**Should manual users find hyperlinks in this chapter do not work, please copy the hyperlink to
Clipboard and paste in browser.**

General Information Chapter for Service Authorization - INTRODUCTION	
~~individual for~~ Service authorization (SA) is the process to approve specific services for an enrolled Medicaid individual. Service authorization must occur prior to service delivery (other than crisis services) and reimbursement.	
Purpose of Service Authorization	
The purpose of SA is to validate that the service requested is needed by the individual and meets DMAS's criteria for reimbursement. All requests for SA must be submitted to DBHDS by the individual's ~~s~~Support Ccoordinator (SC) through the DBHDS Waiver Management System (WaMS). SA does not guarantee payment for the service; payment is contingent upon service delivery, passing all edits contained within the claims payment process in MES (previously in VAMMIS), the individual's continued Medicaid eligibility, the provider's continued Medicaid eligibility, and ongoing necessity for the service. SA is specific to an individual, a provider, a service code, an established quantity of units/hours, and for specific dates of service. SA is performed by DBHDS or by a contracted entity.	
General Information Regarding Service Authorization	
Submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for SA requests.	
The Service Authorization will:	
Approve	An approval for services is rendered when the request for service authorization meets all waiver criteria as contained in the CMS Medicaid Waiver Application and the DD Waiver Regulations [12VAC30-122-10 - 570].
Approved-Modified	A service authorization request may be approved and modified (which results in appeal rights) based on lack of timeliness of submission, services requested were not justified, or services requested did not meet DD Waiver criteria.
Pend for Add'l Information	If additional information is needed from the provider, the service authorization request will be pended. DBHDS will limit the number of pended responses to two for any given request and will approve or deny that request on the third submission, unless there are mitigating circumstances that warrant reconsideration by the DD Waiver Manager and a final disposition will be rendered. If the SC or ~~P~~provider cannot supply the information requested, the SA request will be ~~rejected or~~ denied by DBHDS with a note in WaMS documenting the reason for this action.

Reject	SA requests that do not meet specific data or basic formatting requirements and cannot be processed by Medicaid will be rejected. When a request is rejected, the earliest start date is date of resubmission of a new SA request via WaMS.
Deny	A denial of waiver services (which results in appeal rights) occurs when the individual or elements of the SA request do not meet the DD Waiver criteria in 12VAC30-122-10 – 570 and does not comport with the DD Waiver Manual's policies and procedures. When a request is denied, the earliest start date is the date of resubmission of a new SA request via WaMS.

Standard Definitions - Semi-Predictable Events / DAY SERVICES

Semi-predictable events include, but are not limited to, events such as illness, inclement weather resulting in the closing of day service sites, holidays, individual choice, etc. If a day services provider provides two or more of the following services to an individual (Group Day, Community Engagement, Community Coaching) and flexibility is required to accommodate individual choice and preference and/or inclement weather, etc., then the provider may request additional hours to their SA request for the combination of these services.

The provider may request up to 10 additional hours of day services per week that will allow the individual to choose additional community outings. These hours should be proportional to the overall requested amount of day services. In no circumstances can the additional hours total more than 66 hours per week. The request must include the reason for the additional hours and the provider must state that they understand that only services delivered will be billed. Attendance log and provider documentation must be maintained to verify service delivery. The service authorization staff will add the additional hours provided to that month's authorized hours. Service authorization requests may be submitted after, but in the same month as service delivery.

Standard Definitions - Semi-Predictable Events / HOME-BASED

Semi-predictable events include, but are not limited to, events such as illness, inclement weather resulting in the closing of day or employment service sites, holidays, individual choice, etc. Individuals receiving In-home Support, Companion, or Personal Assistance services have various available natural supports~~,~~ or service provider resources~~,~~ and are required to have back-up plans. Therefore, solutions for accommodating semi-predictable events will vary from person to person.

The back-up plan support should be considered as the first option to provide needed supports during semi-predictable events such as inclement weather, illness, etc. The back-up plan may, in some circumstances, involve the use of paid staff who substitute for those regularly scheduled or at times other than what may be regularly scheduled. However, there are times when a provider may anticipate a need for an increase in service hours due to holidays, doctor visits, etc. and the back-up plan is not an option. In these situations, a provider may submit a service authorization request (if not already included in their annual plan request) that includes:

- The appropriate explanation such as clear notation of the insufficiency of the back-up plan, and
- Planned usage of additional hours and documentation of the supports that will be provided during those specific periods.

The service authorization staff ~~will~~ may add the additional hours provided to that month's authorized hours. Service authorization requests may be submitted after, but in the same month as, service delivery.

Because these home-based services are authorized on a monthly basis, providers will have hours in that month's authorization on which to draw until the emergency request is made and approved. Only emergencies that occur on the last day of the month require a service authorization modification to be submitted that very day.

Changes in Medicaid Assignment

If an individual transitions between fee-for-service and the Medicaid Managed Care program, the following apply:

If the individual was eligible under fee-for-service (not Health Plan enrolled) for dates where the individual has subsequently become enrolled with a DMAS contracted Health Plan:

- The Health Plan will honor the Service Authorization contractor's SA based upon proof of authorization from the provider, DMAS, or the SA Contractor. SA decisions by the DMAS SA contractor are based upon clinical review and apply only to individuals enrolled in Medicaid fee-for-service on dates of service requested.

- The SA contractor decision does not guarantee Medicaid eligibility or fee-for-service enrollment. It is the provider's responsibility to verify individual eligibility and to check for managed care organization (Health Plan) enrollment. For Health Plan enrolled individuals, the provider must follow the Health Plan's SA policy and billing guidelines for services covered through the Health Plan.

Communication

Provider manuals are located on the DMAS Web Portal https://vamedicaid.dmas.virginia.gov ~~https://www.dmas.virginia.gov/~~ and DBHDS website. The DBHDS website has information related to SA for programs identified in this manual. ~~You~~This information may be accessed ~~this information~~ by going to www.dbhds.virginia.gov. Updates or changes to the SA process for the specific services outlined in this manual will be posted in the form of a Medicaid Memo to the DMAS Web Portal. Changes will be incorporated within the manual.

SA for the Developmental Disabilities Waivers – General Information

General Rules for all Services	• Enrollment of individuals seeking waiver services and support is performed by DBHDS. All requests for service authorization must be submitted to DBHDS by the individual's SC. Final determination of total hours/units/dollars cannot exceed the total hours/units/dollars approved by DBHDS. • When an individual's needs or provider's circumstances change (e.g., a need for a change in hours/units/dollars (increase or decrease), re-start after discharge, or transfer to a new provider), the SC must modify the Individual Support Plan (ISP) and ensure that the Plan for Supports or Interim Plan for Supports is provided by affected providers as appropriate. Requests via WaMS to revise a previously approved authorization must be sent to DBHDS via the SC with corresponding supporting documentation. Requests will include start and end dates along with explanation of need for modification and appropriate revision.

	• All services, other than Respite (which may be authorized for a 2-year timeframe), must be re-authorized at least every 12 months. • The authorized start date of services will not be prior to the date the SA request is initially submitted to DBHDS for eligible individual, except for crisis services. • To assure the provider of individual eligibility and that services are authorized as requested, it is recommended that required documents be submitted at least 30 days prior to requested start of services. • Requests for EPSDT Private Duty Nursing services for individuals on the DD waivers should be submitted at least 10 days, but no more than 30 days prior to requested service start or renewal date. All SA requests will be acted upon (i.e., review of the documentation to determine individual eligibility and the need for and appropriateness of the service being requested, followed by approval, denial, rejection, or pend for additional information) within 10 working days following receipt by DBHDS. Turnaround time begins at 12:01 a.m. on the date after the SC submits the request in WaMS. The timeframe does not include the entire span of time needed to process pended requests for additional information. Upon the receipt of a response to ap pend, DBHDS has 10 additional business days to process the request. • Services will not be authorized when the provider of services is the parent or guardian of individuals enrolled in the waiver who are minor children, or in the case of an adult enrolled in the waiver, the adult individual's spouse. • Services will not be authorized for providers of services furnished by other family members living under the same roof as individual receiving services unless there is objective, written documentation as to why there are no other providers available to provide care. "Objective, written documentation" means documentation that demonstrates there are no persons available to provide supports to individual other than unpaid family/caregiver who lives in the home with the individual. See Chap. 2 for more details and examples. • At the time services are authorized, the notice to the provider will include both taxonomy and specialty code(s) required for billing.
Commonwealth Coordinated Care (Plus) Excluded Waiver Services	
Commonwealth Coordinated Care Plus (CCC+) is a program for individuals with full Medicare and Medicaid benefits and meet all eligibility criteria; able to receive coordinated care through managed care environment. Program objective is to coordinate delivery of primary, preventive, acute, behavioral, and long-term care services and supports. "CCC+ services do not cover the DD Waivers. If an individual becomes eligible for or receives a slot in one of these CCC+ excludedthe DD waivers, the individual will be enrolled in the Waiver and may begin	

receiving Waiver services. CCC+ will continue to cover the regular medical services until the end of the month. The individual will be automatically dis-enrolled from CCC+ the last day of that month.

The individual will receive all services through fee-for-service Medicaid or Medicare effective the first day of the next month.

The DMAS service authorization agent will process the service authorization request for the specific waiver services listed for individuals dually enrolled in CCC+. The request must include all the required documentation for a complete service authorization review. Providers will need to adhere to the timeliness requirements for new admission requests.

CCC+ also includes the CCC+ Waiver for those who qualify. The Continuity of Care Service Authorization affects all individuals receiving Personal Assistance in the CCC+ waiver and transitioning to the FIS or CL waivers. When a CCC+ waiver member is transitioning from the CCC+ waiver to a DD Waiver, DD Waiver enrollment, service authorizations and services cannot begin earlier than the first day of the month after ~~the month in which~~the CCC+ waiver service authorization ended. The Continuity of Care Service Authorization transition plan procedure was implemented on 12/30/2019.

Developmental Disabilities Waiver Services (BI/FIS/CL) Requiring Authorization

All requests must be submitted to DBHDS via WaMS by the individual's SC. The ISP must include all required documentation for the requested service(s) and be approved by DBHDS prior to submitting claims in ~~to the~~ MES (previously in VAMMIS).

Proc. Code T1999 Proc. Code T1999	Mod. N/A Mod. U5	Waiver BI, FIS, CL	Assistive Technology ONLY Assistive Technology – Maintenance Cost ONLY

Unit of service = Maximum Medicaid funded expenditure is $5,000.00 per calendar year for all AT – multiple items may be approved up to plan year limit. Dollars not used in the calendar year cannot roll over into the next calendar year.

Units are requested as "1" with straight cost amounts entered in WaMS. No calculation is required. The Service Authorization is entered for a ~~30-day~~30-day time period within the calendar year.

AT is available to individuals receiving at least one other qualifying waiver service.

AT is only available if the item is not available as durable medical equipment through the State Plan for Medical Assistance.

AT requests must be accompanied by an independent, professional consultation/evaluation from a qualified professional who is knowledgeable of that item to verify the needs of the individual for the AT item. The AT provider's quote must be compatible with the evaluation completed by the qualified professional and the monetary quote must be reasonable for the item(s).

AT maintenance entails the upkeep or installation of an item that meets the definition of AT as per 12VAC30-122-270 in order to make or keep the item operational.-

Proc. Code T1023	Mod. N/A	Waiver BI, FIS, CL	Benefits Planning

Unit of service = 1 hour. This service results in the development of written resource documents to assist individuals and their families/legal representatives to better understand the current and future benefits of working, thereby reducing ambivalence about losing necessary supports and benefits if they choose to work or stay on the job.

This service enables individuals to make an informed choice about the initiation of work. This service also provides information and education to working individuals to make successful transition to financial independence.

