary home that are of general utility and are not of direct medical or remedial benefit to the waiver individual must be excluded, including, but not limited to, the following:

    - Carpeting,
    - Roof repairs, central air conditioning or heating,
    - General maintenance and repairs to a home, additions or maintenance of decks,
    - Maintenance and/or replacement or addition of sidewalks, driveways, carports, or adaptations that only increase the total square footage of the home.

- EM will not be covered by Medicaid for general leisure, or diversion items, or those items that are recreational in nature or those items that may be used as an outlet for behavioral supports. Such non-covered items include, but are not be limited to, swing sets, playhouses, climbing walls, trampolines, protective matting and ground cover,

- EM will not include the costs of removal or disposal, or any other costs, of previously installed modifications, whether paid for by DMAS or any other source,

- Providers of EM must not be the individual's spouse, parent (natural, adoptive, step, foster), legal guardians), other legal guardians, or conservator. Providers who supply EM to waiver individuals must not perform consultations or write EM specifications for such individuals,

- The contractor providing the modification must complete an assessment and quote before performing any work,

- EM is not authorized or allowed for the modification of living arrangements that are owned or leased by providers of waiver services or those living in arrangement that are licensed by a DBHDS provider. Specifically, provider-owned or leased setting where residential supports are furnished must already be compliant with the Americans with Disabilities Act and the CMS Home and Community Based Services regulations settings provision.

<u>Service Documentation Requirements</u>

- The appropriate service authorization to be completed by the support coordinator may serve as the plan for supports for the provision of EM service. A rehabilitation engineer

may be involved for EM service if disability expertise is required that a general contractor may not have. The service authorization must include justification and explanation if a rehabilitation engineer is needed. The service authorization request must be submitted to DMAS contractor in order for service authorization to occur,

- Written documentation regarding the process and results of ensuring that the item is not covered by the State Plan for Medical Assistance, for example as durable medical equipment (DME) and supplies and that it is not otherwise available from a DME provider,

- Documentation of the recommendation for the item by an independent professional consultant if an independent professional consultant is required for the individual's needs,

- Documentation of the date services are rendered and the amount of services and supplies,

- Any other relevant information regarding the modification,

- Documentation that the support coordinator, upon completion of each modification, met face-to-face with the individual and the family/caregiver; as appropriate, to ensure that the modifications was completed satisfactorily and is able to be used by the individual,

- Instructions provided to the individual and the family/caregiver; as appropriate, regarding warranty coverage, repairs, maintenance, and complaint resolution.

INDIVIDUAL AND FAMILY/ CAREGIVER TRAINING (IFCT)

Service Description:

Individual and Family/Caregiver Training is the provision of identified training, counseling and education related to disabilities, community integration, family dynamics, stress management, behavior interventions, and mental health to individuals, or families, or caregivers of individuals enrolled in the waiver. The counseling and education provided under this service include assisting the individual with better understanding of his/her disability, increase self-determination and self-advocacy.

DMAS will only reimburse services as defined in the service description, listed in the individual's approved Plan for Supports and that are within the scope of practice of the providers performing the service. (DMAS will not reimburse for training provided through educational courses.)

Criteria

The need for the training, and the training contents, shall assist the individual, family or caregivers with supporting the individual at home. This need must be documented in the individual's ISP.

The training must be necessary in order to improve the individual, family or caregiver's ability to give or receive care and support.

IFCT must be provided by Medicaid Individual and Family/Caregiver Training providers. Such training may only be billed as it is rendered, for example, billed as individual training when rendered to an individual (including two or more caregivers for the same individual), or billed as a group when rendered to a group of individuals. This service will not duplicate other DD Waivers services. This service shall not cover college classes.

For the purposes of this service, "family" defined as the unpaid persons who live with or provide care to an individual served on the waiver, and may include a parent, legal guardian, spouse, children, relatives, a foster parent, or in-laws. "Family" does not include individuals who are employed to care for the individual. All family training must be included on the individual's ISP.

Service Units and Service Limitations

IFCT services is only available through the Family and Individual Supports Waiver (FIS). Individual and Family/Caregiver Training may be authorized up to $4,000 per ISP year. Travel expenses, room and board are not covered. Registration fees for the training, conference or seminar are covered under this service. The intent of the Individual and Family/Caregiver Training are not to duplicate any other Medicaid services. IFCT services cannot be authorized retroactively.
IFCT services may be rendered via an in-person or telehealth model, based upon the structure of training provided. Any training provided via a telehealth model must include both an audio and visual component.

Service Documentation Requirements

The documentation requirements are:

- The provider's Plan for Supports for Individual and Family/Caregiver Training. This must contain:
    - Identifying Information - The individual's name and Medicaid number; provider name and provider number; responsible person and telephone number; effective dates for the service; and semi-annual review dates, if applicable,
    - Training services to be provided and the schedule of such services to accomplish the desired outcomes and supports,
    - Verification of training modality (i.e. in person training vs virtual model), and
    - Specific training.

- Contact notes:
    - Date, location, and time of each training contact,
    - Type of training and hours of training provided, and
    - Persons to whom training was directed.
- Monthly notes:
    - Summary of support/training activities for the month;
    - Dates, locations, and times of service delivery;
    - Plan for supports desired outcome(s) addressed;
    - Specific details of the supports/training conducted;
    - Services delivered as planned or revised; and
    - Effectiveness of the strategies and individuals, families and caregivers' satisfaction with the service.
- Quarterly person centered review are required by the service provider if training extends three months or longer and are to be forwarded to the Support Coordinator and include:
    - Supports related to the Plan for Supports,
    - Individual status and satisfaction with training services, and
    - Desired outcomes and effectiveness of the Plan for Supports.
- If training services extend less than three months, the provider must forward to the Support Coordinator contact notes, monthly notes, or a summary of monthly notes for the quarterly review. The family members who are not directly providing support for the Individual but attended the training/conference, they must include documentation of the registration and details of the training/conference on file,
- Individual and Family Caregiver Training is reimbursed as defined in the service description, listed in the individual's ISP, and that is within the scope of practice of the providers performing the service.

PEER MENTOR SUPPORTS

Service Definition/Description

Peer Mentor Supports provide information, resources, guidance, and support from an experienced, trained peer mentor to an individual who is a waiver recipient. This service is delivered to waiver recipients by other individuals with developmental disabilities who are or have been service recipients, have shared experiences with the individual, and provide support and guidance to him/her. The service is designed to foster connections and relationships which build individual resilience.

Peer Mentor Supports encourage individuals with developmental disabilities to share their successful strategies and experiences in navigating a broad range of community resources beyond those offered through the waiver with waiver participants so that the waiver participant is better able to advocate for and make a plan to achieve integrated opportunities and experiences in living, working, socializing, and staying healthy and safe in his/her own life, as well as to overcome personal barriers which are inhibiting him/her from being more independent. Peer mentoring is intended to assist with empowering the individual receiving the service.

This service is delivered based on the support needs of the individual as outlined in his/her person-centered plan. This service is designed to be short-term and periodic in nature.

Criteria/Allowable Activities

Allowable activities may include the following for the individual as documented in his plan for supports:

- The administering agency facilitates peer to peer "matches" and follows up to assure that the matched relationship meets the individual's expectations;

- The peer mentor has face-to-face contact with the individual to discuss his/her specific interests/desired outcomes related to realizing greater independence and the barriers to achieving them;

- The peer mentor explains community services and programs and suggests strategies to the individual to achieve his/her desired outcomes, particularly related to living more independently, engaging in paid employment and expanding social opportunities in order to ultimately reduce the need for supports from family members or paid staff;

- The peer mentor provides information from his/her experiences to help the individual in problem solving, decision making, developing supportive community relationships and

exploring specific community resources that promote increased independence and community integration; and/or

- The peer mentor assists the individual in developing a personal plan for accessing the identified integrated community activities, supports, services, and/or resources.

Contacts between the Peer Mentor and the individual who is receiving the waiver may be in the form of face-to-face or remote technology that allows the Peer Mentor to view the individual and converse with him. The interactive audio/video connection must be of sufficient audio quality and visual clarity so as to be functionally equivalent to a face-to-face encounter, conducted in a confidential manner and any information sharing consistent with applicable federal and state laws and regulations and DMAS policy. Health Information Portability and Accountability Act of 1996 (HIPPA) confidentiality requirements are applicable.

Service Limitations

The Peer Mentor must not supplant, replace, or duplicate activities that are required to be provided by the support coordinator. Prior to accessing funding for this waiver service, all other available and appropriate funding sources must be explored and exhausted.

Peer Mentors cannot mentor their own family members.

Peer Mentors must be at least 21 years of age. This service is only available to individuals 16 years of age and older.

Individuals who receive supports through DD or other waivers may be peer mentors.

Service Units

The unit of service is an hour.

Peer Mentor Supports is expected to be a short, periodically intermittent, intense service associated with a specific outcome. The total number of hours authorized may be no more than 60 hours in an ISP year. In general, Peer Mentor Supports may be authorized for up to 6 consecutive months; however, if after six months, the 60 hour ISP year limit has not been reached and further supports are still required, a request for additional months of Peer Mentor Supports may be submitted for service authorization.

An administrative cost reimbursement is built into the rate for the administering provider.

Service Documentation Requirements

Providers (administering agencies) will include in each individual's record:

- A copy of the completed, standard, age-appropriate DBHDS approved Supports Intensity Scale®,

- The provider's Plan for Supports, which includes the following required elements:
    - The individual's desired outcomes that describe what is important to and for the individual in observable terms,
    - Support activities and support instructions that are designed to assist in achieving the individual's desired outcomes,
    - The services to be rendered and a general timetable that states when the planned activities will be accomplished, the estimated duration of the individual's need for services, and the Peer Mentor responsible for the delivery of the services specified in the Plan for Supports.

- Documentation in the form of:
    - A log or similar document that confirms the individual's amount of time in services, the dates of all contacts between the Peer Mentor and the individual with the waiver, as well as information regarding the type of supports delivered to the individual. The log must be signed by the Peer Mentor delivering the service. This documentation must correspond with billing. Providers must maintain separate documentation for each type of service rendered for an individual,
    - A written review supported by documentation in the individual's record must be submitted to the Support Coordinator quarterly, during any quarters in which the service was provided, with the Plan for Supports, if modified. This written review will list the dates and nature of contacts and a statement about the individual's satisfaction with the service. The quarterly person-centered review is due to the Support Coordinator no later than 10 days following the end of the quarter. For the annual review and every time the Plan for Supports is updated, the revised Plan for Supports will be reviewed with the individual or family/caregiver, as appropriate, and such review must be documented,
    - All correspondence with the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS,
    - Written documentation of all contacts with family/caregiver, physicians, formal and informal service providers, and all professionals regarding the individual,
    - Documentation of the Peer Mentor's qualifications, as well as criminal background and Child Protective Registry (if the waiver individual is under age 18) checks,

- Administering agency documentation must support all claims submitted for DMAS reimbursement. Claims that are not supported by appropriate documentation are subject to recovery by DMAS as a result of utilization reviews and audits.

TRANSITION SERVICES

Service Definition

Transition Services provide for set-up expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private (community) residence, where the living expenses are the responsibility of the individual. Transition Services may be limited for some community home settings that are already required to provide specific services. Transition Services funds may not be used to supplant or replace existing payment options. The establishment of transition funds are not intended to help with general moving but to aid individuals to successfully live in the community.

Individuals may receive Transition Services through the Community Living, Family and Individual Supports, or the Building Independence waivers. Individuals who leave a qualifying facility, such as Nursing Facility (NF), Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), Institute for Mental Diseases (IMD), Psychiatric Residential Treatment Facility (PRTF), Long-Stay Hospital (LSH), or Group Home and demonstrate a need for Transition Services have up to 30 days after transitioning from the qualifying facility (from discharge date) to apply for Transition Services.

For all individuals utilizing Transition Services the SC must include an outcome related to the service in the person-centered ISP prior to seeking service authorization. The service authorization request must include in the SC's justification for the request the name of the institution from which the individual is transitioning, the community housing to which the individual is transitioning, the date of the move, and the list of items/services to be purchased through Transition Services.

Criteria/Allowable Activities

Eligible individuals are those whose health and safety can be maintained in a community setting and who chose to live in a qualified community residence.

Transition services are furnished only to the extent that:

- They are reasonable and necessary as determined through the transition service plan development process,
- They are clearly identified in the transition, matching a demonstrated need,
- The person is unable to meet such expense(s),

- The goods/services are not the responsibility of another entity, and
- The goods/services cannot be obtained from another source.

This service does not include services or items covered under other waiver service, state plan option, or by other providers.

Allowable costs include, but are not limited to:

- Security deposits and the first month's rent that are required to obtain a lease on a house, condo, apartment or other residence,
- Essential household furnishings and appliances required to occupy and use a community domicile, for example furniture, window coverings, food preparation items, and bed/bath linens,
- Connection or set-up fees or deposits for utility or services access, such as telephone, internet connection, electricity, heating and water,
- Services necessary for the individual's health, safety, and welfare such as pest eradication and one-time cleaning prior to occupancy,
- Moving expenses,
- Needed clothing items,
- Fees to obtain a copy of a birth certificate, identification card, or driver's license, and
- Activities to assess need, arrange for, and procure needed resources.

Non-allowable costs include, but are not limited to:

- Reoccurring charges such as monthly rental or mortgage expenses,
- Food,
- Regular/routine utility charges,
- Household items that are intended for decoration, diversional or recreational purposes, and
- Services or items that are covered under other waiver services such as environmental modifications, electronic home-based services, or assistive technology.

Service Limitations and Service Units

The total cost of transition services must not exceed $5,000, per individual lifetime limit. Coverage is one-time regardless of the amount expended up to $5,000. Coverage of transition services is available for individuals who have resided in a qualified long-term service and supports setting for at least 90 consecutive days.

Transition services are not available to individuals exiting an acute care hospital. Transition Services may be authorized for a maximum of nine (9) months by the DMAS service authorization contractor prior to providing services. The funds are not available to the individual after the conclusion of the nine (9) month authorization period of time. Transition services may be requested up to two months prior to discharge. Authorization must be obtained within 30 days of discharge from the qualifying facility. If not requested within that time frame, the individual will not be considered for transition services.

If transition services authorization is obtained but transition services are not used, the Support Coordinator must submit a cancellation request to the DMAS contractor.

The Support Coordinator must ensure that the requested items are reasonable, necessary, documented in the person-centered ISP, meet the service criteria, and do not exceed the lifetime $5,000 maximum limit. Upon transition, individuals must live in a home where the individual is responsible for his or her own expenses. This may include:

- A home owned or leased by the individual or a family member: The individual or the family member owns or leases the home. In this situation, the individual must retain equal legal rights under the lease or as the owner,

- An apartment with an individual lease: This type of residence must have living, sleeping, bathing and cooking areas over which the individual or the family have domain and control. If the apartment does not have these areas or the individual does not have control over their use, the apartment would not be considered a qualified residence. The unit must have lockable entrance and exit doors, not just locking doors into the building. To meet the requirement for a qualified residence, the individual (or family representative) must sign a lease for an apartment. Apartments can be fair-market (unsubsidized), affordable and subsidized, senior living complexes and/or senior high-rise apartment buildings (to name a few types). The lease cannot require the individual to receive services from a specific company or require him/her to notify the landlord if he/she is absent for a period of time,

- A community-based residential setting in which no more than four unrelated individuals reside. This may include a small group home, a sponsored residential home, or an apartment with a shared living arrangement with roommates. If a residence is licensed,

transition service funds cannot be used to purchase any item that is required to be provided by the licenser.

Individuals receiving DD waiver services must receive support from the local community services board (CSB) and/or the support coordinator to facilitate the purchase of necessary items. These agencies/providers will then submit claims to Medicaid's payment system for reimbursement for transition services.

Service Documentation Requirements

Any and all documentation related to transition services in the individual's support coordination record including:

- Documentation of the need for the requested goods and/or services in the person-centered ISP, including the discussion of need with the individual or family member/caregiver, as appropriate,
- Documentation of the individual's or family member/caregiver's, as appropriate, choice of services or goods to be purchased,
- Documentation of the individual's or family member/caregiver's, as appropriate, choice of vendor, if applicable,
- Documentation of the reasonableness of the expense (consideration should be given to ways to provide the items or service in the least expensive, most cost effective manner as well as durability of the items and maintenance requirements),
- Documentation of the date services are rendered and the amount of services and supplies,
- Any other relevant information regarding the purchase,
- Signature of the individual or family member/caregiver, as appropriate, indicating receipt of the item or service (signature must be placed on the front of the store/vendor receipt),
- Documentation of the individual's or family member/caregiver's, as appropriate, satisfaction regarding completion of the service,
- As appropriate, documentation that the individual receiving transition service has received instructions regarding any warranty, repairs, complaints, and servicing that may be needed, and

- Retention in the record of a receipt for the purchased services and/or goods which documents payment of the fee.

Transition services purchases must match the items that are listed on the Transition Services authorization request. The ISP, housing needs assessment worksheet and transition services worksheet are utilized as documentation to assure eligibility criteria is met.

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	Corresponding Regulation(s)	BI	FIS	CL
Crisis Support Options				
Center-Based Crisis Supports	12VAC30-122	✓	✓	✓
Community-Based Crisis Supports	12VAC30-122-290	✓	✓	✓
Crisis Support Services	12VAC30-350	✓	✓	✓

Center-Based Crisis Services

Service Definition/Description

Center-based crisis support service means planned crisis prevention and emergency crisis stabilization services in a crisis therapeutic home through planned and emergency admissions. This service is designed for individuals who will need ongoing crisis supports. Planned admissions are provided to individuals receiving crisis services who need temporary, therapeutic interventions outside of their home setting to maintain stability. Emergency admissions are provided to individuals who are experiencing an identified behavioral health need or behavior challenge that is preventing them from reaching stability within their home settings.

Criteria/Allowable Activities

Center-based crisis support services are available to individuals enrolled in the FIS, CL, and BI waivers.

Center-based crisis support services are designed for an individual who:

- Has a history of – or is experiencing at least one of the following:
    - Psychiatric hospitalization;
    - Incarceration;
    - Residential or day placement that was terminated; or
    - Behavior that has significantly jeopardized placement.

- Meet at least one of the following:
    - Is currently experiencing a marked reduction in psychiatric, adaptive, or behavioral functioning;
    - Is currently experiencing an increase in emotional distress;
    - Currently needs continuous intervention to maintain stability; or
    - Is causing harm to himself or others.

- Also be:
    - At risk of psychiatric hospitalization;
    - At risk of emergency ICF/IID placement;

  - At immediate risk of loss of community service due to severe situational reaction; or
  - Actually causing harm to himself or others.

- Allowable activities include as appropriate for the individual as documented in the plan for supports:

  - A variety of types of face-to-face assessments (e.g., psychiatric, neuropsychiatric, psychological, behavioral) and stabilization techniques;

  - Medication management and monitoring;

  - Behavior assessment and positive behavior support;

  - Intensive care coordination with other agencies or providers to maintain the individual's community placement;

  - Training for family members/caregivers and providers in positive behavior supports;

  - Skill building related to the behavior creating the crisis such as self-care or ADLs, independent living skills, self-esteem, appropriate self-expression, coping skills, and medication compliance; and

  - Supervising the individual in crisis to ensure his safety and that of other persons in the environment.

Center-based crisis support services may only be authorized following a documented face-to-face assessment conducted by a qualified developmental disabilities professional (QDDP) or qualified mental health professional (QMHP).

Center-based crisis support services may not be used for continuous long-term care. Room and board are not components of this service. Medicaid reimbursement is available only for allowable activities that are authorized and provided according to an approved Plan for Supports, when a qualified provider is providing the services.

The center-based crisis support plan for supports may be developed (or revised, if requesting an extension) and submitted to the support coordinator to request service authorization up to 72 business hours of the requested start date for authorization. Under certain circumstances, the request for authorization would fall outside the 72 hour window. A longer timeframe may be permitted with supporting documentation that indicates the authorization was attempted within the 72 hours.

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Service Limitations

Center-based crisis support service is limited to six months per ISP year and will be authorized in increments of up to a maximum of 30 consecutive days with each authorization.

Center-based crisis supports will be authorized based on the schedule of supports on an individualized basis based on the person's needs, but not for more than 24 hours per day.

Center-based crisis support service may not be provided during the occurrence of the following waiver services and must not be billed concurrently (i.e., same dates and times):

- Group home residential service;
- Sponsored residential service;
- Supported living residential service;
- Respite service;
- In-home support services; or
- Personal assistance services.

Center-based crisis support service is available through the waiver only when it is not available through the State Plan.

Service Units

The service unit is an hour.

Service Documentation Requirements

Providers must include in each individual's record:

Providers must include signed and dated documentation of the following in each individual's record:

- The provider's Plan for Supports containing, at a minimum, the following elements:
    - The individual's desired outcomes that describe what is important to and for the individual in observable terms;
    - Support activities and support instructions that are inclusive of skill-building and that are designed to assist in achieving the individual's desired outcomes;
    - The services to be rendered and the schedule of such services to accomplish the desired outcomes and support activities;
    - A timetable for the accomplishment of the individual's desired outcomes and support activities;

- The estimated duration of the individual's needs for services;
- The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports;
- Documentation regarding any restrictions on the freedoms of everyday life in accordance with human rights regulations and the requirements of the Home and Community-based Services settings regulations (as found in 42 CFR 441.301).

- Supporting documentation that has been developed (or revised, in the case of a request for an extension) and submitted to the to the support coordinator for authorization within 72 hours of the face-to-face assessment or reassessment.

- Written documentation in the form of unique, person-centered progress notes or data collected in a supports checklist, as appropriate, per the plan for supports. This documentation must confirm the individual's days in service to support units of service delivered and provide specific information regarding the individual's responses to various settings and supports, as well as specific circumstances that prevented provision of the scheduled service, should that occur. Observations of the individual's responses to the service must be available in at least a daily note. Data must be collected as described in the ISP, analyzed to determine if the strategies are effective, summarized, then clearly documented in the progress notes or supports checklist. Documentation should be written, signed, and dated on the day the described supports were provided. Documentation that occurs after the date services were provided must be dated with the date the documentation was completed and also include the date the services were provided within the body of the note.

- An attendance log or similar document maintained by the provider that indicates the date, type of service rendered, and the number of hours and units provided, including specific timeframe.

- Documentation must correspond with billing. Providers must maintain separate documentation for each type of service rendered for an individual. Providers' claims that are not adequately supported by corresponding documentation may be subject to recovery of expenditures made.

- All correspondence with the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS.

- Written documentation of contacts made with individual’s family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual.

- Provider documentation must support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by supporting documentation will be subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

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COMMUNITY-BASED CRISIS SUPPORT SERVICE

Service Definition/Description

Community-based crisis support service means planned crisis prevention and emergency crisis stabilization services provided to individuals experiencing crisis events that put them at risk for homelessness, incarceration, or hospitalization or that creates danger to self or others. This service provides supports to individuals in their homes and other community settings. It provides temporary intensive services and supports that avert emergency psychiatric hospitalization or institutional placement or prevent other out-of-home placement. This service is designed to stabilize the individual and strengthen the current living situation so that the individual can be maintained during and beyond the crisis period.

Criteria and allowable activities

Community-based crisis support service is available to individuals enrolled in the FIS, CL, and BI waivers.

Community-based crisis support service provides ongoing supports to the individual who may have:

- A history of multiple psychiatric hospitalizations, frequent medication changes, or setting changes; or

- A history of requiring enhanced staffing due to the individual's mental health or behavioral issues.

Community-based crisis support service are designed for people who have a history of – or are experiencing at least one of the following:

- Previous psychiatric hospitalization;
- Previous incarceration;
- Residential or day placement that was terminated; or
- Behavior that has significantly jeopardized placement.

In addition, the individual must meet at least one of the following:

- Is experiencing a marked reduction in psychiatric, adaptive, or behavioral functioning;
- Is experiencing an increase in extreme emotional distress;
- Needs continuous intervention to maintain stability; or
- Is actually causing harm to himself or others.

The individual must also be:

- At risk of psychiatric hospitalization;
- At risk of emergency ICF/IID placement;
- At immediate threat of loss of community service due to a severe situational reaction; or
- Actually causing harm to himself or others.

Community-based crisis support service allowable activities may be provided in either the individual's home or in community settings, or both. Crisis staff should work directly with the individual and with his current support provider or his family/caregiver, or both. This service includes supports during the provision of any other waiver service and may be billed concurrently (i.e., same dates and times).

This service is provided using, for example, coaching, teaching, modeling, role-playing, problem solving, or direct assistance. Allowable activities include, as may be appropriate for the individual as documented in his plan for supports:

- Psychiatric, neuropsychiatric psychological, and behavioral assessments and stabilization Techniques;

- Medication management and monitoring;

- Behavior assessment and positive behavior support;

- Intensive care coordination with agencies or providers to maintain the individual's community placement;

- Family/caregiver training in positive behavioral supports to maintain the individual in the community;

- Skill building related to the behavior creating the crisis such as self-care or ADLs, independent living skills, self-esteem, appropriate self-expression, coping skills, and medication compliance; and

- Supervision to ensure the individual's safety and the safety of others in the environment.

Community-based crisis support services may only be authorized following a documented face-to-face assessment conducted by a qualified developmental disabilities professional (QDDP) or qualified mental health professional (QMHP).

Medicaid reimbursement is available only for allowable activities that are authorized and provided according to an approved Plan for Supports, when a qualified provider is providing the services.

- The community-based crisis support plan for supports may be developed (or revised, if requesting an extension) and submitted to the support coordinator to request service

authorization up to 72 business hours of the requested start date for authorization. Under certain circumstances, the request for authorization would fall outside the 72 hour window. A longer timeframe may be permitted with supporting documentation that indicates the authorization was attempted within the 72 hours.

Service limitations

This service is only available through a waiver only when it is not available through the State Plan.

Service units

The unit of service for community-based crisis support service is an hour. The service may be authorized for up to 24 hours per day, if necessary, in increments of no more than 15 days at a time. The annual limit is 1,080 hours. Requests for additional community-based crisis support service in excess of the 1,080-hour annual limit will be considered if justification of individual need is provided.

Service documentation and requirements

Providers must include signed and dated documentation of the following in each individual's record:

- The provider's Plan for Supports containing, at a minimum, the following elements:
    - The individual's desired outcomes that describe what is important to and for the individual in observable and measurable terms;
    - Support activities and support instructions that are inclusive of skill-building, as needed, and that are designed to assist in achieving the individual's desired outcomes;
    - The services to be rendered and the schedule of such services to accomplish the desired outcomes and support activities;
    - A timetable for the accomplishment of the individual's desired outcomes and support activities;
    - The estimated duration of the individual's needs for services;
    - The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports; and

- Documentation regarding any restrictions on the freedoms of everyday life in accordance with human rights regulations.

- Supporting documentation that has been developed (or revised, in the case of a request for an extension) and submitted to the to the support coordinator for authorization within 72 hours of the face-to-face assessment or reassessment.

- Written documentation in the form of unique, person-centered progress notes or data collected in a supports checklist, as appropriate, per the plan for supports. This documentation must confirm the individual's days in service to support units of service delivered and provide specific information regarding the individual's responses to various settings and supports, as well as specific circumstances that prevented provision of the scheduled service, should that occur. Observations of the individual's responses to the service must be available in at least a daily note. Data must be collected as described in the ISP, analyzed to determine if the strategies are effective, summarized, then clearly documented in the progress notes or supports checklist. Documentation should be written, signed, and dated on the day the described supports were provided. Documentation that occurs after the date services were provided must be dated with the date the documentation was completed and also include the date the services were provided within the body of the note.

- An attendance log or similar document maintained by the provider that indicates the date, type of service rendered, and the number of hours and units provided, including specific timeframe.

- Documentation to support units of service delivered, and the documentation must correspond with billing. Providers must maintain separate documentation for each type of service rendered for an individual. Documentation must include all correspondence and contacts related to the individual.

- All correspondence with the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS.

- Written documentation of contacts made with individual’s family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual.

- Provider documentation must support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by supporting contemporaneous documentation are subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

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CRISIS SUPPORT SERVICE

Service definition/description

Crisis support service means intensive supports by trained and, where applicable, licensed staff in crisis prevention, crisis intervention, and crisis stabilization for an individual who is experiencing an episodic behavioral or psychiatric event in the community that has the potential to jeopardize the current community living situation. This service is designed to prevent the individual from experiencing an episodic crisis that has the potential to jeopardize his current community living situation, to intervene in such a crisis, or to stabilize the individual after the crisis. This service is also designed to prevent escalation of a crisis, maintain safety, stabilize the individual, and strengthen the current living situation so that the individual can be supported in the community beyond the crisis period.

Crisis support service is designed for individuals experiencing circumstances such as:

- Marked reduction in psychiatric, adaptive, or behavioral functioning;
- An increase in emotional distress;
- Needing continuous intervention to maintain stability; or
- Causing harm to themselves or others.

Criteria and allowable activities

Crisis support service is available to individuals enrolled in the FIS, CL, and BI waivers.
Crisis support service may include as appropriate and necessary the following components:

- Crisis prevention services
  This component provides:
    - Assessment of an individual's medical, cognitive, and behavioral status, as well as predictors of self-injurious, disruptive, or destructive behaviors, with initiation of positive behavior supports to resolve and prevent future occurrence of crisis situations. Training for family/caregivers to avert further crises and to maintain the individual's typical routine to the maximum extent possible.
    - Support for the family and individual through team meetings, revising the behavior plan or guidelines, and other activities as changes to the behavior support plan are implemented and residual concerns from the crisis situation are addressed.

- Crisis intervention services
  This short-term service component provides:

  - Supports during a crisis to prevent further escalation of the situation and to maintain the immediate personal safety of those involved.
  - A highly structured intervention that can include, for example, temporary changes to the person's residence, changes to the person's daily routine, and emergency referral to other care providers.
  - Staff modeling verbal de-escalation techniques including active listening, reflective listening, validation, and suggestions for immediate changes to the situation.

- Crisis stabilization
  This service component enables:

  - Gaining a full understanding of the factors that contributed to the crisis once the immediate threat has resolved and there is no longer an immediate threat to the health and safety of the individual or others.
  - Gaining a full understanding of all of the factors that precipitated the crisis and may have maintained it until trained staff from outside the immediate situation arrived.
  - The development of new plans that may include environmental modifications, interventions to enhance communication skills, or changes to the individual's daily routine or structure.
  - Family/caregivers and other persons significant to the individual to receive training from staff in techniques and interventions to avert future crises.

Crisis support services may only be authorized following a documented face-to-face assessment conducted by a qualified developmental disabilities professional (QDDP) or qualified mental health professional (QMHP).

Medicaid reimbursement is available only for allowable activities that are authorized and provided according to an approved Plan for Supports, when a qualified provider is providing the services.

- The crisis support service plan for supports may be developed (or revised, if requesting an extension) and submitted to the support coordinator to request service authorization up to 72 business hours of the requested start date for authorization. Under certain circumstances, the request for authorization would fall outside the 72 hour window. A longer timeframe may be permitted with supporting documentation that indicates the authorization was attempted within the 72 hours.

Service limitations

This service is only available through a waiver when it is not available through the State Plan.

Service units

- Crisis prevention
    - The unit of the service is one hour and billing may occur up to 24 hours per day if necessary. Crisis prevention may be authorized for up to 60 days per ISP year. Crisis prevention services include supports during the provision of any other waiver service and may be billed concurrently (i.e., same dates and times).
- Crisis intervention
    - The unit of the service is one hour and billing may occur up to 24 hours per day if necessary. Crisis intervention may be authorized in increments of no more than 15 days at a time for up to 90 days per ISP year. Crisis intervention services include supports during the provision of any other waiver service and may be billed concurrently (i.e., same dates and times).
- Crisis stabilization
    - The unit of the service is one hour and billing may occur up to 24 hours per day if necessary. Crisis stabilization may be authorized in increments of no more than 15 days at a time for up to 60 days per ISP year. Crisis stabilization services include supports during the provision of any other waiver service and may be billed concurrently (i.e., same dates and times).

Service documentation and requirements

Providers must include signed and dated documentation of the following in each individual's record:

- The provider's Plan for Supports containing, at a minimum, the following elements:
    - The individual's desired outcomes that describe what is important to and for the individual in observable and measurable terms;
    - Support activities and support instructions that are inclusive of skill-building as appropriate, and that are designed to assist in achieving the individual's desired outcomes;

- The services to be rendered and the schedule of such services to accomplish the desired outcomes and support activities;
- A timetable for the accomplishment of the individual's desired outcomes and support activities;
- The estimated duration of the individual's needs for services;
- The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports; and
- Documentation regarding any restrictions on the freedoms of everyday life in accordance with human rights regulations.

- Supporting documentation that has been developed (or revised, in the case of a request for an extension) and submitted to the support coordinator for authorization within 72 hours of the face-to-face assessment or reassessment.

- Written documentation in the form of unique, person-centered progress notes or data collected in supports checklist, as appropriate, per the plan for supports. This documentation must confirm the individual's days in service to support units of service delivered and provide specific information regarding the individual's responses to various settings and supports, as well as specific circumstances that prevented provision of the scheduled service, should that occur. Observations of the individual's responses to the service must be available in at least a daily note. Data must be collected as described in the ISP, analyzed to determine if the strategies are effective, summarized, then clearly documented in the progress notes or supports checklist. Documentation should be written, signed, and dated on the day the described supports were provided. Documentation that occurs after the date services were provided must be dated with the date the documentation was completed and also include the date the services were provided within the body of the note.

- An attendance log or similar document maintained by the provider that indicates the date, type of service rendered, and the number of hours and units provided, including specific timeframe.

- Documentation to support units of service delivered, and the documentation must correspond with billing. Providers must maintain separate documentation for each type of service rendered for an individual. Documentation must include all correspondence and contacts related to the individual.

- All correspondence with the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS.

- Written documentation of contacts made with individual's family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual.

- Provider documentation must support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by supporting contemporaneous documentation are subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

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	CORRESPONDING REGULATION(S)	BI	FIS	CL
EMPLOYMENT & DAY OPTIONS				
Benefits Planning Services	12VAC30-122-280	✓	✓	✓
Community Coaching Services	12VAC30-122-310	✓	✓	✓
Community Engagement Services	12VAC30-122-320	✓	✓	✓
Employment & Community Transportation	12VAC30-122-400	✓	✓	✓
Group Day Services	12VAC30-122-380	✓	✓	✓
Group & Individual Supported Employment	12VAC30-122-400	✓	✓	✓
Workplace Assistance Services	12VAC30-122-570		✓	✓

BENEFITS PLANNING

Service Definition/Description

Benefits planning is an individualized analysis and consultation service. This service assists recipients of a DD waiver and social security (SSI, SSDI, SSI/SSDI) to understand their personal benefits and explore their options regarding working, how to begin employment, and the impact employment will have on their state and federal benefits. This service includes education and analysis about current benefits' status and implementation and management of state and federal work incentives as appropriate. Benefits planning involves the development of written resource materials which aid individuals and their families/legal representatives in understanding current and future rewards that come from working, thereby reducing uncertainties associated with losing necessary supports and benefits if they choose to work or stay on the job. This service facilitates individuals in making informed choices concerning the initiation of work. Furthermore, it provides information and education to individuals currently employed in making successful transition to financial independence.

Criteria/Allowable Activities

Each of the allowable activities is available contingent on the individual meeting criteria for receipt of the service activity. Receipt of this service must not be tied to the receipt of any other covered waiver or Medicaid service. Benefits planning is authorized on a calendar year basis. This service may only be authorized one time per allowable activity per individual per calendar year. However, a service may be reauthorized within a calendar year if the individual's situation has changed in terms of disability conditions, benefit type, or employment status.

Allowable activities include the following, which may be appropriate for the individual as documented in his plan for supports:

- Pre-employment Benefits Review which may include:

    - Benefits Planning Query (BPQY from Social Security Administration (SSA). Description: A BPQY provides information about an individual's disability cash benefits, health insurance, scheduled continuing disability reviews, representative payee, and work history, as stored in SSA's electronic records. The BPQY is an important planning tool for the individual or other person who may be developing customized services for an individual who expresses interest in employment or remaining on the job.

    - Pre-employment Benefits Summary and Analysis (BS&A). Description: Work with and on behalf of the individual to develop a benefits and net income analysis report with both a current scenario and at least two other potential scenarios involving Social Security work incentives.

    - Employment Change Benefits Summary and Analysis. Description: Work with and on behalf of the individual when he/she experiences a change in employment status to develop a benefits and net income analysis report with both a current scenario and at least two other potential scenarios involving Social Security work incentives.

- Work Incentives Development or Revisions (PASS, IRWE, BWE, IDA): Work with the individual and family/legal representative to develop:

    - Plan to Achieve Self-Support (PASS):

        - Part 1 description: In collaboration with the individual and support system, develop a Plan to Achieve Self-Support (PASS) and ensure submission to the SSA.

        - Part 2 description: Ensure the approval of the PASS plan from the SSA PASS Cadre through modifications or other appropriate services.

    - Impairment Related Work Expenses (IRWE). Description: IRWEs reduce the amount of income that Social Security counts against an individual's benefits by deducting the expense from their total countable wages. In order to qualify for the IRWE, the expense must be related to the individual's disability, work, and be an expense without which he cannot work. This service involves working with the individual to develop and submit appropriate forms and supporting documents to SSA, to successfully obtain the IRWE work incentive.

    - Blind Work Expenses (BWE). Description: Work with and on behalf of an individual confirmed to be blind to develop and submit appropriate forms and

supporting documents to SSA, to successfully obtain the BWE work incentive. Given these circumstances, SSI will not count any earned income when the primary diagnosis is blindness and the expense is reasonably attributed to earning the income, i.e., guide dog, transportation to and from work, etc.

- Individual Development Accounts (IDA). Description: Work with and on behalf of the individual to develop matched asset building savings accounts to assist him/her in saving towards the purchase of a lifelong asset such as a home, education, or to start a business.

- Student Earned Income Exclusion (SEIE). Description: Work with and on behalf of the individual to develop and submit appropriate documents to SSA to receive benefits under the SEIE work incentive. SEIE allows individuals under the age of 22 who regularly attend school or are involved in a vocational education program to exclude earned income up to a certain amount per a month.

- Medicaid While Working – Section 1619(b). Description: Work with and on behalf of the individual to develop and submit an appropriate letter and supporting documents to SSA, local Virginia Department of Social Services (VDSS – Medicaid Eligibility Worker, and Medicaid to receive benefits under 1619(b), which provides the continuation of Medicaid when a beneficiary loses his SSI due to earnings above the SSI threshold.

- Medicaid Works (Virginia's Medicaid Buy-In Program). Description: Work with and on behalf of the individual who is currently eligible for and/or receiving Medicaid to complete and submit the MEDICAID WORKS agreement and supporting documents to the local VDSS, to enroll in the Medicaid Buy-In program (may include Medicaid application or updating the resource section of the Medicaid application). This enables workers with disabilities the opportunity to earn higher income and retain more in savings or resources than is typically allowed by Medicaid. For individuals receiving the DD waiver, DMAS DD staff notify either DBHDS and/or the DD waiver individual's CSB/Support Coordinator of the requirement to hold the DD waiver slot **for up to a 180-day grace period**.

- Work Incentive Revisions. Description: Work with and on behalf of the individual to revise one of the work incentives plans above as determined necessary by a significant change in status.

- Resolution of SSA benefits issues (e.g., Overpayments, Subsidies, Student Earned Income Exclusion, Medicaid While Working)

  - Overpayments. Description: Work with and on behalf of the individual to address Social Security overpayments that arise.

- Subsidies. Description: Work with and on behalf of the individual to develop and submit appropriate documents to SSA to receive the subsidy work incentive.

- Work Activity Reports. Description: Assist the individual family/legal representative in filling out and returning forms to SSA.

- Other Services

  - ABLEnow. Description: Work with and on behalf of the individual and family, if applicable, to open an ABLEnow account to assist the individual to pay for various expenses related to maintaining health, independence and quality of life.

  - Financial Health Assessment. Description: The Financial Health Assessment (FHA) is a tool used to gauge an individual's understanding of his current financial situation.

Service Limitations

Providers may not bill for waiver Benefits Planning services while the eligible individual has an open employment services case with the Department for Aging and Rehabilitative Services (DARS) and is eligible for the same service through DARS.

The annual plan limit for Benefits Planning services is $3,000. No unspent funds from one plan year may be accumulated and carried over to subsequent plan years. The table below denotes allowable units per service within Benefits Planning.

Plan for Achieving Self-Support-Part 1	7.0 hours
Plan for Achieving Self Support-Part 2	12.5 hours
Impairment Related Work Expense	9.0 hours
Blind Work Expense	9.0 hours
1619(b) Medicaid	4.5 hours
Student Earned Income Exclusion	9.0 hours
Subsidy	9.0 hours
Work Activity Reports:	6.0 hours
Medicaid Works	5.5 hours
Overpayment	3.5 hours
Benefits Planning Query	1.0 hours
Pre-Employment BSA	7.0 hours
WorkWORLD Summary and Analysis	7.0 hours
Individual Development Accounts	7.0 hours
Section 301/Able Now	4.5 hours
Financial Health Assessment	3.5 hours
WI Revisions	7.0 hours

The delivery of this service requires a face to face contact with the individual to determine his/her needs and review the product that was developed; however, the actual development of the product/report may be done without the individual present.

Service Documentation Requirements

- Providers must include in each individual's record:
    - The provider's plan for supports that includes the following elements:
        - The individual's desired outcomes that describe what is important to and for the individual in observable and measurable terms;
        - Support activities and support instructions that reflect the service being provided and that are designed to assist in achieving the individual's desired outcomes;
        - The services to be rendered, a timetable for the accomplishment of the individual's desired outcomes and support activities, the estimated duration of the individual's need for services, and the provider responsible for overall coordination and integration of the services specified in the plan for supports.
- Documentation in the form of a note which confirms the amount of time spent with the individual, as well as the amount of time dedicated to completion of the work surrounding the benefits planning activity/document.
- Documentation to support units of service delivered, and the documentation must correspond with billing. Providers must maintain separate documentation for each type of service rendered for an individual.
- All completed documents (the actual product or report that is the outcome of the service) as they relate to Benefits Planning activities. If the individual or the family has withdrawn from the process prior to the document's completion, all portions that were completed should be documented along with a note that describes the circumstances during each session.
    - A written review supported by documentation in the individual's record must be submitted to the support coordinator quarterly, during any quarters in which the service was provided, with the plan for supports, signed by the individual or family member/caregiver, as appropriate, if the plan for supports is modified.
    - Each quarterly person-centered review must contain the following elements:

- A description of the status of each outcome in the plan for supports. Possible statuses include whether the outcome has been achieved, if progress is being made as expected, or if there has been limited or no progress. Any actions needed or that will be taken to resolve barriers or improve progress is noted;

- Information about any newly identified safety risks;

- Any changes desired by the individual or family member/caregiver, as applicable and his/their satisfaction with services;

- Confirmation that all approved services were delivered according to the amount detailed in the plan, or, if not, the reason; and

- Any significant events.

The content of each review must be discussed with the individual and family member/caregiver, as applicable and submitted to the support coordinator within 10 calendar days following the end of each quarter. The discussion must be documented either by the individual and family member/caregiver's signature on the review or a progress note describing the discussion. The due date for the person-centered review is determined by the effective date of the Individual Support Plan and communicated to the provider by the support coordinator.

- Documentation that all available and appropriate funding sources (including those offered by Virginia Medicaid State Plan, the DARS, and the Department of Education (DOE) have been explored and exhausted.

- All correspondence to the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS.

- Provider documentation must support all claims submitted for DMAS reimbursement. Claims that are not supported by appropriate documentation are subject to recovery by DMAS as a result of utilization reviews and audits.

COMMUNITY COACHING

Service Definition/Description

Community coaching is a service designed for individuals who need one-to-one support in a variety of community settings in order to build a specific skill or set of skills to address a particular barrier or barriers identified in their person-centered ISP that prevent individuals from participating in activities of community engagement. In addition to skill building, this service includes routine and safety supports.

The service is individualized for each person. Each person's journey towards community integration is different and may involve multiple steps towards building relationships and natural supports. These steps should progressively build on each other with the end result being the development of relationships and natural supports. Documentation should capture the progress and the individual's response to each step.

Established definitions of "relationships" include the diverse ways individuals associate and connect. One aspect of community integration is having a variety of relationships of varied intensities and depths. These relationships enable individuals to navigate their community more independently and with natural supports.

Relationships should be considered in context of the setting and do not require individuals to connect with the same person at each location but instead to engage with others in the settings and reduce reliance on staff in community settings and increase autonomy and independence. Examples of this include (but are not limited to)

- Requesting location of a restroom from an employee at the location instead of staff,
- Understanding non-verbal cues from others about when to engage,
- When to continue to engage, and when to end engagement.

Additionally, establishing relationships for individuals with non-verbal communication methods include helping to translate non-verbal responses for community members, modeling for community members how to engage with individuals with non-verbal communication skills, and encouraging that direct interaction.

Criteria/Allowable Activities

Community coaching services are available to individuals enrolled in the FIS, CL and BI waivers.

Skill building must be a component of this service unless the individual has a documented progressive condition, in which case community coaching services may focus on maintaining skills and functioning and preventing or slowing regression rather than acquiring new skills or improving existing skills. Each individual's Plan for Supports should minimally have one skill building activity around engagement with community members and one skill building activity around addressing the documented barrier to community engagement.

In addition to being designed to address barriers to engagement, Community Coaching is also intended to be time limited per barrier or steps to address barrier. If progress is not being made, the provider should revisit the barrier and current methodology for addressing this. The meaning of "time limited" is dependent on the individual and his/her support needs. For some individuals time limited may mean six months while for others there are multiple barriers that require specific and targeted intervention. "Barriers to engagement" include a variety of issues and concerns based on the individual's needs. Some examples of barriers to engagement include behavioral support

needs, mobility support needs that cannot be addressed as part of a group, and medical support needs such as for individuals with epilepsy where the provider must assess environments to ensure they do not trigger seizure activity.

While each intervention may be time limited, the service itself may be approved for extended periods of time.

Community coaching activities and supports must be contained in the Plan for Supports and be sensitive to the individual's age, abilities, and personal preferences.

- Allowable activities include:

- One-on-one skill-building and coaching to facilitate participation in community activities and opportunities such as:

    - Activities and public events in the community;
    - Community education, activities, and events, and;
    - Use of public transportation, if available and accessible.

- Skill building and support in positive behavior, relationship building and social skills;

- Routine supports with the individual's self-management, eating and personal care needs in the community. It is permissible for individuals to return to a central location to care for plan-specific hygiene issues;

- Assuring the individual's safety through one to one supervision in a variety of community settings;

- Monitoring the individual's health and physical condition and providing supports with medication and other medical needs; and

- Providing routine supports and safety supports with transportation to and from community locations and resources.

Service Limitations

This service must be provided to one individual at a time per activity with at least one staff person and not as part of a group.

Other than time for planning community activities or if individuals need to return to a central location for plan-specific hygiene issues, this service must be delivered in the community and may

not take place in a licensed residential or day setting or the individual's residence. These activities may not exceed ten percent of the total number of authorized hours per month.

Community coaching should not be used to supplant the expectation of community involvement of other providers or services (e.g., residential), nor should it limit the number and type of staff/others with whom the individual can participate in community activities. Community coaching starts for reimbursement purposes when the individual is en-route to his identified activity. Transportation time should not exceed the value of the activity (for example the provider would not drive one hour to a store when another location of that same store is 10 miles away). This does not negate that there are special events which require longer transportation time.

The community coaching service, alone or in combination with the community engagement service, group day service, workplace assistance service, or supported employment service must not exceed 66 hours per week.

Semi-Predictable Events

Semi-predictable events include, but are not limited to, events such as illness, inclement weather resulting in the closing of day service sites, holidays, individual choice, etc. If a day services provider provides two or more of the following services to an individual (Group Day, Community Engagement, Community Coaching) and flexibility is required to accommodate individual choice and preference and/or inclement weather, etc., then the provider may request additional hours to their service authorization request for the combination of these services. The provider may request up to 10 additional hours of community coaching per week that will allow the individual to choose additional community coaching outings. These hours should be proportional to the requested amount of community coaching.

In no circumstances can the additional hours total more than 66 hours per week. The request must include the reason for the additional hours and the provider must state that they understand that only services delivered will be billed. Attendance log and provider documentation must be maintained to verify service delivery.

The service authorization staff will add the additional hours provided to that month's authorized hours. Service authorization requests may be submitted after, but in the same month as service delivery.

60-Day Assessment

A provider may use a 60-day assessment period for evaluating the individual's need for specific supports. If a provider utilizes an assessment period prior to development and integration of an annual Plan for Supports, a preliminary Plan for Supports must be developed with the team, based

on information in the Personal Profile, Essential Information, the Virginia SIS® or other DBHDS-approved assessment, in addition to other assessment information available to the provider. The Plan for Supports must include the areas to be evaluated and a schedule of services to be provided. Prior to the last day of the assessment period, the provider, with the involvement of the individual, must develop an annual Plan for Supports, and forward it to the case manager for review, approval and reauthorization if required. The start date of the annual Plan for Supports must be no later than day 61 and the end date must correspond to the end date of the annual Individual Support Plan.

Customized Rate

Providers supporting individuals with extraordinary medical or behavioral supports needs, may apply for the customized rate for additional community coaching supports delivered by the provider. See the Customized Rate section per 12VAC30-122-210.

Service Units

The unit of service is one hour.

Service Documentation Requirements

Providers must include signed and dated documentation of the following in each individual's record:

- A completed copy of the age-appropriate, DBHDS-approved SIS® assessment form.
- The provider's Plan for Supports containing, at a minimum, the following elements:
    - The individual's desired outcomes that describe what is important to and for the individual in observable and measurable terms,
    - Support activities and support instructions that are inclusive of skill-building and that are designed to assist in achieving the individual's desired outcomes,
    - The services to be rendered and the schedule of such services to accomplish the desired outcomes and support activities,
    - A timetable for the accomplishment of the individual's desired outcomes and support activities,
    - The estimated duration of the individual's needs for services,
    - The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports.

- Written documentation in the form of unique, person-centered, progress notes or data collected in a supports checklist as appropriate, per the plan for supports. This documentation must confirm the individual's days in service to support units of service delivered and provide specific information regarding the individual's responses to various settings and supports, as well as specific circumstances that prevented provision of the scheduled service, should that occur. Observations of the individual's responses to the service must be available in at least a daily note. Data must be collected as described in the ISP, analyzed to determine if the strategies are effective, summarized, then clearly documented in the progress notes or supports checklist. Documentation should be written, signed, and dated on the day the described supports were provided. Documentation that occurs after the date services were provided must be dated with the date the documentation was completed and also include the date the services were provided within the body of the note.

    - An attendance log or similar document maintained by the provider that indicates the date, type of service rendered, and the number of hours and units provided, including specific timeframe;

    - Documentation must correspond with billing. Providers must maintain separate documentation for each type of service rendered for an individual. Providers' claims that are not adequately supported by corresponding documentation may be subject to recovery of expenditures made; and

    - In a situation whereby the individual’s needs have changed significantly, the plan for supports must be reviewed by the provider. A written review must be completed and supported by documentation in the individual’s record for submission to the support coordinator at least quarterly with the plan for supports, if modified. Each quarterly person-centered review must contain the following elements:

- The plan for supports, if modified. Each quarterly person-centered review must contain the following elements:

    - A description of the status of each outcome in the plan for supports. Possible statuses include whether the outcome has been achieved, if progress is being made as expected, or if there has been limited or no progress. Any actions needed or that will be taken to resolve barriers or improve progress is noted;

    - Information about any newly identified safety risks;

    - Any changes desired by the individual or family member/caregiver, as applicable and his/their satisfaction with services;

- Confirmation that all approved services were delivered according to the amount detailed in the plan, or, if not, the reason; and
- Any significant events.

- The content of each review must be discussed with the individual and family member/caregiver, as applicable and submitted to the Support Coordinator within 10 calendar days following the end of each quarter. The discussion must be documented either by the individual and family member/caregiver's signature on the review or a progress note describing the discussion. The due date for the person-centered review is determined by the effective date of the Individual Support Plan and communicated to the provider by the support coordinator. Four written reviews span the entire ISP year. For the annual updates to the plan for supports and every time supporting documentation is updated, the update must be reviewed with the individual and family member/caregiver, as appropriate, and such review must be documented, either by the individual and family member/caregiver's signature on the review, or a progress note describing the discussion.
  - All correspondence with the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS.
  - Written documentation of contacts made with individual's family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual.
  - For the annual review and in cases where the Plan for Supports is modified, the team must work collaboratively to implement changes needed or desired by the individual. Changes in the Plan for Supports should be shared with the support coordinator and other participating providers, as appropriate.
  - Provider documentation must support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by supporting documentation are subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

COMMUNITY ENGAGEMENT

Service Definition/Description

Community engagement services support and foster an individual's abilities to acquire, retain, or improve skills necessary to build positive social behavior, interpersonal competence, greater independence, employability, and personal choices necessary to access typical activities and functions of community life such as those chosen by the general population. These may include participating in community education or training and volunteer activities.

