

PART III

POLICIES AND PROCEDURES
for
NEW OPTIONS WAIVER PROGRAM



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION of MEDICAL ASSISTANCE PLANS

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**Policy Revision Record
from 2024 to Current¹**

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE	CITATION
			A=Added D=Deleted M=Modified	(Revision required by Regulation, Legislation, etc.)
10/01/2026	3107.2.4	Revised language to reflect outdated terminology	M	N/A
7/1/2026	1701 1702.2.1.7.5.	Added detail regarding examples of activities which constitute as Community Access	A	N/A
7/1/2026	1702.2.11	Added detail regarding transportation requirements for Community Access Services	A	N/A
7/1/2026	2602.2.2	Updated Licensure information to reflect changes from DCH oversight of Community Living Arrangement licensure to DBHDD oversight as a result of 2025 legislation (HB-584)	M	Revision required by legislation
7/1/2026	3303.2	Clarification that nursing notes may be maintained in an electronic format in the individual's record.	M	N/A
7/1/2026	Appendix A	Updated Appendix A to align with service units and limits for Community Access and Prevocational Services	M	N/A
4/1/2026	2601 & 2606	Removed antiquated references to child caring institutions.	D	N/A
4/1/2026	3305.1.1	Clarified age requirement language for recipients of Nursing Services.	M	N/A
4/1/2026	3305.1.1 – 3305.1.3	Renumbering.	M	N/A
1/1/2026	2501	Clarified prevocational employment language and requirements.	M	N/A
1/1/2026	2502.8, 2502.8.1.3, 2502.8.1.4	Clarified prevocational employment requirements.	M	N/A
1/1/2026	3502.4.5	Deleted administrative billing language from Assistive Technology chapter.	D	N/A

¹ The revisions outlined in this Table are from 2024 to current. For revisions prior to 2024, please see prior versions of the policy.

10/1/2025	1602.1.2	Clarified Positive Behavioral Supports Level 1 provider supervision.	M	N/A
10/1/2025	1701	Clarified the preclusion of vocational/employment activities/training under Community Access Services.	M	N/A
10/1/2025	3101.6 & 3101.7	Clarified Transportation Services exclusions.	M	N/A
7/1/2025	1902.1.3.1	Updated licensure hyperlink.	M	N/A
7/1/2025	2205.1-.3	Clarified Participant-Directed Representative language.	M	N/A
7/1/2025	2602.2.2	Replaced licensure hyperlink.	M	N/A
7/1/2025	2802.1.1.2.2	Replaced Durable Medical Equipment Policy Manual hyperlinks.	M	N/A
7/1/2025	3300	Revised chapter to align with current practices.	M	N/A
7/1/2025	Appendix A	Updated Appendix A.	M	N/A
4/1/2025	1705	Clarified language related to Community Access staffing ratios.	M	Policy clarification
4/1/2025	Appendix A	Updated rates, applicable service limits, and other pertinent details	M	Waiver Amendment
1/1/2025	Manual Cover Page	Changed Date from April 1, 2024 to July 1, 2024	M	N/A
1/1/2025	1308	Updated basis for reimbursement	M	Reimbursement amounts and limits already covered in Appendix A
1/1/2025	1408	Updated basis for reimbursement	M	Reimbursement amounts and limits already covered in Appendix A
1/1/2025	1508	Updated basis for reimbursement	M	Reimbursement amounts and limits already covered in Appendix A
1/1/2025	1601	Added specifications for defining ‘high-risk’ behavioral factors	A	Policy clarification
1/1/2025	1701	Policy clarification to distinguish Community Access Group (CAG) facility and community services and to address allowances for transportation billing; Moved discussion of transportation-related activities to ‘covered services’ section.	M	Waiver amendment
1/1/2025	1705	Added staffing ratio allowances for Community-Based Group Community Access Services;	A	Waiver amendment

1/1/2025	1705	Provided clarification regarding transportation billing.	M	Policy clarification
1/1/2025	1807	Updated basis for reimbursement	M	Reimbursement amounts and limits already covered in Appendix A
1/1/2025	1908	Updated basis for reimbursement	M	Reimbursement amounts and limits already covered in Appendix A
1/1/2025	2008	Updated basis for reimbursement	M	Reimbursement amounts and limits already covered in Appendix A
1/1/2025	2108	Updated basis for reimbursement	M	Reimbursement amounts and limits already covered in Appendix A
1/1/2025	2208	Updated basis for reimbursement	M	Reimbursement amounts and limits already covered in Appendix A
1/1/2025	2308	Updated basis for reimbursement	M	Reimbursement amounts and limits already covered in Appendix A
1/1/2025	2408	Updated basis for reimbursement	M	Reimbursement amounts and limits already covered in Appendix A
1/1/2025	2507	Updated basis for reimbursement	M	Reimbursement amounts and limits already covered in Appendix A
1/1/2025	2608	Updated basis for reimbursement; Incorporated tiered category definitions	M	Reimbursement amounts and limits already covered in Appendix A
1/1/2025	2708	Updated basis for reimbursement	M	Reimbursement amounts and limits already covered in Appendix A
1/1/2025	2808	Updated basis for reimbursement	M	Reimbursement amounts and limits

				already covered in Appendix A
1/1/2025	3001	Policy clarification to distinguish service modalities for Supported Employment – Individual	M	Waiver amendment
1/1/2025	3007	Provided Supported Employment – Group allowable staffing ratios	A	Waiver amendment
1/1/2025	3008	Provided specifications for participant-directed supported employment	M	Waiver amendment
1/1/2025	3009	Provided reference to ‘Telemedicine Guidance’ for supported employment	M	Policy clarification
1/1/2025	3108	Updated basis for reimbursement	M	Reimbursement amounts and limits already covered in Appendix A
1/1/2025	3208	Updated basis for reimbursement	M	Reimbursement amounts and limits already covered in Appendix A
1/1/2025	3307	Updated basis for reimbursement	M	Reimbursement amounts and limits already covered in Appendix A
1/1/2025	3408	Updated basis for reimbursement	M	Reimbursement amounts and limits already covered in Appendix A
1/1/2025	3508	Updated basis for reimbursement	M	Reimbursement amounts and limits already covered in Appendix A
1/1/2025	Appendix A	Updates rates, applicable service limits, and other pertinent details.	M	Waiver amendment and policy changes
1/1/2025	Appendix B	Created new Appendix B for enhanced rate requirements for deaf and hard of hearing	A	Waiver amendment
7/1/2024	603.3.1	The policy was modified as follows: Case managers must hold a Bachelor's degree or Master's degree in social work (MSW)...	M	Georgia’s HB1014, line 415.

Chapter 1300: Specific Program Requirements for Adult Occupational Therapy Services Scope of Services

1301. General

Adult Occupational Therapy Services are evaluation and therapeutic services that are not otherwise covered by Medicaid State Plan services. These services address the occupational therapy needs of the adult individual that result from his or her developmental disability. Adult Occupational Therapy Services include occupational therapy evaluation, individual/family education, occupational therapy activities to improve functional performance, and sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands.

Adult Occupational Therapy Services are provided by a Georgia licensed occupational therapist and by order of a physician. These services may be provided in an individual's own or family home, the Occupational Therapist's office, outpatient clinics, facilities in which Community Access or Prevocational Services are provided, Supported Employment work sites, or other community settings specific to community-based therapy goal(s). Adult Occupational Therapy Services may not be provided to individuals receiving Community Residential Alternative Services in the Comprehensive Supports Waiver.

1302. Special Requirements of Participation

1302.1. Individual Provider

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and PART II, Chapter 600 Policies and Procedures for the NOW Program, Adult Occupational Therapy Services providers must meet the following requirements:

- 1302.1.1. Service Provision: Adult Occupational Therapy Services are provided by a Georgia licensed occupational therapist and by order of a physician. Physician orders must be on letterhead or as a prescription from the physician and must indicate either the frequency of OT therapy services or an OT evaluation to determine the frequency of OT therapy services.
- 1302.1.2. Documentation Requirement: Providers, except for providers of participant-directed services, must document the following in the record of each individual receiving Adult Occupational Therapy Services:
 - 1302.1.2.1. Specific evaluation, training or therapeutic assistance provided;
 - 1302.1.2.2. Date and the beginning and ending time when the service was provided;
 - 1302.1.2.3. Location where the service was delivered;
 - 1302.1.2.4. Verification of service delivery, including first and last name and title of the person providing the service and

his or her signature;

1302.1.2.5. Progress towards moving the individual towards independence by meeting the individual ISP.

1302.1.2.6. Adult Occupational Therapy Providers must maintain documentation for the identified need of therapies, frequency and duration of therapy, interventions to be provided, and goal(s) addressing therapies.

1302.1.3. Participant-Directed Services Documentation and other Requirements: Documentation and other requirements for individual providers of participant-directed services are specified in Part II Policies and Procedures for NOW and COMP, Chapter 1200.

1302.1.4. Adult Occupational Therapy Services at Community Access and Prevocational Service Facilities:

1302.1.5. Providers can provide Adult Occupational Therapy Services at facilities where Community Access and Prevocational Services are rendered; however, the services must be documented and billed separately, and any waiver individual receiving multiple services may not receive these services at the same time of the same day.

1302.2. Provider Agencies

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and PART II, Chapter 600 Policies and Procedures for the NOW Program, Adult Occupational Therapy Services provider agencies must meet the following requirements:

1302.2.1. Service Provision: Adult Occupational Therapy Services are provided by a Georgia licensed occupational therapist and by order of a physician. Physician orders must be on letterhead or as a prescription from the physician and must indicate either the frequency of OT therapy services or an OT evaluation to determine the frequency of OT therapy services.

1302.2.2. Types of Agencies: Agencies that provide Adult Occupational Therapy Services are:

1302.2.2.1. Accredited or Certified DD Service Agencies;

1302.2.2.2. Home Health Agencies.

1302.2.3. Staffing Qualifications and Responsibilities:

1302.2.3.1. Accredited or Certified DD Service Agencies rendering Adult Occupational Therapy Services must have staffing

that meets the following requirements:

- 1302.2.3.1.1. Clinical Services Supervisor (CSS) Additional information regarding CSS qualifications can be found in DBHDD Policy Recruitment and Application to Become a Provider of Developmental Disability Services, 02-701.
- 1302.2.3.1.2. Duties of the Clinical Services Supervisor (CSS) include, but are not limited to:
 - 1302.2.3.1.2.1. Oversees the day-to-day operation of the agency;
 - 1302.2.3.1.2.2. Manages the use of agency funds;
 - 1302.2.3.1.2.3. Ensures the development and updating of required policies of the agency;
 - 1302.2.3.1.2.4. Manages the employment of staff and professional contracts for the agency;
 - 1302.2.3.1.2.5. Designates another agency staff member to oversee the agency, in his or her absence.
- 1302.2.4. Provider agencies must have available a sufficient number of employees or professionals under contract that are Georgia licensed occupational therapists to provide Adult Occupational Therapy.
 - 1302.2.4.1. Duties of the occupational therapists include all covered services in Section 1306.
- 1302.2.5. Home Health Agencies rendering Adult Occupational Therapy Services must have staffing that meets the conditions of participation in the Medical Assistance Program as outlined in PART II, Chapter 600 Policies and Procedures for Home Health Services. Agency Policies and Procedures: Each provider agency must develop written policies and procedures to govern the operations of Adult Occupational Therapy services, which follow the Standards for the Georgia Department of

Behavioral Health and Developmental Disabilities, set forth in Part II Policies and Procedures for NOW.

- 1302.2.6. Documentation Requirement: Providers, except providers of participant-directed services, must document the following in the record of each individual receiving Adult Occupational Therapy Services:
- 1302.2.6.1. Specific evaluation, training or therapeutic assistance provided;
 - 1302.2.6.2. Date and the beginning and ending time when the service was provided;
 - 1302.2.6.3. Location where the service was delivered;
 - 1302.2.6.4. Verification of service delivery, including first and last name and title of the person providing the service and his or her signature;
 - 1302.2.6.5. Progress towards moving the individual towards independence by meeting the individual ISP.
 - 1302.2.6.6. Adult Occupational Therapy Providers must maintain documentation for the identified need of therapies, frequency and duration of therapy, interventions to be provided, and goal(s) addressing therapies.
 - 1302.2.6.7. Participant-Directed Services Documentation and other Requirements: Documentation and other requirements for providers of participant-directed services are specified in Part II Policies and Procedures for NOW and COMP, Chapter 1200.
 - 1302.2.6.8. Adult Occupational Therapy Services at Community Access and Prevocational Service Facilities: Providers can provide Adult Occupational Therapy Services at facilities where Community Access and Prevocational Services are rendered; however, the services must be documented and billed separately, and any waiver individual receiving multiple waiver services may not receive these services at the same time of the same day.
 - 1302.2.6.9. Georgia Department of Behavioral Health and Developmental Disabilities Contract/LOA and DBHDD Community Service Standards: Providers must adhere to DBHDD Contract/LOA, DBHDD Community Service Standards and all other applicable DBHDD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DBHDD (see Part

1303. Licensure

- 1303.1. Adult Occupational Therapy Services are provided by a licensed Occupational Therapist in accordance with the applicable Georgia license as required under OCGA Title 43-28-1.
- 1303.2. Home Health Agencies providing Adult Occupational Therapy services must have a Home Health Agency License (State of Georgia Rules and Regulations 290-5-38)

1304. Special Eligibility Conditions

- 1304.1. Adult Occupational Therapy Services are not available until the waiver individual's 21st birthday.
- 1304.2. The need for Adult Occupational Therapy Services must be reflected in the Intake and Evaluation Team approved Individual Service Plan (ISP).
- 1304.3. There is a reasonable expectation by the licensed occupational therapist that the individual can achieve the goal(s) in the necessary time frame.
- 1304.4. All services must be ordered by a physician.