Providers may not request service authorization/bill for waiver Benefits Planning services while the eligible individual has an open employment services case with DARS and is eligible for this through DARS.

This service may be authorized one time per allowable activity per individual per calendar year. However, a service may be reauthorized within a calendar year if the individual's situation has changed in terms of disability conditions, benefit type, or employment status.

All activities may be authorized for and conducted in either a face-to-face or HIPPA compliant telemedicine method of delivery. Allowable activities that can be performed using telemedicine can be performed for up to 100% of the authorized service hours.

The annual calendar year limit for this service is $3,000. Unspent funds from one plan year may not be accumulated and carried over to subsequent plan years.

Activity & Hourly Limit per Activity:

- Plan for Achieving Self-Support-Part 1 hours - 7.0
- Plan for Achieving Self-Support-Part 2 hours - 12.5
- Impairment Related Work Expense hours - 9.0
- Blind Work Expense hours - 9.0
- 1619(b) Medicaid hours - 4.0
- Student Earned Income Exclusion hours - 9.0
- Subsidy hours - 9.0
- Work Activity Reports hours - 6.0
- Medicaid Works hours - 5.5
- Overpayment hours -3.5
- Benefits Planning Query hours - 1.0
- Pre-Employment BSA hours -7.0
- WorkWORLD Summary and Analysis hours -7.0
- Individual Development Accounts hours -7.0
- Section 301/Able Now hours - 4.5
- Financial Health Assessment hours - 3.5

- WI Revisions hours -7.0

Proc. Code H2019 H2019	Mod. U1 UA	Waiver BI, FIS, CL	Center-Based Crisis Supports (PROFESSIONAL) Center-Based Crisis Supports (NON-PROFESSIONAL)

Unit of service = 1 hour. This service may be authorized up to 72 hours after the QDDP or QM~~R~~HP face-~~-~~to-face assessment or reassessment if the service is not available through the State Plan. A longer timeframe may be permitted with supporting documentation that indicates the authorization was attempted within the 72 hours. The SA request must include documentation of the QDDP or QMHP assessment or reassessment.

Service must be limited to six months per ISP year and must be authorized in increments of up to a maximum of 30 days with each authorization.

The service authorization request should include documentation that the individual has a history of at least one of the following:

- Psychiatric hospitalization(s);
- Incarceration;
- Residential/day placement(s) that was terminated; or
- Behavior(s) have significantly jeopardized placement.

Also, the individual must meet at least one of the following:

- Currently ~~E~~experiencing a marked reduction in psychiatric, adaptive, or behavioral functioning;
- Currently ~~E~~experiencing an increase in emotional distress;
- Currently ~~N~~needs continuous intervention to maintain stability; or
- Is ~~C~~causing harm to himself or others.

The individual must also be:

- At risk of psychiatric hospitalization;
- At risk of emergency ICF/IID placement;
- At immediate risk of loss of community service due to severe situational reaction; or
- Actually causing harm to him/herself or others.

The ISP Parts 1-4 and the provider's Part 5 are to be submitted by the SC in WaMS with supporting documentation/justification for this service~~ – the Part 5 is not required for Center-Based Crisis Supports~~.

Proc. Code S9484 Eff. 7/01/21 S9484 Eff. 7/01/21	Mod. U1 N/A	Waiver BI, FIS, CL	COMMUNITY-Based Crisis Supports (PROFESSIONAL) COMMUNITY-Based Crisis Supports (NON - PROFESSIONAL)

Unit of service = 1 hour. This service may be authorized up to 72 hours after the QDDP or QMHP face-~~-~~to-face assessment or reassessment if the service is not available through the State Plan. A longer timeframe may be permitted with supporting documentation that indicates the authorization was attempted within the 72 hours. The SA request must include documentation of the QDDP or QMHP assessment or reassessment.

Service may be authorized for up to 24 hours per day, if necessary, in increments of no more than 15 days at a time.

The annual limit is 1080 hours. Requests for additional hours in excess of the 1080 limit will be considered if justification of the individual need is provided.

Community-based crisis support service provides ongoing supports to the individual who may have:

- A history of multiple psychiatric hospitalizations, frequent medication changes, or setting changes; or
- A history of requiring enhanced staffing due to the individual's mental health or behavioral issues.

The service authorization request should include documentation that the individual has a history of at least one of the following:

- Previous psychiatric hospitalization or hospitalizations;
- Previous incarceration;
- ~~Lost previous r~~Residential/day placement or placements that was terminated; or
- ~~His b~~Behavior or behaviors have jeopardized ~~his~~ community placement.

Also ~~M~~meets at least one of the following:

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

And Also:

- Is at risk of psychiatric hospitalization;
- Is at risk of emergency ICF/IID placement; and/or
- Is at immediate threat of loss of community service due to a severe situational reaction.
- Actually causing harm to self or others.

In addition, the SA request must include documentation that an assessment/re-assessment by a

Qualified Developmental Disabilities Professional (QDDP) was performed.

The ISP Parts 1-4 and the provider's Part 5 are to be submitted by the SC in WaMS with supporting documentation/justification for this service. ~~The Part V is not required for this service.~~

Proc. Code T2013	Mod. N/A	Waiver BI, FIS, CL	Community Coaching

Unit of service = 1 hour. The expected number of weekly units of services are requested and authorized in monthly totals.

~~These services~~ This service, either alone, or in combination with any of the following services: individual and/or group supported employment services, community engagement, group day, and/or workplace assistance must be limited to 66 hours per week.

An initial 60-day assessment plan may be submitted. Prior to the last day of the assessment period, an annual Plan for Supports must be submitted to the SC for review, approval, and reauthorization if required~~for continued authorization~~. The start date of the annual Plan for Supports must be no later than day 61 and the end date must correspond to the end date of the annual ISP.

The maximum service authorization duration is 12 months, and in accordance with ISP's effective from and through dates. The ISP Parts 1-4 and the provider's Part 5 are to be submitted by the SC in WaMS with supporting documentation/justification for this service. Justification should include a description of the specific barrier(s) currently being encountered to support this 1:1 service vs. utilizing Community Engagement. The duration of service authorization is designed to be time limited per barrier or steps to address the barrier. "Time limited" is dependent on the individual and his/her support needs. The service itself may be authorized for extended periods of time.

Skill building must be a component of this service. Each individual's Plan for Supports should minimally have one skill building activity regarding engagement with community members and one skill building activity regarding addressing the documented barrier to community engagement.

Services may be authorized and provided through a telemedicine model; however, not all allowable activities may be authorized/provided through this modality. See Chapter IV for details and examples. Authorization for service delivery via telemedicine is limited to 10% of billable hours.

Services will be provided in the community. A schedule of supports identifying community activities/events should be provided. The Part ~~V~~ 5 should include skill building in relation to specific barriers. The barriers should be clearly identified.

For Semi-Predictable Events / DAY SERVICES please refer to Standard Definitions.

Proc. Code T2013	Mod. U1	Waiver BI, FIS, CL	Community Coaching (CUSTOMIZED)

PLEASE REFER TO MEDICAID MEMO DATED 9/1/2017 FOR ALL INFORMATION PERTAINING TO CUSTOMIZED RATES.

Telemedicine delivery of Community Coaching services is not permitted for individuals receiving the Customized Rate.

Proc. Code T2021	Mod. N/A	Waiver BI, FIS, CL	Community Engagement

Unit of service = 1 hour. The expected number of weekly units of services are requested and authorized in monthly totals.

~~These~~ This service~~s~~, either alone or in combination with any of the following services: individual and/or group supported employment services, group day, community coaching and/or workplace assistance must be limited to 66 hours per week. A menu of supports identifying community activities/events should be provided.

Skill building must be a component of this service. Other than time for planning community activities or if individuals need to return to a central location to care for plan-specific hygiene issues (the total of which will be authorized for no more than 10% of the total number of authorized hours per month), this service will only be authorized to be delivered in the community.

Services may be authorized and provided through a telemedicine model; however, not all allowable activities may be authorized/provided through this modality. See Chapter IV for details and examples. Authorization for service delivery via telemedicine is limited to 10% of billable hours.

~~For Semi-Predictable Events / DAY SERVICES please refer to Standard Definitions.~~

An initial 60-day assessment plan may be submitted. Prior to the last day of the assessment period, an annual Plan for Supports must be submitted to the SC for review, approval, and reauthorization if required~~for continued authorization~~. The start date of the annual Plan for Supports must be no later than day 61 and the end date must correspond to the end date of the annual ISP.

The maximum service authorization duration is 12 months, and in accordance with the ISP's effective from and through dates. The ISP Parts 1-4 and the provider's Part 5 are to be submitted by the SC in WaMS with supporting documentation/justification for this service.

For Semi-Predictable Events / DAY SERVICES please refer to Standard Definitions.

Proc. Code H2015	Mod. N/A	Waiver BI, FIS, CL	Community Guide

Unit of service = 1 hour.

There are two types of Community Guide.

General community guide:
This involves utilizing existing assessment information regarding the individual's general interests in order to determine specific preferred activities and venues that are available in his community to which he desires to be connected (e.g., clubs, special interest groups, physical activities/sports teams, etc.) in order to promote his inclusion and independent participation in the life of his community. The desired result is an increase in daily or weekly natural supports, as opposed to increasing hours of paid supports.

Community housing guide:
This involves supporting an individual's move to independent housing by helping with transition and tenancy sustaining activities. The community housing guide must work in collaboration with the SC, regional housing specialist, and others to enable the individual achieve and sustain integrated, independent living.

Community Guide is expected to be a short, periodically intermittent, intense service associated with a specific outcome. The plan for supports should delineate which type of community guide is being requested.

An individual may receive one or both of the two types of Community Guide services in an ISP year.

Each type of Community Guide service may be authorized for up to 6 consecutive months; however, if after six months, the 120 hour ISP year limit has not been reached and further supports are still required, a request for additional months of Community Guide services may be submitted for service authorization., ~~and the~~l cumulative total across both types may be no more than 120 hours in a plan year.

Community Guide activities conducted not in the presence of the individual, such as researching and contacting potential sites, supports, services and resources, must not comprise more than twenty-five percent of authorized plan for support hours.

For services conducted in the presence of the individual, ~~O~~other than elements of the service which are for community integration purposes, authorization for service delivery via telemedicine for Community Guide may be up to 100% of the authorized and delivered units of service per month, depending on the needs of the individual and what has been identified in the ISP.

The Community Guide must not supplant, replace, or duplicate activities that are required to be provided by the SC.

Prior to accessing funding for this service, all other available and appropriate funding sources must be explored and exhausted.

The ISP Parts 1-4 and the provider's Part 5 are to be submitted by the SC in WaMS with supporting documentation/justification for this service.

Proc. Code S5135	Mod. N/A	Waiver FIS, CL	Agency-Directed Companion Services

Unit of service = 1 hour. Services are requested weekly and authorized in monthly units. A maximum of 8 hours per ~~24 hour~~24-hour day (or 2920 hours per ISP year) may be authorized for this service per ISP year, either singly or for both types of Companion services combined.

May only be authorized for individuals 18 years and older.

Documentation submitted with the service authorization request must confirm that the service is not purely recreational in nature.

Service must not be authorized to include the provision of nursing care procedures including care of ventilators, tube feedings, suctioning of airways, external catheters, or wound care nor must it include the provision of routine support with ADLs (may be provided PRN). The service will not be authorized for family members to sleep unless the individual cannot be left alone at any time. In this situation, Companion services must be required to ensure the individual's safety due to a clear and present danger to the individual as a result of being left unsupervised. Hours authorized must be based on the documented need of the individual. This service does not include skill building.

A back-up plan must be identified in the event the companion cannot provide services to the individual.

