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CHAPTER IV
COVERED SERVICES AND LIMITATIONS

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CHAPTER IV COVERED SERVICES AND LIMITATIONS

INTRODUCTION

Home and Community-Based services through the Individual and Family Developmental Disabilities (DD) Waiver described in this chapter are covered under the Virginia Medicaid Program. At the time of the screening by the DD Waiver Screening Team, the individual makes an informed choice between receiving services in an Intermediate Care Facility for Individuals with Individual Disabilities (ICF/IID) or in the community through the DD Waiver. Providers of DD Waiver services must meet the qualifications described in Chapter II, “Provider Participation Requirements.” Services must be provided in accordance with the service criteria defined in this chapter and in conjunction with the current assessment of the individual’s support needs (the Plan of Care - POC) developed with that individual. A provider is reimbursed only for the amount and type of services approved on the POC and service authorized by DMAS or its contractor.

For any DD Waiver service, a qualified Case Manager working with the individual must complete the POC. The POC is the combination of a current assessment of the individual’s needs in all life areas and the DD Waiver Supporting Documentation form (DMAS-457, see form at www.dmas.virginia.gov under search services) that describes the services and supports needed to address these needs. The supporting documentation developed by individual service providers (including Case Management) describes the manner in which their services will meet the individual’s needs and are incorporated into the POC. The individual and the service providers and individual or guardian must participate in the development of the POC. The providers must submit copies of the supporting documentation at least semi-annually to the Case Manager for review and retention in the individual’s Case Management file. Supporting documentation is referenced throughout this chapter. Please see the forms on the DMAS website (www.dmas.virginia.gov under search services) to determine specific supporting documentation requirements for each service.

For (ICF-IID) facilities covered by §1616(e) of the Social Security Act in which Respite Care as a Home- and Community-Based Waiver service will be provided, the facilities shall be in compliance with applicable standards and requirements for board and care facilities. Health and safety standards shall be monitored through the Department of Behavioral Health and Developmental Services (DBHDS) licensure standards or through Department of Social Services (DSS)-approved standards for Adult Foster Care providers.

COVERED SERVICES

The DD Waiver offers the following services:

- In-home Residential Supports
- Day support
- Prevocational Services

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- Supported Employment
- Personal Care (agency and consumer directed)
- Respite (agency and consumer directed)
- Companion Services (agency and consumer directed)
- Assistive Technology
- Environmental Modifications
- Skilled Nursing Services
- Therapeutic Consultation
- Crisis Stabilization
- Personal Emergency Response System (PERS)
- Family Caregiver Training
- Transition Services

PERSON CENTERED PLANNING

DD Waiver uses “person-centered planning,” which is a variety of approaches or tools to organize and guide life planning with individuals with related conditions, their families, and friends. It is rooted in what is important to and for the individual while taking into consideration all other factors that affect his or her life, including effects of the related condition and issues of health and safety. Focusing on the person in person-centered planning ensures that the service planning team moves beyond program planning for the individual and looks at the whole picture (strengths, capacities, preferences, needs, desired outcomes) of the individual's life. By using person centered planning the team is able to listen, learn and lend support to the individual and family.

TEAM APPROACH FOR COORDINATION OF SERVICES

For individuals receiving DD Waiver services, it is recommended that the team approach involving self-determination is utilized. A team approach involving the individual receiving services helps to ensure the individual's satisfaction with services, health, and safety, and will increase the likelihood that services are coordinated, organized, unduplicated, and are provided without breaks in services. Ultimately, the team approach person centered planning will result in optimal service delivery.

The team approach and person centered planning uses a group of people chosen by the individual (i.e., team members) who work collaboratively with the individual and/or guardian to develop and implement the POC. Teams consist of the individual, the Case Manager, and any provider or direct service staff who are able to serve as important contributors. It also may include any family member, legal guardian, significant other, authorized representative, or friend whom the individual wishes to involve in the planning process. No team member, with the exception of the individual or legal guardian, possesses any more authority than the other. All team members work on behalf of the waiver individual.

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The team approach is the basis for decision-making. The individual or Case Manager, as well as any other team member, may request a team meeting at any time during the plan year. Modifications should not be made to the individual's goals, objectives, activities, or service location without previous communication to the Case Manager and agreement by the team. This can be done via telephone calls or in a team meeting. The team approach allows all providers, the case manager and the individual to discuss issues, behaviors, and suggestions that allow an interdisciplinary approach.

Critical to this team approach is the role the Case Manager plays in effective team communication, coordination, and monitoring of all of the individual's services. The Case Manager serves as the team facilitator and is responsible for the development of the POC. The Case Manager is responsible for ensuring that all team members have had input into the final POC. During team meetings, the individual's needs and preferences are identified and discussed. Through team consensus, the individual's goals and objectives are selected. Each provider documents these goals and objectives in supporting documentation. Once the POC and all supporting documentation have been developed, it is the Case Manager's responsibility to monitor implementation of the POC. Merely sending the signature sheet for the individual or family to sign is not considered part of the team approach or person centered planning. Service quality and individual satisfaction are a shared responsibility and are accomplished through effective and consistent communication between the Case Manager, service providers, and other team members.

TRANSPORTATION FOR INDIVIDUALS RECEIVING DD WAIVER SERVICES

The Department of Medical Assistance Services (DMAS) has contracted with a transportation broker for Transportation services to and from Medicaid-covered services. Because DD Waiver services are covered Medicaid services, this transportation may be used for individuals needing to travel to and from DD Waiver services, Supported Employment sites, and Day Support sites. The following are guidelines for what types of transportation services are to be provided by the broker. The transportation broker has a copy of these guidelines:

Payment will be made for transportation from the individual's place of residence or other designated location, such as school, to the enrolled DD Waiver provider and back to the residence or other designated location.

Payment will be made for transportation to a respite location of an enrolled DD Waiver provider and back to the residence or other designated location.

Exclusions

1. The broker will not arrange or pay service providers for transportation for community integration activities. For transportation purposes, community

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integration trips and field trips are those trips made during the day after the individual has arrived at the center-based provider or after arrival at the first non-center-based activity and before the last non-center based activity. The broker will arrange trips from the center based provider or the last non-center based activity to the individual's residence. Individuals receiving non-center based services can have Medicaid transportation to the first, or only, activity planned for that day, and transportation from the last, or only, activity that day back home.

2. The transportation broker will not request the POC or supporting documentation. The transportation broker may request a Broker Authorization Form to verify weekly schedules (i.e., which days are authorized for DD Waiver services).

The transportation broker will arrange and pay for transportation to and from medical providers for all Medicaid-covered services.

DOCUMENTATION REQUIRED FOR ALL CASE MANAGEMENT AND DD WAIVER SERVICE PROVIDERS

The Provider Agreement requires that the records fully disclose the extent of services provided to individuals receiving Medicaid services. Records must be made available to authorized state and federal personnel in the form and manner requested. Records must clearly document the clinical medical necessity for the service or supports needed, type, schedule, and amount of services to be provided, and actual services rendered.

Specific documentation required for each DD Waiver service is described within this chapter. In addition, Medicaid policy regarding the documentation requirements for any service provider requires the following:

- The individual must be referenced on each page of the record by full name or Medicaid number;
- Documentation must be legible and clear;
- Signatures are required for all documentation or entries and must include, at a minimum, the first initial and last name;
- Errors must be corrected by drawing a line through the incorrect information, adding the correct information, and including the date of the revisions as well as the initials of the person making the revisions. Correction fluid or other methods of obliterating the previous documentation shall not be used;
- The record must contain all the assessment information used to develop the POC and supporting documentation;
- Supporting documentation must contain allowable activities, as specified throughout this chapter, for the service being billed. Reimbursement will only be made for allowable activities;

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- The POC and any revisions to it must be part of the record and reflect the assessment information. All changes in the POC require supporting documentation;
- All DMAS correspondence, including any information relevant to approvals or denials of services, must be in the Case Management file and available at the applicable provider offices;
- The enrolled provider must develop and maintain written documentation for each service billed. Adequate documentation is essential for audits of billed services. The documentation must include, at a minimum, the Medicaid ID number or name of the person receiving services, the type of service rendered, the date and time (when applicable) the service was rendered, the setting in which the service was rendered, the amount of time required to deliver the service, and the signature of the person who rendered the service;
- Progress notes or data collection are also part of the minimum documentation requirements for any agency-directed (AD) service billed and are to convey the individual's status and response to various setting and supports as appropriate as well as progress toward goals and objectives in the POC. If weekly or monthly progress notes are used instead of daily notes, they must clearly reflect the date of entry and the dates of service (e.g., "3/10/00 – For the week of 3/6/00 – 3/10/00: This week in Day Support, Jane...");
- Any drugs prescribed as a part of the individual's treatment, including the quantities, dosage, side effects, and reason for use, must be entered in the DMAS-enrolled provider's record;
- A copy of most recent Long-Term Care Communication Form (DMAS-225) and any updates issued by the local DSS office;
- Written documentation verifying the qualifications of the provider and staff providing the services must be maintained and available for review;
- Written evidence that information regarding the individual must be shared to ensure that services are of high quality, communication flows between service providers and Case Managers, and the individual benefits from services provided to him/her; and
- A signed release from the individual and legal guardian to allow for the sharing of information between provider entities.

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FORMS

All forms referenced in this chapter are located on the Department of Medical Assistance Services (DMAS) website at www.dmas.virginia.gov under “Search Services”.

ELIGIBILITY FOR DD WAIVER SERVICES

Diagnostic Eligibility

In order for an individual six years of age or older to meet diagnostic eligibility for DD Waiver services, the individual must meet ICF-IID level-of-care criteria and have an evaluation completed by a professional licensed to conduct evaluations that states the individual meets the related conditions definition as defined in 42 CFR §435.1009 and does not have a diagnosis of intellectual disabilities as defined by the American Association on Intellectual and Developmental Disabilities (AAIDD) as contained in 12 VAC 30-120-720. This evaluation must be maintained in the individual’s Case Management record, and must meet the level of functioning (LOF) as evidenced by the completion of the LOF by DMAS or the DMAS.

The evaluation must address intellectual functioning, adaptive behavior, and the age at which the diagnosis was made. The evaluation must also be filed in the Case Management record and must reflect the individual’s current LOF. The evaluation must be filed in the Case Management record.

Functional Eligibility

In order to meet functional eligibility for DD Waiver services, all individuals receiving DD Waiver services must meet the ICF-IID level-of-care criteria. This is established by meeting the indicated dependency level in two or more of the categories on the LOF Survey (DMAS-458). (See form at www.dmas.virginia.gov under the search services) The Case Management record must contain the initial LOF that was completed prior to the start date of any Waiver services, and required annual LOF revisions. Individuals identified by the Case Manager, who no longer meet the level-of-functioning criteria for Home and Community-Based Waiver services, must be referred by the Case Manager to DMAS for review.

DD Waiver services must be determined to be an appropriate alternative to avoid placement in an ICF/IID, or to promote exiting from either an ICF/IID placement or other institutional placement. Generally, individuals must be able to leave the home in order to receive training and/or assistance and be deemed appropriate for ICF/IID placement and therefore, the DD Waiver. Individuals who are too medically fragile may be eligible for another Medicaid waiver.

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Financial Eligibility

It is the responsibility of the Department of Social Services or the Department of Family Services (DSS/DFS) office to determine an individual's financial eligibility and patient pay responsibilities for Medicaid. Medicaid policies for individuals who receive Home- and Community-Based services allow a different method of determining income and resource eligibility. Some individuals not otherwise eligible for Medicaid may become eligible for enrollment into the DD Waiver and receive waiver services as well as all other Medicaid-covered services when deemed medically necessary.

Additionally, some of these individuals may also have a patient pay responsibility. For all individuals applying for DD Waiver services, DSS/DFS must receive a Long-Term Care Communication form (DMAS-225 from the Case Manager in order to make these determinations (see the "Authorization of DD Waiver Services" section later in this chapter for Case Manager responsibilities). Eligibility requirements, patient pay determination, and additional responsibilities are described in more detail in this chapter and in Chapters III and V of this manual.

APPLICATION FOR DD WAIVER SERVICES

Individuals or legal guardians may initiate the DD Waiver screening process by downloading a Request for Screening form (DMAS-305) from www.dmas.virginia.gov under search services. Families will complete and send the screening request to the appropriate Child Development Center (CDC) or Virginia Department of Health (VDH) Screening Team (according to the individual's residence

Enrollment in the waiver is dependent upon the number of approved and available slots in the waiver. If there are insufficient slots, eligible individuals are placed on a statewide waiting list and selected for services in the order in which they originally applied (except as noted in the policy related to emergency enrollment as described later in this chapter). To establish a date of application for the DD Waiver, the Child Development Clinic receives and notes the date of the individual's request for screening for DD Waiver services. The Screening Team will initiate a screening with the individual and proceed with determining need, functional eligibility, and diagnostic eligibility for DD Waiver services.

The Screening Team:

1. Meets with the individual (and family caregiver, as applicable), in a timely manner following the individual's request for DD Waiver services;
2. Obtains the individual's (or guardian's, if applicable) consent and signature(s) on a Consent Form in order to gather information from other sources and communicate to DMAS (for a sample, see the "Exhibits" section at the end of this chapter);

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3. Confirms diagnostic and functional eligibility by obtaining or completing the following:
 - The required psychological evaluation or medical documentation, is needed to determine the individual's related condition; and
 - An ICF-IID Level of Functioning (LOF) Survey; and
 - The DD Screening Team together with the individual shall gather relevant medical and social data and identify all services received by and supports available to the individual. The IFDDS Screening Team shall also gather a psychological evaluation or refer the individual to a private or publicly funded psychologist for evaluation of cognitive abilities.

Children under six years of age are not screened until three months prior to the month of their sixth birthday. Children under six years of age may not be added to the wait list until the month of their sixth birthday. For children to transfer to the DD Waiver at age six, the Case Manager shall submit to DMAS the child's most recent LOF form, the POC, and a psychological examination completed no more than 12 months prior to the child's sixth birthday if they are receiving ID Waiver services. Documentation must demonstrate no diagnosis of intellectual disability exists in order for this transfer to the DD Waiver. The psychological evaluation and the screening packet must be forwarded to the Case Manager.

When the individual meets functional and diagnostic criteria for the DD waiver, the CDC or VDH will provide written notification and assure the individual is provided their choice of DD waiver case manager. The Screening Team determines if an individual meets all of the waiver criteria within 45 days of receiving the request for screening and provides the individual with a list of case management providers from which to choose. The individual must choose a Case Manager within 10 calendar days from the date of screening. The Screening Team forwards the screening and forms to the appropriate Case Manager within 10 calendar days of selection of the Case Manager. The Screening Team will explain the Case Manager's role if the individual is placed on the DD waiver wait list

Once the individual is determined to be functionally and diagnostically eligible for the DD Waiver, the Screening Team informs the individual (or family caregiver, as applicable) of the individual's eligibility pending DSS eligibility determination for DD Waiver services and documents the individual's choice of waiver or institutional care by obtaining signatures on the "Documentation of Individual Choice between Institutional Care or Home and Community-Based Services form (DMAS-459)

When the CDC determines that the individual is not eligible based on waiver criteria, the screening team must inform the individual in writing. The

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screening team will forward to the individual the required information of the right to appeal to DMAS.

PLACEMENT ON THE DD WAIVER WAIT LIST

Once the Case Manager has received notice of being selected and receipt of screening materials, they shall contact the individual within 10 days. The Case Manager will arrange to meet face-to-face with the individual within 30 calendar days to assess the individual's situation, complete the Social Assessment, and develop the initial POC if no slots are available. The Case Manager may bill DMAS for one month to set up the POC (DMAS-456). (See form at www.dmas.virginia.gov under search services). The POC will identify services needed and will estimate the annual waiver cost for the individual. If the individual's annual waiver cost is expected to exceed the average annual cost of ICF-IID care, the individual will work with a DMAS Health Care Coordinator for case management. Once the plan of care (DMAS-456) and supporting documentation (DMAS-457) is received and reviewed by DMAS the individual will be placed on the DD waiver wait list.

When a case manager is not able to accept screening materials due to the size of his case load, or provide the required case management services, regardless of the reason, it is the case manager's responsibility to contact DMAS and the CDC immediately upon receipt of that first referral and return the screening packet to the CDC or assist with transfer to a new case manager. The case manager is responsible for contacting the CDC and DMAS when the ability to accept screening referrals resumes.

The completed and signed POC, along with the necessary supporting documentation, must be submitted to DMAS by the Case Manager. Information, from the Case Management provider to enroll an individual in DD Waiver services, must be submitted to:

Mail:

Department of Medical Assistance Services
Division of Long-Term Care
DD Waiver
600 East Broad Street, 10th Floor
Richmond, Virginia 23219

Fax: 804-452-5468

The Case Management provider shall maintain documentation of the submission of materials to DMAS for future reference, if necessary.

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If all eligibility criteria are met and the individual selects the DD Waiver instead of ICF-IID placement:

1. The Case Manager submits to DMAS the DD Waiver POC, including supporting documentation (DMAS-457), for each service listed in the POC and social assessments..
2. DMAS has 14 calendar days to review and approve or deny the POC. If the individual's POC is approved, DMAS will notify the individual in writing, with a copy to the Case Manager:
3. If the Case Manager is notified that additional information is needed by DMAS, the Case Manager must submit the requested information to continue the wait list process. When all required information is received, the individual will be placed on the DD Waiver wait list.
4. If DMAS approves the POC and there are no available slots for that individual, the individual will be placed on the waiting list. DMAS will notify the individual in writing of his/her placement on the waiting list and will copy the Case Manager. If an individual is on Medicaid and eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), the Case Manager should arrange for service eligibility determination under EPSDT. If the individual is on the waiting list and is eligible for and receiving Medicaid, DMAS will pay Case Managers to provide Targeted Case Management services to individuals who have a special service need while they are on the waiting list. Payment cannot be made for Case Management for individuals on the wait list who are not eligible for and receiving Medicaid or who do not have a documented special service need.
5. If the POC is denied, the Case Manager must notify the individual, in writing, of the denial and include appeal rights in the written notification.

When all eligibility criteria are met and the individual selects ICF-IID placement, the CDC will submit the complete screening packet to DMAS.

If the individual selects ICF-IID placement, the Case Manager will contact DMAS and will assist the individual with this option. Individuals may be placed on the DD Waiver waiting list while receiving services in an ICF-IID. In addition, if the individual chooses ICF-IID placement and is placed on a waiting list for an ICF-IID, he/she may be placed on the DD Waiver waiting list at the same time.

Transitioning Six-Year-Old Children from the ID Waiver to the DD Waiver

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- Annually, each Intellectual Disability (ID) Case Manager will identify children receiving the ID Waiver who will be six years of age the following year. If the Case Manager notifies DBHDS that a psychological evaluation, completed no earlier than twelve months prior to the individual's sixth birthday, indicates that the child does not have intellectual disability, DBHDS will simultaneously notify DMAS of the child's potential need to transfer to the DD Waiver. The Case Manager will submit the current LOF, POC, and psychological evaluation to DMAS for review.
- If DMAS determines that:
 - a. The child does not meet DD Waiver eligibility requirements, DMAS will notify the family, the Case Manager, and DBHDS and provide appeal rights to the individual. The child may continue in the ID Waiver if he/she remains eligible. If not, the ID Waiver Case Manager notifies the family of pending termination from the ID Waiver and offers appeal rights regarding termination of those services as well.
 - b. If the child meets DD Waiver eligibility requirements, DMAS will notify the Case Manager, the family and individual, and DBHDS in writing. The ID Waiver slot will be held by the CSB until the child has successfully transitioned. The Case Manager will plan with the child and his/her family the transition to the DD Waiver and will provide the family with a list of DD Waiver Case Managers. If desired by the family, the Case Manager will notify the current ID Waiver providers at this time and discuss their interest in and ability to continue to provide services under the DD Waiver.
- Once the family selects a DD Waiver Case Manager, the ID Waiver Case Manager will submit a copy of the child's current LOF, psychological evaluation, and POC to the DD Waiver Case Manager within 10 business days. The DD Waiver Case Manager will notify the ID Waiver Case Manager of the proposed effective date of the child's DD Waiver POC. The two Case Managers will be responsible for ensuring a seamless transition from one waiver to another for the child. If it appears that the child's MR Waiver service providers will not continue to provide services once he/she is enrolled in the DD Waiver, the child should not be transitioned into the DD Waiver until a DD Waiver service provider can be located. (Both Case Managers will be reimbursed for no more than one month of overlapping services.)
- When the services are in place to allow the transition from the ID to the DD Waiver, DMAS will terminate the child from the ID Waiver and enroll him/her in the DD Waiver. DMAS will inform DBHDS as well as the ID and DD Waiver Case Managers when the child is fully enrolled in the DD Waiver.
- The ID Waiver Case Manager will submit a revised DMAS-225 form to the local DSS/DFS office, DBHDS, and DMAS ending ID Waiver services and

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issue appeal rights at least 10 days prior to the action. Once the time frame for filing an appeal has passed, the child's ID Waiver slot will become available for reassignment.

AUTHORIZATION OF DD WAIVER SERVICES

Except for emergency slots, if DMAS does not have the available slots for an individual, DMAS will notify the individual, and the individual will be placed on the waiting list until such time as additional Center for Medicare and Medicaid (CMS) approved and funded slots are available.

When the Case Manager receives written notification from DMAS that the individual will be enrolled in the DD Waiver, the Case Manager will contact the individual, send the DMAS-225 and the DD Waiver Level of Care Eligibility forms to the local DSS/DFS office, and initiate DD Waiver services within 60 calendar days of Medicaid authorization.

If waiver services listed in the POC are not initiated within 60 days, the Case Manager must submit information to DMAS demonstrating why more time is needed to initiate services. DMAS has the authority to approve or deny the request in 30-day extensions. Final recommendation for authorization of DD Waiver services is the responsibility of DMAS upon recommendation from the Case Management provider and review of the documentation materials. DMAS must receive the Request for Extension letter within the 30-day extension period being requested.

The Case Manager:

1. Completes the Social Assessment (described later in this chapter) no more than one (1) year prior to the start of services and reviews with the individual (and family or guardian, if applicable) all the assessments and information gathered, including, but not limited to, the LOF and appropriate evaluation
2. Determines that the assessment reflects the individual's current status and ensures that the Case Management file contains a copy of this document.
3. Updates any of these documents to comply with timeline requirements. Assists the individual in developing personal goals and desired outcomes of services. Obtains input from the individual, family, or guardian, and other interested parties at the individual's request;
4. Re-evaluates and agrees upon the preferred services for providing appropriate supports to the individual. Identifies and shares with the individual (and family or guardian, if applicable) all available service providers. Arranges for visits or interviews with the providers as desired;
5. Confirms that any interested providers has been enrolled with DMAS as a DD Waiver provider of the specific service under consideration. A provider must

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have a current DMAS Participation Agreement that lists all services for which the provider is eligible to provide and bill (see Chapter II for details);

6. Documents in writing and maintains in the Case Management file the individual's choice of DD Waiver providers. This documentation indicates the specific choice(s) made by the individual or legal guardian. This includes separate choice of Case Manager and Service Facilitator if the Case Manager provides both services;
7. Coordinates a meeting with the individual, anyone of the individual's choice, and service providers to complete the POC, which includes the Social Assessment, primary goals or desired outcomes, documentation of agreement, POCs, and start dates of services (see additional details in the "Case Management Services" section in this chapter);
8. Notifies individuals on the wait list and those enrolled in the waiver and their families of any available EPSDT options and assists the individual with obtaining these options;
9. Works with the individual's school system, as applicable, to ensure coordination of services in the home, community, and the school. Case Managers can accomplish this by documenting the coordination efforts in the POC, in their progress notes, and by attending Individual Education Plan meetings with the individual and the family/caregiver;
10. Reviews the supporting documentation submitted by the providers to confirm that they:
 - Designate supports based upon input from the individual and as noted in the assessment information and agreed to by the team;
 - Include supports that are specific measurable and person centered;
 - Include a schedule of when the provider will offer these supports and services;
 - Include activities that are allowable for Medicaid (service providers must maintain responsibility for assuring all services meet Medicaid requirements);
 - Indicate the total weekly hours or units;
 - Indicate the correct start date; and
 - State the semi-annual review due dates, which correspond to the Case Management review dates (POC dates).