Community engagement provides a wide variety of opportunities to facilitate and build relationships and natural supports in the community, while utilizing the community as a learning environment. These activities are conducted at naturally occurring times and in a variety of natural settings in which the individual actively interacts with persons without disabilities (other than those paid to support the individual). The activities enhance the individual's involvement with the community and facilitate the development of relationships and natural supports.

The service is individualized for each person. Each person's journey towards community integration is different and may involve multiple steps towards building relationships and natural supports. These steps should progressively build on each other and the end result would be the development of relationships and natural supports. Documentation should capture the progress and the individual's response to each step.

Established definitions of "relationships" include the diverse ways individuals associate and connect. One aspect of community integration is having a variety of relationships of varied intensities and depths. These relationships enable individuals to navigate their community more independently and with natural supports.

Relationships should be considered in context of the setting and do not require individuals to connect with the same person at each location but instead to engage with others in the settings and reduce reliance on staff in community settings and increase autonomy and independence. Examples of this include (but are not limited to):

- Requesting location of a restroom from an employee at the location instead of staff,
- Understanding non-verbal cues from others about when to engage,
- When to continue to engage, and when to end engagement.

Additionally, establishing relationships for individuals with non-verbal communication methods include helping to translate non-verbal responses for community members, modeling for community members how to engage with individuals with non-verbal communication skills, and encouraging that direct interaction.

Criteria/Allowable Activities

Community engagement is available to individuals enrolled in the FIS, CL, and BI waivers. This is not a center-based service. Community engagement activities and supports must be contained in the Plan for Supports and be sensitive to the individual's age, abilities, and personal preferences. This service must be provided in the least restrictive and most integrated community settings possible according to the individual's Plan for Supports and individual choice. In addition, community engagement service is available for individuals who can benefit from the supported employment service, but who need community engagement service as an appropriate alternative or in addition to the supported employment service.

Skill building must be a component of this service unless the individual has a documented progressive condition, in which case community engagement services may focus on maintaining skills and functioning and preventing or slowing regression rather than acquiring new skills or improving existing skills.

Allowable activities may include, as appropriate for the individual as documented in his/her plan for supports:

- Skill building, education, support, and monitoring that assists the individual with the acquisition and retention of skills in the following areas while in the community:
    - Participation in activities and public events in the community;
    - Participation in community educational activities and events;
    - Development of interests and activities that encourage therapeutic use of leisure time (where therapeutic use is defined as use that promotes social, emotional, physical, and/or personal wellbeing development);
    - Participation in volunteer experiences, including those that might lead to determining employment interests;
    - Maintenance of contact with family and friends (the individual must have a documented need for skill development to maintain healthy relationships with identified friends or family); and
    - Development of independence in activities of daily living.
- Skill building and education in self-direction designed to enable the individual to achieve one or more of the following outcomes particularly through community collaborations and social connections developed by the provider (e.g., partnerships with community entities such as senior centers, arts councils, etc.):
    - Development of self-advocacy skills (e.g., appropriately speaking up for oneself with one’s family, friends, potential employers, community members, or policy makers. This could also include effective public speaking.);
    - Exercise of civil rights (defined as the rights of individuals to receive equal treatment and to be free from unfair treatment or "discrimination" in a number of settings, including education, employment, housing, and includes activities such voting, public speaking, visiting political officials, key decision makers. This is not an inclusive list of possibilities.);

- Acquisition of skills that promote the ability to exercise self-control and responsibility over services and supports received or needed;
- Acquisition of skills that enable the individual to become more independent, integrated, or productive in the community;
- Development of communication skills and abilities;
- Furtherance of spiritual practices as desired by the individual;
- Participation in cultural activities as desired by the individual;
- Development of skills that enhance career planning goals in the community, where "career planning" includes gaining information to make an informed decision about whether a person wants to work, as well as exploring types of work opportunities and gaining information regarding the person's employment interests and preferences;
- Development of independent living skills;
- Promotion of health and wellness, including administration of medication;
- Development of orientation to the community and mobility in the community;
- Access to and utilization of public transportation so as to develop the ability to achieve the desired destination;
- Interaction with volunteers from the community in program activities.

- Providing routine supports and safety supports with transportation to and from community locations and resources.

Service Limitations

Community engagement may include planning community activities with the individual or individuals present in a group of no more than three individuals. Other than time for planning community activities or if individuals need to return to a central location to care for plan-specific hygiene issues, this service must be delivered in the community and may not take place in a licensed residential or day setting or the individual's residence. These activities may not exceed 10 percent of the total number of authorized hours per month.

Community engagement:

- Should not be used to supplant the expectation of community involvement of other providers or services (e.g., residential);

- Should not limit the number and type of staff/others with whom the individual can participate in community activities; and

- May be provided in groups no larger than three individuals with a minimum of one DSP per activity per provider.

The provider may transport six individuals to two staff to the community but individuals must participate in separate and distinct activities according to the maximum group size. Community engagement begins when the individuals are en route to their identified activity. Transportation time should not exceed the value of the activity (for example the provider would not drive one hour to a store when another location of that same store is 10 miles away.) However, it does not negate that there are special events in which it would be beneficial for the individual to participate that require longer transportation time.

Community engagement service alone or in combination with the group day service, community coaching service, workplace assistance service, or supported employment service must not exceed 66 hours per week.

Semi-Predictable Events

Semi-predictable events include, but are not limited to, events such as illness, inclement weather resulting in the closing of day service sites, holidays, individual choice, etc. If a day services provider provides two or more of the following services to an individual (Group Day, Community Engagement, Community Coaching) and flexibility is required to accommodate individual choice and preference and/or inclement weather, etc., then the provider may request additional hours to their service authorization request for the combination of these services. The provider may request up to 10 additional hours of community engagement per week that will allow the individual to choose additional community outings. These hours should be proportional to the requested amount of community engagement.

In no circumstances can the additional hours total more than 66 hours per week. The request must include the reason for the additional hours and the provider must state that they understand that only services delivered will be billed. Attendance log and provider documentation must be maintained to verify service delivery.

The service authorization staff will add the additional hours provided to that month's authorized hours. Service authorization requests may be submitted after, but in the same month as service delivery.

60-Day Assessment

A provider may use a 60-day assessment period for evaluating the individual's need for specific supports. If a provider utilizes an assessment period prior to development and integration of an annual Plan for Supports, a preliminary Plan for Supports must be developed with the team, based

on information in the Personal Profile, Essential Information, the SIS® or other DBHDS-approved assessment, in addition to other assessment information available to the provider. The Plan for Supports must include the areas to be evaluated and a schedule of services to be provided. Prior to the last day of the assessment period, the provider, with the involvement of the individual, must develop an annual Plan for Supports, and forward it to the case manager for review, approval and reauthorization if required. The start date of the annual Plan for Supports must be no later than day 61 and the end date must correspond to the end date of the annual Individual Support Plan.

Service Units

The unit of service is one hour.

Community engagement is a tiered service for reimbursement purposes. Providers will only be reimbursed for the tier to which the individual has been assigned based on the individual's assessed and documented needs.

Service Documentation Requirements

Providers must include signed and dated documentation of the following in each individual's record:

- A completed copy of the age-appropriate, DBHDS-approved SIS® assessment form.
- The provider's Plan for Supports containing, at a minimum, the following elements:
    - The individual's desired outcomes that describe what is important to and for the individual in observable and measurable terms;
    - Support activities and support instructions that are inclusive of skill-building and that are designed to assist in achieving the individual's desired outcomes;
    - The services to be rendered and the schedule of such services to accomplish the desired outcomes and support activities; and
    - A timetable for the accomplishment of the individual's desired outcomes and support activities.
- The estimated duration of the individual's needs for services;
- The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports;

- Written documentation in the form of unique, person-centered, progress notes or data collected in a supports checklist as appropriate, per the plan for supports. This documentation must confirm the individual's days in service to support units of service delivered and provide specific information regarding the individual's responses to various settings and supports, as well as specific circumstances that prevented provision of the scheduled service, should that occur. Observations of the individual's responses to the service must be available in at least a daily note. Data must be collected as described in the ISP, analyzed to determine if the strategies are effective, summarized, then clearly documented in the progress notes or supports checklist. Documentation should be written, signed, and dated on the day the described supports were provided. Documentation that occurs after the date services were provided must be dated with the date the documentation was completed and also include the date the services were provided within the body of the note;

- An attendance log or similar document maintained by the provider that indicates the date, type of service rendered, and the number of hours and units provided, including specific timeframe;

- Documentation must correspond with billing. Providers must maintain separate documentation for each type of service rendered for an individual. Providers' claims that are not adequately supported by corresponding documentation may be subject to recovery of expenditures made;

- In a situation whereby the individual's needs have changed significantly, the plan for supports must be reviewed by the provider. A written review must be completed and supported by documentation in the individual's record for submission to the support coordinator at least quarterly with the plan for supports, if modified. Each quarterly person-centered review must contain the following elements:

    - A description of the status of each outcome in the plan for supports. Possible statuses include whether the outcome has been achieved, if progress is being made as expected, or if there has been limited or no progress. Any actions needed or that will be taken to resolve barriers or improve progress is noted,

    - Information about any newly identified safety risks;

    - Any changes desired by the individual or family member/caregiver, as applicable and his/their satisfaction with services;

- Confirmation that all approved services were delivered according to the amount detailed in the plan, or, if not, the reason; and

- Any significant events.

The content of each review must be discussed with the individual and family member/caregiver, as applicable and submitted to the Support Coordinator within 10 calendar days following the end of each quarter. The discussion must be documented either by the individual and family member/caregiver's signature on the review or a progress note describing the discussion. The due date for the person-centered review is determined by the effective date of the Individual Support Plan and communicated to the provider by the support coordinator. Four written reviews span the entire ISP year. For the annual updates to the plan for supports and every time supporting documentation is updated, the update must be reviewed with the individual and family member/caregiver, as appropriate, and such review must be documented, either by the individual and family member/caregiver's signature on the review, or a progress note describing the discussion.

- All correspondence with the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS.

- Written documentation of contacts made with individual's family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual.

- For the annual review and in cases where the Plan for Supports is modified, the team must work collaboratively to implement changes needed or desired by the individual. Changes in the Plan for Supports should be shared with the support coordinator and other participating providers, as appropriate.

- Provider documentation must support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by supporting documentation are subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

EMPLOYMENT AND COMMUNITY TRANSPORTATION (ECT)

Service Definition/Description

This service is offered in order to enable individuals to gain access to their place of employment or volunteer activity, other community services or events, activities and resources, homes of family or friends, civic organizations or social clubs, public meetings or other civic activities, and spiritual activities or events as specified by the ISP and when no other means of access is available. The goal of this service is to promote the individual's independence and participation in the life of his/her community. Use of this service is related to the individual's desired outcomes as stated in the ISP. This service is offered in addition to Medicaid funded medical transportation and

transportation services covered under the State plan to and from waiver-funded services, and does not replace them.

Criteria/Allowable Activities

The service may include transportation in a private vehicle by a person such as a co-worker or other community member or the purchase of tickets for public transportation such as bus or subway. In either case, an administering agency must coordinate and bill DMAS.

Up to three individuals may be transported in a single, private vehicle per trip.
The administering agency will ensure that pertinent information about the individual is relayed to the driver of the private vehicle. This may include emergency contact, known medical or behavioral challenges that might impact the driver, other passengers, or the individual while traveling.

The individual and the ECT administering agency must develop an ECT Trip Plan (DMAS – P258) and submit the Trip Plan to the support coordinator. A printout from MapQuest or Google Maps or similar printout for each trip must accompany the Trip Plan to verify the mileage from the point of origin to the destination. Both of these will be submitted for service authorization. Service authorization staff must verify that:

- The trips are related to an ISP goal (e.g., the trip purpose and frequency is congruent with the ISP goal);
- The trips are for non-medical purposes;
- The trip distance estimates are accurate; and
- Whether the individual receives other direct support services from the ECT provider (e.g., employment services, residential services, personal assistance services, etc.). If so, staff will confirm that the proposed private community driver is not a member of the ECT administering provider's staff.

When ECT providers coordinate transportation using a private vehicle with a community driver, service authorization staff will authorize each "one-way trip" and the estimated number of trips per month. A one-way trip begins at the eligible rider's point of origin and ends when the eligible rider reaches his/her destination.

Service Limitations

This service may not be authorized or reimbursed for individuals who can access transportation through the State Plan or other waiver services which include a transportation component. The

individual or legal guardian must attest that he/she does not have sufficient personal financial resources (e.g., through wages) to cover the cost of the transportation himself/herself.

The purchase of tickets for public transportation and dissemination to the individual is coordinated by the administering agency.

An administering agency delivering other waiver services to an individual may not utilize staff to provide ECT and may only bill ECT if the transportation is not a normally required element of service provision (i.e., an allowable activity for the other service(s) the provider delivers to that individual).

The administering agency may not bill for a rider who is not ECT-approved (e.g., a passenger who is the driver's family member, friend, etc.).

Service Units

Private transportation is reimbursed according to a "trip" (which is reimbursed for the round-trip) and the number of individuals being transported to the location (maximum of three). There are three trip rates depending on the **one-way** distance traveled:

- Under 10 miles
- Between 10 – 20 miles
- Over 20 miles.

The trip rate is determined based upon distance traveled, the number of ECT-approved riders, and the rate schedule for the geographic location where the transportation takes place. An administrative cost reimbursement is built into each trip rate.

When a private driver is transporting more than one individual to a single destination, the trip rate for all individuals is the same and is determined by the distance between the first individual picked up and the final destination. For example, the driver picks up individual A and then individual B to take them both to the same workplace. Individual A lives 15 miles from their place of employment. Individual B lives 9 miles from that destination. The administering provider may bill the 10 – 20 mile trip rate for both individuals. Included in that rate is reimbursement for the driver's return trip after dropping off the individuals.

When the ECT administering provider arranges access to public transportation by purchasing public transportation fares such as bus or rail tokens, tickets, passes, fare cards, etc., service authorization staff approves the actual fare cost plus the administrative fee.

Service Documentation Requirements

Administering providers must include in each individual's record:

- A copy of the completed, standard, age-appropriate assessment form, such as the Supports Intensity Scale®.

- The provider's plan for supports in the form of the ECT Trip Plan form.

- Documentation of the trip distance estimate in the form of a MapQuest, Google Maps, or similar printout with point of origin/destination and mileage.

- Documentation to support units of service delivered in the form of a monthly trip log (DMAS-P259) signed by the individual or caregiver/guardian, as appropriate, recording trips taken, that must correspond with billing. Providers must maintain separate documentation for each type of service rendered for an individual.

- A written review, supported by documentation in the individual's record, must be submitted to the support coordinator quarterly, during any quarters in which the service was provided and if modified, with the plan for supports. This written review must list the dates and destinations of trips taken and a statement about the individual's satisfaction with the service. The quarterly person-centered review is due to the Support Coordinator no later than 10 days following the end of the quarter. For the annual review and every time the Plan for Supports is updated, the revised Plan for Supports will be reviewed with the individual or family/caregiver, as appropriate, and such review must be documented.

- For private drivers:

    - Copies of valid drivers' licenses;
    - Copies of the automobile insurance policies;
    - Copies of driving records;
    - Criminal records attestations and Virginia Sex Offender Registry record checks,
    - The driver is responsible for notifying the agency if there are any changes to previously submitted attestations or significant driving record changes vs. requiring the agency to have to obtain this information each year.

- For public transportation, receipts for purchases of bus tickets or fare cards.

- All correspondence to the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS.

- Written documentation of all contacts with family/caregiver, physicians, formal and informal service providers, and all professionals regarding the individual.

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GROUP DAY SERVICES

Service Definition/Description

Group day services are those services designed to enable the individual to acquire, retain, or improve skills of self-help, socialization, community integration, career planning and adaptation via opportunities for peer interactions, community integration, and enhancement of social networks. This service is typically offered in a non-residential setting. Group day is a tiered service for reimbursement purposes.

Group Day activities and supports must be detailed in the Plan for Supports and be sensitive to the individual's age, abilities, and personal preferences.

Criteria/Allowable Activities

Group day services are available to individuals enrolled in the FIS, CL, and BI waivers.

While routine supports may be provided, skill building must be a component of this service unless the individual has a documented progressive condition, in which case group day services may focus on maintaining skills and functioning and preventing or slowing regression rather than acquiring new skills or improving existing skills.

For group day services, an individual must demonstrate the need for skill-building or supports offered primarily in settings other than the individual's own residence that allows an opportunity for being a productive and contributing member of his community. In addition, group day service is available for individuals who can benefit from the supported employment service, but who need group day service as an appropriate alternative or in addition to the supported employment service.

Allowable activities may include, as may be appropriate for the individual as documented in his plan for supports:

- Developing problem-solving abilities, sensory, gross and fine motor control abilities, communication, and personal care skills;
- Developing self, social, and environmental awareness skills;
- Developing skills as needed in:
    - Positive behavior;
    - Using community resources;
    - Community safety and positive peer interactions;
    - Volunteering and participating in educational programs in integrated settings;
    - Forming community connections or relationships.

- Supporting older adults in participating in meaningful retirement activities in their communities (i.e., clubs and hobbies);

- Skill building and routine supports related to ADLs and IADLs;

- Monitoring the individual's health and physical condition and providing supports with medication and other medical needs;

- Providing safety supports in a variety of community settings;

- Career planning and resume developing based on career goals, personal interests, and community experiences; and

- Providing routine supports and safety supports with transportation to and from community locations and resources.

Group day services should be coordinated with the therapeutic consultation plan and any physical, occupational, or speech/language therapies listed in the Individual Support Plan, as applicable.

Service Limitations

- Group day services occur one or more hours per day on a regularly scheduled basis for one or more days per week in settings that are separate from the individual's home;

- Group day staffing ratios are based on the activity and the individual's needs as set out in the individual's plan for supports. There must be at least one staff to seven individuals;

- Group day should not be used to supplant the expectation of community involvement of other providers or services (e.g., residential);

- Group day should not limit the number and type of staff/others with whom the individual can participate in community activities;

- Service providers will be reimbursed only for the amount of group day services that are rendered as established in the individual's approved Plan for Supports based on the setting, intensity, and duration of the service to be delivered.

Group day services cannot be provided in an individual's home or other residential setting without written, prior approval from DBHDS. In this situation, the Plan for Supports must clearly indicate the specific time frame and designate specific day support activities provided in the individual's home or other residential setting. Some examples include:

- An individual's group day Plan for Supports includes allowable support activities at a residential site (e.g., learning or practicing skills related to grounds maintenance), provided these activities are not routinely performed by residents of that home;

- A new individual, or one with serious emotional/behavioral challenges, requires a temporary "phase-in period," with the expected duration to be clearly indicated on the Plan for Supports, to become accustomed to staff, a schedule and routine, riding in a van or car, etc. Only one unit of group day services provided at the individual's home may be billed; and

- Individuals return from community settings to a residence for lunch. The "lunch location" and amount of time allotted for lunch (including preparation and cleanup) must be specified on the day support Plan for Supports."

In instances where group day services staff are required to ride with the individual from his/her home to group day service, the group day service staff time may be billed as group day service, provided that the billing for this time does not exceed 25% of the total time the individual spent in the group day service activity for that day. Documentation must be maintained to verify that billing for group day service staff coverage during transportation does not exceed 25% of the total time spent in the group day service for that day.

Semi-Predictable Events

Semi-predictable events include, but are not limited to, events such as illness, inclement weather resulting in the closing of day service sites, holidays, individual choice, etc. If a day services provider provides two or more of the following services to an individual (Group Day, Community Engagement, Community Coaching) and flexibility is required to accommodate individual choice and preference and/or inclement weather, etc., then the provider may request additional hours to their service authorization request for the combination of these services. The provider may request between 3-5 hours of additional group day services per week that will allow the individual to choose additional community outings. These hours should be proportional to the requested amount of community engagement.

In no circumstances can the additional hours total more than 66 hours per week. The request must include the reason for the additional hours and the provider must state that they understand that only services delivered will be billed. Attendance log and provider documentation must be maintained to verify service delivery.

The service authorization staff will add the additional hours provided to that month's authorized hours. Service authorization requests may be submitted after, but in the same month as service delivery.

60-Day Assessment

A provider may use a 60-day assessment period for evaluating the individual's need for specific supports. If a provider utilizes an assessment period prior to development and integration of an annual Plan for Supports, a preliminary Plan for Supports must be developed with the team, based on information in the Personal Profile, Essential Information, the SIS® or other DBHDS-approved assessment, in addition to other assessment information available to the provider. The Plan for Supports must include the areas to be evaluated and a schedule of services to be provided. Prior to the last day of the assessment period, the provider, with the involvement of the individual, must develop an annual Plan for Supports, and forward it to the case manager for review, approval and reauthorization if required. The start date of the annual Plan for Supports must be no later than day 61 and the end date must correspond to the end date of the annual Individual Support Plan.

Customized Rate

Providers supporting individuals with extraordinary medical or behavioral supports needs, may apply for the customized rate for additional community coaching supports delivered by the provider. See the Customized Rate section per 12VAC30-122-210.

Service Units

The service unit is an hour.

Group day services, alone or in combination with community engagement, community coaching, workplace assistance, or supported employment services, must not exceed 66 hours per week.

Group day service is a tiered service for reimbursement purposes. Providers will only be reimbursed for the individual's assigned level and tier.

Service Documentation Requirements

Providers must include signed and dated documentation of the following in each individual's record:

- A completed copy of the age-appropriate, DBHDS-approved SIS® assessment form.
- The provider's Plan for Supports containing, at a minimum, the following elements:
    - The individual's desired outcomes that describe what is important to and for the individual in observable and measurable terms;
    - Support activities and support instructions that are inclusive of skill-building and that are designed to assist in achieving the individual's desired outcomes;

  - The services to be rendered and the schedule of such services to accomplish the desired outcomes and support activities;
  - A timetable for the accomplishment of the individual's desired outcomes and support activities;
  - The estimated duration of the individual's needs for services.

- The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports.
- Documentation regarding any restrictions on the freedoms of everyday life in accordance with human rights regulations and the requirements of the Home and Community-based Services settings regulations (as found in 42 CFR 441.301).
- Written documentation in the form of unique, person-centered, progress notes or data collected in a supports checklist as appropriate, per the plan for supports. This documentation must confirm the individual's days in service to support units of service delivered and provide specific information regarding the individual's responses to various settings and supports, as well as specific circumstances that prevented provision of the scheduled service, should that occur. Observations of the individual's responses to the service must be available in at least a daily note. Data must be collected as described in the ISP, analyzed to determine if the strategies are effective, summarized, then clearly documented in the progress notes or supports checklist. Documentation should be written, signed, and dated on the day the described supports were provided. Documentation that occurs after the date services were provided must be dated with the date the documentation was completed and also include the date the services were provided within the body of the note.
- An attendance log or similar document maintained by the provider that indicates the date, type of service rendered, and the number of hours and units provided, including specific timeframe.
- Documentation must correspond with billing. Providers must maintain separate documentation for each type of service rendered for an individual. Providers' claims that are not adequately supported by corresponding documentation may be subject to recovery of expenditures made.
- In a situation whereby the individual’s needs have changed significantly, the plan for supports must be reviewed by the provider. A written review must be completed and supported by documentation in the individual’s record for submission to the support coordinator at least quarterly with the plan for supports, if modified. Each quarterly person-centered review must contain the following elements:

- A description of the status of each outcome in the plan for supports. Possible statuses include whether the outcome has been achieved, if progress is being made as expected, or if there has been limited or no progress. Any actions needed or that will be taken to resolve barriers or improve progress is noted;

- Information about any newly identified safety risks;

- Any changes desired by the individual or family member/caregiver, as applicable and his/their satisfaction with services;

- Confirmation that all approved services were delivered according to the amount detailed in the plan, or, if not, the reason; and

- Any significant events.

The content of each review must be discussed with the individual and family member/caregiver, as applicable and submitted to the Support Coordinator within 10 calendar days following the end of each quarter. The discussion must be documented either by the individual and family member/caregiver's signature on the review or a progress note describing the discussion. The due date for the person-centered review is determined by the effective date of the Individual Support Plan and communicated to the provider by the support coordinator. Four written reviews span the entire ISP year. For the annual updates to the plan for supports and every time supporting documentation is updated, the update must be reviewed with the individual and family member/caregiver, as appropriate, and such review must be documented, either by the individual and family member/caregiver's signature on the review, or a progress note describing the discussion.

- All correspondence with the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS.

- Written documentation of contacts made with individual’s family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual;

- For the annual review and in cases where the Plan for Supports is modified, the team must work collaboratively to implement changes needed or desired by the individual. Changes in the Plan for Supports should be shared with the support coordinator and other participating providers, as appropriate;

- Provider documentation must support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by supporting documentation is subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

SUPPORTED EMPLOYMENT

Service Definition/Description

Group and individual supported employment services consists of ongoing supports provided by a job coach that enables individuals to be employed in an integrated work setting where persons without disabilities are employed and may include assisting the individual, either as a sole individual or in small groups, to locate a job or develop a job on behalf of the individual, as well as activities needed by the individual to sustain paid work.

This service is available to individuals for whom competitive employment at or above the minimum wage is unlikely without ongoing supports and who because of their disabilities need ongoing support to perform in a work setting. Group and individual supported employment service may be provided in either of the following service models:

Individual Supported Employment (ISE) Service

Individual supported employment (ISE) service involves one-on-one support that enables individuals to work in an integrated setting. The outcome of this service is sustained paid employment at or above minimum wage in an integrated setting in the general workforce in a job that meets personal and career goals. For this service, reimbursement of supported employment is limited to actual documented interventions or collateral contacts by the provider as required by the individual receiving waiver services. Reimbursement may not be provided for the supervisory activities rendered as a normal part of the regular business setting nor for the amount of time the individual enrolled in the waiver, is merely in the supported employment situation.

Group supported employment (GSE) service

Continuous support provided by staff in a naturally occurring place of employment to groups of two to eight individuals with disabilities and involves interactions with the public and coworkers who do not have disabilities. This service must be provided in a community setting that promotes integration into the workplace and interaction in the workplace between waiver participants and people without disabilities. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in the community. Group supported employment settings must comply with the HCBS setting requirements per 42 CFR 441.301

Criteria/Allowable Activities

Through past experience or assessment information the individual must have demonstrated that competitive employment at or above the minimum wage is unlikely without ongoing supports and that because of the individual's disability, he/she needs ongoing support to perform in a work setting. The individual's assessment and ISP must clearly reflect the individual's need for employment-related skill-building.

This service is designed to support individuals in competitive, integrated positions for whom all options for independence in regards to appropriate job match, reasonable accommodations, and the utilization of natural supports in the workplace have been explored, exhausted and documented. This service is supplementary to individual supported employment in order to maintain stability in the workplace.

Allowable activities for both individual and group supported employment services include the following job development tasks, supports, and training. For DMAS reimbursement to occur, the individual must be present, unless otherwise noted, when these activities occur:

- Vocational or job-related discovery or assessment;
- Person-centered employment planning that results in employment related outcomes;
- Individualized job development, with or without the individual present that produces an appropriate job match for the individual and the employer to include job analysis or determining job tasks, or both;
    - This element is limited to ISE only and is not permitted for GSE;
- Negotiation with prospective employers, with or without the individual present;
- On-the-job training in work skills required to perform the job;
- Ongoing evaluation, supervision, and monitoring of the individual's performance on the job, which does not include supervisory activities rendered as a normal part of the business setting;
- Ongoing support necessary to ensure job retention, with or without the individual present;
- Supports to ensure the individual's health and safety during the hours of work;
- Development of work-related skills essential to obtaining and retaining employment, such as the effective use of community resources, break or lunch areas, and transportation

systems. This may not exceed 25% of the total amount of time the individual is actually being paid to work; and

- Staff provision of transportation between the individual's place of residence and the workplace when other forms of transportation are unavailable or inaccessible. The job coach must be present with the individual during the provision of transportation in order to be reimbursed.

The ISE service model may also consist of *Customized Employment* (CE). This flexible process is designed to personalize the employment relationship between a job candidate or employee and an employer in a way that meets the needs of both. It is based on identifying the strengths, conditions, and interests of a job candidate or employee beginning with discovery and concluding with post-employment supports.

The essential components of customized employment are:

- Discovery - Gathering information from the job seeker and the CE support team (a group of multiple partners, including the employment specialist who all jointly take some responsibility for the job seeker's needs; however, the job seeker is the ultimate decision-maker) to determine the job seeker's interests, skills, and preferences related to potential employment that guide the development of a customized job.

- Job Search Planning - Using the information learned about an individual job seeker in Discovery to develop a plan toward a meaningful employment, determine a list of potential employers, and conduct an informal analysis of benefits which may result in recommending that the SC seek the service of Benefits Planning.

- Job Development and Negotiation - Working collaboratively with the individual and the employer to negotiate a customized job; the provision of supports; and the terms of employment that will match the individual's interests, skills, conditions necessary for success, and specific contributions, and will fill the unmet needs of an employer.

Service Limitations

Only activities that specifically pertain to the individual will be allowable activities under the supported employment service and DMAS will cover this service only after determining that this service is not available from DARS or the local school system.

Group and individual supported employment service alone or in combination with the community engagement service, community coaching service, workplace assistance service, or group day service must not exceed 66 hours per week.

GSE must take place in nonresidential settings separate from the individual's home.

For time-limited and service authorized periods (not to exceed 24 hours) ISE may be provided and billed during the same hours as day services or residential services for purposes of discovery under customized employment.

Individual supported employment service can be provided simultaneously with the workplace assistance service to ensure that the workplace assistant is trained and appropriately supervised about supporting an individual through the best practices of individual supported employment. As well, Individual Supported Employment and personal assistance can be provided simultaneously to ensure the individual receives necessary personal care during the work day.

60-Day Assessment

A provider may use a 60-day assessment period for evaluating the individual's need for specific supports. If a provider utilizes an assessment period prior to development and integration of an annual Plan for Supports, a preliminary Plan for Supports must be developed with the team, based on information in the Personal Profile, Essential Information, the SIS® or other DBHDS-approved assessment, in addition to other assessment information available to the provider. The Plan for Supports must include the areas to be evaluated and a schedule of services to be provided. Prior to the last day of the assessment period, the provider, with the involvement of the individual, must develop an annual Plan for Supports, and forward it to the case manager for review, approval and reauthorization if required. The start date of the annual Plan for Supports must be no later than day 61 and the end date must correspond to the end date of the annual Individual Support Plan.

Service Unit

The unit of service for ISE and GSE is one hour, and the service is limited to 40 hours per week per individual.

Reimbursement for GSE is based on the size of the group.

ISE must be billed according to the DARS fee schedule.

Service Documentation Requirements

- Providers must include signed and dated documentation of the following in each individual's record:
    - A completed copy of the age-appropriate, DBHDS approved SIS®.
    - The provider's plan for supports containing, at a minimum, the following elements:
        - The individual's desired outcomes that describe what is important to and for the individual in observable and measurable terms;

- Support activities and support instructions that are inclusive of skill-building and that are designed to assist in achieving the individual's desired outcomes;

- The services to be rendered and the schedule of such services to accomplish the desired outcomes and support activities;

  - It should be noted that employment and employment related activities do not occur on a set schedule and so therefore a schedule for supports will be an estimation of when the supports will occur and may overlap with other services particularly during job development, situational assessments and placement and training. This may also occurring during actual employment where the individual has changing shifts and hours. Documentation from the employment service organization should include a statement around billing for services only when provided regardless of the schedule.

- A timetable for the accomplishment of the individual's desired outcomes and support activities,

- The estimated duration of the individual's need for services,

- The provider staff responsible for overall coordination and integration of the services specified in the plan for supports,

- For GSE, documentation regarding any restrictions on the freedoms of everyday life in accordance with the requirements of 42 CFR 441.301;

- Documentation of the individual’s ineligibility for supported employment service through DARS or IDEA, as applicable. If the individual is ineligible to receive service through IDEA, documentation is required only for lack of DARS funding. Acceptable documentation for the lack of DARS or IDEA funding would include a letter from either DARS or the local school system or a record of a telephone call, including name, date, and person contacted, documented either in the individual's file maintained by the support coordinator, on the ISP, or on the supported employment provider's supporting documentation. Unless the individual's circumstances change, for example, the individual is seeking a new job, the original verification may be forwarded into the current record or repeated on the supporting documentation on an annual basis;

- Written documentation in the form of unique, person-centered, progress notes or data collected in a supports checklist as appropriate, per the plan for supports. This documentation must confirm the individual's days in service to support units of service delivered and provide specific information regarding the individual's responses to various settings and supports, as well as specific circumstances that prevented provision of the scheduled service, should that occur. Observations of the individual's responses to the service must be available in at least a

daily note. Data must be collected as described in the ISP, analyzed to determine if the strategies are effective, summarized, then clearly documented in the progress notes or supports checklist. Documentation should be written, signed, and dated on the day the described supports were provided. Documentation that occurs after the date services were provided must be dated with the date the documentation was completed and also include the date the services were provided within the body of the note;

- An attendance log or similar document maintained by the provider that indicates the date, type of service rendered, and the number of hours and units provided, including specific timeframe;

- Documentation must correspond with billing. Providers must maintain separate documentation for each type of service rendered for an individual. Providers' claims that are not adequately supported by corresponding documentation may be subject to recovery of expenditures made; In a situation whereby the individual's needs have changed significantly, the plan for supports must be reviewed by the provider. A written review must be completed and supported by documentation in the individual's record for submission to the support coordinator at least quarterly with the plan for supports, if modified. Each quarterly person-centered review must contain the following elements:

    - A description of the status of each outcome in the plan for supports. Possible statuses include whether the outcome has been achieved, if progress is being made as expected, or if there has been limited or no progress. Any actions needed or that will be taken to resolve barriers or improve progress is noted;

    - Information about any newly identified safety risks;

    - Any changes desired by the individual or family member/caregiver, as applicable and his/their satisfaction with services;

    - Confirmation that all approved services were delivered according to the amount detailed in the plan, or, if not, the reason; and

    - Any significant events.

- The content of each review must be discussed with the individual and family member/caregiver, as applicable and submitted to the Support Coordinator within 10 calendar days following the end of each quarter. The discussion must be documented either by the individual and family member/caregiver's signature on the review or a progress note describing the discussion. The due date for the person-centered review is determined by the effective date of the Individual Support Plan and communicated to the provider by the support coordinator. Four written reviews span the entire ISP year. For the annual updates to the plan for supports and every time supporting documentation is updated, the update must be reviewed with the individual and family member/caregiver, as appropriate, and such review must be documented,

either by the individual and family member/caregiver's signature on the review, or a progress note describing the discussion.

- All correspondence with the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS.
- Written documentation of contacts made with individual's family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual.
- For the annual review and in cases where the Plan for Supports is modified, the team must work collaboratively to implement changes needed or desired by the individual. Changes in the Plan for Supports should be shared with the support coordinator and other participating providers, as appropriate.
- Provider documentation must support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by supporting documentation is subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

WORKPLACE ASSISTANCE

Service Definition/Description

Workplace assistance services are supports provided to an individual who has completed job development and completed or nearly completed job placement training (i.e., individual supported employment) but requires more than the typical job coach services, as detailed in the individual supported employment section of this chapter, to maintain stability in his employment. This service is supplementary to individual supported employment service. Workplace assistance service are covered in the Family and Individual Support and Community Living waivers.

Criteria/Allowable Activities

Workplace assistance must not be work skills training that would normally be provided by a job coach, such as supporting the individual in learning the components of the job. Instead the service is designed to help the individual who has learned the basic skills of the job to maintain community employment.

This service is delivered in the individual's natural employment setting, where and when it is needed.

Allowable activities include:

- Habilitative supports (i.e., skill building) related to non-work skills needed for the individual to maintain employment such as appropriate behavior, health maintenance, time management, or other skills without which the individual's continued employment would be endangered;

- Habilitative supports (i.e., skill building) needed to make and strengthen community connections (e.g., facilitating relationships with co-workers, supervisors, customers or using break or lunch time to access local community supports);

- Routine supports with personal care needs; however, this cannot be the sole use of workplace assistance service; and

- Safety supports needed to ensure the individual's health and safety.

Service Limitations

The unit of service is an hour. Workplace assistance service may be provided during the time that the individual being served is working in the community, up to and including 40 hours a week. There is no annual limit on how long this service may remain authorized.

Workplace assistance service must not be provided simultaneously (i.e., the same dates and times) with work-related personal assistance service. This service must not be provided solely for the purpose of providing assistance with ADLs to the individual when the individual is working.

The service delivery ratio is one staff person to one individual receiving waiver services.

The combination of workplace assistance service, community engagement service, community coaching service, supported employment service, and group day service must not exceed 66 hours per week.

Workplace assistance service can be provided simultaneously with individual supported employment (ISE) service to ensure that the workplace assistant is trained and supervised appropriately in supporting the individual through ISE best practices. The long-term expectation is that, after the job coach fades his/her regular involvement with the individual on the job site (i.e., job coach reduces proximity to the individual, reduces the types of prompts provided, and ultimately reduces the amount of time he/she needs to be physically present to assure the individual is able to do the job), the workplace assistant will remain with the individual. It is expected that the job coach and workplace assistant will continue to have periodic contact regarding the job performance/status of the individual.

"Fading," for the purposes of supported employment, is the process of transitioning an individual from external supports, services, and cues to natural supports, services, and cues in the employment environment.

Service Documentation Requirements

- Providers must include signed and dated documentation of the following in each individual's record:
    - A copy of the completed age-appropriate assessment (i.e., Supports Intensity Scale).
    - The provider's plan for supports which includes at a minimum the following:
        - The individual's desired outcomes that describe what is important to and for the individual in observable terms;
        - Support activities and support instructions that are inclusive of skill-building as may be required by the service provided and that are designed to assist in achieving the individual's desired outcomes;
        - The services to be rendered and the schedule for such services to accomplish the desired outcomes and support activities, a timetable for the accomplishment of the individual's desired outcomes and support activities, the estimated duration of the individual's need for services, and the provider staff responsible for overall coordination and integration of the services specified in the plan for supports;
        - Documentation regarding any restrictions on the freedoms of everyday life in accordance with human rights regulations.
- Documentation in the form of unique, person-centered, written documentation in the form of progress notes or data collected in a supports checklist as appropriate, per the plan for supports. These shall be in each individual's record and detail the individual's responses to supports, as well as specific circumstances that prevented provision of the scheduled service, should that occur. Such documentation must be provided to DMAS or its designee upon request. Such documentation should be written, signed, and dated on the day the described supports were provided. Documentation that occurs after the date services were provided must be dated with the date the documentation was completed and also include the date the services were provided within the body of the note.
    - In a situation whereby the individual's needs have changed significantly, the plan for supports must be reviewed by the provider. A written review must be completed and supported by documentation in the individual's record for submission to the support

coordinator at least quarterly with the plan for supports, if modified. Each quarterly person-centered review must contain the following elements:

- The content of each review must be reviewed/discussed with the individual and family member/caregiver, as applicable and submitted to the Support Coordinator within 10 calendar days following the end of each quarter.

- The discussion must be documented either by the individual and family member/caregiver's signature on the review or a progress note describing the discussion.

- The due date for the person-centered review is determined by the effective date of the Individual Support Plan and communicated to the provider by the support coordinator. Four written reviews span the entire ISP year.

- For the annual updates to the plan for supports and every time supporting documentation is updated, the update must be reviewed with the individual and family member/caregiver, as appropriate, and such review shall be documented, either by the individual and family member/caregiver's signature on the review, or a progress note describing the discussion.

- All correspondence to the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS.

- Written progress note documentation of contacts made with the individual's family/caregiver, physicians, providers, and all professionals concerning the individual.

Provider documentation must support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by supporting documentation shall be subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

MANUAL TITLE	Chapter	Page
DEVELOPMENTAL DISABILITIES WAIVERS (BI, FIS, CL) SERVICES MANUAL	IV	133
Chapter Subject	**Page Revision Date**	
COVERED SERVICES AND LIMITATIONS	2/24/2022	

	Corresponding Regulation(s)	BI	FI	CL
MEDICAL AND BEHAVIORAL SUPPORT OPTIONS				
Personal Emergency Response Systems (PERS)	12VAC30-122-470	✓	✓	✓
Private Duty Nursing	12VAC30-122-480		✓	✓
Skilled Nursing	12VAC30-122-520		✓	✓
Therapeutic Consultation	12VAC30-122-550	✓	✓	✓

PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

Service Definition/Description

Personal emergency response system (PERS) service is an electronic device and monitoring service that enables certain individuals to secure help in an emergency. PERS service is limited to those individuals who live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time and who would otherwise require supervision.

Criteria

PERS service is available to individuals enrolled in the FIS, CL, and BI waivers. PERS service may be authorized when there is no one else in the home with the individual enrolled in the waiver who is competent or continuously available to call for help in an emergency. Physician-ordered medication monitoring units may be provided simultaneously with PERS service. These units must be refilled as needed by either a LPN or RN.

PERS service must include an emergency response center staff with fully trained operators who are capable of:

- Receiving signals for help from an individual's PERS equipment 24 hours a day, 365 or 366, as appropriate, days per year,
- Determining whether an emergency exists, and
- Notifying an emergency response organization or an emergency responder that the individual needs emergency help.

The agency providing monitoring services must be capable of continuously monitoring and responding to emergencies under all conditions, including power failures and mechanical malfunctions. The provider is responsible for ensuring that the monitoring agency and the agency's equipment meet the requirements of this section. The monitoring agency must be capable of simultaneously responding to multiple signals for help from multiple individuals' PERS equipment. The monitoring agency's equipment must include the following:

- A primary receiver and a back-up receiver, which must be independent and interchangeable;
- Back-up information retrieval system;
- A clock printer, which must print out the time and date of the emergency signal, the PERS individual's identification code, and the emergency code that indicates whether the signal is active, passive, or a responder test;
- Back-up power supply;
- A separate telephone service;
- A toll-free number to be used by the PERS equipment in order to contact the primary or back-up response center; and
- A telephone line monitor, which must give visual and audible signals when the incoming telephone line is disconnected for more than 10 seconds.

The monitoring agency must maintain detailed technical and operations manuals that describe PERS service elements, including the installation, functioning, and testing of PERS equipment; emergency response protocols; and recordkeeping and reporting procedures.

PERS service must be capable of being activated by a remote wireless device and must be connected to the individual's telephone system. The PERS console unit must provide hands-free voice-to-voice communication with the response center. The activating device must be waterproof, automatically transmit to the response center an activator low battery alert signal prior to the battery losing power, and be able to be worn by the individual.

The emergency response activator must be activated either by breath, by touch, or by some other means and be usable by persons who have visual or hearing impairments or physical disabilities. The emergency response communicator must be capable of operating without external power during a power failure at the individual's home for a minimum period of 24 hours and automatically transmit a low battery alert signal to the response center if the back-up battery is low. The emergency response console unit must also be able to self-disconnect and redial the back-up monitoring site without the individual resetting the system in the event the unit cannot get its signal accepted at the response center.

Providers must furnish, install, maintain, test, and service the PERS equipment, as required to keep it fully operational. The provider must replace or repair the PERS device within 24 hours of the individual's or family/caregiver's notification of a malfunction of the console unit, activating devices, or medication-monitoring unit while the original equipment is being repaired.

PERS equipment must be properly installed all into the functioning telephone line or cellular system of an individual receiving PERS and all necessary supplies must be furnished to ensure that the system is installed and working properly.

The PERS installation must include local seize line circuitry, which guarantees that the unit will have priority over the telephone connected to the console unit should the phone be off the hook or in use when the unit is activated.

The PERS must be installed, tested, and demonstrated to the individual and the individual's family/caregiver, as appropriate, before claims may be submitted for reimbursement to DMAS. The individual, family/caregiver, as appropriate, and responders must be instructed in the use of the PERS.

All installed PERS equipment must be maintained in proper working order. PERS must include back-up monitoring capacity in case the primary system cannot handle incoming emergency signals.

All PERS equipment must be approved by the Federal Communications Commission and meet the Underwriters' Laboratories, Inc. (UL) safety standard Number 1635 for Digital Alarm Communicator System Units and Number 1637, which is the UL safety standard for home health care signaling equipment. The UL listing mark on the equipment will be accepted as evidence of the equipment's compliance with such standard. The PERS device must be automatically reset by the response center after every activation ensuring that subsequent signals can be transmitted without requiring manual reset by the individual enrolled in the waiver or family/caregiver, as appropriate.

Service units

The one-time purchase unit for installation of the PERS device(s) includes installation, account activation, individual and caregiver instruction, and removal of PERS equipment.
A unit of service for PERS monitoring or PERS monitoring and medication monitoring is the one-month rental price set by DMAS.

The unit of service for LPN or RN refilling of the PERS medication monitoring device is 30 minutes.

Service Limitations

PERS service must not be used as a substitute for providing adequate supervision for the individual enrolled in the waiver.

Medication monitoring units and the accompanying LPN or RN visits to refill the unit may not be standalone services, but must be provided in tandem with an overall PERS installation and monthly monitoring service.

Incompatible Services

Group home residential
Sponsored residential
Supported living residential

Service documentation and requirements

- The support coordinator must include signed and dated documentation of the following in each individual's record:
    - The appropriate service authorization to be completed by the support coordinator may serve as the plan for supports for the provision of PERS service. A rehabilitation engineer may be involved for PERS service if disability expertise is required that a general contractor may not have. The plan for supports and service authorization must include justification and explanation if a rehabilitation engineer is needed. The service authorization request must be submitted to the state-designated agency or its designee in order for service authorization to occur;
    - Written documentation regarding the process and results of ensuring that the item is not covered by the State Plan for Medical Assistance as durable medical equipment (DME) and supplies and that the item is not available from a DME provider;
    - Documentation of the recommendation for the item by an independent professional consultant (physical therapist, occupational therapist, behavioral consultant, or similarly credentialed professional) and the amount of service that is needed;
    - Documentation of notification by the designated individual or the individual's representative or family/caregiver, as appropriate, of satisfactory installation or receipt of each PERS device.
- The PERS provider must maintain a data record for each individual receiving PERS service that documents all of the following:
    - Delivery date and installation date of the PERS;
    - The signature of the individual or the individual's family/caregiver, as appropriate, verifying receipt of PERS device;

- Verification by a test that the PERS device is operational, monthly or more frequently as needed;

- Updated and current individual responder and contact information, as provided by the individual or the individual's support coordinator; and

- A case log documenting the individual's utilization of the system and contacts and communications with the individual or the individual's family/caregiver, as appropriate, support coordinator/case manager, or responder.

- The PERS provider must also document and furnish within 30 calendar days of the action taken a written report to the support coordinator/case manager for each emergency signal that results in action being taken on behalf of the individual. This excludes test signals or activations made in error.

- The PERS provider must maintain documentation of any other relevant information regarding the device or modification, as well as instructions regarding any warranty, repairs, complaints, or servicing that may be needed.

Provider documentation must support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by supporting documentation are subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

PRIVATE DUTY NURSING (PDN)

Service Definition/Description

Private duty nursing (PDN) service means nursing services that are provided by a Registered Nurse (RN) or Licensed Practical Nurses (LPN) and are designed to provide the individual continuous nursing care. PDN services are available to individuals who require more hours per week of nursing care than may be provided under Skilled Nursing in the waivers. This means more than 21 hours per week. PDN services are provided for individuals enrolled in the DD waiver who have serious medical conditions and complex health care needs that have been certified by a physician or nurse practitioner (in accordance with § 54.1-2957.02, which states that, whenever a physician's signature is required, a nurse practitioner's signature must also be accepted) as medically necessary to enable the individual to remain at home or in a community residence rather than in a hospital, nursing facility, ICF/IID, or any other type of institution.

PDN service must be delivered as direct one-to-one person-centered nursing care. PDN must support and not replace existing family or paid caregiver responsibilities.

PDN services may be provided concurrently with other services such as the services of direct support professionals in residential or day support settings due to the medical nature of the supports provided.

Criteria/Allowable Activities

Individuals enrolled in the Community Living (CL) or Family and Individuals Supports (FIS) waivers may receive PDN.

The individuals who are authorized to receive this service must require specific PDN service as documented in the individual's plan for supports and ordered by a physician or nurse practitioner. This means that the individual must have a documented need and those needs outlined and nursing services ordered by the medical practitioner. This also means that the ISP cannot be implemented effectively unless the nursing services are authorized and provided.

Private Duty Nursing (PDN) services may be provided to the individual in his/her residence or other community setting on a regularly scheduled basis to facilitate the desired health and safety outcomes as outlined in the individual's ISP.

Allowable activities must be ordered and certified as medically necessary by a Virginia-licensed physician or nurse practitioner on the CMS 485 form.

The allowable activities for PDN may include:

- On-going monitoring of an individual's medical status as it relates to the specified medical and nursing needs;
- Administering medications and other medical treatments ordered specifically for the individual's care;
- Assisting with activities of daily living in conjunction with medical treatment and care; and/or
- Training of family members or other caregivers regarding the nursing care of the individual per the plan for supports.

Service Limitations

The medical necessity for PDN services is documented in the individual's ISP. Once it has been determined by a physician or nurse practitioner that medical necessity can no longer be demonstrated, this service must be terminated and the ISP updated to reflect the change in status.

PDN cannot be provided concurrently (i.e., during the same billing unit timeframe) with skilled nursing services, personal assistance services, respite services, or companion services. Individuals receiving PDN services may not be authorized for skilled nursing services except when skilled

nursing is required for nurse delegation responsibility activities in accordance with 18VAC90-19-280 and are authorized and included in the individual's ISP.

PDN service may not be covered under the waiver if the individual is younger than 21 years of age and is eligible for private duty nursing service covered through Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. The Private Duty Nursing service is a one-to-one service. It is not a group service and thus the services of the nurse may be billed for only one individual at a time.

Examples of Allowable Service Delivery and Billing When There Are Multiple Individuals in the Setting:

1) Two individuals living in the same residence:

   - Individual A requires 12 hours of PDN per day and Individual B requires 12 hours of PDN per day. Each individual is authorized 12 hours per day of PDN service.

   - The residence schedules two of their nurses 12 hours per day each (i.e., two nursing shifts) to provide the service for both Individual A & B and bills no more than a total of 24 hours per day of PDN for the services delivered by the two nurses.

2) Two individuals living in the same residence:

   - Individual A requires 8 hours per day of PDN and Individual B requires 8 hours per day of PDN. Each individual is authorized 8 hours per day of PDN service. Both of their ISPs described PDN service that is to be provided every other 30 minutes throughout the day.

   - The residence schedules one nurse (one nursing shift) 16 hours per day to provide the service for both Individual A & B and bills 16 hours per day of PDN for one nurses scheduled.

Service Units

PDN is rendered and billed in quarter-hour (15-minute) increments.

Service Documentation and Requirements

Private Duty Nursing services providers shall include signed and dated documentation of the following in each individual's record:

- A completed copy of the age-appropriate DBHDS–approved SIS® assessment form or other approved, developmentally appropriate assessment according to the individual's age.

- The provider's Plan for Supports containing, at a minimum, the following elements:

    - The individual's desired health outcomes that describe what is important to and for the individual in observable and measurable terms, particularly related to the individual's diagnoses and relevant medical history;

    - Support activities and support instructions, including nursing tasks and monitoring, that are designed to assist in achieving the individual's desired outcomes;

    - The services to be rendered and the schedule of such services to accomplish the desired outcomes and support activities;

    - A timetable for the accomplishment of the individual's desired outcomes and support activities;

    - The estimated duration of the individual's needs for services;

    - The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports.

- Documentation identifying who was trained on the nursing service plan, including family members/caregivers. This documentation must indicate the dates and times and the content of the training.

- Documentation that the RN and LPN has the experience or skills necessary to perform the tasks as ordered by the physician or nurse practitioner and included in the plan for supports.

- Documentation of the nursing licenses and qualifications of private duty nursing providers.

