201.200 Organized Health Care Delivery System Provider

The DDS CES waiver allows a provider who is licensed and certified as a DDS CES Care Coordination~~case management~~ entity or a DDS CES supportive living services provider to enroll in the Arkansas Medicaid Program as a DDS CES organized health care delivery system (OHCDS) provider.

The option of OHCDS is available to any current or future provider through a written agreement between DDS and the provider entity. The agreement requires each OHCDS provider to guarantee that any sub-contractor will abide by all Medicaid regulations and provides that the OHCDS provider assumes all liability for contract noncompliance. The OHCDS provider must also have a written contract that sets forth specifications and assurances that work will be completed timely, satisfactorily to the beneficiary being served, and with quality maintained. The OHCDS provider is responsible for ensuring that services were delivered and proper documentation, including a signed customer satisfaction statement, has been submitted prior to billing.

As long as the OHCDS provider delivers at least one waiver service directly utilizing its own employees, an OHCDS provider may provide any other DDS CES waiver service via a sub-contract with an entity qualified to furnish the service. The subcontract must ensure financial accountability and that services were delivered, properly documented, and billed. The primary use of OHCDS is consultation, adaptive equipment, environmental modifications, supplemental support and specialized medical supplies.

The OHCDS provider furnishes the services as the beneficiary's provider of choice as described in that beneficiary's person~~-~~-centered service plan (PCSP).

202.200 HCBS Settings Requirements 4-15-17

A. Home and Community-Based Services (HCBS) Settings

All providers must meet the following Home and Community-Based Services (HCBS) Settings regulations as established by CMS. The federal regulation for the new rule is 42 CFR 441.301(c) (4)-(5).

Settings that are HCBS must be integrated in and support full access of beneficiaries receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community, to the same degree of access as beneficiaries not receiving Medicaid ~~CES~~ HCBS.

HCBS settings must have the following characteristics:

1. Chosen by the individual from among setting options including non-disability specific settings (as well as an independent setting) and an option for a private unit in a residential setting.
   a. Choice must be included in the person-centered service plan.
   b. Choice must be based on the individual's needs, preferences and, for residential settings, resources available for room and board.
2. Ensures an individual's rights of privacy, dignity and respect and freedom from coercion and restraint.
3. Optimizes, but does not regiment, individual initiative, autonomy and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

4. Facilitates individual choice regarding services and supports and who provides them.

~~5. The setting is integrated in and supports full access of beneficiaries receiving Medicaid CES to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community, to the same degree of access as beneficiaries not receiving Medicaid CES.~~

6. In a provider-owned or controlled residential setting (e.g., Group Homes), in addition to the qualities specified above, the following additional conditions must be met:

   a. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each CES participant and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

   b. Each individual has privacy in their sleeping or living unit:

      i. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.

      ii. Beneficiaries sharing units have a choice of roommates in that setting.

      iii. Beneficiaries have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

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

   d. Beneficiaries are able to have visitors of their choosing at any time.

   e. The setting is physically accessible to the individual.

   f. Any modification of the additional conditions specified in items 1 through 4 above must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

      i. Identify a specific and individualized assessed need.

      ii. Document the positive interventions and supports used prior to any modifications to the person-centered service plan.

      iii. Document less intrusive methods of meeting the need that have been tried but did not work.

      iv. Include a clear description of the condition that is directly proportionate to the specific assessed need.

      v. Include regular collection and review of data to measure the ongoing effectiveness of the modification.

      vi. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

      vii. Include the informed consent of the individual.

      viii. Include an assurance that interventions and supports will cause no harm to the individual.

211.200 Risk Assessment

A. DDS will not authorize or continue waiver services under the following conditions:

1. The health and safety of the beneficiary, the beneficiary's caregivers, workers or others are not assured;
2. The beneficiary or legally responsible person has refused or refuses to participate in the person-centered case plan development or to permit implementation of the person-centered service plan or any part thereof that is deemed necessary to assure health and safety;
3. The beneficiary or legally responsible person refuses to permit the on-site entry of: ~~case manager~~ care coordinator to conduct required visits, caregivers to provide scheduled care, DDS, DMS, DHS or CMS officials acting in their role as oversight authority for compliance or audit purposes;
4. The beneficiary applying for, or receiving, waiver services requires 24 hour nursing care on a continuous basis as prescribed by a physician;
5. The beneficiary participating in the waiver program is incarcerated, adjudicated as guilty or is an inmate in a state or local correctional facility;
6. The person is deemed ineligible based on DDS Psychological Team assessment or reassessment for meeting ICF/IID~~/DD~~ level of care;
7. The beneficiary is deemed ineligible based on not meeting or not complying with requirements for determining continued Medicaid income eligibility;
8. The beneficiary does not undergo an Independent Assessment by a third party vendor.

B. Safeguards concerning the use of Restraints:

1. Physical restraints (use of a staff member's body to prevent injury to the consumer or another person) are allowed in cases of emergency. An emergency exists when:
   a. The individual has not responded to de-escalation techniques and continues to escalate behavior,
   b. The individual is a danger to self or others, or
   c. The safety of the individual and those nearby cannot be assured through positive reinforcers.

An individual must be continuously under direct observation of staff members during any use of restraints.

If the use of personal restraints occurs more than three times per month, use should be discussed by the interdisciplinary team and addressed in the person-centered service plan. When emergency procedures are implemented, ~~plan of care~~ PSCP revisions including but not limited to, psychological counseling, review of medications with possible medication change or a change in environmental stressors that are noted to precede escalation of behavior may be implemented.

1. Use of mechanical or chemical restraints is not allowed. Seclusion is not allowed.
2. DDS standards require that providers will not allow maltreatment or corporal punishment (the application of painful stimuli to the body in an attempt to terminate behavior or as a penalty for behavior) of individuals. Provider's policies and procedures must state that corporal punishment is prohibited.

C. Safeguards Concerning the use of Restrictive Intervention

1. Restrictive Interventions may be used.

2. DDS Standards require the use of a behavior management plan for all individuals ~~who's~~whose behavior may warrant intervention. The behavior management plan must specify what will constitute the use of restrictive interventions, the length of time to be used, who will authorize the use of restrictive intervention and the methods for monitoring the individual.

   When the behavior plan is implemented, all use of restrictive interventions must be documented in the individual's case record and should include the initiating behavior, length of time of restraint, name of authorizing personnel, names of all individuals involved and outcomes of the event.

3. Restrictive interventions include:

   a. Absence from a specific social activity,

   b. Temporary loss of a personal possession, or

   c. Time out or separation.

4. Restrictive intervention cannot include:

   a. aversive techniques,

   b. restrictions to an individual's rights, including the right to physically leave,

   c. mechanical or chemical restraints, or

   d. seclusion.

These interventions might be implemented to deal with aggressive or disruptive behaviors related to the activity or possession. Staff, families and the individual are trained by the provider to recognize and report unauthorized use of restrictive interventions.