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The Case Manager shall develop the POC, implementing a person-centered planning process with the individual, the individual's family/caregiver, other service providers, and other interested parties identified by the individual and/or family/caregiver, based on relevant, current assessment data. The POC development process determines the services to be provided for individuals, the frequency of services, the type of service provided, and a description of the services offered. All POCs written by the Case Manager must be approved by DMAS prior to seeking authorization for services through the service authorization (Serv Auth) contractor.

For any DD Waiver service provider to begin services, to modify the amount or type of services, or to end services, the DMAS-457 form and the POC must be signed by the individual or family/caregiver, as applicable and submitted to DMAS for review. The Case Manager must also submit the IFDDS Waiver Community Based Care Request for Services Form (DMAS-98) to Serv Auth contractor for final authorization of services. The supporting documentation must clearly describe the reason for the action and include the dated signature of the Case Manager.

The Case Manager will submit to the Serv Auth contractor supporting documentation for waiver services requiring service authorization and for which start dates have been determined. Additional documentation for enrolled individuals may be submitted at later dates as needed and described in the following sections.

11. Once a service provider is secured, the Case Manager will submit a service authorization request to the Serv Auth contractor with the required supporting documentation for waiver services requiring serv auth and for which start dates have been determined. See Appendix D for additional information. Additional documentation for enrolled individuals may be submitted at later dates as needed and described in the following sections

Patient Pay Requirements

For individuals receiving Medicaid long-term care (LTC) services, patient pay is the amount of the individuals' income that must be contributed to the cost of their care. If the individual receiving DD Waiver services has a patient pay obligation, a provider shall use the web-based Automated Response System (ARS) or telephone-based MediCall to verify the amount of the individual's patient pay obligation.

Long-term care (LTC) providers, including case managers, must monitor the ARS/MediCall systems each month for Medicaid LTC individuals in order to determine

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the appropriate amount of patient pay to collect. LTC providers are responsible for collecting the patient pay amount and reducing the claim for Medicaid payment of LTC services by that amount. These verification systems allow the provider to access information regarding Medicaid eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification.

The website to access this system is www.virginiamedicaid.dmas.virginia.gov. 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.

For DD Waiver individuals, when more than one provider furnishes services to an individual, 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 LTC provider, case manager, or service facilitator 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 the individual's eligibility status.

It is the responsibility of the case manager and LTC provider to review the DSS-completed DMAS-225 and to monitor the ARS/MediCall systems for financial eligibility and patient pay obligations. For individuals who have a patient pay obligation, the case manager must identify the provider with the highest potential billing amount and inform the provider that they must collect the patient pay amount. The case manager must maintain a copy of the DMAS-225 in the individual's case management file. The Xerox generated Notice of Approval of Pre-Authorized Services serves as the provider's authorization to bill for DD waiver services.

MEDICAID LTC COMMUNICATION DOCUMENT (DMAS-225)

For communication of information other than patient pay, the Medicaid LTC Communication Form (DMAS-225) will be used by the LTC provider, including the case manager, to report changes in an individual's situation. This form is available on the DMAS website www.dmas.virginia.gov under search services and is used to provide information such as a new address, a different case management agency, interruption in DD Waiver services for 30 calendar days or more, change in health insurance or other third party liability (TPL), discharge from all DD Waiver services, or death. The case manager must forward the DMAS-225, with the top half completed, to notify DSS as

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soon as possible when such changes occur. The exact change in circumstances and reason for the change must be clearly noted on the DMAS-225. The case manager should document communications with DSS regarding changes and receipt of the DMAS-225.

The DMAS-225 with the top portion completed is sent to the LDSS indicating the individual has met the level of care requirements. Following verification that the individual has been screened and approved to receive DD Waiver services, the eligibility worker will determine the individual's Medicaid eligibility, complete the DSS portion of the DMAS-225 and return it to the case manager 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 DMAS-225 is sent by the LDSS when an individual is a new enrollee and when there are changes in the eligibility status. The case manager or provider must monitor the ARS/MediCall systems for financial eligibility and patient pay obligations.

ANNUAL RENEWALS

DD Waiver services must be re-authorized by DMAS at the annual renewal of the POC. A renewal plan, provider supporting documentation and social assessment is required for annual renewals. Individual supporting documentation from the providers must be submitted to the case manager prior to the end date of the previous supporting documentation expiring, even if there are no changes in the services.

Modifications to Services During the Plan of Care (POC) Year

To change the amount or type of service previously authorized, a signed, updated POC with new supporting documentation and a Community Based Care Request for Services Form (DMAS-98) must be submitted to Serv Auth Contractor for final authorization. Revised supporting documentation may not be needed by DMAS for changes in services during the POC year, but must be updated and maintained in the Case Management file. DMAS can request information as needed if a new or revised service authorization is requested.

Multiple Providers

If the individual will be receiving the same service from more than one provider, the Case Manager should clearly describe the circumstances to DMAS on the DMAS- 98 form and POC during enrollment or at annual renewals. If changes occur during the POC year when submission of the POC is not required, the circumstances should be clearly

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described on the supporting documentation. DMAS can request information as needed if a new or revised service authorization for services is requested or required.

Changing Providers/Case Managers

To change a provider for an approved service, the Case Manager must submit to the SA contractor a DMAS-98 form requesting a transfer. Revised supporting documentation is not needed by the Serv Auth contractor for changes in providers during the POC year, but must be updated and maintained in the Case Management file. The Serv Auth Contractor, however, can request information as needed if a new or revised service authorization is requested.

If an individual decides to change Case Management providers, the individual must notify the current Case Manager in writing and provide consent for the Case Manager to exchange information. The current Case Manager must make a complete copy of the individual's file to keep for their records and forward the original file to the new Case Manager within 30 days of notification that the individual is switching Case Managers. If possible, Case Management providers should transfer individuals at the end of a month (with the new Case Manager going into effect at the beginning of the following month) in order to avoid billing problems. The old Case Manager must also submit a revised DMAS-225 form to notify the local DSS/DFS office of the change in Case Managers. The old case manager closes the service authorization as the submitting provider of services informing the new case manager of the last date of service. The new case manager will open the service authorization immediately as the submitting provider of services. DMAS staff will work with the current and new Case Managers to ensure a smooth transition for the individual.

INTERRUPTION OF SERVICES

No DD Waiver services for more than 30 calendar days constitutes an interruption of services.

When all waiver services are interrupted on a temporary basis such as a temporary loss of financial eligibility, admission to an acute care hospital, rehabilitation hospital, Nursing Facility and or ICF- IID, the individual's current situation presents a health and safety risk and DD waiver services are not utilized beyond 30 days, the case manager must:

- Notify the LDSS /DFS via the DMAS 225 form;
- Submit to DMAS an interruption POC and the DMAS 457 with supporting documentation which includes and is not limited to the reason for the interruption and the expected length of time for the interruption. The interruption POC must be submitted in the same month that the interruption occurs.

Upon completion of the review, DMAS will notify the case manager. Voluntary interruptions such as vacations are not an allowable interruption of services and are excluded as a reason for an interruption plan.

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Individual Enters an Institutional Setting:

When the individual enters an institutional setting (nursing home, rehabilitation facility, long-stay hospital, or ICF/IID), he/she must be terminated from the DD Waiver. The Case Manager must immediately notify the local DSS eligibility worker by phone and forward a DMAS-225 form to DSS and DMAS with an explanation of the reason for the interruption or termination.

Resuming Services from an Institutional Setting:

When the individual returns to the community and DD waiver services, waiver re-enrollment is not necessary as long as services are resumed within 90 days of the facility/hospital discharge date. The case manager must:

- Notify the LDSS/DFS via the DMAS 225 with the new start of care date;
- Submit a revision plan of care to DMAS when a change in services is needed and
- Submit a new DMAS 98 Form to the Serv Auth Contractor for approval to resume waiver services.

When waiver services are not initiated within 90 days of the discharge from facility/hospital, the withdrawal from waiver process will be initiated by DMAS and waiver termination will occur.

Termination of All DD Waiver Services

When an individual stops receiving all DD Waiver services, the Case Manager must complete the DMAS-225 form and send it to the local DSS office and DMAS. It must clearly note the reason why services were discontinued. Supporting documentation terminating individual services are not needed when the individual will no longer receive any DD Waiver service. DMAS will use the DMAS-225 form as documentation to end any existing DD Waiver prior authorizations for services. The Case Manager is responsible for notifying DMAS why all services have ended. If it is because the individual is un-enrolling from the waiver, DMAS will send the individual a letter confirming the disenrollment and will provide appeal rights

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SERVICE AUTHORIZATION (SERV AUTH) PROCESS

All DD Waiver services identified on the POC and approved by the team require service authorization by the Serv Auth contractor. The requested start date for services back to the date that the Serv Auth contractor receives the DMAS-98 form may be approved. To ensure the provider that the individual is enrolled in the DD Waiver and that services are authorized as requested, it is recommended that the required documents be submitted at least 10 to 30 working days prior to the requested start of services. All authorization requests generally will be acted upon within 5 business days following receipt by the Serv Auth contractor. The Serv Auth contractor will review the documentation to determine DD Waiver eligibility and appropriateness of services, and approve, deny, or pend requests until receipt of additional information.

For detailed information regarding service authorization of services for the DD Waiver, please refer to Appendix D of this Manual.

EMERGENCY CRITERIA

Individuals must meet Medicaid financial eligibility criteria as well as functional and diagnostic requirements in order to be eligible for Medicaid Waiver services. Except in emergency situations, individuals will be eligible for Medicaid Waiver services on a “first come, first served” basis. Individuals must meet at least one of the emergency criteria to be eligible for immediate access to waiver services without consideration to the length of time an individual has been waiting to receive services. In the absence of waiver services, the individual would not be able to remain in his/her home. All emergency cases are reviewed on an individual and statewide basis in consultation with the Case Manager.

The emergency criteria are:

- The primary caregiver has a serious illness, has been hospitalized, or has died; or
- The individual has been determined by DSS to have been abused or neglected and is in need of immediate waiver services; or
- The individual has behaviors which present risk to personal or public safety; or
- The individual presents an extreme physical, emotional, or financial burden at home, and the family or caregiver is unable to continue to provide care; or

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- The individual lives in an institutional setting and has a viable discharge plan in place.

The “DD Waiver Request for Emergency Consideration” form (DMAS-453a) must be submitted to DMAS in order for individuals to be considered for an emergency slot regardless of their place on the DD Waiver wait list. Individuals must meet at least one of the emergency criteria in Section II of the form to be considered an emergency. DMAS may request additional information describing the emergency.

Once the emergency slots are exhausted, no additional individuals will be admitted to the DD Waiver under the emergency criteria until additional emergency slots become available. A separate wait list will not be maintained for individuals meeting emergency criteria.

DD WAIVER EMERGENCY SLOT ALLOCATION PROCESS

Anytime an emergency slot is available, DMAS staff will follow the Emergency Slot Allocation procedure outlined below:

1. The Case Managers are notified when an emergency slot is available and are asked to review individuals on their caseload for emergency consideration. Case Managers are only to submit names of those individuals on their caseloads who meet emergency criteria.
2. The Case Managers are requested to complete the DD Waiver Emergency Request Form for individuals who meet DD Waiver emergency criteria and attach appropriate supporting documentation that supports the need for emergency consideration for DD Waiver services. Examples of documentation include and are not limited to, recent medical and psychological reports and letters from other professionals working with the individual.
3. DMAS staff send a letter and a copy of the DD Waiver Emergency Request form to the individuals who are not eligible for Case Management or who do not currently have an assigned Case Manager. In the letter, DMAS requests that the individual or the individual’s family or authorized representative submit a request for emergency consideration if the individual meets the emergency criteria.
4. Both the Case Managers and the individuals receiving letters of notification of the DD Waiver emergency slot are provided a 30-day time period to submit requests for emergency consideration to DMAS.
5. At the end of the 30-day period, an interdisciplinary team of DMAS professionals review the requests based on the eligibility criteria for emergency access to the DD Waiver and determine who is in most need to receive an emergency slot based on available documentation.

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- DMAS will review the requests within ten (10) business days and will notify individuals who receive an emergency slot.

MONEY FOLLOWS THE PERSON

Money Follows the Person (MFP) Demonstration Project provides individuals living in nursing facilities, intermediate care facilities for persons with intellectual disability and related conditions (ICF- IIDs), and long-stay hospitals with informed choices and options about transitioning into an integrated community setting.

MFP offers transition services for the individuals transitioning from the institution to the community under DD Waiver.

For more information on MFP see the website at <http://www.olmsteadva.com/mfp/> or Appendix E of the DD Waiver manual.

CASE MANAGEMENT SERVICES

Case Management is a State Plan service covered under the Medicaid Program for individuals participating in the DD Waiver and for Medicaid-eligible individuals on the DD Waiver waiting list with a special service need. In order to be placed on the DD Waiver waiting list, individuals must have been screened and determined eligible for the DD waiver. An initial POC must be developed by the Case Manager and individual/family. It is the responsibility of the Case Manager to assure that each individual is eligible and continues to require DD Waiver services.

Service Definition

Case Management services are activities designed to assist an individual in accessing needed medical, psychiatric, social, educational, vocational, residential, and other supports (such as EPSDT services) essential for living in the community and in developing his/her desired lifestyles.

Case Manager Activities

Case Manager activities include and are not limited to:

- Coordinating initial assessment and annual reassessments of the recipient and planning services and supports, to include the development of a POC. This does not include conducting medical or psychiatric assessments, but may include referral for such assessments;

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2. Coordinating services and treatment plans with other agencies, school systems, and providers;
3. Submitting the DMAS-225 form to the local DSS/DFS office to determine Medicaid financial eligibility and patient pay responsibilities for the individual;
4. Linking the individual to services and supports specified in the POC and submitting service authorization of waiver service requests to the Serv Auth contractor prior to the initiation of services and informing individuals and providers when services are authorized. Case Managers are responsible for informing the recipient of the EPSDT program;
5. Assisting the individual directly for the purpose of developing or obtaining needed resources, including crisis supports;
6. Making collateral contacts to promote implementation of the POC;
7. Monitoring implementation of the POC through regular contact with service providers, and periodic site/home visits to ensure the appropriateness of services and recipient satisfaction;
8. Benefits counseling and coordination of individuals enrolled in a Medicaid MCO. The Case Manager will have the responsibility for ensuring a smooth transition of individuals concurrently enrolled in MCOs and the DD Waiver. This also includes individuals who switch to another Case Manager;
9. Instruction and counseling that guides the individual in problem-solving and decision-making and develops a supportive relationship that promotes implementation of the POC; and
10. Monitoring the quality of services provided: and
11. Monitoring health, safety and satisfaction with services

Criteria

Case Management services must be provided by the assigned Case Manager as frequently and timely as the Medicaid-eligible individual requires assistance. There must be at least one documented contact, activity, or communication, as designated above, and relevant to the POC, during any calendar month for which Case Management services are billed. Written plan development, review, other written work, and telephone contacts to the

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individual are not considered a billable Case Management activity. Developing a person centered POC through a team meeting to prepare the Case Management quarterly review is a billable activity.

Eligibility

To be eligible to receive Case Management services, the individual must be participating in the DD Waiver or be an individual in an institutional setting who is discharge ready and has been determined eligible for DD Waiver services by the Screening Team. Individuals who are not Medicaid beneficiaries but who have been determined to be eligible for the DD Waiver may receive one month of Case Management services in order to develop the POC. Case Management services may not duplicate any other Medicaid or Waiver service.

Plan of Care (POC)

A Plan of Care (POC) must be developed with each individual receiving DD Waiver services. The POC organizes and describes the services and supports necessary for meeting an individual's goals and desires for living successfully in the community. A person-centered approach should be utilized to assure that functional supports are identified, and the individual's desired outcomes are known. It is coordinated by the Case Manager, but is a responsibility shared with the individual, legal guardian (if applicable), family members, and service providers. Factors to be considered when developing this plan may include: the individual's age, primary disability, and LOF, physical or mental health, personal safety, behavior issues, relationships and social supports, home and daily living.

The POC includes:

- a) The social assessment or consumer profile;
- b) The primary goals or outcomes of the individual;
- c) Supporting documentation(DMAS-457) for each DD Waiver service received by the individual (including Case Management), which outlines the objectives and activities planned to assist in meeting the individual's goals; and
- d) A documentation of agreement that is signed by those persons participating in the development and implementation of the POC (DMAS-456).

The POC is signed by the individual or legal guardian, with a begin target date and end date on POC. Simply sending, via mail or fax, the signature sheet for the individual or family to sign is not appropriate. The POC is discussed with the individual or family face to face before it is signed. The signature confirms involvement and agreement with the

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services and supports detailed in the POC. The individual or family must agree with the services, goals and objectives discussed at the POC meeting.

In order to assure cost effectiveness of the DD Waiver, the number of slots available for the waiver are allocated between two “budget” levels. The “budget” is the cost of waiver services only and does not include the costs of other Medicaid-covered services. Other Medicaid services, however, must be counted toward the cost effectiveness of the DD Waiver. All services available under the waiver are available to both levels.

Level one is for an individual whose POC will cost less than \$25,000 per fiscal year. Level two is for an individual whose POC will cost equal to or more than \$25,000. There will be no threshold for budget level two; however, if the actual cost of waiver services exceeds the average annual cost of ICF-IID care on the most recent CMS 372 Report, the individual’s supports will be coordinated by a DMAS Health Care Coordinator.

Social Assessment/Individual Profile

A comprehensive assessment process must be completed by the Case Manager to determine the individual’s need for services and supports and the outcomes desired from the services. This involves the gathering by the Case Manager of relevant social, psychological, medical, and level-of-care information and serves as the basis for the development of the POC and supporting documentation forms. The Social Assessment summarizes the assessment information and includes the individual’s strengths, personal preferences and desires, and previous services or supports that may or may not have been successful. It must be updated annually with any changes that have occurred during the POC year. The social assessment summarizes the current status of the individual in the following areas:

- a) Physical or Mental Health, Personal Safety, and Behavior Issues;
- b) Financial, Insurance, Transportation, and other Resources;
- c) Home and Daily Living;
- d) Education and Vocation;
- e) Leisure and Recreation;
- f) Relationships and Social Supports;
- g) Legal Issues and Guardianship; and
- h) Individual Empowerment, Advocacy, and Volunteerism.

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Monitoring of Service Need

The Case Manager must continuously monitor the appropriateness of the individual's POC and make revisions in the POC as indicated. At a minimum, the Case Manager must review the supporting documentation every three months for individuals enrolled in the DD Waiver to determine if service goals and objectives are being met, assess the individual's satisfaction with the services, confirm the status of the individual's health and welfare, and determine if any modifications are needed to the POC. At least once per POC year this review must be performed with the individual and his family/caregiver(s), as appropriate, present in the individual's home.

The Case Manager must meet with the individual face-to-face to develop the POC. When the individual is enrolled in the DD Waiver, a face-to-face contact with the individual is required a minimum of every 90 days. The purpose of the face-to-face contact is for the Case Manager to observe the individual's status, to verify that services are being provided as described in the POC and supporting documentation, to assess the individual's satisfaction with services, and to determine any unmet needs or changes needed to the POC.

A minimum of one contact or communication by the Case Manager per month with the individual or with the family, service providers, or other organizations on behalf of the individual must be provided in order for Case Management services to be billed for that month. This contact or communication must be meaningful, such as monitoring service delivery, as specified in the POC. Examples may include but are not limited to team meetings, face-to-face meetings with providers, investigating a complaint, etc., and must consist of more than a telephone call to check on the status of the individual. The contact may occur anytime during the month.

DMAS staff review the POC every 12 months or more frequently as required to assure proper utilization of services. Any modification to the amount or type of services in the POC must be approved by DMAS. DMAS will complete annual LOF assessments to determine continued eligibility.

For individuals enrolled in the DD Waiver, the Case Management review process is as follows:

1. Case Management quarterly reviews and semi-annual reviews with providers must be documented and must include a review of all DD Waiver Services listed on the POC in addition to Case Management services. Quarterly reviews from the waiver service providers are filed in the Case Management record. The quarterly review schedule for individual providers is based upon the start date of the POC;
2. Excluding Respite services, Assistive Technology, Environmental Modification, PERS, and Crisis Stabilization (which are considered sporadic and temporary services), all service providers must complete a written semi-annual review with the individual and forward it to the Case Manager within the agreed-upon time

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frame. If any sporadic and temporary services were provided during the time frame, the Case Manager must obtain details of the services from the provider and include this information in the Case Management quarterly report;

3. Prior to the end of the 12-month POC period, the Case Manager schedules a face-to-face visit with the individual or family caregiver (or both) and service providers to reassess service needs and develop a new POC, if services are to continue. Case Managers should not present the Signature Page alone to the individual or family to sign if not attached to a fully completed and dated POC. There must be documentation that the POC meeting took place before the family signs the signature page.
4. Every 365 days (or 366 in a leap year), a new POC is required, even if the hours or units remain the same. Supporting documentation and a POC must be approved by DMAS. This annual POC must be completed in time for re-authorization to occur; however, the effective date of the new POC does not need to begin until the previous one expires;
5. If the individual's needs change or there is a request for changes in services, individual providers can make revisions to the goals, objectives, and strategies of the supporting documentation at any time during the POC year.
 - a. If the individual agrees to the changes in collaboration with the Case Manager, the POC is revised and an effective date for the change is stated on the POC. Details of the revision must be documented and discussed at the face-to-face review;
 - b. If the total hours or units (or both) change at any time during the POC year (additional services, increases or decreases in services, etc.), DMAS authorization of the change reflected in the POC is required prior to requesting service authorization through the contractor. The Case Manager must review supporting documentation from the provider, request revisions as needed, and forward it to the PA contractor for authorization within the required time frame;
 - c. A new "Provider Choice" form may be needed along with an updated Social Assessment and an updated Document of Agreement (signature page), confirming the individual's or guardian's (or both) agreement to the changes; and,
 - d. A Case Manager can add a new service (supporting documentation) to an existing POC at any time during the POC year; however, the end date and semi-annual review dates will coincide with the POC year. If adding new services to the POC, the case manager is required to submit a revision POC to DMAS with supporting documentation for approval.