- The physician's or nurse practitioner's order may be documented on the CMS 485 form or an equivalent form which must include the following:

    - Orders for skilled nursing services that include a specific number of nursing hours per day (i.e., not a range of hours).

- Documentation of the Physician or Nurse Practitioner orders must be completed every six months. This means that the CMS 485 and the individual plan for supports related to PDN services must be updated every six months.

- Documentation that clearly describes the amount and type of nursing interventions provided, results of interventions/treatments including the specific the dates and times of nursing interventions and appropriate signatures.

- Documentation that affirms that the PDN services are provided as a one-to-one service in accordance with the plan for supports.

- In a situation whereby the individual's needs have changed significantly, the plan for supports must be reviewed by the provider. A written review must be completed and supported by documentation in the individual's record for submission to the support coordinator at least quarterly with the plan for supports, if modified. Each quarterly person-centered review must contain the following elements:

    - A description of the status of each outcome in the plan for supports. Possible statuses include whether the outcome has been achieved, if progress is being made as expected, or if there has been limited or no progress. Any actions needed or that will be taken to resolve barriers or improve progress is noted,

    - Information about any newly identified safety risks;

    - Any changes desired by the individual or family member/caregiver, as applicable and his/their satisfaction with services;

    - Confirmation that all approved services were delivered according to the amount detailed in the plan, or, if not, the reason; and

    - Any significant events.

- The content of each review must be discussed with the individual and family member/caregiver, as applicable and submitted to the Support Coordinator within 10 calendar days following the end of each quarter. The discussion must be documented either by the individual and family member/caregiver's signature on the review or a progress note describing the discussion. The due date for the person-centered review is determined by the effective date of the Individual Support Plan and communicated to the provider by the support coordinator. Four written reviews span the entire ISP year. For the annual updates to the plan for supports and every time supporting documentation is updated, the update must be reviewed with the individual and family member/caregiver, as appropriate, and such review must be documented, either by the individual and family member/caregiver's signature on the review, or a progress note describing the discussion.

- All correspondence to the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS.

- Written documentation of all contacts with the individual's family/caregiver, physicians, providers, and all professionals regarding the individual.

Provider documentation must clearly reflect the PDN service authorized and provided and support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by the ISP and the provider's documentation are subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

SKILLED NURSING SERVICES

Service Definition/Description

Skilled Nursing (SN) service means nursing services that are provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) in the form of intermittent care, up to, but not to exceed 21 hours per week as detailed in the individual's ISP. In accordance with 12VAC30-122-520, skilled nursing service must be ordered by a physician and be medically necessary. The medical necessity for skilled nursing services must be documented in the individual's ISP. Once the medical necessity can no longer be demonstrated, this service will be terminated. SN services are provided for individuals enrolled in the DD waiver who have serious medical conditions and complex health care needs and have exhausted their home health benefits under the Commonwealth's Medicaid benefit or other benefits available to the individual and who require specific nursing care.
SN services may be provided concurrently with other services such as those delivered by direct support professionals (DSPs) in residential or day support settings due to the medical nature of the supports provided.

Criteria/ Allowable Activities

Individuals enrolled in the Community Living (CL) or Family and Individuals Supports (FIS) waivers may receive SN.

The individuals who are authorized to receive this service must require specific skilled nursing service as documented in the individual's plan for supports and ordered by a physician or nurse practitioner (in accordance with § 54.1-2957.02, which states that, whenever a physician's signature is required, a nurse practitioner's signature must also be accepted). This means that the individual must have a documented need/those needs outlined and nursing services ordered by the medical practitioner. This also means that the ISP cannot be implemented effectively unless the nursing services are authorized and provided.

SN services may be provided to the individual in his residence or other community setting on a regularly scheduled or intermittent basis to facilitate the desired health and safety outcomes as outlined in the individual's ISP.

Allowable activities must be ordered and certified as medically necessary by a Virginia-licensed physician or nurse practitioner on the CMS 485 form.

The allowable activities for the SN service may include:

- Administering medications and other medical treatments by medical professionals ordered specifically for the individual's care,

- Skilled training of family members, caregivers, and other relevant persons regarding the nursing care of the individual,

- Monitoring an individual's medical status including assessment and observation related to the individual's nursing care and treatment needs specific to the medical orders, desired health outcomes, and the support activities outlined in the individual's ISP,

- Providing consultation and guidance to DSPs or family members/caregivers related to the individual's nursing care and treatment needs specific to the desired health outcomes and recommendations for ongoing care and support activities outlined in the individual's ISP,

- Delegation of nursing tasks to unlicensed paid caregivers (i.e., DSPs) in accordance with nurse delegation regulations in 18VAC90-19 240 – 280.

  Examples of Nurse Delegated Activities:

  - Care of a colostomy to provide the proper care for skin protection to reduce the risk of stoma related complications. Activities may include, but might not be limited to, changing, emptying, or cleaning the pouch system and related documentation.

  - Provision of supplemental oxygen to increase the concentration of inhaled oxygen to reduce the risk of hypoxia. Activities may include, but might not be limited to, managing parts of the oxygen system ordered such as an oxygen concentrator, nasal cannula or simple face mask, or utilizing a pulse oximeter to measure oxygen levels of the blood and related documentation.

- Assuring that all items listed above are carried out in accordance with the plan for supports.

Service Limitations

The Skilled Nursing service must be ordered by a physician or nurse practitioner and must be medically necessary. The medical necessity for Skilled Nursing services is documented in the individual's ISP. Once it has been determined by a physician or nurse practitioner that medical necessity can no longer be demonstrated, this service must be terminated and the ISP updated to reflect the change in status.

SN service cannot be provided unless the individual has exhausted all of the home health benefits available to them under the Commonwealth's Medicaid benefit or other benefit available to the individual.

SN may not be authorized or billed concurrently with private duty nursing except if nurse delegation activities in accordance with 18VAC90-19-240-280 are required by the individual and included in the individual's ISP.

The SN service is a one-to-one service. It is not a group service and thus the services of the nurse may be billed for only one individual at a time.

Examples of Allowable Service Delivery and Billing When There Are Multiple Individuals in the Setting:

Two individuals living in the same residence:

- Individual A requires 6 hours of SN a week and Individual B requires 6 hours of SN a week. SN is delivered to one person at a time.
- The residence schedules their nurse 12 hours a week to provide the service for both Individual A & B and bills 12 hours a week of SN.

Service Units

SN is rendered and billed in quarter-hour (15 minute) increments.

Service Documentation Requirements

Skilled Nursing providers shall include signed and dated documentation of the following in each individual's record:

- A completed copy of the age-appropriate DBHDS–approved SIS® assessment form or other approved, developmentally appropriate assessment according to the individual's age;
- The provider's Plan for Supports containing, at a minimum, the following elements:
  - The individual's desired health outcomes that describe what is important to and for the individual in observable and measurable terms, particularly related to the individual's diagnoses and relevant medical history;
  - Support activities and support instructions, including nursing tasks and monitoring, as well as nurse delegation, as appropriate, that are designed to assist in achieving the individual's desired outcomes;

- The services to be rendered, including specific consultation and guidance activities, and the schedule of such services to accomplish the desired outcomes and support activities;

- A timetable for the accomplishment of the individual's desired outcomes and support activities;

- The estimated duration of the individual's needs for services; and

- The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports.

- Documentation of who was trained on the nursing service plan, including family/caregivers or staff, or both. This documentation must indicate the dates and times and the content of the training. Training of professional staff and/ or family members as appropriate, must be consistent with the Regulations Governing the Practice of Nursing (18VAC90-19-280);

- Documentation of the Physician or Nurse Practitioner orders must be completed every six months. This means that the CMS 485 and the individual plan for supports related to SN services must be updated every six months;

- Documentation must support billing. This includes documentation that justifies the SN services and clearly describes the amount and type of nursing interventions provided, results of interventions/treatments, and the specific dates and times of nursing interventions and appropriate signatures;

- Documentation that affirms that the skilled nursing services are provided as a one-to-one service in accordance with the plan for supports;

- In a situation whereby the individual’s needs have changed significantly, the plan for supports must be reviewed by the provider. A written review must be completed and supported by documentation in the individual’s record for submission to the support coordinator at least quarterly with the plan for supports, if modified. Each quarterly person-centered review must contain the following elements:

    - A description of the status of each outcome in the plan for supports. Possible statuses include whether the outcome has been achieved, if progress is being made as expected, or if there has been limited or no progress. Any actions needed or that will be taken to resolve barriers or improve progress is noted;

    - Information about any newly identified safety risks;

- Any changes desired by the individual or family member/caregiver, as applicable and his/their satisfaction with services;

- Confirmation that all approved services were delivered according to the amount detailed in the plan, or, if not, the reason; and

- Any significant events.

- The content of each review must be discussed with the individual and family member/caregiver, as applicable, and submitted to the Support Coordinator within ten (10) calendar days following the end of each quarter. The due date for the person-centered review is determined by the effective date of the Individual Support Plan and communicated to the provider by the support coordinator.

  - The discussion must be documented either by the individual and family member/caregiver's signature on the review or a progress note describing the discussion. Four written reviews span the entire ISP year. For the annual updates to the plan for supports and every time supporting documentation is updated, the update must be reviewed with the individual and family member/caregiver, as appropriate, and such review must be documented, by the individual, and/or family member/caregiver's signature on the review, as appropriate , or in a progress note describing the discussion;

  - All correspondence with the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS; and

  - Written documentation of all contacts with the individual's family/caregiver, physicians, providers, and all professionals regarding the individual, as well as written confirmation in the form of a signature from the individual or family that they received services.

Provider documentation must clearly reflect the skilled nursing service authorized and provided and support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by the ISP and the provider's documentation are subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

THERAPEUTIC CONSULTATION

Service Definition/Description

Therapeutic consultation service means professional consultation provided by members of psychology, social work, rehabilitation engineering, behavior analysis/consultation, speech-language pathology therapy, occupational therapy, psychiatry, psychiatric clinical nursing, therapeutic recreation, or physical therapy disciplines that are designed to assist individuals,

parents, guardians, family members, and any other providers of support services with implementing the ISP.

This service provides assessments, development of a therapeutic consultation support plan, and teaching in any of these designated specialty areas to assist family members, caregivers, and other providers in supporting the individual enrolled in the waiver.

A "therapeutic consultation support plan" is the assessment-based report of recommendations resulting from a therapeutic consultation that is developed by the professional consultant after he spends time with the individual to determine the individual's needs in his area of expertise. It provides guidance for those who support and care for the individual on how to implement strategies developed by the consultant in order to better support the individual. It is distinct from the plan for supports.

Criteria/Allowable Activities

Therapeutic consultation service is covered in the FIS and CL waivers. To qualify for therapeutic consultation service, the individual must have a documented need for consultation. This means that the ISP cannot be implemented effectively and efficiently unless this form of therapeutic consultation is authorized and provided. The need for this service must be based on the individual's ISP and clinically necessary to the individual. Therapeutic consultation service may be provided in individuals' homes, day support programs, and in other community settings, where they will facilitate implementation of individuals' desired outcomes as identified in their ISP.
Allowable activities for this service may include:

- Interviewing the individual, family members, caregivers, and relevant others to identify issues to be addressed and desired outcomes of consultation;

- Observing the individual in daily activities and natural environments and observing and assessing the current interventions, support strategies, or assistive devices being used with the individual;

- Assessing the individual's need for an assistive device for a modification or adjustment of an assistive device, or both, in the environment or service, including reviewing documentation and evaluating the efficacy of assistive devices and interventions identified in the therapeutic consultation plan;

- Developing data collection mechanisms and collecting baseline data as appropriate for the type of consultation service provided;

- Designing a written therapeutic consultation support plan detailing the interventions, environmental adaptations, and support strategies to address the identified issues and desired outcomes, including recommendations related to specific devices, technology, or

adaptation of other training programs or activities. The plan may recommend training relevant persons to better support the individual simply by observing the individual's environment, daily routines, and personal interactions;

- Demonstrating (i) specialized, therapeutic interventions; (ii) individualized supports; or (iii) assistive devices;

- Training family/caregivers and other relevant persons to assist the individual in using an assistive device; to implement specialized, therapeutic interventions; or to adjust currently utilized support techniques;

- Intervening directly, by behavioral consultants, with the individual and demonstrating to family/caregivers or staff such interventions. Such intervention modalities shall relate to the individual's identified behavioral needs as detailed in established specific goals and procedures set out in the ISP; and

- Consulting related to person centered therapeutic outcomes, in person, over the phone, or via synchronous video feed in accordance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).

Service Limitations

- The unit of service is one hour. Providers may only bill for services rendered to one individual at a time. Group billing or concurrent billing for multiple individuals at the same date/time is not permitted;

- The services must be explicitly detailed in the plan for supports;

- Travel time and written preparation are considered as in-kind expenses, within therapeutic consultation service and will not be reimbursed as separate items. Written preparation which are “in kind” expenses includes written activities that are not included in allowable activities for the service;

- Definition of ‘in-kind’: written activities that are not included in allowable activities for the services. Examples may include a) completion of progress notes completed before or after service delivery; b) creating graphical displays not concurrent with the delivery of other allowable activities; and c) developing quarterly reports not concurrent with the delivery of other allowable activities.

Therapeutic consultation may not be billed solely for purposes of monitoring the individual, nor for direct and ongoing therapy. Therapeutic Consultation for Speech, OT, and PT cannot be billed for the purpose of initial evaluations/assessments as this is covered under the State Option Plan.

Behavioral consultation

- Only behavioral consultation among the therapeutic consultation services may be offered in the absence of any other waiver service.

- Initial requests for behavioral consultation by a provider may not be authorized for more than 180 days. The request must include the Part V, which must outline completion of the Functional Behavioral Assessment (FBA), creation of the behavior support plan, and the plan for data collection.

- Behavioral support plans (BSP), inclusive of FBA information and results, will be submitted with the second authorization that follows the initial authorization. Any baseline data and/or treatment data will be provided with the submission of the second authorization. The request for a second authorization must include a description of training for those who support the individual in the Part V. The initial plan for training must be included in the BSP.

- For any annual reauthorization requests that follow the initial and second authorization requests, the following must be submitted:
    - Summary of quarterly data in an acceptable format (e.g., line graph);
    - Current behavior support plan (inclusive of FBA information and results and statement of validity of previous FBA or indication for reassessment to occur); and
    - Documentation of any training completed within the most recent review period.

The Part V will include training for stakeholders. Any second authorizations and annual reauthorization requests must include measurable outcomes/support activities for each behavior targeted for increase and decrease. The updated plan for training will be included in the BSP.

Other than behavioral consultation, therapeutic consultation service may not include direct therapy provided to individuals enrolled in the waiver and may not duplicate the activities of other services that are available to the individual through the State Plan for Medical Assistance. Behavior consultation may include direct behavioral interventions and demonstration of such interventions to family members or staff in the presence of the individual.

For therapeutic consultation behavioral services, direct therapy consists of the behavioral consultant implementing strategies with the individual that can only be accomplished while being physically present in the same environment as the individual and cannot be accomplished via telehealth modalities. Examples may include, but are not limited to, learning opportunities where the behavioral consultant provides any type of physical guidance or gestural prompts to the individual, providing learning opportunities with materials that need to be physically manipulated by both the behavioral consultant and the individual, or demonstrating interventions to

family/caregivers that require the behavioral consultant to be physically present in the same environment as the family/caregivers and the individual.

Service Documentation Requirements

Providers must include signed and dated documentation of the following in each individual's record:

- A copy of the completed age-appropriate DBHDS-approved SIS® assessment form or other approved, developmentally appropriate assessment.

- A plan for support that contains at a minimum the following elements:

    - Identifying information;
    - Desired outcomes, support activities, and timeframes; and
    - Specific consultation activities.

- A written therapeutic consultation support plan detailing the recommended interventions or support strategies for providers and/or family members/caregivers to better support the individual enrolled in the waiver in the service.

    - Behavior support plans will contain the following information, at a minimum:

        - Demographic information (e.g., name, date of birth, gender, Medicaid ID number, legal status, diagnoses, medication, current living situation, behavior interventionist and credentials);

        - Person-centered information (e.g., admirable qualities, strengths, key people in the person's life, person's goals and desires, communication method, preference assessment results, current schedule, and impact of person's health, mobility, medical status on their life and behavior, and known trauma history, if applicable);

        - History and rationale (i.e., reason for the plan and history of behavioral services and impact of services on behavior);

        - Functional behavior assessment (e.g., FBA methods utilized, location of FBA, and results);

        - Behaviors targeted for decrease;

        - Hypothesized functions of behavior (if not included in the FBA section);

        - Proactive strategies/antecedent interventions;

- Replacement behaviors/behaviors targeted for increase;
- Consequence interventions are a minimum BSP expectation and applicable for any BSP that is targeting challenging behavior reduction and increase in desirable behaviors; inclusion of any additional information beyond other minimum content areas is at the discretion of the author of the behavior plan;
- Safety and crisis guidelines (if applicable);
- Any additional information (i.e., any other relevant information not included in other plan areas); and
- Appropriate signatures and plan for initial and ongoing training.

  - Documentation of who was trained on the plan and when and where should be maintained and a plan for ongoing training should be determined.

- Ongoing progress note documentation of rendered consultative service that may be in the form of contact-by-contact or monthly notes that must be contemporaneously signed and dated, that identify each contact including location and recipient of training activities, the amount of time spent on the activity, what was accomplished, and the professional who made the contact and rendered the service.

- Written quarterly reviews will be completed by the provider to align with the quarters of the individual's ISP. If the consultation service extends beyond one year or when there are changes to the plan for supports, the plan for supports must be reviewed by the provider with the individual, individual's family/caregiver, as appropriate, and the support coordinator and must be submitted to the support coordinator for service authorization, as appropriate.

  - For behavioral consultation, the quarterly review must include graphed data and a summary of this data;
  - For behavioral consultation, the annual review must include graphed or tabled data that is trended across the first three quarters;
  - For behavioral consultation that extends beyond one year, as a part of the shared planning meeting the behaviorist must review the FBA and treatment data and determine if the functions are still valid. A reassessment of the functions of behavior is required when data suggest treatment expectations are not being met

or there has been a significant change in status of the individual that is negatively impacting outcomes. This must be documented in the BSP;

- All correspondence with the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS;

- Written progress note documentation of contacts made with the individual's family/caregiver, physicians, providers, and all professionals concerning the individual;

- A contemporaneously signed and dated final disposition summary that is forwarded to the support coordinator within 30 days following the end of this service and that includes:

    - Strategies utilize;
    - Objectives met;
    - Unresolved issues; and
    - Consultant recommendations.

- Provider documentation must support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by supporting documentation are subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

MANUAL TITLE	Chapter	Page
DEVELOPMENTAL DISABILITIES WAIVERS (BI, FIS, CL) SERVICES MANUAL	IV	153
Chapter Subject	**Page Revision Date**	
COVERED SERVICES AND LIMITATIONS	2/24/2022	

	CORRESPONDING REGULATION(S)	BI	FIS	CL
RESIDENTIAL OPTIONS				
Group Home Residential Services	12VAC30-122-390			✓
Independent Living Supports	12VAC30-122-420	✓		
In-Home Support Services	12VAC30-122-410		✓	✓
Shared Living Services	12VAC30-122-510	✓	✓	✓
Sponsored Residential Services	12VAC30-122-530			✓
Supported Living Services	12VAC30-122-540		✓	✓

GROUP HOME RESIDENTIAL

Service Definition/Description

Group home residential service consists of skill-building, routine supports, general supports, and safety supports that are provided to enable an individual to acquire, retain, or improve skills necessary to successfully live in the community. This service may be provided to individuals who are living in (i) a group home or (ii) the home of an adult foster care provider. The Group home residential service may be provided to the individual continuously up to 24 hours per day by paid staff who are physically present. This service may be provided either individually or simultaneously to more than one individual living in that home, depending on the required support (i.e., toileting, or other personal care activities).

Criteria/Allowable Activities

Group home residential supports are only available to those individuals on the Community Living (CL) waiver.

The allowable activities include, as may be appropriate for the individual as documented in his plan for supports:

- Skill-building and providing routine supports related to ADLs and IADLs such as hygiene supports;
- Skill-building and providing routine supports and safety supports related to the use of community resources, such as transportation, shopping, restaurant dining, and participating in social and recreational activities, and safety supports to ensure the individual's health and safety;
- Supporting the individual in replacing challenging behaviors with positive, accepted behavior for home and community environments, for example (not all inclusive):
    - Developing a circle of friends;

- Handling social encounters with others; or
- Redirecting challenging behavior.

- Monitoring the individual's health and physical condition and providing supports with medication and other medical needs;
- Providing routine supports and safety supports with transportation to and from community locations and resources; and
- Providing general supports, as needed.

Group home residential service must include a skill-building component along with the provision of supports as may be needed by the individuals who are receiving the service.

The following services are not allowed to be authorized during the same date range as group home residential:

- Agency Directed Respite
- Consumer Directed Respite
- Agency Directed Personal Assistance
- Consumer Directed Personal Assistance
- Sponsored Residential
- Supported Living Residential
- Shared Living
- In-home supports
- PERS
- Electronic Home Based Supports
- Environmental Modifications
- Independent Living

Individuals who receive group home residential services may also receive Agency- or Consumer-Directed Companion services; however, the group home provider may not also be the provider of Companion services, as this is duplicative. For individuals receiving group home services, companion services may not be provided by an immediate family member.

60-Day Assessment

A provider may use a 60-day assessment period for evaluating the individual's need for specific supports. If a provider utilizes an assessment period prior to development and integration of an annual Plan for Supports, a preliminary Plan for Supports must be developed with the team, based on information in the Personal Profile, Essential Information, the SIS® or other DBHDS-approved assessment, in addition to other assessment information available to the provider. The Plan for Supports must include the areas to be evaluated and a schedule of services to be provided. Prior to

the last day of the assessment period, the provider, with the involvement of the individual, must develop an annual Plan for Supports, and forward it to the case manager for review, approval and reauthorization if required. The start date of the annual Plan for Supports must be no later than day 61 and the end date must correspond to the end date of the annual Individual Support Plan.

Customized Rate

Providers supporting individuals with extraordinary medical or behavioral supports needs, may apply for the customized rate for additional community coaching supports delivered by the provider. See the Customized Rate section per 12VAC30-122-210.

Service Limitations

The number of licensed beds in a setting reimbursed for group home residential services must not exceed six (6). Group home settings larger than six licensed beds which became DD waiver providers prior to March 31, 2021 may continue to operate and receive Medicaid reimbursement. DMAS may, with the agreement of DBHDS, authorize temporary exceptions to the maximum limit if the site can reasonably accommodate a larger number and if there exists an unforeseen set of circumstances which makes the continuity of care possible only if the exception is made. In compliance with 12VAC35-105-530 G the provider must notify DBHDS Licensing of emergency evacuations after the disaster or emergency is stabilized. The provider should report to DBHDS no later than 24 hours after the incident occurs. It will be the decision of DBHDS Office of Licensing if the circumstances warrant a temporary increase in capacity; it will be the decision of DMAS if billing can occur for services provided while the capacity exceeds six beds.

This process needs to be treated as an emergency situation.

If a group home larger than six licensed beds changes ownership, it will be considered a new setting and the licensed bed capacity limit of six beds will apply for Medicaid reimbursement purposes.

Group home residential services will be authorized for Medicaid reimbursement only when the individual requires these services and they are set out in the Plan for Supports. Those services authorized for reimbursement under Group home residential services may not duplicate those that are funded or provided by another source.

Group home residential services may not be provided, for the purpose of Medicaid reimbursement, to individuals who reside in Nursing Facilities, ICF/IIDs, hospitals, or assisted living facilities. Providers will only be reimbursed for the tier to which the individual has been assigned based on the individual's assessed needs and according to the number of beds in the home. Reimbursement will not include the costs of room and board.

Service Units

The unit of service is one day. Providers may bill the unit of service if any portion of the plan for supports is provided during that day. Billing may not exceed 344 days per ISP year in accordance with the established rate structure.

If an individual moves to a group home with a different provider agency during their ISP year, the 344 days count resets to one on the first day the individual is living with the new provider agency. If an individual moves from one home to another within the same provider agency during their ISP year, the 344 day count does not reset.

Group home residential service is a tiered service for reimbursement purposes, based on the individual's assigned level and tier and the licensed bed capacity of the home. If the number of licensed beds in a group home residential setting changes, a new service authorization request must be submitted.

Service Documentation Requirements

Providers must include signed and dated documentation of the following in each individual's record:

- A completed copy of the age-appropriate, DBHDS-approved SIS® assessment form.
- The provider's Plan for Supports containing, at a minimum, the following elements:
    - The individual's desired outcomes that describe what is important to and for the individual in observable and measurable terms;
    - Support activities and support instructions that are inclusive of skill-building and that are designed to assist in achieving the individual's desired outcomes;
    - The services to be rendered and the schedule of such services to accomplish the desired outcomes and support activities;
    - A timetable for the accomplishment of the individual's desired outcomes and support activities;
    - The estimated duration of the individual's needs for services;
    - The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports; and

- Documentation regarding any restrictions on the freedoms of everyday life in accordance with DBHDS human rights regulations and the HCBS settings requirements of 42 CFR 441.301.

- Written documentation in the form of unique, person-centered, progress notes or data collected in a supports checklist as appropriate, per the plan for supports. This documentation must confirm the individual's days in service to support units of service delivered and provide specific information regarding the individual's responses to various settings and supports, as well as specific circumstances that prevented provision of the scheduled service, should that occur. Observations of the individual's responses to the services outlined in the plan for supports must be available in at least a daily note. Data must be collected as described in the ISP, analyzed to determine if the strategies are effective, summarized, then clearly documented in the progress notes or supports checklist. Documentation should be written, signed, and dated on the day the described supports were provided. Documentation that occurs after the date services were provided must be dated with the date the documentation was completed and also include the date the services were provided within the body of the note.

- Documentation must correspond with billing as defined in 12VAC30-122-120. Providers must maintain separate documentation for each type of service rendered for an individual. Providers' claims that are not adequately supported by corresponding documentation may be subject to recovery of reimbursement made.

- In a situation whereby the individual's needs have changed significantly, the plan for supports must be reviewed by the provider. A written review must be completed and supported by documentation in the individual's record for submission to the support coordinator at least quarterly with the plan for supports, if modified. Each quarterly person-centered review must contain the following elements:

    - A description of the status of each outcome in the plan for supports. Possible statuses include whether the outcome has been achieved, if progress is being made as expected, or if there has been limited or no progress. Any actions needed or that will be taken to resolve barriers or improve progress is noted;

    - Information about any newly identified safety risks;

    - Any changes desired by the individual or family member/caregiver, as applicable and his/their satisfaction with services;

    - Confirmation that all approved services were delivered according to the amount detailed in the plan, or, if not, the reason; and

- Any significant events.

The content of each review must be discussed/reviewed with the individual and family member/caregiver, as applicable and submitted to the Support Coordinator within 10 calendar days following the end of each quarter. The discussion must be documented either by the individual and family member/caregiver's signature on the review or a progress note describing the discussion. The due date for the person-centered review is determined by the effective date of the Individual Support Plan and communicated to the provider by the support coordinator. Four written reviews span the entire ISP year. Each quarterly review will represent the quarterly data however, the fourth quarter will provide an annual summary in addition to the fourth quarter data.

- The annual updates to the plan for supports and every time supporting documentation is updated, the update must be reviewed with the individual and family member/caregiver, as appropriate, and such review must be documented, either by the individual and family member/caregiver's signature on the review, or a progress note describing the discussion.

  - All correspondence with the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS;
  - Written documentation of contacts made with individual's family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual;
  - For the annual review and in cases where the Plan for Supports is modified, the team must work collaboratively to implement changes needed or desired by the individual. Changes in the Plan for Supports should be shared with the support coordinator and other participating providers, as appropriate.

INDEPENDENT LIVING SUPPORT SERVICES

Service Definition/Description

Independent living (IL) means a service provided to adults 18 years of age and older that offers targeted skill building and supports necessary for individuals to secure and maintain their own home in the community. An individual receiving this service typically lives alone or with roommates in the individual's own home or apartment. The supports may be provided in the individual's residence or in other community settings.

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Criteria/Allowable Activities

Individuals eligible for this service must be enrolled in the Building Independence (BI) waiver and living in his or her own home or apartment. The need for IL supports must be clearly indicated in the ISP. Independent living support service will be authorized for Medicaid reimbursement only when the individual requires this service and the service is set out in the plan for supports. This service must include a skill building component along with the provision of supports as needed.

Allowable activities include:

- Skill building and supports which will promote the individual's stability in his own home and community in the absence of a primary caregiver living in the home. This may include skill building and supports in areas such as:
    - Cooking
    - Cleaning
    - Shopping
    - Food Preparation and healthy eating
    - Money management
    - Organization
    - Calendar skills
    - Transportation
    - Coordinating/Scheduling Appointments
- Skill building and supports to promote the individual's community participation and inclusion in meaningful activities;
- Skill building and supports to increase socialization skills and develop/maintain relationships;
- Skill building and supports to improve and maintain the individual's health, safety and fitness, as necessary;
- Skill building and supports to promote the individual's decision making and self-determination;
- Skill building and supports to improve and maintain, as needed, the individual's skills with ADLs and IADLs;

- Routine supports with transportation to and from community locations and resources; and

- General supports, as needed.

Independent Living is compatible with all services available in the BI Waiver.

60-Day Assessment

A provider may use a 60-day assessment period for evaluating the individual's need for specific supports. If a provider utilizes an assessment period prior to development and integration of an annual Plan for Supports, a preliminary Plan for Supports must be developed with the team, based on information in the Personal Profile, Essential Information, the Virginia SIS® or other DBHDS-approved assessment, in addition to other assessment information available to the provider. The Plan for Supports must include the areas to be evaluated and a schedule of services to be provided. Prior to the last day of the assessment period, the provider, with the involvement of the individual, must develop an annual Plan for Supports, and forward it to the case manager for review, approval and reauthorization if required. The start date of the annual Plan for Supports must be no later than day 61 and the end date must correspond to the end date of the annual Individual Support Plan.

Service Limitations

Individuals generally receive up to 21 hours of IL supports per week (Sunday through Saturday) in the individual's home or community settings. Because this service is billed on a monthly (or partial month) basis, if the individual does not receive the full 21 hours one week due to a documented reason (e.g., vacation, hospitalization, illness, refusal), additional hours may be provided, if the individual has a documented need, another week in the month.

This service may not be provided in a licensed residential setting.

Service Units

The IL service unit of service delivery is one month or, when beginning or ending the service, may be a partial month. The partial month unit is billed when fewer than 10 days of IL are delivered in one month. Sufficient hours of service must be provided to meet the requirements set forth in the plan for supports.

Example 1: an individual moves into his apartment on March 23rd. ILS is delivered every day from March 23 through March 31. The provider would bill the partial month rate.

Example 2: an individual has experienced a decline in health and is moving to a group home through the CL waiver. Her apartment move-out date is December 5th. The ILS provider delivered five days of support in December and may bill a partial month.

Service Documentation Requirements

The required documentation for IL is as follows:

- A completed copy of the age appropriate, DBHDS-approved SIS® assessment form.
- The provider's Plan for Supports containing, at a minimum, the following elements:
    - The individual's desired outcomes that describe what is important to and for the individual in observable and measurable terms;
    - Support activities and support instructions that are inclusive of skill-building and that are designed to assist in achieving the individual's desired outcomes;
    - The services to be rendered and the schedule of such services to accomplish the desired outcomes and support activities;
    - A timetable for the accomplishment of the individual's desired outcomes and support activities;
    - The estimated duration of the individual's needs for services;
    - The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports;
    - Documentation regarding any restrictions on the freedoms of everyday life in accordance with DBHDS human rights regulations;
    - Written documentation in the form of unique, person-centered, progress notes or data collected in a supports checklist as appropriate, per the plan for supports. This documentation must confirm the individual's days in service to support units of service delivered and provide specific information regarding the individual's responses to various settings and supports, as well as specific circumstances that prevented provision of the scheduled service, should that occur. Observations of the individual's responses to the service must be available and documented at the time of contact. Data must be collected as described in the ISP, analyzed to determine if the strategies are effective, summarized, then clearly documented in the progress notes or supports checklist. Documentation should be written, signed, and dated on the day the described supports were provided. Documentation that occurs after the date services were provided must be dated with the date the documentation was completed and also include the date the services were provided within the body of the note.

- Documentation must support billing. Providers must maintain separate documentation for each type of service rendered for an individual. Providers' claims that are not adequately supported by corresponding documentation may be subject to recovery of payments made.

- In a situation whereby the individual's needs have changed significantly, the plan for supports must be reviewed by the provider. A written review must be completed and supported by documentation in the individual's record for submission to the support coordinator at least quarterly with the plan for supports, if modified. Each quarterly person-centered review must contain the following elements:

  - A description of the status of each outcome in the plan for supports. Possible statuses include whether the outcome has been achieved, if progress is being made as expected, or if there has been limited or no progress. Any actions needed or that will be taken to resolve barriers or improve progress is noted;

  - Information about any newly identified safety risks;

  - Any changes desired by the individual or family member/caregiver, as applicable and his/their satisfaction with services;

  - Confirmation that all approved services were delivered according to the amount detailed in the plan, or, if not, the reason; and

  - Any significant events.

- The content of each review must be discussed/reviewed with the individual and family member/caregiver, as applicable, and submitted to the Support Coordinator within 10 calendar days following the end of each quarter. The discussion must be documented either by the individual and family member/caregiver's signature on the review or a progress note describing the discussion. The due date for the person-centered review is determined by the effective date of the Individual Support Plan and communicated to the provider by the support coordinator. Four written reviews span the entire ISP year. For the annual updates to the plan for supports and every time supporting documentation is updated, the update must be reviewed with the individual and family member/caregiver, as appropriate, and such review must be documented, either by the individual and family member/caregiver's signature on the review, or a progress note describing the discussion.

  - All correspondence with the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS.

- Written documentation of contacts made with individual's family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual.
- For the annual review and in cases where the Plan for Supports is modified, the team must work collaboratively to implement changes needed or desired by the individual. Changes in the Plan for Supports should be shared with the support coordinator and other participating providers, as appropriate.
- Provider documentation must support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by supporting documentation are subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

IN-HOME SUPPORT SERVICES

Service Definition/Description

In-home support service (IHSS) is a residential service that takes place in the individual's home, family home, or community settings that typically supplements the primary care provided by the individual, family, or other unpaid caregiver and is designed to ensure the health, safety, and welfare of the individual. The individual must be living in his own home or his family home, and must be able to hire and fire providers of this service without having to move. This service must include a skill building component, along with the provision of supports that enable an individual to acquire, retain, or improve the self-help, socialization, and adaptive skills required for successfully living in his community. In-home support service is available to individuals through the FIS and CL waivers.

Criteria/Allowable Activities

To be eligible for IHSS, individuals must require help with adaptive skills necessary to reside successfully in home and community-based settings. In-home support service will be authorized for Medicaid reimbursement only when the individual requires this service and the service is set out in the plan for supports.

Allowable activities include the following as may be appropriate for the individual as documented in his plan for supports:

- Skill-building and routine supports related to ADLs and IADLs;
- Skill-building, routine supports, and safety supports related to the use of community resources, such as transportation, shopping, dining at restaurants, and participating in social and recreational activities;

- Supporting the individual in replacing challenging behaviors with positive, accepted behaviors for home and community environments;

- Monitoring the individual's health and physical condition and providing routine and safety supports with medication or other medical needs;

- Providing supports with transportation to and from community sites and resources; and

- Providing general supports as needed.

60-Day Assessment

A provider may use a 60-day assessment period for evaluating the individual's need for specific supports. If a provider utilizes an assessment period prior to development and integration of an annual Plan for Supports, a preliminary Plan for Supports must be developed with the team, based on information in the Personal Profile, Essential Information, the Virginia SIS® or other DBHDS-approved assessment, in addition to other assessment information available to the provider. The Plan for Supports must include the areas to be evaluated and a schedule of services to be provided. Prior to the last day of the assessment period, the provider, with the involvement of the individual, must develop an annual Plan for Supports, and forward it to the case manager for review, approval and reauthorization if required. The start date of the annual Plan for Supports must be no later than day 61 and the end date must correspond to the end date of the annual Individual Support Plan.

Customized Rate

Providers supporting individuals with extraordinary medical or behavioral supports needs, may apply for the customized rate for additional in-home supports delivered by the provider. See the Customized Rate section per 12VAC30-122-210.

Service Limitations

In-home support services may not typically be provided 24 hours per day, but may be authorized for brief periods up to 24 hours a day when necessary and supported through documentation.

All individuals must have a backup plan prior to initiating services in cases of emergency or should the provider be unable to render services as needed. This backup plan must be shared with the provider and support coordinator at the onset of services and updated with the provider and support coordinator as necessary.

This service may not be provided in a licensed residential setting, such as a supported living program or group residential. The individual must be able to hire and terminate the provider of this service.

Individuals may have IHSS, personal assistance service, and respite service in their ISP, but may not receive these Medicaid-reimbursed services simultaneously (i.e., on the same dates and times).

Services that may not be authorized with IHSS include:

- Supported Living
- Sponsored Residential
- Group Home Residential

Semi-Predictable Events

Semi-predictable events include, but are not limited to, events such as illness, inclement weather resulting in the closing of day or employment service sites, holidays, individual choice, etc. Individuals receiving IHSS have various available natural supports, service provider resources, and are required to have back-up plans. Therefore, solutions for accommodating semi-predictable events will vary from person to person. The back-up plan support should be considered as the first option to provide needed supports during semi-predictable events such as inclement weather, illness, etc. The back-up plan may, in some circumstances, involve the use of paid staff who substitute for those regularly scheduled or at times other than what may be regularly scheduled. However, there are times when a provider may anticipate a need for an increase in service hours due to holidays, doctor visits, etc. and the back-up plan is not an option. In these situations a provider may submit a service authorization request (if not already included in their annual plan request) that includes:

- The appropriate explanation such as clear notation of the insufficiency of the back-up plan; and

- Planned usage of additional hours and documentation of the supports that will be provided during those specific periods.

The service authorization staff will add the additional hours provided to that month's authorized hours. Service authorization requests may be submitted after, but in the same month as service delivery. Because IHSS is authorized on a monthly basis, providers will have hours in that month's authorization on which to draw until the emergency request is made and approved. Only emergencies that occur on the last day of the month require a service authorization modification to be submitted that very day.

Service Units

The unit is one hour and is reimbursed according to the number of individuals served.

This service may be provided to up to three individuals per residential setting. In-home support services is not a tiered service for reimbursement purposes; however, per person reimbursement

decreases with each additional person receiving services according to the approved rate methodology. In-home support services do not include room and board. Services authorized for reimbursement may not duplicate those that are funded or provided by another source.

The in-home support service is reimbursed for the time the DSP is working directly with the individual. Total billing cannot exceed the total hours provided and authorized on the service authorization request. When unavoidable circumstances occur so that a provider is at the individual's home at the designated time but cannot deliver part of the services due to individual or family related situations (such as unanticipated lateness or illness of the individual or family emergency), billing will be allowed for the entire number of hours scheduled for that day. The provider must maintain documentation of the date, times, services that were provided and specific circumstances, which prevented provision of all of the scheduled services. If fewer hours than scheduled in the Plan for Supports are delivered on a regular basis over a 90-day period, the provider must revise the Plan for Supports and submit a new service authorization request. This revision must be reviewed and approved by the support coordinator and authorized by DBHDS.

Service Documentation Requirements

The required documentation for in-home supports services is as follows:

- A completed copy of the standard, assessment form (DBHDS-approved developmental assessment or SIS® assessment form, depending on the individual's age),
- The provider's Plan for Supports containing, at a minimum, the following elements:
    - The individual's desired outcomes that describe what is important to and for the individual in observable and measurable terms;
    - Support activities and support instructions that are inclusive of skill-building and that are designed to assist in achieving the individual's desired outcomes;
    - The services to be rendered and the schedule of such services to accomplish the desired outcomes and support activities;
    - A timetable for the accomplishment of the individual's desired outcomes and support activities;
    - The estimated duration of the individual's needs for services;
    - The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports.

- An attendance log or similar document that is maintained and that indicates the date, type of service rendered, and the number of hours and units provided, including specific timeframe.

- Written documentation in the form of unique, person-centered, progress notes or data collected in a supports checklist as appropriate, per the plan for supports. This documentation must confirm the individual's days in service to support units of service delivered and provide specific information regarding the individual's responses to various settings and supports, as well as specific circumstances that prevented provision of the scheduled service, should that occur. Observations of the individual's responses to the service must be available in at least a daily note. Data must be collected as described in the ISP, analyzed to determine if the strategies are effective, summarized, then clearly documented in the progress notes or supports checklist. Documentation should be written, signed, and dated on the day the described supports were provided. Documentation that occurs after the date services were provided must be dated with the date the documentation was completed and also include the date the services were provided within the body of the note.

- Documentation must correspond with billing as defined in 12VAC30-122-120. Providers must maintain separate documentation for each type of service rendered for an individual. Providers' claims that are not adequately supported by corresponding documentation may be subject to recovery of expenditures made.

- In a situation whereby the individual’s needs have changed significantly, the plan for supports must be reviewed by the provider. A written review must be completed and supported by documentation in the individual’s record for submission to the support coordinator at least quarterly with the plan for supports, if modified. Each quarterly person-centered review must contain the following elements:

    - A description of the status of each outcome in the plan for supports. Possible statuses include whether the outcome has been achieved, if progress is being made as expected, or if there has been limited or no progress. Any actions needed or that will be taken to resolve barriers or improve progress is noted;

    - Information about any newly identified safety risks;

    - Any changes desired by the individual or family member/caregiver, as applicable and his/their satisfaction with services;

    - Confirmation that all approved services were delivered according to the amount detailed in the plan, or, if not, the reason; and

- Any significant events.

- The content of each review must be discussed/reviewed with the individual and family member/caregiver, as applicable and submitted to the Support Coordinator within 10 calendar days following the end of each quarter. The discussion must be documented either by the individual and family member/caregiver's signature on the review or a progress note describing the discussion. The due date for the person-centered review is determined by the effective date of the ISP and communicated to the provider by the support coordinator. Four written reviews span the entire ISP year.

    - For the annual updates to the plan for supports and every time supporting documentation is updated, the update must be reviewed with the individual and family member/caregiver, as appropriate, and such review must be documented, either by the individual and family member/caregiver's signature on the review, or a progress note describing the discussion.

    - All correspondence to the individual and the individual's family/caregiver, as appropriate, the support coordinator/case manager, DMAS, and DBHDS.

    - Written documentation of contacts made with family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual.

    - For the annual review and in cases where the Plan for Supports is modified, the team must work collaboratively to implement changes needed or desired by the individual. Changes in the Plan for Supports should be shared with the support coordinator and other participating providers, as appropriate.

    - Provider documentation must support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by supporting documentation are subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

SHARED LIVING SUPPORTS

Service Definition/Description

Shared living means Medicaid coverage of a portion of the total cost of rent, food, and utilities that can be reasonably attributed to a roommate who has no legal responsibility to financially support the individual who is enrolled in the waiver. The types of assistance provided are expected to vary from individual to individual and shall be set out in a detailed, signed and dated agreement between

the individual and roommate. This service shall require the use of a Shared Living provider (provider agency) enrolled with DMAS. This provider shall be responsible for directly coordinating the services and directly billing DMAS for reimbursement. Shared living services shall be covered in the CL, FIS and BI waivers.

Criteria/Allowable Activities

Shared Living is a one to one arrangement with one roommate providing supports to one individual receiving waiver services. The individual shall select his roommate and together through a person-centered planning process, they shall determine the assistance to be provided by the roommate based on the individual's needs and preferences. The need and choice for the service option will be documented in the individual's person-centered ISP.

- The Shared Living service requires a written agreement between the individual and roommate to cover the following areas: Participation between the individual and the roommate:
    - Specification of the agreed upon type, amount, frequency and delivery of fellowship and companionship supports that will be provided to the individual;
    - Documentation of the *Activities of Daily Living(ADLS)* and *Instrumental Activities of Daily Living* (IADLs) supports to be provided, which may account for no more than 20% of the anticipated time agreed upon between the individual and the roommate;
    - Specification of the preferences of both the individual and the roommate and the agreed upon duties in the residence that will be shared by both.

This agreement shall not include terms or conditions that are disallowed by the waiver or by any other regulatory authority. The roommate will not have responsibility for providing habilitative or medical services.

The reimbursable room and board subsidy for the roommate shall be established through the service authorization process per the CMS-approved rate methodology published on the DBHDS website. Reimbursement will not be made directly to the individual, but routed to the individual through the provider that will in turn transfer the appropriate amount of funds to the individual to cover the roommate's room and board costs. Arrangements for disbursement of funds to cover household expenses will be determined by the individual and the roommate.

The Shared Living provider must complete a background check on the roommate, including but not limited to, a criminal registry check. The roommate must not have been found guilty of having committed any barrier crimes in accordance with both § 37.2-416 – and § 19.2-392.02 of the Code of Virginia. If the roommate is found to have been convicted of a barrier crime, he is no longer eligible to receive Medicaid funding for room and board.

The supports agreement between the individual and roommate, must include a back-up plan in the event that the roommate is unable or unavailable to provide the agreed upon supports. The backup plan may include the family and/or friends of the individual, or if required by the plan, waiver services and supports available to the individual may be temporarily increased during the time the roommate is unavailable. Family members providing back-up support are not responsible for documentation of supports provided.

The individual must reside in his own home or in a residence he leases. A signed, executed copy of the lease agreement, completed Shared Living Attestation form, and documentation of roommate training and background checks (which may not under any circumstances, be shared or transmitted) must be submitted with the service authorization request for the Shared Living service.

Shared Living requires oversight by a provider that will be responsible for quarterly face-to-face monitoring of the service with monthly collateral contacts. The provider and Support Coordinator share oversight of the service through traditional monitoring oversight activities.

- The provider and the Support Coordinator shall work together to monitor the arrangement to ensure that supports are provided as agreed and communicate any problems or issues that arise for appropriate resolution;

- The Support Coordinator and provider shall help mediate and mitigate conflicts that arise,

- The provider and the Support Coordinator are not responsible for removal of the roommate from the residence. This will depend on the tenancy status of the roommate, as dictated by the lease;

- The property owner or law enforcement would intervene, as necessary in the event of criminal or other prohibited activity;

- The provider may access flexible funding for set up activities related to roommate screening and matching for initiation of the service at the current case management rate up to 60 days prior to service authorization. Please see flexible funding guidelines for more information;

- In the event that the roommate exits the arrangement prior to the end of the lease or as outlined in the Supports Agreement, the individual may receive up to 60 days reimbursement through flexible funding for the roommate's portion of the rent to locate a new roommate.

The allowable activities may include:

- Companionship supports, which are further described as:

- The provision of *fellowship,* which means to engage the individual in social, physical or mental activities, such as conversation, games, crafts, accompanying the person on walks, errands, appointments and social and recreational activities.

- Enhanced feelings of security which means to provide necessary social and emotional support to the individual when inside or outside of the residence.

- Limited ADL and IADL supports, which may account for no more than 20% of the anticipated time agreed upon between the individual and the roommate. These are further described as:

  - Assistance with IADLs which are tasks that enable a person to live independently at home, such as meal preparation, light housework, assistance with the physical taking of medications.

  - Assistance with ADLS, either with routine prompting and/or intermittently providing direct assistance for ADLs such as dressing, grooming, feeding, bathing, toileting and transferring.

Service Limitations

- The service is limited to adult individuals aged 18 or above;
- The individual must reside in his or her own home or a leased residence and be named as primary leaseholder;
- Individuals must be receiving at least one other waiver service;
- The roommate must be at least 18 years of age;
- There may be no inherent or explicit employment relationship between the individual and the roommate with no compensation given to the roommate by the individual (or the individual's authorized agents);
- The roommate may not be a service provider to the individual for any waiver service, but he may provide services to another individual;
- The roommate may not be the spouse, parent (biological, adoptive, foster, or stepparent), grandparent, or guardian of the individual;
- The roommate must successfully meet or exceed the training requirements set out in the written agreement, including but not limited to:
  - CPR training;
  - Safety awareness;

- Fire safety and disaster planning; and/or
- Conflict management and resolution.

- Service interruptions will not exceed 60 days to continue eligibility for Shared Living.

- When the Shared Living provider agency determines that their participation as administrative provider for an individual enrolled in the waiver will be discontinued, the provider must give the individual and the individual's family/caregiver, and/or guardian, as appropriate, and the individual's support coordinator, advance written notification of the provider's intent to discontinue services.

  Because two individuals' housing may be impacted by discontinuation/interruption of the Shared Living service, the notification letter must be submitted by the provider for receipt by the individual at least 60 days in advance of the effective date of the planned discontinuation of service. The notification letter must outline the reasons for discontinuing participation in the service.

- Immediately upon receiving the advance notice of the discontinuation of the service, the support coordinator will assist the individual enrolled in the waiver in obtaining authorization of the Shared Living service from another enrolled provider.

The subsidy payment will not be made when the individual lives in the roommate's home, in a residence that is owned or leased by a provider agency, or any other residential arrangement where the individual is not directly responsible for owning or leasing the residence. The Shared Living subsidy payment shall not duplicate:

- Services that are required as a reasonable accommodation under any applicable federal statute;
- Payments made to public agencies or private entities under other program authorities for this same purpose;
- Any other Medicaid waiver service.

Services incompatible with the Shared Living service includes:

- Group Home;
- Sponsored Residential;
- Supported Living Residential Services; and
- Respite Services.

Service Units

The unit of service shall be a month or may be a partial month for months in which the service initiates or ends. A partial month will be used for calculation of the first month's rent when the service is terminated on days 1 through 10 or initiated on day 16 through the end of the month.

Reimbursement for Allowable Expenses

The approvable amount for the room and board subsidy (rent, food and utility costs) shall be the lesser of the roommate's half of the rent cost incurred by the individual receiving waiver services up the maximum allowable amount for the region of the state in which the individual and roommate reside. The maximum reimbursable room and board shall be based on the range of fair market rent (FMR) in the state, using one rate for Northern Virginia and another for the rest of the state (ROS) as established by DMAS.

The reimbursement for up to 50% of the cost of rent and utilities incurred by the individual for the roommate's portion cannot exceed amounts shown in the table below:

Rent/utilities Reimbursement	Rest of State	N. Virginia
Reimbursement for up to 50% of rent & utilities up to the maximum allowance for the ROS and Northern Virginia. **Utilities are reimbursed at a flat rate up to $100 per unit per month.** The $100 utility allowance is applicable under the following conditions: • **The individual does not receive rental assistance*** • The individual's rent is below market for the geographic area and is added to the rent to achieve reimbursable FMR** • Utilities are not included in the rent. *Individuals receiving rental assistance are not eligible for reimbursement of rent or utilities since these costs are factored into the subsidy received by the individual. Individuals receiving rental assistance may only receive	**$553.50 (maximum reimbursement for 50% of rent)**	**$729.00 (maximum reimbursement for 50% of rent)**

reimbursement for food and internet (see chart below). **The FMR referenced includes the 2015 rate in accordance with the last waiver rate change. The Shared Living FMR will increase with the next waiver rate rebase.		

The reimbursement for food and internet services is a flat rate reimbursement determined through a CMS approved rate methodology equal to the following amounts:

Expense	Monthly Reimbursement Amount
Internet Service	**$25.00 monthly reimbursement**
Food	**Up to $240.90 monthly reimbursement** Based on USDA Low-Cost Plan for a 19-50 year old male, June 2015. If the live-in roommate receives monthly SNAP benefits, the benefit amount would be deducted from the monthly reimbursement amount.

The localities listed below are considered "Northern Virginia" (NOVA) according to the FMR areas included in the rate methodology. Any city/county not included in the chart below is ROS.

Northern Virginia Differential Effective July 1, 2015	
Locality	**FIPS Code**
Alexandria City	510
Arlington County	013
Clarke County	043
Fairfax City	600
Fairfax County	059
Falls Church City	610
Fauquier County	061
Fredericksburg City	630
Loudoun County	107
Manassas City	683
Manassas Park City	685

Prince William County	153
Spotsylvania County	177
Stafford County	179

Other Limitations

Often, in order to live in independent housing, individuals receiving waiver services require rental assistance. Rental assistance may include a Housing Choice Voucher, or a state rental subsidy from the Department of Behavioral Health and Developmental Services (DBHDS) State Rental Assistance Program (SRAP), project-based rental assistance, or the rent may be subsidized with funds from an individual's special needs trust or ABLE account.