Before absence from a specific social activity or temporary loss of personal possession is implemented, the individual is first counseled about the consequences of the behavior and the choices they can make.

1. All personnel who are involved in the use of restrictive interventions must receive training in behavior management techniques, as well as, training in abuse and neglect laws, rules and regulations and policies. The personnel must be qualified to perform, develop, implement and monitor or provide direction intervention as applicable.

2. Use of restrictive interventions requires submission of an incident report that must be submitted no later than the end of the second business day following the incident. The DDS Quality Assurance staff investigates each incident and monitors use of restrictive interventions for possible overuse or inappropriate use. DDS Quality Assurance staff will notify entities involved with the complaint or service concern the results of their review. If there is credible evidence to support the complaint or concern, the provider will be required to submit a plan of correction. Failure to complete corrective action measures may result in the provider being placed on provisional status or revocation of certification.

D. Behavior Management Plans:

   Before use of restraints or restrictive interventions, Providers must develop a written behavior management plan to ensure the rights of individuals. The plan must include a provision for alternative methods to avoid the use of restraints and seclusions.

The behavior management plan must be written or supervised by a qualified professional who is at a minimum a Qualified Developmental Disabilities Professional (QDDP):

1. Be designed so that the rights of the individual are protected;
2. Preclude procedures that are punishing, physically painful, emotionally frightening, involve deprivation, or puts the individual at medical risk,
3. Identify the behavior to be decreased,
4. Identify the behavior to be increased,
5. Identify what things should be provided or avoided in the individual's environment on a daily basis to decrease the likelihood of the identified behavior,
6. Identify the methods that staff should use to manage behavior, in order to ensure consistency from setting to setting and from person to person,
7. Identify the event that likely occurs right before a behavior of concern,
8. Identify what staff should do if the event occurs,
9. Identify what staff should do if the behavior to be increased or decreased occurs, and
10. Involve the fewest interventions or strategies as possible.

The behavior management plan must also specify the length of time the restraint or restrictive interventions is to be used, who will authorize the use of restraints or seclusion and the methods for monitoring the individual.

Behavior management plans cannot include procedures that are punishing, physically painful, emotionally frightening, depriving, or that puts the individual at a medical risk.

E. Reports of Use of restraints or restrictive interventions:

All use of restraint must be documented in the individual's case record, including the initiating behavior, length of time of restraint, name of authorizing personnel, names of all individuals involved and outcomes of the event.

1. The use of restraints or seclusion must be reported to the DDS Quality Assurance section via an incident report form that must be submitted no later than the end of the second business day following the incident. The DDS Quality Assurance staff investigates each incident and monitors use of restraints for possible overuse or inappropriate use of restraints or seclusion. DDS Quality Assurance staff will notify entities involved with the complaint or service concern the results of their review. If there is credible evidence to support the complaint or concern, the provider will be required to submit a plan of correction. Failure to complete corrective action measures may result in the provider being placed on provisional status or revocation of certification.
2. Each person working within the provider agency must complete Introduction to Behavior Management, Abuse and Neglect and any other training as deemed necessary as a result of deficiencies or corrective actions.

212.000 Description of Services 3-1-10

DDS CES services provide the support necessary for a beneficiary to live in the community. Without these services, the beneficiary would require institutionalization.

Services provided under this program are as follows:

A. Supportive Living

B. Respite Services

C. Supported Employment

D. Adaptive Equipment

E. Environmental Modifications

F. Specialized Medical Supplies

G. Supplemental Support Service

H. ~~Case Management~~Care Coordination Services

I. Consultation Services

J. Crisis Intervention Services

K. Community Transition Services

213.000 Supportive Living

Supportive living is an array of individually tailored services and activities provided to enable eligible beneficiaries to reside successfully in their own homes, with their family, or in an alternative living residence or setting. Alternative living residences include apartments, leased or owned homes, or provider group homes. Supportive living services must be provided in integrated community settings. The services are designed to assist beneficiaries in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in the home and community based setting. Services are flexible to allow for unforeseen changes needed in schedules and times of service delivery. Services are approved as maximum days that can be adjusted within the annual plan year to meet changing needs. The total number of days cannot be increased or decreased without a revision. Care and supervision for which payment will be made are those activities that directly relate to active treatment goals & objectives.

A. Residential Habilitation Supports

Supports to assist the beneficiary to acquire, retain or improve skills in a wide variety of areas that directly affect the person's ability to reside as independently as possible in the community. The supports that may be provided to a beneficiary include the following:

1. Decision making including the identification of and response to dangerously threatening situations, making decisions and choices affecting the person's life and initiating changes in living arrangement or life activities;

2. Money management, including training, assistance or both in handling personal finances, making purchases and meeting personal financial obligations;

3. Daily living skills including habilitative training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, administration of medications (to the extent permitted under state law) and other areas of daily living including proper use of adaptive and assistive devices, appliances, home safety, first aid and emergency procedures;

4. Socialization, including training, assistance or both, in participation in general community activities, and establishing relationships with peers. Activity training includes assisting the person to continue to participate on an ongoing basis;

5. Community integration experiences, including activities intended to instruct the person in daily living and community living skills in an integrated setting. Included are such activities as shopping, church attendance, sports, participation in clubs, etc. Community experiences include activities and supports to accomplish individual goals or learning areas including recreation and specific training or leisure activities. Each activity is then adapted according to the beneficiary's individual needs. Non-medical transportation to or from community integration experiences is an integral part of this service and is included in the daily rate computation. DDS will assure duplicate billing between waiver services and other Medicaid state plan services will not occur. The habilitation objectives to be served by such training must be documented in the person's service plan. Whenever possible, family, neighbors, friends or community agencies that can provide this service without charge must be utilized.

   Exclusions: Transportation to and from medical, dental and professional appointments inclusive of therapists. Non-medical transportation does not include transportation for other household members.

7. Mobility, including training, assistance or both aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel or movement within the community;

8. Communication, including training in vocabulary building, use of augmentative communication devices and receptive and expressive language;

9. Behavior shaping and management, including training, assistance or both in appropriate expressions of emotions or desires, compliance, assertiveness, acquisition of socially appropriate behaviors or reduction of inappropriate behaviors;

10. Reinforcement of therapeutic services, including conducting exercises or reinforcing physical, occupational, speech and other therapeutic programs;

11. . Health maintenance activities may be provided by a supportive living worker. All health maintenance activities , except injections and IV's, can be done in the home by a designated care aide, such as a supportive living worker. With the exception of injectable medication administration, tasks that beneficiaries would otherwise do for themselves, or have a family member do, can be performed by a paid designated care aide at their direction, as long as the criteria specified in the Arkansas Nurse Practices Consumer Directed Care Act has been met. Health maintenance activities are available in the Arkansas Medicaid State Plan as self -directed services. State plan services must be exhausted before accessing waiver funding for health maintenance activities.