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6. If the change results in a reduction or termination of DD Waiver Services, the Case Manager is required to send the individual a Right to Appeal letter as described below. Termination of services also requires DMAS and DSS/DFS notification;
7. If there are no changes during the POC year in the total hours or units (or both), no new supporting documentation is needed;
8. If there is evidence that 1) the individual, family, or primary caregiver are dissatisfied with services; 2) services are not delivered as described in the POC; or 3) the individual's health and safety are at risk, the Case Manager must take necessary actions and document the results in the individual's appropriate record(s). Necessary actions include but are not limited to: requesting a written response from the provider; reporting the information to the appropriate licensing, certifying, or approving agency, DBHDS, and DMAS; informing the individual of other providers of the service in question; and, as a last resort, after all other options have been exhausted, informing the individual that eligibility may be in jeopardy should he/she choose to continue receiving services from a provider who cannot ensure health and safety. If any time abuse or neglect is suspected, the Case Manager is required to inform the local DSS office.

Health and Safety Issues

When the case manager becomes aware that DD Waiver services and the individual's current support system may not adequately provide for the individual's safety, a report should be made to Adult Protective Services (APS)/Child Protective Services (CPS).

A potential risk is identified as a deterioration in either the individual's condition or environment, or both, which, in the absence of additional support, could result in *neglect*, harm or injury to the individual. An actual threat is the presence of harm or injury to the individual which can be attributed to the individual's deterioration and lack of adequate support (*i.e.*, the individual becomes anemic, malnourished, dehydrated due to the inability to obtain food and water; the individual develops decubitus due to lying in urine or feces, etc.).

To determine whether an actual threat may exist, the agency should consider the following:

1. Is the individual *able to* call for help when needed?
2. Is there a support system available for the individual to *contact*?

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3. Can conditions be arranged for the individual to care for basic needs when the support system is absent?
4. Is the individual medically *or in other ways* at risk when left alone (i.e., is the individual falling frequently?)
5. Has some harm or injury to the individual been reported?
6. Does the individual express fear or concern for his or her welfare?

If answers to the above indicate a potential risk, the case manager should contact protective services for an investigation at 1-888-832-3858. As a mandated reporter, the case manager must report the situation to APS/CPS.

Service Units and Service Limitations

One unit of service is equal to a month of service. 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 meaningful individual-related contact, activity, or communication occurs and is documented.

Case Management services may be billed for services provided to Medicaid-eligible institutionalized individuals (including those in acute care hospitals, ICF-IID facilities, and nursing facilities) during the 60 calendar days preceding discharge. Authorizations for additional Case Management may be obtained in 30-day intervals. The activities of the Case Manager may not duplicate the activities of the institutional discharge planner.

Provider Documentation Requirements

1. A POC, including the Social Assessment and supporting documentation, which addresses the individual's support needs and desires in all life areas must be developed, reviewed, and updated at least annually. The POC and/or updates must be retained as part of the record. The POC or updates must document the need for DD Waiver services and be approved, dated, and signed by the individual (or legal representative) and Case Manager.
2. The Case Manager's supporting documentation is a component of the POC that outlines the Case Management objectives and activities necessary to carry out the plan. The DD Waiver Supporting Documentation form (DMAS-457) must be used for this purpose.

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3. Ongoing documentation, in the form of case notes, must indicate the dates and nature of Case Management services rendered. For individuals receiving Targeted Case Management and those who are enrolled in the DD Waiver, documentation of a face-to-face contact every 90 days must be in the record. This documentation must clearly state that the Case Manager was in the presence of the individual, assessed his/her satisfaction with services, determined any unmet needs, evaluated the individual's status, and assisted with adjustments in the services and supports as appropriate. Case notes may take the form of contact-by-contact entries or a monthly summary corresponding with a contact log, which briefly notes the date, type, and nature of each contact. All entries must be signed (first initial and last name minimum) and dated with month day and year.
4. For individuals enrolled in the DD Waiver, the supporting documentation must be reviewed by the provider of services with the individual, and this review must be submitted to the Case Manager at least semi-annually with goals, objectives, and activities modified as appropriate. The first semi-annual review will be due by the last day of the sixth month from the effective date of the POC.
5. All relevant communication with the providers, individual, family members, DMAS and other state agencies, or other related parties must be documented in the case notes.
6. For individuals enrolled in the DD Waiver, the POC must be reviewed every three months (at a minimum) by the Case Manager and modified as appropriate to assure that identified needs are addressed and needed services are provided. This must include evaluating the semi-annual reviews of all service providers' supporting documentation. The consumer or authorized representative/guardian must sign and date every POC.

Quarterly review documentation must include any revisions to the POC as well as the general status (including health and safety) of the individual, significant events, progress or lack of progress in meeting the POC, and individual or family satisfaction with Case Management services and other services received under the POC.

The due date for the semi-annual review is determined by the effective start date of the POC and, for semi-annual reviews, communicated to the provider by the Case Manager.

7. A new or revised POC must be developed within 365 days (366 in a leap year) of the effective date of the previous plan for enrolled individuals, DMAS approval is required.
8. DMAS must send a letter to the individual notifying him/her of the right to appeal if the individual is found ineligible for services or if the individual is placed on the statewide waiting list.

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Additional Case Management Documentation for Individuals Receiving DD Waiver Services:

1. All individuals enrolled in the DD Waiver must receive Case Management services. Additional Case Management documentation requirements for which individuals receiving DD Waiver services include the following:
 - a. The Case Manager is responsible for the coordination and maintenance of the individual's required medical, psychological, functional, and social assessments, as well as the ICF-IID Level of Functioning Survey (ICF-IID/LOF) (see the DMAS-458 and DMAS-458A forms at www.dmas.virginia.gov under search service section at the end of this chapter). Annual reassessments must be obtained and maintained for the Functional Assessment, Social Assessment, and LOF (DMAS is responsible for conducting annual LOF reassessments.) The Case Manager must make a referral if a new psychological assessment is necessary. A new psychological assessment is necessary at such time as the existing assessment fails to reflect the individual's current psychological status, cognitive abilities, and adaptive functioning. A medical reassessment must be completed as needed for adults and in accordance with Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) schedule requirements for children (see the "Exhibits" section at the end of this chapter);
 - b. All service providers' supporting documentation are components of the POC and must be reviewed and maintained by the Case Manager for a period not less than six years from the start of waiver services for minors, for a period of not less than 6 years from the date they turn 18.
 - c. The Documentation of Individual Choice Between Institutional Care or Home- and Community-Based Services (DMAS-459), see DMAS website- www.dmas.virginia.gov under search services, indicating the individual's desire for DD Waiver services over institutional placement, is required at the initiation of services and should be maintained in the individual's Case Management record. Documentation must be in the Case Management record that the individual is presented with all feasible alternatives of available agency and consumer-directed services for which he/she is eligible under the DD Waiver;

There must be documentation that the choice of provider(s) from among those appropriate and available has been offered when waiver services are initiated, when there is a request for a change in provider(s), when additional services are initiated, or when the individual is dissatisfied with the current provider. Choice must be documented in writing by having the individual (or parent or family caregiver when appropriate) sign a list of available providers and designate the selected provider(s). Document in writing the individual's choice of DD Waiver providers. [See the Individual Choice Form

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(DMAS-459A) on the DMAS website on the DMAS website at www.dmas.virginia.gov under search services.];

- a. A copy of a Authorization to Release Information (DMAS 219) must be maintained in the individual’s file.
- b. The POC states the primary goals for the individual, includes assessment results, and includes the full range of services and supports the individual receives including the amount and frequency of these services. (See the DMAS-456 form in the “Exhibits” section at the end of this chapter.);
- c. For each individual enrolled in DD Waiver services, there must be a copy of the completed DMAS-225 (Medicaid LTC Communication) form (see form on DMAS website www.dmas.virginia.gov under search services) form as required in the individual’s file maintained by the Case Manager.

DD WAIVER SERVICES

DMAS will pay for a range of Home- and Community-Based services for persons with related conditions under the authority of Section 1915(c) Waivers. The services, eligibility determination, authorization process, and provider requirements set forth in this manual apply to DD Waiver programs.

DD Waiver services may include elements of training, assistance, or specialized supervision that allow an individual to achieve or maintain optimum functioning. They may also include those supports that allow an individual to continue living independently with family or in another community residence. The POC must clearly document the areas in which training, assistance, specialized supervision, and other supports are needed. Supporting documentation must identify the specific types of training, assistance, specialized supervision, and other supports to be provided within the individual DD Waiver services.

An individual may receive a minimum of one DD Waiver service, with the exceptions of Environmental Modifications, Assistive Technology, and Therapeutic Consultation services (other than Behavior Consultation) Family Caregiver Training, and PERS. These may only be provided to individuals who are receiving at least one other DD Waiver service. Behavior Consultation may be offered in the absence of any other waiver service when the consultation is determined necessary to prevent institutionalization.

The Case Manager must present the individual with a choice of Consumer-Directed (CD) services or Agency-Directed (AD) services (or a combination of the two service delivery models). When the individual chooses CD services, the Case Manager offers the individual a choice of CD Service Facilitators. The Service Facilitator assists the individual with employing and maintaining Consumer Directed Attendants.

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IN-HOME RESIDENTIAL SUPPORT SERVICES

Service Definition

In-Home Residential Supports are supplemental to the care provided by a parent (natural, adoptive and foster) stepparent or similar caregiver. This service may also support an individual whose level of independence does not require a primary caregiver. An In-Home Residential Support staff person provides training in the home or in the community. Supports are delivered on an individual basis according to the POC and are delivered with a 1:1 staff-to-individual ratio.

In-home residential support services are supports provided primarily in the individual's home, which includes training, assistance, and specialized supervision to enable the individual to maintain or improve his health; assisting in performing individual care tasks; training in activities of daily living; training and use of community resources; providing life skills training; and adapting behavior to community and home-like environments. Emphasis should be on a person-centered approach that empowers and supports each individual in developing his/her own lifestyle. Residential Support may not include room and board or general supervision. DD Waiver services will not be routinely provided for a continuous 24-hour period.

In-Home Residential Supports are supplemental to the care provided by a parent or similar caregiver. This service may also support an individual whose level of independence does not require a primary caregiver. An In-Home Residential Support staff person provides training in the home or in the community. Supports are delivered on an individual basis according to the POC and are delivered with a 1:1 staff-to-individual ratio.

Activities

These activities are:

1. Training in functional skills related to personal care activities (toileting, bathing, and grooming; dressing; eating; mobility; communication; household chores; food preparation; money management; shopping, , laundry, etc.);
2. Training in functional skills related to the use of community resources (transportation, shopping, restaurants, social and recreational activities, etc.);
3. Monitoring health and physical condition and assistance with medication or other medical needs (or both);
4. Assistance with personal care and use of community resources, such as (not all inclusive):

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- Completing personal care tasks when physically unable to learn to do so;
 - Ensuring hygiene and eating needs are met, such as shaving or brushing teeth; or
 - Completing daily tasks, such as laundry, meal preparation, using the bank, or other tasks essential to the individual’s health and welfare.
5. Assistance with arranging transportation to and from training sites and community resources;
 6. Specialized supervision to ensure individual’s health and safety; and
 7. Training in adapting behavior for home and community environments, such as (not all inclusive):
 - Redirecting anger that has been displayed toward others;
 - Handling social encounters with others; and
 - Developing a circle of supports.

Criteria

The amount and type of In-Home Residential Support services that can be authorized are determined by the individual’s assessed training and support needs reflected in the POC and any supporting documentation. In-Home Residential Support services should be provided at a frequency that allows for systematic training and maintenance or improvement of functional supports.

The supporting documentation must indicate the necessary amount and type of activities required by the individual, the schedule of In-Home Residential Support services, the total number of hours per day, and the total number of hours per week of In-Home Residential Support. A formal written behavioral program is required to address behaviors, including self injury, aggression or self-stimulation. This information must be forwarded to the Case Manager along with supporting documentation and the DMAS-457 form.

In-Home Residential Support services do not need to be provided on a daily basis. In-Home Residential Support services may be offered on a periodic basis, as long as the POC documents the individual’s needs and reflects appropriate and allowable activities to be provided on a periodic basis. In-Home Residential Support services will not be authorized when the activities to be performed are not allowable activities as described for In-Home Residential Support services (i.e., services such as Companion Care services where the care provider “sits” with the individual, provides general supervision, or is primarily for Personal Care).

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The Case Manager may request a change in the amount of authorized hours for In-Home Residential Support services on the POC at any time it is justified by individual need. (See Appendix D of this manual for details)

Medicaid reimbursement is available only for In-Home Residential Support services provided when the individual is present and when a qualified provider is providing the services.

- In-Home Residential Support providers may be members of the individual's family, but may not be the parent, of a minor child receiving services, the individual's spouse, or a legally responsible relative or legal guardian for the individual. Payment may not be made 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 the care. Family members who provide In-Home Residential Support services must meet the same standards as providers who are unrelated to the individual. Documentation must demonstrate that the provider has tried without success to provide in-home staff who do not reside with the individual. The staff providing the supports shall not be paid for in-home services through another source, and the staff providing supports must be employed by a Medicaid-enrolled in-home provider. The individual must be authorized for services with the provider for whom the in-home staff providing supports is employed.

When services are rendered by other family members who live under the same roof as the individual, objective written documentation must include the reason why there are no other direct care staff available to provide care, i.e. lives in rural area and the dated failed attempts made by the In-Home residential provider to locate direct care staff (newspaper ads, etc). This information is also required when seeking service authorization from the DMAS Serv Auth contractor and with any revision plan of care submitted to DMAS.

General Supervision

Federal and state regulations prohibit costs for room, board, and general supervision from being billed to Medicaid under the DD Waiver program.

In-Home Residential supports may not supplant primary care (i.e., room, board, and general supervision) available to the individual through non-medical sources (e.g., family, foster care provider, etc.). They may provide only the supplemental assistance and training required to maintain the capacity of the primary care provider to offer care. Support services cannot be authorized unless the individual requires training and support services, which exceed the room, board, and general supervision.

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General supervision consists of the need for staff presence without evidence of the individual's need for staff intervention. General supervision may help assure that appropriate action is taken in an emergency or if an unanticipated incident occurs. However, routine staff activities, such as the examples described below, are not evidence of an individual's need for staff intervention and are therefore considered to be general supervision. Examples (not all-inclusive) of general supervision that may not be billed to Medicaid are:

- Awake staff coverage during nighttime hours if an individual generally sleeps through the night and has no documented medical or behavioral problems that indicate a need for staff intervention to ensure health and safety;
- Routine bed checks;
- Oversight of leisure activities;
- Asleep staff at night on the premises for security or safety reasons (or both);
or
- Staff "on call" during the day while individuals are at a day program or supported employment placement.

Specialized Supervision

Specialized Supervision provides staff presence for ongoing or intermittent intervention to ensure an individual's health and safety. For Medicaid to reimburse for Specialized Supervision, the DMAS-457 form must clearly document the individual's ongoing need for Specialized Supervision. DMAS may request assessment information, recent documentation of Specialized Supervision-related staff intervention (in the form of charts and/or progress notes), and/or staffing patterns in order to corroborate the individual's need for and the provider's ability to actually deliver Specialized Supervision. The DMAS-457 form must indicate in the form of a specialized supervision objective what Specialized Supervision activities the staff will perform and when. Documentation should reflect specialized activities on the part of the staff that relate to the individual's health and safety needs and indicate occurrences of the provision of those needed supports. The intervention provided may be ongoing or intermittent, and the amount of time included in the DMAS-457 form must be based on the individual's assessed needs.

As Specialized Supervision is typically provided in a 1:1 fashion, the provider must have sufficient staff to implement the Specialized Supervision activities for the individual.

In the case of awake overnight staff coverage in an In-Home Residential support plan, Specialized Supervision may include hours throughout the entire night, but only if assessment information documents ongoing night needs. In some cases, an individual may need staff intervention on a regular but unpredictable basis. For example, an individual who has a documented history of uncontrolled seizure disorder may need overnight Specialized Supervision in the form of staff assistance due to the unpredictable

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nature of the disorder, as well as active intervention when seizures occur. In such a case, Specialized Supervision may be included throughout the night.

In other cases, an individual may require predictable Specialized Supervision, such as assistance with toileting at some point each night. Only the amount of time typically involved in providing assistance may be included in the In-Home Residential support plan as Specialized Supervision.

The ongoing need for and utilization of this component of Residential Support should be included in providers' semi-annual reviews similar to training and assistance. If, over a 60-day period, the hours of Specialized Supervision actually provided are consistently less than the scheduled, approved, and determined amount, the provider is expected to revise the DMAS-457 form, the weekly schedule, and amount to reflect this reduction. This revision is reviewed and approved by the Case Manager and approved by the DMAS, as appropriate.

Restrictions with Other Services

Individuals can be authorized for Personal Care, Respite Care, CD services, and In-Home Residential Support services in their POC but cannot receive these services at the same time. In-Home Residential Support services will not be authorized for the primary purpose of supervision or personal care.

Service Units and Service Limitations

In-Home Residential Support Services are reimbursed on an hourly basis for the time the In-Home Residential Support staff is working directly with the individual. Total billing cannot exceed the total hours authorized by DMAS in the individual's approved POC. The provider must maintain documentation of the date, times, and services that were provided, and specific circumstances, which prevented provision of all of the scheduled services. If fewer hours than scheduled in the POC are delivered on a regular basis over a 60-day period, the service provider should determine the reasons, and a revised POC with fewer hours or a change in schedule may need to be developed.

In-Home Residential Support services shall not be authorized in the POC unless the individual requires these services and these services exceed supports provided by the family or other paid or non-paid caregiver. The service may be provided in a private residence or a community setting but excludes assisted living and congregate living settings. Services will not be provided for a continuous 24-hour period. In-Home Residential Support does not include room and board or general supervision. In-Home Residential services cannot be authorized retroactively.

For In-Home direct care staff name changes after Service Authorization for In-Home services, there must be clearly written documentation in the provider records which includes the name of the new direct care staff and the relationship to the waiver individual. Documentation requirements are the same when the new direct care staff is a

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family member or other family member who lives under the same roof. Family members who provide In-Home Residential services must meet the same standards as providers who are unrelated to the individual.

This information is also required when seeking service authorization from the DMAS SA contractor, any revision and annual plan of care submitted to DMAS.

Provider Documentation Requirements

The requirements are:

1. All services, the POC, and ongoing documentation must be consistent with licensing regulations;
2. The appropriate supporting documentation form (DMAS 457) for In-Home Residential Services must be completed and submitted to the Case Manager for continued authorization by the serv auth contractor to occur. Failure to do so will jeopardize the provider's ability to receive reimbursement for services or the provider's DMAS Provider Agreement;
3. Documentation must indicate the dates and times of In-Home Residential Support services and the amount and type of activities provided;
4. The individual's response to various settings and supports as agreed to in the supporting documentation objectives must be documented. Assessment results must be available in at least a daily note or a weekly summary. Data must be collected as described in the POC, analyzed, summarized, and then clearly addressed in the regular supporting documentation;
5. The supporting documentation must be reviewed by the provider with the individual, and this review must be submitted to the Case Manager at least semi-annually with goals, objectives, and activities modified as appropriate. Semi-annual review documentation must include progress on goals and objectives, any revisions to the supporting documentation and also address the general status of the individual, significant events, and the individual's or family's (or both) satisfaction with services. The due date for the semi-annual review is determined by the effective start date of the POC and communicated to the provider by the Case Manager;
6. Documentation must be maintained for supervision of all In-Home Residential Support staff. All significant contacts, as described in this section, must be documented:

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- a. An employee of the provider, typically by position, must be formally designated as the supervisor of each direct care staff person providing In-Home Residential Support services.
 - b. The supervisor must have and document at least one supervisory contact with each direct care staff person per month regarding service delivery and staff performance.
 - c. The supervisor must observe each direct care staff person delivering services at least semi-annually. Staff performance, service delivery in accordance with the POC, and evaluation and evidence of the individual's satisfaction with service delivery by direct care staff must be documented.
 - d. The supervisor must complete and document at least one monthly contact with the individual or family/caregiver regarding satisfaction with services delivered by each direct care staff person.
7. Documentation must be completed and signed by the staff person designated to perform the supervision and must include:
- a. The date of contact/observation;
 - b. The person(s) contacted and observed;
 - c. Staff performance and service delivery for monthly contact and semi-annual home visits;
 - d. Semi-annual observation documentation. This must include documentation of any problems or concerns and individual satisfaction with service provisions; and
 - e. Any action planned or taken to correct problems identified during supervision/oversight within 10 days after the end of the six-month period.

The service provider must submit documentation of the monthly contacts and observations to the Case Manager for review every six months.

PERSONAL CARE SERVICES: AGENCY DIRECTED (AD)

Service Definition

“Personal Care Services” means direct support with personal assistance, ADLs, IADLs, community access, medication and other medical needs, and monitoring health status and physical condition. 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 or participate in community activities. Personal Care Services substitute

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for the absence, loss, diminution, or impairment of a physical, behavioral or cognitive function. An individual who provides agency directed personal care services is a Personal Care Aide (PCA).

Individuals can have Personal Care and In-Home Residential Support services in their POC, but these services cannot be provided simultaneously. Personal Care services may not be provided during the same billable hours as DD Waiver Supported Employment or Day Support.

Activities

The allowable activities include but are not limited to:

1. Assistance with ADLs, such as: bathing or showering, toileting, routine personal hygiene skills, dressing, transferring, etc.:
2. Assistance with monitoring health status and physical condition;
3. Assistance with preparation and eating of meals (preparation only of the individual's meal is allowed);
4. Assistance with housekeeping activities, such as bed making, dusting and vacuuming, laundry, grocery shopping, etc., for the individual only when specified in the individual's POC and essential to the individual's health or welfare (or both); (this activity is provided to the individual only and not to or for areas/ services for the individual's family or caregiver);
5. General supervision to assure the safety of the individual if the individual is under 18 years of age; accompanying the individual to Medicaid appointments when personal care or supervision is required and is not a service that is required to be provided under the ADA or is provided as part of the service that the individual is attending;
6. Assistance and support needed by the individual to participate in social, recreational, and community activities;
7. Assistance with medication and other medical needs, as delegated by the RN in accordance with the Nurse Practice Act. (PCAs are not allowed to administer medication except as allowed by the Virginia Drug Control Act); and
8. Individuals who receive DD Waiver services may work or attend post-secondary school, or both, while receiving services under this waiver. The personal care aide may accompany the individual to work/post-secondary school and may assist the individual with personal care needs during this time.

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Medicaid reimbursement cannot occur for the aide to assist the individual with functions related to the individual completing his or her job/school functions or for supervision time during work or post-secondary school, with the exception of physical assistance provided due to the individual's inability to perform this function due to disability. The provider must develop an individualized POC that addresses the individual's needs at home, work or in the community.

DMAS will review the individual's needs when determining the services that will be provided to the individual in the workplace/post-secondary school and will not authorize the duplication of services that are required as a reasonable accommodation as a part of the Americans with Disabilities Act (ADA) or the Rehabilitation Act of 1973.

For example, if the individual's only need is for assistance during lunch, DMAS would not pay for the aide for any time extending beyond lunch. For an individual whose speech is such that they cannot be understood without an interpreter (not translation of a foreign language), or the individual is physically unable to speak or make herself/himself understood even with a communication device, the aide's services may be necessary. DMAS will pay for the aide's services unless the aide is required to assist the individual as a part of the ADA, or the Rehabilitation Act of 1973.