Individuals using rental assistance with the service shall follow the PHA process for consideration of the roommate to be classified as a Live-in-aide under PHA guidelines. Individuals who receive rental assistance and participate in Shared Living will have a reduced reimbursement for the service. This is because Medicaid programs may not duplicate funding received by individuals through another public funding source.

There are different resources available to individuals, including both personal and public resources. Personal and public resources received by the individual may factor in their ability to qualify for the rental unit. Personal and public resources received by the roommate will be deducted from the allowances in the Shared Living service.

Service Documentation Requirements

- The Shared Living provider will maintain documentation of the actual rent, Shared Living Attestation, roommate training and background check, and submit it with the service authorization request for the shared living service.

- The Shared Living provider will maintain documentation of the following:

    - Executed lease agreement;
    - Ongoing monitoring of the service;
    - The agreement signed by the individual and the roommate that identifies what supports the roommate will provide. The individual's Support Coordinator must also retain a copy of this signed, executed agreement in his file for the particular individual;

- Weekly support checklists, signed by both the individual and the roommate, documenting supports provided (see Shared Living Toolkit Appendix A);
- Documentation of the 90-day quarterly review checklists conducted in the residence with the individual and the roommate, which includes the status of the individual, satisfaction with the service, and resolution of any issues related to service provision (See Shared Living Toolkit Appendix A);
- Shared Living Attestation and Shared Living Determination form generated through the service authorization process (See Shared Living Toolkit Appendix A);
- The following completed training:
  - CPR;
  - Safety awareness;
  - Fire, safety, and disaster planning;
  - Documentation of agreement between parties on individual on conflict management and resolution; and
  - Any other necessary specialized training outlined in the person centered-plan.
- Successful completion of all background checks;
- Documentation of monthly payments made to the individual;

- The Shared Living provider shall submit monthly claims for Shared Living services reimbursement based upon the amount determined through the service authorization process.

SPONSORED RESIDENTIAL SERVICE

Service Definition/Description

Sponsored residential services (SRS) means residential services that consist of skill-building, routine supports, general supports, and safety supports provided in the homes of families or persons (sponsors) who provide supports under the supervision of a DBHDS-licensed provider. This service enables individuals to acquire, retain, or improve the self-help, socialization, and adaptive skills necessary to live a self-directed life in the community. This service may be provided to individuals up to 24 hours per day by the sponsor family or qualified staff.

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Criteria/Allowable Activities

Only individuals enrolled in the Community Living (CL) waiver may receive sponsored residential supports.

This service may only be authorized for Medicaid reimbursement when, through the person-centered planning process, sponsored residential service is determined necessary to meet the individual's needs. This service may be provided individually or simultaneously to up to two individuals living in the same home, depending on the required support.
The allowable activities may include, as may be appropriate for the individual as documented in his plan for supports:

- Skill-building and providing routine supports related to ADLs and IADLs;
- Skill-building and providing routine supports and safety supports related to the use of community resources, such as transportation, shopping, restaurant dining, and participating in social and recreational activities;
- Supporting the individual in replacing challenging behaviors with positive, accepted behavior for home and community environments, for example (not all inclusive):
    - Developing a circle of friends;
    - Handling social encounters with others; or
    - Redirecting challenging behavior.
- Monitoring and supporting the individual's health and physical condition and providing supports with medication and other medical needs;
- Providing routine supports and safety supports with transportation to and from community locations and resources;
- Providing general supports, as needed; and
- Providing safety supports to ensure the individual's health and safety.

Sponsored residential service must include a skill-building component along with the provision of routine and safety supports as may be needed by the individuals who are participating. This service must be provided on an individual-specific basis according to the ISP and service setting requirements.

Services not allowable with SRS include:

- Agency Directed Respite
- Consumer Directed Respite
- Agency Directed Personal Assistance*
- Consumer Directed Personal Assistance*
- Supported Living Residential
- Shared Living
- In-home supports
- Personal Emergency Response Services (PERS)
- Electronic Home Based Supports
- Environmental Modifications
- Group Home Residential

*This does not include personal assistance services required while an individual is at work.

Additionally, for an individual receiving SRS, the DSP providing the following service may not be a member of the sponsored family residing in the SRS home:

- Community Coaching
- Community Engagement
- Companion services

Individuals who receive SRS may also receive Agency- or Consumer-Directed Companion services, however, the SRS provider may not also be the provider of Companion services.

60-Day Assessment

A provider may use a 60-day assessment period for evaluating the individual's need for specific supports. If a provider utilizes an assessment period prior to development and integration of an annual Plan for Supports, a preliminary Plan for Supports must be developed with the team, based on information in the Personal Profile, Essential Information, the SIS® or other DBHDS-approved assessment, in addition to other assessment information available to the provider. The Plan for Supports must include the areas to be evaluated and a schedule of services to be provided. Prior to the last day of the assessment period, the provider, with the involvement of the individual, must develop an annual Plan for Supports, and forward it to the case manager for review, approval and reauthorization if required. The start date of the annual Plan for Supports must be no later than day 61 and the end date must correspond to the end date of the annual Individual Support Plan.

Sponsored residential service settings must comply with the HCBS setting requirements per 42 CFR 441.301 and as described in Chapter II. In these settings, lease or residency agreements must comply with and support individual choice of service and setting.

Customized Rate

Providers supporting individuals with extraordinary medical or behavioral supports needs, may apply for the customized rate for additional community coaching supports delivered by the provider. See the Customized Rate section per 12VAC30-122-210.

Service Limitations

Sponsored residential services must be authorized for Medicaid reimbursement only when the individual requires these services and they are set out in the Plan for Supports.

Sponsored residential service is limited to no more than two individuals per residential setting. Providers may not bill for service rendered to more than two individuals living in the same residential setting.

Providers will not be reimbursed for the costs of room and board.

Service Units

The unit of service is one day. Providers may bill the unit of service if any portion of the plan for supports is provided during that day. Billing must not exceed 344 days per ISP year. The 344-day billing limit is intended to protect providers against lost revenue due to members' occasional absences. The rate models include a 21-day absence factor so that providers are not financially penalized when an individual is absent from the program. This approach allows providers to earn the full annual cost of services over 344 days of billing.

If an individual moves to a sponsored home with a different provider agency during their ISP year, the 344 days count resets to one on the first day the individual is living with the new provider agency. If an individual moves from one home to another within the same provider agency during their ISP year, the 344-day count does not reset.
Sponsored residential service is a tiered service for reimbursement purposes and providers will only be reimbursed for the individual's assigned level and tier.

Service Documentation Requirements

Providers must include signed and dated documentation of the following in each individual's record:

- A completed copy of the age-appropriate, DBHDS-approved SIS® assessment form.
- The provider's Plan for Supports containing, at a minimum, the following elements:

    - The individual's desired outcomes that describe what is important to and for the individual in observable and measurable terms;

- Support activities and support instructions that are inclusive of skill-building and that are designed to assist in achieving the individual's desired outcomes;

- The services to be rendered and the schedule of such services to accomplish the desired outcomes and support activities;

- A timetable for the accomplishment of the individual's desired outcomes and support activities;

- The estimated duration of the individual's needs for services;

- The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports; and

- Documentation regarding any restrictions on the freedoms of everyday life in accordance with DBHDS human rights regulations and the HCBS settings requirements of 42 CFR 441.301.

- Written documentation in the form of unique, person-centered, progress notes or data collected in a supports checklist as appropriate, per the plan for supports. This documentation must confirm the individual's days in service to support units of service delivered and provide specific information regarding the individual's responses to various settings and supports, as well as specific circumstances that prevented provision of the scheduled service, should that occur. Observations of the individual's responses to the service must be available in at least a daily note. Data must be collected as described in the ISP, analyzed to determine if the strategies are effective, summarized, then clearly documented in the progress notes or supports checklist. Documentation should be written, signed, and dated on the day the described supports were provided. Documentation that occurs after the date services were provided must be dated with the date the documentation was completed and also include the date the services were provided within the body of the note.

- Documentation must correspond with billing. , as defined in 12VAC30-122-120. Providers must maintain separate documentation for each type of service rendered for an individual. Providers' claims that are not adequately supported by corresponding documentation may be subject to recovery of expenditures made.

    - A description of the status of each outcome in the plan for supports. Possible statuses include whether the outcome has been achieved, if progress is being made as expected, or if there has been limited or no progress. Any actions needed or that will be taken to resolve barriers or improve progress is noted;

- Information about any newly identified safety risks;
- Any changes desired by the individual or family member/caregiver, as applicable and his/their satisfaction with services;
- Confirmation that all approved services were delivered according to the amount detailed in the plan, or, if not, the reason; and
- Any significant events.

- The content of each review must be discussed/reviewed with the individual and family member/caregiver, as applicable and submitted to the Support Coordinator within 10 calendar days following the end of each quarter. The discussion must be documented either by the individual and family member/caregiver's signature on the review or a progress note describing the discussion. The due date for the person-centered review is determined by the effective date of the ISP and communicated to the provider by the support coordinator. Four written reviews span the entire ISP year.

- For the annual updates to the plan for supports and every time supporting documentation is updated, the update must be reviewed with the individual and family member/caregiver, as appropriate, and such review must be documented, either by the individual and family member/caregiver's signature on the review, or a progress note describing the discussion.

- All correspondence with the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS.

- Written documentation of contacts made with individual's family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual.

- For the annual review and in cases where the Plan for Supports is modified, the team must work collaboratively to implement changes needed or desired by the individual. Changes in the Plan for Supports should be shared with the support coordinator and other participating providers, as appropriate.

- If a family member intends to become the sponsored residential provider, the "Family Member as Sponsor Provider Supporting Documentation Form" and any associated documentation must be submitted with the service authorization request.

- Provider documentation must support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by supporting documentation are subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

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SUPPORTED LIVING

Service Definition/Description

Supported living is a service that typically takes place in a residential setting operated by a DBHDS-licensed provider. This denotes a location in which the individual receiving support services would typically be required to move from the location in order to choose a different provider for the type of services provided in that setting, since the site is leased or sublet to the individual by the provider-owner and continuation of supports at that site is dependent upon receiving services from the provider-owner. The above does not apply when the services is delivered in the individual's own home or apartment.

Supported living consist of skill-building, routine and general supports, and safety supports that enable the individual to acquire, retain, or improve the self-help, socialization and adaptive skills necessary to reside successfully in the community. Supported living will be authorized for Medicaid reimbursement in the plan for supports only when the individual requires this service. This service must include a skill-building component along with the provision of routine or safety supports.

Supported living will be provided to the individual in the form of around-the-clock availability of paid provider staff who have the ability to respond in a timely manner. These services may be provided individually or simultaneously to more than one individual living in the apartment, depending on the individual(s) needs.

Criteria/Allowable Activities

Only individuals who are enrolled in the CL Waiver or FIS Waiver are eligible for Supported Living.

Allowable Activities:

- Skill-building and routine supports related to ADLs and IADLs;
- Skill-building and routine and safety supports related to the use of community resources such as transportation, shopping, restaurant dining, and participating in social and recreational activities. The cost of participation in the actual social or recreational activity will not be reimbursed by Medicaid;
- Supporting the individual in replacing challenging behaviors with positive, accepted behaviors for home and community-based environments, for example (not all inclusive):
    - Developing a circle of friends,
    - Handling social encounters with others, or
    - Redirecting challenging behavior.

- Monitoring and supporting the individual's health and physical conditions and providing supports with medication or other medical needs;

- Providing routine supports and safety supports with transportation to and from community locations and resources;

- Providing general supports as needed;

- Providing safety supports to ensure the individual's health and safety, and

- Providing administrative supports that occur without the individual present. These services can include: scheduling healthcare appointments, benefits management, and speaking with apartment management (as needed).

These services **must** include a skill-building component along with the provision of supports.

60-Day Assessment

A provider may use a 60-day assessment period for evaluating the individual's need for specific supports. If a provider utilizes an assessment period prior to development and integration of an annual Plan for Supports, a preliminary Plan for Supports must be developed with the team, based on information in the Personal Profile, Essential Information, the SIS® or other DBHDS-approved assessment, in addition to other assessment information available to the provider. The Plan for Supports must include the areas to be evaluated and a schedule of services to be provided. Prior to the last day of the assessment period, the provider, with the involvement of the individual, must develop an annual Plan for Supports, and forward it to the case manager for review, approval and reauthorization if required. The start date of the annual Plan for Supports must be no later than day 61 and the end date must correspond to the end date of the annual Individual Support Plan.

Service Limitations

Supported living shall be authorized for Medicaid reimbursement only when the individual requires these services and they are set out in the Plan for Supports. This service shall be provided on an individual-specific basis according to the ISP and service setting requirements. Those services authorized for reimbursement under supported living residential services may not duplicate those that are funded or provided by another source.

Reimbursement shall not occur for the costs of room and board. Medicaid reimbursement shall be available only for supported living residential services, other than the administrative services noted above, provided when the individual is present and when an enrolled Medicaid provider is providing the services.

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Supported living residential service shall not be used solely to provide routine or emergency respite care for the individual's family/caregiver with whom the individual lives.

Services that may not authorized with Supported Living include:

- Agency Directed Respite
- Consumer Directed Respite
- Agency Directed Personal Assistance *
- Consumer Directed Personal Assistance *
- Sponsored Residential
- Group Home Residential
- Shared Living
- In-Home Supports
- PERS
- Electronic Home Based Supports
- Environmental Modifications

*This does not include personal assistance services required while an individual is at work.

Individuals who receive supported living residential services may also receive Agency- or Consumer-Directed Companion services; however, the Supported Living provider may not also be the provider of Companion services, as this is duplicative. For individuals receiving Supported Living, companion service may not be provided by an immediate family member.

Service Units

The unit of service is one day. Providers may bill the unit of service if any portion of the plan for supports is provided during that day. Billing must not exceed 344 days per ISP year. The 344-day billing limit is intended to protect providers against lost revenue due to members' occasional absences. The rate models include a 21 day absence factor so that providers are not financially penalized when an individual is absent from the program. This approach allows providers to earn the full annual cost of services over 344 days of billing.

If an individual moves to a supported living program with a different provider agency during their ISP year, the 344 days count resets to one on the first day the individual is living with the new provider agency. If an individual moves from one home to another within the same provider agency during their ISP year, the 344 day count does not reset.

Service Documentation Requirements

The required documentation for Supported Living is be as follows:

- A completed copy of the age-appropriate, DBHDS-approved SIS® assessment form;

- The provider's Plan for Supports containing, at a minimum, the following elements:
    - The individual's desired outcomes that describe what is important to and for the individual in observable and measurable terms;
    - Support activities and support instructions that are inclusive of skill-building and that are designed to assist in achieving the individual's desired outcomes;
    - The services to be rendered and the schedule of such services to accomplish the desired outcomes and support activities;
    - A timetable for the accomplishment of the individual's desired outcomes and support activities;
    - The estimated duration of the individual's needs for services;
    - The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports; and
    - Documentation regarding any restrictions on the freedoms of everyday life in accordance with DBHDS human rights regulations and the HCBS settings requirements of 42 CFR 441.301.
- Documentation must correspond with billing as defined in 12VAC30-122-120. Providers must maintain separate documentation for each type of service rendered for an individual. Providers' claims that are not adequately supported by corresponding documentation may be subject to recovery of expenditures made.
- Written documentation in the form of unique, person-centered, progress notes or data collected in a supports checklist as appropriate, per the plan for supports. This documentation must confirm the individual's days in service to support units of service delivered and provide specific information regarding the individual's responses to various settings and supports, as well as specific circumstances that prevented provision of the scheduled service, should that occur. Observations of the individual's responses to the service must be available in at least a daily note. Data must be collected as described in the ISP, analyzed to determine if the strategies are effective, summarized, then clearly documented in the progress notes or supports checklist. Documentation should be written, signed, and dated on the day the described supports were provided. Documentation that occurs after the date services were provided must be dated with the date the documentation

was completed and also include the date the services were provided within the body of the note.

- In a situation whereby the individual's needs have changed significantly, the plan for supports must be reviewed by the provider. A written review must be completed and supported by documentation in the individual's record for submission to the support coordinator at least quarterly with the plan for supports, if modified. Each quarterly person-centered review must contain the following elements:

    - A description of the status of each outcome in the plan for supports. Possible statuses include whether the outcome has been achieved, if progress is being made as expected, or if there has been limited or no progress. Any actions needed or that will be taken to resolve barriers or improve progress is noted;

    - Information about any newly identified safety risks;

    - Any changes desired by the individual or family member/caregiver, as applicable and his/their satisfaction with services;

    - Confirmation that all approved services were delivered according to the amount detailed in the plan, or, if not, the reason; and

    - Any significant events.

- The content of each review must be discussed/reviewed with the individual and family member/caregiver, as applicable and submitted to the Support Coordinator within 10 calendar days following the end of each quarter. The discussion must be documented either by the individual and family member/caregiver's signature on the review or a progress note describing the discussion. The due date for the person-centered review is determined by the effective date of the ISP and communicated to the provider by the support coordinator. Four written reviews span the entire ISP year. For the annual updates to the plan for supports and every time supporting documentation is updated, the update must be reviewed with the individual and family member/caregiver, as appropriate, and such review must be documented, either by the individual and family member/caregiver's signature on the review, or a progress note describing the discussion.

- All correspondence with the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS.

- Written documentation of contacts made with individual's family/caregiver, physicians, formal and informal service providers and all professionals concerning the individual.

- For the annual review and in cases where the Plan for Supports is modified, the team must work collaboratively to implement changes needed or desired by the individual. Changes in the Plan for Supports should be shared with the support coordinator and other participating providers, as appropriate.

- Provider documentation must support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by supporting documentation are subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

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	CORRESPONDING REGULATION(S)	BI	FIS	CL
SELF-DIRECTED AND AGENCY-DIRECTED OPTIONS				
Agency Directed Companion Services	12VAC30-122-340		✓	✓
Agency Directed Personal Assistance Services	12VAC30-122-460		✓	✓
Agency Directed Respite Services	12VAC30-122-490		✓	✓
Consumer Directed Services Facilitation	12VAC30-122-500		✓	✓

COMPANION SERVICES: AGENCY-DIRECTED AND CONSUMER-DIRECTED

Service Definition/Description

Companion service provides non-medical care, socialization, or general support to adults 18 years or older. This service is provided either in the individual's home or at various locations in the community.

Criteria/Allowable Activities

Companion services are available for adults who receive the CL or FIS waiver.
Companion services must be provided in accordance with the individual's plan for supports to meet an assessed need of the individual for assistance with IADLs, community access, reminders for medication self-administration, or for support to ensure his or her safety. Companion services are not permitted to be provided for purely recreational purposes.

Companion services may be provided and reimbursed through either an agency-directed or consumer-directed model or a combination of the two. If an individual chooses a combination of agency-directed and consumer-directed supports, the services can be provided on different days or at different times on the same day; however, the services must not be provided on the same days at the same time.

Should an individual elect to receive companion services through the **consumer-directed model**, there are certain requirements that must be met prior to starting services. **For more information, review the "CD Services in Virginia" section.**

All service models individually - are limited to eight hours in a twenty-four hour period. In the consumer-directed model any combination of respite, personal assistance and companion services will be limited to 40 hours per week for a single EOR (see) by the same companion. Companions who live full – or substantial amounts of time - with the individual will not be limited to 40 hours per week per EOR (see http://www.dol.gov/agencies/whd/fact-sheets/79a-flsa-companionship).

Companion services are available for individuals for whom skill building is not the primary objective or when skill-building is received in another service or setting. This service may not supplant an appropriate skill-building service when the individual has the capacity to gain

increased independence (i.e., the individual should access skill-building services as identified to satisfy the need for waiver services)

Companion services may be approved for individuals who are living in a residential setting such as a group home, supported living, or sponsored residential setting if the service need is documented in the plan for supports and does not duplicate services which should be provided by the residential agency.

Allowable activities include:

- Routine supports for IADL needs, including meal preparation, community access and activities, and shopping. Companions provide supports to broadly address any/all supports within the plan for supports, which may address more than IADL's;

- Routine supports with light housekeeping tasks, including bed making, laundry, dusting, and vacuuming, when such services are specified in the individual's plan for supports and are essential to the individual's health and welfare in order to maintain the individual's home environment in an orderly and clean manner;

- Support needed by the individual to participate in social, recreational, or community activities;

- Accompanying the individual to appointments and meetings; and

- Safety supports in the home and community setting, including supporting the individual with self-administration of medications.

Services performed for the convenience of other members of the household (e.g., cleaning rooms used by all family members, cooking meals for the family, washing dishes, family laundering, etc.) are not allowable.

Service Limitations

A companion is not permitted to provide nursing care procedures, including care of ventilators, tube feedings, suctioning of airways, external catheters, or wound care.

A companion may not provide routine support with ADL needs.

Companion services may not be provided at the same time as personal assistance or respite services.

Persons rendering the companion service for reimbursement by DMAS must not be the individual's spouse.

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Provision of Services to More Than One Individual Receiving Companion Services in the Same Household

For services provided in the home when more than one individual receiving companion services lives in the same household, the provider/SF will assess the needs of all individuals independently. Plans for Supports will be developed detailing the amount of time required for each individual for those tasks which must be provided one-to-one, such as assistance with self-administration of medication. For households in which there are two or more individuals receiving DD Waiver services from the same companion/CD employee, the amount of time for tasks which could and should be provided for both individuals at the same time (such as meal preparation, cleaning rooms, laundry, and shopping) must be combined and shared on both Plans for Support.

When two or more individuals who live in the same home request services, the following rules will apply:

- Plans for Support include hours that are unique to each individual for one-to-one tasks and each individual will receive the number of hours required for these in his/her Plan for Supports,

- Time for IADLs such as cooking, housekeeping, grocery shopping, etc., are to be combined, and the hours split between the Plans for Support. For example, if it requires one hour to complete IADLs for both individuals, then 30 minutes will be added to each Plans for Support,

- Safety supports hours are to be split between Plans for Support unless there is justification for one-on-one supervision, and

- The individuals have the right to choose separate providers to provide supports. In this event, follow rules in the first two bullets.

In no circumstances will a companion/CD employee supporting two individuals in the same household be paid for more hours than that person worked during a day.

Companion must not be authorized for anyone younger than 18 years of age. Companion services must not be provided by adult foster care providers or any other paid caregivers for an individual residing in that foster care home. For an individual receiving sponsored residential service, companion service must not be provided by a member of the sponsored family residing in the sponsored residential home.

For an individual receiving group home service, sponsored residential service, or supported living service, companion service must not be provided by an immediate family member (see 12VAC30-122-20).

Companion services will not be authorized for family members to sleep either during the day or during the night unless the individual cannot be left alone at any time. Companion services must be required to ensure the individual's safety due to a clear and present danger to the individual as a result of being left unsupervised.

Semi-Predictable Events

Semi-predictable events include, but are not limited to, events such as illness, inclement weather resulting in the closing of day or employment service sites, holidays, individual choice, etc. Individuals receiving Companion Services have various available natural supports, service provider resources, and are required to have back-up plans. Therefore, solutions for accommodating semi-predictable events will vary from person to person. The back-up plan support should be considered as the first option to provide needed supports during semi-predictable events such as inclement weather, illness, etc. The back-up plan may, in some circumstances, involve the use of paid staff who substitute for those regularly scheduled or at times other than what may be regularly scheduled. However, there are times when a provider may anticipate a need for an increase in service hours due to holidays, doctor visits, etc. and the back-up plan is not an option. In these situations a provider may submit a service authorization request (if not already included in their annual plan request) that includes:

- The appropriate explanation such as clear notation of the insufficiency of the back-up plan, and

- Planned usage of additional hours and documentation of the supports that will be provided during those specific periods.

The service authorization staff will add the additional hours provided to that month's authorized hours. Service authorization requests may be submitted after, but in the same month as service delivery. Because Companion Services is authorized on a monthly basis, providers will have hours in that month's authorization on which to draw until the emergency request is made and approved. Only emergencies that occur on the last day of the month require a service authorization modification to be submitted that very day.

Service Units

The unit of service for companion services is one hour. No more than eight hours per 24-hour day, regardless of service delivery model, may be authorized. The hours to be authorized must be based on the individual's assessed and documented need as reflected in the Plan for Supports. CD employees/attendants are paid at an hourly rate through the F/EA. EORs do not receive compensation for their services.

CD companion services, in conjunction with personal assistance and respite, for one individual is limited to 40 hours per week for an EOR by the same CD employee. An individual may receive

more than 40 hours per week of companion service, if needed, through multiple CD employees/attendants. This limitation does not apply to CD employees/attendants who live with the individual, either full-time or for substantial amounts of time. As noted above, (See http://www.dol.gov/agencies/whd/fact-sheets/79a-flsa-companionship) work no more than 16 hours in a 24-hour period. The 16-hour limit includes hours worked in one day providing a combination of companion, personal assistance, and respite services.

Companion services, whether agency-directed or consumer-directed, are reimbursed only when the individual is present, a qualified provider/CD employee is performing the services, and the allowable activities as outlined in the section "Allowable Activities" have been authorized according to an approved Plan for Supports. The only exception under the consumer-directed model is when the CD employee participates in training at the request of the individual or family member, caregiver, or EOR, as appropriate, that relates directly to the employee's ability to provide support to the individual and the individual's needs. Documentation of these requests and of attendance at a training must be kept in the individual's record.

Service Documentation Requirements

The required documentation for agency-directed companion service providers is as follows. These records must be separated from those of other non-waiver services, such as home health services and must correspond with the actual billing.

- The most recently updated Provider Agency Plan of Care form (DMAS-97A/B), accompanied by the Personal Preferences Tool, or the Plan for Supports. that includes;
    - The individual's desired outcomes which describe what is important to and for the individual in observable and measurable terms;
    - Support activities and support instructions that are designed to assist in achieving the individual's desired outcomes;
    - The services to be rendered and the schedule for such services to accomplish the desired outcomes and support activities;
    - A timetable for the accomplishment of the individual's desired outcomes and support activities;
    - The estimated duration of the individual's need for services; and
    - The provider staff responsible for overall coordination and integration of the services specified in the plan for supports.
- A completed copy of the DBHDS-approved, age appropriate SIS® assessment.

- Written documentation in the form of unique, person-centered, progress notes or data collected in a supports checklist as appropriate, per the plan for supports. This documentation must confirm the individual's days in service to support units of service delivered and provide specific information regarding the individual's responses to various settings and supports, as well as specific circumstances that prevented provision of the scheduled service, should that occur.

- Observations of the individual's responses to the service must be available in at least a daily note. Data must be collected as described in the ISP, analyzed to determine if the strategies are effective, summarized, then clearly documented in the progress notes or supports checklist. Documentation should be written, signed, and dated on the day the described supports were provided. Documentation that occurs after the date services were provided must be dated with the date the documentation was completed and also include the date the services were provided within the body of the note.

- Documentation of supervision that is completed, signed by the staff person designated to perform the supervision and oversight, and includes the following:

    - Date of contact or observation;

    - Person contacted or observed;

    - A summary about the companion's performance and service delivery; and

    - Any action planned or taken to correct problems identified during supervision and oversight.

- In a situation whereby the individual’s needs have changed significantly, the plan for supports must be reviewed by the provider. A written review must be completed and supported by documentation in the individual’s record for submission to the support coordinator at least quarterly with the plan for supports, if modified. Each quarterly person-centered review must contain the following elements:

    - A description of the status of each outcome in the plan for supports. Possible statuses include whether the outcome has been achieved, if outcome status is maintained as expected, or if there has been limited or no progress. Any actions needed or that will be taken to resolve or improve progress is noted;

    - Information about any newly identified safety risks;

    - Any changes desired by the individual or family member/caregiver, as applicable and his/their satisfaction with services;

- Confirmation that all approved services were delivered according to the amount detailed in the plan, or, if not, the reason; and

- Any significant events.

- The content of each review must be discussed with the individual and family member/caregiver, as applicable and submitted to the Support Coordinator within 10 calendar days following the end of each ISP plan quarter. The due date for the person-centered review is determined by the effective date of the Individual Support Plan and communicated to the provider by the support coordinator. Four written reviews span the entire ISP year. For the annual updates to the plan for supports and every time supporting documentation is updated, the update must be reviewed with the individual and family member/caregiver, as appropriate, and such review shall be documented either by the individual and family member/caregiver's signature on the review, or a progress note describing the discussion.

- All correspondence to the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS.

- Written documentation of all contacts with family/caregiver, physicians, formal and informal service providers, and all professionals regarding the individual.

Required documentation for CD Companion:

- CD employees/attendant must complete bi-weekly timesheets for submission to the F/EA.

- Services facilitation documentation requirements as found in the Services Facilitation section of this chapter.

PERSONAL ASSISTANCE: AGENCY-DIRECTED AND CONSUMER-DIRECTED

Service Definition/Description

Personal assistance service means direct support or supervision with (i) ADLs, (ii) IADLs, (iii) access to the community, (iv) monitoring the self-administration of medication or other medical needs, (v) monitoring health status and physical condition, or (vi) work or postsecondary school-related personal assistance. Personal assistance service supports individuals with DD who have physical, behavioral, and/or cognitive challenges.

Personal assistance services may be provided through an agency-directed (AD) or consumer-directed (CD) model or a combination of the two. If an individual chooses a combination of agency-directed and consumer-directed supports, the services can be provided on different days or at different times on the same day; however, the services must not be provided on the same days

at the same time. These services may be provided in home and community settings to enable an individual to maintain the health status and functional skills necessary to live in the community and participate in community activities.

Criteria/Allowable Activities

In order to qualify for the service, the individual must require assistance with ADLs, reminders to take medication or other medical needs, or monitoring his or her health status or physical condition. While assistance with IADLs may be included when specified in the plan for supports as needed by the individual, personal assistance for IADLs will only be authorized when the individual requires assistance with ADLs.

Personal assistance services are available for individuals for whom skill-building is not the primary objective or when skill-building is received in another service or setting. This service may not supplant an appropriate skill-building service when the individual has the capacity to gain increased independence.

Should an individual elect to receive personal assistance through the consumer-directed model, there are certain requirements that must be met prior to starting services. For more information, review the "CD Services in Virginia" section.

Allowable Activities

The allowable activities for personal assistance services include the following:

- Support with ADLs;
- Support with monitoring of health status or physical condition;
- Support with prescribed use of medication and other medical needs;
- Support with preparation and eating of meals;
- Support with housekeeping activities, such as bed-making, cleaning, or the individual's laundry;
- Support with participation in social, recreational, and community activities;
- Assistance with bowel/bladder care needs, range of motion activities, routine wound care that does not include the sterile technique, and external catheter care when trained and supervised by an RN, vital signs and recording of findings;

- Accompanying the individual to appointments or meetings; and

- Safety supports. For a child under 18 years of age the Request for Supervision Hours in Personal Assistance form, DMAS P-257, must be submitted to DBHDS for service authorization purposes when supervision hours are requested to address safety support needs. If a participant is requesting supervision, the provider must fill this form out completely and submit it to DBHDS SA for authorization. The DBHDS SA must approve the request before DMAS will reimburse for this service.

Allowable activities for personal assistance tasks that are performed in accordance with the *Virginia Administrative Code 18VAC90-19-240 et. seq. Delegation of Nursing Tasks and Procedures and the Code of Virginia § 54.1-3001(12)* regarding health care tasks directed by the individual are also allowable. See below for additional information. For services or tasks delegated in accordance with nursing delegation requirements, the RN must be available to the assistant/CD employee and be able to respond to any complications immediately. Whenever an assistant/CD employee is performing any physician-ordered procedure, the delegating RN must document on the DMAS-99 or nursing progress note that the assistant's/CD employee's correct performance of the procedure is being observed and supervised by the RN. This must be documented at least quarterly.

Skilled Services

Services requiring professional skills or invasive therapies, such as tube feedings, Foley catheter irrigations, sterile dressings, or any other procedures requiring sterile technique, cannot be performed by CD attendants/employees with the exception of skilled nursing tasks that fulfill criteria in the section "Exemption of Nurse Delegation Requirements".

Exemption of Nurse Delegation Requirements in the CD Model

For CD services, the *Code of Virginia § 54.1-3001(12)* states: "any person performing state or federally funded health care tasks directed by the consumer which are typically self-performed for an individual who lives in a private residence and who, by reason of disability is unable to perform such tasks but who is capable of directing the appropriate performance of such tasks" is exempted from the Nurse Practice Act and nurse delegation requirements.

Key requirements for the exemption from nurse delegation requirements, which must be performed in accordance with 18VAC90-19-240 through 18VAC90-19-280:

- Applies to **consumer-directed services only;**

- Applies to tasks that are "typically" self-performed;

- The individual receiving service must be capable of directing the attendant in the appropriate performance of the task;
- The individual must live in a private residence; and
- The individual must be unable to perform the tasks due to a disability.

Attending to Personal Assistance Needs of Individuals Who Work or Attend Post-Secondary School or Both

The personal assistant/CD employee may help the individual prepare for and accompany the individual to work and/or post-secondary school and assist the individual with ADLs while in those settings and upon returning to the individual's residence. The assistant/CD employee may not perform any functions related to the individual completing his or her job and/or school functions nor duplicate supported employment services. Supervision/safety supports through personal assistance is not an acceptable service while the individual is at work and/or school. Personal assistance can be provided at the same time as supported employment services and both can be billed for the same days/hours.

DMAS will not provide reimbursement for personal assistance services that are required as a reasonable accommodation as part of the ADA, the Virginians with Disabilities Act, Section 504 of the Rehabilitation Act of 1973, or if they should be provided by DARS or under IDEA. Further, if the individual's only need were for assistance during lunch, DMAS would not pay for the employee for any time extending beyond lunch. For an individual whose speech is such that he or she cannot be understood without an interpreter (not for translation of a foreign language), or the individual is physically unable to speak or make his or herself understood even with a communication device, the assistant/CD employee's services may be necessary all day.

Supervision/Safety Supports

Supervision or "safety supports" is an allowable activity for personal assistance when the purpose is to monitor the well-being of an individual who requires and has a documented need for the physical presence of the assistant/CD employee to ensure his/her safety during times when no other support system is available.

The inclusion of supervision/safety supports in the Plan for Supports for personal assistance is appropriate only in the following situations:

- The individual cannot be left alone at any time due to cognitive or physical challenges;
- The individual is unable to call for help in case of an emergency and there are no competent adults in the home who are capable of dialing 911 in the event of an emergency; and

- To ensure the health, safety, or welfare of the waiver individual.

Supervision/safety supports will not be authorized for family members to sleep nor for family members who operate a business or work from home unless the individual cannot be left alone due to documented safety issues or wandering risk. Supervision cannot be considered necessary because the individual's family or provider is generally concerned about leaving the individual alone, or would prefer to have someone with the individual. There must be a clear and present danger to the individual as a result of being left unsupervised.

Transportation – in the CD Model

Transportation services that are not paid by the Medicaid program are coordinated between the assistant/CD employee and the individual. This includes transportation necessary to implement the Plan for Supports. It is permissible for the assistant/CD employee to transport the individual in the assistant's/CD employee's vehicle. It is advisable, but not required, that the individual or family member/caregiver, as applicable, determine if the assistant/employee has vehicle insurance that covers the insured or the other passenger for the following:

- Against loss from any liability imposed by law for damages;
- Against damages for care and loss of services, because of bodily injury to or death of any person;
- Against injury to or destruction of property caused by accident and arising out of the ownership, use, or operation of such motor vehicle or motor vehicles within the Commonwealth, any other state in the United States, or Canada;
- Subject to a limit, exclusive of interest and costs, with respect to each motor vehicle of $25,000 because of bodily injury to or death of one person in any one accident and, subject to the limit for one person, to a limit of $50,000 because of bodily injury to or death of two or more persons in any one accident; and
- Subject to a limit of $20,000 because of injury to or destruction of property of others in any one accident.

Provision of Services to More Than One Individual Receiving Waiver Services in the Same Household

For services provided in the home when more than one individual receiving personal assistance lives in the same household, the provider/SF will assess the needs of all individuals independently. Plans for Supports will be developed detailing the amount of time required for each individual for those tasks which must be provided one-to-one, such as bathing, dressing, ambulating, etc. For households in which there are two or more individuals receiving DD Waiver services from the

same assistant/CD employee, the amount of time for tasks which could and should be provided for both individuals at the same time (such as meal preparation, cleaning rooms, laundry, and shopping) must be combined and shared on both Plans for Support.

When two or more individuals who live in the same home request services, the following rules will apply:

- Plans for Support include hours that are unique to each individual for one-to-one ADL tasks, and each individual will receive the number of hours required for these in his/her Plan for Supports;

- Time for IADLs such as cooking, housekeeping, grocery shopping, etc., are to be combined and the hours split between the Plans for Support. For example, if it requires one hour to complete IADLs for both individuals, then 30 minutes will be added to each Plans for Support;

- Supervision/safety supports hours are to be split between Plans for Support unless there is justification for one-on-one supervision; and

- The individuals have the right to choose separate providers to provide supports. In this event, follow rules in the first two bullets.

In no circumstances will an assistant/CD employee supporting two individuals in the same household be paid for more hours than that person worked during a day.

Provision of Services for the Convenience of Other Members of an Individual's Household

DMAS will reimburse the assistant/CD employee for services rendered to the individual only. DMAS will not reimburse for services rendered to or for the convenience of other members of the individual's household (for example, cleaning rooms used by all family members, cooking meals for the family, washing dishes used by everyone, family laundering, etc.)

Semi-Predictable Events

Semi-predictable events include, but are not limited to, events such as illness, inclement weather resulting in the closing of day or employment service sites, holidays, individual choice, etc. Individuals receiving Personal Assistance Services have various available natural supports, service provider resources, and are required to have back-up plans. Therefore, solutions for accommodating semi-predictable events will vary from person to person. The back-up plan support should be considered as the first option to provide needed supports during semi-predictable events such as inclement weather, illness, etc. The back-up plan may, in some circumstances, involve the use of paid staff who substitute for those regularly scheduled or at times other than what may be regularly scheduled. However, there are times when a provider may anticipate a need for an

increase in service hours due to holidays, doctor visits, etc. and the back-up plan is not an option. In these situations a provider may submit a service authorization request (if not already included in their annual plan request) that includes:

- The appropriate explanation such as clear notation of the insufficiency of the back-up plan; and

- Planned usage of additional hours and documentation of the supports that will be provided during those specific periods.

The service authorization staff will add the additional hours provided to that month's authorized hours. Service authorization requests may be submitted after, but in the same month as service delivery. Because Personal Assistance Services is authorized on a monthly basis, providers will have hours in that month's authorization on which to draw until the emergency request is made and approved. Only emergencies that occur on the last day of the month require a service authorization modification to be submitted that very day.

Service Units/Service Limitations

The unit of service for personal assistance is one hour. The hours to be authorized must be based on the individual's assessed and documented need as reflected in the Plan for Supports. EORs do not receive compensation for their services.

Personal assistance services, whether agency-directed or consumer-directed, are reimbursed only when the individual is present, a qualified provider/CD employee is performing the services, and the allowable activities as outlined in the section "Allowable Activities" have been authorized according to an approved Plan for Supports. The only exception under the consumer-directed model is when the CD employee participates in training at the request of the individual or family member, caregiver, or EOR, as appropriate, that relates directly to the employee's ability to provide support to the individual and the individual's needs. Documentation of these requests and of attendance at a training must be kept in the individual's record.

Individuals can receive CD/AD personal assistance, CD/AD respite care, CD/AD companion services, Group Day Services, Community Engagement Services and In-Home Residential Support services as outlined in their ISP, but the individual cannot receive these services simultaneously (i.e., on the same day at the same time).

DMAS will not reimburse personal assistance services for individuals who live in assisted living facilities or receive comparable services from another program, service, or payment source.
Personal assistance services are not allowable when the individual receives any of the following services:

- Supported Living*

- Sponsored Residential*
- Group Home Residential*

(*Exceptions may be made by DBHDS on a case-by-case basis for personal assistance services while an individual is at work.)

Consumer-directed personal assistance, in conjunction with companion service and respite, for one individual is limited to 40 hours per week for an EOR by the same CD employee. An individual may receive more than 40 hours per week of respite service, if needed, through multiple CD employees/attendants. This limitation does not apply to CD employees/attendants who live with the individual, either full-time or for substantial amounts of time (See http://www.dol.gov/agencies/whd/fact-sheets/79a-flsa-companionship).

CD employees/attendants may work no more than 16 hours in a 24-hour period. The 16-hour limit includes hours worked in one day providing a combination of companion, personal assistance, and respite services.

The individual must have a backup plan (e.g., agency, a family member, neighbor, or friend) willing and available to assist the individual in the event the assistant/CD employee does not report for work as expected or terminates employment without prior notice. This is the responsibility of the individual and family, caregiver, or EOR, as appropriate, and must be identified in the Plan for Supports. Individuals without a viable backup plan are not eligible for this service.

Scheduled Services Not Provided

The personal assistant/CD employee is responsible for following the Plan for Supports (or DMAS-97A/B and Personal Preferences tool). If the employee does not work the total number of hours during a scheduled day, as listed on the Plan for Support, the assistant/CD employee may provide supports up to the unused hours on another day/days within the same week only if:

- The individual, EOR, and/or primary caregiver, as applicable, requests that the unused time be used on another day that week; and

- The reason to carry over the hours to another day is based on a documented need of the individual. The reason cannot be to allow the assistant/CD employee to make up the unused hours of the week; and

- The total amount of hours worked during the week does not exceed the number of authorized hours for the week on the Plan for Supports (or DMAS-97A/B).

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Service Documentation Requirements

The required documentation for agency-directed/consumer directed personal assistance providers is as follows. These records must be separated from those of other non-waiver services, such as home health services:

- The most recently updated Provider Plan of Care form (DMAS-97A/B), accompanied by the Personal Preferences Tool, or the Plan for Supports that includes:
    - The individual's desired outcomes which describe what is important to and for the individual in observable and measurable terms;
    - Support activities and support instructions;
    - The services to be rendered and the schedule for such services to accomplish the desired outcomes and support activities;
    - A timetable for the accomplishment of the individual's desired outcomes and support activities;
    - The estimated duration of the individual's need for services; and
    - The provider staff responsible for overall coordination and integration of the services specified in the plan for supports.
- A completed copy of the DBHDS-approved, age appropriate SIS® assessment or other approved developmentally appropriate assessment according to the individual's age;
- The initial assessment by the DBHDS-licensed agency supervisor or RN supervisory nurse completed prior to or on the date the service is initiated, subsequent reassessments, and changes to the supporting documentation by the RN supervisory nurse;
- For a child under the age of 18, the DMAS P257 (Request for Supervision Hours in Personal Assistance) form must be submitted to DBHDS for authorization purposes when supervision hours are requested to address safety supports needs;
- Written documentation (including that for the 60-day assessment period for AD personal assistance) in the form of unique, person-centered, progress/daily notes or data collected in a supports checklist as appropriate, per the plan for supports. This documentation must confirm the individual's days in service to support units of service delivered and provide specific information regarding the individual's responses to various settings and supports,

as well as specific circumstances that prevented provision of the scheduled service, should that occur.

- Observations of the individual's responses to the service must be available in at least a daily note. Data must be collected as described in the ISP, analyzed to determine if the strategies are effective, summarized, then clearly documented in the progress notes or supports checklist.

- Documentation should be written, signed, and dated on the day the described supports were provided. Documentation that occurs after the date services were provided must be dated with the date the documentation was completed and also include the date the services were provided within the body of the note.

- The supervisor’s summarizing notes recorded and dated during any contacts with the personal assistant during visits to the individual’s home;

- For CD Services documentation by the personal assistant must also include:

    - The personal assistant’s arrival and departure times;

    - The personal assistant’s comments or observations about the individual enrolled in the waiver to include individual-specific observations of the individual’s physical and emotional condition, daily activities, and responses to services rendered, and;

    - The personal assistants and individual, and the individual’s family/caregiver’s, as appropriate, weekly signatures recorded on the last day of service delivery for any given week to verify that personal assistance services during that week have been rendered.

- The In a situation whereby the individual’s needs have changed significantly, the plan for supports must be reviewed by the provider. A written review must be completed and supported by documentation in the individual’s record for submission to the support coordinator at least quarterly with the plan for supports, if modified. Each quarterly person-centered review must contain the following elements:

    - A description of the status of each outcome in the plan for supports. Possible statuses include whether the outcome has been achieved or maintained as expected, or if there has been limited or no progress. Any actions needed or that will be taken to resolve or improve progress is noted;

    - Information about any newly identified safety risks;

- Any changes desired by the individual or family member/caregiver, as applicable and his/their satisfaction with services;

- Confirmation that all approved services were delivered according to the amount detailed in the plan, or, if not, the reason and

- Any significant events.

The content of each review must be discussed with the individual and family member/caregiver, as applicable and submitted to the Support Coordinator within 10 calendar days following the end of each ISP plan quarter. The due date for the person-centered review is determined by the effective date of the Individual Support Plan and communicated to the provider by the support coordinator. Four written reviews span the entire ISP year. For the annual updates to the plan for supports and every time supporting documentation is updated, the update must be reviewed with the individual and family member/caregiver, as appropriate, and such review must be documented either by the individual and family member/caregiver's signature on the review, or a progress note describing the discussion.

- For bowel and bladder programs, a written physician's order in the individual's file must specify the method and type of digital stimulation and frequency of administration. The RN supervisor must document that the assistant has received special training in bowel and bladder program management, has knowledge of the circumstances that require immediate reporting to a RN, and a RN has observed the assistant performing this function. The assistant's continuing understanding and ability to perform bowel and bladder programs must also be documented in the routine visit note.

- All correspondence to the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS; and

- Written documentation of all contacts with the family/caregiver, physicians, formal and informal service providers, and all professionals regarding the individual.

Provider documentation must support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by supporting documentation are subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

Required documentation for CD Personal Assistance:

- CD employees/attendants must complete bi-weekly timesheets for submission to the F/EA.

- Services facilitation documentation requirements as found in the Services Facilitation section of this chapter.

RESPITE SERVICES: AGENCY-DIRECTED AND CONSUMER-DIRECTED

Service Definition/Description

Respite service is temporary, substitute care that is normally provided on a short-term basis for temporary relief of the unpaid primary caregiver. Respite service enables an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities. The maximum amount of all types of respite services designated to an individual for the unpaid primary caregiver to use is 480 hours in an individual's plan per the state fiscal year.

Respite service may be provided either through an agency-directed or consumer-directed model or a combination of the two. Respite service may be provided:

- In home and community settings, which may be based in the individual's home; or

- Under the agency-directed model by enrolled providers licensed to provide center-based respite service, to include a group home or a sponsored residential home.

Criteria/Allowable Activities

Criteria

https://law.lis.virginia.gov/admincode/title12/agency30/chapter122/section20/

Individuals on the Community Living (CL) and Family and Individual Supports (FIS) waivers may receive Respite services. Respite service is not an allowable service under the Building Independence (BI) waiver.

In order to qualify for the service, the individual must have an unpaid primary caregiver as per 12VAC30-122-20, who has expressed the need for relief of caregiving duties. Paid caregivers are not eligible to use respite. The individual must also require assistance with ADLs, community access, reminders to take self-administered medication or other medical needs, or monitoring his or her health status or physical condition. Respite must be listed as a needed service in the individual's ISP.

If an individual chooses a combination of agency-directed and consumer-directed supports, the services can be provided on different days or at different times on the same day; however, the services must not be provided on the same days and at the same time.

Should an individual elect to receive respite through the consumer-directed model, there are certain requirements that must be met prior to starting services. For more information, review the "Consumer-Directed Requirements for Individual" section.

Allowable Activities

The allowable activities for respite include the following:

- Support with ADLs and IADLs;
- Support with monitoring of health status or physical condition;
- Support with prescribed use of medication and other medical needs;
- Support with preparation and eating of meals;
- Support with housekeeping activities, such as bed-making, cleaning, or the individual's laundry;
- Safety supports;
- Support with participation in social, recreational, and community activities;
- Accompanying the individual to appointments or meetings; and
- Assistance with bowel/bladder care needs, range of motion activities, routine wound care that does not include sterile technique, and external catheter when trained and supervised by an RN.

Provision of Services to Persons in the Same Household with the Individual

DMAS will reimburse the provider/CD employee for services rendered to the individual only. DMAS will not reimburse for services rendered to or for the convenience of other members in the individual's household (e.g., cleaning rooms used equally by all family members, cooking meals for the family, washing family dishes, family laundering, etc.).

Service Units/Service Limitations

The unit of service for respite is one hour. Respite as a service will be authorized for a maximum of 480 hours per state fiscal year. If an individual changes from one waiver to another during the state fiscal year and both waivers have respite as an allowable activity, the amount of respite for the individual will not reset until the next state fiscal year. Individuals who receive respite through a combination of the agency-directed and consumer-directed models or through multiple providers cannot receive more than a total of 480 hours of respite services from those combined methods. Any time provided as respite above and beyond 480 hours will not be reimbursed by DMAS.

Respite service, whether agency-directed or consumer-directed, is reimbursed only when the individual is present, a qualified provider/CD employee is performing the services, and the

allowable activities as outlined in the section "Allowable Activities" have been authorized according to an approved Plan for Supports.

Exceptions apply under the consumer-directed model when the CD employee participates in training at the request of the individual or family member, caregiver, or EOR, as appropriate, that relates directly to the employee's ability to provide support to the individual and the individual's needs. Documentation of these requests and of attendance at a training must be kept in the individual's record.

Individuals can receive AD/CD personal assistance, AD/CD respite, AD/CD companion services, and In-Home Residential Support services as outlined in their ISP, but cannot receive these services on the same day at the same time.

Respite services are not allowable when the individual receives any of the following services:

- Supported Living
- Sponsored Residential
- Group Home Residential

Respite may not be billed when the individual resides in an Assisted Living Facility or by DSS-approved Adult Foster Care providers when the individual resides in that home.

Skill development is not provided with respite service.

Neither form of respite service may include skilled nursing service, with the exception of nursing tasks that are delegated (trained and monitored) by a RN following nurse delegation regulations (18VAC90-19-240 through 18VAC90-19-280, regulated in Chapters 30 (§ 54.1-3000 et seq.) and 34 (§ 54.1-3400 et seq.) of Title 54.1 of the Code of Virginia, as appropriate).Authorization may be given for same timeframe but not delivered concurrently.

The CD respite employee cannot be the unpaid primary caregiver under any circumstance as it conflicts with the purpose of the respite service.

Consumer-directed respite, in conjunction with companion service and personal assistance, for one individual is limited to 40 hours per week for an EOR by the same CD employee. An individual may receive more than 40 hours per week of respite service, if needed, through multiple CD employees/attendants. This limitation does not apply to CD employees/attendants who live with the individual, either full-time or for substantial amounts of time (See http://www.dol.gov/agencies/whd/fact-sheets/79a-flsa-companionship).

CD employees/attendants may work no more than 16 hours in a 24-hour period. The 16-hour limit includes hours worked in one day providing a combination of companion, personal assistance, and respite services.

The provider of AD respite services must have a back-up plan in case the respite assistant does not report for work as expected or terminates employment without prior notice. The agency will provide a back-up assistant from their internal pool or a sub-contract with another provider. The individual receiving respite services must be notified that their scheduled assistant is unavailable so that they are able to choose not to have services from a different assistant. A provider who is authorized to provide respite must have an agreement with another agency(s) when this emergency process is used that includes a reminder that all staff will meet the basic competency requirements and confirmation of a criminal background check in accordance with the requirements set forth in 12VAC30-122-120 B. The process should include, at a minimum:

- The agency that holds the service authorization will communicate to the back-up provider the specifics of the shift (time and place) where coverage is needed.

- If the back-up provider has an available respite assistant and confirms that they are available to cover the shift(s), then the supervisor from the agency holding the service authorization will communicate via phone call to the assistant who will fill the shift. During this call, the supervisor will outline the expectations of the shift and pertinent person-centered information such as the individual's preferred method of communication, allergies, dietary considerations, medical information, etc.

- The provider holding the service authorization will communicate with the individual about the change in assistants, as soon as is feasible, so that the individual can decide if they wish to receive the service or use a natural support on that day.

- If the agency that holds the service authorization is unable to provide a respite assistant for a time-period longer than 2 weeks, the provider will contact the individual's support coordinator to inform them of the difficulty meeting the person's needs.

In addition, the individual receiving either AD or CD respite must have a backup plan (for example, a family member, neighbor, or friend) willing and available to assist the individual in the event the attendant does not report for work as expected or terminates employment without prior notice. This is the responsibility of the individual and family, caregiver, or EOR, as appropriate, and must be identified in the Plan for Supports. The backup plan will be reviewed by the support coordinator to determine if it is appropriate. Individuals without a viable backup plan are not eligible for this service.