B. Companion and Activities Therapy

Companion and activities therapy services provide reinforcement of habilitative training. This reinforcement is accomplished by using animals as modalities to motivate beneficiairies to meet functional goals. Through the utilization of an animal's presence, enhancement and incentives are provided to beneficiaries to practice and accomplish such functional goals as follows:

1. Language skills;

2. Increase range of motion;

3. Socialization by developing the interpersonal relationships skills of interaction, cooperation and trust and the development of self-respect, self-esteem, responsibility, confidence and assertiveness;

Exclusions: This service does not include the purchase of animals, the cost of veterinary or other care, food, shelter or ancillary equipment that may be needed by the animal that is providing reinforcement.

C. Direct Care Supervision

The direct care supervisor employed by the supportive living provider is responsible for assuring the delivery of all supportive living direct care services including the following activities:

1. The coordination of all direct service workers who provide care through the direct service provider;
2. Serving as liaison between the beneficiary, parents, legal representatives, care coordinator ~~case management~~ entity and DDS officials;
3. Coordinating schedules for both waiver and generic service categories;
4. Providing direct planning input and preparing all direct service provider segments of any initial plan of care and annual continued stay review;
5. Assuring the integrity of all direct care service Medicaid waiver billing;
6. Arranging for staffing of all alternative living settings;
7. Assuring transportation as identified in beneficiary's person-centered service plan specific to supportive living services;
8. Assuring timely collaboration with the ~~case management~~care coordination entity to obtain comprehensive behavior and assessment reports, continued person-centered case plans with revisions as needs change, and information and documents required for ICF/ID~~/DD~~ level of care and waiver Medicaid eligibility determination;
9. Reviewing the person's records and environments in which services are provided by accessing appropriate professional sources to determine whether the person is receiving appropriate support in the management of medication. Minimum components are as follows:

   The direct care supervisor has an on-going responsibility for monitoring beneficiary medication regimens. While the provider may not staff a person on a 24/7 schedule, the provider is responsible around the clock to ensure that the person-centered service plan identifies and addresses all the needs with other supports as necessary to assure the health and welfare of the beneficiary.

   a. Staff, at all times, are aware of the medications being used by the beneficiary.
   b. Staff are knowledgeable of potential side effects of the medications being used by the person through the prescribing physician, nurse and pharmacist at the time medications are ordered.
   c. All medications consumed are prescribed or approved by the beneficiary's physician or other health care practitioner.
   d. The beneficiary or legally responsible person is informed by the prescribing physician about the nature and effect of medication being consumed and consent to the consumption of those medications prior to consumption.
   e. Staff are implementing the service provider's policies and procedures as to medication management, appropriate to the beneficiary's needs as monitored by the direct care supervisor in accordance with acceptable personnel policies and practices and by the ~~case manager~~care coordinator at least monthly.
   f. If psychotropic medications are being used for behavior, the direct care supervisor and ~~case manager~~ care coordinator are responsible to assure appropriate positive behavior programming is present and in use with

programming reviews at least monthly.

g. The consumption of medications is monitored at least monthly by the direct care supervisor to ensure that they are accurately consumed as prescribed.

h. Toxicology screenings are conducted on a frequency determined by the prescribing physician with ~~case manager~~ care coordinator oversight.

i. Any administration of medication or other nursing tasks or activities are performed in accordance with the Nurse Practice and Consumer Directed Care Acts and are monitored by the direct care supervisor in accordance with acceptable personnel practices and by the ~~case manager~~ care coordinator at least monthly.

j. Medications are regularly reviewed to monitor their effectiveness, to address the reason for which they were prescribed and for possible side effects.

k. Medication errors are effectively detected by the direct care supervisor by review of the medication log and with appropriate response up to and inclusive of incident reporting and reporting to the Nursing Board.

l. Frequency of monitoring is based on the physician's prescription for administration of medication.

m. The physician approving the service level of support and the person-~~-~~centered service plan is responsible for monitoring and determining contraindications when multiple medications are prescribed. A minimum review is at the annual continued stay review of the person-~~-~~centered service plan for approval and recertification.

Direct care staff are required to complete daily activity logs for activities that occur during the work timeframe with such activities linked to the person-~~-~~centered service plan objectives. The direct care supervisor is required to monitor the work of the direct care staff and to sign-off on timesheets maintained to document work performed. All monitoring activities, reviews and reports must be documented and available upon request from authorized DDS or DMS staff.

NOTE: Failure to satisfactorily document activities according to DMS requirements may result in non-payment of services.

~~D. Person-Centered Service Plan Development~~

~~Person-Centered Service Plan Development is a service provided through supportive living that consists of the development of the PSCP. The Person-Centered Service Plan is a treatment plan developed and driven by the beneficiary and/or parent or guardian to deliver specific services to enhance and maintain community living, support the person in all major life activities, determine the person's choices about their life, assist the person in carrying out those choices, access employment services, and assist the person with integrating into the life and activities of his or her community. The Person-Centered Service Plan Developer is responsible for developing and implementing the PCSP.~~

Persons may access both supportive living and respite on the same date as long as the two services are distinct, do not overlap and the daily rate maximum is correctly prorated as to the portion of the day that each respective service was actually provided. DDS monitors this provision through retrospective annual look behind with providers responsible to maintain adequate time records and activity case notes or activity logs that support the service deliveries. Maximum daily rate is established in accordance with budget neutrality wherein both supportive living and respite cannot exceed the daily maximum.

Controls in place to assure payments are only made for services rendered include requirement by assigned staff to complete daily activity logs for activities that occurred during the work timeframe with such activities linked to the person-centered case plan objectives; supervision of staff by the direct care supervisor with sign off on timesheets maintained weekly; audits and reviews conducted by DDS Quality Assurance annually and at random; DDS Waiver Services annual retrospective reviews, random attendance at planning meetings and visits to the home; DMS random audits; and oversight by the chosen and assigned ~~case manager~~care coordinator. Retainer payments may be made to providers of habilitation while the ~~waiver participant~~ beneficiary ~~is~~ is hospitalized or absent from his/her home.

213.200 Supportive Living Exclusions 3-1-10

Only hired caregivers may be reimbursed for supportive living services provided.

The payments for these services exclude the costs of room and board, including general maintenance, upkeep or improvement to the beneficiary's own home or that of his or her family.

Routine care and supervision for which payment will not be made are defined as those activities that are necessary to assure a person's well-being but are not activities that directly relate to active treatment goals and objectives.

It is the responsibility of the provider to assure compliance with State and Federal Department of Labor, Wage and Hour Laws.

213.300 Benefit Limits for Supportive Living

The maximum daily rate for the supportive living array, which includes both supportive living and respite services, is based upon the tier of support identified in the beneficiaries person centered service plan, after completion of the independent assessment. This daily rate includes provider indirect costs for each component of service. DDS must prior authorize daily rates for all tiers of support.