1305. Prior Approval

Adult Occupational Therapy Services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any version changes. The need for Adult Occupational Therapy must be an identifiable assessed need in the ISP and directly related to the disability.

1306. Covered Services

Reimbursable Adult Occupational Therapy Services include the following based on the assessed need of the individual and as specified in the approved ISP:

- 1306.1. Occupational therapy evaluation.
- 1306.2. Therapeutic activities to improve functional performance.
- 1306.3. Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environment demands.
- 1306.4. Individual/family education.

- 1306.5. Therapeutic exercise programs including muscle strengthening, neuromuscular facilitation, sitting and standing balance and endurance and increased range of motion
- 1306.6. Muscle strengthening and endurance to facilitate transfers from wheelchairs and the use of other equipment.

1307. Non-Covered Services

- 1307.1. Services that duplicate any family education or training provided through Natural Supports Training (NST) Services.
- 1307.2. Services that occur simultaneously or on the same day as NST Services.
- 1307.3. Adult Occupational Therapy Services do not include in-home therapeutic services for the treatment of an illness or injury that are covered in Home Health Services under the regular Medicaid State Plan.
- 1307.4. Transportation to and from these services is not included in the rate.
- 1307.5. Group Therapy Activities.
- 1307.6. Not covered for conditions not related to DD diagnosis.
- 1307.7. Services that have not been ordered by a physician.
- 1307.8. Services in a hospital.
- 1307.9. Payment is not made for those goods and services covered by the State Medicaid Plan except where an individual's need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.
- 1307.10. Co-payment towards other insurance sources.

1308. Basis for Reimbursement

The reimbursement rates for Adult Occupational Therapy Services are found in Appendix A.

1309. Participant-Direction Options

- 1309.1. Participants can choose the self-direction option with Adult Occupational Therapy Services.
- 1309.2. An individual serving as a representative for a waiver participant in self-directed services is not eligible to be a participant-directed of Adult Occupational Therapy Services.
- 1309.3. For details on participant-direction, see Part II Policies and Procedures for NOW and

1310. Telehealth Option

- 1310.1. All components of Adult Occupational Therapy can be safely provided via telehealth modalities according to prevailing best practice standards published by the American Occupational Therapy Association and in accordance with the applicable Georgia license requirements under O.C.G.A. § 43-28-7.
- 1310.2. Therapists are expected to use synchronous audio/video technology for telehealth sessions.

Telephone calls and store and forward (asynchronous) modalities are not allowed for billable therapy evaluation and services.
- 1310.3. All contracted waiver providers are covered entities and obligated to abide by HIPAA and state privacy law. Providers are required to use only HIPAA compliant platforms while offering telehealth services. All contracted providers must sign business associate agreements with the operating agency, as required by HIPAA. Adult Occupational Therapists wishing to use telehealth modalities to deliver evaluation or treatment services must obtain valid signed consent from the individual or the legal decision-maker.
- 1310.4. Telehealth services must be rendered in quiet environment with attendance limited to the individual and whoever is assisting the clinician during the session as informant and/or following hands-on direction.
- 1310.5. General instructions about providing staff training include guidance that any documents including photographs of the individual should be developed to protect the privacy of the individual (e.g., individuals photographed positioned in alternate positioning equipment for staff training are clothed).
- 1310.6. For more information regarding telehealth guidance, please refer to the telehealth guidance, located at www.mmis.georgia.gov, Click Provider Information-Provider Manuals.

Chapter 1400: Specific Program Requirements for Adult Physical Therapy Services Scope of Services

1401. General

Adult Physical Therapy Services are evaluation and therapeutic services that are not otherwise covered by Medicaid State Plan services. These services address the physical therapy needs of the adult individual that result from his or her developmental disability. Adult Physical Therapy Services include physical therapy evaluation, individual/family education, and therapeutic exercises to develop sitting and standing balance, strength and endurance, and range of motion and flexibility. Adult Physical Therapy Services also consist of muscle strengthening and endurance to facilitate transfers from wheelchairs and the use of other equipment.

Adult Physical Therapy Services are provided by a Georgia licensed physical therapist and by order of a physician. These services may be provided in an individual's own or family home, the Physical Therapist's office, outpatient clinics, facilities in which Community Access or Prevocational Services are provided, Supported Employment work sites, or other community settings specific to community-based therapy goal(s).

1402. Special Requirements of Participation

1402.1. Individual Provider

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and PART II, Chapter 600 Policies and Procedures for the NOW Program, Adult Physical Therapy Services providers must meet the following requirements:

- 1402.1.1. Service Provision: Adult Physical Therapy Services are provided by a Georgia licensed physical therapist and by order of a physician. Physician orders must be on letterhead or as a prescription from the physician and must indicate either the frequency of PT therapy services or a PT evaluation to determine the frequency of PT therapy services.
- 1402.1.2. Documentation Requirement: Providers, except for providers of individual-directed services, must document the following in the record of each individual receiving Adult Physical Therapy Services:
 - 1402.1.2.1. Specific evaluation, training or therapeutic assistance provided;
 - 1402.1.2.2. Date and the beginning and ending time when the service was provided;
 - 1402.1.2.3. Location where the service was delivered;
 - 1402.1.2.4. Verification of service delivery, including first and last name and title of the person providing the service and his or her signature;

- 1402.1.2.5. Progress towards moving the individual towards independence by meeting the individual ISP.
- 1402.1.2.6. Adult Physical Therapy providers maintain documentation for: the identified need of therapies, frequency and duration of therapy, interventions to be provided, and goal(s) addressing therapies.
- 1402.1.3. Participant-Directed Services Documentation and other Requirements: Documentation and other requirements for individual providers of participant-directed services are specified in Part II Policies and Procedures for NOW and COMP, Chapter 1200.
- 1402.1.4. Adult Physical Therapy Services at Community Access and Prevocational Service Facilities: Providers can provide Adult Physical Therapy Services at facilities where Community Access and Prevocational Services are rendered; however, the services must be documented and billed separately, and any waiver individual receiving multiple waiver services may not receive these services at the same time of the same day.
- 1402.2. Provider Agencies

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and PART II, Chapter 600 Policies and Procedures for the NOW Program, Adult Physical Therapy Services provider agencies must meet the following requirements:

 - 1402.2.1. Service Provision: Adult Physical Therapy Services are provided by a Georgia licensed physical therapist and by order of a physician. Physician orders must be on letterhead or as a prescription from the physician and must indicate either the frequency of PT therapy services or a PT evaluation to determine the frequency of PT therapy services.
 - 1402.2.2. Types of Agencies: Agencies that provide Adult Physical Therapy Services are:
 - 1402.2.2.1. Accredited or Certified DD Service Agencies;
 - 1402.2.2.2. Home Health Agencies.
 - 1402.2.3. Staffing Qualifications and Responsibilities:
 - 1402.2.3.1. Accredited or Certified DD Service Agencies rendering Adult Physical Therapy Services must have staffing that meets the following requirements:
 - 1402.2.3.1.1. Clinical Services Supervisor (CSS) Additional information regarding CSS qualifications can be found in

DBHDD Policy Recruitment and Application to Become a Provider of Developmental Disability Services, 02-701.

1402.2.3.1.2. Duties of the CSS include, but are not limited to:

1402.2.3.1.2.1. Oversees the day-to-day operation of the agency;

1402.2.3.1.2.2. Manages the use of agency funds;

1402.2.3.1.2.3. Ensures the development and updating of required policies of the agency;

1402.2.3.1.2.4. Manages the employment of staff and professional contracts for the agency;

1402.2.3.1.2.5. Designates another agency staff member to oversee the agency, in his or her absence.

1402.2.3.1.3. Provider agencies must have available a sufficient number of employees or professionals under contract that are Georgia licensed physical therapists to provide Adult Physical Therapy Services.

1402.2.3.1.4. Duties of the physical therapists include all covered services in Section 1406.

1402.2.3.2. Home Health Agencies rendering Adult Physical Therapy Services must have staffing that meets the conditions of participation in the Medical Assistance Program as outlined in PART II, Chapter 600 Policies and Procedures for Home Health Services.

1402.2.4. Agency Policies and Procedures: Each provider agency must develop written policies and procedures to govern the operations of Adult Physical Therapy services, which follow the Standards for the Georgia Department of Behavioral Health and Developmental Disabilities (see Part II Policies and Procedures for NOW and COMP, Chapter 603).

- 1402.2.5. Documentation Requirement: Providers, except for providers of participant-directed services, must document the following in the record of each individual receiving Adult Physical Therapy Services:
- 1402.2.5.1. Specific evaluation, training or therapeutic assistance provided;
 - 1402.2.5.2. Date and the beginning and ending time when the service was provided;
 - 1402.2.5.3. Location where the service was delivered;
 - 1402.2.5.4. Verification of service delivery, including first and last name and title of the person providing the service and his or her signature;
 - 1402.2.5.5. Progress towards moving the individual towards independence by meeting the individual ISP.
 - 1402.2.5.6. Adult Physical Therapy providers maintain documentation for: the identified need of therapies, frequency and duration of therapy, interventions to be provided, and goal(s) addressing therapies.
- 1402.2.6. Participant-Directed Services Documentation and other Requirements: Documentation and other requirements for providers of participant-directed services are specified in Part II Policies and Procedures for NOW, Chapter 1200.
- 1402.2.7. Adult Physical Therapy Services at Community Access and Prevocational Service Facilities: Providers can provide Adult Physical Therapy Services at facilities where Community Access and Prevocational Services are rendered; however, the services must be documented and billed separately, and any waiver individual receiving multiple services may not receive these services at the same time of the same day.
- 1402.2.8. DBHDD Contract/LOA and DBHDD Community Service Standards: Providers must adhere to DBHDD Contract/LOA, DBHDD Community Service Standards and all other applicable DBHDD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DBHDD (refer to Part II Policies and Procedures for NOW).

1403. Licensure

- 1403.1. Adult Physical Therapy Services are provided by a licensed Physical Therapist in accordance with the applicable Georgia license as required under OCGA Title 43-33-1.
- 1403.2. Home Health Agencies providing Adult Physical Therapy services must have a Home Health Agency License (State of Georgia Rules and Regulations 290-5-38).

1404. Special Eligibility Conditions

- 1404.1. Adult Physical Therapy Services are not available until the waiver individual's 21st birthday.
- 1404.2. The need for Adult Physical Therapy Services must be reflected in the Intake and Evaluation Team approved Individual Service Plan (ISP).
- 1404.3. There is a reasonable expectation by the licensed physical therapist that the individual can achieve the goal(s) in the necessary time frame.
- 1404.4. All services must be ordered by a physician.

1405. Prior Approval

Adult Physical Therapy Services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any version changes. The need for Adult Physical Therapy must be an identifiable assessed need in the ISP and directly related to the disability.

1406. Covered Services

Reimbursable Adult Physical Therapy Services include the following based on the assessed need of the individual and as specified in the approved ISP:

- 1406.1. Physical therapy evaluation.
- 1406.2. Therapeutic procedures.
- 1406.3. Therapeutic exercises to develop strength and endurance, and range of motion and flexibility.
- 1406.4. Individual/family education.
- 1406.5. Therapeutic exercise programs including muscle strengthening, neuromuscular facilitation, sitting and standing balance and endurance and increased range of motion
- 1406.6. Muscle strengthening and endurance to facilitate transfers from wheelchairs and the use of other equipment.

1407. Non-Covered Services

- 1407.1. Services that duplicate any family education or training provided through Natural Supports Training (NST) Services.
- 1407.2. Services that occur simultaneously or on the same day as NST Services.
- 1407.3. Adult Physical Therapy Services do not include in-home therapeutic services for the treatment of an illness or injury that are covered in Home Health Services under the regular Medicaid State Plan.