~~For Semi-Predictable Events / HOME-BASED please refer to Standard Definitions.~~

For an individual receiving group home, sponsored residential or supportive living services, Companion services will not be authorized to be delivered by an immediate family member.

For an individual receiving sponsored residential services, Companion services will not be authorized to be delivered by a member of the sponsored family residing in the sponsored residential home.

The maximum service authorization duration is 12 months, and in accordance with the ISP's effective from and through dates. The ISP Parts 1-4 and the provider's Part 5 are to be submitted by the SC in WaMS with supporting documentation/justification for this service.

For Semi-Predictable Events / HOME-BASED please refer to Standard Definitions.

Proc. Code S5136	Mod. N/A	Waiver FIS, CL	Consumer-Directed Companion Services

Unit of service = 1 hour; requested hours/week is multiplied by 2 and approved in bi-weekly units. A maximum of 8 hours per 24-hour day (or 2920 hours per ISP year) may be authorized for this service per ISP year, either singly or for both types of Companion services combined.

May only be authorized for individuals 18 years and older.

Documentation submitted with the service authorization request must confirm that the service is not purely recreational in nature.

Service must not be authorized to include the provision of nursing care procedures including care of ventilators, tube feedings, suctioning of airways, external catheters, or wound care nor must it include

the provision of routine support with ADLs (may be provided PRN).). The service will not be authorized for family members to sleep unless the individual cannot be left alone at any time. Hours authorized must be based on the documented need of the individual. This service does not include skill building.

A back up plan must be identified in the event the companion cannot provide services to the individual.

Any combination of CD respite service, CD personal assistance service, and CD companion service must be limited to ~~56~~40 hours per week for a single employer of record (EOR) by the same CD companion. An individual may be authorized to receive more than 40 hours per week of CD companion service, if needed, through multiple CD employees. Companions who live with the individual, either full time or for substantial amounts of time, must not be restricted to only ~~56~~40 hours per week for the single EOR.

~~tHE~~ The CD companion must not provide more than 16 hours of consumer-directed services per 24 hour period~~day~~. The 16-~~-~~hour limit must include hours worked in one day providing a combination of companion, personal assistance, and respite services.

All CD services require the services of a Services Facilitator or an unpaid person (such as a family member) acting~~s~~ in this capacity. If the individual is not going to direct his own services, an EOR must be identified.

Family/caregivers acting as the employer on behalf of the individual (EOR) may not also be the CD employee.

For an individual receiving group home, sponsored residential or supportive living services, Companion services will not be authorized to be delivered by an immediate family member.

For an individual receiving sponsored residential services, the companion must not be a member of the sponsored family residing in the sponsored residential home.

The maximum service authorization duration is 12 months, and in accordance with the ISP's effective from and through dates. The ISP Parts 1-4 and the Part 5 or a Personal Preference tool with a DMAS 97, the DMAS 99, and a schedule are to be submitted by the SC in WaMS with supporting documentation/justification for this service.

Proc. Code T2034 ——— T2034	Mod. U1 ——— N/A	Waiver BI, FIS, CL	Crisis Support Services (PROFESSIONAL) ——— Crisis Support Services (NON-PROFESSIONAL

Unit of service = 1 hour. This service may be authorized up to 72 hours after the QDDP or QMHP face-to-face assessment or reassessment if the service is not available through the State Plan. A longer timeframe may be permitted with supporting documentation that indicates the authorization was attempted within the 72 hours. The SA request must include documentation of the QDDP or QMHP assessment or reassessment.

~~The ser~~13~~service~~vice Service is designed for individuals experiencing circumstances such as:

- marked reduction in psychiatric, adaptive, or behavioral functioning;
- an increase in emotional distress;
- needing continuous intervention to maintain stability; or
- causing harm to themselves or others.

This service includes Crisis Prevention, Crisis Intervention, & Crisis Stabilization.

- Crisis Prevention: the unit of service must be one hour and authorization may be for up to 24 hours per day. Crisis prevention may be authorized for up to 60 days per ISP year. May be authorized concurrently (same dates and times) with any other waiver service.
- Crisis Intervention: the unit of service must be one hour and authorization may be for up to 24 hours per day. Crisis intervention may be authorized in increments of no more than 15 days at a time for up to 90 days per ISP year. May be authorized concurrently (same dates/times) with any other waiver service.
- Crisis Stabilization: the unit of service must be one hour and authorization may be for up to 24 hours per day. Crisis stabilization may be authorized in increments of no more than 15 days at a time for up to 60 days per ISP year. May be authorized concurrently (same dates and times) with any other waiver service.

~~The SA request must include documentation that the service is being requested following an assessment/re-assessment by a Qualified Developmental Disabilities Professional (QDDP) or Qualified Mental Health Professional (QMHP).~~

The ISP Parts 1-4 and the provider's Part 5 are to be submitted by the SC in WaMS with supporting documentation/justification for this service. **~~The Part V is required for this service~~**

Proc. Code A9279	Mod. N/A	Waiver BI, FIS, CL	Electronic Home-Based Supports (EHBS)

Unit of service = Maximum Medicaid funded expenditure is $5000.00~~T~~ per ISP year for all EHBS – multiple items may be approved up to plan year limit.

Units are entered in straight cost amounts and the SA is entered for a ~~30 day~~30-day time period within the ISP year. For ongoing monitoring services, the service authorization must be requested in 3-~~-~~month intervals throughout the ISP year.

Units are entered in straight cost amounts. Services may be requested for up to 3 months at a time for ongoing maintenance services; however, the actual SA is entered for one 30-day time period within those three months and billing must be submitted for those dates.

Authorization Period	Billing Period	Claims Date
30 Days	90 Days	Within the Authorization Period

For example: The authorization within WaMS is opened for 30 days (start date-1/1/24, end date-1/30/24) for a service delivery period, which could be up to 90 days (1/1/24-3/31/24).

Provider can submit a billing claim to DMAS to include the cost of up to 90 days of services for one unit on one day during the service authorization period between 1/1/24-1/30/24 (which are the auth dates within WaMS.)

Individual must be 18 years of age or older and be physically capable of using the equipment provided.

EHBS requests must be for services provided in the least expensive manner possible that will meet

the identified need of the individual. Costs cannot be carried over from one ISP year to another (i.e., a requested service cannot be split between 2 authorization periods to approve part of funding in one ISP year and remaining funding for same EHBS item in next ISP year).

Equipment/supplies already covered by any other Medicaid covered service must not be authorized under this waiver service. EHBS service must not be authorized for individuals who are receiving residential supports that are reimbursed on a daily basis (group home, sponsored residential, or supported living services).

Service authorization request must include a description of the item requested by the SC and actual cost to the provider via an invoice. Documentation must match the name of the item and the total cost of the item.

A preliminary needs assessment must be completed by an independent professional consultant (including an Occupational Therapist, a Licensed Behavior Analyst or similarly licensed professionals qualified to recommend assistive technologies, such as a Primary Care Physician, Psychiatric Provider, or a Physical Therapist). The independent professional consultant ~~technology specialist (~~cannot be employed by the requesting provider~~)~~. The professional consultant may review and provide a signed statement of recommendation on the optional form "Assessment Tool for Electronic Home-based Supports" in lieu of completing their own preliminary needs assessment ~~is an option for this purpose~~. This optional form can be found on the DBHDS website at https://dbhds.virginia.gov/developmental-services/provider-network-supports/. –Regardless of the form, the purpose of the assessment is to determine the best type and use of technology and overall cost effectiveness of various options. This assessment along with a written recommendation completed by the EHBS provider detailing the agreed upon technology items and an itemized invoice for each item must be submitted with the service authorization request prior to the delivery of any goods and services and prior to the submission of any claims for Medicaid reimbursement.

This service or item will decrease the need for other Medicaid services (e.g., reliance on staff supports); AND/OR promote inclusion in the community; AND/OR increase the individual's safety in the home environment.

The maximum service authorization duration is 12 months, and in accordance with the ISP's effective from and through dates. The ISP Parts 1-4 ~~and the provider's Part 5~~ are to be submitted by the SC in WaMS with supporting documentation/justification for this service. No Part 5 is required.

Proc. Code A0090	Mod. N/A	Waiver BI, FIS, CL	Employment & Community Transportation (Private Vehicle)

Unit = One-way trip distance (Trip Rates: Under 10 miles, 10 – 20 miles, over 20 miles). This service is authorized in order to enable the individual to gain access to his/her place of employment, volunteer activity, other community services or events, activities and resources, homes of family or friends, civic organizations or social clubs, public meetings or other civic activities, and spiritual activities or events as specified by the support plan and when no other means of access is available.

This service may only be authorized if its use is related to the individual's desired outcome(s) as stated in the ISP.

The service includes transportation in a private vehicle by a person such as a co-worker or other community member. It may be provided by the individual's family member or legally responsible person, but may not be:

- The guardian, parent, ~~step-parent~~stepparent of an individual under the age of 18, or
- Spouse of an adult who is receiving the service.

Up to three individuals may be transported in a single, private vehicle per trip. This service must not be authorized or reimbursed for individuals who can access transportation through the State Plan or other waiver services, which include a transportation component.

Private transportation is reimbursed according to a "trip" (which is reimbursed for the round-trip) and the number of individuals being transported to the location (maximum of three). ~~There are three trip rates depending on the one-way distance traveled:~~

- ~~Under 10 miles~~
- ~~Between 10 – 20 miles~~
- ~~Over 20 miles~~

When a private driver is transporting more than one individual to a single destination, the trip rate for all individuals is the same and is determined by the distance between the first individual picked up and the final destination.

A provider delivering other waiver services to an individual may not utilize staff to provide ECT and may only request authorization for ECT if the transportation would not be a normally required element of service provision.

Documentation that must be submitted along with the service authorization request includes: ECT Trip Plan form ~~and the trip distance estimate in the form of a MapQuest, Google Maps, or similar printout with point of origin, destination, and mileage~~.

Proc. Code A0110	Mod. N/A	Waiver BI, FIS, CL	Employment & Community Transportation (Public Transportation & ECT)

Unit = public transportation ticket fee. This service is authorized in order to enable the individual to gain access to his/her place of employment, volunteer activity, other community services or events, activities and resources, homes of family or friends, civic organizations or social clubs, public meetings or other civic activities, and spiritual activities or events as specified by the support plan and when no other means of access is available.

This service may only be authorized if its use is related to the individual's desired outcome(s) as stated in the ISP. The service includes the purchase of tickets for public transportation such as bus or subway.

When the ECT administering provider arranges access to public transportation by purchasing public transportation fares such as bus or rail tokens, tickets, passes, fare cards, etc., SA approves the actual fare cost plus the administrative fee. Therefore, the cost of tickets, etc. for public transportation along with the purpose/destination of the trip must be submitted to the SA staff.

Proc. Code A0120	Mod. N/A	Waiver BI, FIS, CL	Public Transportation via Para-Transit

Unit = para-transit fare. This service is authorized in order to enable the individual to gain access to his/her place of employment, volunteer activity, other community services or events, activities and resources, homes of family or friends, civic organizations or social clubs, public meetings or other civic activities, and spiritual activities or events as specified by the support plan and when no other means of access is available.

This service may only be authorized if its use is related to the individual's desired outcome(s) as stated in the ISP.

The service includes the purchase of tickets for public transportation such as para-transit bus/vehicle.

When the ECT administering provider arranges access to public transportation by purchasing public transportation fares such as bus or rail tokens, tickets, passes, fare cards, etc., SA staff approves the actual fare cost plus the administrative fee. Therefore, the cost of tickets, etc. for public transportation along with the purpose/destination of the trip must be submitted to the SA staff.