Tier 3: Maximum Daily Rate is $391.95, with a maximum of $143,061.75 annually.

Tier 2: Maximum Daily Rate is $184.80 with a maximum of $67,452.00 annually.

All units must be billed in accordance with the beneficiary's person centered service plan. Extensions of benefits will be provided when extended benefits are determined to be medically necessary.

~~Person-Centered Service Plan Development may be billed when the beneficiary enters the Waiver and must be reviewed at least annually or more frequently if there is documentation of a significant change of condition that requires an update in the beneficiary's treatment plan.~~

~~Yearly maximum of 1 per year (prior authorization for additional PCSP development can be requested).There will be a maximum rate of $90.00 per Plan development.~~

See Section 260.000 for billing information.

See Section 224.000 for payment guidelines of relatives or legal guardians.

216.000 Adaptive Equipment

The adaptive equipment service includes an item or a piece of equipment that is used to increase, maintain or improve functional capabilities of individuals to perform daily life tasks that would not be possible otherwise. The adaptive equipment service provides for the purchase, leasing, and as necessary, repair of adaptive, therapeutic and augmentative equipment that enables individuals to increase, maintain or improve their functional capacity to perform daily life tasks that would not be possible otherwise.

Adaptive equipment needs for supportive employment are included. This service may include specialized equipment such as devices, controls or appliances that will enable the person to perceive, to control or to communicate with the environment in which they live.

Adaptive equipment includes "enabling technology," that empower the beneficiary to gain independence through customizable technologies to allow them to safely perform activities of daily living without assistance, while still providing for monitoring and response for those beneficiaries, as needed. Enabling technology must be shown to meet a goal of the beneficiary's person--centered service plan, ensure beneficiary's health and safety, and provide for adequate monitoring and response for beneficiary's needs. Before enabling technology will be provided, it must be documented that an assessment was conducted and a plan was created to show how the enabling technology will meet those requirements.

Equipment may only be covered if not available to the beneficiary from any other source. Professional consultation must be accessed to ensure that the equipment will meet the needs of the beneficiary when the purchase will at a minimum, but not necessarily, exceed $500.00. Consultation must be conducted by a medical professional as determined by the beneficiary's condition for which the equipment is needed. All items must meet applicable standards of manufacture, design and installation.

All adaptive equipment must be solely for the waiver beneficiary. All purchases must meet the conditions for desired quality at the least expensive cost. Generally, any modifications over $1,000.00 will require three bids with the lowest bid with comparable quality being awarded; however, DDS may require three bids for any requested purchase.

Computer equipment may be approved when it allows the beneficiary control of his or her environment, assists in gaining independence or when it can be demonstrated that it is necessary to protect the health and safety of the person. The waiver does not cover supplies. Printers may be approved for non-verbal persons.

Communication boards are allowable devices. Computers may be approved for communication when there is substantial documentation that a computer will meet the needs of the person more appropriately than a communication board.

Software will be approved only when required to operate the accessories included for environmental control or to provide text-to-speech capability.

Conditions: The care and maintenance of, adaptive equipment, vehicle modifications, and personal emergency response systems are entrusted to the beneficiary or legally responsible person for whom the aids are purchased. Negligence (defined as failure to properly care for or perform routine maintenance of) shall mean that the service will be denied for a minimum of two plan years. Any abuse or unauthorized selling of aids by the beneficiary or legally responsible person shall mean the aids will not be replaced using waiver funding.

Exclusions:

A. Swimming pools (in-ground or above ground) and hot tubs are not allowable as either an environmental modification or adaptive equipment.

~~B.~~

~~C.~~

E. Computer supplies.

F. Computer desk or other furniture items are not covered.

G. Medicaid purchased equipment cannot be donated if the equipment being donated is needed by another waiver beneficiary residing in the residence.

217.000 Environmental Modifications

Environmental modifications are made to or at the waiver beneficiary's home, required by the person-centered service plan and are necessary to ensure the health, welfare and safety of the beneficiary or that enable the beneficiary to function with greater independence and without which the beneficiary would require institutionalization.

Environmental modification may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities , installation of specialized electric and plumbing systems to accommodate medical equipment, installation of sidewalks or pads to accommodate ambulatory impairments, and home property fencing when medically necessary to assure non-elopement, wandering or straying of persons who have dementia, Alzheimer's disease or other causes of memory loss or confusion as to location or decreased mental capacity or aberrant behaviors.

Expenses for the installation of the environmental modification and any repairs made necessary by the installation process are allowable. Portable or detachable modifications that can be relocated with the beneficiary and that have a written consent from the property owner or legal representative will be considered. Requests for modification must include an original photo of the site where modifications will be done; to scale sketch plans of the proposed modification project; identification of other specifications relative to materials, time for project completion and expected outcomes; labor and materials breakdown and assurance of compliance with any local building codes. Final inspection for the quality of the modification and compliance with specifications and local codes is the responsibility of the waiver ~~case manager~~care coordinator. Payment to the contractor is to be withheld until the work meets specifications including a signed customer satisfaction statement.

All services must be provided as directed by the beneficiary's person-centered service plan and in accordance with all applicable state or local building codes.

Environmental modifications must be made within the existing square footage of the residence and cannot add to the square footage of the building.

Modifications are considered and approved as single, all-encompassing projects and, as such, cannot be split whereby a part of the project is submitted in one service plan year and another part submitted in the next service plan year. Any such activity is prohibited. All modifications must be completed within the plan of care year in which the modifications are approved.

All purchases must meet the conditions for desired quality at the least expensive cost. Generally, any modifications over $1,000.00 will require three bids with the lowest bid with comparable quality being awarded, however, DDS may require three bids for any requested modification.

Environmental modifications may only be funded through the Waiver if not available to the beneficiary from any other source. If the beneficiary may receive environmental modifications through the Medicaid State Plan, a denial by utilization review will be required prior to approval for funding through the Waiver.

218.000 Specialized Medical Supplies

A physician must order or document the need for all specialized medical equipment. All items must be included in the person-centered service plan. Specialized medical equipment and supplies include:

A. Items necessary for life support or to address physical conditions along with the ancillary supplies and equipment necessary for the proper functioning of such items.

B. Durable and non-durable medical equipment not available under the Arkansas Medicaid State Plan that is necessary to address beneficiary functional limitations.

C. Necessary medical supplies not available under the Arkansas Medicaid State Plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the state plan and exclude those items that are not of direct medical or remedial benefit to the beneficiary. All items shall meet applicable standards of manufacture, design and installation. The most cost effective item will be considered first.

Additional supply items are covered as a waiver service when they are considered essential and medically necessary for home and community-care. Covered items include:

A. Nutritional supplements

B. Non-Prescription medications. Alternative medicines not Federal Drug Administration approved are excluded from coverage.