- 1407.4. Transportation to and from these services is not included in the rate.
- 1407.5. Group Therapy Activities.
- 1407.6. Not covered for conditions not related to DD diagnosis.
- 1407.7. Services that have not been ordered by a physician.
- 1407.8. Services in a hospital.
- 1407.9. Payment is not made for those goods and services covered by the State Medicaid Plan except where an individual's need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.
- 1407.10. Co-payment towards other insurance sources.

1408. Basis for Reimbursement

The reimbursement rates for Adult Physical Therapy Services are found in Appendix A.

1409. Participant-Direction Options

- 1409.1. Participants can choose the self-direction option with Adult Physical Therapy Services.
- 1409.2. An individual serving as a representative for a waiver participant in self-directed services is not eligible to be a participant-directed provider of Adult Physical Therapy Services.
- 1409.3. For details on participant-direction (see Part II Policies and Procedures for NOW and COMP, Chapter 1200).

1410. Telehealth Options

- 1410.1. All components of Adult Physical Therapy can be safely provided via telehealth modalities according to prevailing best practice standards published by the American Physical Therapy Association and the applicable Georgia license requirements under O.C.G.A. § 43-33-11.
- 1410.2. Therapists are expected to use synchronous audio/video technology for telehealth sessions. Telephone calls and store and forward (asynchronous) modalities are not allowed for billable therapy evaluation and services.
- 1410.3. All contracted waiver providers are covered entities and obligated to abide by HIPAA and state privacy law. Providers are required to use only HIPAA compliant platforms while offering telehealth services. All contracted providers must sign business associate agreements with the operating agency, as required by HIPAA. Physical therapists wishing to use telehealth modalities to deliver evaluation or treatment services must obtain valid signed consent from the individual or the legal decision-maker.
- 1410.4. Telehealth services must be rendered in quiet environment with attendance limited to the individual and whoever is assisting the clinician during the session as informant

and/or following hands-on direction.

- 1410.5. General instructions about providing staff training include guidance that any documents including photographs of the individual should be developed to protect the privacy of the individual (e.g., individuals photographed positioned in alternate positioning equipment for staff training are clothed).
- 1410.6. For more information regarding telehealth guidance, please refer to the telehealth guidance, located at www.mmis.georgia.gov, Click Provider Information-Provider Manuals.

Chapter 1500: Specific Program Requirements for Adult Speech and Language Therapy Services Scope of Services

1501. General

Adult Speech and Language Therapy Services cover evaluation and therapeutic services that are not otherwise covered by Medicaid State Plan services. These services address the speech and language therapy needs of the adult individual that result from his or her developmental disability. Adult Speech and Language Therapy Services include the evaluation of speech language, voice, and language communication, auditory processing, and/or aural rehabilitation status. Adult Speech and Language Therapy Services also consist of individual/family education, speech language therapy, and therapeutic services for the use of speech-generating devices, including programming and modification. Adult Speech and Language Therapy Services also includes assessment of oral feeding and swallowing skills, and, if indicated, development and implementation of intervention to improve swallowing and reduce aspiration risk.

Adult Speech and Language Therapy Services are provided by a Georgia licensed speech and language pathologist and by order of a physician. These services may be provided in an individual's own or family home, the Speech and Language Pathologist's office, outpatient clinics, facilities in which Community Access or Prevocational Services are provided, Supported Employment work sites, or other community settings specific to community-based therapy goal(s).

1502. Special Requirements of Participation

1502.1. Individual Provider

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and PART II, Chapter 600 Policies and Procedures for the NOW Program, Adult Speech and Language Therapy Services providers must meet the following requirements:

1502.1.1. Service Provision: Adult Speech and Language Therapy Services are provided by a Georgia licensed speech and language pathologist and by order of a physician. Physician orders must be on letterhead or as a prescription from the physician and must indicate either the frequency of speech and language therapy services or a speech and language evaluation to determine the frequency of speech and language therapy services.

1502.1.2. Documentation Requirement: Providers, except for providers of participant-directed services, must document the following in the record of each individual receiving Adult Speech and Language Therapy Services:

1502.1.2.1. Specific evaluation, training or therapeutic assistance provided;

1502.1.2.2. Date and the beginning and ending time when the service was provided;

- 1502.1.2.3. Location where the service was delivered;
- 1502.1.2.4. Verification of service delivery, including first and last name and title of the person providing the service and his or her signature;
- 1502.1.2.5. Progress towards moving the individual towards independence by meeting the individual ISP.
- 1502.1.2.6. Adult Speech and Language Therapy providers maintain documentation for: the identified need of therapies, frequency and duration of therapy, interventions to be provided, and goal(s) addressing therapies.
- 1502.1.3. Participant-Directed Services Documentation and other Requirements: Documentation and other requirements for individual providers of participant-directed services are specified in Part II Policies and Procedures for NOW, Chapter 1200.
- 1502.1.4. Adult Speech and Language Therapy Services at Community Access and Prevocational Service Facilities: Providers can provide Adult Speech and Language Therapy Services at facilities where Community Access and Prevocational Services are rendered; however, the services must be documented and billed separately, and any waiver individual receiving multiple services may not receive these services at the same time of the same day.
- 1502.2. Provider Agencies

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and PART II, Chapter 600 Policies and Procedures for the NOW Program, Adult Speech and Language Therapy Services provider agencies must meet the following requirements:

 - 1502.2.1. Service Provision: Adult Speech and Language Therapy Services are provided by a Georgia licensed speech and language pathologist and by order of a physician. Physician orders must be on letterhead or as a prescription from the physician and must indicate either the frequency of speech and language therapy services or a speech and language evaluation to determine the frequency of speech and language therapy services.
 - 1502.2.2. Types of Agencies: Agencies that provide Adult Speech and Language Therapy Services are:
 - 1502.2.2.1. Accredited or Certified DD Service Agencies;
 - 1502.2.2.2. Home Health Agencies.

1502.2.2.2.1. Staffing Qualifications and Responsibilities:

1502.2.2.2.1.1. Accredited or Certified DD Service Agencies rendering Adult Speech and Language Therapy Services must have staffing that meets the following requirements:

1502.2.2.2.1.2. Clinical Services Supervisor (CSS). Additional information regarding CSS qualifications can be found in DBHDD Policy Recruitment and Application to Become a Provider of Developmental Disability Services, 02-701.

Duties of the CSS include, but are not limited to:

Oversees the day-to-day operation of the agency;

Manages the use of agency funds;

Ensures the development and updating of required policies of the agency;

Manages the employment of staff and professional contracts for the agency;

Designates another agency staff member to oversee the agency, in his or her absence.

Provider agencies must have available a sufficient number of employees or professionals under contract that are Georgia licensed speech and language pathologists to provide Adult

Speech and Language Therapy Services.

Duties of the Speech and Language Pathologist include all covered services in Section 1506.

Home Health Agencies rendering Adult Speech and Language Therapy Services must have staffing that meets the conditions of participation in the Medical Assistance Program as outlined in PART II, Chapter 600 Policies and Procedures for Home Health Services.

- 1502.2.3. Agency Policies and Procedures: Each provider agency must develop written policies and procedures to govern the operations of Adult Speech and Language Therapy services, which follow the Standards for the Georgia Department of Behavioral Health and Developmental Disabilities as stated in Part II Policies and Procedures for NOW.
- 1502.2.4. Documentation Requirement: Providers, except for providers of participant-directed services, must document the following in the record of each individual receiving Adult Speech and Language Therapy Services:
 - 1502.2.4.1. Specific evaluation, training or therapeutic assistance provided;
 - 1502.2.4.2. Date and the beginning and ending time when the service was provided;
 - 1502.2.4.3. Location where the service was delivered;
 - 1502.2.4.4. Verification of service delivery, including first and last name and title of the person providing the service and his or her signature;
 - 1502.2.4.5. Progress towards moving the individual towards independence by meeting the individual ISP.
 - 1502.2.4.6. Adult Speech and Language Therapy providers maintain documentation for: the identified need of therapies, frequency and duration of therapy, interventions to be provided, and goal(s) addressing therapies.
- 1502.2.5. Participant-Directed Services Documentation and other Requirements: Documentation and other requirements for providers of participant-

directed services are specified in Part II Policies and Procedures for NOW, Chapter 1200.

- 1502.2.6. Adult Speech and Language Therapy Services at Community Access and Prevocational Service Facilities: Providers can provide Adult Speech and Language Therapy Services at facilities where Community Access and Prevocational Services are rendered; however, the services must be documented and billed separately, and any waiver individual receiving multiple waiver services may not receive these services at the same time of the same day.
- 1502.2.7. DBHDD Contract/LOA and DBHDD Community Service Standards: Providers must adhere to DBHDD Contract/LOA, DBHDD Community Service Standards and all other applicable DBHDD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DBHDD (see Part II Policies and Procedures for NOW, Chapter 603).

1503. Licensure

- 1503.1. Adult Speech and Language Therapy Services are provided by a licensed Speech and Language Pathologist in accordance with the applicable Georgia license as required under OCGA Title 43-44-1.
- 1503.2. Home Health Agencies providing Adult Speech and Language Therapy services must have a Home Health Agency License (State of Georgia Rules and Regulations 290-5-38)

1504. Special Eligibility Conditions

- 1504.1. Adult Speech and Language Therapy Services are not available until the waiver individual's 21st birthday.
- 1504.2. The need for Adult Speech and Language Therapy Services must be reflected in the Intake and Evaluation Team approved Individual Service Plan (ISP).
- 1504.3. There is a reasonable expectation by the licensed speech and language pathologist that the individual can achieve the goal(s) in the necessary time frame.
- 1504.4. All services must be ordered by a physician.

1505. Prior Approval

Adult Speech and Language Therapy Services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any ISP version changes. The need for Adult Speech and Language Therapy must be an identifiable assessed need in the ISP and directly related to the disability.

1506. Covered Services

Reimbursable Adult Speech and Language Therapy Services include the following based on the

assessed need of the individual and as specified in the approved ISP:

- 1506.1. Evaluation of speech language, voice, and language communication, auditory processing, and/or aural rehabilitation.
- 1506.2. Individual treatment of speech, language, voice, communication, and/or auditory processing.
- 1506.3. Therapeutic services for the use of speech-generating device, including programming and modification.
- 1506.4. Individual/family education.

1507. Non-Covered Services

- 1507.1. Services that duplicate any family education or training provided through Natural Supports Training (NST) Services.
- 1507.2. Services that occur simultaneously or on the same day as NST Services.
- 1507.3. In-home therapeutic services for the treatment of an illness or injury that are covered in Home Health Services under the regular Medicaid State Plan.
- 1507.4. Transportation to and from these services is not included in the rate.
- 1507.5. Group Therapy Activities.
- 1507.6. Not covered for conditions not related to DD diagnosis.
- 1507.7. Services that have not been ordered by a physician.
- 1507.8. Services in a hospital.
- 1507.9. Payment is not made for those goods and services covered by the State Medicaid Plan except where an individual's need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.
- 1507.10. Co-payment towards other insurance sources.

1508. Basis for Reimbursement

The reimbursement rates for Adult Speech and Language Therapy Services are found in Appendix A.

1509. Participant-Direction Options

- 1509.1. Participants can choose the self-direction option with Adult Speech and Language Therapy Services.
- 1509.2. An individual serving as a representative for a waiver participant in self-directed services is not eligible to be a participant-directed provider of Adult Speech and Language Therapy Services.

- 1509.3. For details on participant-direction, see Part II Policies and Procedures for NOW and COMP, Chapter 1200.

1510. Telehealth Options

- 1510.1. All components of Speech and Language Therapy can be safely provided via telehealth modalities according to prevailing best practice standards published by the American Speech and Language Hearing Association and in accordance with the Georgia license requirements under O.C.G.A. § 43-44-7.
- 1510.2. Therapists are expected to use synchronous “in real time” audio/video technology for telehealth sessions. Telephone calls and store and forward (asynchronous) modalities are not allowed for billable therapy evaluation and services
- 1510.3. All contracted waiver providers are covered entities and obligated to abide by HIPAA and state privacy law. Providers are required to use only HIPAA compliant platforms while offering telehealth services. Speech and Language Therapists wishing to use telehealth modalities to deliver evaluation or treatment services must obtain valid signed consent from the individual or the legal decision-maker.
- 1510.4. Telehealth services must be rendered in quiet environment with attendance limited to the individual and whoever is assisting the clinician during the session as informant and/or following hands-on direction.
- 1510.5. General instructions about providing staff training include guidance that any documents including photographs of the individual should be developed to protect the privacy of the individual (e.g., individuals photographed positioned in alternate positioning equipment for staff training are clothed)
- 1510.6. Adult Speech and Language Therapy Services may be provided through a telehealth delivery model with the following exceptions: Adult Swallowing/Feeding Therapy; Adult Swallowing/Feeding Therapy self-directed; Adult Swallowing/Feeding Evaluation, Adult Swallowing/Feeding Evaluation self-directed. For more information regarding acceptable Adult Swallowing/Feeding Therapy, please reference section 1501.
- 1510.7. For more information regarding telehealth guidance, please refer to the telehealth guidance, located at www.mmis.georgia.gov, Click Provider Information-Provider Manuals.