Proc. Code S5165	Mod. N/A	Waiver BI, FIS, CL	Environmental Modifications ONLY

Unit of service = Maximum Medicaid funded expenditure is $5,000.00 per calendar year for all EM procedure codes, regardless of the waiver for which EM service is approved and regardless of whether the individual changes waivers over the course of the calendar year. Multiple items may be approved up to the plan year limit. The service authorization request must include a description of the items/modification requested from the SC and the actual cost to the provider via an itemized invoice.

Units are requested with actual cost amounts entered on the SA request in WaMS. The Service Authorization is approved for a 30-day period within the calendar year.

Cost cannot be carried over from one year to another (i.e., a request for an item/modification cannot be split between 2 authorization periods to approve part of the funding in one calendar year and the remaining funding in the next year).

EM is available to individuals receiving at least one other qualifying waiver service. Providers must not

be the spouse, parents or legal guardians of the individual enrolled in the waiver.

This service will not be authorized to:

- Add to the total square footage of the home;

Adapt living arrangements that are owned or leased by providers of waiver services (i.e., group homes, adult foster care homes, sponsored residential homes

-);

Make modifications that are reasonable accommodation requirements of the Americans with Disabilities Act, the Virginians with Disabilities Act, and the Rehabilitation Act (this includes modifications at worksites or other community settings

-);

Adapt or improve the home for the purpose of general utility that is not of direct medical or remedial benefit to the individual enrolled in the waiver (e.g., carpeting, roof repairs, and central air conditioning

- ~~—~~);

- Purchase items for general leisure, diversion items, or those items that are recreational in nature or may be used as an outlet for behavioral supports;

Cover the costs of removal or disposal, or any other costs, of previously installed modifications, whether paid for by DMAS or any other source
e;

- Purchase or lease a vehicle or perform regularly scheduled upkeep and maintenance of the vehicle, except upkeep and maintenance of the modifications that were covered under EM;

- Adapt vehicles that are owned or leased by paid providers of waiver services;
- ~~s;~~

- Bring a substandard dwelling up to minimum habitation standards; or
- Adapt or improve a vehicle for the purpose of general utility vs. direct medical or remedial benefit to the individual.

Documentation must match the name of the items/modification and the total cost as listed on the ISP.

Service authorization may not be made for providers of EM who are the individual's spouse, parent (natural, adoptive, step, foster), legal guardian, or conservator. Providers who supply EM to waiver individuals must not perform consultations or write EM specifications for such individuals,

The service authorization must include justification and explanation if a rehabilitation engineer is needed.

~~The maximum service authorization duration is for a 30-day period within the calendar year.~~ The ISP Parts 1-4 ~~and the Plan for Supports (Part 5)~~ are to be completed/submitted by the SC in WaMS with supporting documentation/justification for this service. No Part 5 is required.

Proc. Code 99199	Mod. U4	Waiver BI, FIS, CL	Environmental Modifications – Maintenance Costs ONLY

Unit of service = 1 per month. A unit of service must include administrative costs, time, labor, and supplies associated with the maintenance, monitoring, and adjustments of the EM. A unit of service is the actual cost of the maintenance/repair of installed EM.

Maximum Medicaid funded expenditure is $5000.00 per calendar year for all EM procedure codes, regardless of the waiver for which EM service is approved and regardless of whether the individual changes waivers over the course of the calendar year. Multiple items may be approved up to plan year limit.

Costs cannot be carried over from one calendar year to another.

EM Maintenance is repair for items paid for by the Waiver.

The maximum service authorization duration is for a 30-day period within the calendar year. The ISP Parts 1-4 ~~and the Plan for Supports (Part 5)~~ are to be completed/submitted by the SC in WaMS with supporting documentation/justification for this service. No Part 5 is required.

Proc. Code 97150	Mod. U1	Waiver BI, FIS, CL	Group Day Support

Unit of service = 1 hour. The expected number of weekly units of services are requested and authorized in monthly totals. ~~These services~~This service, either alone or in combination with any of the following services: individual and/or group supported employment services, community engagement, ~~group day,~~ community coaching and/or workplace assistance must be limited to 66 hours per week. A menu of supports identifying community activities/events should be provided.

~~For **Semi-Predictable Events / DAY SERVICES** please refer to Standard Definitions.~~

The Plan for Supports/Part 5~~V~~ must include skill building (unless the individual has a documented progressive condition in which case this service may focus on maintaining skills and functioning and preventing or slowing regression rather than acquiring new skills or improving existing skills). A schedule of supports is required.

An initial 60-day assessment plan may be submitted. Prior to the last day of the assessment period, an annual Plan for Supports must be submitted to the SC for review, approval, and reauthorization if required~~for continued authorization~~. The start date of the annual Plan for Supports must be no later than day 61 and the end date must correspond to the end date of the annual ISP.

Services may be authorized and provided through a telemedicine model; however, not all allowable activities may be authorized/provided through this modality. See Chapter IV for details and examples. Authorization for service delivery via telemedicine is limited to 10% of billable hours.

Time spent by the provider transporting the individual to and from the service (up to 25% of the total service time) may be included.

Group day services must comply with the HCBS setting requirements. The plan must document any restrictions on the freedoms of everyday life in accordance with the HCBS settings regulations.

The maximum service authorization duration is 12 months and in accordance with the ISP's effective from and through dates. The ISP Parts 1-4 and the provider's Plan for Supports (Part 5) are to be submitted by the SC in WaMS with supporting documentation/justification for this service.

For Semi-Predictable Events / DAY SERVICES please refer to Standard Definitions.

Proc. Code T2025	Mod. N/A	Waiver BI, FIS, CL	Group Day Support (Customized Rate)

PLEASE REFER TO MEDICAID MEMO DATED 9/1/2017 FOR INFORMATION PERTAINING TO CUSTOMIZED RATES

Telemedicine delivery of group day services is not permitted for individuals receiving the Customized Rate.

Proc. Code H2022	Mod. See Below*	Waiver CL	Group Home Residential

***Modifiers: UA = 4 or fewer persons/home, U2 = 5 persons/home, U3 = 6 persons/home, U4 = 7 persons/home, U5 = 8 persons/home, U6 = 9 persons/home, U7 = 10 persons/home, U8 = 11 persons/home, U9 = 12 persons/home**

Unit of service = 1 day. Services are authorized according to licensed home capacity. This is a tiered service. Services and may be authorized for 344 days per year.

An initial 60-day assessment plan may be submitted. Prior to the last day of the assessment period, an annual Plan for Supports must be submitted to the SC for review, approval, and reauthorization if required~~for continued authorization~~. The start date of the annual Plan for Supports must be no later than day 61 and the end date must correspond to the end date of the annual ISP.

A Plan for Supports/Part ~~V~~5, which must include skill building and a schedule of supports, is required for authorization of group home residential services.

Group home residential services must comply with the HCBS setting requirements. The plan must document any restrictions on the freedoms of everyday life in accordance with the HCBS settings regulations.

The maximum service authorization duration is 12 months and in accordance with the ISP's effective from and through dates. The ISP Parts 1-4 and the provider's Plan for Supports (Part 5) are to be submitted by the SC in WaMS with supporting documentation/justification for this service.

Proc. Code	Mod. N/A	Waiver CL	Group Home Residential (Customized)
T2016			

PLEASE REFER TO MEDICAID MEMO DATED 9/1/2017 FOR INFORMATION PERTAINING TO CUSTOMIZED RATES.

Proc. Code H2024	Mod. See Below*	Waiver BI, FIS, CL	Group Supported Employment

***UA = 2 or fewer individuals/group, U2 = more than 2; up to 4 individuals/group, U3 = more than 4 individuals/group**

Unit of service = 1 hour. Group Supported Employment must not exceed 40 hours per week~~. These services~~ This service, either alone, or in combination with any of the following services: individual supported employment services, community engagement, community coaching, group day, and/or workplace assistance must be limited to 66 hours per week.

An initial 60-day assessment plan may be submitted. Prior to the last day of the assessment period, an annual Plan for Supports must be submitted to the SC for review, approval, and reauthorization if required~~for continued authorization~~. The start date of the annual Plan for Supports must be no later than day 61 and the end date must correspond to the end date of the annual ISP.

Documentation must be submitted with the SA request that Supported Employment Services cannot be obtained from the school system (for those less than 22 years) nor from Department of Aging and Rehabilitative Services. This must include the name of the DARS or school representative who made the determination and the date it was received.

Services may be authorized and provided through a telemedicine model; however, not all allowable activities may be authorized/provided through this modality. See Chapter IV for details and examples. Authorization for service delivery via telemedicine is limited to 10% of billable hours.

~~Time spent by the provider transporting the individual to and from group supported employment (up to 25% of the total service time) may be included.~~

A plan for supports/Part ~~V~~5 to include skill building and a schedule of supports is required. Group supported employment services must comply with the HCBS setting requirements. The plan must document any restrictions on the freedoms of everyday life in accordance with the HCBS settings regulations.

The plan must reflect that the service is to be provided in a community setting that promotes integration into the workplace, interaction in the workplace between participants and persons without disabilities, and that support is provided by staff to groups of two to eight individuals.

The maximum service authorization duration is 12 months and in accordance with the ISP's effective from and through dates. The ISP Parts 1-4 and the provider's Plan for Supports (Part 5) are to be submitted by the SC in WaMS with supporting documentation/justification for this service.

Proc. Code T2032	Mod. U1 for partial month	Waiver BI	Independent Living Supports

Unit of service = 1 month or partial month for months in which the service begins or ends. If the beginning or ending month time frame is less than 10 days, request the service using partial month modifier.

May only be provided to adults 18 years and older.

A Plan for Supports/Part 5~~V~~, which includes skill building and a schedule of supports, is required. In general, the service must be approved for no more than 21 hours within a week (Sunday through Saturday).

Justification should indicate the individual's living arrangement and setting. ~~These services~~ This service must not be authorized to be provided in a licensed residential setting.

An initial 60-day assessment plan may be submitted. Prior to the last day of the assessment period, an annual Plan for Supports must be submitted to the SC for review, approval, and reauthorization if required~~for continued authorization~~. The start date of the annual Plan for Supports must be no later than day 61 and the end date must correspond to the end date of the annual ISP.

The maximum service authorization duration is 12 months and in accordance with the ISP's effective from and through dates. The ISP Parts 1-4 and the provider's Plan for Supports (Part 5) are to be submitted by the SC in WaMS with supporting documentation/justification for this service.

Proc. Code S5111	Mod. N/A	Waiver FIS	Individual & Family Caregiver Training (IFCT)

Unit of service = maximum Medicaid funded expenditure is up to $4,000.00 per ISP year.

May be authorized for individuals and their family/caregivers (where "family" is defined as the unpaid people who live with or provide care to an individual served by the waiver and may include a parent, a legal guardian, a spouse, children, relatives, a foster family, or in-laws but must not include persons who are compensated to care for the individual), as appropriate.

ISP Parts 1-4 and an abbreviated Plan for Supports that includes (1) identifying information about the provider, (2) effective dates for the service, (3) person-centered review dates (if applicable), (4) expected outcomes of the training, and (5) specific training or activities showing frequency, location, dates and times, and to whom the training will be provided are to be submitted by the SC in WaMS with supporting documentation/justification and the cost for this service.

This service may be authorized for and conducted in either a face-to-face or HIPPA compliant telemedicine method of delivery. Allowable activities that can be performed using telemedicine can be performed for up to 100% of the authorized service hours.

Travel and room and board expenses must not be authorized.

The service may be authorized for providers that have the necessary licensure/certification as required for their profession, as well as seminars and conferences organized by the enrolled provider entities.

Proc. Code H2023	Mod. N/A	Waiver BI, FIS, CL	Individual Supported Employment

Unit of service = 1 hour. Individual Supported Employment must not exceed 40 hours per week.