C. Prescription drugs, minus the cost of drugs covered by Medicare Part D, when extended benefits available under the Arkansas Medicaid State Plan.

When the items are included in Arkansas Medicaid State Plan services, a denial of extension of benefits by DMS Utilization Review will be required prior to approval for waiver funding by DDS.

220.000 ~~Case Management~~Care Coordination Services

Care coordination is ensuring that specialty services are coordinated and appropriately delivered by specialty providers. Care Coordination will be provided to waiver beneficiaries until they are attributed to a PASSE. Care Coordination is not available to beneficiaries who have been attributed to a PASSE. These beneficiaries will receive care coordination through the PASSE entity.

~~It~ Care Coordination includes the following activities:

1) Health education and coaching;

2) Coordination with other healthcare providers for diagnostics, ambulatory care, and hospital services;

3) Assistance with social determinants of health, 3 such as access to healthy food and exercise;

4) Promotion of activities focused on the health of a patient and the community, including without limitation outreach, quality improvement, and patient panel management;

5) Coordination of Community-based management of medication therapy.

The care coordinator is responsible for the total plan of care for each beneficiary assigned to him or her. This includes, but is not limited to, the following:

1) Behavioral Health Treatment Plan;

2) Person--Centered Service Plan;

3) Primary Care Physician Care Plan;

4) Individualized Education Program;

5) Individual Treatment Plans for developmental clients in day habilitation programs;

6) Nutrition Plan;

7) Housing Plan;

8) Any existing Work Plan;

9) Justice system-related plan;

10) Child welfare plan; or

11) Medication management plan.

The care coordinator is responsible for obtaining copies of all treatment and service plans related to an individual beneficiary and coordinating services between those plans. The goal is to prevent duplication of services, ensure timely access to all needed services, and identify any service gaps for the beneficiary. The ultimate goal of the care coordinator is to assist the beneficiary in remaining in the most appropriate and least restrictive setting for that beneficiary.

Other services provided by the care coordinator include:

1) Coordinating and arranging all CES waiver services and other state plan services;

2) Identifying and accessing needed medical, social, educational and other publicly funded services (regardless of funding source);

3) Identifying and accessing informal community supports needed by eligible beneficiaries and their families.

4) Monitoring and reviewing services provided to the beneficiary to ensure all plan services are being provided and to ensure the health and safety of the beneficiary;

5) Facilitating crisis intervention;

6) Providing guidance and support to meet generic needs;

7) Conducting appropriate needs assessments and referral for resources;

8) Monitoring services provided to ensure quality of care and case reviews which focus on the beneficiary's progress in meeting goals and objectives established on existing case plans;

9) Providing assistance relative to obtaining waiver Medicaid eligibility and ICF/IID level of care eligibility determinations;

10) Ensuring submission of timely (advanced) and comprehensive behavior and assessment reports, continued PCSPs, revisions as needs change and information and documents required for ICF/IID level of care and waiver Medicaid eligibility determinations;

11) Arranging for access to advocacy services as requested by beneficiary.

12) Providing assistance upon receipt of DDS or DHS notices or denials, including assistance with the reconsideration and appeal process.

The care coordinator will also be responsible for assisting the beneficiary with transitioning between service settings, for example with transition from the residential treatment setting to community based care.

Care coordination services must be available to attributed beneficiaries 24 hours a day through a hotline or web-based application.

If a beneficiary has already been assigned to or selected a PCP or PCMH, that PCP or PCMH will be responsible for coordinating the beneficiary's medical care. If the beneficiary does not have a PCP selected, care coordinator must assist the beneficiary with selecting a PCP or provide a referral to a PCP.

A care coordinator cannot have more than ~~25~~50 beneficiaries on its caseload at any one time. The care coordinator must make a monthly face-to-face contact with each beneficiary assigned. The care coordinator must also obtain all treatment plans for the beneficiary and obtain all medical records for the beneficiary in order to adequately coordinate services, identify health needs, and provide health coaching and health education.

If the beneficiary is seen in an emergency room or urgent care clinic or is admitted to an acute inpatient psychiatric facility, the care coordinator must follow up with the beneficiary within seven (7) days of discharge from the facility. The follow up visit is to ensure that all discharge instructions are being followed and any follow-up appointments have been scheduled. Care coordination services must be available to attributed beneficiaries 24 hours a day.

~~Case management services assist beneficiaries in gaining access to needed waiver services and other Arkansas Medicaid State Plan services, as well as medical, social, educational and other generic services, regardless of the funding source to which access is available.~~

~~Case management services include responsibility for guidance and support in all life activities. The intent of case management services is to enable waiver beneficiaries to receive a full range of appropriate services in a planned, coordinated, efficient and effective manner.~~

~~These activities include locating, coordinating, assuring the implementation of and monitoring:~~

~~A. All proposed waiver services~~

~~B. Other Medicaid state plan services~~

~~C. Needed medical, social, educational and other publically funded services, regardless of the funding source~~

~~D. Informal community supports needed by beneficiaries and their families~~

~~Case management services consist of the following activities:~~

~~A. Arranging for the provision of services and additional supports~~

~~B. Monitoring and reviewing beneficiary services included in the person centered service plan~~

~~C. Facilitating crisis intervention~~

~~D. Guidance and support to obtain generic services and supports~~

~~E. Case planning~~

~~F. Needs assessment and referral for resources~~

~~G. Monitoring to assure quality of care and Case reviews that focus on the beneficiary's progress in meeting goals and objectives established through the case plan~~

~~H. Providing assistance relative to obtaining Waiver Medicaid eligibility and ICF/ID/DD level of care eligibility determinations~~

~~I. Assuring the integrity of all case management Medicaid Waiver billing in that the service delivered must have prior authorization and meet required waiver service definitions and must be delivered before billing can occur~~

~~J. Assuring submission of timely (advance) and comprehensive behavior and/or assessment reports, continued person centered service plans, revisions as needs change, and information and documentation required for ICF/ID/DD level of care and waiver Medicaid eligibility determinations~~

~~K. Arranging for access to advocacy services as requested by the beneficiary~~

~~L. Monitoring and reviewing services to assure health and safety of the beneficiary~~

~~N. Upon receipt of DDS approvals or denials of requested services, ensure that a copy is provided to the beneficiary or legal representative.~~

~~O. Provides assistance with the appeals process when the appeal option is chosen by the beneficiary or legal representative.~~

~~P. Planning meetings are scheduled by the case manager on behalf of the beneficiary, at a time and in a location that is convenient for the beneficiary or legal representative. The planning meeting will only include the case manager, the beneficiary or legal representative and other persons invited by the beneficiary.~~

~~Case Management~~Care Coordination will be provided up to a maximum of a 90 day transition period for all persons who seek to voluntarily withdraw from waiver services unless the individual does not want to continue to receive the service. The transition period will allow for follow up to assure that the person is referred to other available services and to assure that the person's needs can be met through optional services. It also serves to assure that the person understands the effects and outcomes of withdrawal and to ascertain if the person was coerced or otherwise was unduly influenced to withdraw. During this 90 day timeframe, the person remains enrolled in the waiver, the case remains open, and waiver services will continue to be available until the beneficiary finalizes their intent to withdraw.