Chapter 1600: Specific Program Requirements for Behavioral Supports Services Level 1 & Level 2 Scope of Services

1601. General

Behavior Support Services are a combination of learning based and systemic interventions and strategies to assist the individual with the management of challenging behaviors that interfere with activities of daily living, social interactions, work, or similar situations with the outcome of the individual learning new skills and reducing or replacing problem behaviors. Services are authorized for individuals whose challenging behaviors are dangerous or disruptive and present a risk to health and safety to the individual, peers, and others with a level of interruption to daily activities and community integration. A Positive Behavior Support Plan is used to address challenging behaviors that occur with interventions tied to specific goal(s) and objective(s). The purpose of a behavior support plan is to improve behavior over time.

Behavior Support Service delivery includes structured tasks that consist of a comprehensive functional behavioral assessment of challenging behavior, direct observation, data collection, analysis, and graphing, development of a behavior support plan, competency-based training of identified professional and supervisory staff responsible for training of direct support staff/informal care providers, and routine review of behavior plan efficacy and adjustments to the plan based on review findings. These services are provided in settings where problem behaviors occur that may include an individual's own or family home, behavior supports provider office, outpatient clinics, facilities in which Community Access Services or Prevocational Services are provided, Support Employment work sites, residential, or other community settings.

Behavior Support Services are provided by appropriately qualified professionals with a specific level of expertise in behavior supports evaluation and services for people with intellectual and developmental disabilities (I/DD).

Behavior Support Service needs for individuals whose behaviors, while challenging, typically present moderate risk to health and safety with moderate disruption to daily activities and community participation. Individuals determined at high risk in the community are those with behaviors that have resulted in significant physical injury to self or others, pose ongoing potential risk of harm to self or others, resulted in significant property destruction, caused repeated calls to law enforcement for assistance or intervention, engaged in behaviors that resulted in frequent changes to placement or inability to remain in a preferred residence due to behaviors, required frequent use of restrictive procedures, or required frequent or intermittent emergency crisis services. Individuals are determined high-risk by the provider when at least one of the following is documented in the behavior support plan:

- 1601.1. Material changes in behavior: A series of changes and events or a change in condition that places the individual at high risk for disruption of placement and requires crisis or emergency interventions.
- 1601.2. Intervention by law enforcement: A behavioral event involving for law enforcement intervention.
- 1601.3. Functional or cognitive decline: A change in condition when an individual becomes unable to perform activities of daily living and/or cognitive decline (the gradual loss of thinking abilities such as learning, remembering, paying attention, reasoning) requiring

review to determine if behavior support services are appropriate.

Level 2 Specific Description:

Behavior Support Services Professionals are those whose State license levels and specialized behavior supports training provide the authority to evaluate and develop behavior support plans. Board Certified Behavior Analysts also have the authority and expertise to evaluate within the scope of the population and service. Specific tasks performed by Level 2 practitioners include comprehensive functional behavioral assessments, direct observation, data analysis, and graphing, design and development of behavior support plans, review of the effectiveness of interventions, and plan adjustments. Level 2 practitioners may also provide tasks allowed under Level 1 description such as competency-based training of a behavior support plan to staff and/or family, fidelity monitoring of plan implementation, data collection and tracking but may delegate these tasks to a Level 1 practitioner.

All Level 2 behavior support service professionals must be approved by DBHDD.

Level 1 Specific Description:

Behavior Support Services Professionals work with moderate and high risk individuals. While Level 1 Behavior professionals work with high risk individuals, they do so under the supervision and collaboration of a Level 2 Behavior Professional. Specific tasks performed by Level 1 practitioners include staff and/or family competency-based training, behavior observation, and ongoing communication with families and staff related to plan interventions and behavior tracking. Specific tasks performed by Level I practitioners include staff and/or family competency-based training of a behavior support plan, behavior observation, fidelity monitoring of plan implementation, and ongoing communication with families and staff related to plan interventions, and behavior data collection and tracking, and coordination with the supervising Level 2 Behavior Support Service provider.

All level 1 behavior support service professionals must be approved by DBHDD.

All enrolled providers, agency-based or individual, will comply with DBHDD standards and policies which outline individual rights, core values, and the philosophy of service delivery within a person-centered model and consistent with empirical knowledge and best practices related to positive behavior supports.

Expectations/Outcomes:

A comprehensive functional behavior assessment is conducted to determine the causes of the challenging behaviors and develop positive behavior support plans that reflect the best practice standards for Behavioral Supports in the delivery of services and Person-Centered Values.

Positive behavior support plans are developed in collaboration with all appropriate clinical team members, family/guardians, and the individual. All professional and/or supervisory staff responsible for direct training of provider staff/informal care providers and for monitoring of program implementation receive competency-based training on implementation and monitoring of positive behavior support plans.

Positive behavior support plans utilize approaches that are person centered, strength based, teach desired replacement behaviors, and are valued by the clinical team members, family/guardian, and the individual.

Positive behavior support plans utilize non-punitive, non-restrictive procedures and interventions.

Positive behavior support plans focus on analyzing the function of challenging behavior to identify, teach new skills, and strengthen prosocial alternatives and increase the individual's ability to interact appropriately and effectively in the least restrictive and natural environment.

Positive behavior support plans are based on empirical data, observation and data/ documentation and take into consideration and account for the role that medical and environmental factors play in the manifestation of challenging behaviors.

Implemented positive behavior support plans are monitored on a regularly scheduled basis and reviewed for efficacy and needed adjustments and modifications are made in a timely manner.

Implemented positive behavior support plans can be empirically demonstrated within a reasonable amount of time to be effective in achieving established goal(s) of improving quality of life for the individual and realistic in terms of the individual's ability to master the necessary skill(s).

Positive Behavior Support Plans will be discontinued when non-restrictive procedures are no longer employed, and program objective(s)/goal(s) are met.

1602. Requirements for Enrollment and Participation

1602.1. Individual Provider

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and PART II, Chapter 600 Policies and Procedures for the COMP Program, Positive Behavioral Supports Services individual providers must meet the following requirements:

1602.1.1. Provider Qualification Level 2- Individual providers of Positive behavior Support services Level 2 must meet the following requirements at enrollment and continued service enrollment:

1602.1.1.1. Education/Training

1602.1.1.1.1. Minimum of a Master' Degree in psychology, behavior analysis, education, counseling, social work, or Board Certified Behavior Analyst and two years' experience;

Or

1602.1.1.2. Licensure/certification in one of the following categories:

1602.1.1.2.1. Licensure:

1602.1.1.2.1.1. Psychologist (OCGA 43-39-1)

1602.1.1.2.1.2. Licensed Professional Counselor (OCGA 43-10A-1)

1602.1.1.2.1.3. Licensed Clinical Social Worker (OCGA 43-10A-1)

1602.1.1.2.1.4. Psychiatrist (OCGA 43-24-20)

Or

1602.1.1.2.2. Certification:

1602.1.1.2.2.1. Board Certified Behavior Analyst (certified through the Behavior Analyst Certification Board)

1602.1.1.3. Other Standard:

1602.1.1.3.1. Specialized training and/or experience in applied behavior principles to include functional assessment, data analysis, behavior interventions/ replacement behaviors, and risk identification/amelioration.

1602.1.1.3.2. Two years' experience with the identified population, individuals with intellectual/developmental disabilities, or

1602.1.1.3.3. Staff meets all licensure, educational, and/or certification criteria

1602.1.1.3.4. Documentation of staff monitoring/supervision and training of implementation of behavior support plans

1602.1.1.3.5. Continuing Education Training- Documented completion of 10 hours of annual training related to behavior supports offered through courses, seminars, or conferences and/or training

provided by the Department of Behavioral Health and Developmental Disabilities.

1602.1.1.3.6. Criminal records check in accordance with Criminal History Records Checks for Contractors, DBHDD Policy 04-104 (including process for reporting CRC status change);
<https://gadbhdd.policystat.com>

1602.1.1.3.7. Guidelines Requirement: refer to “Best Practices for Behavioral Supports” found on the DBHDD website and Guidelines for Supporting Adults with Challenging Behaviors in Community Settings.

1602.1.2. Provider Qualifications Level 1 - Individual providers of Positive Behavioral Supports services Level 1 must meet the following requirements at initial enrollment and for continued service approval: (Note: Level 1 Providers will not be enrolled for billing but must be reviewed and approved at this level). Level 1 providers must be supervised by a Level 2 provider.

1602.1.2.1. Education/Training

1602.1.2.1.1. Minimum of a Master’s Degree in psychology, education, counseling, or social work and two years’ experience;

Or

1602.1.2.2. Licensure/certification in one of the following categories:

1602.1.2.2.1. Licensure:

1602.1.2.2.1.1. Psychologist (OCGA 43-39-1)

1602.1.2.2.1.2. Licensed Professional Counselor (OCGA 43-10A-1)

1602.1.2.2.1.3. Licensed Clinical Social Worker (OCGA 43-10A-1)

1602.1.2.2.1.4. Psychiatrist (OCGA 43-

24-20)

1602.1.2.2.1.5. Licensed Master Social Worker (OCGA 43-10A-1)

1602.1.2.2.1.6. Licensed Associate Professional Counselor

Or

1602.1.2.2.2. Certification:

1602.1.2.2.2.1. Board Certified Behavior Analyst (certified through the Behavior Analyst Certification Board)

1602.1.2.2.2.2. Board Certified Assistant Behavior Analyst (certified through the behavior Analyst Certification Board)

1602.1.2.3. Other Standard:

1602.1.2.3.1. Specialized training and/or experience in basic applied behavior principles to include understanding of plan implementation, data collection, behavior interventions/replacement behaviors, and risk identification/amelioration.

1602.1.2.3.2. Two years' experience with the identified population, individuals with intellectual/developmental disabilities, or

1602.1.2.3.3. One year of experience with the identified population and supervision by an individual who meets qualifications in Level 2

1602.1.2.3.4. Continuing Education Training- Documented completion of 10 hours of annual training related to behavior supports offered through courses,

seminars, or conferences and/or training provided by the Department of Behavioral Health and Developmental Disabilities.

1602.1.2.3.5. Criminal records check in accordance with Criminal History Records Checks for Contractors, 04-104 (including process for reporting CRC status change); <https://gadbhdd.policystat.com>

1602.1.2.3.6. Guidelines Requirement: refer to “Best Practices for Behavioral Supports” found on the DBHDD website and Guidelines for Supporting Adults with Challenging Behaviors in Community Settings found in Appendix Part III Policy.

1602.2. Agency Provider

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and PART II, Chapter 600 Policies and Procedures for the COMP Program agency providers must meet the following requirements:

1602.2.1. Types of Agencies

1602.2.1.1. Types of Agencies: Agencies that provide Positive Behavior Supports Level 2 are:

1602.2.1.1.1. Behavior Support Services Agency

1603. Behavioral Support Services Level 2 at Community Access, Prevocational Service Facilities and in Residential Settings

Positive Behavioral Supports Services may be provided at facilities or residential settings however, the Level 1 and Level 2 services must be documented and billed separately. The behavior professional is responsible for observations in the settings where the behavior(s) occurs, amount of time spent providing the service, and documentation of the positive behavior support services provided at the specific facility and offsite service tasks. Examples of documentation of activities provided at a facility, whether a residential or a day service facility include assessment, data collection, observation, training, and on-site monitoring. Examples of documentation of offsite activities include development of the behavior support plan, data analysis/graphing, and tracking outcomes. A complete copy of the Positive Behavior Support Plan and data analysis summaries/graphs must be maintained on site for use in training and review with direct service staff and uploaded into the case management system.

Positive Behavior Support Plans developed for use in supporting the same individual in various settings must include interventions specific to the setting, if applicable, but provide holistic strategies

across all settings which may require positive behavior interventions. The Positive Behavior Support Plan is developed for the individual and must be shared/trained across the environments where problem behavior occurs and in which the person receives support for the purpose of assuring consistent implementation.

1604. Documentation Requirements

All Positive Behavior Support Service Providers must document the following in the record of each individual receiving Positive Behavior Support Services:

- 1604.1. Specific task/activity or assistance provided including assessment, plan development, intervention and methods outline, data tracking methods, analysis and intervention outcomes, training, and monitoring;
- 1604.2. Date, beginning and ending time when the service was delivered;
- 1604.3. Location where the service was delivered;
- 1604.4. Description of behaviors in observable, measurable terms with frequency, precipitating events, and tracking methods;
- 1604.5. Progress toward individual goal(s), desired outcomes in the individual's action plan;
- 1604.6. Description of outcomes specific to each intervention to include but not limited to behavioral changes, ability to increase community integration, acquisition of new skills, improvement in quality of life or other positive outcomes.
- 1604.7. Attestation of service delivery through signature and legible, printed first and last name and title/description of the person providing the service.