~~These~~ This service~~s~~, either alone, or in combination with any of the following services: Group Supported Employment services, Community Engagement, Community Coaching; Group Day, and/or Workplace Assistance must be limited to 66 hours per week.

Documentation must be submitted with the SA request that supported employment services cannot be obtained from the school system (for those less than 22 years) nor from Department of Aging and Rehabilitative Services. This must include the name of the DARS or school representative who made the determination and the date it was received.

An initial 60-day assessment plan may be submitted. Prior to the last day of the assessment period, an annual Plan for Supports must be submitted to the SC for review, approval, and reauthorization if required~~for continued authorization~~. The start date of the annual Plan for Supports must be no later than day 61 and the end date must correspond to the end date of the annual ISP.

A plan for supports/Part ~~V~~5 which includes skill building and a schedule of supports is required. (Job development can overlap with other services due to the fluidity of this specific activity).

Services may be authorized and provided through a telemedicine model; however, not all allowable activities may be authorized/provided through this modality. See Chapter IV for details and examples. Authorization for service delivery via telemedicine is limited to 10% of billable hours.

For time-limited periods (not to exceed 24 hours) ISE may be requested and authorized during the same hours as day services or residential services for purposes of discovery under customized employment. ISE may also be requested and authorized concurrently with personal assistance services on the job.

The maximum service authorization duration is 12 months and in accordance with the ISP's effective from and through dates. The ISP Parts 1-4 and the provider's Plan for Supports (Part 5) are to be submitted by the SC in WaMS with supporting documentation/justification for this service.

Proc. Code H2014	Mod. See Below*	Waiver FIS, CL	In-Home Support Services

*** UA = 1 individual supported, U2 = 2 individuals simultaneously supported, U3 = 3 individuals simultaneously supported**
Unit of service = 1 hour. Services are requested weekly and authorized in monthly hours. The service may be authorized to up to three individuals per residential setting. H2014 (no modifier) If more than one Individual residing in the home has a IHSS authorization with the same agency, H2014 (no modifier) may be used when service delivery alternates between more than one Individual.

~~These~~ This service~~s~~ must not typically be authorized 24 hours per day but may be authorized for brief periods up to 24 hours a day when necessary and supported by documentation of this need. This service must not be authorized for the individual simultaneously with the coverage of group home residential, supported living residential, or sponsored residential services. Individuals may have in-home supports, personal assistance, and respite services in their ISP but must not be authorized to receive these Medicaid-reimbursed services simultaneously.

A back-up plan must be identified in the event the provider cannot provide services to the individual.

Services may be authorized and provided through a telemedicine model; however, not all allowable activities may be authorized/provided through this modality. See Chapter IV for details and examples. Authorization for service delivery via telemedicine is limited to 20% of billable hours.

An initial 60-day assessment plan may be submitted. Prior to the last day of the assessment period, an annual Plan for Supports must be submitted to the SC for review, approval, and reauthorization if required~~for continued authorization~~. The start date of the annual Plan for Supports must be no later than day 61 and the end date must correspond to the end date of the annual ISP.

~~For Semi-Predictable Events / HOME-BASED please refer to Standard Definitions.~~
The maximum service authorization duration is 12 months and in accordance with the ISP's effective from and through dates. ISP Parts 1-4 and the provider's Plan for Supports (Part 5) are to be submitted by the SC in WaMS with supporting documentation/justification for this service.

~~12 months and in accordance with the ISP's effective from and through dates. ISP Parts 1-4 and the provider's Plan for Supports (Part 5) are to be submitted by the SC in WaMS with supporting documentation/justification for this service.~~

For Semi-Predictable Events / HOME-BASED please refer to Standard Definitions.

Proc. Code H2014	Mod. U1	Waiver FIS, CL	In-Home Support Services (Customized)

PLEASE REFER TO MEDICAID MEMO DATED 9/1/2017 FOR ALL INFORMATION PERTAINING TO CUSTOMIZED RATES.

Telemedicine delivery of In-home Support Services is not permitted for individuals receiving the Customized Rate.

Proc. Code H0038	Mod. N/A	Waiver BI, FIS, CL	Peer Mentoring Services

Unit of service = 1 hour.

This service is delivered to waiver recipients by other individuals with developmental disabilities who are or have been service recipients, have shared experiences with the individual, and provide support and guidance to him/her.

Peer Mentor Supports is authorized as a short, periodically intermittent, intense service associated with a specific outcome. Peer Mentor Supports may be authorized for up to 6 consecutive months, and the cumulative total across that timeframe may be no more than 60 hours in a plan year. If, after six months, the 60 hour ISP year limit has not been reached and further supports are still required, a request for additional months of Peer Mentor Supports may be submitted for service authorization.

The Peer Mentor must not supplant, replace, or duplicate activities that are required to be provided by the SC.

Prior to accessing funding for this waiver service, all other available and appropriate funding sources must be explored and exhausted.

Peer Mentors cannot mentor their own family members.

Peer Mentors must be at least 21 years of age and may provide these supports only to individuals 16 years of age and older.

Individuals who receive supports through DD or other waivers may be peer mentors.

All activities may be authorized to be delivered in either a face-to-face or HIPPA-compliant telemedicine method of delivery that allows the Peer Mentor to view the individual and converse with him. Allowable activities that can be performed using telemedicine can be performed for up to 100% of the service hours.

ISP Parts 1-4 and the administering agency's Plan for Supports (Part 5) are to be submitted by the SC in WaMS with supporting documentation/justification for this service.

Proc. Code H2021	Mod. TD	Waiver BI, FIS, CL	(PERS) Personal Emergency Response Services - RN

Unit of service = ½ hour for a bi-weekly total. Weekly units multiplied by 0.5.

Must be authorized in conjunction with S5185 – "PERS and Medication Monitoring." Must be physician ordered. Both H2021 TD and S5185 must be authorized in tandem with an overall PERS installation and monthly monitoring service.

PERS services are limited to those individuals who live alone, or are alone for significant parts of the day, have no regular caregiver for extended periods of time, or when there is no one else in the home who is competent or continuously available to call for help in an emergency so that the individual would otherwise require extensive routine supervision.

May not be authorized for individuals who receive group home, sponsored residential, or supported living services.

The maximum service authorization duration is 12 months, and in accordance with the ISP's effective from and through dates. ISP Parts 1-4 are to be submitted by the SC in WaMS with supporting documentation/justification for this service. No Part 5 is required.

Proc. Code H2021	Mod. TE	Waiver BI, FIS, CL	(PERS) Personal Emergency Response Services - LPN

Unit of service = ½ hour for a bi-weekly total. Weekly units multiplied by 0.5.

Must be authorized in conjunction with S5185 – "PERS and Medication Monitoring." Must be physician ordered. Both H2021 TE and S5185 must be authorized in tandem with an overall PERS installation and monthly monitoring service.

PERS services are limited to those individuals who live alone, or are alone for significant parts of the day, have no regular caregiver for extended periods of time, or when there is no one else in the home who is competent or continuously available to call for help in an emergency so that the individual would otherwise require extensive routine supervision.

May not be authorized for individuals who receive group home, sponsored residential, or supported living services.

The maximum service authorization duration is 12 months and in accordance with the ISP's effective from and through dates. ISP Parts 1-4 are to be submitted by the SC in WaMS with supporting documentation/justification for this service. No Part 5 is required.

Proc. Code S5160	Mod. N/A	Waiver BI, FIS, CL	(PERS) Personal Emergency Response Services - Installation

Unit of service = 1 month. A unit of service must include administrative costs, time, labor, and supplies associated with the installation. One-time installation of the unit must include installation, account activation, individual and caregiver instruction, and removal of PERS equipment.

PERS services are limited to those individuals who live alone, or are alone for significant parts of the day, have no regular caregiver for extended periods of time, or when there is no one else in the home who is competent or continuously available to call for help in an emergency so that the individual would otherwise require extensive routine supervision.

May not be authorized for individuals who receive group home, sponsored residential, or supported living services.

A request for S5161 – "PERS Monitoring" must also be submitted.

PERS Installation is generally authorized one time per provider for a one-month period unless there is a break in service or individual changes physical location.

The maximum service authorization duration is one-month and in accordance with ISP's effective from and through dates. ISP Parts 1-4 are to be submitted by the SC in WaMS with supporting documentation/justification for this service. No Part 5 is required.

Proc. Code S5160	Mod. U1	Waiver BI, FIS, CL	(PERS) Personal Emergency Response Services (Installation & Med. Monitoring)

Unit of service = 1 month. A unit of service must include administrative costs, time, labor, and supplies associated with the installation. The one- time installation of the unit must include installation, account activation, individual and caregiver instruction, and removal of PERS equipment. A request for S5185 - "PERS and Medication Monitoring" must also be submitted.

Must be physician ordered. Must have a PERS system.

Generally authorized one time per provider for a one-month period unless there is a break in service or individual changes physical location.

PERS services are limited to those individuals who live alone, or are alone for significant parts of the day, have no regular caregiver for extended periods of time, or when there is no one else in the home who is competent or continuously available to call for help in an emergency so that the individual would otherwise require extensive routine supervision.

The maximum service authorization duration is one-month, and in accordance with ISP's effective from and through dates. ISP Parts 1-4 to be submitted by SC in WaMS with supporting documentation/justification for this service. No Part 5 is required.

Proc. Code S5185	Mod. N/A	Waiver BI, FIS, CL	(PERS) Personal Emergency Response Services (Medication Monitoring)

Unit of service = 1 per month. A unit of service must include administrative costs, time, labor, and supplies associated with the monitoring and adjustments of the PERS. A unit of service is the one-month rental price set by DMAS.

Individual must have a PERS system. If S5160 U1 – "PERS and Medication Monitoring Installation" is not also requested, the provider must verify that the PERS Medication Monitoring system is already installed (e.g., through private pay).

PERS Medication Monitoring must be physician ordered and authorized for a certain number of months per year, up to 12 months per service authorization per plan year.

PERS services are limited to those individuals who live alone, or are alone for significant parts of the day, have no regular caregiver for extended periods of time, or when there is no one else in the home who is competent or continuously available to call for help in an emergency so that the individual would otherwise require extensive routine supervision.

The maximum service authorization duration is up to 12 months, and in accordance with ISP's effective from and through dates. ISP Parts 1-4 are to be submitted by the SC in WaMS with supporting documentation/justification for this service. No Part 5 is required.

Proc. Code S5161	Mod. N/A	Waiver BI, FIS, CL	(PERS) Personal Emergency Response Services (Monitoring)

Unit of service = 1 per month. A unit of service must include administrative costs, time, labor, and supplies associated with the maintenance, monitoring, and adjustments of the PERS. A unit of service is the one-month rental price set by DMAS.

Must have an installed PERS system. If S5160 – "PERS Installation" is not also requested, the provider must verify that the PERS system is already installed (e.g., through private pay).

PERS services are limited to those individuals who live alone, or are alone for significant parts of the day, have no regular caregiver for extended periods of time, or when there is no one else in the home who is competent or continuously available to call for help in an emergency so that the individual would otherwise require extensive routine supervision.

The maximum service authorization duration is 12 months, and in accordance with the ISP's effective from and through dates. ISP Parts 1-4 are to be submitted by the SC in WaMS with supporting documentation/justification for this service. No Part 5 is required.

Proc. Code T1019	Mod. N/A	Waiver FIS, CL	Agency-Directed Personal Assistance Services

Unit of service = 1 hour. Services are requested weekly and authorized in monthly hours.

An initial 60-day assessment plan may be submitted. Prior to the last day of the assessment period, an annual Plan for Supports must be submitted to the SC for review, approval, and reauthorization if required~~for continued authorization~~. The start date of the annual Plan for Supports must be no later than day 61 and the end date must correspond to the end date of the annual ISP.