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 Personal Care Aides with the exception of skilled nursing tasks that are delegated or performed in accordance with 18VAC90-20-420 through 18VAC90-20-460

Criteria

Supervision of Direct Care Staff

The Personal Care Agency shall employ or subcontract with a registered nurse (RN) who will provide ongoing supervision of all Personal Care Aides. The supervising RN shall be currently licensed to practice in the Commonwealth of Virginia and have at least two (2) years of related clinical nursing experience that may include work in an acute care hospital, public health clinic, home health agency, ICF/IID, or a nursing facility. The start-of-care date is the first day the Personal Care Attendant provides hands-on care. For DBHDS licensed providers, a residential supportive in-home supervisor provides ongoing supervision for all personal care aides. The provider agency is responsible to ensure all staff meet any certifications, licensure, or registration, as applicable and as required by applicable State law.

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Requests must be received within 10 days of the start of care, or service authorization will begin on the date received at the Serv Auth contractor.

The RN Supervisor or residential supervisor must make an initial assessment in the home prior to the start of supports for all new individuals admitted to Personal Care and will develop the supporting documentation. The RN or residential supervisor shall make supervisory visits as often as needed to ensure both quality and appropriateness of services. The minimum frequency of these visits is every 30 - 90 days calendar days depending on the individual's needs.

The supervising RN's or residential supervisor summary shall note:

- Whether Personal Care services continue to be appropriate;
- Whether the POC is adequate to meet the needs or if changes are indicated in the POC; Changes must be included in the supporting documentation.
- Any special tasks performed by the aide (e.g., assistance with bowel/bladder programs, range-of-motion (ROM) exercises, etc.) and the aide's qualifications to perform these tasks;
- Individual's satisfaction with the service;
- Hospitalization or change in medical condition or functioning status;
- Other services received and their amount; and
- The presence or absence of the aide in the home during the RN's or LPN's visit.
- The supervisor shall identify any gaps in the Personal Care Aide's ability to provide services as identified in the individual's POC and provide training as indicated based on continuing evaluations of the Personal Care Aide's performance and the individual's needs.

If there is evidence that: The individual or primary caregiver, if appropriate, is dissatisfied with the service; services are not delivered as described in the POC; or the individual's health or safety are at risk; the RN or residential supervisor must take necessary actions to correct the problems identified. These actions must be documented in the record.

The provider will employ and directly supervise Personal Care Aides who will provide direct care to Personal Care individuals. Each aide hired by the provider agency shall be evaluated by the provider agency to ensure compliance with the minimum qualifications as required by DMAS and described in Chapter II. Staff and agencies shall meet any

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certifications, licensure, or registration, as applicable and as required by applicable State law.

Criminal Record Check

All PCA's must complete a criminal record check. The agency provider submits the criminal record check forms to the Virginia State Police on behalf of the individual prior to the start of PCA services and whenever the individual hires a new PCA. Agency providers will also pay the \$15.00 fee for a criminal record check on behalf of the individual and provides the individual with the results of the criminal record check request and document in the individual's record that the individual has been informed of the results of the criminal record check. If the PCA has been convicted of crimes described in 12 VAC 30-120-770, the PCA will no longer be reimbursed under this program for services provided to the individual effective the date the criminal record was confirmed. If the criminal record check is not returned to the agency provider within 45 days of initiation of services or the initiation of the background request, the PCA will not continue to receive reimbursement. The agency provider must submit a criminal record check within 15 calendar days of employment pertaining to the PCA employees on behalf of the individual as appropriate.

The provider agency is responsible for notifying DMAS whenever a PCA is found to have been convicted of any of the crimes listed below.

p Home care organizations are prohibited from hiring, for compensated employment, persons who have been convicted of crimes specified in Section 32.1-162.9:1 of *The Code of Virginia* and 12 VAC 30-120-770.

Section 32.1-162.9:1 of the *Code of Virginia* also specifies an applicant may be hired if the applicant is convicted of one misdemeanor specified in the convictions described in this section that involves abuse or neglect or moral turpitude, provided five years have elapsed since the conviction.

If the PCA is providing services to an individual less than 18 years of age, the PCA must be screened through the DSS/DFS Child Protective Services Registry. If the registry confirms a founded complaint against the PCA, they will no longer be reimbursed under this program for services provided to the individual effective the date the Child Protective Services Registry information was confirmed.

Other Criteria

The individual must require some assistance with ADLs in order to obtain authorization and payment for Personal Care. Training the individual is not expected under Personal Care services.

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Personal Care services are not required to be offered on a daily basis.

The Case Manager may request of DMAS a change in the amount of authorized hours for Personal Care services on the POC at any time it is justified by individual need. Following DMAS approval, the Case Manager must submit the IFDDS Waiver Community Based Care Request for Services form (DMAS 98) to the Serv Auth contractor for service authorization of the increase or decrease in service.

Medicaid reimbursement is available only for Personal Care services provided when the individual is present and when a qualified provider is providing the services.

- Personal Care service providers may be related to the individual, but may not be the parent, (natural, adoptive or foster) or stepparents of a minor child receiving services, the individual's spouse, or legally responsible relatives or legal guardian of the individual. Payment may not be made for services furnished 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 the care. Documentation demonstrates:
 - A) The provider has tried without success to staff the case with aides who do not reside with the individual;
 - B) The aide providing the care is not a member of the individual's immediate family or the individual's legal guardian;
 - C) Is not being paid for personal care services through another source;
 - D) The staff providing the care is employed by a Medicaid-enrolled Personal care provider and;
 - E) The family member meets the same standards as providers who are unrelated to the waiver individual.

Inability of an Agency to Provide Services and Substitution of Aides

When a Personal Care Aide is absent and the provider agency has no other aide available to provide services, the provider agency is to do the following:

1. If a provider cannot supply a Personal Care Aide to render authorized services, the provider may either obtain a substitute aide from another agency (if the lapse in coverage is to be less than two weeks in duration) or may transfer the individual's services to another agency. The provider that has the authorization to provide services to the individual must contact the Case Manager to determine if additional service -authorization is necessary.

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2. If no other provider is available who can supply an aide, the provider shall notify the individual or family and Case Manager so that they may find another available provider of the individual's choice. Authorization by the Serv Auth contractor is required in those cases in which services are transferred to another provider.

Service Units and Service Limitations

The unit of service for Personal Care is one hour. The individual must have an emergency backup plan (e.g. a family member, neighbor, or friend willing and available to assist the individual) in case the Personal Care Aide does not show up for work as expected. This is the responsibility of the individual and family and must be identified in the supporting documentation. Individuals who do not have an emergency backup plan are not eligible to receive Personal Care services.

Provider Documentation Requirements

The provider shall maintain all records of each individual. At a minimum, these records shall contain:

- The most current POC and any supporting documentation (DMAS 97A/B and DMAS 99); Supporting Documentation Form (DMAS 457) for DBHDS providers.
- All Personal Care Aides under DBHDS licensed supportive in-home provider must pass an objective standardized test of knowledge, skills and abilities approved by DBHDS.
- Initial assessment by the RN Supervisory Nurse completed prior to or on the date services are initiated, subsequent reassessments and changes to the supporting documentation by the RN supervisor or residential supervisor;
- RN or residential supervisor notes recorded and dated during any contacts with the Personal Care Aide and during supervisory visits to the individual's home;
- All correspondence to the individual, family members, the Case Manager, and DMAS;
- Reassessments made during the provision of services;
- Contacts made with family, physicians, DMAS, the Case Manager, formal and informal service providers, and all professionals concerning the individual;
- All documentation by a substitute aide;
- All Personal Care Aide Records. The Personal Care Aide Record shall contain:

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- The specific services delivered to the individual by the aide and the individual's responses;
- The aide's arrival and departure times; documentation must clearly reflect how much time is spent providing personal care versus supervision;
- The aide's weekly comments or observations about the individual to include observations about the individual's physical and emotional condition, daily activities, and responses to services rendered; and
- Aide log signatures and dates. The aide's and individual's weekly dated signatures to verify that services during the week have been rendered.
- Signatures, times, and dates shall not be placed on the aide record prior to the last date of the week that the services are delivered.

The supporting documentation must be reviewed by the provider with the individual and this review submitted to the Case Manager semi-annually with modifications made as appropriate. Semi-annual review documentation must include any revisions to the supporting documentation and also address the general status of the individual, significant events, and individual or family, or both, satisfaction with services. The due date for the semi-annual review is determined by the effective start date of the POC and communicated to the provider by the Case Manager.

Provision of Services to More Than One Individual in the Same Household

For services provided in the home when more than one individual lives in the same household, the provider will assess the needs of all authorized individuals independently and develop the amount of time required for each individual for those tasks which must be provided independently, such as bathing, dressing, ambulating, etc. For households in which there are two or more individuals receiving DD Waiver services from the same provider, the amount of time for tasks which could and should be provided for both individuals simultaneously (such as meal preparation, cleaning rooms, laundry, and shopping) must be combined.

When two individuals who live in the same home request services, the following rules will apply:

- POCs are to be developed separately for ADLs, and each individual will receive the number of hours required for his/her POC;
- Time for instrumental activities of daily living (IADLs) such as cooking, housekeeping, grocery shopping, etc., are to be combined and the hours split

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between the POCs. For example, if it requires one hour to complete IADLs for both individuals, then 30 minutes will be added to each POC;

- Supervision or Companion hours are to be split between the POCs unless there is justification for one-on-one supervision; and
- The individuals have the right to choose separate agencies to provide care. In this event, follow rules in the first two bullets.

Examples of those services that may be provided in the same household to more than one individual are Personal Care, Respite Care, Consumer-Directed Personal Care Attendant services, Consumer-Directed Respite, Companion Care, and Consumer-Directed Companion Care.

RESPITE CARE: AGENCY-DIRECTED (AD)

Service Definition

Respite Services are specifically designed to provide temporary, substitute care for the unpaid, primary caregiver. These services are provided on a short-term basis because of the absence or need for routine or periodic relief of the primary caregiver. They are provided in an individual's home, other community residence or in other community sites.

Activities

The allowable activities include but are not limited to:

1. Assistance with ADLs, such as bathing or showering, toileting, routine personal hygiene skills, dressing, transferring, etc;
2. Assistance with monitoring health status and physical condition;
3. Assistance with medication and other medical needs;
4. Assistance with preparation and eating of meals (preparation only of the individual's meal is allowed);
5. Assistance with housekeeping activities, such as bed making, dusting and vacuuming, laundry, grocery shopping, etc., when specified in the individual's POC and essential to the individual's health and welfare (this activity is provided to the individual only and not to or for the individual's family or caregiver);
6. Support to assure the safety of the individual;

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7. Accompanying the individual to appointments or meetings when personal care or supervision is required; and
8. Assistance or supervision (or both) needed by the individual to participate in social, recreational, or community activities.

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 Respite Care Aides with the exception of skilled nursing tasks that are delegated or performed in accordance with 18VAC90-20-420 through 18VAC90-20-460.

Criteria

Respite services may only be offered to individuals who have an unpaid primary caregiver who requires temporary relief to avoid institutionalization of the individual. Respite services are designed to focus on the need of the primary caregiver for temporary relief and to help prevent the breakdown of the primary caregiver due to the physical burden and emotional stress of providing continuous support and care to the dependent individual.

Training of the individual is not expected with Respite services.

Respite services may not be provided by DSS-approved Adult Foster Care/Family Care providers to an individual residing in that home.

The Case Manager may request a change in the amount of authorized hours for Respite services on the POC at any time it is justified by individual need.

Medicaid reimbursement is available only for Respite services provided when the individual is present and when a qualified provider is providing the services.

Supervision of Direct Care Staff

For DBHDS licensed providers, a residential supportive in-home supervisor provides ongoing supervision for all aides and shall perform all of the activities required of RNs.

The Respite Care provider shall employ or subcontract with and directly supervise an RN, who will provide ongoing supervision of all aides.

The RN shall be currently licensed to practice in the Commonwealth of Virginia and have at least two years of related clinical nursing experience, which may include work in an acute care hospital, public health clinic, home health agency, or nursing facility.

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Based on continuing evaluations of the aides' performance and individual's needs, the RN supervisor shall identify any gaps in the aides' ability to function competently and shall provide training as indicated.

1. The RN supervisor must make an initial assessment visit prior to the start of services for any individual admitted to Respite Care. The RN Supervisor must also perform any subsequent reassessments or changes to the supporting documentation;
2. The RN shall make supervisory visits as often as needed to ensure both quality and appropriateness of services.
 - a. When Respite Care services are received on a routine basis, the minimum acceptable frequency of these supervisory visits shall be every 30 to 90 days;
 - b. When Respite Care services are not received on a routine basis but are episodic in nature, the RN is not required to conduct a supervisory visit every 30 to 90 days. Instead, the RN Supervisor must conduct the initial home visit with the aide immediately preceding the start of care and make a second home visit within the Respite Care period;
 - c. .When Respite Care services are routine in nature and offered in conjunction with Personal Care, the 30-to-90 day supervisory visit conducted for Personal Care may serve as the RN visit for Respite Care. However, the RN Supervisor shall document supervision of Respite Care separately. For this purpose, the same individual record can be used with a separate section for Respite Care documentation;

The provider shall employ and directly supervise aides who provide direct care to Respite Care individuals. Each aide hired by the provider shall be evaluated by the provider agency to ensure compliance with minimum qualifications.

Inability of a Provider to Provide Services and Substitution of Aides

When an aide is absent and the provider has no other aide available to provide services, the provider is responsible for ensuring that services continue to the individual within a reasonable amount of time.

1. If a provider cannot supply an aide to render authorized services, the agency may either obtain a substitute aide from another provider if the lapse in coverage is expected to be less than two weeks in duration, or may transfer the individual's services to another provider. The Respite Care provider that has the authorization to provide services to the individual must contact the Case Manager to determine if additional pre-authorization is necessary.

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2. If no other provider is available who can supply an aide, the provider shall notify the individual or family and Case Manager so that they may find another available provider of the individual's choice.
3. During temporary, short-term lapses in coverage not to exceed two weeks in duration, a substitute aide may be secured from another Respite Care provider agency or other home care agency. Under these circumstances:
 - a. The authorized Respite Care provider is responsible for providing the supervision for the substitute aide.
 - b. The authorized Respite Care provider must obtain a copy of the aide's daily records signed by the individual and the substitute aide from the Respite Care agency providing the substitute aide. All documentation of services rendered by the substitute aide must be in the individual's record. The documentation of the substitute aide's qualifications must also be obtained and recorded in the personnel files of the pre-authorized care provider. The two providers involved are responsible for negotiating the financial arrangements of paying the substitute aide.
 - c. Only the authorized provider may bill DMAS for services rendered by the substitute aide.
4. Substitute aides obtained from other providers may be used only in cases where no other arrangements can be made for individual Respite Care services coverage and may be used only on a temporary basis. If a substitute aide is needed for more than two weeks, the case must be transferred to another Respite Care provider that has the aide capability to serve the individual or individuals.

Service Units and Service Limitations

The unit of service for Respite Care services is one hour. Respite Care services provided in any combined setting are limited to 480 hours per state fiscal year. Individuals who are receiving both Consumer-Directed (CD) and Agency-Directed (AD) Respite Care services cannot exceed 480 hours per state fiscal year combined.

Individuals can have Respite Care and In-Home Residential Support services in their POC but cannot receive In-Home Residential Supports and Respite Care services at the same time. The individual must have an emergency back-up plan in case the Respite Care Aide does not show up for work as expected.

Provider Documentation Requirements

The provider shall maintain all records of each Respite Care individual. These records shall be separated from those of other Non-Home- and Community-Based Care services,

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such as Companion services or Home Health. These records shall be reviewed periodically by DMAS staff. At a minimum, these records shall contain:

1. Documentation by the RN Supervisory or residential supervisor to include the initial assessment completed prior to or on the date services are initiated, notes are recorded and dated during significant contacts with the aide and during supervisory visits to the individual's home, and reassessments are made by the RN during the provision of services;
2. Respite Care services must have person centered supporting documentation that reflects the results of an initial assessment (and subsequent reassessments as needed) and includes the activities that will be provided during the respite period and the approximate hours that will be allowed for each activity. The Provider Agency Plan of Care form (DMAS-97A/B:or DMAS 457 for licensed DBHDS providers; see form on DMAS website at www.dmas.virginia.gov under "search services") may be used for this purpose;
3. Documentation indicating the dates and times of Respite Care services and the amount and type of service provided must be in the individual's record. The Aide Record form (DMAS-90) may be used for this purpose see the form on the DMAS website at www.dmas.virginia.gov under "search services");
4. The appropriate supporting documentation forms (DMAS-97A/B and DMAS-99 and DMAS-457 (for licensed DBHDS providers) must be completed and submitted to the Case Manager for authorization by the Serv Auth contractor to occur. At the annual review, the provider must ensure that the Case Manager receives a copy of the revised supporting documentation prior to its due date. Failure to do so could jeopardize the provider's ability to bill for services or the provider's DMAS Provider Agreement;
5. All correspondence to the individual and DMAS;
6. All contacts made with the family, physicians, the Case Manager, and all professionals concerning the individual;
7. If the service is being provided by a DMAS-enrolled Personal Care/Respite Care agency (does not apply to DBHDS-licensed agencies), the supervising RN must document in a summary note following significant contacts with the aide and during supervisory visits to the individual's home. DBHDS licensed providers must document in a progress note following significant contacts with the aide and during supervisory visits The RN summary note shall include the following:
 - a. Whether Respite Care services continue to be appropriate;
 - b. Whether the POC is adequate to meet the individual's needs or if changes are indicated in the POC;

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- c. Any special tasks performed by the aide (e.g., assistance with bowel/bladder programs, ROM exercises, etc.) and the aide's qualifications to perform these tasks;
 - d. The individual's satisfaction with the service;
 - e. Any hospitalization or change in medical condition or functioning status;
 - f. Other services received and the amount; and
 - g. The presence or absence of the aide in the home during the nurse's visit.
8. The individual's record must contain:
- a. The specific services delivered to the individual by the aide and the individual's response;
 - b. The arrival and departure time of the aide or individual if going out of the home for Respite Care services;
 - c. Comments or observations recorded about the individual. Aide comments must include, at a minimum, observation of the individual's physical and emotional condition, daily activities, and the individual's response to services rendered; and
 - d. The signature of the aide and the individual each week that Respite Care services have been provided to verify that Respite Care services have been rendered. These signatures, times, and dates shall not be placed in the record prior to the date that services are delivered. These aide records must be filed in the record within 14 calendar days of services being rendered.
9. Semi-annual reviews are not required, as this service is typically delivered on an intermittent basis. However, Respite Care providers should regularly communicate with the individual's Case Manager about service provision and related issues.

SKILLED NURSING SERVICES

Service Definition

Skilled Nursing services are available to individuals with serious medical conditions and complex health care needs, which require specific Skilled Nursing services ordered by a physician and which cannot be accessed under the Virginia *State Plan for Medical*

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Assistance. These services must be necessary to enable an individual to live in a non-institutional setting in the community and cannot be provided by non-nursing personnel. Skilled Nursing services are intended to provide skilled intervention with an emphasis on individual and caregiver teaching. Skilled Nursing services are not intended to provide long-term maintenance care. The RN may delegate some tasks; however, it is at the discretion of the RN whether specific tasks may be delegated in accordance with the Nurse Practice Act. The individual's POC must state that this service is necessary in order to prevent institutionalization. Services are provided in an individual's home or community setting, or both.

Activities

The allowable activities include but are not limited to:

1. Monitoring of an individual's medical status;
2. Administering medications and other medical treatment; or
3. Training or consultation with family members, other providers directly involved in the individual's care, and other persons responsible for carrying out an individual's POC to monitor the individual's medical status and to administer medications and other medically related procedures consistent with the Nurse Practice Act (Title 54.1, Code of Virginia, Subtitle III, Chapters 30 and 34).

Criteria

If an individual has Skilled Nursing needs that are short-term and intermittent in nature, the Case Manager must assist the individual to access Skilled Nursing services under the *Virginia State Plan for Medical Assistance*. State Plan Home Health provides short-term intermittent Skilled Nursing services for five visits without service authorization. It must be accessed through a Home Health Agency that has a Provider Agreement with DMAS for Skilled Nursing services. Additional visits after the initial five visits require service authorization from the Serv Auth contractor. Reimbursement for Skilled Nursing services will not be made for services that may be delivered prior to the attending physician's dated signature on the individual's plan of care in the form of physician's orders.

The Case Manager is responsible for inquiring whether an individual is receiving services through Home Health at the time that waiver services are initiated. If the individual receives Home Health services that are comparable to services available under the DD Waiver, the Case Manager must notify the individual and the Home Health provider. If the individual desires Skilled Nursing services under the DD Waiver, the Case Manager must facilitate the transfer of the Skilled Nursing services to the DD Waiver or identify another available provider of Skilled Nursing services following the use of available Home Health Skilled Nursing, and other Medicaid programs.

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Skilled Nursing services under the DD Waiver are those procedures that cannot be provided by non-nursing personnel, consistent with the state's Nurse Practice Act. Skilled Nursing services may be provided by persons related to the waiver individual, but may not be members of the immediate family, which is defined as parents of minor children, spouses or legally responsible relatives for the individuals. Payments may not be made to 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 the care. Relatives who provide nursing services must meet the same standards as providers who are unrelated to the individual. A foster care provider may not be the skilled nursing services provider for the same persons to whom they provide foster care.

The Case Manager may request a change in the amount of authorized hours for Skilled Nursing services on the POC at any time it is justified by individual need.

Medicaid reimbursement is available only for Skilled Nursing services provided when the individual is present (with the exception of family or staff consultation and training regarding the individual's medical needs) and when a qualified Virginia Medicaid-enrolled provider is providing the services. DMAS will not reimburse for simultaneous Skilled Nursing services through the Medicaid EPSDT benefit and Medicare Home Health Skilled Nursing services.

Skilled Nursing services is comprised of both skilled and hands-on care of either a supportive or health-related nature and may include, but will be limited to, all Skilled Nursing care as ordered on the physician-certified POC, assistance with ADLs, administration of medications or other medical needs, and monitoring of the health status and physical condition of the individual.

Service Units and Service Limitations

The unit of service is one hour and must be explicitly detailed in the POC and specifically ordered by a physician as medically necessary to prevent institutionalization. Case Managers must receive copies of all correspondence between the provider agency and DMAS. Skilled Nursing services cannot be authorized retroactively.

Skilled Nursing hours will not be reimbursed while the individual is receiving emergency care or an inpatient in an acute care hospital or during emergency transport to such facilities. The attending RN or LPN may not transport the waiver individual to such facilities.

Skilled Nursing services may be ordered but will not be provided simultaneously with respite care or personal care services.