1605. Waiver Individual Eligibility Criteria

The need for Behavior Support Services must be related to the individual's clinically validated behavioral needs and be therapeutic in nature.

1605.1. Eligibility Criteria:

Eligibility does not constitute approval or prior authorization of services. Approval and Prior Authorization of Positive Behavior Supports Services are based on a clinical assessment and validation of behavior support needs. A clinical assessment of need for Positive Behavior Support Services is conducted when one or more of the following eligibility criteria are met:

- 1605.1.1. HRST score of 2 or higher on Item E. Clinical Issues Affecting Daily Life (documentation must indicate behavioral challenges as the clinical issue)
- 1605.1.2. HRST score of 2 or higher on Item F. Self-Abuse
- 1605.1.3. HRST score of 2 or higher on Item G. Aggression Toward Others or

Property

- 1605.1.4. HRST score of 3 or higher on Item U. Emergency Room Visits (documentation must indicate behavioral challenges as the clinical issue)
- 1605.1.5. HRST score of 2 or higher on Item V. Hospital Admissions (documentation must indicate behavioral challenges as the clinical issue)
- 1605.1.6. HRST score of 4 on Item Q. Treatments (documentation must indicate 1:1 staffing need due to behavioral issues)
- 1605.1.7. Placement in Crisis Home in the last 12 months (documentation must indicate that placement was due to behavioral challenges)
- 1605.1.8. Provision of In-Home Mobile Crisis Services in the last 12 months
- 1605.1.9. Admission to a Crisis Stabilization Unit in the last 12 months
- 1605.1.10. Arrest, detention, or intervention by law enforcement in the last 12 months
- 1605.1.11. SIS score of 7 or higher on Total Score for Section 1B: Behavioral Supports Needed

1606. Prior Approval

Positive Behavior Supports Services must be authorized prior to service delivery at least annually in conjunction with the Individual Service Plan (ISP) development and with any ISP revisions.

1607. Covered Services

Reimbursable Positive Behavior Supports Services include the following based on the assessed need of the individual and specified in the approved ISP:

- 1607.1. Functional assessment of behavior and other diagnostic assessment of behavior.
- 1607.2. Development and monitoring of Positive Behavior Support plans with specific criteria for the acquisition and maintenance of appropriate behaviors for community living and behavioral intervention for the reduction of challenging behaviors.
- 1607.3. Training and coaching paid and unpaid supporters on recommended interventions and outcomes tracking.
- 1607.4. Intervention modalities related to the identified behavioral needs of the individual.
- 1607.5. Individual specific skills or replacement behavior acquisition training.
- 1607.6. Family and/or direct support staff education and training on Positive Behavior Supports.

1608. Non-Covered Services

- 1608.1. Services that duplicate any family education or training provided through Natural Supports Training (NST) Services.
- 1608.2. Services that occur simultaneously or on the same day as NST Services.
- 1608.3. Services in a hospital.
- 1608.4. Restrictive behavioral interventions, including chemical or mechanical restraints and seclusion, prohibited by state law or regulations.
- 1608.5. Transportation to and from these services is not included in the rate.
- 1608.6. Payment is not made, directly or indirectly, to members of the individual's immediate family, except as approved as indicated in Part II Policies and Procedures for COMP and NOW, Chapter 900
- 1608.7. Payment is not made for those goods and services covered by the State Medicaid Plan except where an individual's need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.
- 1608.8. Services provided by a staff member not qualified under Section 1802.

1609. Basis for Reimbursement

See Appendix A for Basis for Reimbursement.

1610. Participant-Direction Option

- 1610.1. Participants may choose the self-direction option for Positive Behavioral Supports Services Level 1 and Level 2 however the employee must meet all enrollment criteria outlined in Section 1802.
- 1610.2. An individual serving as a representative for a waiver participant in self-directed services is not eligible to be a participant-directed provider of Positive Behavioral Supports Services Level 1 and Level

1611. Telehealth Option

- 1611.1. Some components of Behavior Supports Services can be provided via a telehealth modality to supplement in-person service delivery. The following components are the only components that are allowable for a telehealth option:
 - 1611.1.1. Indirect assessment component for functional behavior assessment;
 - 1611.1.2. Follow up or refresher staff training for behavior support plans;
 - 1611.1.3. Additional fidelity monitoring of plan implementation and oversight;
 - 1611.1.4. Distant site observations of the individual for the purposes of consultation, modeling, and recommendations for interventions to

staff/caregivers in real time;

- 1611.1.5. Team meetings for the purpose of gathering feedback related to behavior support plans effectiveness; and
- 1611.1.6. Review of data analysis summaries and behavior graphing.
- 1611.2. Behavior Support Service Providers should evaluate their and the individual's telehealth readiness by meeting the legal, professional, and ethical requirements of these services according to Telehealth related Ethics and Guidelines from The Association for Behavior Analysis International (ABAI); and The Council of Autism Service Providers (CASP) Practice Parameters for Telehealth Implementation of Applied Behavior Analysis, Second Edition and any additional governing telehealth service delivery guidance
- 1611.3. Behavior Support Service Professionals must use two-way, real time [synchronous] interactive communication to exchange clinical/behavioral information with the individual, staff, or family from one site to another via a secure electronic communication system. Providers should have an action plan should technology fail. Telephone calls and store and forward (asynchronous) modalities are not allowed for billable behavior support services. The transmission of the individual's behavioral or medical information from an originating site to the behavior support service provider at a distant site without the presence of the individual is not allowed for billable behavior support services.
- 1611.4. The Behavior Support Service provider must obtain signed consent to render a service via telehealth from the individual or designated representative as applicable.
- 1611.5. Behavior Support Service Providers are covered entities and obligated to abide by the HIPAA and state privacy law. Practitioners are required to use only HIPAA compliant platforms while delivering telehealth services. All contracted providers must sign business associate agreements with the operating agency, as required by HIPAA.
- 1611.6. Telehealth services must be rendered in a quiet environment with optimal view, internet connectivity and sound between sites with attendance of the individual and/or other informants and caregivers as determined by the behavior support service provider for the telehealth service date.
- 1611.7. General instructions about providing staff training include guidance that any telehealth services with the individual present should protect the individual's dignity and privacy (e.g. individuals are clothed, not observed engaging in daily living activities such as bathing, dressing, toileting, etc).
- 1611.8. For more information regarding telehealth guidance, please refer to the telehealth guidance, located at www.mmis.georgia.gov, Click Provider Information-Provider Manuals.

Chapter 1700: Specific Program Requirements for Community Access Services Scope of Services

1701. General

Community Access Services has three distinct categories, Community Access Individual, Community Access Participant Directed Activity, and Community Access Group. Community Access services are individually planned to meet the individual's needs and preferences for active community participation. Community Access services are provided outside the individual's place of residence. These services can occur during the day, the evenings, and weekends. Services include design of activities and environments for the individual to learn and/or use adaptive skills required for active community participation and independent functioning. These activities include training in socialization skills as well as personal assistance such as eating/hydration, ambulation, transferring, personal hygiene, all aspects of toileting, self-administration of medication and other supports not covered under skilled nursing.

Community Access Individual (CAI) services are provided to an individual, with a one-to-one staff to participant ratio. CAI services can be directly linked to goals and expectations of improvement in skills. The intended outcome of CAI services is to improve the individual's access to the community through increased skills, increased natural supports, and/or less paid supports. CAI services are designed to be teaching and coaching in nature. These services assist the individual in acquiring, retaining, or improving socialization and networking, independent use of community resources, and adaptive skills required for active community participation outside the individual's place of residence. CAI services may include programming to reduce inappropriate and/or maladaptive behaviors. CAI services are not facility-based.

Community Access Group (CAG) services are designed to provide oversight, assist with daily living, socialization, communication, and mobility skills building and supports in a group. CAG services may include programming to reduce inappropriate and/or maladaptive behaviors. Services are provided to groups of individuals, with a staff to individual ratio of one to two or more. Program staffing is determined based on the needs of the individuals in the group.

CAG services may be provided in a facility or a community as appropriate for the skill being taught or specific activity supported. Facility-based services occur at a fixed, non-residential site that is provider owned, controlled, or operated. The direct care staff to individual ratio for facility-based services cannot exceed one (1) to ten (10). Community-based services occur in settings that are not owned, controlled, or operated by the provider. The direct care staff to individual ratio for community-based services cannot exceed one (1) to five (5).

Community Access Participant Directed Activity services are for individuals who are participant directed and participate in authorized community activities as outlined in Section 1705—Covered Services in order to address functional impairment and/or therapeutic needs of the waiver participant.

For CAG programs, transportation to and from the participant's point of origin or home may be billed for up to one hour per day at the center-based CAG rate, except for participants receiving Community Residential Alternative (CRA) services as the CRA provider is expected to transport the participant to and from their CAG program.

All Community Access Services do not include educational services otherwise available through a program funded under 20 USC Chapter 3, section 1400 of the Individuals with Disabilities Education

Act (IDEA). Community Access services must not duplicate or be provided at the same period of the day as Community Living Support, Supported Employment, Prevocational Services (i.e, any vocational or employment activities/training are not allowable under Community Access services) or Transportation services. An individual serving as a representative for a waiver participant in self-directed services may not provide Community Access services. Community Access services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any ISP version changes.

The NOW Program is intended for those goods and services that are not covered by the State Medicaid Plan or those instances in which a participant's need exceeds State Plan coverage limits and exceptions to the coverage limits are not available. Community Access Services Providers offer (or arrange when needed) any of the standard services listed in section 1705 – Covered Services that are needed by the participants served and specified in the participants' Individual Service Plans.

1702. Special Requirements of Participation

Note: Effective with June 1, 2009 Individual Service Plans and plans developed thereafter, Community Access Individual Services cannot be provided in facilities.

1702.1. Individual Provider

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and PART II, Chapter 600 Policies and Procedures for the NOW Program, Community Access Services providers must meet the following requirements:

1702.1.1. Individual providers of Community Access services must:

1702.1.1.1. Be 18 years or older;

1702.1.1.2. Have current CPR and Basic First Aid certifications;

1702.1.1.3. Have the experience, training, education or skills necessary to meet the individual's needs for Community Access services as demonstrated:

1702.1.1.3.1. Direct Support Professional (DSP) Certification or

1702.1.1.3.2. Copy of high school diploma/transcript or General Education Development (GED diploma; and at least six (6) months of experience providing behavioral health related service to individuals with developmental disabilities, or documented experience providing specific supports to individuals with disabilities.

- 1702.1.1.4. Have evidence of an annual health examination with signed statement from a physician, nurse practitioner, or physician assistant that the person is free of communicable disease;
- 1702.1.1.5. Agree to or provide required documentation of a criminal records check, prior to providing Community Access services.
- 1702.1.1.6. Meet transportation requirements in NOW Part II Chapter, Section 905 if transporting individuals
- 1702.1.2. Documentation Requirement: Providers, except for providers of participant-directed services, must document the following in the record of each individual receiving Community Access Services:
 - 1702.1.2.1. Specific activity, training, or assistance provided;
 - 1702.1.2.2. Date and the beginning and ending time when the service was provided;
 - 1702.1.2.3. Location where the service was delivered;
 - 1702.1.2.4. Verification of service delivery, including first and last name and title (if applicable) of the person providing the service and his or her signature;
 - 1702.1.2.5. Progress towards moving the individual towards independence by meeting the individual ISP.
- 1702.1.3. Participant-Directed Services Documentation and other Requirements: Documentation and other requirements for employees of participant-directed services are specified in Part II Policies and Procedures for NOW and COMP, Chapter 1200.

1702.2. Provider Agencies

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and PART II, Chapter 600 Policies and Procedures for the NOW Program, Community Access Services provider agencies must meet the following requirements:

- 1702.2.1. Staffing Qualifications and Responsibilities

Provider agencies rendering Community Access Services must have staffing that meets the following requirements:

 - 1702.2.1.1. A designated agency director. Additional information regarding director qualifications can be found in DBHDD Policy Recruitment and Application to Become

a Provider of Developmental Disability Services, 02-701.