Assistance with ADLs, reminders to take medication or other medical needs, or monitoring of the individual's health status or physical condition must be documented in the Plan for Supports as essential to the health and welfare of the individual.

Personal assistance for IADLs will only be authorized when the individual requires assistance with ADLs. Personal Assistance will not be authorized for the convenience of other members of the individual's household (for example, cleaning rooms used by all family members, cooking meals for the family, washing dishes used by everyone, family laundering, etc.).

This service does not include skill building. Personal assistance services may be authorized for individuals for whom skill building is not the primary objective or when skill building is received in another service or setting.

This service may be authorized for individuals in the workplace and post-secondary educational institutions as long as ~~these~~ this service~~s should~~ is not ~~be~~ provided by DARS, under IDEA, or if they are an employer's responsibility under the Americans with Disabilities Act, the Virginians with Disabilities Act, or § 504 of the Rehabilitation Act. Work-related personal assistance services must not duplicate services provided under Workplace Assistance.

This service must not be authorized to include nursing (neither practical nor professional nursing) services with the exception of nursing tasks that may be delegated.

~~For Semi-Predictable Events / HOME-BASED please refer to Standard Definitions.~~

Supervision/safety supports will not be authorized for family members to sleep nor for family members who operate a business or work from home unless the individual cannot be left alone due to documented safety issues or wandering risk. Supervision cannot be considered necessary because the individual's family or provider is generally concerned about leaving the individual ~~alone, or~~alone or would prefer to have someone with the individual. There must be a clear and present danger to the individual as a result of being left unsupervised.

For a child under the age of 18, the DMAS P257 (Request for Supervision Hours in Personal Assistance) form must be submitted to DBHDS for authorization purposes when supervision hours are requested to address safety supports needs.

Documentation submitted with the authorization request must include the individual's back-up plan for times when Personal Assistance supports cannot occur as regularly scheduled.

The service must not be authorized for individuals who receive residential services in a group home, sponsored residential home, supported living setting or who live in assisted living facilities, or receive comparable services from another program or service.

The maximum service authorization duration is 12 months, and in accordance with the ISP's effective from and through dates. The ISP Parts 1-4 and the Part 5 or a Personal Preference tool with a DMAS 97, the DMAS 99, and a schedule are to be submitted by the SC in WaMS with supporting documentation/justification for this service.

For Semi-Predictable Events / HOME-BASED please refer to Standard Definitions.

Proc. Code S5126	Mod. N/A	Waiver FIS, CL	Consumer-Directed Personal Assistance

Unit of service = 1 hour. Services are requested weekly and authorized in bi-weekly (BW) units.

All CD services require the services of a Services Facilitator or an unpaid person (such as a family member) acting in this capacity.

If the individual is not going to direct his own services, an Employer of Record (EOR) must be identified in the authorization request.

Assistance with ADLs, reminders to take medication or other medical needs, or monitoring of the individual's health status or physical condition must be documented in the Plan for Supports as essential to the health and welfare of the individual.

Personal assistance for IADLs will only be authorized when the individual requires assistance with ADLs. Personal Assistance will not be authorized for the convenience of other members of the individual's household (for example, cleaning rooms used by all family members, cooking meals for the family, washing dishes used by everyone, family laundering, etc.).

This service does not include skill building. Personal assistance services may be authorized for individuals for whom skill building is not the primary objective or when skill building is received in another service or setting.

Service may be authorized for individuals in the workplace and post-secondary educational institutions as long as these services should not be provided by DARS, under IDEA, or if they are an employer's responsibility under the Americans with Disabilities Act, the Virginians with Disabilities Act, or § 504 of the Rehabilitation Act. Work-related personal assistance services must not duplicate services provided under supported employment.

Any combination of CD Companion service, CD Personal Assistance service and CD Respite service delivered by a single CD employee must be limited to ~~56~~40 hours per week for an EOR. An individual may receive more than ~~56~~40 hours per week of CD PA, if needed, through multiple CD employees. CD employees who live with the individual either full-time or for substantial amount of time ~~must~~ are not ~~be~~ limited to ~~56~~40 hours per week. CD employees will not be authorized to work more than 16 hours in a 24-hour period. The 16-hour limit includes hours worked in one day providing a combination of companion, personal assistance, and respite services.

Supervision/safety supports will not be authorized for family members to sleep nor for family members who operate a business or work from home unless the individual cannot be left alone due to documented safety issues or wandering risk.

Supervision cannot be considered necessary because the individual's family or provider is generally concerned about leaving the individual ~~alone, or~~alone or would prefer to have someone with the individual. There must be a clear and present danger to the individual as a result of being left unsupervised.

For a child under the age of 18, the DMAS P257 (Request for Supervision Hours in Personal Assistance) form must be submitted to DBHDS for authorization purposes when supervision hours are requested to address safety supports needs.

Documentation submitted with the authorization request must include the individual's back-up plan in case the consumer-directed (CD) employee does not report for work as expected or terminates employment without prior notice.

This service must not be authorized to include nursing (neither practical nor professional nursing) services with the exception of nursing tasks that may be delegated. An exception to this is if the individual is capable of directing the appropriate performance of the health care tasks, which are typically self-performed for an individual who lives in a private residence and who, because of his disability, is unable to perform such tasks.

The service must not be authorized for individuals who receive residential services in a group home, sponsored residential home, supported living setting or who live in assisted living facilities, or receive comparable services from another program or service.

Family/caregivers acting as the employer on behalf of the individual (EOR) may not also be authorized as the CD employee.

The maximum service authorization duration is 12 months, and in accordance with ISP's effective from and through dates. The ISP Parts 1-4 and the Part 5 or a Personal Preference tool with a DMAS 97, the DMAS 99, and a schedule are to be submitted by the SC in WaMS with supporting documentation/justification for this service.

Proc. Code T1002 RN, T1003LPN	**Mod. N/A**	**Waiver FIS, CL**	**Private Duty Nursing (PDN)**

The unit of service = 15 minutes. Services are requested weekly and authorized in monthly hours.

PDN services are continuous nursing care provided on a one-to-one basis for individuals enrolled in the DD waivers who have serious medical conditions and complex health care needs that have been certified by a Virginia licensed physician or nurse practitioner on the CMS-485, which must accompany the authorization request.

Individuals enrolled in the waiver must not be authorized to receive private duty nursing services concurrently with skilled nursing services (except when skilled nursing is required for nurse delegation responsibility activities), respite, companion, or personal assistance services.

PDN services may be authorized to be provided to the individual in his/her residence or other community setting on a regularly scheduled basis and are available to individuals who require more hours per week of nursing care than may be provided under Skilled Nursing in the waivers. This means more than 21 hours per week.

PDN must support and not replace existing family or paid caregiver responsibilities.

PDN services may be provided concurrently with other services such as the services of direct support professionals in residential or day support settings due to the medical nature of the supports provided.

The maximum service authorization duration is 6 months, and in accordance with ISP's effective from and through dates. PDN services are authorized based on the ~~DMAS-62 form~~, the Home Health Certification and Plan of Care form (CMS-485) signed by a physician/nurse practitioner~~, and any required documentation as detailed in the most current instructions for the DMAS-62~~.

In addition, the ISP Parts 1-4, the provider's Part 5 and a schedule of proposed delivery of hours are to be submitted by the SC in WaMS with supporting documentation/justification for this service. Initial requests can be submitted for up to 60 days and subsequent requests can be submitted for up to 6 months.

FOR CHILDREN **under the age of 21**- EPSDT Private Duty Nursing Services **RN (T1002), LPN (T1003).**.

The unit of service = 15 minutes. Services are requested weekly and authorized in monthly hours.

Individuals under age 21 must access these services through Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and, if the child does not meet EPSDT criteria, he will not meet the criteria for PDN under the waivers. ~~EPSDT.~~

Private duty nursing is available only to individuals who meet medical necessity criteria for private duty nursing services. Per the EPSDT manual definition of a "home," EPSDT PDN will not be authorized for individuals residing in licensed residential homes. Those individuals will be authorized under DD waiver regulations.

Requests for EPSDT PDN should be submitted at least 10 days, but no more than 30 days prior to the requested service start or renewal date.

EPDST PDN services are authorized based on the, DMAS-62 form, the Home Health Certification and Plan of Care form (CMS-485) signed by a physician/nurse practitioner and any required documentation as detailed in the most current instructions for the DMAS-62. The Medical Needs Assessment Form (DMAS- 62) is required for initial requests (which are authorized for a maximum of 60 days) and updated every six months. If an individual transfers from one nursing agency to another, a new plan of care, DMAS-225, and Medical Needs Assessment (DMAS-62) is required. If an increase in hours is requested, this must be supported by the DMAS-62.

Congregate Private Duty Nursing (G0493, G0494) – EPSDT ONLY:

The unit of service = 15 minutes. Services are requested weekly and authorized in monthly hours.

Congregate private duty nursing is provided by one nurse when more than one individual who requires private duty nursing resides in the same home. Congregate private duty nursing must be limited to a maximum ratio of one private duty nurse to two individuals who receive nursing via EPSDT. When three or more waiver/EPSDT individuals share a home, service staff ratios are determined by assessing the combined needs of the individuals. Individuals who receive Congregate PDN usually require individual nursing hours in addition to the congregate hours.

~~Services are requested weekly and multiplied by 4.6 to equal the monthly units (MO).~~ Private duty

nursing services are limited to the hours of skilled medical care and skilled supervision as specified in the ~~POC~~ PFS and limited to the number of hours approved by DMAS. Plans may be submitted for any time period between 60 days and 6 months.

Congregate nursing hours are approved in full for each individual. The hours are based on the care needs for each child. The approved hours are not divided between the individuals receiving congregate PDN care.

Individuals receiving Congregate PDN may also qualify for Individual Nursing Hours based on medical needs either when the other individual is not present (e.g., different school schedule, illnesses) or due to a higher intensity medical need which necessitates intermittent individualized (1:1) care.

Congregate PDN services are authorized based on the, DMAS-62 form, the Home Health Certification and Plan of Care form (CMS-485) signed by a physician/nurse practitioner and any required documentation as detailed in the most current instructions for the DMAS-62. The Medical Needs Assessment Form (DMAS- 62) is required for initial requests (which are authorized for a maximum of 60 days) and updated every six months. If an individual transfers from one nursing agency to another, a new plan of care, DMAS-225, and Medical Needs Assessment (DMAS-62) is required. If an increase in hours is requested, this must be supported by the DMAS-62.

The Medical Needs Assessment Form (DMAS- 62) is required for initial requests (which are authorized for a maximum of 60 days) and updated ~~at a minimum of~~ every six months. If an individual transfers from one nursing agency to another, a new plan of care, DMAS-225, and Medical Needs Assessment (DMAS-62) is required. If an increase in hours is requested, this must be supported by the DMAS-62.

The Home Health Certification and Plan of Care form (CMS 485) must be signed and dated by the physician within 10 business days of the initial Start of Care. Reauthorizations to continue services must be signed, dated, and received before the previous period ends.

School-based Nursing

1) Services may be approved for school-based nursing supports although the hours used during the school day, if authorized by DBHDS, do count toward the number of hours allowed based on the individual's medical need for care.
2) In order to authorize School-based Nursing, a copy of the ISP must be submitted with the request for PDN.

Proc. Code T1005	Mod. N/A	Waiver FIS, CL	Agency-Directed Respite Services

Unit of service = 1 hour. A maximum of 480 hours may be authorized per fiscal year, inclusive of all types of respite combined.

1) If an individual has a Respite authorization, a second type (i.e., CD Respite) or provider may be authorized to provide Respite up to the maximum hrs/yr. but will only be authorized for different days or hours of the day from the first type of Respite.