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Provider Documentation Requirements

There must be:

1. Supporting documentation that notes the specific Skilled Nursing services to be provided and the estimated amount of time required to perform these services. The CMS-485 form (available from the Centers for Medicare and Medicaid Services) may be used for this purpose..The supporting documentation must specify any training of family or staff (or both) to be provided, including the names of the training participants and the content of the training (consistent with the Nurse Practice Act);
2. Documentation of medical necessity by a physician. This may be accomplished by having a physician sign the CMS-485 form. Alternatively, the physician may provide a statement, which specifies Skilled Nursing services required by the individual. The need for the skilled services of a RN or LPN must be specified as well as the number of nursing hours needed. A physician's order for Skilled Nursing services must be obtained prior to services beginning and must be retained in the individual's record. The documentation must be signed by the physician within 21 days of the implementation of the CMS-485 form. If the physician's signature is not received within 21 days, reimbursement for this service will not be made until the date the physician signs the CMS-485 form. The POC must be reviewed at least every six (6) months by the physician and any time the POC changes. If the physician's signature is not obtained timely, the provider is subject to overpayment or denial of payment;
3. Documentation of the provider's nursing license/qualifications;
4. Any changes to the POC must be ordered by a physician prior to implementation;
5. Documentation indicating the dates and times of Skilled Nursing services and the amount and type of service or training provided;
6. A POC that has been reviewed by the provider. This review must be submitted to the Case Manager at least every three months or when changes are made to the POC as needed. Semi-annual review documentation must include any revisions to the POC and also address the general status of the individual, significant events, and individual or family satisfaction with services. The due date for the semi-annual review is determined by the effective start date of the POC and is communicated to the provider by the Case Manager; and

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ENVIRONMENTAL MODIFICATIONS (EM)

Service Definition

Environmental Modifications are physical adaptations to an individual's home, primary place of residence, primary vehicle, and, in some instances, a workplace, which provide direct medical or remedial benefit to the individual. These adaptations are necessary to ensure the health, welfare, and safety of the individual, or directly enable the individual to function with greater independence in the home and work site. Without these adaptations, the individual would require institutionalization.

All services shall be provided in accordance with applicable state or local building codes.

The purpose of Environmental Modifications is to modify, not make general improvements to the home. Environmental Modifications are for pre-existing structures. Items which are of general leisure or recreation and educational purposes are not permitted. Such prohibited items include and are not limited to swing sets, playhouses, climbing walls, trampolines, hot tubs, pools, basketball or other courts, protective matting or ground cover, or exercise equipment. Environmental Modification is not diversional or used as an outlet for adaptive/mal-adaptive behavioral issues. Environmental Modifications cannot take place at any site owned and operated by a residential program. Environmental Modifications are to modify not furnish new additions to a home.

Activities

The modifications and activities are:

1. Physical adaptations to a house or primary place of residence necessary to ensure an individual's health or safety (installation of specialized electric and plumbing systems to accommodate medical equipment and supplies, etc.);
2. Physical adaptations to a house or primary place of residence that enable an individual to live in a non-institutional setting and to function with greater independence that do not increase the square footage of the primary place of residence (installation of ramps and grab-bars, widening of doorways, modifications to bathroom facilities, etc.);
3. Environmental modifications to the work site (which exceed reasonable accommodation requirements of the Americans with Disabilities Act); and
4. Modifications to the primary vehicle being used by the individual. This service does not include the purchase of vehicles.

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Criteria

This service is available to individuals who are receiving at least one other DD Waiver service and Case Management.

In order to qualify for these services, the individual shall have a demonstrated need for equipment or modifications of a remedial or medical benefit offered primarily in an individual's home, vehicle, community activity setting, or day program to specifically improve the individual's personal functioning and are medically necessary. Such modifications may include, but will not necessarily be limited to, the installation of ramps and grab-bars, widening of doorways and other adaptations to accommodate wheelchairs, modification of bathroom facilities (but not strictly for cosmetic purposes), or installation of specialized electrical and plumbing systems required to accommodate the medical equipment and supplies which are necessary for the individual's welfare. This service shall encompass those items not otherwise covered in the *Virginia State Plan for Medical Assistance* or through another program.

Medically necessary includes those services or specialized medical equipment or supplies that are not covered for reimbursement under the State Plan for Medical Assistance that are reasonable, proper, and necessary for the treatment of an illness, injury or deficit.

The Case Manager could possibly deal with four different providers in order to complete one modification, for example:

1. A Rehabilitation Engineer or Rehabilitation Specialist may be used to evaluate the individual's needs and subsequently act as Project Manager, assuring functionality of the environmental modification through quality assurance inspections once the project is finished. Alternatively, the Rehabilitation Engineer may actually design and personally complete the modification. A Physical Therapist, Speech Therapist, or Occupational Therapist, available through the *Virginia State Plan for Medical Assistance* or DD Waiver Therapeutic Consultation, may also be utilized to evaluate the needs for environmental modifications;
2. A Building Contractor may design and complete the structural modification;
3. A vendor who supplies the necessary materials may be separately reimbursed or supplies may be included in the bill of the Building Contractor or Rehabilitation Engineer; or
4. A Durable Medical Equipment (DME) provider enrolled with DMAS must perform and bill for modifications.

A Rehabilitation Engineer might be required if (for example):

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- The Environmental Modification involves combinations of systems which are not designed to go together; or
- The structural modification requires a Project Manager to assure that design and functionality meet ADA accessibility guidelines.

Service Units and Service Limitations

The maximum Medicaid-funded expenditure is \$5,000 per plan year. Costs for Environmental Modifications cannot be carried over from one POC year to the next and must be authorized each POC year. Unexpended portions of this maximum amount may not be accumulated across one or more years to be expended in a later year

Modifications may not be used to bring a substandard dwelling up to minimum habitation standards. This service does not include those adaptations or improvements to the home, which are of general utility and are not of direct medical or remedial benefit to the individual (i.e. carpeting, roof repair, central air conditioning, general maintenance and repairs to a home, additions or maintenance of decks, maintenance/replacement addition of sidewalks, driveways, carports, or adaptations which only increase the total square footage of the home.etc.). Adaptations that add to the total square footage of the home are not allowable expenditures. This service entails limited physical adaptation to preexisting structures and will not include new additions to an existing structure which simply increase the structure's square footage. Also excluded are modifications that are reasonable accommodation requirements of the Americans with Disabilities Act, Virginians with Disabilities Act, and the Rehabilitation Act. Environmental Modifications will be covered in the least expensive, most cost-effective manner. Services for Environmental Modifications cannot be authorized retroactively. Shipping, freight and delivery are not billable to DMAS or to the waiver individual, as such charges are considered non-covered; only the actual cost of materials and labor is reimbursed. There will be no additional markup. 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.

DMAS does not repurchase items paid for with DD Waiver funds unless those items have specific time frames of usefulness (i.e., quarterly maintenance on lifts). Additional repairs are considered on an individual basis.

Providers of Environmental Modifications cannot be spouses, parents (natural, adoptive, foster) or step parents of individuals requesting services. Providers that supply environmental modification for an individual may not perform assessment/consultation, design or inspect environmental modification for that individual. Any request for a change in cost (increase or decrease) requires justification, supporting documentation of medical need and an authorized approval from the DMAS Serv Auth contractor.

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When two or more waiver individuals live in the same home or apartment, the EM will be shared to the extent practicable consistent with the type of requested modification. There will not be duplication of previous EM services with the same residence such as multiple wheelchair ramps or additional modifications previously approved. Proposed modifications that are to be made 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.

EM will not be approved for Medicaid coverage when the waiver individual resides in a residential provider's facility program, such as sponsored homes, congregate residential and supported living settings. EM will not be covered by Medicaid if, for example, the Fair Housing Act, the Virginia Fair Housing Law or the Americans with Disabilities Act requires the modification to be completed by a third party.

Provider Documentation Requirements

The requirements are:

1. Supporting documentation and (DMAS-457), which documents the need for the service, the process to obtain the service (contacts with potential contractors of service, costs, etc.), and the time frame during which the service is to be provided. This includes a separate notation of the design, labor, and supplies or materials (or both). The POC must include documentation of the reason that a Rehabilitation Engineer is needed, if one is to be involved;
2. Documentation of the date services are rendered and the amount of services and supplies;
3. Any other relevant information regarding the modification;
4. Documentation of notification by the individual or individual's representative of satisfactory completion of the service;
5. Instructions regarding any warranty, repairs, complaints, and servicing that may be needed; and
6. Case managers must, upon completion of each modification, meet face-to-face with each individual and assure that the individual can use the modification safely and appropriately and are satisfied with the completed Environmental Modification.
7. EM provider will ensure that all work and products are delivered, installed and in good working order prior to the end of the plan of care year. The date of service on the provider claim must be within the service authorization approval dates,

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which may be prior to the completion date as long as the work commenced during the serv auth approval dates. The service authorization will not be modified to accommodate installation delays. All requests for cost changes (either increases or decreases) must be submitted to DMAS or the DMAS designated Serv Auth contractor for revision and must include justification and supporting documentation of medical needs.

ASSISTIVE TECHNOLOGY (AT)

Service Definition

Assistive Technology is specialized medical equipment, supplies, devices, controls, and appliances not available under the *Virginia State Plan for Medical Assistance*, which are medically necessary and enable individuals to increase their abilities to perform ADLs or to perceive, control, or communicate with the environment in which they live, or which are necessary to their proper functioning. Assistive Technology devices are expected to be portable.

Medically necessary includes those services or specialized medical equipment or supplies that are not covered for reimbursement under the State Plan for Medical Assistance that are reasonable, proper, and necessary for the treatment of an illness, injury or deficit.

Activities

The equipment and activities are:

1. Specialized medical equipment, ancillary equipment, and supplies necessary for life support not available under the *Virginia State Plan for Medical Assistance*;
2. Durable or non-durable medical equipment (DME) and supplies not available under the *Virginia State Plan for Medical Assistance*;
3. Adaptive devices, appliances, and controls not available under the *Virginia State Plan for Medical Assistance* that enable an individual to be more independent in areas of Personal Care and ADLs; and
4. Equipment and devices not available under the *Virginia State Plan for Medical Assistance*, which enable an individual to communicate more effectively.

Criteria

This service is available to individuals who are receiving at least one other DD Waiver service and Case Management.

Providers cannot be spouses or parents (natural, adoptive or foster) or stepparents of the waiver individual.

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Items will not be approved for purposes of convenience for the caregiver or restraint of the individual,, recreation, leisure, diversional purposes, an outlet for adaptive/maladaptive behavioral issues, or educational purposes. Such items including and not limited to, swing sets, playhouses, bowling balls, tricycles/bicycles, trampolines, television sets, video equipment/games, computer games, playing cards, printers, scanners, musical, educational, vocational software or hardware, sporting equipment, exercise equipment, etc. are not covered.

Assistive Technology shall be covered in the least expensive, most cost-effective manner.

Equipment or supplies already covered by the *Virginia State Plan for Medical Assistance* may not be purchased under DD Waiver Assistive Technology. A copy of the Durable Medical Equipment and Supplies List is available from DMAS and should be used to ascertain whether an item is covered through the *Virginia State Plan for Medical Assistance* before requesting it through the DD Waiver. All questionable items should be verified with the DMAS HELPLINE (1-800-552-8627 or 1-800-852-6080). DME information can also be found on the DMAS website by reviewing the *DME Provider Manual*(Appendix B) at <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal> Equipment and supplies must be purchased from a Medicaid enrolled DME provider, if available.

Each Assistive Technology item must be recommended and determined appropriate to meet the individual's needs by the following professionals, prior to approval by the Serv Auth contractor:

Examples of Assistive Technology Devices (not a comprehensive list)	Professional Assessment Required
Organizational Devices	Occupational Therapist, Psychologist, or Psychiatrist
Computer/Software or Communication Device	Speech Language Pathologist or Occupational Therapist
Orthotics, such as braces for hands, arms, feet, legs, etc.	Physical Therapist , Physician or Orthotist
Writing Orthotics	Occupational Therapist or Speech Language Pathologist
Support Chairs	Physical Therapist or Occupational Therapist
Specialized Toilets	Occupational Therapist or Physical Therapist

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Other Specialized Devices/Equipment	Physician, Speech Language Pathologist, Behavioral Consultant, Psychologist, Psychiatrist, Physical Therapist, or Occupational Therapist; depending on the device or equipment
Specially Designed Utensils for Eating	Occupational Therapist or Speech Language Pathologist
Weighted Blankets/Vests	Physical Therapist, Occupational Therapist, Psychologist, or Behavioral Consultant

All professional evaluations must be signed by a qualified professional. The professional evaluation includes the trial period of time for the individual to use the device and documentation of any follow up training that is going to be provided for the recommended items. Providers that supply AT for an individual may not perform assessment/consultation, write specifications, or inspect AT for that individual

For items not included above or for a specific request, contact DMAS for assistance with determining the appropriate professional required to make the recommendation. Items such as furniture will not be approved if they are of general utility and are not of direct medical benefit.

The Assistive Technology provider's quote must be compatible to the evaluation completed by the qualified professional. Case Managers and vendors must ensure that requests for software are compatible with the individual's current computer.

A Rehabilitation Engineer 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 unit,, for the total cost of all Assistive Technology being requested for a specific time frame

The maximum Medicaid-funded expenditure is \$5,000.00 per POC year. Assistive Technology shall be covered in the least expensive, most cost-effective manner. The cost for Assistive Technology cannot be carried over from one POC year to the next, and must be authorized each POC year. Services for Assistive Technology cannot be authorized retroactively. The usual and customary charge is payment in full. Unexpended portions of this maximum amount may not be accumulated across one or more years to be expended in a later year. The service authorization cannot be modified to accommodate

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delays in product deliveries. In such situations, new service authorizations must be sought by the provider. When two or more waiver individuals live in the same home, the Assistive Technology may be shared to the extent practicable consistent with the type of Assistive Technology.

DMAS does not repurchase items paid for with AT funds unless those items have specific time frames of usefulness (i.e., computer – 5 years). DMAS does not pay for duplicate items such as software and later updates to original purchases. This is considered carry over from one plan year to the next. Medicaid does not reimburse for any AT devices or services which may have been rendered prior to authorization from DMAS or the designated Serv Auth contractor. Any request for a change in cost (increase or decrease) requires justification, supporting documentation of medical need and a Serv Auth approved by DMAS or designated Serv Auth contractor. The vendor must receive a copy of the professional evaluation in order to purchase the items recommended by the medical professional. If a change is necessary then the vendor must notify the assessor to ensure the items meet the individual's need.

Shipping, freight and delivery are not billable to DMAS or to the waiver individual, as such charges are considered non-covered. AT equipment and supplies are not rented but will be purchased through a Medicaid-enrolled durable medical equipment (DME) provider. All products must be delivered, demonstrated, installed and in working order prior to submitting any claim for them to Medicaid.

Additional repairs are considered on an individual basis.

Provider Documentation Requirements

The document requirements are:

1. Supporting documentation, which includes the a copy of the approved POC, need for the service, the process to obtain this service (contacts with potential vendors or contractors, or both, of service, costs, etc.); and the time frame during which the service is to be provided. This includes separate notations of evaluation, design, labor, and materials. The supporting documentation must include the reason that a Rehabilitation Engineer or Certified Rehabilitation Specialist is needed, if one is to be involved. A Rehabilitation Engineer or Certified Rehabilitation Specialist may be involved if disability expertise is required that a General Contractor will not have;
2. Written documentation regarding the process and results of ensuring that the item is not covered by the Virginia *State Plan for Medical Assistance* as Durable Medical Equipment and Supplies and that it is not available from a DME provider when purchased elsewhere;

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3. Documentation of the date services are rendered and the amount of service needed;
4. Any other relevant information regarding the device or modification;
5. Documentation in the Case Management Record of Notification by the designated individual or individual's representative of satisfactory completion of the service;
6. 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 services commence during the approved dates;
7. The AT provider is required to deliver and ensure the individual is trained to use the equipment prior to the end of the plan of care year and provide instructions regarding any warranty, repairs, complaints, or servicing that may be needed;
8. Case Managers, upon delivery and or installation of AT, must perform a face-to-face visit to assure that the individual can use the AT safely and appropriately.

DAY SUPPORT

Service Definition

Day Support services include training, assistance, or specialized supervision for the acquisition, retention, or improvement in self-help, socialization, and adaptive skills. It allows peer interactions and an opportunity for community and social integration. Specialized supervision provides staff presence for ongoing or intermittent intervention to ensure an individual's health and safety.

These services typically take place in non-residential settings, separate from the home in which the individual resides. Day Support services shall focus on enabling the individual to attain or maintain his/her maximum functional level and shall be coordinated with any physical, occupational, or speech/language therapies listed in the POC. In addition, Day Support services may serve to reinforce skills or lessons taught in school, therapy, or other settings. Services shall normally be furnished one or more hours per day on a regularly scheduled basis for one or more days per week.

Activities

The allowable activities include but are not limited to:

1. Functional training in self, social, and environmental awareness skills;
2. Functional training in sensory stimulation and gross and fine motor skills;

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3. Functional training in communication and personal care;
4. Functional training in the use of community resources, community safety, appropriate peer interactions, and social skills;
5. Functional training in learning and problem-solving skills;
6. Functional training in adapting behavior to social and community settings;
7. Assistance with personal care and use of community resources;
8. Specialized supervision to ensure individual's health and safety;
9. Opportunities to use functional skills in community settings; and
10. Staff coverage for transportation of the individual between training and service activity sites.

Criteria

For Day Support services, individuals shall have demonstrated the need for functional training, assistance, and specialized supervision offered in settings other than the individual's own residence which allow an opportunity for being productive and contributing members of communities. Day Support services are only be available for individuals who cannot benefit from Supported Employment services and who need the services for: accessing In-Home Supported Living services; increasing levels of independent skills within current daily living situations; or sustaining skills necessary for continuing the level of independence in current daily living situations.

Medicaid reimbursement is available only for Day Support allowable activities that are authorized and are provided in accordance with the POC and DMAS 457 form when the individual is present and when a qualified provider is providing the services.

Types and Levels of Day Support

The amount and type of Day Support included in the individual's POC is determined according to the level of staff involvement required for that individual. There are two types of Day Support: Center-Based, which is provided primarily in a single location/building, or Non Center-Based, which is provided primarily in community settings.

Both types of Day Support may be provided at either Intensive or Regular Levels. To be authorized at the Intensive Level, the individual must meet at least one of the following criteria:

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- Requires physical assistance to meet basic personal care needs (toileting, feeding, etc.);
- Has extensive disability-related difficulties and requires additional ongoing support to fully participate in programming and to accomplish individual service goals; or
- Requires extensive personal care or constant supports to reduce or eliminate behaviors that preclude full participation in the program. A formal, written behavioral program is required to address behaviors such as, but not limited to, withdrawal, self-injury, aggression, or self-stimulation.

Service Sites

Day Support cannot be regularly or temporarily (e.g., due to inclement weather or illness of the individual) provided in an individual's home or other residential setting without written prior approval from the DMAS. In this situation, the supporting documentation must clearly indicate the specific time frame and designate specific Day Support activities provided in the individual's home or other residential setting. In particular, Non-Center-Based Day Support services must be separate and distinguishable from either In-Home Residential Support services or Personal Care services. There must be separate supporting documentation. If the same record is used to document both services, each must be clearly differentiated in documentation and corresponding billing. Examples of situations that may be exceptions to the prohibition against Day Support activities in the individual's home are:

- An individual is new to the service or experiences serious emotional or behavioral problems and requires a "phase-in period" to become accustomed to staff, a schedule and routine, riding in a van or car, etc. This phase-in period must be temporary with its expected duration clearly indicated in the Day Support supporting documentation. During this "phase-in period," only one (1) unit of Day Support services provided at the individual's home may be billed; and
- An individual returns from community settings to his/her residence for lunch. The "lunch location" and amount of time allotted for lunch must be specified on the Day Support supporting documentation. A reasonable amount of time may be designated on the supporting documentation for eating lunch, including the associated preparation and cleanup. The majority of training related to meal preparation should occur within In-Home Residential Support supporting documentation.

Service Units and Service Limitations

Any services started prior to the receipt of authorization by DMAS will not be reimbursed. The services must be explicitly detailed in the POC.

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Once the POC has been developed and approved by DMAS, additional units may be requested. To request additional units, the service provider must contact the Case Manager to request the additional units from DMAS. The need for additional units must be submitted to DMAS with the request documented in the individual's record. Case Managers must receive copies of all correspondence between the provider agency and the Serv Auth contractor. These documents are subject to review during Utilization Review. Services for Day Support cannot be authorized retroactively.

Billing is for a block of service:

- One block is ≥ 1 to ≤ 3 hours and 59 minutes of service a day;
- Two blocks are ≥ 4 to ≤ 6 hours and 59 minutes of service a day; and
- Three blocks are ≥ 7 hours to ≤ 9 hours and 59 minutes of service a day.

In order to bill for services for a given day, the individual must have received at least one full hour of service as described in the plan of care. For example:

- If the individual leaves $\frac{1}{2}$ hour after arriving for any reason, no services may be billed.
- If the individual receives 1 hour and 30 minutes of service, the provider may bill for 1 block of service.
- If the individual receives 5 hours and 45 minutes of service, the provider may bill for 2 blocks of service.
- If the individual receives 7 hours and 15 minutes of service, the provider may bill for 3 blocks of service.

Transportation is not billable as a Day Support service.

The supporting documentation must provide an estimate of the amount of Day Support required by the individual. This service, either as a stand-alone service or in combination with Pre-Vocational and/or Supported Employment services, shall be limited to 780 blocks per POC year.

Provider Documentation Requirements

The provider documentation requirements are:

1. For DBHDS-licensed programs, supporting documentation and ongoing documentation consistent with licensing regulations. For CARF-certified

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programs, supporting and ongoing documentation consistent with documentation described in this section;

2. The supporting documentation (DMAS 457) and schedule must be reviewed by the provider with the individual, and this review must be submitted to the Case Manager at least semi-annually with goals, objectives, and activities modified as appropriate. Semi-annual review documentation must include any revisions to the supporting documentation and also address the general status of the individual, significant events, and individual/family satisfaction with services. The due date for the semi-annual review is determined by the effective start date of the POC and communicated to the provider by the Case Manager. Failure to do so could jeopardize the provider's ability to bill for services or the provider's DMAS Provider Agreement;
3. An attendance log or similar document must be maintained which indicates the date, type of services rendered, and number of hours and units provided (including specific time frame);
4. Documentation must indicate whether the services were Center-Based or Non-Center-Based;
5. Regardless of the intensity, if Day Support services are requested, in order to verify which of these criteria the individual are documentation must be present in the individual's record to indicate the specific supports and the reasons they are needed. There must be clear documentation of the ongoing needs and associated staff supports for Day Support services; and

SUPPORTED EMPLOYMENT

Service Definition

Supported Employment means work in settings in which persons without disabilities are typically employed. It is especially designed for individuals with developmental disabilities facing severe impediments to employment due to the nature and complexity of their disabilities, irrespective of age or vocational potential.

Supported Employment services are available to individuals with related conditions for whom competitive employment at or above the minimum wage is unlikely without ongoing supports and who, because of their disability, need ongoing post-employment support to perform in a work setting.

Supported Employment services shall include training in specific skills related to paid employment and provision of ongoing or intermittent assistance or specialized training to enable an individual to maintain paid employment. The supporting documentation must contain documentation regarding whether Supported Employment services are available in vocational rehabilitation agencies through the Rehabilitation Act of 1973 or in Special

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Education services through § 602(16) and (17) of the Individuals with Disabilities Education Act. Providers of DARS and IDEA services cannot be reimbursed by Medicaid with the DD Waiver funds. Waiver service providers are reimbursed only for the amount and type of Supported Employment services included in the individual's approved POC based on the intensity and duration of the service delivered. Reimbursement shall be limited to actual interventions by the provider of Supported Employment, not for the amount of time the individual is in the Supported Employment environment.