The State of Arkansas adheres to CMS regulation as it relates to conflict-free case management. ~~Case Management~~ Care Coordination services may not include the provision of direct services to the beneficiary that are typically or otherwise covered as service under CES Waiver of State Plan. The organization may not provide ~~case management~~care coordination services to any person to whom they provide any direct services without adhering to the following firewalls and protections:

A. The individual who performs the annual needs based assessment may not be a provider of services on the person centered service plan and may not provide direct care;

B. Participant should be encouraged to advocate or have an advocate present during all planning meetings; and

C. Provides will administratively separate ~~case management~~care coordination functions and staff and direct care functions and staff.

~~Case management~~Care Coordination services are available at two tiers of support. They are:

A. ~~Tier 3: Requiring paid caresupport and services 24 hours per day, seven days a week; and~~

B. ~~Tier 2: Requiring less than 24 hours a day, seven days a week of paid caresupport and services.~~

Tier 2 – The individual meets the institutional level of care criteria but does not currently require 24 hours a day of paid support and services to maintain his or her current placement.

Tier 3 – The individual meets the institutional level of care criteria and does require 24 hours a day of paid support and services to maintain his or her current placement.

The minimum requirement for service contacts is a~~s follows~~ monthly face-to-face contact. After the initial contact, the monthly contact can be made via viedeoconferencing.~~:~~

~~A. At least one contact monthly; and~~

~~B. At least one face-to-face contact per quarter~~

Abeyance: It is sometimes necessary to place a case in abeyance to allow the case to remain open while the beneficiary is temporarily placed in a licensed or certified treatment program for the purpose of behavior, physical, or health treatment or stabilization. ~~On a monthly basis, the case manager must conduct a monitoring contact and report the status to DDS. When a beneficiary is place in abeyance, there is a requirement of one visit or one contact per month by the Care Coordinator.~~Monthly contacts shall continue when a beneficiary is in abeyance.

See Section 260.000 for billing information.

220.010 Person-Centered Service Plan Development

Person-Centered Service Plan Development is a service provided through supportive living that consists of the development of the PSCP. The Person-Centered Service Plan is a treatment plan developed and driven by the beneficiary and/or parent or guardian to deliver specific services to enhance and maintain community living, support the person in all major life activities, determine the person's choices about their life, assist the person in carrying out those choices, access employment services, and assist the person with integrating into the life and activities of his or her community. The Person-Centered Service Plan Developer is responsible for developing and implementing the PCSP.

Person-Centered Service Plan Development may be billed when the beneficiary enters the Waiver and must be reviewed at least annually or more frequently if there is documentation of a significant change of condition that requires an update in the beneficiary's treatment plan.

Yearly maximum of 1 per year (prior authorization for additional PCSP development can be requested).There will be a maximum rate of $90.00 per Plan development.

220.100 Transitional ~~Case Management~~Care Coordination

~~Case Management~~Care Coordination services may be available during the last 180 consecutive days of a Medicaid eligible person's institutional stay to allow ~~case management~~care coordination activities to be performed related to transitioning the person to the community. The person must be approved and in the waiver program for ~~case management~~care coordination to be billed.

220.200 Benefit Limits for ~~Case Management~~Care Coordination

There is a maximum reimbursement limit of $173.33~~117.70~~ per month. ~~and $1,412.40 annually per person per year~~.

Abeyance will be approved in three month increments when the beneficiary will be out of service for at least one month. Abeyance cannot exceed one year.

~~Case management~~Care Coordination ~~is only provided through the Waiver to beneficiary who are age 21 and over. All medically necessary case management services are provided to children under the age of 21 through the Medicaid State Plan EPSDT benefit.~~

224.000 Payment to Relatives or Legal Guardians 3-1-10

Payment for waiver services will not be made to the adoptive or natural parent, step-parent or legal representative or legal guardian of a person less than 18 years old. Payments will not be made to a spouse or a legal representative for a person 18 years of age or older. The employment of eligible relatives (regardless of the waiver beneficiary's age) shall require prior approval from DDS authority.

Payment to relatives, other than parents of minor children, legal guardians, custodians of minors or adults, or the spouse of adults, must be prior approved by DDS to provide services. For purposes of exclusion, "parent" means natural or adoptive parents and step parents. For any service provider, all DDS qualifications and standards must be met before the person can be approved as a paid service provider. Qualified relatives, other than as specified in the foregoing, can provide any service.

In no case will a parent or legal guardian be reimbursed for the provision of transportation for a minor.

Controls for services rendered: All care staff are required to document all services provided daily according to their work schedules, direct care support service supervisors are responsible for the day to day supervision and monitoring of the direct care staff; ~~case managers~~care coordinators are responsible to periodically review with the beneficiary any problems in care delivery and report any deficiencies to the Waiver DD Specialist and DDS Quality Assurance provider certification staff. DDS specialists conduct a 100% review of service utilization for each ~~plan of care~~ person-centered service plan at the time of each plan of care 12 month expiration date to identify any gaps in approved services with corrective action by the provider to be taken; DDS Quality Assurance conducts annual provider reviews; and DMS conducts both random Quality Assurance audits and audits specific to the financial integrity of services delivered.

230.200 Level of Care Determination 3-1-10

Based on intellectual and behavioral assessment submitted by the provider, the ICF/IID~~/DD~~ level of care determination is performed by the Division of Developmental Disabilities. The ICF/IID~~/DD~~ level of care criteria provides an objective and consistent method for evaluating the

need for institutional placement in the absence of community alternatives. The level of care determination must be completed and the beneficiary determined to:

(1) Require the level of care provided in an ICF/IID; and

(2) Need institutionalization in an ICF/IID in the near future (in a month or less) but for the provision of waiver services.

Recertification, based on intellectual and behavioral assessments submitted by the provider at appropriate age milestones, will be performed by DDS to determine the beneficiary's continuing need for an ICF/IID~~/DD~~ level of care.

The annual level of care determination is made by a QDDP (physician).

230.210 Tiers of Support 3-1-10

Coverage is provided within two tiers of support.

The two tiers are as follows:

Tier 2 – The individual meets the institutional level of care criteria but does not currently require 24 hours a day of paid support and services to maintain his or her current placement.

Tier 3 – The individual meets the institutional level of care criteria and does require 24 hours a day of paid support and services to maintain his or her current placement.