- 1702.2.1.2. Duties of the Agency Director include, but are not limited to:
 - 1702.2.1.2.1. Oversees the day-to-day operation of the agency;
 - 1702.2.1.2.2. Manages the use of agency funds;
 - 1702.2.1.2.3. Ensures the development and updating of required policies of the agency;
 - 1702.2.1.2.4. Manages the employment of staff and professional contracts for the agency;
 - 1702.2.1.2.5. Designates another agency staff member to oversee the agency, in his or her absence.
- 1702.2.1.3. At least one agency employee or professional under contract with the agency must:
 - 1702.2.1.3.1. Be a Developmental Disability Professional (DDP) (for definition, see Part II Policies and Procedures for NOW and COMP Appendix J);
 - 1702.2.1.3.2. Have responsibility for overseeing the delivery of Community Access Services to individuals.
- 1702.2.1.4. The same individual may serve as both the agency director and the Developmental Disability Professional;
- 1702.2.1.5. A minimum of one (1) direct care staff member for every ten (10) individuals served in Group Community Access Services and minimum of one (1) direct care staff members for every one (1) individual served in Individual Community Access Services;
- 1702.2.1.6. Direct Care Staff must:
 - 1702.2.1.6.1. Be 18 years or older; Have a high school diploma or equivalent (General Educational Development or GED) or have a minimum score of 75 on the Test of Functional Health Literacy for Adults (TOFHLA) or Short Test of Functional Health Literacy for Adults (STOFHLA)

- 1702.2.1.6.2. Meet transportation requirements in NOW Part II Chapter, Section 905 if transporting individuals
- 1702.2.1.6.3. Be provided with a basic orientation prior to direct contact with individuals and show competence in:
 - 1702.2.1.6.3.1. The purpose and scope of Community Access Services, including related policies and procedures;
 - 1702.2.1.6.3.2. Confidentiality of individual information, both written and spoken;
 - 1702.2.1.6.3.3. Rights and responsibilities of individuals;
 - 1702.2.1.6.3.4. Requirements for recognizing and reporting suspected abuse, neglect, or exploitation of any individual:
 - 1702.2.1.6.3.5. To the DBHDD;
 - 1702.2.1.6.3.6. Within the organization;
 - 1702.2.1.6.3.7. To appropriate regulatory or licensing agencies; and
 - 1702.2.1.6.3.8. To law enforcement agencies
- 1702.2.1.7. Duties of the Direct Care Staff include, but are not limited to:
 - 1702.2.1.7.1. Provides direct assistance in self-help, socialization, and adaptive skills training, retention and improvement to individual individuals and groups of individuals;

- 1702.2.1.7.2. Provides direct assistance in training, retraining or improving the access to and use of community resources by individual individuals or groups of individuals;
- 1702.2.1.7.3. Implements the behavioral support plans of individuals to reduce inappropriate and/or maladaptive behaviors and to acquire alternative adaptive skills and behaviors;
- 1702.2.1.7.4. Provides active support and direct assistance in individuals' participation in community social, recreational and leisure activities;
- 1702.2.1.7.5. Provides individual-specific assistance, such as assistance with personal care which includes but is not limited to eating/hydration, ambulation, transferring, personal hygiene, all aspects of toileting, self-administration of medication and other supports not covered under skilled nursing.
- 1702.2.1.8. The agency has adequate direct care staff with First Aid and CPR certifications to assure having at least one staff person with these certifications on duty during the provision of facility-based or community-based Community Access services.
- 1702.2.1.9. The type and number of all other staff associated with the organization (such as contract staff, consultants) are:
 - 1702.2.1.9.1. Properly trained or credentialed in the professional field as required;
 - 1702.2.1.9.2. Present in numbers to provide services and supports to individuals as required;
 - 1702.2.1.9.3. Experienced and competent in the services and support they provide.
- 1702.2.1.10. National criminal records check (NCIC) documentation for all employees and any volunteers who have direct care, treatment, or custodial responsibilities for individuals served by the agency.
- 1702.2.2. Agency Policies and Procedures - Each provider agency must develop written policies and procedures to govern the operations of Community

Access services, which follow the Standards for the Georgia Department of Behavioral Health and Developmental Disabilities (see Part II Policies and Procedures for NOW and COMP, Chapter 603).

- 1702.2.3. Documentation Requirement: Providers, except for providers of participant-directed services, must document the following in the record of each individual receiving Community Access Services:
 - 1702.2.3.1. Specific activity, training, or assistance provided;
 - 1702.2.3.2. Date and the beginning and ending time when the service was provided;
 - 1702.2.3.3. Location where the service was delivered;
 - 1702.2.3.4. Verification of service delivery, including first and last name and title (if applicable) of the person providing the service and his or her signature;
 - 1702.2.3.5. Progress towards moving the individual towards independence by meeting the individual ISP
- 1702.2.4. Participant-Directed Services Documentation and other Requirements: Documentation and other requirements for providers of participant-directed services are specified in Part II Policies and Procedures for NOW, Chapter 1200.
- 1702.2.5. Co-Employer Provider Agencies: Co-Employer Provider Agencies cannot provide facility-based Community Access Service.
- 1702.2.6. Community Access and Other Services in the Same Facility:
 - 1702.2.6.1. Providers rendering facility-based Community Access and other services (e.g., Prevocational Services and adult therapy services) can provide these services in the same facility; however, the services must be documented and billed separately, and any waiver individual receiving multiple services may not receive these services at the same time of the same day.
 - 1702.2.6.2. Providers may grant access to other Medicaid providers for the provision of services at the facility; however, the services must be documented and billed separately, and any waiver individual receiving multiple services may not receive these services at the same time of the same day.
- 1702.2.7. Providers, except for providers of participant-directed services, must utilize methods, materials, and settings that meet the following:
 - 1702.2.7.1. Set positive expectations for life experiences of people

- with disabilities, which result in enhanced personal independence and productivity, greater active community participation, and/or increased community integration;
- 1702.2.7.2. Facilitate the provision of individual-specific supports through a supports network;
- 1702.2.7.3. Are appropriate to the chronological age of individuals;
- 1702.2.7.4. Are culturally normative.
- 1702.2.8. Providers must meet the following requirements for staff-to-individual ratios:
 - 1702.2.8.1. Group Community Access Services: a staff to individual ratio of one to two or more, not to exceed one (1) to ten (10). Specialized or intense needs of individuals may warrant a lower staff to individual ratio than the upper limit allowed. On site reviews of the service will focus on the specialized needs of Group Community Access Services individuals.
 - 1702.2.8.2. Individual Community Access Services: a one-to-one staff to individual ratio.
- 1702.2.9. DBHDD Contract/LOA and DBHDD Community Service Standards: Agency providers must adhere to DBHDD Contract/LOA, DBHDD Community Service Standards and all other applicable DBHDD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DBHDD (see Part II Policies and Procedures for NOW and COMP, Chapter 603).
- 1702.2.10. Physical Environment
 - 1702.2.10.1. Providers who render facility-based Community Access Services must provide these services in a facility that meets the following requirements:
 - 1702.2.10.1.1. Accessibility: Is accessible to and usable by individuals and meets Americans with Disabilities Act (ADA) accessibility requirements for facilities.
 - 1702.2.10.1.2. Building Construction and Maintenance: Is constructed, arranged, and maintained so as to provide adequately for health, safety, access, and wellbeing of the

individuals.

- 1702.2.10.1.3. Building Codes: Is in compliance with all local building codes and other applicable codes;
- 1702.2.10.1.4. Lighting: Provides adequate lighting for individuals' activities and safety;
- 1702.2.10.1.5. Ventilation: Is adequately ventilated at all times by either mechanical or natural means to provide fresh air and the control of unpleasant odors;
- 1702.2.10.2. Floor Space: Has adequate floor space to safely and comfortably accommodate the number of individuals for all activities and services provided in that space;
- 1702.2.10.3. Furnishings: Has sufficient furniture for use by individuals, which provide comfort and safety; are appropriate for population served, including any individuals with physical, visual, and mobility limitations; and provide adequate seating and table space for individual activities in the facility, including dining if applicable; Is accessible to and usable by individuals and meets Americans with Disabilities Act (ADA) accessibility requirements for facilities.
- 1702.2.10.4. Environmental/Sanitation: Is in good repair and clean inside and outside of the facility, including being free from litter, extraneous materials, unsightly or injurious accumulations of items and free from pest and rodents;
- 1702.2.10.5. Temperature Conditions: Has an adequate central heating and cooling system or its equivalent at temperature ranges that are consistent with the individual health needs and comfort of individuals;
- 1702.2.10.6. Equipment Maintenance: Maintains all essential mechanical, electrical, and individual activity, care and support equipment in safe operating condition;
- 1702.2.10.7. Drinking Fountain: Must have drinking fountain(s) approved by the Georgia Department of Behavioral Health and Developmental Disabilities, Division of Public Health or provide access to single disposable cups to individuals, with individuals disposing of the used cups immediately after use;
- 1702.2.10.8. Restrooms: Has a minimum of at least two toilets and lavatories available, with accessibility for individuals

with physical and mobility limitations, including installed grab bars;

1702.2.10.9. Individual Activities and Dining Space: Has one or more clean, orderly, and appropriate furnished rooms of adequate size designated for individual activities and, if applicable, dining. If the facility has a single room for individual activities and dining, the room provides sufficient space to accommodate both activities without interfering with each other;

1702.2.10.10. Medication Storage: Assures that medications are:

1702.2.10.10.1. Stored under lock and key at all times. A staff member may keep medications needed for frequent or emergency use. The provider stores medications that require refrigeration in a locked container in the refrigerator;

1702.2.10.10.2. Kept in original containers with original labels intact or in labeled bubble packs from a pharmacy;

1702.2.10.10.3. Handled in accordance with current applicable State laws and regulations.

1702.2.10.11. Documentation of Self-Administration of Medications: The facility maintains documentation of all self-administration of medications supervised by facility staff. The documentation record must include the name of the medication, dosage, date, time, and name of the staff person who assists the individuals in the self-administration of medications by the individual.

1702.2.10.12. Evacuation Plan: The facility formulates a plan for evacuation of the building in case of fire or disaster. This plan is posted in a clearly visible place in each room. All employees are instructed and kept informed of their duties under the plan.

1702.2.10.13. Food Services: The following only apply if the facility stores, prepares, or distributes food:

1702.2.10.13.1. The facility observes and complies with all of the Rules of Georgia Department of Behavioral Health and Developmental Disabilities, Public Health, Chapter 290-5-14, Food Service and any local health ordinances when engaged in the storage, preparation, and distribution of food.

Note. The Department will allow the facility to be exempted from the Food Service Permit requirement if all the facility does is use a microwave to heat up food participants bring to the facility.

This exception is allowed only if:

The microwave oven is clean, in good repair, and free of unsanitary conditions

The microwave oven is allowed for warming of permitted foods and beverages based on the provider's internal policies and procedures.

All food and utensils are handled in a sanitary manner.

1702.2.10.13.2. Meals and snacks are prepared either on site or under subcontract with an outside vendor who agrees to comply with the food and nutritional requirements. The facility posts its current Food Service Permit and inspection report or the subcontracted vendor's current Food Service Permit and inspection report.

1702.2.10.13.3. The facility has a designated kitchen area for receiving food, facilities for warming or preparing cold food, and clean-up facilities including hot and cold running water. The facility provides palatable, nutritious and attractive meals and snacks that meet the nutritional requirements of each member.

1702.2.11. Transportation: The individual's family or representative may choose to transport the member to the Community Access facility. Transportation is required between point of origin and activities in settings primarily utilized by people with disabilities (a reasonable amount of transportation not to exceed one hour per day, is billable). Transportation to and from the facility or hub (CAG-Community) at the beginning and end of day that is billed as CAG can be delivered, when appropriate to the support needs of the individual, at the 1:10 facility or hub. Point of origin is defined as any location that individuals are available for pick-up that is safe and appropriate for the individual based on the approved Individual Service Plan.

1702.2.12. Individual Site Enrollment: Part I Policies and Procedures for Medicaid/PeachCare for Kids require that each provider enroll at each location where services are provided to Medicaid members. Each

individual, facility-based Community Access site must be individually enrolled. Individual site enrollment applies only to facility-based Community Access sites.

1703. Special Eligibility Conditions

- 1703.1. Community Access Services are only for individuals for whom the service is not available under a program funded under 20 USC Chapter 3, section 1400 of the Individuals with Disabilities Education Act (IDEA).
- 1703.2. The need for Community Access Services must be related to the individual disability and services must be therapeutic in nature.

1704. Prior Approval

Community Access services must be authorized prior to service delivery by the operating agency at least in conjunction with the Individual Service Plan development and with any ISP version changes.

1705. Covered Services

Reimbursable Community Access Services for the distinct categories include the following based on the assessed need of the individual.