Two individuals in the same home may share supports delivered by one assistant/CD employee; however, the number of hours billed, may not exceed the number of hours the assistant/CD employee worked. When two individuals who live in the same home request respite services, the needs of both will be assessed independently and the amount of time required for each individual determined for those tasks which must be provided independently (such as bathing, dressing, ambulating, etc.). The amount of time for tasks that could and should be provided for both

individuals simultaneously (such as meal preparation, cleaning rooms, laundry, etc.) must be combined and the hours split between the individuals.

Service Documentation Requirements for Agency Directed

The required documentation for agency-directed respite service providers is as follows. If the individual already receives personal assistance services under the waiver, one record may be maintained; however, separate sections must be reserved for the documentation of the two services. These records shall be separated from those of other non-waiver services, such as home health services:

- The most recently updated Provider Plan of Care form (DMAS-97A/B), accompanied by the Personal Preferences Tool, or the Plan for Supports that includes:
    - The individual's desired outcomes which describe what is important to and for the individual in observable and measurable terms;
    - Support activities and support instructions that are designed to assist in achieving the individual's desired outcomes;
    - The services to be rendered and the schedule for such services to accomplish the desired outcomes and support activities;
    - A timetable for the accomplishment of the individual's desired outcomes and support activities;
    - The estimated duration of the individual's need for services; and
    - The provider staff responsible for overall coordination and integration of the services specified in the plan for supports.
- A completed copy of the DBHDS-approved age appropriate SIS® assessment or other approved developmentally appropriate assessment according to the individual's age;
- Written documentation in the form of unique, person-centered, progress notes or data collected in a supports checklist as appropriate, per the plan for supports. This documentation must confirm the individual's days in service to support units of service delivered and provide specific information regarding the individual's responses to various settings and supports, as well as specific circumstances that prevented provision of the scheduled service, should that occur. Observations of the individual's responses to the service must be available in at least a daily note. Data must be collected as described in the ISP, analyzed to determine if the strategies are effective, summarized, then clearly

documented in the progress notes or supports checklist. Documentation should be written, signed, and dated on the day the described supports were provided. Documentation that occurs after the date services were provided must be dated with the date the documentation was completed and also include the date the services were provided within the body of the note;

- As respite services are typically delivered on an intermittent basis, Person-centered (quarterly) reviews are required only following those quarters in which respite services are provided. If respite services are delivered, respite providers must regularly communicate with the individual's support coordinator about service provision and any related issues. The Plan for Supports must be reviewed by the provider when the individual's needs change significantly. Each quarterly person-centered review must contain the following elements:

    - A description of the status of each outcome in the plan for supports. Possible statuses include whether the outcome has been achieved and maintained, or if there has been limited or no progress. Any actions needed or that will be taken to resolve or improve progress is noted;

    - Information about any newly identified safety risks;

    - Any changes desired by the individual or family member/caregiver, as applicable and his/their satisfaction with services;

    - Confirmation that all approved services were delivered according to the amount detailed in the plan, or, if not, the reason; and

    - Any significant events.

- The content of each review must be discussed with the individual and family member/caregiver, as applicable and submitted to the Support Coordinator within 10 calendar days following the end of each ISP plan quarter. The due date for the person-centered review is determined by the effective date of the Individual Support Plan and communicated to the provider by the support coordinator. Four written reviews span the entire ISP year. For the annual updates to the plan for supports and every time supporting documentation is updated, the update must be reviewed with the individual and family member/caregiver, as appropriate, and such review must be documented either by the individual and family member/caregiver's signature on the review, or a progress note describing the discussion.

- All correspondence to the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS;

- Written documentation of all contacts with the family, caregiver, physicians, formal and informal service providers, and all professionals regarding the individual.

- Provider documentation must support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by supporting documentation are subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

Required documentation for CD Respite:

- CD employees/attendants must complete bi-weekly timesheets for submission to the F/EA.
- Services facilitation documentation requirements as found in the Services Facilitation section of this chapter.

CONSUMER DIRECTED SERVICES & SERVICES FACILITATION

CD services, sometimes referred to as self-directed services, mean that individuals, or their representatives, if applicable, have decision-making authority over certain services and take direct responsibility to manage their services with the assistance of a system of available supports. The CD service delivery model is an alternative to traditionally delivered and managed services, such as an agency delivery model. Self-direction of services allows individuals to have the responsibility for managing all aspects of service delivery in a person-centered planning process.

CD services promote personal choice and control over the delivery of specific services available in DD waivers. For example, individuals are afforded the decision-making authority to recruit, hire, train, supervise, and fire the employees who furnish their services. The Centers for Medicare & Medicaid Services (CMS) calls this "employer authority."

CD Services in Virginia

There are three CD services available in the DD Waivers: CD Personal Assistance, CD Companion, and CD Respite services. The individual is the employer in these services, and, as such, is responsible for hiring, training, supervising, and firing their CD employees/attendants.

In order to ensure CD services are an appropriate option for the individual, he/she must meet the following requirements:

- The individual must have an Employer of Record (EOR). The EOR can be the individual or can be a family member, neighbor, or other person known to the individual, however, the EOR may not be the Services Facilitator. If an individual is unable to independently direct and manage his/her own CD services or if the individual is under the age of 18, the

individual must designate another person 18 years or older to serve as the EOR. The EOR is not reimbursed by DMAS for services rendered.

- The EOR shall be the employer in this service and shall be responsible for advertising, interviewing, hiring, training, supervising, and firing CD employees/attendants. Specific EOR duties regarding the employee(s) include checking references, determining that basic qualifications are met, training, supervising performance, and submitting and approving the work shift entries to the fiscal employer agent (F/EA) on a consistent and timely basis. The EOR should monitor the individual's receipt of CD supports to ensure proper care is being provided and CD services are adequate to address the individual's needs. It is not the responsibility of DMAS or the Services Facilitator to train the CD services employee.

- The individual, the family/caregiver, or EOR, as appropriate, must have a backup plan in case the CD services employee does not show up for work or is unexpectedly terminated from employment. Individuals who do not have a documented backup plan are not eligible for this service.

The EOR for an individual cannot be the paid employee for the individual. Each EOR may only be the employer for one individual; however, an exception is allowable whereby the EOR can serve multiple individuals if those individuals all reside at the same address. The EOR is not required to reside with the individual however, the EOR should have sufficient contact in order to perform the required duties.

Additional information and guidance on being an EOR can be found in the EOR manual on the DMAS website. CD employees/attendants are not eligible at this time for Worker's Compensation.

Services facilitation agencies provide supportive services and training to EORs for the hiring, training, supervising, and firing responsibilities of the CD services employees. Services facilitation is a separate waiver service and is used only in conjunction with consumer-directed personal assistance, respite, or companion services.

Support coordinators must document in the ISP the individual's choice for the consumer-directed model and whether or not the individual chooses service facilitation. The support coordinator must document in the individual's record that the individual will serve as the EOR or that there is a need or desire for another person to serve as the EOR on behalf of the individual.

The DMAS contracted F/EA provides tools needed to support an EOR's success in managing supports and assists with employment tasks such as:

- Facilitating CD employee background checks;
- Employee record retention;

- Processing time sheets and issuing paychecks;
- Withholding and filing employer and employee related payroll taxes;
- Compliance with Federal and State rules and regulations;
- Providing spending summaries (On-line access available).

No more than two individuals who live in the same home are permitted to share the authorized work hours of a CD personal assistance, companion or respite employee within any given employee's shift.

When two individuals who live in the same home request CD services, the Services Facilitator will assess the needs of all authorized individuals independently and determine the amount of time required for each individual for those tasks which must be provided independently, such as bathing, dressing, ambulating, etc.

An individual who has chosen consumer direction may choose, at any time, to voluntarily change one or more of their consumer directed services to the agency-directed model as long as he/she/they continues to qualify for the specific services. The services facilitator and the support coordinator are responsible for assisting the individual with the change of services from consumer-directed to agency-directed.

Involuntary disenrollment from CD services may also occur. The services facilitator or support coordinator, as appropriate, is required to initiate involuntary disenrollment from consumer direction of an individual enrolled in the waiver when any of the following conditions occur:

- The health, safety, or welfare of the individual enrolled in the waiver is at risk;
- The individual or EOR demonstrates consistent inability to hire and retain a CD employee; or
- The individual or EOR is consistently unable to manage their CD employee, as may be demonstrated by a pattern of serious discrepancies with timesheets.
- If the individual does not choose a services facilitator and a family member or other caregiver is not willing or able to assume the services facilitation duties, then the support coordinator shall notify DMAS or its designated service authorization contractor and the consumer-directed services shall be discontinued.

Prior to involuntary disenrollment, the services facilitator or support coordinator, as appropriate, shall:

- Verify that essential training has been provided to the EOR to improve the problem condition or conditions;

- Document in the individual's record the conditions creating the necessity for the involuntary disenrollment and actions taken by the services facilitator or support coordinator, as appropriate;

- Discuss with the individual and the EOR, if the individual is not the EOR, the agency-direction option that is available and the actions needed to arrange for such services while providing a list of potential providers;

- Provide written notice to the individual and EOR, if the individual is not the EOR, of the action, the reasons for the action, and the right of the individual to appeal, pursuant to 12VAC30-110, such involuntary termination of consumer-direction. Except in emergency situations in which the health or safety of the individual is at serious risk, such notice shall be given at least 10 business days prior to the effective date of the termination of consumer-direction. In cases of an emergency situation, notice of the right to appeal shall be given to the individual but the requirement to provide notice at least 10 business days in advance shall not apply; and

- If the services facilitator initiates the involuntary disenrollment from consumer-direction, the SF shall inform the support coordinator of such action and the reasons for the action.

In either voluntary or involuntary disenrollment, the individual enrolled in the waiver must be afforded the opportunity to select an agency from which to continue to receive his/her/their personal assistance, companion, or respite services. If the individual either fails to select an agency or refuses to do so, then personal assistance, companion or respite services, as appropriate, will be discontinued.

Services Facilitation

Service Definition

"Services facilitation" means a service that assists the individual or EOR, as appropriate, in arranging for, directing, and managing services provided through the consumer-directed model of service delivery. Services facilitation service is a separate service and shall be used only in conjunction with consumer-directed personal assistance, respite, or companion services.

"Services facilitator" means (i) a DMAS-enrolled provider, (ii) a DMAS-designated entity, or (iii) one who is employed by or contracts with a DMAS-enrolled services facilitator that is responsible for supporting the individual or EOR, as appropriate, by ensuring the development and monitoring of the plan for supports for consumer-directed services, providing employee management training, and completing ongoing review activities as required. "Services facilitator" shall be deemed to mean the same thing as "consumer-directed services facilitator."

If an individual choosing consumer-directed services chooses not to receive support from a CD services facilitator, then another family member or caregiver, other than the EOR, can perform all of the duties. The family member or caregiver serving as the SF will not be reimbursed by DMAS for performing these duties or meeting these requirements.

The individual's support coordinator/case manager may also function as the paid services facilitator. The support coordinator/case manager serving as the SF must meet all of the requirements of a CD services facilitator, including documentation requirements identified for services facilitation.

For transitions from the CCC Plus Waiver to a DD Waiver, to ensure a seamless transition and mitigate service interruption, a continuity of care service authorization process for personal assistance services is available. For individuals transitioning from the CCC Plus Waiver to a Community Living (CL) or Family and Individual Supports (FIS) Waiver, DBHDS service authorization staff will honor the number of hours of personal care services authorized for an individual enrolled in the CCC Plus Waiver. The period for continuity of care service authorization for CL and FIS Waiver personal assistance services is 30 days. Transitions from the CCC Plus Waiver to a DD waiver will only occur on the first day of a month. The SF has a role to play in this process in order to ensure continuity of care.

Personal assistance services continuity of care service authorization:

- The Support Coordinator contacts the individual receiving services and asks for consent for the Support Coordinator and services facilitator/agency provider to exchange information.
- The Support Coordinator contacts the MCO Care Coordinator to determine the existing number of authorized personal care hours currently in place in order to initiate the continuity of care service authorization process. If the Support Coordinator does not know who the MCO Care Coordinator is, they should call the health plan directly.
- The services facilitator/agency provider will either a) upload into WaMS the CCC Plus Waiver plan of care (DMAS 97A/B) which covers all required elements; or b) provide a summary statement to include 1) level of support required for ADLs; 2) who is the unpaid primary caregiver; 3) who is the EOR; 4) who is the staff; and finally 5) a back-up plan. The direct entry is under ‘modified use’ for this summary. The services facilitator/agency provider notes in the justification box in WaMS “continuity of care service authorization request.”
- The Support Coordinator confirms the number of authorized personal care hours on the DMAS 97A/B is consistent with the hours reported by the MCO Care Coordinator. If accurate, the Support Coordinator submits the continuity of care service authorization request (DMAS 97A/B) to DBHDS. If the hours on the DMAS 97A/B are not consistent

with the authorized hours, the Support Coordinator requests a revised DMAS 97A/B that reflects the currently authorized hours.

- DBHDS service authorization staff will approve the 30-day service authorization for personal assistance services for the same number of hours approved by the CCC Plus health plan on the DMAS 97A/B as for personal care or (as per the above, incorporate this detail into the summary statement.
- The services facilitator/agency provider completes and submits to DBHDS all required assessments and documentation for CL or FIS Waiver service authorization of personal assistance services by the 20th of the month that the continuity of care authorization is in effect. It is imperative that the services facilitator/agency provider submit this information timely to avoid an interruption in services and/or payment of CD employees/attendants. DD waiver service authorization requests received after the 30 day continuity of care period will result in a start date of the date the request is received, which will result in a lapse in service authorization and payment for services rendered.
- DBHDS service authorization staff process the service authorization for personal assistance services following standard operating procedures.
- For consumer-directed services, the services facilitator must submit the Fiscal Agent Request Form to the FE/A and initiate the change in fiscal employer agent, if applicable, and the change from CCC Plus Waiver services to DD Waiver services.
- The Support Coordinator provides the MCO Care Coordinator with an update on authorized services rendered under the DD waiver.
- Continued collaboration with the MCO Care Coordinator occurs to ensure appropriate, comprehensive care planning with primary and acute services.

Criteria & Allowable Activities

Providers of Services Facilitation services have an important role in assuring success in CD services and an individual's opportunity to self-direct those services. The activities below detail the requirements of providers of services facilitation services.

- Services facilitators are responsible for training EORs to direct CD services. This training should include selecting, hiring, training, supervising, and authorizing timesheets of employees providing their CD services;
- Services facilitators are responsible for making an initial comprehensive home visit to collaborate with the individual and the individual's family/caregiver, as appropriate. This initial home visit must include the following outcomes: (i) identification of the individual's needs for a requested consumer-directed service; (ii) assistance to the individual and the

individual's family/caregiver, as appropriate with the development of the plan for supports with; (iii), and provision of employer management training to the EOR on his responsibilities as an employer. The service facilitator must provide employer management training to the EOR within seven days of the initial visit, if not during the context of that visit;

- The initial comprehensive home visit may be completed only once upon the individual's entry into the consumer-directed model of service, regardless of the number or type of consumer-directed services that an individual is approved to receive or a change in the HCBS waiver in which the individual is enrolled. If an individual changes service facilitators, the new services facilitator must complete a reassessment visit in lieu of an initial comprehensive visit;

- The employer management training must be completed before the EOR may hire a CD services employee who is to be reimbursed by DMAS;

- After the initial visit, the services facilitator is responsible for continued monitoring of the individual's plan for supports quarterly, and more often as needed - which may be conducted by telephone to prepare the quarterly report to the support coordinator. Monthly visits are not required. If CD respite services are provided, the services facilitator must review the utilization of CD respite service either every six months or upon the use of 240 respite service hours, whichever comes first;

- The services facilitator is required to have an in-person meeting with the individual at least every six months to reassess the individual's needs and to ensure appropriateness of any CD service received by the individual. During these in-person visits, the services facilitator shall observe, evaluate, and consult with the individual, EOR, and the individual's family/caregiver, as appropriate, for the purpose of assessing the adequacy and appropriateness of CD services;

- Additionally, the services facilitator, during routine quarterly visits, is responsible for reviewing and verifying timesheets, as needed, to ensure that the number of hours approved in the plan for supports are being provided and are not exceeded. If discrepancies are identified, it is expected that the services facilitator discuss these with the EOR to resolve discrepancies and notify the fiscal/employer agent that administers payroll services on behalf of the individual. If an individual is consistently identified as having discrepancies in his timesheets, the services facilitator must contact the support coordinator. Failure to review and verify timesheets and maintain documentation of such reviews shall subject the provider to recovery of payments made by DMAS.

Additional requirements and expectations for the provision of SF include:

- The services facilitator must be available during standard business hours to the individual or EOR by telephone;
- The services facilitator will assist the individual or EOR with employer issues as requested by either the individual or EOR;
- The services facilitator must complete the assessments, reassessments, and supporting documentation necessary for consumer-directed service;
- Services facilitation will be provided on an as-needed basis as mutually agreed to by the individual, EOR, and services facilitator but, at a minimum, routine quarterly visits. Services facilitation services shall be documented in the supporting documentation for CD services, and the services facilitation provider shall bill consistent with the supporting documentation. Claims that are not adequately supported by this supporting documentation, may be subject to a DMAS recovery of expenditures;
- If an EOR is consistently unable to hire and retain a CD services employee, the services facilitator must contact the support coordinator and DBHDS service authorization to transfer the individual, at the choice of the individual, to a provider that provides Medicaid-funded agency-directed companion service, personal assistance service, or respite care service, as may be appropriate;
- If an individual enrolled in CD services has a lapse (meaning there is no documented use of Personal Care, Respite or Companion hours during that period) in CD services for more than 60 consecutive calendar days, the services facilitator, or the family/caregiver functioning as the services facilitator must notify the support coordinator so that CD service may be discontinued, and the option afforded to the individual to change to agency-directed service as long as the individual still qualifies for the service. The individual cannot be his/her own SF.

Service Units and Limits

The SF may not be the individual enrolled in the waiver; a direct service provider; the individual's spouse; a parent or legal guardian of the individual who is a minor child; or the EOR who is employing the assistant or companion;

The SF must document the individual’s back-up plan in case the CD employee does not report to work as expected or terminates employment without notice;

Should a CD employee not report or work or terminate employment without notice, the SF, upon the individual’s or EOR’s request, may provide management training to ensure that the EOR is able to recruit and employ a new CD employee.

Service Documentation and Requirements

The services facilitator must maintain a record of each individual containing elements as set out in this section. The services facilitator's record about the individual must contain:

- Documentation of all employer management training provided to the individual enrolled in the waiver and the EOR, as appropriate, including the individual's or the EOR's, as appropriate, receipt of training on his responsibility for the accuracy and timeliness of the assistant's or companion's timesheets;

- All documents signed by the individual enrolled in the waiver or the EOR, as appropriate, hat acknowledge their legal responsibilities as the employer;

- All contacts and consultations documented in the individual's medical record. Failure to document such contacts and consultations will be subject to a DMAS recovery of payments made;

- All copies of the consumer-directed plan for support, all supporting documentation related to consumer-directed services, and DMAS-225 (Medicaid Tong-Term Care Communication Form);

- A completed copy of the standard, assessment form (DBHDS-approved developmental assessment or SIS® assessment form, depending on the individual’s age);

- Services facilitation notes recorded and dated at the time of service delivery. The written summary of visits must include at minimum:

    - Discussion with the individual and EOR or individual's family/caregiver, as appropriate, as to whether the particular consumer-directed service is adequate to meet the individual's needs;

    - Any suspected abuse, neglect, or exploitation and to whom it was reported;

    - Any special tasks performed by the CD employee and the employee's qualifications to perform these tasks;

    - The individual's and EOR's or individual's family/caregiver's, as appropriate, satisfaction with the CD employee’s service;

    - Any hospitalization or change in medical condition, functioning, or cognitive status; and

- The presence or absence of the assistant in the home during the services facilitator's visit.

- All correspondence to the individual and EOR, as appropriate, to others concerning the individual, and to the support coordinator, DMAS, and DBHDS.

- In a situation whereby the individual's needs have changed significantly, the plan for supports must be reviewed by the provider. A written review must be completed and supported by documentation in the individual's record for submission to the support coordinator at least quarterly with the plan for supports, if modified. Each quarterly person-centered review must contain the following elements:

  - A description of the status of each outcome in the plan for supports. Possible statuses include whether the outcome has been achieved, if progress is being made as expected, or if there has been limited or no progress. Any actions needed or that will be taken to resolve barriers or improve progress is noted;

  - Information about any newly identified safety risks;

  - Any changes desired by the individual or family member/caregiver, as applicable and his/their satisfaction with services;

  - Confirmation that all approved services were delivered according to the amount detailed in the plan, or, if not, the reason; and

  - Any significant events.

- The content of each review must be discussed with the individual and family member/caregiver, as applicable and submitted to the Support Coordinator within calendar days following the end of each ISP plan quarter. The discussion must be documented either by the individual and family member/caregiver's signature on the review or a progress note describing the discussion. The due date for the person-centered review is determined by the effective date of the Individual Support Plan and communicated to the SF by the support coordinator. Four written reviews span the entire ISP year. For the annual updates to the plan for supports and every time supporting documentation is updated, the update must be reviewed with the individual and family member/caregiver, as appropriate, and such review must be documented, either by the individual and family member/caregiver's signature on the review, or a progress note describing the discussion.

  - Contacts made with the individual's family/caregiver, physicians, providers, and all professionals concerning the individual.

- Service facilitation records must be provided to DMAS or DBHDS upon request.

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CHAPTER V
BILLING INSTRUCTIONS

INTRODUCTION

The purpose of this chapter is to explain the procedures for billing the Department of Medical Assistance Services (DMAS) for Individual and Family Developmental Disabilities (DD) Waiver services. Billing procedures for DD Waiver services are identical except for the procedure codes used to identify the type of service rendered.

Two major areas are covered in this chapter:

- **General Information** - This is information about the timely filing of claims, claims inquiries, and billing supply procedures; and
- **Billing Procedures** - Instructions are provided on the completion of the claim forms and the submission of adjustment requests.

ELECTRONIC SUBMISSION OF CLAIMS

Electronic billing is a fast and effective way to submit Medicaid claims. Claims will be processed faster and more accurately because electronic claims are entered into the claims processing system directly. Providers may submit claims by direct dial-up at no cost per claim, using toll-free telephone lines.

Electronic Data Interchange (EDI) is a fast and effective way to submit Medicaid claims. Claims will be processed faster and more accurately because electronic claims are entered into the claims processing system directly. Most personal, mini, or mainframe computers can be used for electronic billing. For more information contact our fiscal agent, Xerox State Healthcare, LLC:

Phone: (866)-352-0766
Fax number: (888)-335-8460
Website: https://www.virginiamedicaid.dmas.virginia.gov or by mail

Xerox State Healthcare, LLC
EDI Coordinator
Virginia Medicaid Fiscal Agent
P.O. Box 26228
Richmond, Virginia 23260-6228

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DIRECT DATA ENTRY (DDE)

As part of the 2011 General Assembly Appropriation Act - 300H which requires that all new providers bill claims electronically and receive reimbursement via Electronic Funds Transfer (EFT) no later than October 1, 2011 and existing Medicaid providers to transition to electronic billing and receive reimbursement via EFT no later than July 1, 2012, DMAS has implemented the Direct Data Entry (DDE) system. Providers can submit claims quickly and easily via the Direct Data Entry (DDE) system. DDE will allow providers to submit Professional (CMS-1500), Institutional (UB-04) and Medicare Crossover claims directly to DMAS via the Virginia Medicaid Web Portal. Registration thru the Virginia Medicaid Web Portal is required to access and use DDE. The DDE User Guide, tutorial and FAQs can be accessed from our web portal at: www.virginiamedicaid.dmas.virginia.gov. To access the DDE system, select the Provider Resources tab and then select Claims Direct Data Entry (DDE). Providers have the ability to create a new initial claim, as well as an adjustment or a void through the DDE process. The status of the claim(s) submitted can be checked the next business day if claims were submitted by 5pm. DDE is provided at no cost to the provider.

TIMELY FILING

The Medical Assistance Program regulations require the prompt submission of all claims. Virginia Medicaid is mandated by federal regulations [42 CFR § 447.45(d)] to require the initial submission of all claims (including accident cases) within 12 months from the date of service. Providers are encouraged to submit billings within 30 days from the last date of service or discharge. Federal financial participation is not available for claims, which **are not** submitted within 12 months from the date of the service. Submission is defined as actual, physical receipt by DMAS. In cases where the actual receipt of a claim by DMAS is undocumented, it is the provider's responsibility to confirm actual receipt of a claim by DMAS within 12 months from the date of the service reflected on a claim. If billing electronically and timely filing must be waived, submit the DMAS-3 form with the appropriate attachments. The DMAS-3 form is to be used by electronic billers for attachments. (See Exhibits) Medicaid is not authorized to make payment on these late claims, except under the following conditions:

Retroactive Eligibility - Medicaid eligibility can begin as early as the first day of the third month prior to the month of application for benefits. All eligibility requirements must be met within that time period. Unpaid bills for that period can be billed to Medicaid the same as for any other service. If the enrollment is not accomplished in a timely way, billing will be handled in the same manner as for delayed eligibility.

Delayed Eligibility - Medicaid may make payment for services billed more than 12 months from the date of service in certain circumstances. Medicaid denials may be overturned or other actions may cause eligibility to be established for a prior period. Medicaid may make payment for dates of service more than 12 months in the past when the claims are for an enrollee whose eligibility has been delayed. It is the provider's obligation to verify the patient's Medicaid eligibility. Providers who have rendered care for a period of delayed eligibility will be notified by a copy of

a letter from the local department of social services which specifies the delay has occurred, the Medicaid claim number, and the time span for which eligibility has been granted. The provider must submit a claim on the appropriate Medicaid claim form within 12 months from the date of the notification of the delayed eligibility. A copy of the "signed and dated" letter from the local department of social services indicating the delayed claim information must be attached to the claim.

Denied claims – Denied claims must be submitted and processed **on or before thirteen months from date of the initial denied claim where the initial claim was filed within the 12 months limit to be** considered for payment by Medicaid. The procedures for resubmission are:

- Complete invoice as explained in this billing chapter.
- **Attach** written documentation to justify/verify the explanation. This documentation may be continuous denials by Medicaid or any dated follow-up correspondence from Medicaid showing that the provider has actively been submitting or contacting Medicaid on getting the claim processed for payment. Actively pursuing claim payment is defined as documentation of contacting DMAS at least every six months. Where the provider has failed to contact DMAS for six months or more, DMAS shall consider the resubmission to be untimely and no further action shall be taken. If billing electronically and waiver of timely filing is being requested, submit the claim with the appropriate attachments. (The DMAS-3 form is to be used by electronic billers for attachments. See exhibits)

Accident Cases - The provider may either bill Medicaid or wait for a settlement from the responsible liable third party in accident cases. However, all claims for services in accident cases must be billed to Medicaid within 12 months from the date of the service. If the provider waits for the settlement before billing Medicaid and the wait extends beyond 12 months from the date of the service, Medicaid shall make no reimbursement.

Other Primary Insurance - The provider should bill other insurance as primary. However, all claims for services **must be billed to Medicaid within 12 months from the date of the service.** If the provider waits for payment before billing Medicaid and the wait extends beyond 12 months from the date of the service, Medicaid shall make no reimbursements. If payment is made from the primary insurance carrier after a payment from Medicaid has been made, an adjustment or void should be filed at that time.

Other Insurance - The member can keep private health insurance and still be covered by Medicaid or FAMIS Plus. The other insurance plan pays first. Having other health insurance does not change the co-payment amount that providers can collect from a Medicaid member. For members with a Medicare supplemental policy, the policy can be suspended with Medicaid coverage for up to 24 months while the member has Medicaid without penalty from their insurance company. The members must notify the insurance company. The member must notify the insurance company within 90 days of the end of Medicaid coverage to reinstate the supplemental insurance.

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Submit the claim in the usual manner by mailing the claim to billing address noted in this chapter.

BILLING INVOICES

The requirements for submission of billing information and the use of the appropriate billing invoice depend upon the type of service being rendered by the provider and/or the billing transaction being completed. Listed below is the billing invoice to be used for billing assisted living services:

- Health Insurance Claim Form CMS-1500 (02-12)

If submitting on paper, the requirement to submit claims on an original CMS-1500 claim form is necessary because the individual signing the form is attesting to the statements made on the reverse side of this form; therefore, these statements become part of the original billing invoice.

Medicaid reimburses providers for the coinsurance and deductible amounts on Medicare claims for Medicaid members who are dually eligible for Medicare and Medicaid. However, the amount paid by Medicaid in combination with the Medicare payment will not exceed the amount Medicaid would pay for the service if it were billed solely to Medicaid.

AUTOMATED CROSSOVER CLAIMS PROCESSING

Most claims for dually eligible members are automatically submitted to DMAS. The Medicare claims processors will submit claims based on electronic information exchanges between these entities and DMAS. As a result of this automatic process, the claims are often referred to as "crossovers" since the claims are automatically crossed over from Medicare to Medicaid.

To make it easier to match to providers to their Virginia Medicaid provider record, providers are to begin including their Virginia Medicaid Identification as a secondary identifier on the claims sent to Medicare. When a crossover claim includes a Virginia Medicaid Identification, the claim will be processed by DMAS using the Virginia Medicaid number rather the Virginia Medicare vendor number. This will ensure the appropriate Virginia Medicaid provider is reimbursed.

When providers send in the 837 format, they should instruct their processors to include the Medicaid provider number and use qualifier "1D" in the appropriate reference (REF) segment for provider secondary identification on claims. Providing the Virginia Medicaid Identification on the original claim to Medicare will reduce the need for submitting follow-up paper claims.

DMAS has established a special email address for providers to submit questions and issues

related to the Virginia Medicare crossover process. Please send any questions or problems to the following email address: Medicare.Crossover@dmas.virginia.gov.

REQUESTS FOR BILLING MATERIALS
Health Insurance Claim Form CMS-1500 (02-12)

The CMS-1500 (02-12) is a universally accepted claim form that is required when billing DMAS for covered services. The form is available from form printers and the U.S. Government Printing Office. Specific details on purchasing these forms can be obtained by writing to the following address:

U.S. Government Print Office
Superintendent of Documents
Washington, DC 20402
(202)512-1800 (Order and Inquiry Desk)

Note: The CMS-1500 (02-12) will not be provided by DMAS.

The request for forms or Billing Supplies must be submitted by:

1. Mail Your Request To:
   Commonwealth Mailing
   1700 Venable St.,
   Richmond, VA 23223

2. Calling the DMAS order desk at Commonwealth Martin 804-780-0076 or, by Faxing the DMAS order desk at Commonwealth Martin 804-780-0198.

All orders must include the following information:

- Provider Identification Number
- Company Name and Contact Person
- Street Mailing Address (No Post Office Numbers are accepted)
- Telephone Number and Extension of the Contact Person
- The form number and name of the form
- The quantity needed for each form

Please DO NOT order excessive quantities.

Direct any requests for information or questions concerning the ordering of forms to the address above or call: (804) 780-0076.

REMITTANCE/PAYMENT VOUCHER

DMAS sends a check and remittance voucher with each weekly payment made by the Virginia Medical Assistance Program. The remittance voucher is a record of approved, pended, denied,

adjusted, or voided claims and should be kept in a permanent file for five (5) years.

The remittance voucher includes an address location, which contains the provider's name and current mailing address as shown in the DMAS' provider enrollment file. In the event of a change-of-address, the U.S. Postal Service **will not** forward Virginia Medicaid payment checks and vouchers to another address. Therefore, it is recommended that DMAS' Provider Enrollment and Certification Unit be notified in sufficient time prior to a change-of-address in order for the provider files to be updated.

Providers are encouraged to monitor the remittance vouchers for special messages since they serve as notifications of matters of concern, interest and information. For example, such messages may relate to upcoming changes to Virginia Medicaid policies and procedures; may serve as clarification of concerns expressed by the provider community in general; or may alert providers to problems encountered with the automated claims processing and payment system.

ANSI X12N 835 HEALTH CARE CLAIM PAYMENT ADVICE

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid, comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The 835 Claims Payment Advice transaction set is used to communicate the results of claim adjudication. DMAS will make a payment with electronic funds transfer (EFT) or check for a claim that has been submitted by a provider (typically by using an 837 Health Care Claim Transaction Set). The payment detail is electronically posted to the provider's accounts receivable using the 835.

In addition to the 835 the provider will receive an unsolicited 277 Claims Status Response for the notification of pending claims. For technical assistance with certification of the 835 Claim Payment Advice please contact our fiscal agent Xerox State Healthcare, LLC at (866) 352-0766.

CLAIM INQUIRIES AND RECONSIDERATION

Inquiries concerning covered benefits, specific billing procedures, or questions regarding Virginia Medicaid policies and procedures should be directed to:

Customer Services
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

A review of additional documentation may sustain the original determination or result in an approval or denial.

Telephone Numbers

1-804-786-6273 Richmond Area and out-of-state long distance
1-800-552-8627 In-state long distance (toll-free)

Enrollee verification and claim status may be obtained by telephoning:

1-800- 772-9996	Toll-free throughout the United States
1-800- 884-9730	Toll-free throughout the United States
1-804- 965-9732	Richmond and Surrounding Counties
1-804- 965-9733	Richmond and Surrounding Counties

Enrollee verification and claim status may also be obtained by utilizing the Web-based Automated Response System. See Chapter I for more information.

BILLING PROCEDURES

Physicians and other practitioners must use the appropriate claim form or billing invoice when billing the Virginia Medicaid Program for covered services provided to eligible Medicaid enrollees. Each enrollee's services must be billed on a separate form.

The provider should carefully read and adhere to the following instructions so that claims can be processed efficiently. Accuracy, completeness, and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Completed claims should be mailed to:

Department of Medical Assistance Services
Practitioner
P.O. Box 27444
Richmond, Virginia 23261-7444

Or

Department of Medical Assistance Services
CMS Crossover
P. O. Box 27444
Richmond, Virginia 23261-7444

ELECTRONIC FILING REQUIREMENTS

DMAS is fully compliant with 5010 transactions and will no longer accept 4010 transactions after March 30, 2012.

The Virginia MMIS will accommodate the following EDI transactions according to the specification published in the Companion Guide version 5010

270/271 Health Insurance Eligibility Request/ Response Verification for Covered Benefits (5010)
276/277 Health Care Claim Inquiry to Request/ Response to Report the Status of a Claim (5010)
277 - Unsolicited Response (5010)
820 - Premium Payment for Enrolled Health Plan Members (5010)
834 - Enrollment/ Disenrollment to a Health Plan (5010)
835 - Health Care Claim Payment/ Remittance (5010)

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835 - Health Care Claim Payment/ Remittance (5010)
837 - Dental Health Care Claim or Encounter (5010)
837 - Institutional Health Care Claim or Encounter (5010)
837 - Professional Health Care Claim or Encounter (5010)
NCPDP - National Council for Prescription Drug Programs Batch (5010)
NCPDP - National Council for Prescription Drug Programs POS (5010)
Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims.

All 5010/D.0 Companion Guides are available on the web portal: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/EDICompanionGuides or contact EDI Support at 1-866-352-0766 or Virginia.EDISupport@xerox.com.

Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims.

For providers that are interested in receiving more information about utilizing any of the above electronic transactions, your office or vendor can obtain the necessary information at our fiscal agent's website: https://www.virginiamedicaid.dmas.virginia.gov.

CLAIMCHECK

- Effective June 3, 2013, DMAS implemented the Medicaid National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) and Medically Unlikely Edits (MUE) edits. This implementation was in response to directives in the Affordable Care Act of 2010. These new edits will impact all Physicians, Laboratory, Radiology, Ambulatory Surgery Centers, and Durable Medical Equipment and Supply providers. Effective January 1, 2014, all outpatient hospital claims will be subject the the NCCI edits thru the EAPG claim processing. Please refer to the Hospital Manual, Chapter 5 for details related to EAPG. The NCCI/ClaimCheck edits are part of the daily claims adjudication cycle on a concurrent basis. The current claim will be processed to edit history claims. Any adjustments or denial of payments from the current or history claim(s) will be done during the daily adjudication cycle and reported on the providers weekly remittance cycle. All NCCI/ClaimCheck edits are based on the following global claim factors: same member, same servicing provider, same date of service or the date of service is within established pre- or post-operative time frame. All CPT and HCPCS code will be subject to both the NCCI and ClaimCheck edits. Upon review of the denial, the provider can re-submit a corrected claim. Any system edits related to timely filing, etc. are still applicable.

- PTP Edits:
  CMS has combined the Medicare Incidental and Mutually Exclusive edits into a new PTP category. The PTP edits define pairs of CPT/HCPCS codes that should not be reported together. The PTP codes utilize a column one listing of codes to a column two listing of codes. In the event a column one code is billed with a column two code, the column one code will pay, the column two code will deny. The only exception to the PTP is the application of an

accepted Medicaid NCCI modifier. **Note**: Prior to this implementation, DMAS modified the CCI Mutually Exclusive edit to pay the procedure with the higher billed charge. This is no longer occurring, since CMS has indicated that the code in column one is to be paid regardless of charge.

- MUE Edits:
  DMAS implemented the Medicaid NCCI MUE edits. These edits define for each CPT/HCPCS code the maximum units of service that a provider would report under most circumstances for a single member on a single date of service and by same servicing provider. The MUEs apply to the number of units allowed for a specific procedure code, per day. If the claim units billed exceed the per day allowed, the claim will deny. With the implementation of the MUE edits, providers must bill any bilateral procedure correctly. The claim should be billed with one unit and the 50 modifier. The use of two units will subject the claim to the MUE, potentially resulting in a denial of the claim. Unlike the current ClaimCheck edit which denies the claim and creates a claim for one unit, the Medicaid NCCI MUE edit will deny the entire claim.

- Exempt Provider Types
  DMAS has received approval from CMS to allow the following provider types to be exempt from the Medicaid NCCI editing process. These providers are: Community Service Boards (CSB), Federal Health Center (FQHC),Rural Health Clinics (RHC), Schools and Health Departments. These are the only providers exempt from the NCCI/editing process. All other providers billing on the CMS 1500 will be subject to these edits.

- Service Authorizations:
  DMAS has received approval from CMS to exempt specific CPT/HCPCS codes which require a valid service authorization. These codes are exempt from the MUE edits however, they are still subject to the PTP and ClaimCheck edits.

- Modifiers:
  Prior to this implementation, DMAS allowed claim lines with modifiers 24, 25, 57, 59 to bypass the CCI/ClaimCheck editing process. With this implementation, DMAS now only allows the Medicaid NCCI associated modifiers as identified by CMS for the Medicaid NCCI. The modifier indicator currently applies to the PTP edits. The application of this modifier is determined by the modifier indicator of "1"or "0" in the listing of the NCCI PTP column code. If the column one, column two code combination has a modifier indicator of "1", a modifier is allowed and both codes will pay. If the modifier indicator is "0", the modifier is not allowed and the column two code will be denied. The MUE edits do not contain a modifier indicator table on the edit table. Per CMS, modifiers may only be applied if the clinical circumstances justify the use of the modifier. A provider cannot use the modifier just to bypass the edit. The recipient's medical record **must** contain documentation to support the use of the modifier by clearly identifying the significant, identifiable service that allowed the use of the modifier. DMAS or its agent will monitor and audit the use of these modifiers to assure compliance. These audits may result in recovery of overpayment(s) if the medical record does not appropriately demonstrate the use of the modifiers.

Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI PTP edit include: E1 –E4, FA, F1 – F9, TA T1 – T9, LT, RT, LC, LD, RC, LM, RI, 24, 25, 57, 58, 78, 79, 27, 59, 91. Modifiers 22, 76 and 77 are not Medicaid PTP NCCI approved modifiers. If these modifiers are used, they will not bypass the Medicaid PTP NCCI edits.

Reconsideration

Providers that disagree with the action taken by a ClaimCheck/NCCI edit may request a reconsideration of the process via email (ClaimCheck@dmas.virginia.gov) or by submitting a request to the following mailing address:

Payment Processing Unit, Claim Check
Division of Program Operations
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

There is a 30-day time limit form the date of the denial letter or the date of the remittance advice containing the denial for requesting reconsideration. A review of additional documentation may sustain the original determination or result in an approval or denial of additional day(s). Requests received without additional documentation or after the 30-day limit will not be considered.

BILLING INSTRUCTIONS REFERENCE FOR SERVICES REQUIRING SERVICE AUTHORIZATION

Please refer to the “Service Authorization” Appendix in the manual.

BASIS OF PAYMENT

A request for payment must be made under the Medicaid eligibility number of the person receiving the services and whose Medicaid eligibility number appears on the billing invoice.

Federal regulation 42 CFR 447.15 requires providers to accept Medicaid payment as payment in full for the service rendered. The provider may not bill DMAS or the member for the difference (if any) between the allowed charge and the provider's actual charge.

The provider must bill any other possibly liable third party prior to billing DMAS. Provider must submit bill within 12 months from date of service. DMAS will pay the difference between the Program's allowable fee and any payment made by another third party if that payment is less than the allowable fee.

Medicaid reimburses providers for the coinsurance and deductible amounts on Medicare claims for Medicaid members who are dually eligible for Medicare and Medicaid. However, the amount

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paid by Medicaid in combination with the Medicare payment will not exceed the amount Medicaid would pay for the services if it were billed solely to Medicaid.

INSTRUCTIONS FOR USE OF THE CMS-1500 (02-12), BILLING FORM

STARTING 04/01/2014 AND AFTER

The Direct Data Entry (DDE) CMS-1500 claim form on the Virginia Medicaid Web Portal will be updated to accommodate the changes to locators 21 and 24E on 4/1/2014. Please note that providers are encouraged to use DDE for submission of claims that cannot be submitted electronically to DMAS. Registration thru the Virginia Medicaid Web Portal is required to access and use DDE. The DDE User Guide, tutorial and FAQ's can be accessed from our web portal at: www.virginiamedicaid.dmas.virginia.gov. To access the DDE system, select the Provider Resources tab and then select Claims Direct Data Entry (DDE). Providers have the ability to create a new initial claim, as well as an adjustment or a void through the DDE process. The status of the claim(s) submitted can be checked the next business day if claims were submitted by 5pm. DDE is provided at no cost to the provider. Paper claim submissions should only be submitted when requested specifically by DMAS.

To bill for services, the Health Insurance Claim Form, CMS-1500 (02-12), invoice form must be used for paper claims **received on or after April 1, 2014**. The following instructions have numbered items corresponding to fields on the CMS-1500 (02-12). The purpose of the CMS-1500 (02-12) is to provide a form for participating providers to request reimbursement for covered services rendered to Virginia Medicaid members.

SPECIAL NOTE: The provider number in locator 24J must be the same in locator 33 unless the Group/Billing Provider relationship has been established and approved by DMAS for use.

Locator		Instructions
1	**REQUIRED**	**Enter an "X" in the MEDICAID box for the Medicaid Program. Enter an "X" in the OTHER box for Temporary Detention Order (TDO) or Emergency Detention Order (EDO).**
1a	**REQUIRED**	**Insured's I.D. Number -** Enter the 12-digit Virginia Medicaid Identification number for the member receiving the service.
2	**REQUIRED**	**Patient's Name -** Enter the name of the member receiving the service.
3	NOT REQUIRED	Patient's Birth Date
4	NOT REQUIRED	Insured's Name
5	NOT REQUIRED	Patient's Address

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Locator		Instructions
6	NOT REQUIRED	Patient Relationship to Insured
7	NOT REQUIRED	Insured's Address
8	NOT REQUIRED	Reserved for NUCC Use
9	NOT REQUIRED	Other Insured's Name
9a	NOT REQUIRED	Other Insured's Policy or Group Number
9b	NOT REQUIRED	Reserved for NUCC Use
9c	NOT REQUIRED	Reserved for NUCC Use
9d	NOT REQUIRED	Insurance Plan Name or Program Name
10	**REQUIRED**	**Is Patient's Condition Related To: -** Enter an "X" in the appropriate box. a. Employment? b. Auto accident c. Other Accident? (This includes schools, stores, assaults, etc.) NOTE: The state postal code should be entered if known.
10d	Conditional	**Claim Codes (Designated by NUCC)** Enter "ATTACHMENT" if documents are attached to the claim form.
11	NOT REQUIRED	Insured's Policy Number or FECA Number
11a	NOT REQUIRED	Insured's Date of Birth
11b	NOT REQUIRED	Other Claim ID
11c	**REQUIRED** **If applicable**	**Insurance Plan or Program Name** Providers that are billing for non-Medicaid MCO copays only- please insert "HMO Copay".
11d	**REQUIRED** **If applicable**	**Is There Another Health Benefit Plan?** Providers should only check Yes, if there is other third party coverage.
12	NOT REQUIRED	Patient's or Authorized Person's Signature
13	NOT REQUIRED	Insured's or Authorized Person's Signature
14	**REQUIRED** **If Applicable**	**Date of Current Illness, Injury, or Pregnancy** **Enter date MM DD YY format** **Enter Qualifier 431 – Onset of Current Symptoms or Illness**
15	NOT REQUIRED	Other Date
16	NOT REQUIRED	Dates Patient Unable to Work in Current Occupation
17	**REQUIRED** **If applicable**	**Name of Referring Physician or Other Source** – Enter the name of the referring physician.
17a shaded red	**REQUIRED** **If applicable**	**I.D. Number of Referring Physician** - The '1D' qualifier is required when the Atypical Provider Identifier (API) is entered. The qualifier 'ZZ' may be entered if the provider taxonomy code is needed to adjudicate the claim.

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Locator		Instructions
		Refer to the Medicaid Provider manual for special Billing Instructions for specific services.
17b	**REQUIRED** **If applicable**	**I.D. Number of Referring Physician** - Enter the National Provider Identifier of the referring physician.
18	NOT REQUIRED	Hospitalization Dates Related to Current Services
19	**REQUIRED** **If applicable**	**Additional Claim Information** Enter the CLIA #.
20	NOT REQUIRED	Outside Lab
21 A-L	**REQUIRED**	**Diagnosis or Nature of Illness or Injury** - Enter the appropriate ICD diagnosis code, which describes the nature of the illness or injury for which the service was rendered in locator 24E. Note: Line 'A' field should be the Primary/Admitting diagnosis followed by the next highest level of specificity in lines B-L. **Note: ICD Ind. Not required at this time.**
22	**REQUIRED** **If applicable**	**Resubmission Code – Original Reference Number**. Required for adjustment and void. See the instructions for Adjustment and Void Invoices.
23	**REQUIRED** **If applicable**	**Prior Authorization (PA) Number** – Enter the PA number for approved services that require a service authorization.

NOTE: The locators 24A thru 24J have been divided into open areas and a shaded line area. **The shaded area is ONLY for supplemental information**. DMAS has given instructions for the supplemental information that is required when needed for DMAS claims processing. **ENTER REQUIRED INFORMATION ONLY.**

24A lines 1-6 open area	**REQUIRED**	**Dates of Service -** Enter the from and thru dates in a 2-digit format for the month, day and year (e.g., 01/01/14). DATES MUST BE WITHIN THE SAME MONTH

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Locator	**Instructions**
24A lines 1-6 red shaded **REQUIRED If applicable**	**DMAS requires the use of qualifier 'TPL'.** This qualifier is to be used whenever an actual payment is made by a third party payer. The 'TPL' qualifier is to be followed by the dollar/cents amount of the payment by the third party carriers. Example: Payment by other carrier is $27.08; red shaded area would be filled as **TPL27.08**. No spaces between qualifier and dollars. No $ symbol but the decimal between dollars and cents is required. **DMAS requires the use of the qualifier 'N4'.** This qualifier is to be used for the National Drug Code (NDC) whenever a HCPCS drug related code is submitted in 24D to DMAS. No spaces between the qualifier and the NDC number. **NOTE: DMAS is requiring the use of the Unit of Measurement Qualifiers following the NDC number for claims received on and after May 26, 2014. The unit of measurement qualifier code is followed by the metric decimal quantity** **Unit of Measurement Qualifier Codes:** **F2 – International Units** **GR – Gram** **ML – Milliliter** **UN – Unit** **Examples of NDC quantities for various dosage forms as follows:** **a. Tablets/Capsules – bill per UN** **b. Oral Liquids – bill per ML** **c. Reconstituted (or liquids) injections – bill per ML** **d. Non-reconstituted injections (I.E. vial of Rocephin powder) – bill as UN (1 vial = 1 unit)** **e. Creams, ointments, topical powders – bill per GR** **f. Inhalers – bill per GR** **BILLING EXAMPLES:** **TPL, NDC and UOM submitted:** **TPL3.50N412345678901ML1.0** **NDC, UOM and TPL submitted:** **N412345678901ML1.0TPL3.50** **NDC and UOM submitted only:**

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Locator **Instructions**

N412345678901ML1.0

TPL submitted only:

TPL3.50

Note: Enter only TPL, NDC and UOM information in the supplemental shaded area. (see billing examples)
All supplemental information is to be left justified.

SPECIAL NOTE: DMAS will set the coordination of benefit code based on information supplied as followed:

- If there is nothing indicated or 'NO' is checked in locator 11d, DMAS will set that the patient had no other third party carrier. This relates to the old coordination of benefit code 2.
- If locator 11d is checked 'YES' and there is nothing in the locator 24a red shaded line; DMAS will set that the third party carrier was billed and made no payment. This relates to the old coordination of benefit code 5. **An EOB/documentation must be attached to the claim to verify non payment**.
- If locator 11d is checked 'YES' and there is the qualifier 'TPL' with payment amount (TPL15.50), DMAS will set that the third party carrier was billed and payment made of $15.50. This relates to the old coordination of benefit code 3.

24B open area **REQUIRED** **Place of Service -** Enter the 2-digit CMS code, which describes where the services were rendered.

24C open area **REQUIRED If applicable** **Emergency Indicator -** Enter either 'Y' for YES or leave blank. **DMAS will not accept any other indicators for this locator.**

24D open area **REQUIRED** **Procedures, Services or Supplies – CPT/HCPCS –** Enter the CPT/HCPCS code that describes the procedure rendered or the service provided.
Modifier - Enter the appropriate CPT/HCPCS modifiers if applicable.

24E open area **REQUIRED** **Diagnosis Code -** Enter the diagnosis code reference letter A-L (pointer) as shown in Locator 21 to relate the date of service and the procedure performed to the primary diagnosis. The primary diagnosis code reference letter for each service should be listed first. **NOTE: A maximum of**

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Locator		Instructions
		4 diagnosis code reference letter pointers should be entered. Claims with values other than A-L in Locator 24-E or blank may be denied.
24F open area	**REQUIRED**	**Charges -** Enter your total usual and customary charges for the procedure/services.
24G open area	**REQUIRED**	**Days or Unit -** Enter the number of times the procedure, service, or item was provided during the service period.
24H open area	**REQUIRED If applicable**	**EPSDT or Family Planning -** Enter the appropriate indicator. Required only for EPSDT or family planning services. 1 - Early and Periodic, Screening, Diagnosis and Treatment Program Services 2 - Family Planning Service
24I open	**REQUIRED If applicable**	**NPI –** This is to identify that it is a NPI that is in locator 24J
24 I red-shaded	**REQUIRED If applicable**	**ID QUALIFIER –T**he qualifier 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 24J open line. The qualifier '1D' is required for the API entered in locator 24J red shaded line.
24J open	**REQUIRED If applicable**	**Rendering provider ID# -** Enter the 10 digit NPI number for the provider that performed/rendered the care.
24J red-shaded	**REQUIRED If applicable**	**Rendering provider ID#** - The qualifier '1D' is required for the API entered in this locator. The qualifier 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 24J open line.
25	NOT REQUIRED	Federal Tax I.D. Number
26	**REQUIRED**	**Patient's Account Number** – Up to **FOURTEEN** alpha-numeric characters are acceptable.
27	NOT REQUIRED	Accept Assignment
28	**REQUIRED**	**Total Charge -** Enter the total charges for the services in 24F lines 1-6
29	**REQUIRED If applicable**	**Amount Paid – For personal care and waiver services only** – enter the patient pay amount that is due from the patient. **NOTE:** The patient pay amount is taken from services billed on 24A - line 1. If multiple services are

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Locator		Instructions
		provided on same date of service, then another form must be completed since only one line can be submitted if patient pay is to be considered in the processing of this service.
30	NOT REQUIRED	Rsvd for NUCC Use
31	**REQUIRED**	**Signature of Physician or Supplier Including Degrees or Credentials -** The provider or agent must sign and date the invoice in this block.
32	**REQUIRED If applicable**	**Service Facility Location Information –** Enter the name as first line, address as second line, city, state and 9 digit zip code as third line for the location where the services were rendered. **NOTE:** For physician with multiple office locations, the specific Zip code must reflect the office location where services given. Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code.
32a open	**REQUIRED If applicable**	**NPI # -** Enter the 10 digit NPI number of the service location.
32b red shaded	**REQUIRED If applicable**	**Other ID#:** - The qualifier '1D' is required for the API entered in this locator. The qualifier of 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 32a open line.
33	**REQUIRED**	**Billing Provider Info and PH # -** Enter the billing name as first line, address as second line, city, state and 9-digit zip code as third line. This locator is to identify the provider that is requesting to be paid**.** **NOTE: Do NOT** use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code. The phone number is to be entered in the area to the right of the field title. Do not use hyphen or space as separator within the telephone number.
33a open	**REQUIRED**	**NPI –** Enter the 10 digit NPI number of the billing provider.
33b red shaded	**REQUIRED If applicable**	**Other Billing ID -** The qualifier '1D' is required for the API entered in this locator. The qualifier 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 33a open line. **NOTE: DO NOT** use commas, periods, space, hyphens or other punctuations between the qualifier and the number.