Activities

The allowable activities include and are not limited to:

1. Individualized assessment and development of employment-related goals and objectives;
2. Individualized job development for the individual's placement that produce an appropriate job match for the individual and the employer such as development of resumes, cover letters, completion of job applications, assisting the individual in job interviewing, development of situational assessment sites, negotiation with prospective employers, job analysis, job carving, job customization and evaluation of work site;
3. On-the-job training in work and work-related skills required to perform the job such as development of task analysis, reasonable accommodations, compensatory strategies, assessing the need for assistive technology, and career advancement and training for job-upgrading support;
4. Ongoing employee evaluation, supervision, and monitoring of the individual's performance on the job, which are required because of the individual's disabilities but which do not include supervisory activities rendered as a normal part of the business setting;
5. Ongoing support services necessary to maintain job stability and assure job retention including the development of natural supports within the workplace, off-site support services (family support, residential provider support of employment), and the resolution of transportation issues;
6. Safety supports to ensure the individual's health and safety;
7. Development of related skills essential to obtaining and retaining employment, such as the effective use of community resources, break/lunch areas, use of assistive technology, and transportation systems and mobility training; and

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8. Contacts with the employer, family members, or other support services necessary for initiating, maintaining, and evaluating successful employment for a particular individual.

Criteria

Supported Employment may be provided in one of two models. Individual Supported Employment is defined as intermittent support, usually provided one-on-one by a job coach to an individual in a supported employment position who, during most of the time on the job site, performs independently. Individual supported employment may also include support to establish or maintain self-employment, including home-based employment. Group Supported Employment is defined as continuous support provided by staff to eight or fewer individuals with disabilities in an Enclave, Work Crew, Entrepreneurial model, or Bench work model. An Entrepreneurial model of Supported Employment is a small business employing fewer than eight individuals with disabilities and usually involves interactions with the public and with co-workers without disabilities. An example of the Benchwork model is a small, non-profit electronics assembly business that employs individuals without disabilities to work alongside eight or fewer individuals with significantly complex needs and provides daily opportunities for community integration. The individual's assessment and POC must clearly reflect the individual's need for training and supports to acquire or maintain paid employment.

Restrictions with Other Services

Providers for persons eligible for or receiving Supported Employment services funded under §110 of the *Rehabilitation Act of 1973* [through the Aging and Rehabilitative Services (DARS)] or §602(16) and (17) of the *Individuals with Disabilities Education Act* (through Special Education services) cannot receive payment for this service through Medicaid DD Waiver services. The Case Manager must assure that Supported Employment services are not available through these sources and document the findings in the individual's Case Management record. When services are provided through these sources, the POC will not include them as a requested waiver service. Supported Employment under the DD Waiver is usually a long-term service and is generally provided following time-limited DRS Supported Employment.

Only job development tasks that specifically pertain to include the individual are allowable job search activities under DD Waiver Supported Employment and only after determining this service is not available from DARS. Supported Employment Services can be provided when an individual is transitioning from Day Support Services. The providers must agree on when an individual is in Day Support when he/she is in Supported Employment and bill accordingly. When the individual is attending Supported Employment then Day Support will not be utilized during those hours and vice versa. A functional assessment should be conducted to evaluate each individual in his/her home environment and community settings.

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A functional assessment should be conducted to evaluate each individual in his/her home environment and community settings.

Other Criteria

The supporting documentation must provide the amount of Supported Employment required by the individual. Service providers are reimbursed only for the amount and type of Supported Employment included in the individual's POC.

For the individual job placement model, reimbursement of Supported Employment will be limited to actual documented interventions or employment-related collateral contacts by the provider, not for the amount of time the individual is in the supported employment situation.

Service Units and Service Limitations

Any Supported Employment services started prior to the receipt of authorization by DMAS will not be reimbursed. The services must be explicitly detailed in the supporting documentation. To request additional hours/units, the service provider must contact the Case Manager and request the additional hours/units. The need for additional hours/units must be documented in the individual's record. Case Managers must receive copies of all correspondence between the provider agency and DMAS. These documents are subject to review during audits and quality management review visit.

Supported Employment for individual job placement will be billed on an hourly basis no more than 40 hours/week may be billed. Transportation is not included in this service. Services for Supported Employment cannot be authorized retroactively. In instances where an individual is utilizing transportation services and staff is required to ride with the individual (in addition to the driver) to and from supported employment activities, billing for this time cannot exceed 25 percent of the total time spent in the supported employment activity for that day

Group models of Supported Employment (enclaves, work crews, Entrepreneurial and Benchwork models of Supported Employment) will be billed according to the DMAS fee schedule at the unit rate.

Units of service:

- One unit is 1 to 3.99 hours of service a day;
- Two units are 4 to 6.99 hours of service a day; and
- Three units are 7 or more hours of service a day.
- The supporting documentation must provide an estimate of the amount of Day Support required by the individual. This service, either as a stand-alone service or in

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combination with Pre-Vocational and/or Day Support services, shall be limited to 780 units or its equivalent under DMAS fee schedule per POC year.

Provider Documentation Requirements

The documentation requirements are:

1. Lack of Department of Aging and Rehabilitative Services (DARS) or Special Education funding for the service must be documented in the individual's record, as applicable. If the individual is older than 22 years, and, therefore, not eligible for Special Education funding, documentation is required only for the lack of DARS funding. Acceptable documentation would include a copy of a letter from DARS or the local school system, or a record of a phone call (the name, date, and person contacted) documented in the Case Manager's case notes, Personal Profile, or Social Assessment, or on the Supported Employment supporting documentation. If the individual's circumstances change, they can be forwarded into the current record or repeated on the POC or revised Personal Profile or Social Assessment on an annual basis. As DARS is not responsible for "extended services" (or "follow along") in supported employment for individuals with DD, documentation that an individual remains in extended services in supported employment with no change in circumstances would be sufficient.

A change in circumstances, which might warrant a new verification of the lack of DARS funding, would include the loss of a Supported Employment placement or the need for a job change or upgrade, in which DARS-funded job development and initial on-the-job training could be available;

2. For Commission-on-Accreditation-of-Rehabilitation-Facilities-certified (CARF) pro-grams, there must be ongoing documentation consistent with CARF certification;
3. An attendance log or similar document must be maintained which indicates the date, type of services rendered, and number of hours or units provided (including the specific time frame);
4. Supporting documentation (DMAS-457) and ongoing documentation consistent with licensing regulations, if a DBHDS-licensed program;
5. For non-DBHDS programs certified as Supported Employment programs, there must be supporting documentation that contains, at a minimum, the following elements:
 - a. The individual's strengths, desired outcomes, required or desired supports, and training needs;
 - b. The individual's goals and, for a training goal, a sequence of measurable objectives to meet the above identified outcomes;

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- c. The services to be rendered and the frequency of services to accomplish the above goals and objectives;
 - d. The person(s) or organization(s) that will provide the services specified in the statement of services;
 - e. A timetable for the accomplishment of the individual's goals and objectives;
 - f. The estimated duration of the individual's needs for services;
 - g. The person(s) responsible for the overall coordination and integration of the services specified in the plan; and
 - h. Daily or weekly progress notes are requested and must provide specific information regarding the individual's response to various settings and supports as agreed to in the objectives.
6. The supporting documentation must be reviewed by the provider with the individual, and this review must be submitted to the Case Manager at least semi-annually with goals, objectives, and activities modified as appropriate. Semi-annual review documentation must include any revisions to the POC and also include the general status of the individual, significant events, and individual or family satisfaction with services. The due date for the semi-annual review is determined by the effective start date of the POC.

PRE-VOCATIONAL SERVICES

Service Definition

Pre-Vocational services are services to prepare an individual for un-/paid employment, but are not job-task oriented. Pre-Vocational services are provided for individuals who are not expected to be able to join the general work force without supports or to participate in a transitional, sheltered workshop within one year of beginning waiver services (excluding Supported Employment services or programs). Activities included in this service are not directed at teaching specific job skills but at underlying rehabilitative goals such as accepting supervision, attendance, task completion, problem solving, and safety.

Criteria

In order to qualify for Pre-Vocational services, the individual shall have a demonstrated need for support in skills that are aimed toward preparation for paid or unpaid employment that may be offered in a variety of community settings.

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Types of Prevocational Services

There are two types of Prevocational Services: Center-Based, which is provided primarily in a single location with other individuals with disabilities, or Non Center-Based, which is provided primarily in community settings. Both types of Prevocational Services may be provided at either Intensive or Regular Levels. The level of Prevocational Services included in the individual's POC is determined according to the level of staff involvement required for that individual. To be authorized at the Intensive Level, the individual must meet at least one of the following criteria:

- Requires physical assistance to meet basic personal care needs (toileting, feeding, etc.) or;
- Has extensive disability-related difficulties and requires additional ongoing support to fully participate in programming and to accomplish individual service goals; or
- Requires extensive personal care or constant supports to reduce or eliminate behaviors that preclude full participation in the program. A formal, written behavioral program is required to address behaviors such as, but not limited to, withdrawal, self-injury, aggression, or self-stimulation.

Service Units and Limitations

Units of service:

- One unit shall be 1 to 3.99 hours of service a day.
- Two units are 4 to 6.99 hours of service a day.
- Three units are 7 or more hours of service a day.

Services shall normally be furnished four or more hours per day on a regularly scheduled basis for one or more days per week unless provided as an adjunct to other day activities included in an individual's POC.

Billing is for one unit of service. This service is limited to 780 units per POC year. If this service is used in combination with Day Support and/or Supported Employment services, the combined total units for these services cannot exceed 780 units per POC year. Pre-Vocational services may be provided in center or non-center-based settings. There must be documentation about whether Pre-Vocational services are available in vocational rehabilitation agencies through §110 of the Rehabilitation Act of 1973 or through the Individuals with Disabilities Education Act (IDEA). When services are provided through these sources, they will not be authorized as a waiver service. Pre-

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Vocational services may only be provided when the individual's compensation is less than 50% of the minimum wage.

Provider Documentation Requirements

In addition to meeting the general conditions and requirements for Home- and Community-Based services participating providers as specified in 12VAC30-120-730 and 12VAC30-12-740, Pre-Vocational service providers must also meet the following requirements:

- a. Be a vendor of Extended Employment services, Long-Term Employment services, or Supported Employment services for DRS, or is licensed by DMHMRSAS as a Day Support services provider.
- b. Ensure and document that persons providing Pre-Vocational services have training in the characteristics of related conditions, appropriate interventions, training strategies, and support methods for individuals with related conditions and functional limitations.
- c. Must maintain a record for each individual receiving Pre-Vocational services. At a minimum, the record must contain the following:
 1. A Functional Assessment conducted by the provider to evaluate each individual in the Pre-Vocational environment and community settings.
 2. A POC containing, at a minimum, the following elements: (DBHDS licensing regulations require the following for POCs.)
 - a. The individual's needs and preferences;
 - b. Relevant psychological, behavioral, medical, rehabilitation, and nursing needs as indicated by the assessment;
- c. Individualized strategies including the intensity of services needed;
- d. A communication plan for individuals with communication barriers including language barriers; and
- e. The behavior treatment plan, if applicable.
3. The POC must be reviewed by the provider quarterly, annually, and more often as needed, modified as appropriate, and with written results of these reviews submitted to the Case Manager. For the annual review and in cases where the POC is modified, the POC must be reviewed with the individual or family/caregiver.

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4. In instances where Pre-Vocational staff is required to travel with the individual to and from Pre-Vocational services, the Pre-Vocational staff time may be billed for Pre-Vocational services, provided that the billing for this time does not exceed 25% of the total time spent in Pre-Vocational services for that day. Documentation must be maintained to verify that billing for Pre-Vocational staff coverage during transportation does not exceed 25% of the total time spent in the Pre-Vocational services for that day.
5. A copy of the most recently completed DMAS-122 form. The provider must clearly document efforts to obtain the completed DMAS-122 form from the Case Manager.

THERAPEUTIC CONSULTATION

Service Definition

Therapeutic Consultation provides expertise, training, and technical assistance in any of the following specialty areas to assist family members, caregivers, and other service providers in supporting the individual. The specialty areas are:

- a. Psychology;
- b. Social Work;
- c. Therapeutic Recreation;
- d. Speech and Language Therapy;
- e. Occupational Therapy;
- f. Physical Therapy;
- g. Rehabilitation Engineering;
- h. Psychiatry;
- i. Psychiatric Clinical Nursing. and
- j. Behavioral Consultation

Activities

The allowable activities are:

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1. Interviewing the individual, family members, caregivers, and relevant others to identify issues to be addressed and desired outcomes of consultation;
2. Observing the individual in daily activities and natural environments;
3. Assessing the individual's need for an assistive device or modification and/or adjustment in the environment or services;
4. Developing data collection mechanisms and collecting baseline data;
5. Observing and assessing current interventions, support strategies, or assistive devices being used with the individual;
6. Developing written supporting documentation detailing the interventions, environmental adaptations, and support strategies to address the identified issues and desired outcomes; this may include recommendations related to specific devices, technology, or adaptation of other training programs or activities;
7. Demonstrating specialized, therapeutic interventions, individualized supports, or assistive devices;
8. Training family/caregiver and other relevant persons to assist the individual in using an assistive device, to implement specialized, therapeutic interventions, or adjust currently utilized support techniques;
9. Training relevant persons to better support the individual simply by observing the individual's environment, daily routines, and personal interactions;
10. Reviewing documentation and evaluating the efficacy of assistive devices or the activities and interventions identified in the supporting documentation; and
11. Training and technical assistance to family members, caregivers, and other individuals primarily responsible for carrying out the individual's POC.

Criteria

In order to qualify for these services, the individual must have a demonstrated need for consultation in any of these services. Documented need indicates that the POC could not be implemented effectively and efficiently without such consultation.

The individual's POC must clearly reflect the individual's needs, for specialized consultation as documented in the social assessment, which must be provided to caregivers/providers in order to implement the POC effectively.

DD Waiver Therapeutic Consultation services may not include direct therapy provided to waiver individuals, nor duplicate the activities of other services that are available to the individual through the *Virginia State Plan for Medical Assistance*.

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Therapeutic Consultations shall be available to individuals who are receiving at least one other qualifying waiver service and Case Management services. Only Behavioral Consultation may be provided in the absence of other DD Waiver services when the consultation provided to informal caregivers is determined to be necessary to prevent institutionalization.

It is recommended that a supervisory staff person at the receiving agency participate in the Therapeutic Consultation, so that, in the event of staff turnover, the consultation and POC can be shared with new staff and additional Therapeutic Consultation is not requested. The provider or family may request additional Therapeutic Consultation, if needed.

Therapeutic Consultation services may be provided in In-Home Residential or Day Support settings or in office settings in conjunction with another waiver service.

Therapeutic Consultations shall be available to individuals who are receiving at least one other waiver service and Case Management services.

Service Units and Service Limitations

Any services started prior to the receipt of approval by DMAS or prior to the receipt of the service request by the Serv Auth contractor and authorization of services will not be reimbursed. The services must be explicitly detailed in supporting documentation by the Therapeutic Consultation provider. To request additional hours, the service provider must contact the Case Manager and request the need for the additional hours. The need for additional hours must be documented in the individual's record, and a revised POC must be submitted by the Case Manager to DMAS for approval. Following DMAS approval, the Case Manager must submit the DDS Waiver Community Based Care Request for Services form (DMAS 98) to the SA contractor for authorization of the increase or decrease in service. (See Appendix D of this manual for details.) Case Managers must receive copies of all correspondence between the provider, DMAS and the Serv Auth contractor. These documents are subject to review during a quality management review visit. Services for Therapeutic Consultation cannot be authorized retroactively.

The unit of service is one hour. However, the services must be explicitly detailed in the supporting documentation. Travel time, written preparation, and telephone communication are in-kind expenses within this service and are not billable as separate items.

Therapeutic Consultation may not be billed solely for purposes of monitoring. These consults are for evaluation/ treatment planning, training and technical assistance and are not billable as sessions and/or therapy. Any additional requested hours are limited to

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assessments, evaluations and training only and require supporting documentation of additional services needed in the same POC year.

Behavior consultation is provided by a behaviorist who focuses on target behaviors that need to be modified by observing the situation, making recommendations for change and implementing positive reinforcement with the individual, family and providers. The ultimate goal is an intervention that replaces the individual's targeted behavior with socially acceptable appropriate behaviors that increase community integration. The support plan should emphasize the positive approach with effective treatment designed to attain and maintain appropriate behaviors and prevent additional challenging behaviors from occurring.

Provider Documentation Requirements

The documentation requirements are:

1. Supporting documentation for Therapeutic Consultation. This must contain:
 - a. 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;
 - b. Targeted objectives, time frames, or expected outcomes;
 - c. Specific consultation activities (frequency, where, when, and to whom); and
 - d. The expected products.

2. Monthly and contact notes shall include:
 - a. Summary of consultative activities for the month;
 - b. Dates, locations, and times of delivery;
 - c. Supporting documentation objectives addressed;
 - d. Specific details of the activities conducted;
 - e. Services delivered as planned or modified; and
 - f. Effectiveness of the strategies and the individual's and caregiver's satisfaction with service.

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3. Semi-annual reviews are required by the service provider if consultation extends three months or longer and are to be forwarded to the Case Manager and include:
 - a. Activities related to the supporting documentation;
 - b. Individual status and satisfaction with services; and
 - c. Consultation outcomes and effectiveness of the POC.

When Therapeutic Consultation services extend less than three months, the provider must forward to the Case Manager contact notes, monthly notes, or a summary of such to the Case Manager for semi-annual review;

4. A written support plan within the supporting documentation detailing the interventions and strategies for staff, family, and caregivers to use to better support the individual in the service; and
5. The Final Disposition Summary is forwarded to the Case Manager within 30 days following the end of the service and must include:
 - a. Strategies utilized;
 - b. Objectives met;
 - c. Unresolved issues; and
 - d. Consultant recommendations.

CRISIS STABILIZATION SERVICES

Service Definition

Crisis Stabilization is direct intervention (and may include one-to-one supervision) of persons with developmental disabilities who are experiencing serious psychiatric or behavioral problems, which jeopardize their current community living situation. The goal is to provide temporary intensive services and supports to avert emergency psychiatric hospitalization or institutional admission or to prevent other out-of-home placement. The intent is to stabilize the individual and to strengthen the current living situation so the individual can be maintained in the community during and beyond the crisis period.

Activities

The allowable activities include and are not limited to:

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1. Psychiatric, neuro-psychiatric, and psychological assessments, and other functional assessments and stabilization techniques;
2. Medication management and monitoring;
3. Behavioral assessment;
4. Intensive care coordination with other agencies and providers to assist the planning and delivery of services and supports to maintain community placement of the individual;
5. Training of family members and other caregivers and service providers in positive behavioral supports to maintain the individual in the community; and
6. Temporary Crisis Supervision (as a separate billable service) to ensure the safety of the individual and others.

Criteria

Crisis Stabilization services may not be used for continuous long-term care. Room and board and general supervision are not components of this service.

Assessment of Need

The individual must meet at least one of the following criteria:

- a. Is experiencing marked reduction in psychiatric, adaptive, or behavioral functioning;
- b. Is experiencing extreme increase in emotional distress;
- c. Needs continuous intervention to maintain stability; or
- d. Is causing harm to self or others.

The individual must be at risk of at least one of the following:

- a. Psychiatric hospitalization;
- b. Emergency ICF/IID placement;
- c. Disruption of community status (living arrangement, day placement, or school); or
- d. Causing harm to self or others.

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Crisis Stabilization services may only be authorized following a documented face-to-face assessment conducted by a qualified professional (as defined in Chapter II of this manual under provider qualifications for Crisis Stabilization services). If appropriate, the assessment will be conducted jointly with a Qualified Developmental Disability Professional (QDDP) or other appropriate professional(s).. The actual service units per episode will be based on the documented clinical needs of the individual being served. Extension of services, beyond the 15-day limit per authorization must be authorized following a documented face-to-face reassessment conducted by a qualified mental retardation professional. If appropriate, the reassessment will be conducted jointly with a QDDP or other appropriate professional(s)..

The Case Manager may request a change in the amount of authorized hours for Crisis Stabilization services on the POC at any time it is justified by individual need.

Allowable Settings

DD Waiver Crisis Stabilization services may be provided directly in, but not limited to, the following settings:

- a. The home of an individual who lives with family or other primary caregiver(s);
- b. The home of an individual who lives independently or semi-independently to augment any current services and support;
- c. A day program or setting to augment current services and supports; and
- d. A Respite Care setting to augment current services and supports.

Crisis Supervision

Crisis Supervision may be provided as a component of Crisis Stabilization services only if clinical or behavioral interventions allowed under this service are also provided during the authorized period.

Crisis Supervision must be provided one-to-one and face-to-face with the individual. It may be provided by the same provider of Crisis Stabilization Clinical or Behavioral services or a different provider.

Service Units and Service Limitations

The actual service units per episode will be based on the documented clinical needs of the individual being served. Extension of services beyond the 15-day limit per authorization must be authorized following a documented face-to-face reassessment conducted by a qualified professional. If appropriate, the assessment and any reassessments shall be conducted jointly with a QDDP or other appropriate professional or professionals.

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Requests for an extension of Crisis Stabilization services beyond the 15-day limit must be prior authorized by the DMAS contractor prior to the implementation of the additional services. Any additional services started prior to the receipt of authorization by the Serv Auth contractor will not be reimbursed until the date of authorization by the Serv Auth contractor. The need for additional services must be explicitly detailed in supporting documentation. To request additional hours, the service provider must contact the Case Manager and request the need for the additional hours. The need for additional hours must be documented in the individual's record and must be submitted to the Serv Auth contractor upon request. This documentation is subject to review during a Utilization Review visit. Crisis Stabilization services must be requested within 72 business hours of the start of services. If the request is received after this time frame, the service will be authorized on the date it is received.

DD Waiver Crisis Stabilization Clinical or Behavioral services are billed in hourly service units and must be prior authorized by the Serv Auth contractor for a maximum of 15 days per request. Crisis Stabilization and Supervision can be provided to an individual no more than 60 calendar days in a POC year. Crisis Supervision, if provided within the authorized period as a component of this service, is separately billed in hourly service units.

Provider Documentation Requirements

The documentation must contain:

1. The need for service or extension of service must be clearly documented following a documented face-to-face assessment/reassessment by a qualified developmental disabilities professional as described in Chapter II of this manual;
2. Supporting documentation (DMAS 457) must be developed (or revised, if requesting an extension) within 72 hours of an assessment or reassessment. The standard DD Waiver Supporting Documentation form (see form at DMAS website www.dmas.virginia.gov under search services) may be used for this purpose;
3. Documentation indicating the dates and times of Crisis Stabilization services and the amount and type of service provided as well as the specific information, regarding the individual's response to services and supports as agreed to in supporting documentation, must be in the individual's record; and
4. Documentation of the qualifications of providers must be maintained for review by DMHMRSAS or DMAS staff.