2) If the maximum hrs/yr is already authorized, the first provider must submit a termination or decrease before a second provider can be authorized for the balance.

Respite must be aligned to the individual's ISP year and may be authorized for a maximum of 24 months~~,~~ but must appear on the ISP each plan year for appropriate SA.

There must be identified with the service authorization request an unpaid primary caregiver residing in the home who requires temporary relief of their care giving responsibilities. If the unpaid primary caregiver does not live in the home, justification is required to demonstrate how the identified person is considered a “primary caregiver.”

The individual must require assistance with ADLs, community access, reminders to take self-administered medication or other medical ~~needs, or~~needs or monitoring of~~r her~~ health status or physical condition.

Respite assistance must not be authorized to include either practical or professional nursing services. This service must not include nursing services with the exception of nursing tasks that may be delegated.

Respite will not be authorized for services rendered to or for the convenience of other members in the individual’s household (e.g., cleaning rooms used equally by all family members, cooking meals for the family, washing family dishes, family laundering, etc.).

The primary caregiver must not be authorized to serve as the paid respite assistant.

Required documentation for service authorization includes a Plan for Supports/Part 5~~V~~ or a Personal Preference tool with a DMAS 97 ~~and the DMAS 99~~.

Skill development must not be authorized for Respite services.

Documentation submitted with the authorization request must include the individual’s back-up plan (e.g., family member, neighbor, or friend) in case the respite assistant does not report for work as expected or terminates employment without prior notice.

Respite may be authorized for individuals who receive AD/CD personal assistance, AD/CD companion services, and/or In-Home Residential Support, but these services cannot be authorized for the same day at the same time.

Respite must not be authorized for individuals receiving group home, supported living, or sponsored residential services. Respite must not be authorized for individuals who reside in an Assisted Living Facility or by DSS approved Adult Foster Care providers when the individual resides in that home.

The maximum service authorization duration is up to 24 months, and in accordance with ISP’s effective from and through dates. The ISP Parts 1-4 and the provider’s Plan for Supports (Part 5) or a Personal Preference tool with a DMAS 97 ~~and the DMAS 99~~ are to be submitted by the SC in WaMS with supporting documentation/justification for this service.

Proc. Code S5150	Mod. N/A	Waiver FIS, CL	Consumer-Directed Respite

Unit of service = 1 hour. A maximum of 480 hours may be authorized per fiscal year, inclusive of all types of respite combined.

- If individual has a Respite authorization, a second type (i.e., AD Respite) or provider may be authorized to provide Respite up to the maximum hrs/yr. but will only be authorized for different days or hours of the day from the first type of Respite.
- If the maximum hrs/yr is already authorized, the first provider must submit a termination or decrease before a second provider can be authorized for the balance.

The individual must require assistance with ADLs, community access, reminders to take self-administered medication or other medical ~~needs, or~~needs or monitoring of her health status or physical condition. Skill development must not be authorized for Respite services.

Respite will not be authorized for services rendered to or for the convenience of other members in the individual's household (e.g., cleaning rooms used equally by all family members, cooking meals for the family, washing family dishes, family laundering, etc.).

Respite may be authorized for individuals who receive AD/CD personal assistance, AD/CD companion services, and/or In-Home Residential Support, but these services cannot be authorized for the same day at the same time.

Respite must not be authorized for individuals receiving group home, supported living or sponsored residential services. Respite must not be authorized for individuals who reside in an Assisted Living Facility or by DSS approved Adult Foster Care providers when the individual resides in that home.

Any combination of Companion service, Personal Assistance service and CD ~~r~~Respite service delivered by a single CD employee must be limited to ~~56~~40 hours per week for an EOR. An individual may receive more than ~~56~~ 40hours per week of CD services, if needed, through multiple CD employees.

CD employees who live with the individual either full-time or for substantial amount of time ~~must~~ are not ~~be~~ limited to ~~56~~ 40hours per week. CD employees will not be authorized to work more than 16 hours in a 24- hour period. The 16-hour limit includes hours worked in one day providing a combination of companion, personal assistance, and respite services.

All CD Services require the services of a Services Facilitator or an unpaid person (such as a family member) acting in this capacity.

If the individual is not going to direct his own services, an Employer of Record (EOR) must be identified in the authorization request.

Respite must be aligned to the individual's ISP year and may be authorized for 24 months but must appear on the ISP each plan ~~your~~ year for appropriate service authorization.

This service must not be authorized to include nursing (neither practical nor professional nursing) services with the exception of nursing tasks that may be delegated. An exception to this is if the individual is capable of directing the appropriate performance of the health care tasks, which are typically self-performed for an individual who lives in a private residence and who, because of his disability, is unable to perform such tasks.

~~Required documentation includes a Plan for Supports/Part V or a Personal Preference tool with a DMAS 97 and the DMAS 99~~. ~~Skill development must not be provided via Respite services.~~

Documentation submitted with the authorization request must include the individual's back-up plan (e.g., family member, neighbor, or friend) in case the respite assistant does not report for work as expected or terminates employment without prior notice.

~~Respite must not be authorized for individuals receiving group home, supported living or sponsored residential services.~~

There must be identified with the service authorization request an unpaid primary caregiver residing in the home who requires temporary relief of their care giving responsibilities. If the unpaid primary caregiver does not live in the home, justification is required to demonstrate how the identified person is considered a "primary caregiver."

Family/caregivers acting as the employer on behalf of the individual (EOR) may not also be the CD employee. The primary caregiver must not be authorized to serve as the paid CD employee for this service.

The maximum service authorization duration is 24 months, and in accordance with ISP's effective from and through dates. The ISP Parts 1-4 and the provider's Plan for Supports (Part 5) or a Personal Preference tool with a DMAS 97 ~~and the DMAS 99~~ are to be submitted by the SC in WaMS with supporting documentation/justification for this service.

Proc. Code T1020	Mod. N/A	Waiver BI, FIS, CL	Shared Living Services

Unit of service = 1 month or partial month (for months in which the service begins or ends) room and board for roommate. A partial month must be used for calculation of the last month's rent when the lease is terminated on days 1 through 10 or for calculation of the first month's rent when the lease is initiated on day 16 through the end of the month.

The approvable amount for the room and board subsidy (rent, food and utilities costs) must be the lesser of the roommate's half of the rent costs or the maximum allowable amount for the region of the state in which the individual and roommate live as established by DMAS. Documentation of the actual amount of rent must be submitted simultaneously with the request for SA.

Service authorization must not be made for roommates who are a service provider to the individual for any waiver service, the individual's spouse, parent (biological, adoptive, foster or stepparent), grandparent, or legal guardian.

The individual must be 18 years of age or older and reside in his own home or in a residence leased by him for which he is the primary leaseholder.

Service~~s~~ must not be authorized for individuals who are simultaneously receiving group home residential, supported living residential, sponsored residential, or respite services.

The individual must be receiving at least one other waiver service in order to receive Medicaid coverage of shared living.

The administrative provider must assure that there is a back-up plan in place in the event that the roommate is unable or unavailable to provide supports. Documentation submitted with the authorization request (the supports agreement between the individual and roommate) must include the individual's

back-up plan.
A ~~signed, executed copy of the lease agreement,~~ completed Shared Living Attestation form, signed supports agreement and documentation of *completion* of roommate training and background checks (background check *results* may not, under any circumstances, be shared or transmitted) must be submitted with the SA request for the Shared Living service. The signed lease and rental assistance documentation should be referenced to complete the attestation form. If there is a discrepancy in the information submitted on the attestation form, the signed lease or other documentation may be requested by the service authorization consultant for clarification. The Supports Agreement between the individual and roommate may include limited ADL and IADL supports, which may account for no more than 20% of the anticipated time agreed upon between the individual and the roommate. The service authorization consultant will use the information from the attestation form to complete the Shared Living Calculator. The Shared Living Calculator populates the reimbursement amount received by the individual on behalf of the roommate and the amount retained by the provider on the Shared Living Determination Form. The support coordinator will upload this form to WaMs as the final step in the service authorization approval process. The maximum service authorization duration is 12 months, and in accordance with ISP's effective from and through dates. The ISP Parts 1-4 are to be submitted by the SC in WaMS with supporting documentation/justification for this service. Part 5 is not required.

Proc. Code *See Below	**Mod. N/A**	**Waiver FIS, CL**	**Skilled Nursing (SN)**

***LPN:S9124; RN:S9123**

The unit of service = 15 minutes. Services are requested weekly and authorized in monthly (MO) hours.

Skilled nursing service is a one-to-one service appropriate for individuals with nursing needs that are intermittent in nature, not to exceed 21 hours per week. SN services are authorized for individuals who have serious medical conditions and complex health care needs.

Skilled nursing service must be ordered by a physician or nurse practitioner and be medically necessary. The medical necessity must be documented in the individual's ISP.; These services must not duplicate services available through the state plan.

Individuals enrolled in the waiver must not be authorized to receive skilled nursing services concurrently with private duty nursing services (except if nurse delegation activities are required by the individual and included in the individual's ISP) or personal assistance services.

SN services may be authorized to be delivered concurrently with other services such as those delivered by direct support professionals (DSPs) in residential or day support settings due to the medical nature of the supports provided.

SN services may be authorized to be delivered to the individual in his residence or other community setting on a regularly scheduled or intermittent basis to facilitate the desired health and safety outcomes as outlined in the individual's ISP.

Services are authorized for the length of the physician's orders with the maximum duration being 6 months, and in accordance with the ISP's effective from and through dates. The ISP Parts 1-4 and provider's Part 5 and a CMS 485, signed by a physician/nurse practitioner and a schedule of the proposed delivery of hours are to be submitted by the SC in WaMS with supporting documentation/justification for this service.

Proc. Code	Mod.	Waiver	Sponsored Residential Services
T2033	N/A	CL	

Unit of service = 1 day. ~~Services are authorized according to licensed home capacity.~~ This is a tiered service. Service~~s~~s may be authorized for 344 days per year.

An initial 60-day assessment plan may be submitted. Prior to the last day of the assessment period, an annual Plan for Supports must be submitted to the SC for review, approval, and reauthorization if required~~for continued authorization~~. The start date of the annual Plan for Supports must be no later than day 61 and the end date must correspond to the end date of the annual ISP.

A Plan for Supports/Part ~~V~~5, which must ~~to~~ include skill building and a schedule of supports, is required for authorization of sponsored residential services.

Sponsored residential services must comply with the HCBS setting requirements. The plan must document any restrictions on the freedoms of everyday life in accordance with the HCBS settings regulations.

The Family as Sponsor Provider Supporting Documentation Form and any associated documentation must be submitted along with the ISP in WaMS if the sponsor is a family member of the individual receiving services. The Family as Sponsor Form is not required after the first authorization as long as the sponsored provider remains the same family member.

Services which cannot be authorized for individuals receiving Sponsored Residential include: AD/CD Respite, AD/CD Personal Assistance (other than work-related PA), Supported Living, Group Home Residential, Shared Living, In-home Supports, PERS, EHBS, and Environmental Modifications.

Individuals who receive SRS may also be authorized to receive Agency- or Consumer- Directed Companion services; however, the SRS provider may not also be the provider of Companion services.

For an individual receiving SRS, the DSP providing the following services may not be a member of the sponsored family residing in the SRS home: Community Coaching, Community Engagement, Companion services.

The maximum service authorization duration is up to 12 months, and in accordance with the ISP's effective date from and through dates. The ISP Parts 1-4 and provider's Part 5 are to be submitted by the SC in WaMS with supporting documentation/justification for this service.