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Special Note: Taxonomy

With the implementation of the National Provider Identifier (NPI), it will become necessary in some cases to include a taxonomy code on claims submitted to DMAS for all of our programs: Medicaid, FAMIS, and SLH. Prior to using the NPI, DMAS assigned a unique number to a provider for each of the service types performed. But with NPI, a provider may only have one NPI and bill for more than one service type with that number. Since claims are adjudication and paid based on the service type, our system must determine which service type the provider intended to be assigned to a particular claim. If the NPI can represent more than one service type, a taxonomy code must be sent so the appropriate service type can be assigned.

Type of Service	Taxonomy Code(s)	Major Procedure Code Billed (required modifiers are not noted)	Comments
Private Duty Nursing	163WC2100X	T1002, T1003	
Personal Care	3747P1801X	H2021, T1005, T1019, S5126, S5135, S5136, S5150, S5160, S5161, S5165, S5185	
Respite	385H00000X	T1002, T1003, T1005, S5135 S5136, S9125,	
Home Health	251E00000X	0550, 0551, 0559, 0571, 0424, 0421, 0431, 0434, 0441, 0444, 0542	
Family Care Training	None	S5111	These providers must use their DMAS-assigned API.
Adult Day Health	261QA0600X	S5102	
Assisted Living	310400000X 311500000X	T1020 (Regular) T2031 (Alzheimer's)	
Mental Health-Mental Retardation Community Services	251C00000X	H0040, H2000, H2011, H2014, H2021, H2023, H2024, H2025, T1002, T1003, T1005, T1019, T1028, T1999, S5109, S5116, S5126, S5135, S5136, S5150, S5165, 97139, 97535, 97537, 99509, 99199	
Case Management-Baby Care	251B00000X	99420, G9001, G9002, A0160, S0215, S9442, S9446, 97802, 97803, S5131	
Case Management Waiver	171M00000X ---------- 251B00000X	H2000, S5109, S5116, S5135, S5165, T1016,T1028, 97139, 97535, 97537, 99199, 99509	For AIDS Waiver for Services Facilitator CM Services. ---------- For all other waiver case management services.
Treatment Foster			These providers must use their

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Care	None	T1016	DMAS-assigned API.

Rejection Codes: (when the taxonomy is denied)
EDI Remark: Medicaid Edit- Reject

N94: 1359- Billing Taxonomy Code Does Not Cross-reference to Provider Type

N94: 1392- Taxonomy Code Does Not Cross-reference to Provider Type

N288: 1393- No service Taxonomy Code on the Claim

N255: 1394- No Billing Provider Taxonomy Code on the Claim

Instructions for the Completion of the Health Insurance Claim Form, CMS-1500 (02-12), as an Adjustment Invoice

The Adjustment Invoice is used to change information on an approved claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (02-12), except for the locator indicated below.

Locator 22 Medicaid Resubmission

Code - Enter the 4-digit code identifying the reason for the submission of the adjustment invoice.

1023 Primary Carrier has made additional payment
1024 Primary Carrier has denied payment
1025 Accommodation charge correction
1026 Patient payment amount changed
1027 Correcting service periods
1028 Correcting procedure/service code
1029 Correcting diagnosis code
1030 Correcting charges
1031 Correcting units/visits/studies/procedures
1032 IC reconsideration of allowance, documented
1033 Correcting admitting, referring, prescribing, provider identification number
1053 Adjustment reason is in the Misc. Category

Original Reference Number/ICN - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted. Only one claim can be adjusted on each CMS-1500 (02-12) submitted as an Adjustment Invoice. (Each line under Locator 24 is one claim.)

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NOTE: ICNs can only be adjusted through the Virginia MMIS up to three years from the **date the claim was paid**. After three years, ICNs are purged from the Virginia MMIS and can no longer be adjusted through the Virginia MMIS. If an ICN is purged from the Virginia MMIS, the provider must send a refund check made payable to DMAS and include the following information:

- A cover letter on the provider's letterhead which includes the current address, contact name and phone number.
- An explanation about the refund.
- A copy of the remittance page(s) as it relates to the refund check amount.

Mail all information to:

Department of Medical Assistance Services
Attn: Fiscal & Procurement Division, Cashier
600 East Broad St. Suite 1300
Richmond, VA 23219

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Instructions for the Completion of the Health Insurance Claim Form CMS-1500 (02-12), as a Void Invoice

The Void Invoice is used to void a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (02-12), except for the locator indicated below.

Locator 22 Medicaid Resubmission

Code - Enter the ~~4~~-digit code identifying the reason for the submission of the void invoice.

1042	Original claim has multiple incorrect items
1044	Wrong provider identification number
1045	Wrong enrollee eligibility number
1046	Primary carrier has paid DMAS maximum allowance
1047	Duplicate payment was made
1048	Primary carrier has paid full charge
1051	Enrollee not my patient
1052	Miscellaneous
1060	Other insurance is available

Original Reference Number/ICN - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be voided. Only one claim can be voided on each CMS-1500 (02-12) submitted as a Void Invoice. (Each line under Locator 24 is one claim).

NOTE: ICNs can only be voided through the Virginia MMIS up to three years from the **date the claim was paid**. After three years, ICNs are purged from the Virginia MMIS and can no longer be voided through the Virginia MMIS. If an ICN is purged from the Virginia MMIS, the provider must send a refund check made payable to DMAS and include the following information:

- A cover letter on the provider's letterhead which includes the current address, contact name and phone number.
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Group Practice Billing Functionality

Providers defined in this manual are not eligible to submit claims as a Group Practice with the Virginia Medicaid Program. Group Practice claim submissions are reserved for independently enrolled fee-for-service healthcare practitioners (physicians, podiatrists, psychologists, etc.) that share the same Federal Employer Identification Number. Facility-based organizations (NPI Type 2) and providers assigned an Atypical Provider Identifier (API) may not utilize group billing functionality.

Medicare Crossover: If Medicare requires you to submit claims identifying an individual Rendering Provider, DMAS will use the Billing Provider NPI to adjudicate the Medicare Crossover Claim. You will not enroll your organization as a Group Practice with Virginia Medicaid.

For more information on Group Practice enrollment and claim submissions using the CMS-1500 (02-12), please refer to the appropriate practitioner Provider Manual found at www.dmas.virginia.gov.

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SPECIAL BILLING INSTRUCTIONS

Locator 24D Procedures, Services or Supplies

CPT/HCPCS – Enter the appropriate procedure code from the following list.

Rates can be retrieved on the DMAS website: www.dmas.virginia.gov.

State Plan Services

National Code	Modifier	DESCRIPTION	FEES
T2023	U3	Support Coordination	

Waiver Services

National Code	Modifier	DESCRIPTION	FEES
H2014		In-Home Residential Support	
H2023		Supported Employment, Individual Placed Prevocational	
H2024		Supported Employment, Enclave/Work Crew	
97537		Day Support, Regular Intensity, Center Based	
97537	U1	Day Support, High Intensity, Center Based	
97537		Day Support, Regular Intensity, Non-Center Based	
97537	U1	Day Support, High Intensity, Non-Center Based	
97139		Therapeutic Consultation	
N/A		(Environmental Modification, Rehab Engineer)	
S5165		Environmental Modifications Only	

N/A		(Environmental Modification, Supply Only)
N/A		(Environmental Modification, Transportation Mod.)
99199	U4	Environmental Modification, Maintenance Costs Only
N/A		(Assistive Technology, Rehab Engineer)
T1999		Assistive Technology Only
T1999	U5	Assistive Technology, Maintenance Costs Only
T1019		Personal Assistance *Northern Virginia* *Rest of State*
T1005		Respite Services *Northern Virginia* *Rest of State*
S5150		Consumer-Directed Respite Services *Northern Virginia* *Rest of State*
H2000		Initial Comprehensive Visit *Northern Virginia* *Rest of State*
S5109		Employee Management Training *Northern Virginia* *Rest of State*
99509		Routine Home Visit *Northern Virginia* *Rest of State*
T1028		Reassessment Visit *Northern Virginia* *Rest of State*
S5116		Management Training *Northern Virginia* *Rest of State*

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99199	U1	Criminal Record Check
99199		CPS Registry Check
S5126		Consumer-Directed Personal Assistance *Northern Virginia* *Rest of State*
S5135		Companion Services *Northern Virginia* *Rest of State*
S5160		PERS Installation *Northern Virginia* *Rest of State*
S5160	U1	PERS and Medication Monitoring Installation *Northern Virginia* *Rest of State*
S5161		PERS Monitoring *Northern Virginia* *Rest of State*
S5185		PERS and Medication Monitoring *Northern Virginia* *Rest of State*
H2021	TD	PERS Nursing Services/RN *Northern Virginia* *Rest of State*
H2021	TE	PERS Nursing Services/LPN *Northern Virginia* *Rest of State*
S5111		Family/Caregiver Training
H0040		Crisis Supervision
H2011		Crisis Stabilization
T1002		Skilled Nursing Services/RN *Northern Virginia* *Rest of State*

T1003		Skilled Nursing Services/LPN *Northern Virginia* *Rest of State*
S5136		Consumer-Directed Companion Services *Northern Virginia* *Rest of State*
H2025		Pre-vocational Services, Regular Intensity
H2025	U1	Pre-vocational Services, High Intensity

EDI BILLING (ELECTRONIC CLAIMS)

Please refer to X-12 Standard Transactions & our Companion Guides that are listed in the chapter.

SPECIAL BILLING INSTRUCTIONS FOR PERSONAL/RESPITE CARE

Locator 14 — Date of Current Illness, Injury, or Pregnancy

Date care began is located on the DMAS-93 (P.A. Letter)

Locator 24D — Procedures, Services or Supplies

CPT/HCPS – Enter the appropriate procedure code from the following list:

T1019	Personal Care
T1005	Respite care services, aide/hr.
S9125	Respite care services, LPN/hr.

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Locator 29 for CMS-1500 (02-12) Amount Paid

Enter the patient pay amount except for Personal Care. (For Personal Care see instructions for Locator 29). Patient pay and primary carrier payments can be combined if applicable. EOB should be attached to claim.

Locator 29 Amount Paid

Enter the patient pay amount for Personal Care only.

INVOICE PROCESSING

The Medicaid invoice processing system utilizes a sophisticated electronic system to process Medicaid claims. Once a claim has been received, imaged, assigned a cross-reference number, and entered into the system, it is placed in one of the following categories:

- Remittance Voucher
    - **Approved** - Payment is approved or placed in a pended status for manual adjudication (the provider must not resubmit).
    - **Denied** - Payment cannot be approved because of the reason stated on the remittance voucher.
- No Response - If one of the above responses has not been received within 30 days, the provider should assume non-delivery and rebill using a new invoice form. **The provider's failure to follow up on these situations does not warrant individual or additional consideration for late billing.**

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EXHIBITS

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE / TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State) YES NO	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. A. B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. / 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. Rsvd for NUCC use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. b.		33. BILLING PROVIDER INFO & PH. # ( ) a. b.		

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB 0938-1197 FORM 1500 (02-12)

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

CLAIM ATTACHMENT FORM

Attachment Control Number (ACN) :

Patient Account Number (20 positions limit)*	**MM**	**DD**	**CCYY**	**Sequence Number (5 digits)**
	Date of Service			

*Patient Account Number should consist of numbers and letters only. NO spaces, dashes, slashes or special characters.

Provider Number:	**Provider Name:**

Enrollee Identification Number:

Enrollee Last Name:	**First Name:**	**MI:**

☐ **Paper Attached** ☐ **Photo(s) Attached** ☐ **X-Ray(s) Attached**

☐ **Other (specify)** _____

COMMENTS: _____

_____

_____

_____

_____

_____

THIS IS TO CERTIFY THAT THE FOREGOING AND ATTACHED INFORMATION IS TRUE, ACCURATE AND COMPLETE. ANY FALSE CLAIMS, STATEMENTS, DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS

Authorized Signature _____ **Date Signed** _____

Mailing addresses are available in the Provider manuals or check DMAS website at www.dmas.virginia.gov Attachments are sent to the same mailing address used for claim submission. Use appropriate PO Box number.

DMAS - 3 R 6/03

INSTRUCTIONS FOR THE COMPLETION OF THE DMAS-3 FORM. THE DMAS-3 FORM IS TO BE USED BY EDI BILLERS ONLY TO SUBMIT A NON-ELECTRONIC ATTACHMENT TO AN ELECTRONIC CLAIM.

Attachment Control Number (ACN) should be indicated on the electronic claim submitted. The ACN is the combined fields 1, 2 and 3 below. (i.e. Patient Account number is 123456789. Date of service is 07/01/2003. Sequence number is 12345. The ACN entered on the claim should be 1234567890701200312345.) IMPORTANT: THE ACN ON THE DMAS-3 FORM MUST MATCH THE ACN ON THE CLAIM OR THE ATTACHMENT WILL NOT MATCH THE CLAIM SUBMITTED. IF NO MATCH IS FOUND, CLAIM MAY BE DENIED. ATTACHMENTS MUST BE SUBMITTED AND ENTERED INTO THE SYSTEM WITHIN 21 DAYS OR THE CLAIM MAY RESULT IN A DENIAL.

1. **Patient Account Number** – Enter the patient account number up to 20 digits. Numbers and letters only should be entered in this field. **Do not** enter spaces, dashes or slashes or any special characters.

2. **Date of Service** – Enter the from date of service the attachment applies to.

3. **Sequence Number** –Enter the provider generated sequence number up to 5 digits only.

4. **Provider Number** – Enter the Medicaid Provider number.

5. **Provider Name** – Enter the name of the Provider.

6. **Enrollee Identification Number** – Enter the Medicaid ID number of the Enrollee.

7. **Enrollee Last Name -** Enter the last name of the Enrollee.

8. **First** – Enter the first name of the Enrollee.

9. **MI –** Enter the middle initial of the Enrollee.

10. **Type of Attachment –** Check the type of attachment or specify.

11. **Comment –** Enter comments if necessary.

12. **Authorized Signature –** Signature of the Provider or authorized Agent.

13. **Date Signed** – Enter the date the form was signed.

Attachments are sent to the same mailing address used for claim submission. Use appropriate PO Box number. Mailing addresses are available in the Provider manuals or check the DMAS website at www.dmas.virginia.gov.

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CHAPTER VI
QUALITY MANAGEMENT REVIEW AND UTILIZATION REVIEW

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Chapter VI
QUALITY MANAGEMENT REVIEW

INTRODUCTION

Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of the care and services paid through Medicaid, including review of utilization of the services by providers and by individuals. These reviews are mandated by Title 42 Code of Federal Regulations, Parts 455 and 456, and may be conducted by DMAS or its designated agent. The Department of Medical Assistance Services (DMAS) conducts periodic quality management reviews (QMRs) on all programs. In addition, DMAS conducts compliance reviews on providers that are found to provide services in excess of established norms, or by referrals and complaints from agencies or individuals.

Participating Medicaid providers are responsible for ensuring that requirements for services rendered are met in order to receive payment from DMAS. This chapter provides information on QMR and Compliance Reviews conducted by DMAS.

GENERAL REQUIREMENTS FOR QUALITY MANAGEMENT REVIEW (QMR AND COMPLIANCE REVIEWS)

By federal law, DMAS is the single state authority responsible for the supervision of the administration of home and community-based waivers in the Commonwealth of Virginia and will perform routine QMRs of waiver services and providers.

DMAS or its designated agent will conduct ongoing monitoring of compliance of a provider with DMAS participation standards and policies. A QMR includes a review of the provision of services to ensure that services are being provided in accordance with DMAS regulations, policies, and procedures. A provider's noncompliance may result in a request for a corrective action plan, provision of technical assistance, or referral to the Division of Program Integrity for determination of retractions.

DMAS or its designated agent will conduct QMRs of waiver services provided by all providers to ensure the health, safety, and welfare of the individual and the individual's satisfaction with services. The reviews will focus on the Centers for Medicare and Medicaid's (CMS') assurances of individual service plans, including individual preferences, services being delivered in accordance with the Plan for Supports and the identification and inclusion of risks. In order to

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monitor the health, safety and welfare of individuals the QMR also includes the review of documents and reports related to incident reporting (i.e. incident reports, APS reports, CPS reports, Department of Behavioral Health and Developmental Services (DBHDS) incident reporting system). In addition to assessing the individual's ongoing need for Medicaid-funded long-term care, another purpose of the reviews is to ensure an individual's satisfaction with services and providers, and that individual choice of services and person-centered planning are being carried out. This may involve interviews with the individual and/or the family/caregiver, as appropriate.

During QMR and compliance reviews, staff will monitor the provider's compliance with overall provider participation requirements. Particular attention is given to staffing qualifications as described in Chapter II of this manual. Staff will request registered nurses' (RNs') and other health professionals' licenses, including those of licensed practical nurses (LPNs), Certified Nursing Assistants (CNAs), and others who have provided services. In addition, staff request work references or the documentation of attempts to obtain them, documentation of any required training and/or certification, documentation of criminal background checks, and any other staffing requirements as identified in DMAS and DBHDS regulations and policies. The provider is responsible for ensuring that all staff of the provider agency meets the minimum requirements and qualifications at the start of the employment. For consumer-directed services, the employer of record (EOR) is responsible to ensure that all stated requirements are met in the hiring and employment of attendants providing consumer-directed services.

During reviews, DMAS staff will identify any areas of concern, technical assistance needs, the plans for addressing those needs, and any recommendations that staff may have. DMAS staff may also require additional documentation to verify that the provider agency is in compliance with DMAS provider agreements and policies, including requirements for ownership of provider agencies. It is the responsibility of the provider to know and fulfill all applicable state and federal requirements relating to the services that the provider has a participation agreement to provide.

Providers are continually assessed to ensure they conform to Medicaid participation standards and program policies. The provider is assessed on its ability to render consistent, high-quality care to individuals in need of an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) level of care and who are receiving services through the Developmental Disabilities (DD) Waivers. Information used to make this assessment includes any DMAS desk or on-site reviews of the documentation submitted by the provider, the provider's files, interviews with staff and with individuals and, visits to homes or program locations. DMAS bases its assessment of the provider on a comprehensive evaluation of the provider's overall performance in relation to the following:

- Individuals served by the provider meet the program's eligibility criteria. If DMAS or its designated agent determines, during the QMR or at any other time, that the individual receiving waiver services no longer meets eligibility standards or criteria for waiver services as set forth in DMAS regulations, DMAS will review and request

that the individual be removed from the waiver and that alternative services be discussed with the individual.

- Services rendered must meet the individual's identified needs, be in accordance with an active plan for supports, and be within the program's guidelines. The provider is responsible for continuously assessing the individual's needs through observation and communication between the provider, the individual and other provider staff. The plan for supports must be revised in accordance with any substantial change in the individual's status, and the individual's record must contain documentation of any such change. This also includes the provider's responsibility to identify and inform the support coordinator or to obtain any other services that the individual requires to remain in the community (e.g., durable medical equipment and supplies, etc.).

- Provider documentation must support all services billed to DMAS.

- Document and maintain written semi-annual supervision notes for each Direct Support Professional (DSP) that are signed by the supervisor. Additionally,

- For DBHDS-licensed entities, the provider must provide ongoing supervision of all companions and/or DSP staff consistent with the requirements of 12VAC35-105.

- For providers who are licensed by VDH or have accreditation from a CMS-recognized organization as a personal care or respite care provider, they must provide ongoing supervision of companion or DSP staff consistent with regulatory requirements.

- Prepare and maintain unique person-centered progress note written documentation in each individual's record about the individual's responses to services and rendered supports and of specific circumstances that prevented provision of the scheduled service, should that occur. Such documentation should be written, signed, and dated on the day the described supports were provided. However, documentation that occurs after the date services were provided must be dated for the date the entry is recorded and the date of actual supports delivery is to be noted in the body of the note. In instances when the individual does not communicate through words, the provider must note his observations about the individual's condition and observable responses, if any, at the time of service delivery.

- Examples of unacceptable person-centered progress note written documentation include:

    - Standardized or formulaic notes;
    - Notes copied from previous service dates and simply re-dated;
    - Notes that are not signed and dated by staff who deliver the service, with the date services were rendered; and

- Notes that do not document the individual's unique opinions or observed responses to supports;

- Maintain an attendance log or similar document that indicates the date services were rendered, type of services rendered, and number of hours or units provided (including specific timeframe for services with a unit of service shorter than one day) for each service type except for one-time services such as assistive technology, environmental modifications, transition services, individual and family caregiver training, electronic home-based supports, services facilitation, and personal emergency response system support, where initial documentation to support claims will suffice.

- Services must be of a quality that meets the health and safety needs and the rights of the individual. Quality of supports is best assured through an emphasis on communication and respect between the individual and provider staff, and between the individual and the provider agency representative who is responsible for the oversight of the plan. Some of the elements included in quality of supports are:

  - Consistency of supports;
  - Continuity of supports;
  - Adherence to the plan for supports; and
  - Consideration for the health, safety, and welfare needs of the individual.

- Providers opting to use an electronic signature for documentation purposes must comply with the following:

  - The electronic signature can be clearly identified
  - The electronic signature identifies the individual signing the document and the date of the signature,
  - The electronic signature cannot be altered once it is attached to a document
  - The date of the signature cannot be altered once attached to the signature
  - Documents cannot be signed electronically by anyone other than the individual required to sign the document, and
  - Documents containing electronic signatures can be printed out upon the request of QMR Analyst.

- The provider will maintain a record for each individual. If more than one service is provided, the record will be divided by service. Forms that may be used are available on the DMAS website at **www.dmas.virginia.gov** or the DBHDS website at **http://www.dbhds.virginia.gov**

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DMAS will review the provider's performance in all the outcome areas to determine the provider's ability to achieve high quality supports and conform to DMAS regulations and policies. DMAS is responsible for providing feedback to the provider regarding those areas that may need improvement. During QMR reviews, DMAS will review individual files and conduct site visits to assess the quality of supports and continued appropriateness of services. DMAS will evaluate the individual's status, satisfaction with the service, and appropriateness of the current plan for supports. If the plan for support is found to be inadequate, DMAS will require a revision of the plan to meet the needs of the individual.

DMAS conducts QMRs and compliance reviews to assure that the services provided are appropriate and comply with the policies and procedures for the provision of services under the DD Waivers. For the general requirements, DMAS uses the following procedures:

- DMAS or its designated agent will conduct an on-site review and/or desk review by the provider of each service periodically.

- The sampling method includes both random selections and records reviewed to examine specific variables, such as numbers of individuals served, types of services rendered, etc.

- QMRs and compliance reviews may be unannounced.

- Providers may be asked to bring program records to a central location.

- During an on-site QMR or compliance review, staff will review the individual's record in the provider's place of business/offices, paying specific attention to the Plan for Supports, supervisory notes (RN and SF), daily records, support logs or progress notes, screening documentation, and any other documentation that is necessary to determine if services were rendered appropriately. Staff may also meet or talk with at least one individual or primary caregiver to determine individual satisfaction with waiver services and the provider. The provider may be asked to assist in setting up this visit. In all cases, the primary caregiver is encouraged to participate in the review of the individual's supports during QMR reviews.

- Upon completion of on-site activities for a QMR, DMAS staff will meet with designated staff to conduct an exit conference, The purpose of the exit conference is for DMAS to provide a general overview of the QMR findings, preliminary actions required, and recommendations that may help the provider correct problems in documentation or billing practices.

- Following the QMR review, a written report of the findings is sent to the provider. During the review process, staff will offer technical assistance and consultation to the

provider regarding DMAS regulations, policies, and procedures or may refer providers to DBHDS staff for more in-depth technical assistance or training. If questions arise regarding compliance issues, staff will provide information and assistance. Any uncorrected compliance issues may result in the termination of the provider contract.

- If a corrective action plan is requested, the provider will have 30 days (unless otherwise indicated) from receipt of the QMR report to submit the plan to DMAS for approval. At that time, the provider may submit additional documentation for review.

- If there are findings that are related to licensing procedures, a letter stating these findings may be submitted to other agencies, as appropriate (e.g., Department of Health Professions, or DBHDS).

- DMAS will follow up on any corrective action plans that are submitted to ensure that corrective procedures within the plan are implemented by the provider.

- See the Compliance Review Section of this manual for additional information regarding written findings from these types of reviews.

REVIEW OF ID AND DD TARGETED CASE MANAGEMENT AND DD WAIVERS SERVICES

In addition to the general QMR and compliance review requirements, DMAS also reviews for specific requirements for the provision of ID/DD Targeted Case Management and ID & DD Waivers Services. These requirements are: 1) eligibility for services; 2) that the services are based on comprehensive and ongoing assessment and person-centered planning; 3) that services are delivered, reviewed, and modified as appropriate; 4) that the provider is qualified; and 5) that the services are consistent with billing limitations. Specific requirements for each area follow.

Eligibility for ID or DD Case Management Services

- There is basis for initiating DD or ID Targeted Case Management services.
    - There must be documentation of diagnostic eligibility (DD diagnosis for DD Targeted Case Management services and ID diagnosis for ID Targeted Case Management per Code of Virginia § 37.2-100) in the record of an individual receiving DD or ID Targeted Case Management services.
    - There must be documentation that the individual requires and receives active case management services.

- ID or DD Targeted Case Management services must not duplicate any other Medicaid service provided under the Virginia State Plan for Medical Assistance or under any waiver including the DD waivers.

- There is basis for initiating 90-day ID Targeted Case Management.

  - Referral information for an individual to receive 90-day ID Targeted Case Management services must be clearly documented and provide a basis for this service. This includes evidence in the case management record that: a) the individual had not previously received formal case management services; b) the individual did not have diagnostic information necessary to determine eligibility; c) there was reason to suspect the presence of ID; and d) there was an indication of a need for ongoing active case management services.

  - Documentation must indicate that the 90-day Plan for Supports began no earlier than the date of the initial face-to-face contact with the individual and ended when the assessment information (diagnosis and need for active case management) was completed, but no later than 90 days from the start date. Billing can occur for a maximum of three months. If prior to the end of the 90 calendar days, an individual is determined ineligible, appropriate notification of the right to appeal must be sent to the individual.

Eligibility for DD Waivers Services

- The individual meets the diagnostic criteria for DD as described in Chapter IV.

- The individual meets functional eligibility. For individuals receiving DD Waivers services, the ICF/IID level of functioning survey, the Virginia Individual Developmental Disability Eligibility Survey (VIDES infant, child, or adult) must be in the support coordination/case management record, have been completed no more than six months prior to the start of waiver services, and document that the individual meets the dependency level in 2 or more for children and infants and 3 or more for adults. This must be reviewed and completed annually and reflect the current status of the individual.

- There is basis for initiating DD Waivers services.

  - The support coordination/case management record for an individual receiving DD waiver services must indicate that the individual meets both diagnostic and functional eligibility as described above.

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- Documentation must be evident that the individual is receiving Targeted Case Management at the time DD waiver services are initiated and during any month in which DD waiver services are provided. A support coordination/case management Plan for Supports must be available in the record.

- For the DD waivers, documentation must indicate that the individual meets the priority one criteria (outlined in Chapter IV) at the time of enrollment.

- The individual continues to meet eligibility for services.

  - It must be clearly documented in the support coordination/case management record that the individual's eligibility and need for continuation of any DD Waivers services is reviewed at least annually.

  - To confirm continued diagnostic eligibility for DD Waivers services, the support coordination/case management record must contain evidence that the individual has a developmental disability. There should be documentation that an updated psychological or other evaluation is completed whenever the individual's functioning has undergone significant change and is no longer reflective of the past psychological or other evaluation. The psychological or other evaluation must be completed by a licensed professional with documented training in conducting the evaluation.

  - The support coordination/case management record of individuals receiving DD Waivers services must contain a VIDES that was administered on an annual basis by the support coordinator/case manager. The individual must meet the indicated dependency level in two or more (for infants) or three or more (for children and adults) of the categories on the VIDES. The support coordinator/case manager will indicate on the VIDES what information from the medical record was used in scoring.

- **Comprehensive and Ongoing Assessment and Planning**

  - An Individual Support Plan is completed and reviewed.

- The support coordination/case management record must include an Individual Support Plan that organizes the services and supports that are provided to the individual. The five essential components of an Individual Support Plan include:

  - The Essential Information (including risk assessment)

  - Personal Profile to include the individual's vision for a good life and desired outcomes including risk mitigation;

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- Shared planning
- A documentation of agreement signed (may be a signature page) by those participating in the development and implementation of the Individual Support Plan.
- A separate Plan for Supports for each waiver - service requested and received by the individual (including DD and ID Targeted Case Management., which outlines the activities planned to assist in meeting the individual's needs and in attaining the individual's desired outcomes; and
- There must be evidence that the Individual Support Plan is reviewed by the support coordinator/case manager and updated annually (every 12 months) and whenever changes or service modifications occur.

- There is comprehensive and current assessment information.
  - There must be a Personal Profile in the support coordination/case management record, completed by the team, no earlier than one year prior to start date of services and updated annually. The Personal Profile summarizes the individual's vision of a good life, his/her talents and contributions, and "what's working/what's not working" in the following life areas:
    - Home
    - Community and interests
    - Relationships
    - Work and alternates to work
    - Learning and other pursuits
    - Money
    - Transportation and travel
    - Health and safety
  - Additionally, the support coordinator/case manager maintains the Essential Information, updated at least annually and as needed, which includes:
    - Contact information
    - Emergency contacts/representation
    - Psychological or other developmental disabilities diagnostic evaluation
    - Current VIDES Support Coordination and provider contacts
    - Communication and sensory supports
    - Health, medications and physicals

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- Summary of social/developmental/behavioral/family history/previous interventions and outcomes
- Summary of employment and educational background
- Active medical and behavioral support needs/risk assessment
- Ability to access services and supports
- Legal, financial, and advocacy issues

- There should be medical information in the support coordination/case management record for any individual receiving DD waivers services. Individuals receiving DD waivers services must have a medical examination completed no earlier than 12 months prior to the start of waiver services. Documentation should indicate that additional evaluations occur whenever indicated. Medical examinations of children should follow the schedule of the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) administered by DMAS.

- The support coordination/case management record for an individual receiving DD Waiver services should contain the Virginia SIS^{TM} (completed every fourth year by a contractor) and a risk assessment completed no more than 12 months prior to the start date of waiver services:

    - At least every four years for those individuals who are 22 years of age and older;
    - At least every three years for those individuals who are 16 years of age through 21 years of age; or
    - Every two years for individuals five years through 15 years of age when the individual is using a tiered service.
    - For children younger than five years of age, an alternative industry assessment instrument approved by DBHDS, such as the Early Learning Assessment Profile, will be completed by the appropriate professional every two years for service planning purposes.

- The above assessment information must be provided to the services providers to be available to use to develop their Plans for Supports.

- The individual and others, as appropriate, are involved in the planning process.

    - Documentation must indicate that the individual (or legal guardian, when appropriate) provided consent to exchange information with other agencies. The support coordination/case management record of an individual must contain a signed copy of this form, completed prior to the initiation of the DD Waiver services.

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- Documentation must indicate that the individual (or legal guardian, when appropriate) was given the choice between institutional care and DD Waivers services, as appropriate. The support coordination/case management record must contain a copy of the form entitled "Documentation of Individual Choice between Institutional Care or Home- and Community-Based Services" (DMAS 459-C or Virginia Informed Choice DMAS 460/459A). This form is required at the initiation of any waiver services and should be maintained in the individual's support coordination/case management record.

- Documentation must be in the support coordination/case management record that the individual has been presented with all feasible alternatives of available agency and consumer-directed services for which he or she is eligible under the DD Waivers (this is done on the Individual Choice form (DMAS 459c) or Virginia Informed Choice DMAS 460/459A).

- Documentation must indicate that the individual (or legal guardian, when appropriate) was informed of all DD waivers providers in the community and had the option of choosing from among qualified providers. It must be clear that the choice of providers was offered no more than six months prior to the initiation of any waiver services, whenever new services were added, when changes occur in providers, or when requests are made by the individual. The individual's record must contain a copy of the form entitled, "Virginia Informed Choice" (DMAS-460/459A).

- Documentation must indicate that the individual (or legal guardian or family) was involved in the development of the Individual Support Plan. The team should meet within 30 calendar days of the waiver enrollment date to discuss the individual's needs, existing supports, and agency-directed and consumer-directed service options for developing the Individual Support Plan. At a minimum, the individual's (and family/caregiver, as appropriate) input and satisfaction with the plan should be documented by signature(s) on the ISP in addition to the support coordinator's/case manager's signature. The individual must sign each provider's plans for support.

- Documentation must indicate that the individual (or legal guardian) was informed of any changes in services, provided the opportunity for input, and agreed to the changes before they were implemented. Documentation of this involvement should accompany any changes to the Individual Support Plan.

- For any termination or decrease of ID or DD Targeted Case Management, DD Waivers services, the support coordination/case management record must contain written notification to the individual of the pending action and the right to appeal. See the appeal section in Chapter II for specific requirements.

- The Support Coordinator/Case Manager receives and reviews each Plan for Supports.
    - Each Plan for Supports must be completed prior to the initiation of services and must designate supports based on current information, reflective of the individual's desires, input, and other assessment information and agreed to by the team.
    - Each Plan for Supports must clearly describe the activities of the individual and staff. There must be a separate document maintained by the provider containing the support instructions that are related to the measurable support activities detailed in the Plan for Supports, as appropriate for the individual and congruent with the type and amount of service units approved through the Waiver Management System (WaMS).
    - Each Plan for Supports must include activities and supports that are meaningful and address the individual's desired outcomes. Each Plan for Supports must satisfy the specific Medicaid criteria and service limitations for each service as described in Chapter IV.
    - The general schedule of supports must be consistent with the service units authorized for that service.
    - When a 60-day assessment period is utilized for any type of residential support, personal assistance (agency-directed), any type of day service, or supported employment services, there must be evidence that the individual is new to the program/provider and a preliminary Plan for Supports and general schedule of supports are included in the record. Documentation must confirm attendance and provide specific information as described in the Plan for Supports support activities. There must be an annual Plan for Supports, based upon the assessment information, developed prior to the last day of the assessment period.

Services are Delivered, Reviewed, and Modified as Needed

- Services occur as planned or are adjusted to accommodate the individual's needs and requests.
    - There must be ongoing documentation in the record of each service provider regarding the services provided to the individual and available for review by the support coordinator/case manager, DBHDS, DMAS, and the individual or family or both, in accordance with applicable policies and regulations. Documentation can include case notes, various modes of measurable data collection, attendance records, notes regarding significant incidents, results of medical appointments/consults and daily progress notes/support logs.

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- The record must document a minimum of one support coordination/case management face-to-face contact with the individual within each 90-calendar day period with a 10-calendar day grace period. There must be evidence that the case manager assessed the individual's satisfaction with services (through observation and interviews with the individual and significant others), determined any unmet needs, evaluated the individual's status, and assisted with adjustments in the services and supports as appropriate. Missed face-to-face contacts with no documented reason, particularly patterns of missed contacts, may result in the entire quarter being disallowed for reimbursement.

- Each service provider's records (including support coordination/case management) must contain documentation that corresponds to the Plan for Supports support activities and indicates that services have been provided according to the plan. While this data may take many forms, it should be appropriate to the individual's supports and demonstrate that his or her desired outcomes are being addressed.

- Services are reviewed at least quarterly.

  - There must be documentation that the support coordinator/case manager reviewed on a quarterly basis all services provided (including Targeted Case Management services). A 30-calendar day grace period to complete the person-centered (quarterly) review of the Individual Support Plan will be permitted. However, the original person-centered review due dates remain unaffected by the date the review is completed.

  - There must be evidence that person-centered reviews for the waiver services are completed and sent to the support coordinator/case manager no more than 10 calendar days following the end of each quarter as determined by the effective start date of Individual Support Plan. However, the original person-centered review due dates remain unaffected by the date the review is completed.

  - The person-centered review for each service, including support coordination/case management, will be reviewed to determine if it addresses a) the effectiveness of the services; b) any significant events; c) the individual's and, when appropriate, the family's/caregiver's satisfaction with the services and other input; and d) changes in the desired outcomes, support activities or instructions when they are ineffective or upon the individual's request.

- A comprehensive review of each service occurs annually (every 12 months).

  - The support coordination/case management record will be reviewed to determine if the annual review includes a combination of record review, observation of service delivery,

and interviews with the individual and family to determine if the services provided are effective and match the individual's needs and desired outcomes.

- All providers must be invited to the meeting and participate in the development of the new Individual Support Plan annually (no longer than 365 days – 366 days in a leap year – between Individual Support Plan effective dates). There is no grace period.

Provider Qualifications

There is documentation of the needed license, certification, vendor agreement, or approval.

- It is the responsibility of the service provider to maintain documentation, readily available for review, which verifies the provider's staff qualifications.
- Provider qualifications and expectations are outlined in Chapters II and IV of this manual.

Services Delivered are Consistent with Service Limits

- Services must be authorized or preauthorized as appropriate.
  - All DD waivers providers must have a current DMAS Participation Agreement that lists all services for which the provider is eligible to provide and bill.
  - DD waivers services require authorization by DBHDS in order for the provider to be eligible for reimbursement. Consumer-directed (CD) services facilitation does not require service authorization. The number of hours does require authorization.
  - Terminations of single waiver services are processed via the WaMS. Terminations of all waiver services must be reflected on a completed DMAS-225.
- There must be documentation that services were provided in accordance with the service plan and as billed.
  - Billing for ID or DD Targeted Case Management services must be supported by a minimum of one direct or individual-related contact, activity, or communication and must be documented each month relevant to the Individual Support Plan during any month for which a claim for ID or DD Targeted Case Management is submitted. Written work and travel time are excluded. Billing for 90-day ID Targeted Case Management may only occur for a maximum of three months.
  - Billing for group day services, community coaching, community engagement, and group supported employment services must be supported by attendance documentation that

verifies individual participation in the service in accordance with the Plan for Supports. The billing should indicate a total number of hours that is equal to or greater than the number of hours billed each day in a month. The documentation must include, at a minimum, the date services were rendered, the number of hours provided, the activities to support the type of service delivered.

- In instances where group day services staff are required to ride with the individual to and from group day service, the group day service staff time may be billed as group day service, provided that the billing for this time does not exceed 25% of the total time the individual spent in the group day service activity for that day. Documentation will be maintained to verify that billing for group day service staff coverage during transportation does not exceed 25% of the total time spent in the group day service for that day.

- Additionally, there must be documentation to support the one (1) staff to one (1) individual ratio required for community coaching, the one (1) staff to three (3) individuals ratio required for community engagement and the one(1) staff to seven (7) individuals ratio required for group day service. There must be documentation to support that no more than 10% of the total number of authorized hours per month is used for planning community activities for community engagement.

- Billing for individual supported employment services, and workplace assistance services must be supported by documentation of actual interventions or collateral contacts by the provider, not for the amount of time the individual is in the supported employment situation. A log or similar document which shows the date, hours, and type of service rendered, in accordance with the Plan for Supports must be maintained.

- Billing for residential support services:

    - In-home services are billed for actual service hours. Independent living supports is authorized for monthly/partial monthly units. Documentation must include dates, the amount of time, and services that were provided in accordance with the Plan for Supports. When unavoidable circumstances occur such that a provider is at an individual's home at the designated time, but cannot provide services for the entire period scheduled, billing is allowed for the entire number of hours scheduled that day, as long as some portion of the Plan for Supports is implemented. It is expected that this will occur rarely, and there will be detailed documentation of the date, original schedule, time services were actually provided, and specific circumstances which prevented provision of all of the scheduled services. If this occurs on a regular basis over a 90-day period, the support coordinator/case manager should determine the reasons, and a new Plan for Supports with fewer hours or a change in schedule must be developed.

    - Billing for shared living services should be supported by documentation related to the

portion of rent, food, and utilities reasonably attributed to the person who resides with the individual as well as the provision of services noted in agreement

- Group home residential, supported living, and sponsored residential services are billed using a daily rate based on the supports level assignment for each individual. Documentation of support activities provided in accordance with the Plan for Supports will be maintained by the provider in a daily format and should demonstrate that the individual is regularly receiving services as scheduled and support the assigned supports level.

- Billing for therapeutic consultation, community-based crisis supports, crisis support services, center-based crisis supports, private duty nursing, skilled nursing, and agency-directed respite, agency-directed personal assistance, or agency-directed companion services must be supported by documentation of the types, dates and the amount of time required for actual service delivery.

- Billing for consumer-directed services is supported by employee time sheets that are signed by the individual (or employer of record) and employee.

- Billing for environmental modifications and assistive technology must be supported by bills from contractors, rehabilitation engineers (if required), and equipment purchase receipts.

- Billing for personal emergency response systems (PERS) and Electronic Home-Based Supports (EHBS) must be supported by documentation regarding the installation of and training required to use the required device(s). Monthly billing for the ongoing monitoring services must be supported by documentation of the provision of this monitoring service occurred. In the case of PERS, this takes the form of at least monthly testing of the PERS device as well as documentation of each emergency signal which results in action being taken of behalf of the individual.

- Billing for transition services must be supported by item purchase receipts with a description of the item(s) included.

- Billing for Individual and Family Caregiver Training must be supported with documentation to verify the training took place, the individual or family/ caregiver participated in training and what information was taught during the training.

- It is not permissible to automatically bill each month at the maximum amount authorized. For all services, if the amount billed for a given service in the month audited does not correspond to documented hours/units of services delivered it may result in disallowance of payment during compliance reviews.

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- All billing must be supported by the required documentation as outlined throughout this manual. As a result of reviews conducted by DMAS, areas of non-compliance will be cited in the written report of findings. A corrective action plan will be requested if citations result from the quality management review. The following is a non-inclusive list of circumstances that may result in a request for an corrective action plan or may result in denial of payment during compliance reviews:

  - Absence of a current Plan for Supports;
  - Services not delivered as described in the Plan for Supports;
  - Services rendered to an ineligible individual: if diagnostic assessment and/or VIDES do not reflect eligibility for ID or DD Targeted Case Management or DD Waivers;
  - Support coordination/case management face-to-face contacts that are not completed in a timely manner (every 90 days with a 10-day grace period);
  - Any periods of services billed for which there is an absence of or inadequate documentation to support that the services were rendered (amounts, type, absence of data, assessment information, etc.);
  - Any periods of service billed during which the staff were not certified, qualified, or properly trained, the provider had not fulfilled the terms of the Participation Agreement, and/or the required license/certification/approval had been revoked or converted to a provisional license
  - Any identified billing errors, such as inaccuracies in service amounts, incorrect or absent deductions of patient-pay amount, incorrect dates of service, duplication of services, etc.;
  - There is no documentation reflecting the need for a service or for that level of service; and
  - Absence in the support coordinator's/case manager's record of a current VIDES or the presence of a most recent VIDES that does not meet the requirements for eligibility.
  - The provider must meet all other criteria and documentation requirements found elsewhere in this manual, as well as in applicable regulations and laws.

- If the individual has a patient-pay amount, a provider will use the electronic patient pay process. Local departments of social services (LDSS) will enter data regarding an individual's patient pay amount obligation in to the Medicaid Management Information

System (MMIS) at the time action is taken on a case either as a result of an application for long-term care services, redetermination of eligibility, or reported change in an individual's situation. These types of occurrences will cause the LDSS to initiate data entry of patient pay into the MMIS.

When more than one provider furnishes services to an enrollee, or the provider to be responsible for collecting the patient pay changes, the DMAS-225 will be used to advise the LDSS staff which provider is responsible for collecting the individual's patient pay obligation. The support coordinator/case manager should complete the Provider NPI# (or API) data field on the DMAS-225. The DMAS-225, when completed by the LDSS, will then be used to inform the LTC provider of his or her responsibility.

For communication of information other than patient pay, the Medicaid LTC Communication Form (DMAS-225) will be used by the support coordinator/case manager to report changes in an individual's situation. This form is available on the DMAS website and is used to provide information on a new address, a different support coordination/case management agency, income, interruption in DD Waivers services for more than 30 days, discharge from all DD Waivers services, or death. The case manager must forward the DMAS-225 to notify DSS when such changes occur. The support coordinator/case manager should document communications.

- If a patient-pay amount is required, the billing indicates the correct amount.

  If there is a patient-pay amount, the CMS-1500, the billing invoice required by DMAS, must indicate that amount.

- Designated DD Waivers services are not used when available from the primary source.

  - The individual's support coordinator/case manager must document before the onset of service delivery that supportive employment services are not available through the Department of Aging and Rehabilitative Services (DARS) or special education funding (as through the Individuals with Disabilities Education Act or IDEA for individuals under 22 years.

  - There must be documentation that it was determined that equipment or supplies provided to an individual under assistive technology services are not available under the *State Plan for Medical Assistance (State Plan)*. This may be documented in the individual's support coordination/case management record by noting the results of reviewing the "Durable Medical Equipment (DME) and Supplies" list available in the DMAS DME and Supplies provider manual for a given item or the results of a telephone inquiry to the DMAS Helpline about the item's availability through the *State Plan*, or both. There must be

documentation for any equipment, supplies, and technology not purchased from a DME provider showing that it was not available from a DME provider. See Chapter IV for additional information.

Annual Level of Care Reviews

Federal regulations under which waiver services are made available mandate that every individual receiving services be reviewed each year to assure he or she continues to meet level-of-care criteria for that waiver. Reassessments will be conducted at least annually, as determined by the individual's needs, and at any time when a change in the individual's condition indicates the need for reassessment.

Support coordinators/case managers will be required to submit documentation to DBHDS each year to verify that the individual continues to meet eligibility using the VIDES; this documentation will be reviewed by DBHDS staff.

If it is found that an individual no longer meets the level of care, the support coordinator/case manager will inform all providers and services will be terminated in accordance with the procedures detailed in Chapter IV of this manual. DMAS can require repayment of overpaid money if agencies continue to serve individuals who do not meet the level of care for which they are authorized without notifying DBHDS of the change in level of care and the need for discontinuation of services.

REQUIRED DOCUMENTATION

Documentation will be maintained in accordance with applicable statutes and policies. Waiver services that fail to meet DMAS criteria set forth in this manual are not reimbursable. Reimbursement is not permitted in the following situations (not an all-inclusive list):

- Service authorization not obtained and/or not available at DMAS' request;
- Request for service authorization not submitted by the provider;
- Patient pay requirement for the individual, but not indicated on CMS-1500 and paid by DMAS;
- The provider does not meet the qualification criteria;
- The provider staff's personnel files fail to verify that the minimum qualifications outlined in Chapter II are met;
- The individual resides in a nursing facility (NF), an ICF/IID, or a hospital; or
- Duplicate hours or units are billed.

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Business and Professional Records

Providers must maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the business. An example of documents in this area is human resources documentation. These policies apply even if the provider discontinues operation. DMAS will be notified in writing of the storage location and procedures for obtaining records for review should the need arise. The location, agent, or trustee will be within the Commonwealth of Virginia.

Individual Records

- The CSB/BHA/provider will maintain for each DD waivers individual the following documentation for review by DBHDS and DMAS staff for a period not less than six years from the individual's last date of service (for minors, not less than five years from the date they turn 18) or as provided by applicable State laws, whichever period is longer:
    - The comprehensive assessment and Individual Support Plans;
    - All Plans of Support from every provider;
    - All supporting documentation related to any change in the Individual Support Plan; and
    - All related communication with the providers, individual, consultants, DBHDS, DMAS, DSS, DARS, or other related parties.
- The service providers must maintain the following documentation for review by DBHDS and DMAS staff for a period not less than six years from the individual's last date of service (for minors, not less than five years from the date they turn 18) or as provided by applicable State laws, whichever period is longer:
    - All assessments, reassessments, and Plans for Supports;
    - All attendance logs, if applicable, documenting the date services were rendered and the length of time (# of units) and type of services;
    - Appropriate data, progress notes, or support logs reflecting the individual's status and, as appropriate, progress or lack of progress toward the desired outcomes on the Plan for Supports; and
    - Any other documentation to support that services provided are appropriate and necessary to maintain the individual in the home and in the community.

- The provider must recognize the confidentiality of individual record information and provide safeguards against loss, destruction, or unauthorized use. The individual's written consent is required for the release of information not authorized by law. All information pertaining to an individual must be included in the individual's record.

- Records of individuals receiving waiver services must be retained for six years from the date of service and not less than six years after the date of discharge. The provider must maintain medical records on all individuals in accordance with accepted professional standards and practice. The records must be completely and accurately documented, readily accessible, legible, and systematically organized to facilitate the retrieval and compilation of information. If the individual is under 18 years of age, his or her medical records must be retained not less than six years after the individual turns 18.

- All provider contacts with the individual, family members, health professionals, the preauthorization contractor, DMAS, etc. are filed in the individual's records promptly.

- All waiver services record entries and other documentation must be signed with the first initial and last name of the author and dated (month, day, and year). If checklists or similar data collection forms are "initialed," the provider must ensure that there is a current and accurate "crosswalk" of the authors' initials to the names in the record.

- Correction fluid or other forms of deleting information must not be used to make corrections to the individual's record. When an error is made during documentation, a single line must be drawn through the erroneous information; the revision must be initialed by the person making the revision. If an error in a note is corrected at a later time, the person must draw a single line through the error and initial and date the error.

- The individual must be referenced on each page of the record by his or her full name or Medicaid number.

- Documentation must be legible.

COMPLIANCE REVIEWS

DMAS staff or a DMAS-designated contractor routinely conduct reviews to ensure that the services provided to Medicaid individuals are medically necessary, are appropriate, and are provided by a qualified provider. Medically necessary services are those services that are covered under the State Plan or home and community-based waiver and that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the individual's functioning. Providers and individuals receiving services are identified for review by systems-generated exception reporting using various sampling methodologies or by referrals and complaints from

agencies or individuals. Exception reports developed for providers compare an individual provider's billing activities with those of the provider peer group.

To ensure a thorough and fair review, DMAS staff or a DMAS contractor review all cases using available resources, including appropriate consultants, and make on-site reviews or perform desk audits of medical and other individual and provider records as necessary.

DMAS or a DMAS-designated contractor will review a sample of paid claims for the audit period. Overpayments may also be calculated based upon review of all claims submitted during a specified time period.

Decisions identified in the written report may be appealed by the CSB/BHA or provider. The procedures for submitting an appeal are specified in the cover letter that accompanies the report and must be submitted within 30 days of receipt of the letter.

Providers will be required to refund payments made by Medicaid if they are found to have billed Medicaid contrary to law or regulation, failed to maintain any record or adequate documentation to support their claims, or billed for medically unnecessary services. In addition, due to the provision of poor quality services or as a result of any of the above concerns, Medicaid may restrict or terminate the provider's participation in the Program.

FRAUDULENT CLAIMS

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Since payment of claims is made from both state and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or state court. The program maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

Provider Fraud

The provider is responsible for reading and adhering to applicable state and federal regulations and to the requirements set forth in this manual. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by his or her signature or the signature of his or her authorized agent on each invoice that all information provided to DMAS is true, accurate, and complete. Although claims may be prepared and submitted by an employee, providers will still be held responsible for ensuring their completeness and accuracy.

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Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with appropriate supportive evidence:

Supervisor, Provider Review Unit
Program Integrity Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Investigations of allegations of provider fraud are the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel from that unit for investigative purposes. Referrals are to be made to:

Director, Medicaid Fraud Control Unit
Office of the Attorney General
202 N. 9th Street
Richmond, Virginia 23219

Recipient Fraud

The Recipient Audit Unit of DMAS investigates allegations about fraud or abuse by individuals. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid benefits or failed to report changes that, if known, would have resulted in ineligibility. The unit also investigates incidences of card sharing and prescription forgeries.