~~Tier 2: Institutional Level of Care - requiring less than 24 hours per day, seven days a week of paid support and services.~~

~~Tier 23: Institutional Level of Care; 24/7.~~

Tiers will be determined through an Independent Assessment conducted by a third party vendor that will assess the ~~participant~~ beneficiary in ~~the following~~ three (3) areas. Refer to the Independent Assessment Provider manual for a complete listing of areas assessed.

~~1. Individual Areas, including:~~

~~a. Medical history, current medical conditions, or conditions observed by the assessor or self-reported by the individual;~~

~~b. Behavioral;~~

~~c. Home living activities;~~

~~d. Community activities;~~

~~e. Employment;~~

~~f. Health and safety assessment; and~~

~~g. Social functioning~~

~~2. Caregiver (natural supports) Areas, including:~~

~~a. Physical/behavioral (health);~~

~~b. Involvement;~~

~~c. Social resources;~~

~~d. Family stress; and~~

e. Safety

3. Current Risk Assessment Review, including:

a. Safety Plan, if available;

b. Behavior Plan;

c. Physical Plan; and

d. Medical Plan

The Independent Assessment must be used in conjunction with the application packets and other applicable functional assessments to create the person-centered service plan.

230.300 Comprehensive Diagnosis and Evaluation 3-1-10

A comprehensive diagnosis and evaluation (D&E) must be administered in order to determine that applicants are persons with a developmental disability prior to receiving CES Waiver services from the DDS.

The comprehensive diagnosis and evaluation includes a series of examinations and observations performed or validated and approved by professionals leading to conclusions and findings.

The examinations and/or assessments include, but are not limited to:

A. A thorough medical examination and other evaluations deemed necessary by the physician

B. A psychological assessment

C. A social history/sociological examination

D. An educational assessment, if applicable

E. An appraisal of adaptive behavior

F. All other examinations, assessments and evaluations necessary to describe the beneficiary's needs

G. Areas of Need form

Failure to submit the reassessments in advance of eligibility expiration date will result in the denial of case management care coordination reimbursement for the period the determination is overdue. Failure to obtain any required eligibility determination, whether initial or subsequent time-bound reassessments, may result in the beneficiary's case being closed.

When a beneficiary's case has been closed, the affected person must make a new request for services through the waiver program intake process in order for services to continue. This will be considered a new application to the waiver program.

230.400 Person Centered Service Plan

During the initial sixty (60) days of DDS CES waiver services, a beneficiary receives services based on a DDS pre-approved initial interim person centered service plan that provides for care coordinationcase management at the prevailing rate, up to 60 days; and supportive living services for direct care supervision, up to 60 days. It may include transitional funding when the person is transitioning from an institution to the community. Persons residing in a Medicaid

reimbursed facility may receive ~~case management~~care coordination the last 180 consecutive days of the institutional stay.

NOTE: The fully developed person-centered service plan may be submitted, approved and implemented prior to the expiration of the initial person-centered service plan. The initial plan period is simply the maximum time frame for developing, submitting, obtaining approval from DDS and implementing the person-centered service plan. An extension may be granted when there is supporting documentation justifying the delay.

Prior to expiration of the interim service plan, each beneficiary eligible for CES waiver services must have an individualized, specific, written person-centered service plan developed by a multi-agency team including a Person-Centered Service Plan Developer and approved by the DDS authority. The members of the team will determine services to be provided, frequency of service provision, number of units of service and cost for those services while ensuring the beneficiary's desired outcomes, needs and preferences are addressed. Team members and a physician, via the DDS 703 form, certify the beneficiary's condition (level of care) and appropriateness of services initially and at the annual continued stay review. The person centered service plan development is conducted once every 12 months in accordance with the continued stay review date or as changes in the beneficiary's condition require a revision to the person-centered service plan.

The person-centered service plan must be designed with consideration given to the Independent Assessment results and to assure that services provided will be:

A. Specific to the beneficiary's unique circumstances and potential for personal growth.

B. Provided in the least restrictive environment possible.

C. Developed within a process assuring participation of those concerned with the beneficiary's welfare. Participants of the multi-agency team included the beneficiary's chosen ~~case manager~~care coordinator, the beneficiary or legal representative and additional persons whom the beneficiary chooses to invite to the planning meeting, as long as all rules pertaining to confidentiality and conflict of interest are met. If invited, the DDS Waiver Specialist attends the planning meetings randomly, in an effort to assure an annual 10% attendance ratio. Mandatory attendance by the ~~case manager~~care coordinator is required to assure the written person centered service plan meets the requirements of regulations, the desires of the beneficiary or legal representative, is submitted timely, and is approved by DDS prior to service delivery.

D. Monitored and adjusted to reflect changes in the beneficiary's needs. A person centered service plan revision may be requested at any time the beneficiary's needs change.

E. Provided within a system which safeguards the beneficiary's rights.

F. Documented carefully, with assurance that appropriate records will be maintained.

G. Will assure the beneficiary's and others' health and safety. The person centered service plan development process identifies risks and makes sure that they are addressed through backup plans and risk management agreements, including how and who will be responsible for ongoing monitoring of risk level and risk management strategies, and how staff will be trained regarding those risks. A complete description of backup arrangements must be included in the person centered service plan. All strategies must be designed to respect the needs and preferences of the beneficiary. All risk management strategies must be analyzed by the team at least quarterly as part of the PCSP review.

H. Consider cost-efficient options that foster independence, such as shared staffing and other adaptions. When such options are not utilized in the PCSP for a Tier 3 participant, it must

be documented that the participant's health and safety require one on one staffing, twenty-four hours a day.

The Person-Centered Service Plan Developer will be responsible for the development and implementation of the PCSP.

230.410 Person-Centered Service Plan Required Documentation

A. General Information

Identification information must include:

1. Beneficiary's full name and address
2. Beneficiary's Medicaid number
3. Guardian or Power of Attorney with an address (when applicable)
4. Number of individuals with ID/IIDD residing in home of waiver beneficiary and type of residence.
5. Physician Level of Care Certification
6. Names, titles and signatures of the multi-agency team members responsible for the development of the beneficiary's person-centered service plan.
7. Results of the Independent assessment and any other functional assessments used to develop the person-centered service plan.

B. Budget Sheet, Worksheets and Provider Information

Information must include:

1. Identification of the type waiver services to be provided
2. The name of the provider delivering the service
3. Total amount by service
4. Total plan amount authorized
5. Beginning and ending date for each service
6. Supported Living Array worksheet listing units and total cost by service and level of support
7. Adaptive Equipment, Environmental Modifications, Specialized Medical Supplies, Supplemental Support, and Community Transition worksheets listing units and total cost by service
8. Provider Information sheet showing ~~case management~~care coordination provider, ~~case manager~~care coordinator, supportive living provider, person-centered service plan developer and direct care supervisor

C. Narrative justification for the revision to the initial plan of care must, at a minimum, justify the need for requested services. Narrative justification for annual continued stay reviews must address utilization of services used or unused within the past year, justify new services requested and address risk assessment.