CONSUMER-DIRECTED (CD) SERVICES

There are three Consumer-Directed (CD) services available in the DD Waiver: CD Attendant Care, CD Companion, and CD Respite services. The individual is the

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employer in these services, and, as such, is responsible for hiring, training, supervising, and firing CD Attendants and CD Respite Care Attendants. If the individual is unable to independently manage his/her own CD services or if the individual is under 18 years of age, a family member/ caregiver must serve as the employer on behalf of the individual.

No more than two individuals who live in the same home are permitted to share the authorized work hours of the CD Attendant, CD Companion, or CD Respite Care Attendant 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.

Specific duties of the individual (or individual's family member/caregiver serving as employer of record on behalf of the individual) regarding the CD Attendant or CD Respite Care Attendant and CD Companion include checking references, determining that the employee meets basic qualifications, training, supervising performance, and submitting time sheets to the Fiscal Agent on a consistent and timely basis. CD Attendants, CD Companions, and CD Respite Care Attendant are not eligible for Worker's Compensation.

The DMAS-97A/B form must be completed on each individual for each CD service. Specific amounts of time rounded to the nearest 15 minutes are to be placed in the box under each specific task. The LOC score must be completed. If hours are above the LOC cap, increases must be approved prior to starting the increase over the cap.

All CD services require the services of a Fiscal Agent (currently DMAS) and Services Facilitator (DMAS-enrolled provider) and must be authorized by the Serv Auth contractor.

CD Attendant Care, CD Companion, and CD Respite Services

Service Definition

Consumer Directed Attendant Care includes assistance with ADLs (eating, drinking, personal hygiene, toileting, transferring and bowel/bladder control), bowel/bladder programs, ROM exercises, routine wound care (which does not include sterile technique), and external catheter care. Supportive services are those, which substitute for the absence, loss, diminution, or impairment of a physical function. When specified, Supportive services may include assistance with instrumental activities of daily living (IADLs) (meal preparation, shopping, housekeeping, laundry, and money management) which are incidental to the care furnished, or which are essential to the health and welfare of the individual. CD Attendant Care shall not include either practical or professional nursing services as defined in the Nurse Practice Act.

CD Companion service is a covered service when its purpose is to supervise or monitor those individuals who require the physical presence of an aide to ensure their safety

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during times when no other supportive individuals are present. In no instance will Companion Care be approved in excess of eight hours per day.

The inclusion of companion services in the POC is appropriate only when the individual cannot be left alone at any time due to mental or severe physical incapacitation. This includes individuals who cannot use the phone to call for help due to a physical or neurological disability. Individuals may receive companion services due to their inability to call for help if PERS is not appropriate for them.

Companion services shall not be covered if required only because the individual does not have a telephone in the home or because the individual does not speak English.

There must be a clear and present danger to the individual as a result of being left unsupervised. Companion services cannot be authorized for individuals whose only need for companion services is for assistance exiting the home in the event of an emergency.

A companion cannot provide supervision to individuals on ventilators, requiring continuous feedings, or requiring suctioning of their airways.

Companions may not be the individual's spouse. Other family members living under the same roof as the individual being served may not provide companion services unless there is objective, written documentation as to why there are no other providers available to provide services.

Respite care means services provided for the relief of the unpaid primary caregiver of eligible individuals who are unable to care for themselves that are provided on an episodic or routine basis because of the absence of or need for relief of these unpaid caregivers. CD Respite Care includes assistance with ADLs. Supportive services are those, which substitute for the absence, loss, diminution, or impairment of a physical function. When specified, Supportive services may include assistance with IADLs, which are incidental to the care furnished, or which are essential to the health and welfare of the individual. Services are provided in an individual's home, other community residence, and other community sites. CD Respite Care shall not include either practical or professional nursing services as defined in the Nurse Practice Act. CD Respite Care services may be provided in a community setting or in camps.

Individuals who receive DD Waiver services may work or attend post-secondary school, or both, while receiving services under this waiver. The personal care attendant may accompany the individual to work/post-secondary school and may assist the individual with personal care needs while the individual is at work/post-secondary school.

DMAS will not pay for the aide to assist the individual with functions related to the individual completing his or her job/school functions or for supervision time during work or post-secondary school, with the exception of physical assistance provided due to the individual's inability to perform this function due to disability.

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DMAS will review the individual's needs when determining the services that will be provided to the individual in the workplace/post-secondary school. The provider must develop an individualized POC that addresses the individual's needs at home, work or in the community.

DMAS will not duplicate services that are required as a reasonable accommodation as apart of the Americans with Disabilities Act (ADA) or the Rehabilitation Act of 1973. For example, if the individual's only need is for assistance during lunch, DMAS would not pay for the attendant for any time extending beyond lunch. For an individual whose speech is such that they cannot be understood without an interpreter (not translation of a foreign language), or the individual is physically unable to speak or make herself/himself understood even with a communication device, the attendant's services may be necessary. DMAS will pay for the attendant's services unless the aide is required to assist the individual as a part of the ADA, or the Rehabilitation Act of 1973.

Activities

Work-Related Personal Care services will only be available to individuals who also require Personal Care Attendant services to meet their ADLs. Workplace supports through the DD Waiver will not be provided if they are services provided by the Aging and Rehabilitative Services (DARS), under IDEA, or if they are an employer's responsibility under the Americans with Disabilities Act or Section 504 of the Rehabilitation Act. Work-Related Personal Care Attendant services will not duplicate services provided under Supported Employment.

DMAS will only reimburse services defined below as Consumer Directed Attendant care and CD Respite services. Services to be provided by CD Attendants and CD Respite Care Attendants are limited to the following:

- Assisting with care of the teeth and mouth;
- Assisting with grooming (includes care of the hair, shaving, and ordinary care of the nails);
- Assisting with bathing of the individual in bed, in the tub, in the shower, or a sponge bath. Routine maintenance and care of external condom catheters is considered part of the bathing process. This care applies only to external and not in-dwelling catheters (e.g., Foley catheters);
- Providing routine skin care, such as applying lotion to dry skin, not to include topical medications or any type of product with an "active ingredient;"
- Assisting the individual with dressing and undressing;

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- Assisting the individual with turning and changing position, transferring, and ambulating;
- Assisting the individual with moving on and off of the bedpan, commode, or toilet;
- Assisting the individual with eating or feeding;
- Supervision as needed;
- Assisting the individual with self-administered medications and assuring that the individual receives medications at prescribed times not to include pouring or, in any way, determining the dosage of medication;
- Administration of bowel and bladder programs by the CD Attendant or CD Respite Care Attendant under special training and supervision by a RN. in accordance with 18VAC90-20-420 through 18VAC90-20-460 and *The code of Virginia* § 54.1-3001. 12. The CD Attendant may be authorized to administer physician-ordered bowel and bladder programs to individuals who do not have other support available. The RN contracted by the provider must observe the CD Attendant or CD Respite Care Attendant performing this function. This authorization can only be given for these reasons. (None of the procedures included here may be administered except as part of a physician-ordered bowel program.);
 - a) The provider has documented that the CD Attendant or CD Respite Care Attendant has received special training in bowel and bladder program management;
 - b) The CD Attendant or CD Respite Care Attendant has knowledge of the circumstances that require immediate reporting to the individual's physician;
 - c) It is the CD Services Facilitation provider's responsibility to assure that the CD Attendant or CD Respite Care Attendant hired by the individual has received adequate training;
 - d) Certain conditions exist that would contraindicate having the CD Attendant or CD Respite Care Attendant perform a bowel program (e.g., patients prone to dysreflexia such as high level quadriplegics, head-and-spinal-cord-injured patients, and some stroke patients). The bowel program may include, if necessary, a laxative, enemas, or suppositories to stimulate defecation.

However, the laxative cannot be "administered" by the CD Attendant, even through part of the bowel program (suppositories are an exception to this and can be administered if ordered by the physician as part of a bowel

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program). Replacement of a colostomy bag as part of the bath is included. Digital stimulation and removal of feces within the rectal vault may be a necessary part of the bowel maintenance or training program. However, removal of impacted material is not permitted; and

- e) The bladder program may not include any invasive procedures such as catheterization, instillation, or irrigation but can include bladder-training activities. Bladder retraining is limited to time management of urination without any invasive procedures or voiding stimulation. The RN contracted by the CD Services Facilitation provider must be available to the CD Attendant or CD Respite Care Attendant and be able to respond to any complications immediately;
- ROM exercises ordered by the physician may be performed by the CD Attendant and/or the CD Respite Care Attendant when the CD Attendant and/or the CD Respite Care Attendant has been instructed by the RN in the administration of maintenance of ROM exercises, and a return demonstration or correct performance of these exercises has been witnessed and documented by the RN. This does not include strengthening exercises or exercises aimed at retraining muscle groups, but includes only those exercises used to maintain current range of movement without encountering resistance;
- The CD Attendant and/or CD Respite Care Attendant can perform routine wound care that does not include sterile treatment or sterile dressings. This includes care of a routine decubitus, defined as a decubitus that is superficial or does not exceed stage II. A stage II is one that penetrates to the underlying subcutaneous fat layer, shows redness, edema, and induration, at times with epidermal blistering or desquamation. Normal wound care would include flushing with normal saline solution, washing the area, drying the area, and applying dry dressings as instructed by the nurse supervisor. This does not include the application of any creams, ointments, sprays, powders, or occlusive dressings;
- Checking the temperature, pulse, respiration, and blood pressure and recording and reporting as required; and
- Home Maintenance Activities – These activities, which are related to the maintenance of the home or preparation of meals, should only be included on the supporting documentation for individuals who do not have someone available to perform these duties (either living in the home or routinely coming in to provide assistance). Individuals living in the home with the individual who would be expected to perform housekeeping and cooking activities for themselves should provide the individual’s home maintenance activities while completing their own. These activities are:
 - Preparing and serving meals, not to include menu planning for special diets;

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- Washing dishes and cleaning the kitchen;
- Making the bed and changing linens;
- Cleaning the individual's bedroom, bathroom, and rooms used primarily by the waiver individual;
- Listing of supplies to be purchased by the individual;
- Shopping for necessary supplies for the individual if no one else is available to perform the service; and
- Washing the individual's laundry when no other family members are available or able.

Services Excluded from Coverage/Reimbursement - Personal Care Attendant /Respite Care

DMAS will not reimburse CD Attendants or CD Respite Care Attendants for any services that are not listed above. These include, but are not limited to, the following activities:

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 or CD Respite Care Attendants. with the exception of skilled nursing tasks that are delegated or performed in accordance with [18VAC90-20-420](#) through [18VAC90-20-460](#) and *The code of Virginia* § 54.1-3001. 12.

Provision of Services for Other Members of the Individual's Household

DMAS will reimburse the CD Attendant,, CD Respite Care Attendant or CD Companion only for services rendered to the individual. DMAS will not reimburse the CD Attendant, CD Respite Care Attendant or CD Companion for services rendered to or for the convenience of other members of the individual's household (e.g., cleaning rooms used by all family members, cooking meals for the family, washing dishes, family laundering, etc.) DMAS also will not reimburse for the provision of unauthorized services.

Provision of Services to More Than One Individual in the Same Household

For services provided in the home when more than one individual lives in the same household, the provider will assess the needs of all authorized individuals independently

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and develop the amount of time required for each individual for those tasks which must be provided independently, such as bathing, dressing, ambulating, etc. For households in which there are two or more individuals receiving DD Waiver services from the same provider, the amount of time for tasks which could and should be provided for both individuals simultaneously (such as meal preparation, cleaning rooms, laundry, and shopping) must be combined and shared on both plans of care.

When two individuals who live in the same home request services, the following rules will apply:

- POCs are to be developed separately for ADLs, and each individual will receive the number of hours required for his/her POC;
- Time for IADLs such as cooking, housekeeping, grocery shopping, etc., are to be combined and the hours split between the POCs. For example, if it requires one hour to complete IADLs for both individuals, then 30 minutes will be added to each POC;
- Supervision or Companion hours are to be split between the POCs unless there is justification for one-on-one supervision; and
- The individuals have the right to choose separate agencies to provide care. In this event, follow rules in the first two bullets.

Examples of those services that may be provided in the same household to more than one individual are Personal Care, Respite Care, CD Attendant Care services, and CD Respite, Companion Care, and CD Companion Care services.

Transportation

The CD Attendant, CD Respite Care Attendant, or CD Companion may be allowed to transport the individual in the individual's vehicle or accompany the individual to assist with his/her ADLs or IADLs as stated and documented in the individual's supporting documentation. The CD Attendant, CD Respite Care Attendant or CD Companion may drive the individual in the individual or aide's vehicle if all of the following criteria are met:

- The total time required by the CD Attendant, CD Companion, or CD Respite Care Aide for the day, including the time required to drive the individual, does not exceed the individual's weekly authorized hours. If the total time required exceeds the daily hours, the additional time may be deducted from another day in that week as long as this does not jeopardize the individual's health and safety. DMAS will not reimburse the gas and mileage expenses;
- The individual's or aide's vehicle is registered in the Commonwealth of Virginia;

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- The owner of the vehicle has current automotive insurance containing collision, comprehensive, and liability coverage with a minimum of 100-300-50. The insurance will insure the individual and cover the CD attendant as a driver of the individual's vehicle;
- The CD Attendant, CD Respite Care Attendant or CD Companion has a valid Virginia driver's license; and
- It is necessary to assist the individual with his/her ADLs or IADLs as documented in the individual's supporting documentation.

Criteria

In order to qualify for CD Respite or CD Attendant services, the individual shall have demonstrated a need for Personal Care in ADLs, medication monitoring, other medical needs, or monitoring health status or physical condition or home maintenance activities.

CD Attendant CD Respite Care and CD Companion shall be available to individuals who would otherwise require the level of care provided in an ICF-ID. Individuals 18 years of age or older, who want to direct their own CD Attendants, CD Respite Care Attendants and CD Companion must complete a DMAS-95 Addendum form with the Services Facilitator to determine if the individual is capable of independently managing his/her services. If the individual is unable to independently manage his own services, a family caregiver can serve as the employer of record on behalf of the individual. Individuals with cognitive impairments may not be able to manage their own care. If individuals receiving services are under 18 years of age, the family caregiver will act on behalf of the minor. Individuals who are eligible for CD Attendant Care, CD Respite Care or CD Companion Care must have the capability to hire and train their own CD Attendant Care, CD Respite Care or CD Companion Care and supervise the Personal Care Attendant's performance or have a family caregiver capable of doing this as employer of record on behalf of the individual. Training of the individual is not expected with CD Attendant Care, CD Companion, and CD Respite.

The individual is the employer in these services, and is responsible for hiring, training, supervising, and, if necessary, firing CD Attendants, CD Respite Care Aides or CD Companions. The individual or individual's family caregiver will serving as employer of record on behalf of the individual and will monitor the individual's receipt of CD supports. Specific duties include checking references of CD Attendants, CD Respite Care Attendants and CD Companions determining that CD Attendants Care Attendants and CD Companions meet basic qualifications, training CD Attendants, CD Respite Care and CD Companions supervising the CD Attendant's, CD Respite Care Attendants or CD Companion's performance, and submitting time sheets to the CD Services Facilitator and Fiscal Agent on a consistent and timely basis. The individual must have an emergency backup plan in case the CD Attendant CD Respite Care Attendant or CD Companion

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does not show up for work as expected or terminates employment without prior notice. This is the responsibility of the individual and family and must be identified in the supporting documentation. Individuals who do not have a backup plan are not eligible for service.

Medicaid reimbursement is available only for CD Attendant Care, CD Respite or CD Companion services provided when the individual is present (with the exception of the CD Attendant's, CD Respite Care Attendant or CD Companion's attendance at training at the request of the individual or family member/caregiver) and when a qualified provider is providing the services. The start-of-care date is the first day the CD Attendant provides hands-on care. A request must be received within 10 days of the start of care, or service authorization will begin on the date received by the Serv Auth contractor.

Service Units and Service Limitations

One unit of service is one hour.

Individuals can have CD Attendant, CD Respite Care, CD Companion service, and In-Home Residential Support services in their POC but cannot simultaneously receive these services. CD Attendants, CD Respite Care Attendants and Companions are paid an hourly rate and the CD Services Facilitators are paid separately from the CD Attendants. Respite Care Attendants and Companions are paid by the Fiscal Agent on behalf of the individual, and CD Services Facilitators bill DMAS directly for providing Supportive services. CD Attendants and CD Respite Care Attendants may not be the parents (legal, stepparent, adoptive or foster) of individuals who are minors, or the individual's spouse. Payment will not be made for services furnished by other family members living under the same roof as the individual receiving services unless there is objective, written documentation as to why there are no other providers available to provide the care.

CD Respite Care is limited to 480 hours per individual per state fiscal year. Those who receive CD Respite and AD Respite Care cannot receive more than 480 hours of Respite Care services combined.

CD Services - Fiscal Agent Responsibilities

The Fiscal Agent will perform certain tasks as an agent for the individual who is receiving CD services (as the employer of the CD Attendant, CD Respite Care Attendant or CD Companion). The Fiscal Agent will provide a packet of employment information and necessary forms to the individual or family member/caregiver. The forms must be completed and returned to the Fiscal Agent before the CD Attendant, CD Respite Care Attendant or CD Companion can be employed. The Fiscal Agent will handle responsibilities for the individual by paying the CD Attendant, CD Respite Care Attendant or CD Companion and the related employment taxes (not to include individual state and federal income tax). The Fiscal Agent will seek and obtain all necessary

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authorizations and approvals of the Internal Revenue Services (IRS) in order to fulfill all of these duties.

CD Service Facilitator Responsibilities

1. Initial Visit: Upon being selected by the individual or family member/caregiver, the CD Services Facilitator must make an initial comprehensive in-home visit for the purpose of eliciting from the individual or family member/caregiver serving as employer of record all individual needs to be addressed in the supporting documentation. This must occur prior to the start of services for any individual choosing to receive CD services.

The CD Services Facilitator will also provide the individual with a copy of the *Employee Management Manual* ((see <https://www.virginiamedicaid.virginia.gov/wps/portal>).The CD Services Facilitator will ensure that the individual understands his/her rights and responsibilities in the program and signs all of the Participation Agreements found in the *Employee Management Manual* (with the Selection of Service, Fiscal Agent, and CD Services Facilitator). These forms must be signed before the individual can begin employing CD Attendants or CD Respite Care Attendants or CD Companions in the program. The CD Services Facilitator shall send the originals to the Fiscal Agent and keep a copy for the individual's file.

The initial comprehensive visit is done only once upon the individual's entry into the CD service. If an individual changes his/her CD Service Facilitator, the new provider must bill for reassessment visit in lieu of an initial visit.

2. Development of the CD Services Supporting Documentation: The information gathered during the comprehensive visit should result in the development of the supporting documentation for the appropriate CD service(s) for the individual. A copy of this supporting documentation will be forwarded to the Case Manager by the Service Facilitator to initiate the authorization process.
3. Employee Management Training: The CD Service Facilitator, using the *Employee Management Manual*, must provide the individual with training on his/her responsibilities as an employer within seven days of receipt of the authorization of the CD Attendant or CD Respite Care Attendant or CD Companion services (CD Services Facilitators can complete the comprehensive visit and individual training in the same day, if appropriate). During the individual training, the CD Services Facilitation provider must train the individual on his/her duties as employer. To assure that the training content for Employee Management Training meets the acceptable requirements, the CD Service Facilitator must use the *Employee Management Manual* as a guide to meet these requirements (see Appendix B). Regardless of the method of training received, documentation must be present indicating

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the training has been received prior to the individual's employing of a CD Attendant, CD Respite Care Attendant or CD Companion.

4. Routine (On-site) Visits:

CD Attendant Services: After the comprehensive visit, the CD Services Facilitator shall conduct two on-site routine visits within 60 days of the initiation of CD Attendant services (once per month) to monitor and ensure both the quality and appropriateness of the services being provided. After the first two routine on-site visits, the CD Services Facilitator and individual can decide how frequent the routine on-site visits will be held. The CD Services Facilitator is responsible for conducting routine on-site visits at the individual's home every 30-90 days to ensure appropriateness of services. These meetings shall include times when services are scheduled to be delivered. The CD Services Facilitator must record all significant contacts in the individual's file.

CD Respite Care Services: After the comprehensive visit, the CD Services Facilitator will periodically review the utilization of CD Companion services at least every six months or more often as needed. CD Respite Care services at a minimum of every six months or upon the use of 300 Respite Care hours, whichever comes first.

During visits to the individual's home, the CD Services Facilitator must consult with the individual or family member/caregiver (or both) to evaluate and document the adequacy and appropriateness of the CD services. If a health and safety issue is noted by the CD Services Facilitator during a visit, he/she is obligated to report this to the Case Manager and Child Protective Services/Adult Protective Services, as appropriate.

The CD Services Facilitator's documentation of this visit may be in the form of a progress note or a standardized form. The Community Based Care Recipient Assessment Report (DMAS-99) is available on the DMAS website (www.dmas.virginia.gov) on the "Search Forms" webpage when you enter "99" in the "Number/Name" field.

In addition to the routine information that must be documented in the CD Services Facilitator's routine visit summary, there are several areas that require special documentation by the CD Service Facilitator:

- A. Bowel and Bladder Program - A written physician's order in the individual's file must specify the method and type of digital stimulation and frequency of administration. The CD Services Facilitator must document that the CD Attendant or CD Respite Care Attendant has received special training in bowel and bladder program management, has knowledge of the circumstances that require immediate reporting to the RN Services Facilitator, if a RN has observed the CD Attendant or CD

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Respite Care Attendant performing this function. The CD Attendant's or CD Respite Care Attendant's continuing understanding and ability to perform bowel and bladder programs must also be documented in the routine visit note.

- B. Range-of-Motion (ROM) Exercises - The written physician order, which indicates the need and extent of ROM exercises to be performed, must be in the individual's file. The CD Services Facilitator must document in the individual's record that the CD Attendant or CD Respite Care Attendant has been instructed by the CD Services Facilitator, if a RN in the administration and maintenance of ROM exercises and that the CD Attendant's or CD Respite Care Attendant's correct performance of these exercises has been witnessed and documented by the CD Services Facilitator, if a RN. The continued need for ROM exercises and the monitoring of the CD Attendant's or CD Respite Care Attendant's performance of these exercises must be noted in the routine visit note.
- C. Routine Wound Care - During each visit, the CD Services Facilitator must document the status of the wound and the monitoring of the individual's care.
- D. Catheter Care - When routine care of an external condom catheter is to be provided by the CD Attendant or CD Respite Care Attendant, the CD Service Facilitator must indicate in the initial comprehensive visit note that the CD Attendant or CD Respite Care Attendant is providing condom care and what instructions the CD Attendant or CD Respite Care Attendant has received regarding this care. Documentation must indicate the CD Attendant's or CD Respite Care Attendant's ability to perform this procedure.

MD orders, for tasks requiring MD orders, must be obtained every six months. It is appropriate for the attendant to chart tasks that are not included in the supporting documentation for the individual's POC if the individual has a need for the task to be done. The attendant should note why this task was performed and whether the need for this task continues to exist. It is then the responsibility of the CD Services Facilitator to determine whether there is a need for the task to be included on the POC on an ongoing basis and make whatever changes are appropriate.