Proc. Code T2033	**Mod. U1**	**Waiver CL**	**Sponsored Residential Services (Customized Rate)**
PLEASE REFER TO MEDICAID MEMO DATED 9/1/2017 FOR INFORMATION PERTAINING TO CUSTOMIZED RATES			
Proc. Code H0043	**Mod. N/A**	**Waiver FIS, CL**	**Supported Living Services**

Unit of service = 1 day. ~~Services are authorized according to licensed home capacity.~~ This is a tiered service. Services may be authorized for 344 days per year.

A Plan for Supports/Part 5~~V~~, which must include skill building and a schedule of supports, is required for authorization of supported living services.

An initial 60-day assessment plan may be submitted. Prior to the last day of the assessment period, an annual Plan for Supports must be submitted to the SC for review, approval, and reauthorization if required~~for continued authorization~~. The start date of the annual Plan for Supports must be no later than day 61 and the end date must correspond to the end date of the annual ISP.

Services which cannot be authorized for individuals receiving Supported Living include: AD/CD Respite, AD/CD Personal Assistance (other than work-related PA), Sponsored Residential, Group Home Residential, Shared Living, In-home Supports, PERS, EHBS, and Environmental Modifications.

Individuals who receive supported living residential services may also be authorized to receive AD or CD Companion services; however, the Supported Living provider may not also be the provider of Companion services. For individuals receiving Supported Living, companion service may not be authorized to be provided by an immediate family member.

Supported living services must comply with the HCBS setting requirements. The plan must document any restrictions on the freedoms of everyday life in accordance with the HCBS settings regulations.

The maximum service authorization duration is 12 months, and in accordance with the ISP's effective from and through dates. The ISP Parts 1-4 and the provider's Part 5 are to be submitted by the SC in WaMS with supporting documentation/justification for this service.

Proc. Code H0043	**Mod. U1**	**Waiver FIS, CL**	**Supported Living Services (Customized Rate)**
PLEASE REFER TO MEDICAID MEMO DATED 9/1/2017 FOR INFORMATION PERTAINING TO CUSTOMIZED RATES			
Proc. Code 97139	**Mod. N/A**	**Waiver FIS, CL**	**"Therapeutic Consult, OT, PT, SLP, Board Cert. Beh. Analysts, Lic. Beh. Analysts, Lic. Beh. Therapists, Lic. Assist. Beh. Therapists"**

Unit of service = 1 hour.

Documentation of at least one other qualifying Waiver service currently authorized.

Behavior consultation may be authorized as a stand-alone service.

The individual must need consultation by qualified professionals who may work individually or as a team to assist individuals, family members, parents, and/or any providers of support services in implementation of the waiver ISP.

~~These services~~ This service must not duplicate the activities of other services that are available to the individual under State Plan for Medical Assistance. For example, Therapeutic Consultation for Speech, OT, and PT cannot be billed for the purpose of initial evaluations/assessments as this is covered under the State Option Plan.

Travel time and written preparation are considered as in-kind expenses, within therapeutic consultation service and will not be authorized as separate items. Written preparation which are "in kind" expenses ~~includes~~include written activities that are not included in allowable activities for the service.

All activities may be conducted in either a face-to-face or HIPPA-compliant telemedicine method of delivery. Allowable activities that can be performed using telemedicine can be performed for up to 100% of the service

Therapeutic consultation may not be authorized solely for purposes of monitoring the individual, nor for direct and ongoing therapy (other than for behavior consultation).

The maximum service authorization duration is 12 months, and in accordance with the ISP's effective from and through dates. The ISP Parts 1-4 and the provider's Part 5 are to be submitted by the SC in WaMS with supporting documentation/justification for this service. ***REMINDER***The Part 5~~V~~ is required for the initial Therapeutic Consultation. Thereafter, it will be included in the plan.

Proc. Code 97530	Mod. N/A	Waiver FIS, CL	Therapeutic Consult., Other Professional: LCSWs, Rec. Therapist, Positive Behavioral Support Facilitators, LCPs

Unit of service = 1 hour.

Documentation of at least one other qualifying waiver service currently authorized. Only behavioral consultation may be provided in the absence of other waiver services.

The individual must need consultation by qualified professionals who may work individually or as a team to assist individuals, family members, parents, and/or any providers of support services in implementation of the waiver ISP.

~~These~~ This service~~s~~ must not duplicate the activities of other services that are available to the individual under State Plan for Medical Assistance.

Travel time and written preparation are considered as in-kind expenses, within therapeutic consultation service and will not be authorized as separate items. Written preparation which are "in kind" expenses ~~includes~~include written activities that are not included in allowable activities for the service.

All activities may be conducted in either a face-to-face or HIPPA-compliant telemedicine method of delivery. Allowable activities that can be performed using telemedicine can be performed for up to 100% of the service

Therapeutic consultation may not be authorized solely for purposes of monitoring the individual, nor for direct and ongoing therapy (other than for behavior consultation).

The maximum service authorization duration is 12 months, and in accordance with the ISP's effective

from and through dates. The ISP Parts 1-4 and the provider's Part 5 are to be submitted by the SC in WaMS with supporting documentation/justification for this service.

Proc. Code H2017	Mod. N/A	Waiver FIS, CL	Therapeutic Consultation, Psychologist/Psychiatrist

Unit of service = 1 hour.

Documentation of at least one other qualifying Waiver service currently authorized.

The individual must need consultation by qualified professionals to assist individuals, family members, parents, and/or any providers of support services in implementation of the waiver ISP.

~~These~~ This service~~s~~ must not duplicate the activities of other services that are available to the individual under State Plan for Medical Assistance.

Travel time and written preparation are considered as in-kind expenses, within therapeutic consultation service and will not be authorized as separate items. Written preparation which are "in kind" expenses ~~includes~~include written activities that are not included in allowable activities for the service.

All activities conducted in the presence of the individual may be conducted in either a face-to-face or HIPPA-compliant telemedicine method of delivery. Allowable activities that can be performed using telemedicine can be performed for up to 100% of the service

Therapeutic consultation may not be authorized solely for purposes of monitoring the individual, nor for direct and ongoing therapy.

The maximum service authorization duration is 12 months, and in accordance with the ISP's effective from and through dates. The ISP Parts 1-4 and the provider's Part 5 are to be submitted by the SC in WaMS with supporting documentation/justification for this service.

Proc. Code 97139, 97530	Mod. N/A	Waiver FIS, CL	Therapeutic Consultation, Behavioral Services

Unit of service= 1 hour.

In addition to the requirements above for these billing codes, the following apply for Behavior Consultation:

Initial Authorizations: initial requests may not be authorized for more than 180 days. Initial authorizations are specific to an individual receiving behavioral services for the first time or if the individual transfers to another provider.

Documentation Requirements - First (Initial) Request:

Part 5~~V~~ – which must outline the following:

- Completion of the Functional Behavior Assessment (FBA).
- Creation of the Behavior Support plan (BSP)
- Plan for data collection.

Second Authorization: authorization post 180- day deadline until ISP annual date.

Documentation Requirements - Second Request:

- Behavior Support Plan, inclusive of an FBA (that may be within the plan or as a separate document).
- Any baseline data or treatment data collected used in formulating the plan
- Part 5V must include a description of training for those supporting the individual and parallel what is included in the training of the BSP.
  - ~~included in the training section of the BSP.~~
- Part 5V must include measurable benchmarks for behaviors targeted for increase and decrease in the "I no longer want/need support when…" area.
  - ~~longer want/need support when…" area.~~

ISP Renewals: Annual ISP date until next Annual ISP date.

Documentation Requirements - ISP Renewals:

- Graphical display with progress summary covering at least the current review period.
- Current BSP (with a review of the FBA results and data, as well as a statement of the validity of the previous
- FBA or indication of reassessment/revision/update to occur).
-
- Documentation of any training completed within the timeframe of the most recent review period.
- Part 5V must include a description of any additional training for those supporting the individual and parallel what is included in the training section of the BSP.
- Measurable benchmarks for behaviors targeted for increase & decrease in the "I no longer want/need supports when…" area of Part 5.
  ~~supports when…" area of Part 5V.~~
- If a reassessment needs to occur, a request for this must be indicated in the Part 5V.

Document Submission Review:
The SA staff is responsible for reviewing the request for the presence of required document submission in accordance with the regulations and not to complete a peer/clinical review for appropriate behavior analysis clinical application.

Proc. Code T2038	Mod. N/A	Waiver BI, FIS, CL	Transition Services

Unit of service = 1 month. Maximum Medicaid expenditure available for one transition per individual per lifetime is $5000. Transition services can be authorized only for individuals who have resided in a qualified long-term service and supports setting for at least 90 consecutive days.

Transition Services funds may not be used to supplant or replace existing payment options. Transition funds are not intended to help with general moving but to aid individuals to successfully live in the community.

This service may be authorized for up to 9 months from the start date. The request must be made within 30 days of the discharge date from a qualifying facility to a qualified residence. Transition services may be requested up to two months prior to discharge.

This service may be authorized for individuals leaving a qualifying facility, such as Nursing Facility (NF), Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), Institute for Mental Diseases (IMD), Psychiatric Residential Treatment Facility (PRTF), Long-Stay Hospital (LSH), or Group Home. Transition services are not available to individuals exiting an acute care hospital.

Documentation submitted with the authorization request must include the type of qualified residence into which the individual is transitioning, which must be a home in which he/she is directly responsible for his/her own living expenses. This can include a home owned or leased by the individual or a family member in which the individual retains equal legal rights under the lease or as the owner, a leased apartment that has living, sleeping, bathing and cooking areas over which the individual or the family have domain and control and lockable entrance and exit doors, or a community-based residential setting in which no more than four unrelated individuals reside. The latter may include a small group home, a sponsored residential home, or an apartment with a shared living arrangement with roommates. If a residence is licensed, transition service funds cannot be used to purchase any item that is required to be provided by the licenser.

The maximum service authorization duration is up to 9 months, and in accordance with ISP's effective from and through dates. ISP Parts 1-4 are to be submitted by the SC in WaMS with the transition services worksheet and housing needs assessment worksheet and any other supporting documentation/justification for this service. No Part 5 is required.

Proc. Code H2025	Mod. N/A	Waiver FIS, CL	Workplace Assistance Services

Unit of service = 1 hour. Services are requested weekly and authorized in monthly increments. Workplace Assistance must not exceed 40 hours per week.

~~These~~ This service~~s~~, either alone or in combination with or in combination with any of the following services: Individual and/or Group Supported Employment services, Community Engagement, Community Coaching and/or Group Day must be limited to 66 hours per week.

The service delivery ratio must be 1 to 1.

The service must not be authorized to include work skill training which would normally be provided by a job coach, such as supporting the individual in learning the components of the job. Services must facilitate the maintenance of and inclusion in an employment situation.

Workplace Assistance may be authorized for individuals who have completed job development and completed or nearly completed job placement training (i.e., individual supported employment) but require more than the typical job coach services to maintain stability in his employment.

~~Prior ISE authorization (either DARS or DD Waiver) is required for Workplace Assistance to be authorized.~~ ISE and Workplace Assistance authorizations may be provided simultaneously for the workplace assistant to receive training.

Services may be authorized and provided through a telemedicine model; however, not all allowable activities may be authorized/provided through this modality. See Chapter IV for details and examples. Authorization for service delivery via telemedicine is limited to 10% of billable hours.

A Plan for Supports/Part V to include skill building and a schedule of supports is required for authorization of workplace assistance.

There is no annual limit on how long these services may remain authorized.

The service must not be provided solely for the purpose of providing assistance with ADLs to the individual when the individual is working.

This service must not be authorized simultaneously with work-related Personal Assistance services.

The maximum service authorization duration is 12 months, and in accordance with the ISP's effective from and through dates. The ISP Parts 1-4 and the provider's Part 5 are to be submitted by the SC in WaMS with supporting documentation/justification for this service.