D. The person-centered service plan must include:

1. Identification of individual objectives.
2. Frequency of review of the objectives.
3. List of medical and other services, including waiver and non-waiver services necessary to obtain expected objectives.

4. Expected outcomes including any service barriers

E. Product and service cost effectiveness certification statement, with supporting documentation, certifying that products, goods and services to be purchased meet applicable codes and standards and are cost competitive for comparable quality.

241.000 Approval Authority 3-1-10

For the purpose of person-centered service plan approvals, DDS is the Medicaid authority.

A. The DDS prior authorization process requires that all ~~pervasive level~~ Tier 3 ~~of~~ support service plans, problematic service plans, or plans not clearly based on documented need must have approval by DDS Person-Centered Service Plan Review Team.

1. Problematic is based on individual circumstances, a change in condition, or a new service request as determined by the DDS Waiver Specialist or by request of the ~~case~~care coordinator, or the person-centered service plan developer.

2. The DDS ~~Plan of Care~~ Person-Centered Service Plan Review Team consists of the DDS Waiver Program director or designee, DDS Waiver Area Managers, DDS Psychology Team member and other expert professionals such as nurses, physicians or therapists. The DDS Waiver Specialist is responsible for presenting the case to the team. The waiver ~~participant~~ beneficiary or legal representative is permitted to attend the meeting and present supporting evidence why the services requested should be approved, as long as all rules pertaining to confidentiality and conflict of interest are met.

3. The DDS Waiver Specialist must conduct an in-home visit for all Tier 3 service plans and may conduct an in-home visit for problematic service plans or plans that are not based on documented needed. Failure of the beneficiary or legal representative to permit DDS from conducting the in-home visit may result in the denial of service request and may result in case closure.

B. All Tier 2 service plans will be subject to a local level approval process.

C~~B~~. All waiver services must be needed to prevent institutionalization.

D. All beneficiaries receiving medications must also receive appropriate support in the management of medication(s). The use of psychotropic medications for behavior will require the development, implementation and monitoring of a written positive behavior plan.

E. Service requests that will supplant Department of Education responsibilities WILL NOT be approved. This includes voluntary decisions to withdraw from, or never enter the Department of Education, public school system. The waiver does not provide educational services, including educational materials, equipment supplies or aids.

F. All person-centered service plans are subject to review by a qualified physician and random audit scrutiny by DDS Specialists, DDS Area Managers, DDS Licensure staff or DMS Quality Assurance staff. In addition, the following activities will occur:

1. Review of provider standards and actions that provide for the assurance of a beneficiary's health and welfare

2. Monitoring of compliance with standards for any state licensure or certification requirement for persons furnishing services provided under this waiver

3. Assurance that the requirements are met on the date that the service is furnished

4. Quality assurance reviews by DDS staff include announced and unannounced quarterly on-site home visits

5. Random review equal to a percent as prescribed by DDS Licensure Unit's certification policy.

G. All service requests are subject to review by DDS and may necessitate the gathering and submission of additional justification, information and clarification before prior approval is made. In this event, it is the primary responsibility of the ~~case management~~care coordination provider, with cooperation from the procurement source, to satisfy the request(s) within the prescribed time frames.

H. It is the responsibility of the ~~case management~~care coordination services provider with cooperation from the direct services providers to ensure that all requests for services are submitted in a timely manner to allow for DDS prior authorization activities prior to the expiration of existing plans or expected implementation of revisions.

I. Initially, a beneficiary receives up to three months of DDS CES waiver services based on a DDS pre-approved interim service plan. The pre-approved interim plan will include care coordination ~~case management~~ and supportive living service for direct care supervision and may include community transition services when the person is transitioning from an institution to the community. For transitional~~-~~ care coordination~~case management~~, the sixty (60) day interim plan begins with the date of discharge.

1. At any time during the initial 60 days or transitional care coordination~~case management~~ period, the PCSP Developer ~~case manager~~ will complete the planning process and submit a detailed person-~~-~~centered service plan that identifies all needed, medically necessary services for the remainder of the plan of care year. Once approval is obtained, these services may be implemented.

2. Waiver services will not be reimbursed for any date of service that occurs prior to the date the beneficiary's person-~~-~~centered service plan is approved, the date the beneficiary is determined to be ICF/I/ID~~/DD~~ eligible, or the date the beneficiary is deemed Medicaid waiver eligible, whichever date is last.

3. All changes of service or tier revisions must have prior authorization. Services that are not prior authorized will not be reimbursed.

J. Emergency approvals may be obtained via telephone, facsimile or e-mail, with retroactive reimbursement permitted as long as the notice of emergency, with request for service change, is received by DDS within 24 hours from the time the emergency situation was known. All electronically transmitted requests for emergency services must be followed with written notification and requests must be supported with documented proof of emergency. Failure to properly document proof of emergency shall result in approval being rescinded.

262.000 DDS CES Waiver Procedure Codes 3-1-10

The following procedure codes and any associated modifier(s) must be billed for DDS CES Waiver Services. Prior authorization is required for all services.

Procedure Code	M1	M2	PA	Description	Unit of Service	National POS Codes

Procedure Code	M1	M2	PA	Description	Unit of Service	National POS Codes
H2016			Y	Supportive Living	1 Day	12, 99, 14
H2023			Y	Supported Employment: discovery/career planning	Outcome payment	99
			Y	Supported Employment: Employment Path	Outcome payment	
			Y	Supported Employment: Job Development	Outcome payment	
			Y	Supported Employment: Job Coaching	Outcome payment	
			Y	Supported Employment: Extended Services	Outcome payment	
S5151			Y	Respite Services	1 Day	12, 99, 14, 54
T2020	UA		Y	Supplemental Support Services	1 package	12, 99, 14
T2022			Y	~~Case Management Services~~Care Coordination	1 Month	12, 99, 14
T2025			Y	Consultation Services	1 Hour	12, 99, 14
T2028			Y	Specialized Medical Equipment	1 Package	12, 99,14
T2020	UA	U1	Y	Community Transition Services	1 Package	99, 14, 54
T2022	U2		Y	Transitional ~~Case Management~~Care Coordination	1 Month	99, 14, 54
T2034	U1	UA	Y	Crisis Intervention Services	1 Hour	99,12
K0108			Y	CES environmental modifications	1 Package	12
S5160			Y	Adaptive equipment, personal emergency response system (PERS), installation and testing,	1 Package	12, 14
S5161			Y	Adaptive equipment, personal emergency response system (PERS), service fee, per month, excludes installation and testing	1 package	12, 14
S5162			Y	Adaptive equipment, personal emergency response system (PERS), purchase only	1 Package	12, 14
S5165	U1		Y	CES adaptive equipment, per service	1 Package	12, 14