If it is determined that benefits to which the individual was not entitled were approved, corrective action is taken by referring individuals for criminal prosecution or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the United States Code and Virginia Administrative Code, DMAS will sanction an individual who is convicted of Medicaid fraud by a court. That individual will be ineligible for Medicaid for a period of twelve months beginning with the month of fraud conviction.

Referrals should be made to:

Supervisor, Recipient Audit Unit
Program Integrity Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Email: RecipientFraud@dmas.virginia.gov
Fax: (804) 371-0881

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT (CMM) PROGRAM

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DMAS providers may refer Medicaid individuals suspected of inappropriate use or abuse of Medicaid services to the Division of Program Integrity within the Department of Medical Assistance Services. Referred individuals will be reviewed by staff to determine if the utilization meets regulatory criteria for restriction to a primary physician or pharmacy in the Client Medical Management (CMM) Program. If CMM enrollment is not indicated, Program Integrity staff may educate individuals on the appropriate use of medical services, including emergency room services.

Referrals may be made by telephone, fax, or in writing. Written referrals should be mailed to:

Department of Medical Assistance Services
Division of Program Integrity
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Telephone: (804) 452-5472
Fax: (804) 371-8891
CMM Helpline: 1-888-323-0589

When making a referral, provide the name and Medicaid number of the individual and a brief statement about the nature of the quality management problems, as well as the provider name and telephone number. Hospitals continue to have the option of using the "Non-Emergency Use of the Emergency Room" Referral Form when reporting emergency room abuse. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals.

Electronic Notification of Appeal Rights

When an individual applies for services available under DD waivers the support coordinator/case manager will provide the individual with information about the right to appeal. When initial DD Waivers services are authorized or whenever services for an individual already receiving DD waivers services are increased, decreased, denied or terminated, a notification letter will automatically be generated through the VAMMIS and sent to the provider and individual. The individual's letter indicates the approved, decreased, terminated or denied services and limits and includes the right to appeal if services have been terminated, suspended, reduced, or denied.

Support Coordinator/Case Manager/Provider Responsibilities in Notification of Appeal Rights

In the cases below, because a notification letter is not generated by VAMMIS or because the action will occur prior to VAMMIS electronic notification, the support coordinator/case manager is responsible for notifying the individual in writing of the following actions and the right to appeal these actions:

- An individual's request for a Medicaid-covered service (such as DD waivers, ICF/IID, or TCM) is denied or offered at a decreased level. This does not mean that a particular

provider cannot provide the service, it means that a particular service is determined by the CSB/BHA not to be needed for a particular individual;

- A request for an increase in hours or units or a request for additional services is denied by the CSB/BHA;
- When the CSB/BHA is requesting a decrease or termination of services and 10 business days advance notice is required (as described below);
- TCM services are terminated;
- Individual meets DD waivers' criteria, but is not enrolled in one of the DD waivers, and his or her name is placed on the waiting list;
- Individual is suspended from any service (see Chapter IV for exceptions); and
- Individual's name is moved from the priority one to priority two or three category or from priority two to priority three category of the waiting list or removed from the wait list.

The contents of the notification letter must include:

- What action the support coordinator/case manager or provider intends to take;
- The reason(s) for the intended action;
- The specific regulations that support, or the change in federal or state law that requires the action;
- An explanation of the individual's right to request a hearing;
- The right to request an expedited evidentiary hearing
- An explanation of the circumstances under which the services are continued if a hearing is requested;
- An explanation of the requirement for the individual to reimburse DMAS if the support coordinator's/case manager's/provider's action is upheld, if the individual continued to receive a Medicaid covered service;
- The effective date of the action; and
- The right to representation.

Advance Notification

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Unless otherwise specified, written notification must be mailed by the support coordinator/case manager to the individual or authorized representative/guardian at least 10 business days prior to the date of action when a provider reduces or terminates one or all Medicaid-covered service(s).

Exceptions to the 10 Business Day Advance Notice Requirement
Written notice is required in the following cases, but advance notice is not. These include:

- When the support coordinator/case manager has factual information confirming the death of an individual;
    - When an individual or guardian provides a written request indicating that:
- He or she no longer wishes services; OR
    - He or she gives information that requires termination or reduction and indicates an understanding of the action required by supplying this information;
- The individual has been admitted to an institution and is ineligible for further services, including a regular admission to an ICF/IID, NF, or rehabilitation hospital, or has been incarcerated;
- Individual loses financial eligibility for Medicaid;
- The individual's whereabouts are unknown, and he or she cannot be located for the provision of services;
- The CSB/BHA establishes the fact that the individual has been accepted for Medicaid services by another state, Territory, or Commonwealth;
- The individual's physician prescribes a change in the level of care;
- The health and safety of the individual or others are endangered (if appropriate, the support coordinator/case manager or provider must immediately notify the local DARS Adult Protective Services or DSS Child Protective Services, as well as DBHDS Offices of Human Rights and Licensing, as required); or
- When the individual's request for admission into a Medicaid-covered service or when the individual's request for an increase in a Medicaid covered service is denied or not acted upon promptly (90 days or 45 days respectively) for any reason.

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All notification letters generated by the CSB/BHA must be filed in the support coordination/case management record.

Provider Discontinues Services

In non-emergency situations in which a participating provider intends to discontinue services to an individual, the provider will give the individual or family/caregiver and support coordinator/case manager 10 days advance written notice for services provided in non-residential settings. The letter will provide the reasons the provider is discontinuing services and the effective date. The individual is not eligible for appeal rights in this situation and may pursue obtaining services from another provider.

In an emergency situation in which the health and safety of the individual or provider personnel is endangered, the 10 business day advance written notice notification period will not be required, however, the case manager must be notified prior to discontinuing services.

In a provider owned or operated residential setting the provider must follow the terms of the lease/residency agreement when terminating services and/or attempting to evict an individual from the residence. Individuals receiving Medicaid HCBS who reside and receive services in a provider owned or controlled residential setting will have the same or comparable protections related to evictions as individuals not receiving Medicaid HCBS.

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APPENDIX A
DEFINITION OF TERMS

Abuse	Practices that are inconsistent with sound fiscal, business, or medical practices and result in unnecessary costs to the Virginia Medicaid/FAMIS Program, or in reimbursement for services that are not medically necessary or that fail to meet professionally-recognized standards for health care. Abuse also means the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, sexual abuse or exploitation of an individual.
Accommodation	A type of room; e.g., private, semi-private, ward, etc.
Adjudicate	To determine whether a claim should be paid or disallowed.
Adjustments	Changes made to correct an error in the billing or processing of a claim.
Atypical Provider Identifier (API) Number	A unique 10-digit identification issued to providers by DMAS. An API Number is issued for non-health care (atypical) providers and for providers in an MCO network who do not participate with Medicaid/FAMIS.
Adverse Action	Any action taken by DMAS or its designee to deny, reduce, terminate, delay or suspend a covered service. Any action taken to deny payment in whole or part to a provider of Medicaid services.
Aid Category	A designation within federal or State regulations under which an individual may be eligible for public assistance. Also, a numerical identifier for VAMMIS of the covered group in which the person is enrolled.

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Allowed Charge	That part of the reported charge that qualified as a covered benefit, and is eligible for payment under the Virginia Medicaid/FAMIS Program.
Ancillary Services	Services available to individuals other than room and board for which charges are customarily made in addition to a routine service charge; e.g., pharmacy, x-ray, lab, and medical supplies.
Appeal	A request for review of an adverse action to determine whether the action complied with Medicaid laws, regulations, and/or policy, or a challenge to any DMAS adverse action affecting a provider's reimbursement.
Appeal Procedure	The process of reviewing, at the member's request, any adverse action taken by DMAS or its designee to deny, reduce, terminate, delay, or suspend eligibility or a covered service in accordance with 42 CFR §431 *et seq.*, and the Virginia Administrative Code at 12VAC30-110-10 through 12VAC30-110-370, or the process for challenging an action taken by DMAS adversely affecting a provider's reimbursement, in accordance with the Virginia Administrative Process Act §2.2 - 4000 et *seq* and DMAS appeal regulations at 12VAC30-20-500 ***et*** seq. The appeal procedure shall be governed by the Department's regulations and any and all applicable laws and court orders.
Attending Physician	The physician who has the overall responsibility for the patient's medical care and treatment.
Automated Response System (ARS)	Web-based Internet Eligibility Verification system that provides twenty-four-hour-a- day, seven-day-a-week Internet access to eligibility information, service limits, claim status, prior authorizations, provider check status,

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	pharmacy prescriber identification lookup, as well as MCO enrollment information.
BabyCare	Prenatal group patient education, nutrition services, and homemaker services for pregnant women and care coordination for high-risk pregnant women and infants up to age two.
Barrier Crime	Barrier crime laws, as defined in Code of Virginia § 63.2-1719, prohibit persons convicted of certain statutorily defined crimes from obtaining employment with certain employers, mostly those employers specializing in the care of vulnerable populations, such as children, the elderly, and those with mental disabilities.
Benefits	Services covered under the Virginia Medicaid/FAMIS Program.
CAP	Corrective Action Plan.
Capitation Payment	A payment the Department makes periodically to a Contractor on behalf of each member enrolled under a contract for the provision of medical services under the State Plan, regardless of whether the particular member receives services during the period covered by the fee.
Capitation Rate	The monthly amount, payable to the Contractor, per member, for all expenses incurred by the Contractor in the provision of contract services as defined herein.
Categorically Needy	Under Medicaid, categorically needy cases are aged, blind, or individuals with disabilities or families and children who are otherwise eligible for Medicaid and who meet the financial eligibility requirements for Aid to Dependent Children (ADC), Supplemental Security Income (SSI), or an optional state supplement.
CFR (Code of Federal Regulation)	Medicaid federal regulations are located at 42 CFR 430 through 42 CFR 505.

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CHIP	Virginia's Child Health Insurance program (CHIP) for low-income children. The program is funded under Title XXI of the Social Security Act, and is known as FAMIS.
Claim	An itemized statement of services rendered by health care providers (such as hospitals, physicians, dentists, etc.), billed electronically or on the CMS 1500 or UB-04.
ClaimCheck	McKesson ClaimCheck is an automated procedure coding review software. ClaimCheck reviews claims submitted for billing inconsistencies and errors during claims processing. All ClaimCheck edits are based on the following global claim factors: same recipient, same provider, same date of service or date of service is within established pre- or post-operative time frame. The process involves all Physician and Laboratory Service claims. ClaimCheck edits are based on guidelines as specified in the CPT Manual as well as guidelines from the American Medical Association (AMA), the Centers for Medicare and Medicaid (CMS) to include the Correct Coding Initiative (CCI) edits and specialty society guidelines.
Client Medical Management Program (CMM)	An utilization-control program designed to promote proper medical management of essential health care and enhance service efficiency.
Clinic	A facility for the diagnosis and treatment of outpatients.
Centers for Medicare and Medicaid Services (CMS)	The Federal agency of the United States Department of Health and Human Services that is responsible for the administration of Title XIX and Title XXI of the Social Security Act.

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CMS-1500	The CMS-1500 is the uniform professional hardcopy claim form. It is the only hardcopy claim form that CMS accepts from professional providers (e.g., physicians, DME providers, Independent Laboratories, etc.)
Coinsurance	The portion of Medicare- or other insurance- allowed charges for which the patient would be responsible if no other insurance is responsible.
Community Services Board	A citizens' board, which provides mental health, intellectual disability, and substance abuse programs and services within the political subdivision or political subdivisions participating on the board.
Comprehensive Services Act (CSA)	The legislation that created a collaborative system of services and funding that is child centered, family focused, and community based to address the strengths and needs of troubled and at-risk youth and their families.
Concurrent Review	Encompasses aspects of patient management that take place during the provision of services at an inpatient level of care or during an ongoing outpatient course of treatment.
Copayment	The portion of Medicaid/FAMIS-allowed charges which an individual is required to pay directly to the provider for certain services or procedures rendered.
Cosmetic Surgery	Cosmetic surgery includes any surgical procedure solely directed at improving appearance.
Covered Group	Federal and state laws describe the groups of people who may be eligible for Medicaid/FAMIS. These groups of people are called Medicaid/FAMIS covered groups. The eligibility rules and medical services available are different for certain covered groups. People who meet one of the covered groups criteria may be

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	eligible for Medicaid/FAMIS coverage if their income and resources are within the required limits of the covered group.
Covered Services	Services and supplies for which Medicaid/FAMIS will reimburse.
Crossover Claims	Claims for which both Titles XVIII (Medicare) and XIX (Medicaid) are liable for services rendered to a member entitled to benefits under both programs.
Cultural Competency	The ability of health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs brought by the patient to the health care encounter.
Current Procedural Terminology (CPT)	A HCPCS component developed by the American Medical Association.
Customary Charge	The amount providers usually bill Medicaid individuals for furnishing particular services or supplies.
Date of Service (DOS)	The date or span of days that services were received by an individual.
DDE (Direct Data Entry)	An alternative way to submit claims via the web. Under HIPAA, this is the direct entry of data that is immediately transmitted into a health plan's computer. Virginia Medicaid is currently working with the fiscal agent on a DDE solution.
Deductible (Medicare)	The dollar amount that the Medicare/Medicaid member must pay toward the cost of covered benefits before Medicare payment can be made for additional services. Medicaid pays the Medicare Part B deductible for eligible members. Medicare Part A deductible is paid by Medicaid within the Program limits.

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Dental Benefits	The covered dental services available to Medicaid/FAMIS eligible children as well as the limited, emergency services available to Medicaid eligible adults.
Dental Benefits Administrator	The DMAS-contracted entity through which Medicaid dental benefits are offered. Also known as a DBA.
Department	The Virginia Department of Medical Assistance Services (DMAS).
Dependent	A spouse or child who is entitled to benefits under the Virginia Medicaid/FAMIS Program.
DESI Drugs	Drug products identified by the Federal Food and Drug Administration, in the Drug Efficacy Study Implementation Program, as lacking substantial evidence of effectiveness.
Diagnosis	The identity to recognize the nature of a condition, cause, or disease.
Direct Personal Supervision	Supervision rendered at the site of treatment by the responsible participating provider.
Diagnostic Related Groupings (DRGs)	A classification system for inpatient hospital claims for reimbursement purposes. DMAS currently uses it to reimburse inpatient hospital medical-surgical services.
DMAS	The Department of Medical Assistance Services. The Department of Medical Assistance Services is the State Agency designated by the General Assembly of Virginia, under the provision of Title XIX of the Social Security Act, to administer Virginia's Medical Assistance Program.
DSS (Department of Social Services)	The agency responsible for determining eligibility for medical assistance programs and the provision of related social services. This includes the local and the state DSS.

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Dual Eligibles	Medicare beneficiaries who are also enrolled in the Medicaid program
Duplicate Claim	A claim which is the same as one previously paid. Also, a claim deemed by DMAS to be an identical claim as one previously submitted.
Enhanced Ambulatory Patient Grouping	Enhanced Ambulatory Patient Grouping (EAPG) is the new payment methodology developed and licensed by 3M for Virginia Medicaid's Ambulatory Surgical Centers (ASCs) with dates of service on or after April 5, 2010. The methodology defines EAPGs as allowed outpatient procedures and ancillary services that reflect similar patient characteristics and resource utilization performed by ASCs. DMAS currently uses it to reimburse ambulatory surgery centers.
Early Intervention (EI)	Early Intervention (EI) services are provided through Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq.), as amended, and in accordance with 42 C.F.R. §440.130(d), which are designed to meetthe developmental needs of each child and the needs of the family related to enhancing the child's development, and are provided to children from birth to age three who have (i) a 25% developmental delay in one or more areas of development, (ii) atypical development, or (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.
–OR–	
Early Intervention (EI)	Developmental supports and services that are performed in natural environments to meet the developmental needs of Medicaid or FAMIS eligible children, ages zero to three years of age, who have a 2% or greater delay in one or more developmental areas, atypical development, or diagnosed condition with a high probability of delay.

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Elective Surgery	Surgery which is not medically necessary to restore or materially improve a body function.
Eligible Person	An individual satisfying the requirement for Virginia Medicaid/FAMIS in accordance with the State Plan of the Virginia Medical Assistance Program under Title XIX or FAMIS under Title XXI, who has been certified and enrolled as such by a local social services department or FAMIS CPU.
Emergency Custody Order (ECO)	An emergency custody order by local law enforcement to take custody of a person believed to be mentally ill and in need of an psychiatric evaluation ECO limited to maximum 4 hours.
Encounter	Any covered or enhanced service received by a member through a DMAS contractor.
Encryption	A security measure process involving the conversion of data into a format that cannot be interpreted by outside parties
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	Medicaid's comprehensive and preventive child health program for individuals under the age of 21.
Estimated Acquisition Cost (EAC)	Cost for drugs determined by the Virginia Medicaid Program for reimbursement.
Explanation of Medicaid Benefits (EOMB)	A statement mailed once per month to selected individuals to allow them to confirm the services which they received.
Family Access to Medical Insurance Security (FAMIS)	Virginia's CHIP program that operates under Title XXI of the Social Security Act and provides comprehensive health benefits to children through the age of 18, in families with incomes at or below 200 percent of the federal poverty level who do not have any health insurance coverage and are not eligible for Medicaid.

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Family Planning Services	Any medically-approved means, including diagnosis, treatment, drugs, supplies and devices, and related counseling, which are furnished or prescribed by or under the supervision of a physician for individuals of child-bearing age for purposes of enabling such individuals freely to determine the number or spacing of their children.
FAMIS Member	Persons enrolled in DMAS' FAMIS program who are eligible to receive services under the State Child Health Plan under Title XXI of the Social Security Act.
FAMIS Plus Member	Child under the age of 19 who meets "medically indigent" criteria under Medicaid program rules, and who receives the full Medicaid benefit package and have no cost- sharing responsibilities.
FAMIS Moms	Virginia's Health Insurance program for low-income pregnant women whose family income is above Medicaid limits and at or below 200% FPL. It is a TitleXXI of the Social Security Act program, known as FAMIS MOMS.
FAMIS *Select*	Virginia's Child Health Insurance Premium Assistance program for FAMIS eligible children. It is a Title XXI of the Social Security Act program, known as FAMIS ***Select.*** Benefits are provided through the private or employer sponsored plan. There is no wrap around coverage in FAMIS ***Select,*** with the exception of immunizations .
Federal Information Processing Standards Codes (FIPS codes)	A standardized set of numeric or alphabetic (also known as city/county code) codes issued by the National Institute of Standards and Technology (NIST) to ensure uniform identification of geographic entities through all federal government agencies.

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Federally Qualified Health Centers (FQHCs)	Community-based facilities that provide comprehensive primary care and preventive care, including health, oral, and mental health/substance abuse services.
Fee-for-Service (FFS)	The Department's traditional health care payment system in which physicians and other providers receive a payment for each unit of service they provide.
Fiscal Year (State)	Fiscal Year is from July 1 through June 30.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or State law.
Freedom of Choice	The patient's freedom to choose between institutional placement or community based services, and/or an available program, service, or a participating provider of service.
FTE	Full-time equivalent position.
Health Insurance Portability & Accountability Act of 1996 (HIPAA)	Title II of HIPAA protects the confidentiality and integrity of individually identifiable health information past, present, or future.
Home and Community–Based Services (HCBS) Waiver	The range of community services approved by the Centers for Medicare and Medicaid Services (CMS) pursuant to C1915c of the Social Security Act 420.SC. § 1396 (c) to be offered to individuals as an alternative to institutionalization.

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HCPCS	The Centers for Medicare and Medicaid Services Common Procedure Coding System (HCPCS) contains services not included in CPT, such as ambulance, audiology, physical therapy, speech pathology, and vision care and such supplies as drugs, durable medical equipment, orthotics, prosthetics, and other medical and surgical supplies.
HIPP (Health Insurance Premium Payment Program)	Premium assistance program for individuals enrolled in full coverage Medicaid that provides premium assistance subsidy for the employee share of employer sponsored group health insurance when it is determined to be cost effective.
HIPP For Kids	Premium assistance program for children under the age of 19 enrolled in full coverage Medicaid that reimburses the employee share of qualified employer sponsored coverage. The employer must contribute at least 40% to cost of the premium.
International Classification of Diseases, Clinical Modification (ICD-CM)	A standardized listing of descriptive terms and identifying codes for reporting diagnoses and medical services performed in the inpatient or outpatient facility.
Inpatient	An individual admitted to a hospital, nursing facility, an intermediate care facility, or a residential treatment center.
Intermediate Care Facility (ICF/MR)	A facility or distinct part of another facility certified by the Virginia Department of Health, as meeting the federal certification regulations for an intermediate care facility for persons with mental retardation/intellectual disability or related conditions. These facilities must address the total needs of the resident which include physical, intellectual, social, emotional, and habilitation and must provide "active treatment".
Institution for Mental Disease (IMD)	A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis,

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	treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases 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, whether or not it is licensed as such. An institution for individuals with mental retardation/intellectual disability is not an institution for mental diseases.
Intensive Care	Constant observation care to critically ill or injured patients in a critical care unit.
Length of Stay (LOS)	The total number of days a patient stays in a facility such as a hospital. Length of stay would only apply to acute general psychiatric and intensive rehab hospital admissions.
Legend Drugs	Drugs which bear the federal caution: "Federal Law Prohibits Dispensing a Drug Without a Prescription."
Level of Care (LOC)	The level of service that an individual needs based on their assessment which includes functional activities of daily living, medical and/or nursing, or behavioral needs.
Long-Stay Hospital (LSH)	A Virginia Medicaid designation for hospital care that is a slightly higher level of care than Nursing Facilities.
Long-Term Acute Care Hospitals (LTAC)	A Medicare facility designation as determined by the U.S. Secretary of Health and Human Services that specializes in heating patients with serious and often complex medical conditions, DMAS recognizes these facilities as Acute Care Facilities.

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Maintenance Drug	A drug that is prescribed to treat a medical condition that requires continuous administration for an indefinite period of time.
Managed Care Organization (MCO)	An entity that meets the participation and solvency criteria defined in 42 CFR Part 438 and has an executed agreement with the Department to provide services covered under the Medallion 3.0 and FAMIS programs. Virginia Medicaid Managed Care is a state program that helps people who have Medicaid get the health care services they need.
Maximum Allowable Cost (MAC) (Upper Limits)	The upper limit allowed by the Virginia Medicaid Program for certain drugs.
Medallion 3.0	A fully capitated, risk-based, mandatory Medicaid/FAMIS Plus managed care program.
Medicaid Member	Any person identified by the Department who is enrolled in Medicaid.
Medicaid Fraud Control Unit (MFCU)	The unit established within the Office of the Attorney General to audit and investigate providers of services furnished under the Virginia State Plan for Medical Assistance, as provided for the Code of Virginia § 32.1-320, as amended.
Medicaid Works (Medicaid Buy-In Program)	Medicaid Works allows working people with disabilities whose income is no greater than 80% FPL to pay a premium to participate in the Medicaid program.
MediCall	A toll-free telephone number providing 24-hour-per-day, seven-day-a-week access to current member data necessary to verify eligibility for Medicaid/FAMIS services.
Medical Necessity	Those services which are reasonable and necessary for the diagnosis or treatment of an illness, condition, injury, or to improve the function of a disability, consistent with community standards of medical practice and in accordance with Medicaid/FAMIS

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	policy.
Medically Complex	Those who have a complex medical or behavioral health condition and a functional impairment, or an intellectual or developmental disability. Also includes individuals who receive long-term services and supports.
Medically Indigent	Pregnant women, children, and other individuals who meet certain income and/or age requirements and who are eligible for some or all of the covered Medicaid services.
Medically Needy	Individuals whose income and resources exceed those levels for assistance established under a State or federal plan but are insufficient to meet their costs of health and medical services.
Medicare Part A (Hospital Insurance)	Covers inpatient care in hospitals, critical access hospitals, and skilled nursing facilities. It also covers hospice care and some home health care.
Medicare Part B (Supplementary Medical Insurance)	Covers doctors' services, outpatient hospital care, and some other medical services that Part A does not cover, such as some of the services of physical and occupational therapists, and some home health care. Medicare Part B helps pay for these covered services and supplies when they are medically necessary.

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Member	An individual who meets the Virginia Medicaid/FAMIS eligibility requirements and is receiving or has received medical services.Member Enrollment The determination by a local department of social services or central processing unit of an individual's eligibility for Medicaid, FAMIS Plus or FAMIS and subsequent entry into VAMMIS.
National Drug Code (NDC)	A drug code used in pharmacy and other healthcare practitioner claims to identify a drug dispensed.
National Provider Identifier (NPI)	A unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS).
Non-Legend Drugs	Over-the-Counter Drugs.
Nursing Facility (NF)	A nursing facility or a distinct part of another facility which provides, on a regular basis, services to individuals who do not require the degree of care and treatment which a hospital or specialized care unit is designed to provide, but who require care and services which meet the established written criteria.
Nutritional Supplement	A nutritional supplement refers to enteral or parenteral nutrients given to an individual to make up for deficient nutritional intake.
Open Enrollment	The timeframe in which Members are allowed to change from one MCO to another, without cause, which occurs at least once every 12 months per 42 CFR 438.56 (c)(1) and (f)(1). Open enrollment will occur from October 1st – December 18th for a January 1 effective date. Individuals eligible through Medicaid expansion will have an open enrollment period from November 1st – December 18th for a January 1st effective date. Within sixty (60) calendar days prior to the open enrollment begin date, the Department will inform Members of the opportunity to remain with the

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	current plan or change to another plan without cause. Those Members who do not choose a new health plan during the open enrollment period shall remain in his or her current health plan selection until their next open enrollment period.
Outliers	Statistical term. An observation that lies an abnormal distance from other values in a random sample from a population. Also used in hospital reimbursement for a hospital discharge with charges higher than a threshold which entitles the facility to additional reimbursement.
Outpatient	A beneficiary who receives medical services but is not admitted to a hospital, hospital, or other institutional setting.
Over-Utilization	Medically unnecessary use of the Virginia Medicaid/FAMIS Program by any provider and/or Medicaid individual.
PACE (Program of All-inclusive Care for the Elderly)	PACE provides the entire spectrum of health and long-term care services (preventive, primary, acute and long-term care services) to their members on a per member, per month basis.
Participating Provider	A person, organization, or institution with a current valid participation agreement with DMAS who or which will (1) provide the service, (2) submit the claim, and (3) accept as payment in full the amount paid by the Virginia Medicaid/FAMIS Program.
Payer of Last Resort	The Medicaid program by law is intended to be the payer of last resort; that is, all other available third party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid.
Personal Comfort Items	Items which do not contribute directly to the treatment of a condition, illness, or injury or to the functioning of a malformed body part and are not covered by Medicaid/FAMIS.

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Plan of Care	Plan of care is comprised of individual service plans as dictated by the persons' health care and support needs.
Plan First	The limited benefit Medicaid fee-for-service family planning program. Men and women who have income less than or equal to 200 percent of the federal poverty level may be eligible for Plan First if they are not eligible for a full benefit medical assistance program.
Pre-admission Screening Team (PAS)	The team comprised of a nurse and social worker from the local departments of health and local departments of social services OR the hospital discharge planners charged to perform the assessment to determine the appropriate level of care needs for long-term care services for an individual. The entity contracted with DMAS that is responsible for performing preadmission screening pursuant to 32.1-330 of the Code of Virginia.
Primary Care Physician	A physician responsible for supervising, coordinating, and providing initial and primary medical care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care.
Primary Care Provider (PCP)	A primary care physician or nurse practitioner practicing in accordance with state law who is responsible for supervising, coordinating, and providing initial and primary medical care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care.
Procedure Code	A code used to identify a medical service or procedure performed by a provider.
Protected Health Information (PHI)	Individually identifiable patient information, including demographics, which relates to a person's health, health care, or payment for health care.

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Provider	An institution, facility, agency, person, corporation, partnership, or association approved by the Department which accepts as payment in full for providing benefits the amounts paid pursuant to a provider agreement with the Department.
Provider Number	A ten-digit number assigned to identify each provider of services.
Qualified Medicare Beneficiary (QMB)	A low-income Medicare beneficiary eligible for Medicaid coverage of Medicare premiums and of the deductible and coinsurance up to the Medicaid payment limit less any applicable copayments on allowed charges for Medicare-covered services.
Qualified Medicare Beneficiary--Extended (QMB--Extended)	A low-income Medicare beneficiary eligible for Medicaid coverage of Medicare premiums and of the deductible and coinsurance up to the Medicaid payment limit on allowed charges for all Medicare- covered services plus coverage of all other Medicaid-covered services.
Qualified Disabled and Working Individuals (QDWI)	Persons with disabilities who are working and who meet certain income limits and are eligible for Medicaid payment of the Medicare Part A premiums only.

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Quality Monitoring (QM)	The ongoing process of assuring that the provision of health care service is appropriate, timely, accessible, available, and medically necessary and in keeping with established guidelines and standards.
Referral	A request by a provider for a participant to be evaluated and/or treated by a different physician, usually a specialist, or to receive specific services.
Remittance Voucher	A notice sent to providers that advises on the status of claims received. Paid, denied, pended, voided, and adjusted claims are reported on remittance vouchers.
Reported Charge	The total amount submitted on the claim form by a provider of services for reimbursement.
Resident	An individual admitted to a nursing facility, assisted living facility, or other institutional placement.
Residential Treatment Facility	A 24-hour-per-day specialized form of highly organized, intensive, and planned therapeutic interventions, which shall be utilized to treat severe mental, emotional, and behavioral disorders of individuals 21 years old or younger. All services must be provided at the facility as part of the therapeutic milieu.
Retroactive Eligibility	Eligibility in which a person was determined to be eligible for a period of time prior to the month in which the application was initiated. The retroactive period is the three months prior to the application month. Once retroactive eligibility is established, Medicaid/FAMIS coverage begins the first day of the earliest retroactive month in which eligibility exists. Retroactive coverage in FAMIS is only available for newborns.

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Retrospective Review	Warranted when a patient's eligibility for Medicaid/FAMIS coverage has been determined after the service has been rendered and retroactive eligibility has been granted or as otherwise allowed by the appropriate manuals/regulations.
Routine Services	Inpatient routine services in a facility are those services included by the provider in a daily service charge - sometimes referred to as the "room and board" charge. Included in routine services are certain services, supplies, and use of equipment and facilities for which a separate charge is not customarily made.
Rural Health Clinic	Is a clinic located in a rural, medically under-served area; facility as defined in 42C.F.R. § 491.2.
School Health Services	Any service rendered on property of a local education agency or public school. Services must be included in an individualized education program (IEP).
Secure Email	Applies to sensitive email being passed over the Internet in some form of encrypted format.
Service Authorization (Srv Auth)	Formerly referred to as prior authorization, the approval necessary for specified services for a specified member by a specified provider before the requested services may be performed and payment made.
Service Authorization Request	Where not otherwise defined in this manual, a service authorization request shall consist of a written request from the provider (prior to providing the service), identifying the requested service (including the CPT/HCPCS or ADA codes), the patient's name and Medicaid number, and the condition being (to be) treated with documentation supporting the medical necessity, a description of the requested service, the anticipated length of treatment, the prognosis, and the estimated cost of the service.

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Services Facilitator (CDSF)	A provider enrolled with DMAS who is responsible for management training and review activities as required by DMAS for consumer-directed care.
Shall	Indicates a mandatory requirement or a condition to be met.
Spend-Down	A Medicaid individual eligible for Medicaid for a limited period of time because his or her income exceeds the limits and all other eligibility factors are met. The applicant's incurred medical expenses must equal or exceed the difference between his or her income and the Medicaid income limit.
SSI (Supplemental Security Income)	The federal program administered by the Social Security Administration (SSA) that pays monthly benefits to people with limited income and resources who are disabled, blind, or age 65 or older. Blind or disabled children, as well as adults, can get SSI benefits. In Virginia, SSI members must apply for Medicaid separately; Medicaid is not automatic.
State	Commonwealth of Virginia.
State Agency	The Department of Medical Assistance Services is the State Agency designated by the General Assembly of Virginia, under the provision of Title XIX of the Social Security Act, to administer Virginia's Medical Assistance Program.
State Fair Hearing	The Department's evidentiary hearing process. Any "action" or appeal decision rendered by the MCO may be appealed by the member to the DMAS Client Appeals Division. The Department conducts evidentiary hearings in accordance with regulations at 42 C.F.R. §.§ 431.200 through 431.250 and 12 VAC 30-110-10 through 12 VAC 30-1 10-380.
State Plan for Medical Assistance (State Plan)	The comprehensive written statement submitted by the Department to the Centers for Medicare and Medicaid Services

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	(CMS) for approval, describing the nature and scope of the Virginia Medicaid program and giving assurance that it will be administered in conformity with the requirements, standards, procedures and conditions for obtaining Federal financial participation.
Temporary Detention Order (TDO)	A temporary custody order by sworn petition to any magistrate to take into custody a person believed to be mentally ill and in need of hospitalization and transported to a location to be evaluated pursuant to 42 D.F.R. 441.150 and Code of Virginia, 16.1-335 et seq. and 37.1-67.1 et seq. Centers for Medicare and Medicaid Services.
Third Party Liability (TPL)	Any individual, entity or program (including other government programs or insurance) that is or may be liable to pay all or part of the medical cost for which benefits were paid by the medical assistance programs under the State Plan.
Title XVIII	That portion of the Social Security Act which authorizes the Medicare Program.
Title XIX	That portion of the Social Security Act which authorizes the Medicaid Program.
Title XXI	That portion of the Social Security Act that authorizes the Children's Health Insurance Program, known as FAMIS.
Treatment Foster Care Case Management	Is a component of treatment foster care through which a case manager provides treatment planning, monitors the treatment plan, and links the child to other community resources as necessary to address the special identified needs of the child. TFC-CM focuses on a continuity of services that is goal-directed and results-oriented. Services shall not include room and board...
UB-04	The UB-04, also known as the Form CMS-1450, is the uniform institutional provider hardcopy claim form. It is the only

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	hardcopy claim form that CMS accepts from institutional providers (e.g., hospitals, Skilled Nursing Facilities, Home Health Agencies, etc.)
UMCF (Uninsured Medical Catastrophe Fund)	UMCF was established by the 1999 General Assembly to provide funds for uninsured persons who need treatment for a life threatening illness or injury. An uninsured medical catastrophe includes a life- threatening illness or injury requiring specialized medical treatment, hospitalization or both that if left untreated would more than likely result in death. There is a three page application form that must be completed and mailed to DMAS. Eligibility for funds are determined on a first come, first served basis based on the date the original application is received.
Uniform Assessment Instrument (UAI)	The multidimensional, standardized Assessment tool, which assists the assessor to determine a member's social, physical health, mental health, and functional abilities, and provides a comprehensive assessment of the individual.
Utilization Management	The process of evaluating the necessity, appropriateness and efficiency of health care services against established guidelines and criteria.
Virginia's Acute and Long Term Care Program (VALTC)	Delivery system that integrates acute and long-term care. Effective September 1, 2007, individuals already MCO-enrolled who then become eligible for Home and Community-Based Waiver programs except for the Technology Assisted Waiver will remain in their MCO for acute care services.
Virginia Administrative Code (VAC)	Contains administrative regulations for State Agencies. Available as a searchable database at http://leg1.state.va.us/lis.htm
Virginia Medicaid Management Information System (VAMMIS)	The medical assistance eligibility, enrollment, and payment information

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	system of the Virginia Department of Medical Assistance Services.
Web Portal	A secure web site offering a broad array of resources and services to registered providers.

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Appendix B Service Authorization

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INTRODUCTION

Service authorization (SA), formally known as prior authorization, is the process to approve specific services for an enrolled Medicaid, FAMIS Plus or FAMIS individual by a Medicaid enrolled provider prior to service delivery and reimbursement. Some services do not require SA and some may begin prior to requesting authorization.

Purpose of Service Authorization

The purpose of service authorization is to validate that the service requested is medically necessary and meets DMAS criteria for reimbursement. All requests for SA shall be submitted to Department of Behavioral Health and Developmental Services (DBHDS) by the individual's support coordinator through the DBHDS Waiver Management System (WaMS). Service authorization does not guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process, the individual's continued Medicaid/FAMIS eligibility, the provider's continued enrollment as a DMAS provider, and ongoing medical necessity for the service. Service authorization is specific to an individual, a provider, a service code, an established quantity of units, and for specific dates of service. Service authorization is performed by DMAS or by a contracted entity.

General Information Regarding Service Authorization

Various submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for SA requests.

The SA entity will approve, pend, reject, or deny all completed SA requests. DBHDS will be authorizing the following services under EPSDT:

- **S9123, S9124 – EPSDT Private Duty Nursing (Individual RN and LPN)**
- **G0493 and G0494 - EPSDT Private Duty Nursing (Congregate RN and LPN)**
- **T5999 – EPSDT Assistive Technology**

Changes in Benefit Plans

Because the individual may transition between fee-for-service and the DMAS contracted managed care program, the SA entity will honor the DMAS contracted MCO service authorization if the client has been retroactively disenrolled from the MCO. Similarly, the MCO will honor the SA contractor's authorization based upon proof of authorization from the provider, DMAS, or the SA Contractor that services were authorized while the

individual was eligible under fee-for-service (not MCO enrolled) for dates where the individual has subsequently become enrolled with a DMAS contracted MCO.

SA decisions by the DMAS SA contractor are based upon clinical review and apply only to individuals enrolled in Medicaid or FAMIS fee-for-service on dates of service requested. The SA contractor decision does not guarantee Medicaid or FAMIS eligibility or fee-for-service enrollment. It is the provider's responsibility to verify individual eligibility and to check for managed care organization (MCO) enrollment. For MCO enrolled members, the provider must follow the MCO's SA policy and billing guidelines.

Communication

Provider manuals are located on the DMAS portal www.dmas.virginia.gov and DBHDS website. The DBHDS website has information related to the SA processes for programs identified in this manual. You may access this information by going to www.dbhds.virginia.gov or contacting the DD Waivers helpline at 807-663-7290.

The SA entity provides communication and language needs for non-English speaking callers free of charge and has staff available to utilize the Virginia Relay service for the deaf and hard-of-hearing.

Service Authorization for the Developmental Disabilities Waivers

General Information

Prior to requesting authorization of services under the DD waivers, an individual must be deemed Medicaid eligible by the Department of Social Services and meet waiver eligibility criteria. It is important to note that an individual can only be enrolled in one waiver at a time; if transferring from one waiver to another, there cannot be overlaps in dates. Please see Chapter IV for enrollment processes. All Individual Support Plans (ISP) will be submitted each plan year with a maximum duration of 12 months regardless of the time of year the plan was initiated.

Developmental Disabilities Waiver Services (BI/FIS/CL) Requiring Authorization

Prior to submitting claims to the DMAS Virginia Medicaid Management Information System (VAMMIS) all requests must be submitted to DBHDS via the Waiver Management

System (WaMS) by the individual's support coordinator and include the Individual Support Plan approved by DBHDS.

REVIEW CRITERIA TO BE USED

EPSDT specialized services are available only for Medicaid members **under age 21.** *EPSDT specialized services are not a covered service by DMAS for individuals age 21 and older.*

Specialized services through the EPSDT program are used to correct or ameliorate physical or developmental disability identified during EPSDT screening services and the individual may be referred by the EPSDT screener or Primary Care Provider (PCP) for specific services. These services must be medically necessary with appropriate documentation to support each service authorization request. Coverage may be denied if the requested service is not medically necessary according to this criteria or is generally regarded by the medical profession as investigational/experimental or not meeting the standard of practice. All approvals must meet these agency criteria.

EPSDT specialized services are not available under the Virginia *State Plan for Medical Assistance.* Specialized services or items consist of a range of unique individualized services that are medically necessary to correct or ameliorate persons under the age of 21. Specialized services are available through Managed Care Organizations (MCO) and in Fee for Service (FFS) with the same scope of benefit. Select EPSDT services are authorized as part of the DD Waiver service coordination directly by DBHDS.

Services, equipment or supplies already covered by the Virginia *State Plan for Medical Assistance* may not be requested for reimbursement under EPSDT.

Individuals enrolled in Home and Community-Based waivers that provide a service available through EPSDT must obtain the service through EPSDT. These services include Assistive Technology and Private Duty Nursing. Requests which do not meet the medical necessity criteria through the EPSDT program may not be provided through the waiver program.

EPSDT Assistive Technology

Assistive Technology is defined as specialized medical equipment, supplies, devices, controls, and appliances not available under the Virginia *State Plan for Medical Assistance.* Assistive Technology items directly enable individuals to increase their abilities to perform ADLs or to perceive, control, or communicate with the environment in which they live. Assistive Technology items are expected to be portable.

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To meet the definition of Assistive Technology, requested items must meet all of the following requirements. Assistive Technology must:

- be able to withstand repeated use;
- be primarily and customarily used to serve a medical purpose and be medically necessary and reasonable for the treatment of the individual's disability or to improve a physical or mental condition;
- generally not be useful to a person in the absence of a disability, physical or mental condition; and
- be appropriate for use in both the home and community.

Service Authorization Review Process:

Criteria: Only Assistive Technology items that are determined to be medically necessary may be covered for reimbursement by DMAS. The following criteria must be satisfied through the submission of adequate and verifiable documentation satisfactory to DMAS or the contractor. Assistive Technology must be:

- A reasonable and medically necessary part of an Individual Support plan;
- Consistent with the individual's diagnosis and medical condition, particularly the functional limitations and symptoms exhibited by the individual;
- Not furnished solely for the convenience of the family, attending physician, or other practitioner or supplier;
- Consistent with generally accepted professional medical standards (i.e., not experimental or investigational); and
- Provided at a safe, effective, and cost-effective level that is suitable for use by the individual.

Assistive Technology must directly support the individual and be for the express purpose of diagnosing, treating or preventing (or minimizing the adverse effects of) illness, injury or other impairments to an individual's physical or mental health. Therefore, services that do not directly support the individual or environmental services dealing exclusively with an individual's surroundings rather than the individual are not covered. Further, even if the requested service does involve some direct support for the individual, it cannot be

covered unless the device is related to the diagnosis reason for the service request. Example, if a child can effectively communicate, they don't need an iPad for communication. The child needs to be diagnosed with a communication disorder or autism with communication difficulties and documented that the iPad can benefit their communication.

Individuals and caregivers are responsible for determining if the individual is receiving the appropriate Assistive Technology in the school system and suggesting that the child's Individualized Education Plan (IEP) include Assistive Technology. In cases where Assistive Technology is requested for use during school hours and not included in the IEP, the provider must obtain documentation from the school indicating why the Assistive Technology is not included in the child's IEP. Items covered under the Individuals with Disabilities Education Act (IDEA) cannot be covered under EPSDT. Items intended to be used in a school setting that are needed for educational purposes are not covered**.** For information regarding Medicaid covered school services, please see the School Health Services Manual located on the DMAS web portal at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual.

Timeliness:

Timeliness for provider submission does apply.

- Assistive technology requests must be submitted by the provider prior to the assistive technology service being delivered.

- Service authorization approvals that are completed prior to the assistive technology service being rendered are approved for the dates of service requested by the provider; 1 unit for 30 days.

- Administrative denials would occur if the provider did not respond to a pended request for initial clinical information or submitted a request after the assistive technology service was rendered and the member is not retro-eligible.

- Established timeframes listed above are also applicable to out of state providers. The only exception is for those out of state providers who are not enrolled as a participating provider with Virginia Medicaid.

Requests for new Assistive Technology devices must contain the following:

1. Physician Letter of Medical Necessity
2. Therapist's evaluation report (If signed by the physician this can serve as the Letter of Medical Necessity)
3. Quote from supplier to document provider's wholesale cost or cost description for

requests to exceed allowed reimbursement rates. Provider to submit quote, showing cost and if request approved, then markup cost 30%.

4. Provider to document why a specific device is medically justified over a standard, less expensive device.

Any medical necessity denials for EPSDT Assistive Technology for individuals under the age of 21, are performed at a Physician Review level at DMAS. This does not apply to administrative denials.

EPSDT Private Duty Nursing

Private duty nursing is continuous medically necessary nursing provided for an individual. Private duty nursing agencies provide professional nursing services to individuals in a home or community-based setting. Private duty nursing must be provided by a registered nurse (RN) or licensed practical nurse (LPN) employed by a DMAS-enrolled private duty nursing provider.

Congregate Private Duty Nursing (G0493, G0494): *Congregate private duty nursing is provided by one nurse when more than one individual who requires private duty nursing resides in the same home*. Congregate private duty nursing shall be limited to a maximum ratio of one private duty nurse to two individuals who receive nursing via the Waiver or EPSDT. When three or more waiver/EPSDT individuals share a home, service staff ratios are determined by assessing the combined needs of the individuals. Congregate cases may require individual nursing hours in addition to the congregate hours.

Individual Private Duty Nursing (S9123, S9124): Individual Private Duty Nursing (PDN) service means nursing services that are provided by a Registered Nurse (RN) or Licensed Practical Nurses (LPN) to one individual and are designed to provide the individual continuous nursing care. PDN services are available to individuals who require more hours per week of nursing care than may be provided under Skilled Nursing in the waivers.

Private duty nursing provides individualized medically necessary nursing treatment or preventive nursing supports that correct, ameliorate or maintain the health condition.
Private duty nursing services are limited to the hours of skilled medical care and skilled supervision as specified in the POC and limited to the number of hours approved by DMAS. Plans may be submitted for any time period between 60 days and 6 months.

Criteria: The EPSDT Medical Needs Assessment form will determine the medical necessity for EPSDT nursing for a total day's duration. There are five levels of nursing care. Nursing needs of the individual indicate the type and complexity of care. The amount of care authorized may differ from this level based on the plan of care and the hours in

which the nursing services are scheduled. Private duty nursing services are limited to the hours of skilled medical care and skilled supervision as specified in the POC and limited to the number of hours approved by DMAS. Private duty nursing service authorizations may be valid for the duration of the POC.

The levels of private duty nursing care are defined as:

- ❒ **A** Score (1-6) points
  Maximum nursing (Individual Consideration up to 8 hrs / day)
- ❒ **B** Score (7-22) points
  Maximum nursing 8 hrs / day
- ❒ **C** Score (23-36) points
  Maximum nursing 12 hrs / day
- ❒ **D** Score (37-49) points
  Maximum nursing 16 hrs / day
- ❒ **E** Score (50 or more) points
  Maximum nursing (Individual Consideration)

Timeliness: Timeliness for provider submission does apply. Initial request for services must be submitted 10 business days prior to the start of care (SOC). The CMS 485 must be signed and dated by the physician within 10 business days of the initial SOC. Continued stay reviews are required to be submitted to the Contractor prior to the end of the current decision.

New Requests:

- Signed and dated DMAS-62 form by the physician, physician's assistant, or certified nurse practitioner.

- Home Health Certification and Plan of Care (use the CMS 485 or equivalent to meet documentation requirements) signed and dated by the physician.

Continuation Requests

- DMAS-62 - Medical Needs Assessment Form (a new DMAS-62 is required every 6 months) signed and dated by the physician, physician's assistant, or certified nurse practitioner.

  Home Health Certification and Plan of Care (may use the CMS 485 or equivalent to meet documentation requirements) signed and dated by the ordering physician who is most familiar with the care needs of the individual. The CMS 485 must be reviewed and updated by the ordering physician with each continuation request.

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- The Home Health Certification and Plan of Care must contain the individual's Medicaid ID number, provider number, and documentation which reflects the nursing care as described in the Medical Needs Assessment (DMAS-62) form.

Any medical necessity denials for EPSDT Private Duty nursing for individuals under the age of 21, are performed at a Physician Review level at DMAS. This does not apply to administrative denials.

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SERVICE AUTHORIZATION EPSDT SERVICES

Exhibit 1:

Service & Procedure Code	Children enrolled in Medicaid/ FAMIS Plus MCOs*	Children enrolled in Medicaid/FAMIS Plus Fee-For-Service (FFS) (Includes FAMIS FFS)	Coverage for children enrolled in FAMIS MCOs*
Assistive Technology Code #T5999	Contact DBHDS for service authorization*	Services authorized through DBHDS	Not covered
Private Duty Nursing PDN/RN – S9123 PDN/LPN – S9124	Contact DBHDS for service authorization*	Services authorized through DBHDS	Contact child's MCO for service authorization*

*Contact information for Managed Care Organizations (MCOs) can be found at **www.virginiamanagedcare.com** or by calling the **Medicaid Managed Care Help Line at 1-800-643-2273**.

*. These EPSDT Services are available to members enrolled in the FAMIS MCO benefit: Behavioral Therapy, Private Duty Nursing, Hearing Aids and "traditional" Inpatient services.

These EPSDT Services are available to members enrolled in the FAMIS Fee-for-Service (FFS) benefit: Assistive Technology, Private Duty Nursing, Hearing Aids, "traditional" Inpatient services, Behavioral Therapy and Personal Care.

EPSDT Timely Submission Chart

Exhibit 2:

Service Type	Timely Submittal Requirements
EPSDT PDN	Initial Authorization requests for EPSDT Private Duty Nursing must be submitted at least 10 days, but no more than 30 days prior to the requested service start or renewal date. For continuation (renewal) of care, the request must be submitted at least 10 days prior to the end date of the current authorized period.

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APPENDIX C

DD WAIVER DEFINITIONS

INTRODUCTION

The following words and terms when used in chapter(s) 2, 4, or 6 shall have the following meanings, as identified in regulation, unless the context clearly indicates otherwise:

Should there be any changes to definitions, please refer to 12VAC30-122-20.

12VAC30-122-20. Definitions

"AAIDD" means the American Association on Intellectual and Developmental Disabilities.

"Activities of daily living" or "ADLs" means personal care tasks, for example, bathing, dressing, using a toilet, transferring, and eating or feeding. An individual's degree of independence in performing these activities is a part of determining appropriate level of care and service needs.

"Agency-directed model" means a model of service delivery where an agency is responsible for providing direct support staff, for maintaining individuals' records, and for scheduling the dates and times of the direct support staff's presence in an individual's home and in community.

"Appeal" means the process used to challenge actions regarding services, benefits, and reimbursement provided by Medicaid pursuant to 12VAC30-110 and 12VAC30-20-500 through 12VAC30-20-560.

"Assistive technology" or "AT" means specialized medical equipment and supplies, including those devices, controls, or appliances specified in the individual support plan but not available under the State Plan for Medical Assistance that (i) enable individuals to increase their abilities to perform ADLs ; (ii) enable individuals to perceive, control, or communicate with their environment ; (iii) actively participate in other waiver services that are part of their plan for supports; or (iv) are necessary to the proper functioning of the specialized equipment.

"Back-up plan" means provision for alternative arrangements for the delivery of services that are critical to participant well-being in the event that the provider responsible for furnishing the services fails or is unable to deliver them.

"Barrier crime" means those crimes listed in § 19.2-392.02 of the Code of Virginia and as they apply to §§ 32.1-162.9:1, 37.2-314, 37.2-416, 37.2-506, 37.2-607, and 63.2-1719 of the Code of Virginia.

"Behavioral health authority" or "BHA" means the same as defined in § 37.2-100 of the Code of Virginia.

"Benefits planning" means an individualized analysis and consultation service that assists recipients of a DD waiver and social security (SSI, SSDI, SSI/SSDI) to understand their personal benefits and explore their options regarding working, how to begin employment, and the impact employment will have on their state and federal benefits.

"BI" means the Building Independence Waiver as further described in 12VAC30-122-240.

"Center-based crisis support services" means crisis support services provided in a crisis therapeutic home.

"Centers for Medicare and Medicaid Services" or "CMS" means the unit of the U.S. Department of Health and Human Services that administers and funds the Medicare and Medicaid programs.

"Challenging behavior" means behaviors of such intensity, frequency, and duration that the physical safety of the individual or others is placed in serious jeopardy or the behavior limits access to the community. Challenging behavior may include withdrawal, self-injury, injury to others, aggression, or self-stimulation.

"CL" means the Community Living Waiver as described in 12VAC30-122-250.

"Community-based crisis support services" means crisis support services provided to individuals in their homes and in community settings.

"Community coaching" means a service designed for individuals who require one-to-one support in a variety of community settings in order to develop specific skills to address barriers that prevent that individual from participating in community engagement services.

"Community engagement" means, for the purpose of building relationships and natural supports, services that support and foster individuals' abilities to acquire, retain, or improve skills necessary to build positive social behavior, interpersonal competence, greater independence, employability, and personal choice necessary to access typical activities and benefits of community life equal to those available to the general population. Community engagement services shall be provided in groups no larger than three individuals with a minimum of one DSP.