- 1705.1. Community Access Group
 - 1705.1.1. Services in facility-based and community-based settings outside the individual's own or family home or any other residential setting
 - 1705.1.2. Design and development of activities in any location outside the individual's own or family home or any other residential setting that assist the individual to learn, use, and/or maintain adaptive skills required for active community participation and independent functioning, which includes services provided on behalf of a specific individual as well as direct services.
 - 1705.1.3. Assistance in acquiring, retaining, or improving self-help, socialization, and adaptive skills for active community participation and independent functioning outside the individual's own or family home, such as assisting the individual with money management, teaching appropriate shopping skills, and teaching nutrition and diet information.
 - 1705.1.4. Assistance in acquiring, retaining, or improving access to and use of community resources that increases participation in integrated community activities, such as training and active support to use public transportation, banks, automated tellers, and restaurants.
 - 1705.1.5. Provision of oversight and assistance with daily living, socialization, communication, and mobility skills building and supports in a group.
 - 1705.1.6. Implementation of behavioral support plans to reduce inappropriate and/or maladaptive behaviors and to acquire alternative adaptive skills

and behaviors.

- 1705.1.7. Recreational and leisure activities that support the individual's active, local community participation and are therapeutic in nature, such as teaching a individual how to participate in and take advantage of community social and recreational activities or providing active support for an individual in community recreational and leisure activities.
- 1705.1.8. Facilitating volunteer roles in the community and participation in self-advocacy type activities.
- 1705.1.9. Other related, individual-specific assistance, such as assistance with personal care and self-administration of medications, and nursing services, and health maintenance activities.
- 1705.1.10. Transportation is required between point of origin and activities in settings primarily utilized by people with disabilities (a reasonable amount of transportation, defined as up to one hour per day, is billable). Point of origin is defined as any location that individuals are available for pick up that is safe and appropriate for the individual based on the approved Individual Service Plan. When transportation is to and from other community destinations, separate payment for transportation only occurs when the NOW's distinct Transportation Services are authorized.
- 1705.1.11. Transportation of an individual that occurs during the course of Community Access services and is aligned with an individual's service plan and goals.

1705.2. Community Access Individual

- 1705.2.1. Services in non-facility, community-based settings outside the individual's own or family home or any other residential setting
- 1705.2.2. Design and development of activities in any non-facility, community-based location outside the individual's own or family home or any other residential setting that assist the individual to learn, use, and/or maintain adaptive skills required for active community participation and independent functioning, which includes services provided on behalf of a specific individual as well as direct services.
- 1705.2.3. Assistance in acquiring, retaining, or improving socialization, and adaptive skills for active community participation and independent functioning outside the individual's own or family home, such as assisting the individual with money management, teaching appropriate shopping skills, using public transportation, and teaching nutrition and diet information.
- 1705.2.4. Assistance in acquiring, retaining, or improving socialization and networking, independent use of community resources, and adaptive skills required for active community participation outside the individual's place of residence.

- 1705.2.5. Individual-specific teaching and coaching of skills for access to the community, including communication, mobility, money management, and shopping skills.
- 1705.2.6. Implementation of behavioral support plans to reduce inappropriate and/or maladaptive behaviors and to acquire alternative adaptive skills and behaviors.
- 1705.2.7. Teaching and coaching a individual how to participate in and take advantage of community social and recreational activities.
- 1705.2.8. Facilitating volunteer roles in the community and participation in self-advocacy type activities.
- 1705.2.9. Other related, individual-specific assistance, such as assistance with personal care and self-administration of medications, nursing services, and health maintenance activities.
- 1705.2.10. Transportation of an individual that occurs during the course of Community Access services and is aligned with an individual's service plan and goals.
- 1705.3. Community Access Participant Directed Activity
 - 1705.3.1. Services for individuals who are participant directed and participate in community activities designed to address functional impairment and/or therapeutic needs of the waiver individual, which include therapeutic camp programs, therapeutic support groups, and physical fitness and weight reduction programs.
 - 1705.3.2. Providers must meet the following requirements for staff-to- individual ratios:
 - 1705.3.2.1. Facility-Based Group Community Access Services: a staff to individuals ratio of one to two or more, not to exceed one (1) to ten (10). The staff to individual ratio may be smaller than the upper limit allowed; the actual ratio must be as indicated by the individualized needs of the individuals.
 - Community-Based Group Community Access Services: a staff to individual ratio of one to two or more, not to exceed one (1) to five (5). The staff to individual ratio may be more intense than the upper limit allowed; the actual ratio must be as indicated by the individualized needs of the individuals. Additional details about funded staffing ratios can be found at: <https://www.healthmanagement.com/burns-reports/georgia-waiver-rates/>.

1705.3.2.2. Individual Community Access Services: a one-to-one staff to individual ratio.

1705.3.3. Physical Environment

Providers who render facility-based Community Access Services must provide these services in a facility that meets the following requirements:

- 1705.3.3.1. Accessibility: Is accessible to and usable by individuals and meets Americans with Disabilities Act (ADA) accessibility requirements for facilities.
- 1705.3.3.2. Building Construction and Maintenance: Is constructed, arranged, and maintained so as to provide adequately for health, safety, access, and wellbeing of the individuals.
- 1705.3.3.3. Building Codes: Is in compliance with all local building codes and other applicable codes;
- 1705.3.3.4. Lighting: Provides adequate lighting for individuals' activities and safety;
- 1705.3.3.5. Ventilation: Is adequately ventilated at all times by either mechanical or natural means to provide fresh air and the control of unpleasant odors;
- 1705.3.3.6. Floor Space: Has adequate floor space to safely and comfortably accommodate the number of individuals for all activities and services provided in that space;
- 1705.3.3.7. Furnishings: Has sufficient furniture for use by individuals, which provide comfort and safety; are appropriate for population served, including any individuals with physical, visual, and mobility limitations; and provide adequate seating and table space for individual activities in the facility, including dining if applicable; Is accessible to and usable by individuals and meets Americans with Disabilities Act (ADA) accessibility requirements for facilities.
- 1705.3.3.8. Environmental/Sanitation: Is in good repair and clean inside and outside of the facility, including being free from litter, extraneous materials, unsightly or injurious accumulations of items and free from pest and rodents;
- 1705.3.3.9. Temperature Conditions: Has an adequate central heating and cooling system or its equivalent at temperature ranges that are consistent with the individual health needs and comfort of individuals;
- 1705.3.3.10. Equipment Maintenance: Maintains all essential

- mechanical, electrical, and individual activity, care and support equipment in safe operating condition;
- 1705.3.3.11. Drinking Fountain: Must have drinking fountain(s) approved by the Georgia DBHDD, Division of Public Health or provide access to single disposable cups to individuals, with individuals disposing of the used cups immediately after use;
- 1705.3.3.12. Restrooms: Has a minimum of at least two toilets and lavatories available, with accessibility for individuals with physical and mobility limitations, including installed grab bars;
- 1705.3.3.13. Individual Activities and Dining Space: Has one or more clean, orderly, and appropriate furnished rooms of adequate size designated for individual activities and, if applicable, dining. If the facility has a single room for individual activities and dining, the room provides sufficient space to accommodate both activities without interfering with each other;
- 1705.3.3.14. Medication Storage: Assures that medications are:
- 1705.3.3.14.1. Stored under lock and key at all times. A staff member may keep medications needed for frequent or emergency use. The provider stores medications that require refrigeration in a locked container in the refrigerator;
 - 1705.3.3.14.2. Kept in original containers with original labels intact or in labeled bubble packs from a pharmacy;
 - 1705.3.3.14.3. Handled in accordance with current applicable State laws and regulations.
- 1705.3.3.15. Documentation of Self-Administration of Medications: The facility maintains documentation of all self-administration of medications supervised by facility staff. The documentation record must include the name of the medication, dosage, date, time, and name of the staff person who assists the individuals in the self-administration of medications by the individual.
- 1705.3.3.16. Evacuation Plan: The facility formulates a plan for evacuation of the building in case of fire or disaster. This plan is posted in a clearly visible place in each room. All employees are instructed and kept informed of their duties under the plan.

1705.3.3.17. Food Services: The following only apply if the facility stores, prepares, or distributes food:

1705.3.3.17.1. The facility observes and complies with all of the Rules of Department of Human Services (DHS), Public Health, Chapter 290-5-14, Food Service and any local health ordinances when engaged in the storage, preparation, and distribution of food.

Note. The Department will allow the facility to be exempted from the Food Service Permit requirement if all the facility does is use a microwave to heat up food participants bring to the facility.

This exception is allowed only if:

The microwave oven is clean, in good repair, and free of unsanitary conditions

The microwave oven is allowed for warming of permitted foods and beverages based on the provider's internal policies and procedures.

All food and utensils are handled in a sanitary manner.

1705.3.3.17.2. Meals and snacks are prepared either on site or under subcontract with an outside vendor who agrees to comply with the food and nutritional requirements. The facility posts its current Food Service Permit and inspection report or the subcontracted vendor's current Food Service Permit and inspection report.

1705.3.3.17.3. The facility has a designated kitchen area for receiving food, facilities for warming or preparing cold food, and clean-up facilities including hot and cold running water. The facility provides palatable, nutritious and attractive meals and snacks that meet the nutritional requirements of each member.

1705.3.4. Transportation: The individual's family or representative may choose to transport the member to the Community Access facility. Transportation is required between point of origin and activities in setting primary

utilized by people with disabilities (a reasonable amount of transportation, defined as up to one hour per day, is billable). Point of origin is defined as any location that individuals are available for pick-up that is safe and appropriate for the individual based on the approved Individual Service Plan.

1706. Non-Covered Services

- 1706.1. Educational services otherwise available through a program funded under 20 USC Chapter 3, section 1400 of the Individuals with Disabilities Education Act (IDEA), including private school tuition, Applied Behavior Analysis (ABA) in schools, school supplies, and tutors.
- 1706.2. Activities, training, or services provided in the individual's home or family home or family home, or host home/life sharing arrangement, foster home, personal care home, community living arrangement, group home, or any other residential setting.
- 1706.3. Medically related services that are not allowable by State law, rules, and regulations.
- 1706.4. Admission fees, Memberships, Subscriptions, Donations, or related items.
- 1706.5. Registration Fees unless participant-directed services.
- 1706.6. Out of state camps.
- 1706.7. Community Access services must not duplicate or be provided at the same time of the same day as Community Living Support, Supported Employment, Prevocational Services or Transportation Services.
- 1706.8. Payment is not made, directly or indirectly, to members of the individual's immediate family, except as approved as indicated in Part II Policies and Procedures for NOW and COMP, Chapter 900.
- 1706.9. Non-covered health maintenance activities as defined in Rules and Regulations for Proxy Caregivers Used in Licensed Healthcare Facilities, Chapter 111-8-100.
- 1706.10. Payment is not made for those goods and services covered by the State Medicaid Plan except where an individual's need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.

1707. Basis for Reimbursement

The reimbursement rate for Community Access Services is found in Appendix A. Transportation provided through Community Access Services is included in the cost of doing business and incorporated in the administrative overhead cost

Separate payment for transportation only occurs when the NOW's distinct Transportation Services are authorized.

1708. Participant-Direction Options

- 1708.1. Participants can choose the self-direction or co-employer options with Community Access Services.
- 1708.2. An individual serving as a representative for a waiver participant in self-directed services is not eligible to be a participant-directed provider of Community Access Services.
- 1708.3. For details on participant-direction, see Part II Policies and Procedures for NOW and COMP, Chapter 1200.

Chapter 1800: Specific Program Requirements for Community Guide Services Scope of Services

1801. General

Community Guide Services are direct assistance to participants in skills building and information in meeting participant-direction responsibilities. These services are available only for participants who choose the participant-direction option for service delivery. The participant, with the Support Coordinator, determines the amount of Community Guide Services, if any, and the specific services that the Community Guide will provide. The specific Community Guide Services for the participant are specified in the Individual Service Plan. Participants may elect to receive Community Guide Services, and when elected, participants choose their Community Guide.

Community Guide Services are individualized services designed to assist participants in meeting their responsibilities in the participant-direction option for service delivery. Community Guides provide information, direct assistance, and training to participants in support of participant direction. The intended outcome of these services is to improve the participant's knowledge and skills for participant direction.

Community Guides assist and train participants to build the skills required for participant direction, such as exploring and brokering available community resources, problem solving and decision-making, being an effective employer of support workers, developing and managing the individual budget, and record keeping. Information provided by the Community Guide helps the participant's understanding of provider qualifications, record keeping, and other participant-direction responsibilities.

The scope, intensity, and frequency of Community Guide Services may change over time, based on the needs of the participant. Community Guide Services providers offer (or arrange when needed) any of the standard services listed in section 1805 – Covered Services that are needed by the participants served and specified in the participants' Individual Service Plans.