- 5. Reassessment Visit: Once every six months, the CD Services Facilitator must provide a full assessment of the individual's current medical, functional, and social support status and a complete summary of all services received. The six-month reassessment may coincide with the DMAS request for the DMAS-99, but it must be completed once every six months regardless of whether the DMAS-99 is due. Documentation of the six-month reassessment must include a complete review of the individual's needs and available supports, and a review of the POC. Additionally, CD Services

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Facilitators should conduct reassessment visits for individuals who require reassessment because they are transferring from another CD Services Facilitator or who have a change in their level of care.

During visits to the individual's home, the CD Service Facilitator shall observe, evaluate, and document the adequacy and appropriateness of CD Attendant and CD Respite Care or CD Companion services with regard to the individual's current functioning and cognitive status and medical and social needs in the established POC.

The CD Service Facilitator must document:

- Any change in the previously documented individual's medical condition, functioning status, and social support. The CD Service Facilitator is expected to know the ICF-ID criteria and to apply these criteria when assessing whether the individual continues to meet the criteria to receive services. If the CD Service Facilitator determines that the individual does not meet the criteria for CD services, the CD Services Facilitator Supervisor must notify the Case Manager;
- Whether CD services are adequate to meet the individual's needs and whether changes need to be made;
- Any special tasks performed by the CD Attendant, and CD Respite Care Attendant or CD Companion qualifications to perform these tasks;
- The individual's and/or family member's/caregiver's (as appropriate) satisfaction with services;
- Hospitalization or change in medical condition, functioning, or cognitive status;
- Other services received and their amount;
- Dates of and reasons for any service lapses (hospitalization admission and discharge dates, attendant not available, etc.);
- The presence or absence of the CD Attendant, CD Respite Care Attendant or CD Companion in the home during the visit;
- A review of time sheets: The CD Services Facilitator must review the CD Attendant's ,CD Respite Care Attendant's and CD Companion time sheets, which are submitted by the individual, to determine whether the CD Attendant ,CD Respite Care Attendant or CD Companion and the individual are recording the approved number of hours. If a discrepancy occurs, the CD Services Facilitator should notify the Fiscal Agent;

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- In addition to the typical information that must be documented in the CD Services Facilitator’s reassessment visit summary, there are several areas (such as bowel/bladder programs, ROM exercises, catheter and wound care) that, when they are part of an individual’s supporting documentation due to physician’s orders, require monitoring by a RN and special documentation by the CD Services Facilitator (See above section, “Routine (On-site) Visits”, for more details);
6. Management Training: This training is provided by the CD Services Facilitator upon the request of the individual or family member/caregiver. This may be additional management training for the individual or family member/caregiver or special training for the CD Attendant, CD Respite Care Attendant or CD Companion at the request of the individual. CD Services Facilitators can provide up to four hours of management training on behalf of an individual or family member/caregiver within any six-month period. Each hour of management training is billed as one unit. Management training can also be used to reimburse the CD Service Facilitator for the costs of TB testing required of CD Attendants, CD Respite Care Attendants and CD Companions. CD Services Facilitation providers can bill DMAS for the costs of these requirements on behalf of the individual by billing for these costs in units and maintaining documentation of these costs in the individual’s file.
7. Criminal Record Check:
All CD Attendants, CD Respite Attendants and CD Companions must complete a criminal record check as a condition of employment within 15 calendar days of employment. The prospective employee must complete his/her portion of the “Criminal History Record Name Search Request” form (in the Employment Packet sent by the fiscal agent), have his/her signature notarized and return the form to the fiscal agent. When the individual receiving CD services is a minor (under age 18), a VDSS CPS Registry check form has to be completed by the prospective employee. The fiscal agent will submit the form(s) to the appropriate authorities and inform the individual and family/caregiver, as appropriate, of the results. If the CD employee has been convicted of a “barrier” crime pursuant to §37.2-314 of the Code of Virginia, continued Medicaid reimbursement is prohibited following results of the background check. The employer must terminate the employee; however, time sheets must be submitted to the fiscal agent up to the date of separation.

When an individual chooses to hire a CD Attendant, CD Respite Care Attendant or CD Companion who has been convicted of a misdemeanor not involving abuse or neglect, the CD employer must sign an Acceptance of Responsibility for

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Employment form. In making this decision, individuals or family members/caregivers sign the Acceptance of Responsibility for Employment form agreeing, by employing CD Attendant, CD Respite Care Attendant or CD Companion, to hold harmless from any claims and responsibility DMAS, the CD Services Facilitator, and the Fiscal Agent. This form must be kept in the individual's file.

8. Consumer Directed Attendant Registry: The CD Services Facilitation provider shall maintain a CD Attendant Registry. The registry shall be a list that contains the names of persons who have experience with providing CD Respite, CD Attendant, or CD Companion services or who are interested in providing CD Respite, CD Attendant services. The registry shall be maintained as a supportive source for the individual who may use the registry to obtain the names of potential CD Attendants. DMAS does not require CD Services Facilitation providers to verify a CD Attendant's qualifications prior to enrollment in a registry. CD Attendants may choose not to be listed in the registry.
9. Monitoring: The CD Services Facilitator is responsible for taking appropriate action to assure continued appropriate and adequate service to the individual. Appropriate actions may include: counseling a CD Attendant, CD Respite Attendant or CD Companion about the services to be provided to the individual (at the individual's request); counseling or training an individual regarding his/her responsibilities as an employer; or requesting from the Case Manager an increase or decrease to the individual's POC as needed after discussing with the individual the need for additional services. Any time the CD Services Facilitation provider is unsure of the action that needs to be taken, the provider should contact the Case Manager.
10. Availability: The CD Services Facilitator must be available by telephone to the individual receiving CD services or their family/caregiver as appropriate during normal business hours, have voice mail capability and return phone calls within 24 hours or have an approved back-up CD Services Facilitator
11. Verification of Time Sheets: The CD Services Facilitator shall relay the completed DMAS-225 form (and subsequent updates) received from the Case Manager to the Fiscal Agent for use in processing time sheets. The CD Services Facilitator shall review copies of the time sheets during routine on-site visits to ensure that the hours of services provided are consistent with the supporting documentation and POC. If the individual is unable to sign the time sheets and no other family member/caregiver is able to sign, the individual may make an "X." If the individual is unable to sign or make an "X," the CD Services Facilitator must make a notation made in the front of the individual record that "individual is unable to sign."

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Provider Documentation Requirements

The CD Services Facilitator must maintain records for each individual served. At a minimum, these records must contain:

1. All copies of the POC and supporting documentation (DMAS-97A/B and DMAS-99) that reflect the results of the CD Services Facilitator's initial comprehensive visit (and subsequent reassessment visits, as needed), including the types of assistance (allowable activities) that will be provided and the approximate hours. The start date on the supporting documentation will be the start date of Services Facilitation services for the individual. At the annual POC review, the Services Facilitator must ensure that the Case Manager receives a copy of the updated supporting documentation prior to its due date. Failure to do so will jeopardize the provider's ability to bill for services or the provider's DMAS Provider Agreement;
2.
 - a) The most recent DMAS-225 form;
 - b) The Services Facilitator must clearly document efforts to obtain the completed DMAS-225 form from the Case Manager;
 - c) If CD services are the only services an individual is receiving and that individual is assigned a patient pay, the patient pay amount is to be deducted from the Personal Care Attendant's or CD Respite Care Attendants's or CD Companion's Medicaid reimbursement, and the individual is responsible for remitting the patient pay to the CD Attendant, CD Respite Care Attendant or CD Companion
3. A consent form authorizing release and communication of confidential information to related providers;
4. CD Services Facilitation notes recorded and dated at the time of service delivery documenting any contacts with the individual and family member/caregiver (as applicable) and visits to the individual's home;
5. All correspondence to the individual and family member/caregiver, the Case Manager, and DMAS;
6. Updates to information about the individual made during the provision of services;
7. Records of contacts made with family, physicians, DMAS, formal and informal service providers, and all professionals concerning the individual;
8. All training provided to the CD Attendant or CD Respite Care Attendant or CD Companion on behalf of the individual or family member/caregiver;

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9. All management training provided to the individual or family member/caregiver, including the individual's or family member's/caregiver's responsibility for the accuracy of the CD Attendant's or CD Respite Care Attendant's, or CD Companion's time sheets;
10. All documents signed by the individual or the family member/caregiver that acknowledge the responsibilities of the services; and
11. Documentation of routine and reassessment visits and review of supporting documentation. The supporting documentation must be reviewed by the CD Services Facilitator, and this review must be submitted to the Case Manager, at least semi-annually, with modifications made as appropriate.

Copies of all documentation submitted to DMAS or the Serv Auth contractor are subject to review by state and federal Medicaid representatives. The records contained in the chart must be current within two weeks at all times.

Although the services of the CD Service Facilitator do not require authorization, all criteria and documentation requirements must be met for the entire time the service is provided.

FAMILY/CAREGIVER TRAINING

Service Definition

Family/Caregiver Training is the provision of identified training and education related to disabilities, community integration, family dynamics, stress management, behavior interventions, and mental health to a parent, other family members, or a primary caregiver. For purposes of this service, "family" is defined as the unpaid persons who live with or provide care to a waiver individual, and may include a parent, spouse, children, relatives, a legal guardian, foster family, or in-laws. "Family" does not include individuals who are employed to care for the individual. All family training must be included in the individual's POC.

DMAS will only reimburse services as defined in the service description, listed in the individual's approved POC, 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 content of the training in order to assist family or caregivers with maintaining the individual at home must be documented in the individual's POC and by the provider with supporting documentation (DMAS-457). The training must be necessary in order to improve the family or caregiver's ability to give care and support.

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Family/Caregiver Training must be provided on an individual basis, in small groups, or through seminars and conferences provided by Medicaid-certified 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. DMAS only pays for registration fees.

Service Units and Service Limitations

Family/Caregiver Training services must be billed on an hourly basis and be pre-authorized by the Serv Auth contractor. Family members or primary caregivers can receive up to 80 hours of Family/Caregiver Training services per POC year. Family/Caregiver Training services cannot be authorized retroactively.

Provider Documentation Requirements

The documentation requirements are:

1. Supporting documentation for Family/Caregiver Training. This must contain:
 - a. 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;
 - b. Targeted objectives or time frames or expected outcomes; and
 - c. Specific training/activities (frequency, where, when, and to whom).
2. Contact notes:
 - a. Date, location, and time of each training contact;
 - b. Type of activities and hours of service provided; and
 - c. Persons to whom activities were directed.

or

Monthly notes:

 - a. Summary of training activities for the month;
 - b. Dates, locations, and times of service delivery;
 - c. POC objective(s) addressed;

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- d. Specific details of the activities conducted;
 - e. Services delivered as planned or modified; and
 - f. Effectiveness of the strategies and individual's and caregivers' satisfaction with the service.
3. Semi-annual reviews are required by the service provider if training extends three months or longer and are to be forwarded to the Case Manager and include:
 - a. Activities related to the supporting documentation;
 - b. Individual status and satisfaction with services; and
 - c. Training outcomes and effectiveness of the POC.
 4. If training services extend less than three months, the provider must forward to the Case Manager contact notes, monthly notes, or a summary of such to the Case Manager for the semi-annual review. For family members who are not on the caseload of the Family Caregiver Trainer but attended the training/conference, documentation of the registration and details of the training/conference are required

PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS)

Service Definition

PERS is a device that enables certain individuals at high risk of institutionalization to secure help in an emergency. PERS monitors individual safety in the home and provides access to emergency assistance for medical or environmental emergencies through the provision of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation and via the individual's home telephone line. When appropriate, PERS may also include medication monitoring devices.

DMAS will only reimburse services as defined in the service description, listed in the individual's approved POC, and that are within the scope of practice of the providers performing the service.

Criteria

PERS services are limited to those individuals who live alone or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. PERS and Medication Monitoring services are not stand-alone services; and Medication Monitoring units must be physician ordered. Individuals must be receiving PERS services and Medication Monitoring services simultaneously.

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PERS can only be authorized when no one else is in the home who is competent or continuously available to call for help in an emergency.

Service Units and Service Limitations

A unit of service shall include administrative costs, time, labor, and supplies associated with the installation, maintenance, and monitoring of the PERS. A unit of service is a one-month rental price set by DMAS. The one-time installation of the unit(s) shall include installation, account activation, individual and caregiver instructions, and removal of PERS equipment.

PERS services shall be capable of being activated by a remote wireless device and be connected to the individual's telephone line. The PERS console unit must provide hands-free voice-to-voice communication with the response center. The activating device shall be waterproof, shall 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.

In cases where medication monitoring units must be filled by the provider, the person filling the unit must be a RN or a LPN. The units can be refilled every 14 days, or as medications change. The nurses must be employed by an agency that has a Participation Agreement with DMAS to provide Nursing services. PERS services cannot be authorized retroactively.

The PERS provider is prohibited from performing all types of direct marketing activities to Medicaid individuals. Direct marketing means either (1) conducting directly or indirectly door-to-door, telephonic, or other "cold call" marketing of services at residences and provider sites; (2) mailing directly; (3) paying "finder's fees;" (4) offering financial incentives, rewards, gifts, or special opportunities to eligible individuals as inducements to use their services; (5) continuous, periodic marketing activities to the same prospective individual (e.g., monthly, semi-annual, or annual giveaways) as inducements to use their services; OR (6) engaging in marketing activities that offer potential customers rebates or discounts in conjunction with the use of services or other benefits as a means of influencing individuals' use of provider's services.

Additional PERS Requirements

The PERS provider must properly install all PERS equipment into the individuals' functioning telephone line and must furnish all supplies necessary to ensure that the system is installed and working properly.

The PERS installation shall include local seize-line circuitry, which guarantees the unit to 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.

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A PERS provider must maintain all installed PERS equipment in proper working order. The PERS provider must have back-up monitoring capacity in case the primary system cannot handle incoming emergency signals.

Standards for PERS Equipment

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 Number for home health care signaling equipment. The UL listing mark on the equipment will be accepted as evidence of the equipment's compliance with this standard. The PERS device must be automatically reset by the response center after each activation, ensuring that subsequent signals can be transmitted without requiring manual reset by the individual.

A PERS provider shall furnish education, data, and ongoing assistance to DMAS and Case Managers to familiarize staff with the service, allow for ongoing evaluation and refinement of the program, and shall instruct the individual, family caregiver, and responders in the use of the PERS service.

The emergency response activator must be activated either by breath, by touch, or by some other means, and must be usable by persons who are visually or hearing impaired or physically disabled. 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 it cannot get its signal accepted at the response center.

Monitoring agencies must be capable of continuously monitoring and responding to emergencies under all conditions, including power failures and mechanical malfunctions. It shall be the PERS provider's responsibility to assure that the monitoring agency and the agency's equipment meets the following requirements. The monitoring agency must be capable of simultaneously responding to multiple signals for help from 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;
- A 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;
- A back-up power supply;

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- 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.

Provider Documentation Requirements

A PERS provider must maintain a data record for each PERS individual at no additional cost to DMAS. The record shall document all of the following:

- Delivery date and installation date of the PERS;
- Individual/caregiver signature verifying receipt of PERS device;
- The PERS device is operational as verified, minimally, by a monthly test;
- Updated and current individual responder and contact information, as provided by the individual or the individual's care provider; and
- A case log documenting individual system utilization and individual or responder contacts/communications.

The monitoring agency must maintain detailed technical and operations manuals that describe PERS elements, including the installation, functioning, and testing of PERS equipment; emergency response protocols; and record keeping and reporting procedures.

The PERS provider shall document and furnish, within 30 days, a written report to the Case Manager about each emergency signal, which results in action being taken on behalf of the individual. This shall exclude test signals or activations made in error.

COMPANION CARE SERVICES: AGENCY-DIRECTED (AD)

Service Definition

Companion Care services is a covered service when its purpose is to supervise or monitor those individuals who require the physical presence of an aide to ensure their safety during times when no other caregivers are available.

Companion Care services consist of non-medical care and supervision provided to an adult age 18 years of age or older. The provision of Companion Care services does not entail hands-on nursing care and is provided in accordance with a therapeutic goal in the

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supporting documentation. This shall not be the sole service used to divert individuals from institutional care.

Criteria

The inclusion of Companion Care services in the POC is appropriate only when the individual cannot be left alone at any time due to mental or severe physical incapacity.. This includes individuals who cannot use a phone to call for help due to a physical or neurological disability. Individuals may receive Companion Care services due to their inability to call for help if PERS is not appropriate for them.

Individuals who have a current, uncontrolled medical condition, which would make them unable to call for help during a an emergency, can be approved for Companion Care services if there is documentation that the individual has had recurring events during the two-month period prior to the authorization of Companion Care services. Companion Care services shall not be covered if required only because the individual does not have a telephone in the home or because the individual does not speak English.

There must be a clear and present danger to the individual as a result of being left unsupervised. Companion Care services cannot be authorized for persons whose only need for Companion Care services is for assistance exiting the home in the event of an emergency or for socialization.

Service Units and Limitations

Companion Care services are available to adults only, ages 18 and older.

Companion Care services must be billed on an hourly basis. The amount of Companion Care time included in the POC must be no more than is necessary to prevent the physical deterioration or injury to the individual. In no event may the amount of time relegated solely to Companion Care services on the POC exceed eight hours per day.

A Companion Care Aide cannot provide supervision to individuals who are on ventilators, continuous feeding tubes, or those who require suctioning of their airways.

Companion Care 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, secondary to the individual's severe agitation and physically wandering behavior. Companion services must be required to ensure the individual's safety, secondary to a clear and present danger to the individual as a result of being left unsupervised.

Companion Care services can be authorized when no one else who is in the home that is competent to call for help in an emergency. Companion Care services may not be provided at the same time a Personal Care Attendant is providing care. Companion Care services cannot be authorized retroactively.

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Provider Documentation Requirements

1. The provider agency must conduct an initial home visit prior to initiating Companion Care services to document the efficacy and appropriateness of services and to establish a service plan for the individual. There must be supporting documentation (DMAS-99 and DMAS-457) that reflects the results of this initial assessment (and subsequent reassessments as needed) and includes the specific assistance that will be provided and the approximate hours that will be allowed for each activity.
2. The provider agency must provide documentation of follow-up home visits to monitor the provision of services quarterly or as often as needed.
3. Documentation indicating the dates and times of Companion Care services and the amount and type of service provided must be in the individual's record. The companion's documentation should also include weekly comments or observations about the individual's status and his/her response to services.
4. All correspondence to the individual, family/caregiver, Case Manager, and DMAS.
5. Contacts made with family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individuals.
6. The Companion Care Services Supervisor must document the following in a summary note after significant contacts with the companion and quarterly home visits with the individual:
 - a. Whether Companion Care services continue to be appropriate.
 - b. Whether the plan is adequate to meet the individual's needs or changes are indicated in the plan.
 - c. The individual's satisfaction with the service.
 - d. The presence or absence of the Companion Care Aide during the supervisor's visit.
7. The supporting documentation must be reviewed by the provider with the individual, and this review must be submitted to the Case Manager at least semi-annually with modifications made as appropriate. Semi-annual documentation must include any revisions to the supporting documentation and also address the general status of the individual, significant events, and the individual's or family's (or both) satisfaction with services. The due date for the semi-annual review is determined by the effective start date of the POC and communicated to

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the provider by the Case Manager.

Advance Notification

Unless otherwise specified, written notification must be mailed by the Case Manager to the individual or legal guardian at least 10 days prior to the date of action when an agency reduces, suspends, or terminates one or all Medicaid-covered service(s).

Exceptions to the 10-Day Advance Notice Requirements

The 10-day advance written notice is required to be sent to the individual or legal guardian except in the following instances: (Note that the written notice is required, even though advance notice is not.)

1. When the agency has factual information confirming the death of an individual;
2. When an individual or guardian provides a written request indicating that:
 - a) He/she no longer wishes services to continue; OR
 - b) He/she gives information that requires termination or reduction and indicates an understanding of the action required by supplying this information;
3. The individual has been admitted to an institution and is ineligible for further services, including a regular admission to an ICF-ID or a nursing home, or has been incarcerated;
4. The individual's whereabouts are unknown, as evidenced by returned mail;
5. The agency establishes the fact that the individual has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth;
6. The individual's physician prescribes a change in the level of care;
7. 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 for any reason (i.e., diagnostic or functional eligibility, funding, no provider, etc.).

All notification letters must be filed in the Case Management record.

If the individual is currently receiving the services and requests a DMAS appeal hearing, before the effective date of termination, suspension, or reduction, the DD Waiver provider may not terminate, suspend, or reduce services until the hearing officer renders a decision. After receiving confirmation from the individual or family/caregiver that an appeal has been filed and prior to the date for the proposed change, the Case Manager must notify (verbally or in writing) the provider agency that an appeal is in progress to

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enable the agency to continue services at the same level if the individual chooses. Similarly, the slot of an individual who has been terminated from the waiver may not be allocated to another individual until the 45th day following notification of action. Should the individual file an appeal during that time frame, the slot must remain assigned to its current individual until that individual's appeal rights have been exhausted.

Money paid for services provided to the individual as a result of the required continuation of services during the appeal process is subject to recovery by DMAS if the agency's action is upheld.

Provider Discontinues Services

In non-emergency situations in which a participating provider intends to discontinue services to an individual, the provider shall give the individual or family/caregiver and Case Manager 10 calendar days advance written notification. The letter shall provide the reasons the provider is discontinuing services and the effective date. The effective date shall be at least 10 calendars days from the date of the notification letter. 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 agency personnel is endangered, the 10-day advance written notification period shall not be required, however the Case Manager must be notified prior to discontinuing services. When appropriate, the local DSS/DFS Adult Protective Services or Child Protective Services Agency must be notified immediately. DBHDS Offices of Licensing and Human Rights must also be notified as required under the provider's license.

MAINTAINING RECORDS

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 (HR) documentation. These policies apply even if the agency discontinues operation. DMAS shall be notified in writing of the storage location and procedures for obtaining records for review should the need arise. The location, agent, or trustee shall be within the Commonwealth of Virginia; and

1. Such records must be retained for at least six years from the last date of service or as provided by applicable state laws, whichever period is longer. If an audit is initiated within the required retention period, the records shall be retained until the audit is completed and every exception is resolved; and
2. Records of minors shall be kept for at least six years after such minor has reached the age of 18 years.

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Individual Records

1. The Case Manager must maintain for each DD Waiver individual the following documentation for review by DMAS staff for a period not less than five years from the individual's last date of services.
 - a) The comprehensive assessment and all POCs;
 - b) All supporting documentation from any provider;
 - c) The most recently completed DMAS-225 form, which is to be updated annually by the local DSS/DFS office;
 - d) All supporting documentation related to any change in the POC; and
 - e) All related communication with the providers, individual, consultants, DBHDS, DMAS, DSS, DARS, Serv Auth Contractor, or other related parties.

2. The individual service providers must maintain the following documentation for review by DMAS staff for a period not less than five years from the individual's last date of service for adults and records of minors shall be kept for at least six years after such minor has reached the age of 18 years:
 - a) All supporting documentation (including DMAS-225);
 - b) An attendance log which documents the date services were rendered and the amount and type of services;
 - c) Appropriate progress notes reflecting the individual's status and, as appropriate, progress or lack of progress toward the goals on the supporting documentation; and
 - d) Any documentation to support that services provided are appropriate and necessary to maintain the individual in the home and in the community.