"Community Guide" means direct assistance to promote individuals' self-determination through brokering specific community resources that lead to connection to and independent participation in integrated, independent housing, or community activities so as to avoid isolation.

"Community services board" or "CSB" means the same as defined in § 37.2-100 of the Code of Virginia.

"Companion" means a person who provides companion services for compensation by DMAS.

"Companion services" means nonmedical care, support, and socialization provided to an adult individual age 18 years and older in accordance with a therapeutic goal in the individual support plan. Companion services are not purely recreational in nature and shall not provide routine support with ADLs.

"Consumer direction" means a model of service delivery for which the individual or the individual's employer of record, as appropriate, shall be responsible for hiring, training, supervising, and firing of the person who provides the direct support or specific services covered by DMAS and whose wages are paid by DMAS through its fiscal agent.

"Crisis support services" means intensive supports by trained and, where applicable, licensed staff in crisis prevention, crisis intervention, and crisis stabilization for an individual who is experiencing an episodic behavioral or psychiatric event that has the potential to jeopardize his current community living situation.

"Customized rate" means a reimbursement rate that may be available to group home residential, sponsored residential, supported living residential, group day, community coaching, and in-home support service providers that exceeds the normal rate applicable to the individual receiving these specific services.

"DARS" means the Department for Aging and Rehabilitative Services.

"DBHDS" means the Department of Behavioral Health and Developmental Services.

"DBHDS staff" means persons employed by or contracted with DBHDS.

"Developmental Disability Waivers" or "DD Waivers" means the waiver program established in this chapter and consisting of the FIS, CL, and BI waivers.

"Developmental disability" means the same as defined in § 37.2-100 of the Code of Virginia.

"Direct support professional," "direct care staff," or "DSP" means staff members identified by the provider as having the primary role of assisting an individual on a day-to-day basis with routine personal care needs, social support, and physical assistance in a wide range of daily living activities so that the individual can lead a self-directed life in his own community. This term shall exclude consumer-directed staff and services facilitation providers.

"DMAS" means the Department of Medical Assistance Services.

"DMAS staff" means persons employed by or contracted with DMAS.

"Electronic home-based support" or "EHBS" means goods and services based on current technology, such as Smart Home®, and includes purchasing electronic devices, software, services, and supplies that allow individuals to use technology in their residences to achieve greater independence and self-determination and reduce the need for staff intervention but

that are not otherwise covered through other benefits in the DD Waivers or through the State Plan for Medical Assistance.

"Electronic visit verification" or "EVV" means a telephone, computer-based system, or other electronic technology used in real time to document, verify, and report the delivery of certain specified information about the provision of in-home or other community location, personal care, respite, companion services, and home health services. The EVV system shall report the precise time that services begin and end.

"Employer of record" or "EOR" means the person who performs the functions of the employer in the consumer-directed model of service delivery and may be the individual enrolled in the waiver, a family member, an unpaid caregiver, or another designated person.

"Employment and community transportation" means a service offered to enable individuals to gain access to an individual's place of employment or volunteer activity, other community services or events, activities and resources, homes of family or friends, civic organizations or social clubs, public meetings or other civic activities, and spiritual activities or events as specified by the support plan and when no other means of access is available.

"Employment services organization" means providers of employment services with DARS. DARS verifies that these providers meet criteria to be providers through a DARS-recognized accrediting body.

"Enroll" with respect to an individual means (i) the local department of social services has determined the individual's financial eligibility for Medicaid as set out in 12VAC30-122-60; (ii) the individual has been determined by the support coordinator to be at risk of institutionalization and to meet the functional eligibility requirements in the Virginia Intellectual Developmental Disabilities Eligibility Survey form, which is referenced in 12VAC30-122-70, for the waiver; (iii) the Department of Behavioral Health and Developmental Services has verified the availability of a waiver slot for the individual; and (iv) the individual has agreed to accept the waiver slot.

"Environmental modifications" or "EM" means physical adaptations to the individual's home or primary vehicle that are necessary to ensure the individual's health and welfare or to enable functioning with greater independence.

"EPSDT" means the Early and Periodic Screening, Diagnosis and Treatment program administered by DMAS for children younger than 21 years of age according to federal guidelines that prescribe preventive and treatment services for Medicaid eligible children and as defined in 12VAC30-50-130.

"Face-to-face contact" means an in-person meeting between the support coordinator and the individual and family/caregiver, as appropriate, for the purpose of assessing the individual's status and determining satisfaction with services, including the need for additional services and supports.

"Family" means, for the purpose of receiving individual and family/caregiver training services, the unpaid people who live with or provide care to an individual served by the waiver and may include a parent, a legal guardian, a spouse, children, relatives, a foster family, or in-laws but shall not include persons who are compensated to care for the individual.

"FIS" means the Family and Individual Support Waiver as further described in 12VAC30-122-260.

"General supports" means staff presence to ensure that appropriate action is taken in an emergency or an unanticipated event and includes (i) awake staff during nighttime hours; (ii) routine bed checks; (iii) oversight of unstructured activities; or (iv) asleep staff at night on premises for security or safety reasons.

"Group day services" means services for the individual to acquire, retain, or improve skills of self-help, socialization, community integration, employability, and adaptation via opportunities for peer interactions, community integration, and enhancement of social networks.

"Group home residential services" means skill-building, routine supports, general supports, and safety supports that are provided in a residence licensed by DBHDS or an adult foster care home approved by the local department of social services that enable the individual to acquire, retain, or improve skills necessary to lead a self-directed life in his own community.

"Home and community-based waiver services," "HCBS," or "waiver services" means the range of community services approved by CMS pursuant to § 1915(c) of the Social Security Act to be offered to persons as an alternative to institutionalization.

"ICF/IID" means a facility or distinct part of a facility that (i) is licensed by DBHDS; (ii) meets the federal certification regulations for an intermediate care facility for individuals with intellectual disabilities and individuals with related conditions; nd (iii) addresses the total needs of the individuals, which include physical, intellectual, social, emotional, and habilitation, and (iv) provides active treatment as defined in 42 CFR 483.440.

"IDEA" means the Individuals with Disabilities Education Act (20 USC § 1400 et seq.).

"Immediate family member" means spouses, parents (as "parent" is defined in this section), children (biological, adoptive, foster, step,) and siblings of the individual in the waiver.

"Independent living" means an individual living on his own with sufficient opportunities to direct his life and make informed choices, including the freedom to pursue activities fitting his capabilities and interests while maximizing full participation in community life.

"Individual" means the Commonwealth's citizen, including a child, who meets the income and resource standards in order to be eligible for Medicaid-covered services, has a diagnosis of developmental disability, and is eligible for the DD Waivers. The individual

may be a person on the DD Waiver waiting list or an enrolled person who is receiving these waiver services.

"Individual support plan" or "ISP" means a comprehensive, person-centered plan that sets out the supports and actions to be taken during the year by each provider, as detailed in each provider's plan for supports to achieve desired outcomes, and goalsnd dreams. The individual support plan shall be developed collaboratively by the individual, the individual's family/caregiver, as appropriate, providers, the support coordinator, and other interested parties chosen by the individual and shall contain the DMAS-approved ISP components as set forth in 12VAC30-122-190.

"Individual supported employment" means services that consist of ongoing, one-on-one supports provided by a job coach that enable the individual to be employed in an integrated work setting and may include assisting the individual to locate a job or develop a job on behalf of the individual, as well as activities needed to sustain paid work by the individual.

"Individual's responses to services" means the individual's behaviors in and responses to the services. In the case of an individual who does not communicate through spoken language, this shall mean the individual's condition and observable responses.

"In-home support services" means residential services that take place primarily in the individual's home, family home, or community settings that typically supplement the primary care provided to himself or by family or another unpaid caregiver and are designed to enable the individual to lead a self-directed life in the community while ensuring his health, safety, and welfare.

"Instrumental activities of daily living" or "IADLs" means skills that are needed to successfully live independently such as meal preparation, shopping, housekeeping, laundry, and money management and do not include ADLs.

"Job coach" means the person who instructs individuals with disabilities utilizing structured intervention techniques to help the individual learn to perform job tasks to the employer's specifications and to learn the interpersonal skills necessary to be accepted as a worker at the job site and in related community contacts.

"LEIE" means List of Excluded Individuals and Entities. For the purpose of the use of LEIE, the use of the word "individual" shall not refer to the enrolled waiver individual.

"Levels of support" means the level (1-7) that is assigned to an individual based on the SIS® score, the results of the Virginia Supplemental Questions, and, as needed, a supporting document review verification process.

"Licensed practical nurse" or "LPN" means a person who is licensed or holds multistate licensure privilege pursuant to Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia to practice practical nursing as defined in § 54.1-3000 of the Code of Virginia.

"LMHP" means a licensed mental health professional as defined in 12VAC30-50-130.

"LMHP-resident" means the same as defined in 12VAC30-50-130.

"LMHP-RP" means the same as defined in 12VAC30-50-130.

"LMHP-supervisee" means the same as defined in 12VAC30-50-130.

"Medically necessary" means an item or service provided for the diagnosis or treatment of an individual's condition consistent with community standards of medical practice s determined by DMAS and needed to maintain an individual in the community instead of placement in an institution.

"Own home" means an individual residence that meets the legal definition of a residential dwelling that can be owned or leased by an individual.

"Parent" means a person who is biologically or naturally related, a foster parent, step-parent, or an adoptive parent to the individual enrolled in the waiver.

"Participating provider" means an entity that meets the standards and requirements set forth by DMAS and has a current, signed provider participation agreement with DMAS.

"Peer mentor supports" means information, resources, guidance, and support from an experienced, trained peer mentor to an individual who is a waiver recipient.

"Person-centered planning" means a fundamental process that focuses on what is important to and for an individual and the needs and preferences of the individual to create an individual support plan.

"Personal assistance service" means direct support or supervision with (i) ADLs, (ii) IADLs, (iii) access to the community, (iv) monitoring the self-administration of medication or other medical needs, and (v) monitoring health status and physical condition. Personal assistance services may occur in the home, community, work site, or postsecondary school.

"Personal assistant" means a person who provides personal assistance services employed either by a provider agency or under consumer direction.

"Personal emergency response system" or "PERS" means an electronic device and monitoring service, and also may include medication monitoring units, that enable individuals to secure help in an emergency.

"Personal profile" means a point-in-time synopsis of what an individual enrolled in the waiver wants to maintain, change, improve in his life, or goals and outcomes to achieve, and shall be completed by the individual and another person, such as his support coordinator or family/caregiver, chosen by the individual to help him plan before the annual planning meeting where it is discussed and then finalized to inform the individual supports plan process.

"Plan for supports" means each provider's plan for supporting the individual enrolled in the waiver in achieving the individual's desired outcomes and facilitating the individual's health and safety. The provider plan for supports is one component of the individual support plan.

"Positive behavior support" means n applied science that uses educational methods to expand an individual's behavior repertoire and systems change methods to redesign an individual's living environment to enhance the individual's quality of life by minimizing his challenging behaviors to enable him to lead a self-directed life in the community. a set of research-based strategies used to increase quality of life and decrease challenging behavior by teaching new skills and making changes in a person's environment.

"Primary caregiver" means the primary person who consistently assumes the role of providing direct care and support without compensation for such care to the individual enrolled in the waiver to enable the individual to live a self-directed life in the community.

"Private duty nursing services" means individual and continuous nursing care for individuals who have a serious medical condition or complex health care needs, or both, and that has been certified by a physician as medically necessary to enable the individual to remain in a community setting rather than in a hospital, nursing facility, or ICF/IID. This service may be provided concurrently with other services.

"Progress notes" means individual-specific written documentation that (i) contains unique differences specific to the individual's circumstances and the supports provided, and the individual's responses to such supports; (ii) is signed and dated by the person who rendered the supports; and (iii) is signed and dated s soon as is practicable but no longer than one week after the referenced service. on the day the described supports were provided. Documentation that occurs after the date supports were provided shall be dated for the date the entry is recorded and the date of supports delivery shall be noted in the body of the note.

"Qualified developmental disabilities professional" or "QDDP" means a professional who (i) possesses at least one year of documented experience working directly with individuals who have developmental disabilities; (ii) is one of the following: a doctor of medicine or osteopathy, a registered nurse, a provider holding at least a bachelor's degree in a human service field including sociology, social work, special education, rehabilitation engineering, counseling, or psychology; and (iii) possesses the required Virginia or national license, registration, or certification in accordance with his profession, if applicable.

"Quality management review" or "QMR" (i) means a process used by DMAS to monitor provider compliance with DMAS participation standards and policies and to ensure an individual's health, safety, and welfare and individual satisfaction with services and (ii) includes a review of the provision of services to ensure that services are being provided in accordance with DMAS regulations, policies, and procedures.

"Registered nurse" or "RN" means a person who is licensed or holds multistate licensure privilege pursuant to Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia to practice professional nursing.

"Respite services" means temporary substitute for care that is normally provided by the unpaid primary caregiver and shall be provided on a short-term basis due to the absence of or need for routine or periodic relief of the primary caregiver or other unpaid caregiver.

"Routine supports" means supports that assist the individual with ADLs and IADLs, if appropriate.

"Safety supports" means specialized assistance that is required to ensure an individual's health and safety.

"Service authorization" means the process to approve specific services for an enrolled Medicaid individual by a DMAS service authorization designee prior to service delivery and reimbursement in order to validate that the service requested is medically necessary and meets DMAS requirements for reimbursement. Service authorization does not guarantee payment for the service.

"Services facilitation" means a service that assists the individual or EOR, as appropriate, in arranging for, directing, and managing services provided through the consumer-directed model of service delivery.

"Services facilitator" means (i) a DMAS-enrolled provider, (ii) a DMAS-designated entity, or (iii) one who is employed by or contracts with a DMAS-enrolled services facilitator that is responsible for supporting the individual or EOR, as appropriate, by ensuring the development and monitoring of the plan for supports for consumer-directed services, providing employee management training, and completing ongoing review activities as required. "Services facilitator" shall be deemed to mean the same thing as "consumer-directed services facilitator."

"Shared living" means an arrangement in which a roommate resides in the same household as the individual receiving waiver services and provides an agreed-upon, limited amount of supports in exchange for which a portion of the total cost of rent, food, and utilities that can be reasonably attributed to the roommate is reimbursed to the individual.

"Skill building" means those supports that help the individual gain new skills and abilities and was previously called training.

"Skilled nursing services" means short-term nursing services (i) ordered by a physician and listed in the plan for supports that are not otherwise available under the State Plan for Medical Assistance, (ii) provided within the scope of § 54.1-3000 et seq. of the Code of Virginia and the Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia), and (iii) provided by a registered nurse or by a licensed practical nurse under the supervision of a registered nurse who is licensed to practice in the state or who holds a multistate licensure privilege. Skilled nursing services are to be used to train and provide consultation, using

nurse delegation as appropriate, and oversight of direct staff s appropriate consistent with the Department of Health Professions requirements for delegation of tasks.

"Slot" means an opening or vacancy in waiver services.

"SSI" means social security income provided by the U.S. Social Security Administration.

"Sponsored residential services" means residential services that consist of skill-building, routine supports, general supports, and safety supports provided in the homes of families or persons (sponsors) who provide supports for no more than two individuals under the supervision of a DBHDS-licensed provider that enable the individuals to acquire, retain, or improve the self-help, socialization, and adaptive skills necessary to live a self-directed life in the community.

"State Plan for Medical Assistance" or "Plan" means the Commonwealth's legal document approved by CMS identifying the covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act.

"Support coordination/case management" means assessing and planning of services; linking the individual to services and supports identified in the individual support plan; assisting the individual directly for the purpose of locating, developing, or obtaining needed services and resources; coordinating services and service planning with other agencies and providers involved with the individual; enhancing community integration; making collateral contacts to promote the implementation of the individual support plan and community integration; monitoring the individual to assess ongoing progress and ensuring that authorized services are delivered; and educating and counseling the individual to guide him to develop supportive relationships that promote the individual support plan.

"Support coordinator" means the person who provides support coordination services to an individual in accordance with 12VAC30-50-440 and 12VAC30-50-490. Formerly, this was referred to as case manager and may be either an employee of a CSB or of a private entity contracted with the local CSB.

"Supported living residential service" means a service taking place in n apartment a residential setting operated by a DBHDS-licensed provider of supervised living residential service or supportive in-home service that consists of skill-building, routine supports, general supports, and safety supports that enable the individual to acquire, retain, or improve self-help, socialization, and adaptive skills necessary to live a self-directed life in home and community settings.

"Supporting documentation" means any written or electronic materials used to record and verify the individual's support needs, services provided, and contacts made on behalf of the individual and may include, for example, the personal profile, individual support plan, providers' plans for supports, progress notes, reports, medical orders, contact logs, attendance logs, and assessments.

"Supports" means paid and nonpaid assistance that promotes the accomplishment of an individual's desired outcomes. There shall be four types of supports: (i) routine supports that assist the individual in ADLs and IADLs, if appropriate; (ii) skill building supports to help the individual gain new abilities; (iii) safety supports that are required to ensure the individual's health and safety; and (iv) general supports that provide general oversight.

"Supports Intensity Scale®" or "SIS®" means an assessment tool and form that is published by the American Association on Intellectual and Developmental Disabilities and administered through a thorough interview process that measures and documents an individual's practical support requirements in personal, school-related or work-related, social, behavioral, and medical areas to suggest the types and intensity levels of the supports required by that individual to live a self-directed life in the community and to inform the discussion in the person-centered planning process.

"Therapeutic consultation" means professional consultation provided by members of psychology, social work, rehabilitation engineering, behavioral analysis, speech therapy, occupational therapy, psychiatry, psychiatric clinical nursing, therapeutic recreation, physical therapy, or behavior consultation disciplines that are designed to assist individuals, parents, family members, and any other providers of support services with implementing the individual support plan.

"Tiers of reimbursement" means four different rates of provider reimbursement associated with certain DD waiver services, which are tied to an individual's level of support need as determined by the Supports Intensity Scale®.

"Transition services" means the same as defined in 12VAC30-120-2010.

"VDSS" means the Virginia Department of Social Services.

"Virginia Individual Developmental Disabilities Eligibility Survey" or "VIDES" means the required level of care tool for demonstrating functional eligibility for the DD waivers. There are three types: adult, child, and infant.

“Waiver Management System” (WaMS) is the data management system that manages the DD waivers; houses a record of the Individualized Service Plan (ISP); is the entry point to request Service Authorization for DD waiver services; and acts as a conduit for communication between Providers, Support Coordinators, and DBHDS.

“Waiver Slot Assignment Committee” (WSAC) is the impartial body of trained volunteers established for each locality or region with responsibility for recommending to DBHDS individuals eligible for a waiver slot according to their urgency of need at the time a slot becomes available. All WSACs must be composed of community members who are not employees of a CSB or a private provider of either support coordination or waiver services and are knowledgeable of and have experience in the developmental disabilities service system. When a slot is available, the CSB will contact the WSAC facilitator, who will coordinate with DBHDS staff to call a meeting of the committee as soon as possible.

"Workplace assistance service" means supports provided to an individual who has completed job development and completed or nearly completed job placement training but requires more than the typical job coach services, as in 12VAC30-122-400, to maintain stabilization in his employment.

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APPENDIX D

SERVICE AUTHORIZATION (SRV AUTH) FOR INDIVIDUAL AND FAMILY DEVELOPMENTAL DISABILITIES SUPPORT (IFDDS) WAIVER

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General Information Chapter for Service Authorization

Introduction

Service authorization (Srv Auth), formally known as prior authorization, is the process to approve specific services for an enrolled Medicaid, FAMIS Plus or FAMIS individual by a Medicaid enrolled provider prior to service delivery and reimbursement. Some services do not require Srv Auth and some may begin prior to requesting authorization.

Purpose of Service Authorization

The purpose of service authorization is to validate that the service requested is medically necessary and meets DMAS criteria for reimbursement. Service authorization does not guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process, the individual's continued Medicaid eligibility, the provider's continued Medicaid eligibility, and ongoing medical necessity for the service. Service authorization is specific to an individual, a provider, a service code, an established quantity of units, and for specific dates of service. Service authorization is performed by DMAS or by a contracted entity.

General Information Regarding Service Authorization

Various submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for Srv Auth requests.

The Srv Auth entity will approve, pend, reject, or deny all completed Srv Auth requests. Requests that are denied for not meeting medical necessity criteria are automatically sent to medical staff for review. All denials based on the lack of medical necessity, not meeting criteria, etc. are sent to a physician for reconsideration; denials for administrative issues such as timeliness, enrollment date, etc. go to a Licensed Clinical Supervisor for reconsideration. When a final disposition is reached, the individual and the provider are notified in writing of the status of the request.

Changes in Medicaid Assignment

Because the individual may transition between fee-for-service and the Medicaid managed care program, the Srv Auth entity will honor the Medicaid MCO service authorization if the individual has been retroactively dis-enrolled from the MCO. Similarly, the MCO will honor the Srv Auth contractor's authorization based upon proof of authorization from the provider, DMAS, or the Srv Auth Contractor that services were authorized while the individual was eligible under fee-for-service (not MCO enrolled) for dates where the individual has subsequently become enrolled with a DMAS contracted MCO Srv Auth decisions by the DMAS Srv Auth contractor are based upon clinical review and apply only to individuals enrolled in Medicaid fee-for-service on dates of service requested. The Srv Auth contractor decision does not guarantee Medicaid eligibility or fee-for-service enrollment. It is the provider's responsibility to verify individual eligibility and to check for managed care organization (MCO) enrollment. For MCO enrolled individuals, the provider must follow the MCO's Srv Auth policy and billing guidelines for services covered through the MCO.

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Commonwealth Coordinated Care

Commonwealth Coordinated Care is a program where members who have full Medicare and Medicaid benefits and meet all eligibility criteria are able to receive coordinated care through a managed care environment. The program objective is to coordinate delivery of primary, preventive, acute, behavioral, and long-term care services and supports.

CCC services do not cover the following waivers: Tech Waiver, DD Waiver, ID Waiver, Day Support, and Alzheimer Waivers. If a member becomes eligible for or receives a slot in one of these CCC excluded waivers, the member will be enrolled in the Waiver and may begin receiving Waiver services. CCC will continue to cover the regular medical services until the end of the month. The member will be automatically disenrolled from CCC the last day of that month. The member will receive all services through fee-for-service Medicaid or Medicare effective the first day of the next month. The DMAS service authorization contractor will process the service authorization request for the specific waivers/services listed for members dually enrolled in CCC. The request must include all the required documentation for a complete service authorization review. Providers will need to adhere to the timeliness requirements for new admission requests.

Communication

Provider manuals are located on the DMAS Web Portal and KEPRO website. The contractor's website has information related to the service authorization processes for programs identified in this manual. You may access this information by going to http://dmas.kepro.com. For educational material, click on the *Training* tab and scroll down to click on the *General* or *Waiver* tab.

The Srv Auth entity provides communication and language needs for non-English speaking callers free of charge and has staff available to utilize the Virginia Relay service for the deaf and hard-of-hearing.

Updates or changes to the Srv Auth process for the specific services outlined in this manual will be posted in the form of a Medicaid Memo to the DMAS Web Portal. Changes will be incorporated within the manual.

Service Authorization for Waiver Services

General Information

Prior to requesting authorization of services under the waivers, the individual must be deemed Medicaid eligible by the Department of Social Services and meet waiver criteria. Criteria for enrollment differs from waiver to waiver. The following chart indicates the Srv Auth entity that will accept requests for enrollment, and the alternate institutional placement. It is important to note that an individual can only be enrolled in one waiver at a time; if transferring from one waiver to another, there cannot be overlaps in dates. Please see Chapter IV for enrollment processes.

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Waiver	Send Enrollment To	Alternate Institutional Placement
Elderly or Disabled with Consumer Direction (EDCD) Waiver	KEPRO	Skilled Nursing Facility
Individual and Family Developmental Disabilities Support (IFDDS)Waiver	DBHDS	Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
Technology Assisted (Tech) Waiver	DMAS	Skilled Nursing Facility or Acute Hospital
Intellectual Disability (ID) Waiver (formerly Mental Retardation Waiver)	DBHDS	Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
Day Support (DS) Waiver for Individuals with Intellectual Disability	DBHDS	Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
Alzheimer's Assisted Living (AAL)Waiver	KEPRO	Skilled Nursing Facility

DD Waiver Services Requiring Authorization

(All requests must be approved through DBHDS on the Plan of Care prior to submitting to Srv Auth Contractor.)

IFDDS Waiver Services

Service Definition	Procedure Code	Documentation Required for Service Authorization
Therapeutic Consultation	97139	Documentation of at least one other qualifying Waiver service currently authorized. Service must be approved on the DMAS DD POC. Effective January 1, 2013, the maximum service authorization duration is up to 12 months, and in accordance with Plan's effective from and through dates.

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Day Support - Regular, Center or Non-Center Based	97537	Service must be approved on the DMAS DD POC. 780 units per POC year maximum, either as a stand-alone service, or in combination with Supported Employment and/or Pre-Vocational Services. Effective January 1, 2013, the maximum service authorization duration is up to 12 months, and in accordance with Plan's effective from and through dates.
Day Support - High Intensity, Center or Non-Center Based	97537 U1	Service must be approved on the DMAS DD POC. 780 units per POC year maximum, either as a stand-alone service, or in combination with Supported Employment and/or Pre-Vocational Services. Effective January 1, 2013, the maximum service authorization duration is up to 12 months, and in accordance with Plan's effective from and through dates.
Crisis Stabilization – Supervision	H0040	Service must be approved on the DBHDS DMAS DD POC. Effective January 1, 2013, the maximum service authorization duration is up to 15 consecutive days; up to 4 authorizations annually (annual total 60 days), and in accordance with Plan's effective from and through dates.
Crisis Stabilization - Intervention	H2011	Service must be approved on the DMAS DD POC. Effective January 1, 2013, the maximum service authorization duration is 15 consecutive days; up to 4 authorizations annually (annual total 60 days).
In-Home Residential Support	H2014	Documentation of the name of the In-Home Residential Support direct care staff and the relationship to the Member. This is not the name of the Provider agency. Service must be approved on the DMAS DD POC. Effective January 1, 2013, the maximum service authorization duration is up to 12 months, and in accordance with Plan's effective from and through dates.
Personal Emergency Response System - Installation	S5160	Documentation of at least one other qualifying Waiver service currently authorized. (PERS cannot be a sole service). Service must be approved on the DMAS DD POC. PERS cannot be authorized for individuals who have Supervision currently authorized as a component of Personal Care. Must be requested with S5161, PERS Monthly Monitoring.

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		Effective January 1, 2013, the maximum service authorization duration is up to 30 days, and in accordance with Plan's effective from and through dates.
Personal Emergency Response System - Installation (with medication monitoring)	S5160, U1	Documentation of at least one other qualifying Waiver service currently authorized. (PERS cannot be a sole service). Service must be approved on the DMAS DD POC. PERS cannot be authorized for individuals who have Supervision currently authorized as a component of Personal Care. Must be requested with S5185, PERS and Medication Monthly Monitoring, and PERS Nursing (H2021 TD or H2021 TE) Effective January 1, 2013, the maximum service authorization duration is up to 30 days, and in accordance with Plan's effective from and through dates.
PERS Monthly Monitoring	S5161	Documentation of at least one other qualifying Waiver service currently authorized. (PERS cannot be a sole service). Documentation of a previous PERS installation (i.e. through private pay) if monitoring request is not accompanied by a request for the installation OR the individual does not have an existing authorization for a PERS installation (S5160). Service must be approved on the DMAS DD POC. PERS cannot be authorized for individuals who have Supervision currently authorized as a component of Personal Care. Effective January 1, 2013, the maximum service authorization duration is up to 12 months, and in accordance with Plan's effective from and through dates.
PERS Monthly Monitoring with Medication	S5185	Documentation of at least one other qualifying Waiver service currently authorized. (PERS cannot be a sole service). Documentation of a previous PERS and medication monitoring installation (i.e. through private pay) if monitoring request is not accompanied by a request for the installation OR the individual does not have an existing authorization for a PERS installation (S5160 U1). Service must be approved on the DMAS DD POC. Must be requested with PERS Nursing (H2021 TD or H2021 TE). PERS cannot be authorized for individuals who have Supervision currently authorized as a component of Personal Care.

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PERS Nursing, RN	H2021, TD	Documentation of at least one other qualifying Waiver service currently authorized. (PERS cannot be a sole service). Documentation of a previous PERS and medication monitoring installation (i.e. through private pay) if monitoring request is not accompanied by a request for the installation OR the individual does not have an existing authorization for a PERS installation. Service must be approved on the DMAS DD POC. Must be requested with or already authorized for S5185 (PERS and Medication Monitoring). PERS cannot be authorized for individuals who have Supervision currently authorized as a component of Personal Care. Effective January 1, 2013, the maximum service authorization duration is up to 12 months, and in accordance with Plan's effective from and through dates.
PERS Nursing LPN	H2021, TE	Documentation of at least one other qualifying Waiver service currently authorized. (PERS cannot be a sole service). Documentation of a previous PERS and medication monitoring installation (i.e. through private pay) if monitoring request is not accompanied by a request for the installation OR the individual does not have an existing authorization for a PERS installation. Service must be approved on the DMAS DD POC. Must be requested with or already authorized for S5185 (PERS and Medication Monitoring). PERS cannot be authorized for individuals who have Supervision currently authorized as a component of Personal Care. Effective January 1, 2013, the maximum service authorization duration is up to 12 months, and in accordance with Plan's effective from and through dates.
Supported Employment - Individual	H2023	Service must be approved on the DMAS DD POC. 2080 units per POC year maximum, either as a stand-alone service, or in combination with Prevocational and/or Day Support Services. Effective January 1, 2013, the maximum service authorization duration is up to 12 months, and in accordance with Plan's effective from and through dates.

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Supported Employment - Enclave (Group)	H2024	Service must be approved on the DMAS DD POC. 780 units per POC year maximum, either as a stand-alone service, or in combination with Prevocational and/or Day Support Services. Effective January 1, 2013, the maximum service authorization duration is up to 12 months, and in accordance with Plan's effective from and through dates.
Pre-Vocational Services- Regular Intensity	H2025	Service must be approved on the DMAS DD POC. 780 units per POC year maximum, either as a stand-alone service, or in combination with Supported Employment and/or Day Support Services. Effective January 1, 2013, the maximum service authorization duration is up to 12 months, and in accordance with Plan's effective from and through dates.
Pre-Vocational Services - High Intensity	H2025 U1	Service must be approved on the DMAS DD POC. 780 units per POC year maximum, either as a stand-alone service, or in combination with Supported Employment and/or Day Support Services. Effective January 1, 2013, the maximum service authorization duration is up to 12 months, and in accordance with Plan's effective from and through dates.
Family Caregiver Training	S5111	Documentation of name and title of the professional providing the training, and the name of the individual being trained and their relationship to the Medicaid Member. Documentation of at least one other qualifying Waiver service currently authorized. Service must be approved on the DMAS DD POC. Effective January 1, 2013, the maximum service authorization duration is up to 12 months, and in accordance with Plan's effective from and through dates.
Personal Care Services, Agency	T1019	Service must be approved on the DMAS DD POC. For readmissions post discharge or transfer to a new Provider, documentation submitted must include the following: DMAS 99: The signature date must be on or before the new start of care date (cannot approve prior to sign date), Functional status, diagnoses, current medication list, current health status, current medical nursing needs, current therapies and/or special medical procedures, current waiver services currently receiving, name of the personal care aide/attendant, weekly hours attendant will provide care, specific hours the attendant is in the home, name of the unpaid

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		primary caregiver and relationship to member, if Primary Caregiver (PCG) resides with the member, type of care provided by PCG, if member receives PERS, is individual is in need of PERS or Supervision. Aides/Attendants cannot be the parents of minor individuals receiving services, or the spouse of the individual receiving services. Attendants cannot be the family/caregivers that are directing the individuals care. When the individual is readmitted or transfers to another provider and the hours are not changing and remain within cap, there is no need to submit a plan of care (DMAS 97A/B), however the date the new plan of care was completed must be documented with the Service Authorization (SA) submission to KEPRO. If there is an increase or decrease in hours from the previous authorization/Provider, information from the new POC (DMAS 97A/B) and justification for the change in hours is required for review. Documentation from the POC required as follows: DMAS 97 A/B: POC breakdown of hours per day; ADL composite score, back up plan, POC effective and signature date. DMAS100 (If supervision being requested): Cognitive status, physical incapacity, ability to call via telephone for help, unstable medical conditions, seizures, current support system (does PCG live with member, does PCG work outside of the home - including hours of work schedule to include travel time, and times the attendant is in the home), listing of current support system/back-up for when attendant is absent from the home. **All forms listed above must be uploaded in Atrezzo.** Effective January 1, 2013, the maximum service authorization duration is up to 12 months, and in accordance with Plan's effective from and through dates
Personal Care Services - Consumer Directed	S5126	Documentation of the name of person directing the care and relationship to the member, name of the attendant providing the care and relationship to the member (DMAS 99). Approval may not be granted for services rendered by other family members who live under the same roof as the individual, unless there is objective written documentation as to why there are no other providers available to provide care. Service must be approved on the DMAS DD POC.

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		For readmissions post discharge or transfer to a new Provider, documentation submitted must include the following: DMAS 99: The signature date must be on or before the new start of care date (cannot approve prior to sign date), Functional status, diagnoses, current medication list, current health status, current medical nursing needs, current therapies and/or special medical procedures, current waiver services currently receiving, name of the personal care aide/attendant ,weekly hours attendant will provide care, specific hours the attendant is in the home, name of the unpaid primary caregiver and relationship to member, if Primary Caregiver (PCG) resides with the member, type of care provided by PCG, if member receives PERS, is individual is in need of PERS or Supervision. Aides/Attendants cannot be the parents of minor individuals receiving services, or the spouse of the individual receiving services. Attendants cannot be the family/caregivers that are directing the individual's care. When the individual is readmitted or transfers to another provider and the hours are not changing and remain within cap, there is no need to submit a plan of care (DMAS 97A/B), however the date the new plan of care was completed must be documented with the Service Authorization (SA) submission to KEPRO. If there is an increase or decrease in hours from the previous authorization/Provider, information from the new POC (DMAS 97A/B) and justification for the change in hours is required for review. Documentation from the POC required as follows: DMAS 97 A/B: POC breakdown of hours per day; ADL composite score, back up plan, POC effective and signature date. DMAS100 (If supervision being requested): Cognitive status, physical incapacity, ability to call via telephone for help, unstable medical conditions, seizures, current support system (does PCG live with member, does PCG work outside of the home- including hours of work schedule to include travel time, and times the attendant is in the home), listing of current support system/back-up for when attendant is absent from the home. **All forms listed above must be uploaded in Atrezzo.** Effective January 1, 2013, the maximum service authorization duration is up to 12 months, and in accordance with Plan's effective from and through dates.
Respite Care-	T1005	Documentation of the name of the unpaid Primary Caregiver.

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Services Agency	(RESPI)	Service must be approved on the DMAS DD POC. For readmissions post discharge or transfer to a new Provider: Documentation must include the date of the most recent DMAS 99 (assessment). Approval may not be granted for services rendered by other family members who live under the same roof as the individual, unless there is objective written documentation as to why there are no other providers available to provide care. Aides/Attendants cannot be the parents of minor individuals receiving services, or the spouse of the individual receiving services. Attendants cannot be the family/caregivers that are directing the individuals care. Effective April 1, 2014, the maximum service authorization duration is up to 24 months, and in accordance with Plan's effective from and through dates Respite must be included on the annual plan to receive funding for the next year; however service authorization does not have to be requested from the service authorization contractor until 30 Days prior to the current authorization ending. **All forms listed above must be uploaded in Atrezzo.** A maximum of up to 480 hrs. may be authorized per plan year.
Respite Care - Consumer Directed	S5150	Documentation of the name of the unpaid Primary Caregiver, name of person directing the care and relationship to the member, and the name of the person providing the care and relationship to the Member. (DMAS 99) Service must be approved on the DMAS DD POC. For readmissions post discharge or transfer to a new Provider: Documentation must include the date of the most recent DMAS 99 (assessment). Approval may not be granted for services rendered by other family members who live under the same roof as the individual, unless there is objective written documentation as to why there are no other providers available to provide care. Aides/Attendants cannot be the parents of minor individuals receiving services, or the spouse of the individual receiving services. Attendants cannot be the family/caregivers that are

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		directing the individuals care. Effective April 1, 2014, the maximum service authorization duration is up to 24 months, and in accordance with Plan's effective from and through dates. Respite must be included on the annual plan to receive funding for the next year; however service authorization does not have to be requested from the service authorization contractor until 30 Days prior the current authorization ending. **All forms listed above must be uploaded in Atrezzo.** A maximum of up to 480 hrs. may be authorized per plan year.
Skilled Nursing, RN	T1002	Documentation of the Physician's signature date on the CMS 485 and the effective start of care date of the physician's order. (Services cannot be approved prior to the physician's signature date). Service must be approved on the DMAS DD POC. Service may be authorized for up to 6 months per request in accordance with the date range covered by the CMS 485 and the DMAS DD POC. Effective January 1, 2013, the maximum service authorization duration is up to 12 months, and in accordance with Plan's effective from and through dates.
Skilled Nursing, LPN	T1003	Documentation of the Physician's signature date on the CMS 485 and the effective start of care date of the physician's order. (Services cannot be approved prior to the physician's signature date). Service must be approved on the DMAS DD POC. Service may be authorized for up to 6 months per request in accordance with the date range covered by the CMS 485 and the DMAS DD POC. Effective January 1, 2013, the maximum service authorization duration is 12 up to months.
Transition Services	T2038	DBHDS **FUNCTION ONLY**: The IFDDS Case Manager must submit requests for Transition Services directly to the DBHDS Healthcare Coordinator for authorization. Effective January 1, 2013, the maximum service authorization duration is up to 9 months, and in accordance with Plan's effective from and through dates.

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		The maximum Medicaid funded expenditure is $5000.00 per individual lifetime.
Assistive Technology	T1999	Documentation of at least one other qualifying Waiver service currently authorized. Actual cost of item requested must be included with request (wholesale cost). Service must be approved on the DMAS DD POC. The maximum Medicaid funded expenditure is $5000.00 per plan year. Dates of service authorized cannot crossover the calendar or DD POC year. Effective January 1, 2013, the maximum service authorization duration is up to 30 days, and in accordance with Plan's effective from and through dates.
Assistive Technology, Maintenance	T1999, U5	Documentation of at least one other qualifying Waiver service currently authorized. Actual cost of item requested must be included with request (wholesale cost). Service must be approved on the DMAS DD POC. The maximum Medicaid funded expenditure is $5000.00 per plan year. Dates of service authorized cannot crossover the DD POC year. Effective January 1, 2013, the maximum service authorization duration is up to 30 days, and in accordance with Plan's effective from and through dates.
Environmental Modifications, Structural	S5165	Documentation of at least one other qualifying Waiver service currently authorized. Service must be approved on the DMAS DD POC. The maximum Medicaid funded expenditure is $5000.00 per plan year. Dates of service authorized cannot crossover the DD POC year. Effective January 1, 2013, the maximum service authorization duration is up to 30 days, and in accordance with Plan's effective from and through dates.
Environmental Modifications, Maintenance	99199, U4	Documentation of at least one other qualifying Waiver service currently authorized. Service must be approved on the DMAS DD POC. The maximum Medicaid funded expenditure is $5000.00 per plan year. Dates of service authorized cannot crossover the calendar or DD POC year.

		Effective January 1, 2013, the maximum service authorization duration is up to 30 days, and in accordance with Plan's effective from and through dates.
Companion Care - Agency	S5135	Service must be approved on the DMAS DD POC. Companion Care (CC) is limited to 2080 hours per POC year for both types of CC combined. Note: CC is not authorized for persons whose only need for CC is for assistance exiting the home in the event of an emergency and/or socialization. Effective January 1, 2013, the maximum service authorization duration is up to 12 months, and in accordance with Plan's effective from and through dates..
Companion Care - Consumer Directed	S5136	Service must be approved on the DMAS DD POC. Companion Care (CC) is limited to 2080 hours per POC year for both types of CC combined. Note: CC is not authorized for persons whose only need for CC is for assistance exiting the home in the event of an emergency and/or socialization. Effective January 1, 2013, the maximum service authorization duration is up to 12 months, and in accordance with Plan's effective from and through dates.

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After the Case Manager obtains confirmation of enrollment by DBHDS, they must assure that the contractor receives the current approved Plan of Care (DMAS 456) prior to submitting requests for service. All services identified on the DMAS 456 must be approved by DBHDS as evidenced by the Health Care Coordinators signature and date. Services are not authorized retroactively, unless specifically indicated within Chapter IV.

The MMIS generates letters to providers, case managers, and enrolled individuals depending on the final determination.

DMAS will not reimburse providers for dates of service prior to the date authorized on the notification letter. All final determination letters, as well as correspondence between various entities, are to be maintained in the individuals file, and are subject to review during Quality Management Review (QMR) and/or post payment audit.

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All service requests must be submitted through the Case Manager. For IFDDS service requests, only Consumer Directed (CD) services, Personal Care (including Supervision), Companion Care, Crisis Stabilization, and Respite Care can be authorized retroactively with a start of care (SOC) date prior to the date the Srv Auth Contractor receives request (and only if approved by DBHDS on the POC retroactively). All **other** services may be approved with a start of care on or after the date the request was submitted to the Srv Auth Contractor (regardless of when approved by DBHDS on the POC).

Plans of Care and Service Authorizations

Service requests revolve around the POC date. Upon initial enrollment to the DD Waiver, services must begin within 60 days or an extension letter, approved by a DMAS Health Care Coordinator, must be obtained and sent to the contractor. (See Chapter IV for more details on extension letters.) All POCs must be reviewed, signed and dated by the enrolled individual indicating agreement to the POC.

Plans of care must be renewed annually. If the POC is not renewed prior to the last date in the previously approved year, the service(s) will be ended and will not be reinstated until a renewal plan is received by the contractor.

Plan revisions are necessary when there has been a change in the amount of an existing service, or a service has added or terminated from the individuals plan. If adding a service, the POC revision must be approved by DBHDS, sent to the contractor, then the request for the additional service made.

SUBMITTING REQUESTS FOR SERVICE AUTHORIZATION

Service Authorization reviews will be performed by DMAS' service authorization contractor, Keystone Peer Review Organization, (KEPRO). All submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for service authorization requests submitted to KEPRO.

Providers must submit new or transfer requests to KEPRO within ten business days of the start of care date in order for the request to be timely. If a provider is late submitting the request, KEPRO will review the request and make a determination from the date it was received. The days/units that were not submitted timely will be denied, and appeal rights provided on the DMAS service authorization letter.

Providers must submit a service authorization request if a member requires continued services or the current authorization will end without renewal. There are no automatic renewals of service authorizations. All authorizations should be submitted prior to the first date services are rendered or prior to the last day of the current authorization in order for submissions to be timely and to avoid any gaps in service.

****Note to providers, the information submitted to KEPRO for service authorization must be documented in the medical record at the time of request. The request for service authorization**

must be appropriate to adequately meet the individual's needs. Any person who knowingly submits information to KEPRO containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

PROCEDURAL CHANGE SUBMITTING SERVICE AUTHORIZATION REQUESTS TO KEPRO

Effective September 1, 2015, service authorization requests must be submitted electronically utilizing KEPRO's provider portal Atrezzo Connect (also known as Atrezzo).

How to Register for Atrezzo
Provider registration is required to use Atrezzo Connect. The registration process for providers happens immediately on-line. To register, go to http://dmas.kepro.com, and click on "*Register*" to be prompted through the registration process. Newly registering providers will need their 10-digit Atypical Provider Identification (API) or National Provider Identification (NPI) number and their most recent remittance advice date for YTD 1099 amount. If you are a new provider who has not received a remittance advice from DMAS, please contact KEPRO at 1-888-827-2884 or atrezzoissues@kepro.com to receive a registration code which will allow you to register for KEPRO's Atrezzo Connect Portal. Atrezzo Connect User Guide is available at http://dmas.kepro.com : Click on the *Training* tab, then the *General* tab.

All submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media type, for service authorization requests submitted to KEPRO.

Submitting through Atrezzo puts the request in the reviewer queue immediately. Service authorization checklists and/or questionnaires may be accessed on KEPRO's website to assist the provider in assuring specific information is included with each request. Providers may access this information by going to http://dmas.kepro.com.

Already Registered with Atrezzo but Need Help Submitting Requests
It is imperative that providers currently registered use the portal for submitting all requests. For waiver providers, this includes admissions, discharges, continuation of care, change in hours, transfers, responding to pend requests, and all other transactions.

Registered Atrezzo providers do not need to register again. If a provider is successfully registered, but need assistance submitting requests through the portal, contact KEPRO at 1-888-827-2884 or atrezzoissues@kepro.com.

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If a provider has registered for Atrezzo, and forgot their password, please contact the provider's administrator to reset the password or utilize the 'forgot password' link and respond to the security question to regain access. If additional assistance is needed by the administrator contact KEPRO at 1-888-827-2884 or atrezzoissues@kepro.com.

If the person with administrative rights is no longer with the organization, contact KEPRO at 1-888-827-2884 or atrezzoissues@kepro.com to have a new administrator set up.

When contacting KEPRO please leave caller's full name, area code and phone number and the best time to be contacted.

Processing Requests at KEPRO

KEPRO will approve, pend, reject, or deny requests for service authorization. When a final disposition is reached, KEPRO notifies the provider. The member and provider will receive a letter from DMAS regarding the status of the authorization request through the MMIS letter generation process.

If there is insufficient information to make a final determination of medical necessity, KEPRO will pend the request back to the provider and request additional information. The response includes specific timeframes for the additional information to be sent to KEPRO. If the information is not received within the time frame requested by KEPRO, the information that was provided during the initial request will be automatically sent to a physician for review and a final determination will be made. In the absence of clinical information, the request will be submitted to the KEPRO supervisor for review and final determination. Providers and members are issued appeal rights through the MMIS letter generation process for any adverse determination. Instructions on how to file an appeal is included in the MMIS generated letter.

Providers are given one opportunity to respond to a pended case. Providers must respond electronically utilizing KEPRO's provider portal Atrezzo Connect (also known as Atrezzo). If the provider chooses to submit information prior to the pended due date, the case will be reviewed after the pended information is received. After a case is reviewed and a decision has been rendered any additional information submitted after that timeframe will not be considered as part of the initial request.

If services cannot be approved for members under the age of 21 using the current criteria, KEPRO will then review the request by applying EPSDT criteria.

Review Criteria to be used

DMAS criteria for medical necessity will be considered if a service is covered under the State Plan and is reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve functional disability. Coverage may be denied if the requested service is not medically necessary according to this criteria or is generally regarded by the medical profession as investigational/experimental or not meeting the standard of practice.

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HOW TO DETERMINE IF SERVICES NEED SERVICE AUTHORIZATION

In order to determine if services need to be service authorized, providers should go to the DMAS website: http://dmasva.dmas.virginia.gov and look to the right of the page and click on the section that says Procedure Fee Files which will then bring you to this: http://www.dmas.virginia.gov/Content_pgs/pr-ffs_new.aspx. You will now see a page entitled DMAS Procedure Fee Files. The information provided there will help you determine if a procedure code needs service authorization or if a procedure code is not covered by DMAS.

To determine if a service needs Service Authorization, you would then determine whether you wish to use the CSV or the TXT format. The CSV is comma separated value and the TXT is a text format. Depending on the software available on your PC, you may easily use the CSV or the TXT version

The TXT version is recommended for users who wish to download this document into a database application. The CSV Version opens easily in an EXCEL spreadsheet file. Click on either the CSV or the TXT version of the file. Scroll until you find the code you are looking for. The Procedure Fee File will tell you if a code needs to be prior authorized as it will contain a numeric value for the PA Type, such as one of the following:

00-No PA is required
01-Always needs a PA
02-Only needs PA if service limits are exceeded
03-Always need PA, with per frequency.

To determine whether a service is covered by DMAS you need to access the Procedure Rate File Layouts page from the DMAS Procedure Fee Files. Flag codes are the section which provides you special coverage and/or payment information. A Procedure Flag of “999” indicates that a service is non-covered by DMAS.

Early Periodic Screening Diagnosis and Treatment (EPSDT)

Service Authorization Section

The EPSDT service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. Federal law (42 CFR § 441.50 et seq) requires a broad range of outreach, coordination, and health services under EPSDT distinct from general state Medicaid program requirements. EPSDT is geared to the early assessment of children’s health care needs through periodic screenings. The goal of EPSDT is to assure that health problems are diagnosed and treated as early as possible, before the problem becomes complex and treatment more costly. Examination and treatment services are provided at no cost to the individual.

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Any treatment service which is not otherwise covered under the State's Plan for Medical Assistance can be covered for a child through EPSDT as long as the service is allowable under the Social Security Act Section 1905(a) and the service is determined by DMAS or a DMAS-contracted managed care organization as medically necessary. Therefore, services may be approved for persons under the age of 21 enrolled in Medicaid, FAMIS Plus and FAMIS Fee For Service (FFS) if the service/item is physician ordered and is medically necessary to correct, ameliorate (make better) or maintain the individual's condition. (Title XIX Sec. 1905*.[42 U.S.C. 1396d]* (r)(5)).

All Medicaid and FAMIS Plus services that are currently service authorized by the Srv Auth contractor are services that can potentially be accessed by children under the age of 21. However, in addition to the traditional review, children who are initially denied services under Medicaid and FAMIS Plus require a secondary review due to the EPSDT provision. Some of these services will be approved under the already established criteria for that specific item/service and will not require a separate review under EPSDT; some service requests may be denied using specific item/service criteria and need to be reviewed under EPSDT; and some will need to be referred to DMAS. Specific information regarding the methods of submission may be found at the contractor's website, http://DMASKEPRO.com. Click on Virginia Medicaid. They may also be reached by phone at 888-827-2884 or 804-622-8900.

EPSDT is not a specific Medicaid program. EPSDT is distinguished only by the scope of treatment services available to children who are under the age of 21. Because EPSDT criteria (service/item is physician ordered and is medically necessary to correct, ameliorate "make better" or maintain the individual's condition) must be applied to each service that is available to EPSDT eligible children, EPSDT criteria must be applied to all service authorization reviews of service authorized Medicaid services. Service requests that are part of a community based waiver are the sole exception to this policy. Waivers are exempt from EPSDT criteria because the federal approval for waivers is strictly defined by the state. The waiver program is defined outside the parameters of EPSDT according to regulations for each specific waiver. However, waiver individuals may access EPSDT treatment services when the treatment service is not available as part of the waiver for which they are currently enrolled.

Examples of EPSDT Review Process:

- The following is an example of the type of request that is reviewed using EPSDT criteria: A durable medical equipment (DME) provider may request coverage for a wheelchair for a child who is 13 who has a diagnosis of cerebral palsy. When the child was 10, the child received a wheelchair purchased by DMAS. DME policy indicates that DMAS only purchases wheelchairs every 5 years. This child's spasticity has increased and he requires several different adaptations that cannot be attached to his current wheelchair. The contractor would not approve this request under DME medical necessity criteria due to the limit of one chair every 5 years. However, this should be approved under EPSDT because the wheelchair does ameliorate his medical condition and allows him to be transported safely.

- Another example using mental health services would be as follows: A child has been routinely hitting her siblings; the child has received 20 individualized counseling sessions and 6 family therapy sessions to address this behavior. Because the behavior has decreased, but new problematic behaviors have developed such as nighttime elopement and other dangerous physical activity, more therapy was requested for the child. The service limit was met for this service. But because there is clinical evidence from the therapy providers to continue treatment, the contractor should approve the request because there is clinically appropriate evidence which documents the need to continue therapy in a variation or continuation of the current treatment modalities.

The review process as described is to be applied across all non-waiver Medicaid programs for children. A request cannot be denied as not meeting medical necessity unless it has been submitted for physician review. DMAS or its contractor must implement a process for physician review of all denied cases.

When the service needs of a child are such that current Medicaid programs do not provide the relevant treatment service, then the service request will be sent directly to the DMAS Maternal and Child Health Division for consideration under the EPSDT program. Examples of non-covered services are inclusive of but are not limited to the following services: hearing aids, substance abuse treatment, non-waiver personal care, assistive technology, and nursing. All service requests must be a service that is listed in (Title XIX Sec. 1905.*[42 U.S.C. 1396d]* (r)(5)).