1802. Special Requirements of Participation

1802.1. Individual Provider

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and PART II, Chapter 600 Policies and Procedures for the NOW Program, Community Guide Services providers must meet the following requirements:

1802.1.1. Individual Providers of Community Guide Services must:

1802.1.1.1. Be 18 years or older;

1802.1.1.2. Have a minimum of a bachelor's degree in a human service field and experience in providing direct assistance to individuals with disabilities to network within a local community or comparable training, education or skills;

- 1802.1.1.3. Agree to or provide required documentation of a criminal records check, prior to providing Community Guide services;
- 1802.1.1.4. Be knowledgeable about resources in any local community in which the provider is a Community Guide;
- 1802.1.1.5. Have demonstrated connections to the informal structures of any local community in which the provider is a Community Guide;
- 1802.1.1.6. Have an understanding of Community Guide services, DD waiver participant-direction service delivery requirements, and strategies for working effectively and communicating clearly with individuals with DD and their families/representatives;
- 1802.1.1.7. Attend all mandatory, DBHDD training.

1802.1.2. Participant-Directed Services Documentation and other Requirements: Documentation and other requirements for individual providers of participant-directed services are specified in Part II Policies and Procedures for NOW, Chapter 1200.

1802.1.3. Duties of the Community Guide include but are not limited to the covered services in 1805.

1802.2. Provider Agencies

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and PART II, Chapter 600 Policies and Procedures for the NOW Program, Community Guide Services provider agencies must meet the following requirements:

1802.2.1. Staffing Qualifications and Responsibilities

Provider agencies rendering Community Guide Services must have staffing that meets the following requirements:

- 1802.2.1.1. A designated agency director. Additional information regarding director qualifications can be found in DBHDD Policy Recruitment and Application to Become a Provider of Developmental Disability Services, 02-701.
- 1802.2.1.2. Duties of the Agency Director include, but are not limited to:

- 1802.2.1.2.1. Oversees the day-to-day operation of the agency;
 - 1802.2.1.2.2. Manages the use of agency funds;
 - 1802.2.1.2.3. Ensures the development and updating of required policies of the agency;
 - 1802.2.1.2.4. Manages the employment of staff and professional contracts for the agency;
 - 1802.2.1.2.5. Designates another agency staff member to oversee the agency, in his or her absence.
- 1802.2.1.3. At least one agency employee or professional under contract with the agency must:
 - 1802.2.1.3.1. Be a Developmental Disability Professional (DDP) (for definition, see Part II Policies and Procedures for NOW and COMP);
 - 1802.2.1.3.2. Have responsibility for overseeing the delivery of Community Guide Services to participants.
- 1802.2.1.4. The same individual may serve as both the agency director and the Developmental Disability Professional;
- 1802.2.1.5. Provider agencies must have available a sufficient number of employees that meet the Community Guide experience, training, education or skills qualification specified above for Individual Providers to provide all Community Guide Services that are needed by the participants served and specified in the participants' Individual Service Plans.
- 1802.2.1.6. Duties of the Community Guide include but are not limited to the covered services in 1805.
- 1802.2.2. Agency Policies and Procedures - Each provider agency must develop written policies and procedures to govern the operations of Community Guide Services, which follow the Standards for the Georgia Department of Behavioral Health and Developmental Disabilities (see Part II Policies and Procedures for NOW).
- 1802.2.3. Participant-Directed Services Documentation and other Requirements: Documentation and other requirements for providers of participant-directed services are specified in Part II Policies and Procedures for NOW, Chapter 1200.

- 1802.2.4. DBHDD Contract/LOA and DBHDD Community Service Standards: Providers must adhere to DBHDD Contract/LOA, DBHDD Core Requirements for All Providers and all other applicable DBHDD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DBHDD (see Part II Policies and Procedures for NOW, Chapter 603).

1803. Special Eligibility Conditions

- 1803.1. Community Guide Services are only for participants who opt for participant-direction.
- 1803.2. The participant determines the amount of Community Guide Services, if any, and the specific services that the Community Guide will provide.
- 1803.3. The specific Community Guide Services for the participant are specified in the Individual Service Plan.
- 1803.4. Participants may elect to receive Community Guide Services, and when elected, participants choose their Community Guide.
- 1803.5. The need for Community Guide Services must be related to the individual disability.

1804. Prior Approval

Community Guide Services must be authorized prior to service delivery by the applicable DBHDD Field Office at least annually in conjunction with the Individual Service Plan development and with any ISP version changes.

1805. Covered Services

Reimbursable Community Guide Services include the following based on the assessed need of the participant.

- 1805.1. Direct assistance to participants in exploring and brokering available community resources.
- 1805.2. Direct assistance to participants in meeting their participant-direction responsibilities.
- 1805.3. Information and assistance that helps the participant in problem solving and decision-making.
- 1805.4. Information and assistance that helps the participant in developing supportive community relationships and other resources that promote implementation of the Individual Service Plan.
- 1805.5. Assistance with developing and managing the individual budget;
- 1805.6. Assistance with recruiting, hiring, training, managing, evaluating, and changing employees;
- 1805.7. Assistance with scheduling and outlining the duties of employees;

- 1805.8. Training the participant to be an effective employer of support workers;
- 1805.9. Information and assistance in understanding provider qualifications, record keeping and other participant-direction requirements.

1806. Non-Covered Services

- 1806.1. Community Guide services cannot duplicate Support Coordination services.
- 1806.2. Community Guides cannot provide other direct waiver services, including Support Coordination, to any waiver participant.
- 1806.3. Community Guide agencies cannot provide Support Coordination services.
- 1806.4. Payment is not made, directly or indirectly, to members of the individual's immediate family, except as approved as indicated in Part II Policies and Procedures for NOW, Chapter 900.
- 1806.5. Payment is not made for those goods and services covered by the State Medicaid Plan except where a participant's need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.

1807. Basis for Reimbursement

The reimbursement rate for Community Guide Services is found in Appendix A.

1808. Participant-Direction Options

- 1808.1. Participants can choose the self-direction or co-employer options with Community Guide Services.
- 1808.2. An individual serving as a representative for a waiver participant in self-directed services is not eligible to be a participant-directed provider of Community Guide Services.
- 1808.3. For details on participant-direction, see Part II Policies and Procedures for NOW, Chapter 1200.

Chapter 1900: Specific Program Requirements for Community Living Support (CLS) Services Scope of Services

1901. General Description of CLS Services

Community Living Support (CLS) Services are individually designed to support the acquisition, retention, or improvement of life skills to facilitate residence in a waiver individual's own or family home. Personal care/assistance may be a component part of CLS services but the focus of personal assistance should be teaching the skills related to activities of daily living and instrumental activities of daily living. CLS services are offered to individuals who live in their own or family homes.

CLS services may include any of the following:

Training and assistance with activities of daily living (ADLs), such as bathing, dressing toileting, and transferring,

Teaching and assistance in performance of instrumental activities of daily living (IADLs), such as personal hygiene, light housework, laundry, meal preparation, grocery and other shopping, using the telephone, and medication and money management.

Oversight and supervision of individuals unable to be left alone as assessed by DBHDD staff and under available funding.

CLS services include any transportation delivered to facilitate the individual's participation in grocery or personal shopping, banking and other community activities that support the goal(s) of the waiver individual and/or family. CLS services may include health-related activities such as basic first aid, arranging and/or transporting waiver individuals to medical appointments, accompanying individuals on medical appointments, tracking and documenting health-related daily activities such as intake and output, reminding individuals to take medication, assisting with or supervising self-administration of medication and other tasks that do not require the skill level of a licensed professional. Other tasks may be assigned by a licensed professional under the Proxy Caregiver Rule: Chapter 111-8-100 Rules and Regulations for Proxy Caregivers Used in Licensed Healthcare Facilities.

Direct personal care/assistance may be a component part of CLS services but should not be the only service provided to an individual. Rather, teaching skills that promote self-performance of the activities is the focus in all instances feasible. The frequency and duration of CLS service is designed to address specific needs determined by the Supports Intensity Scale, the Health Risk Screening Tool, and other individual-centered assessment information. The service need responsive to personal goal(s) is specified in the Individual Service Plan. Medically-related services do not include direct nursing services, if required to treat, evaluate, or monitor specific conditions. (Policies and Procedures for Nursing Services directly reimbursed through COMP Waiver Program are outlined in Part III Policies and Procedures for Comprehensive Supports Waiver Program.)

CLS services are reimbursed in 15-minute unit increments using three distinct categories: basic, extended, and shared CLS defined as follows:

Basic CLS is defined as service delivered during visits of 11 or fewer units (2.75 hours) of service per visit. Note: CLS service delivered in two or more distinct visits per day may be billed under Basic CLS to accommodate travel required between visits.

Extended CLS is billed for visits of more than 12 units (3.00 hours) per visit.

Shared CLS reimbursement includes two- and three-person group rates. Shared CLS is designed to accommodate voluntary home-sharing of waiver individuals, allowing one staff person to provide CLS services to groups of two or three waiver individuals.

Note: Shared CLS is provided to waiver individuals in their own leased or owned single-family home or apartment.

Personal Assistance Retainer

The personal assistance retainer is a component of Community Living Support Services designed to allow continued payment for Community Living Support services while an individual is hospitalized or otherwise away from the home. Staff may not provide services in a hospital or nursing home setting but are retained in order to ensure stability of staff upon the individual's return home. The retainer allows continued payment to direct support caregivers for up to thirty (30) days per calendar year for absences of individual from his or her home.

1902. Special Requirements of Participation

1902.1. General Description of Provider Requirements

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and PART II, Chapter 600 Policies and Procedures for the COMP and NOW Programs, all providers of services described in this manual must meet the following requirements:

1902.1.1. Accredited or Certified DD Service Agencies rendering Services must have staffing that meets the following requirements:

1902.1.1.1. A designated agency director. Additional information regarding director qualifications can be found in DBHDD Policy Recruitment and Application to Become a Provider of Developmental Disability Services, 02-701.

1902.1.1.2. Duties of the Agency Director include, but are not limited to:

1902.1.1.2.1. Oversees the day-to-day operation of the agency;

1902.1.1.2.2. Manages the use of agency funds;

1902.1.1.2.3. Ensures the development and updating of required policies of the agency;

1902.1.1.2.4. Manages the employment of staff and professional contracts for the agency;

1902.1.1.2.5. Designates another agency staff member

to oversee the agency, in his or her absence.

- 1902.1.1.3. At least one agency employee or professional under contract with the agency must be a Developmental Disability Professional (DDP) (for definition, Provider Manual for Community Developmental Disability Providers at <http://dbhdd.org/files/Provider-Manual-DD.pdf>)
- 1902.1.1.4. The same individual may serve as both the agency director and the Developmental Disability Professional
- 1902.1.1.5. Provider agencies must have available a sufficient number of employees or professionals

Service-specific staff duties are outlined in the following chapters.

- 1902.1.2. Agency Policies and Procedures: Each provider agency must develop written policies and procedures to govern the operations of the agency and which follow the Provider Manual for Community Developmental Disability Providers for the Georgia Department of Behavioral Health and Developmental Disabilities found at <http://dbhdd.org/files/Provider-Manual-DD.pdf>.
- 1902.1.3. DBHDD Contract/LOA and DBHDD Community Service Standards: Providers must adhere to DBHDD Contract/LOA, DBHDD Community Service Standards and all other applicable DBHDD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the Department of Behavioral Health and Developmental Disabilities (see Part II Policies and Procedures for COMP, Chapter 603)

1902.1.3.1. Licensure

Provider agencies that render CLS Services must hold a current Private Home Care Provider License from the Department of Community Health, Healthcare Facilities Regulation Division (HFR). Licensure level must be commensurate with the level of service delivered:
Level 2: personal care tasks; and/or
Level 3: companion or sitter tasks

Please refer to <https://dch.georgia.gov/divisionsoffices/hfrd/hfrd-laws-regulations> for information about specific licensure regulations.

CLS allows enrollment of agency providers. For more information about provider enrollment, please refer to

Part II, Chapters 600 – 1200, Policies and Procedures
For Comprehensive Supports Waiver Program (Comp)
and New Options Waiver Program (Now) General
Manual

1902.1.3.2. Supervision and Direct Support Staff Duties

1902.1.3.2.1. Supervision of Direct Support Staff

All agency providers must comply with staff supervision requirements as defined in Private Home Care licensure Rules.

1902.1.3.2.2. Duties of Direct Support Staff include, but are not limited to:

1902.1.3.2.2.1. Provide direct assistance to the individual in self-help, socialization, and adaptive skills training, retention and improvement;

1902.1.3.2.2.2. Provide personal care and protective oversight and supervision;

1902.1.3.2.2.3. Implement the behavioral support plans of individuals to reduce inappropriate and/or maladaptive behaviors and to acquire alternative adaptive skills and behaviors;

1902.1.3.2.2.4. Provide assistance and training on independent community living skills, such as personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, and medication and money management.

1902.1.3.2.2.5. Provide assistance in

completing Outcomes and Goal(s) according to the current Individual Support Plan.

1902.1.3.2.3. Other Requirements

The agency has adequate direct care staff with First Aid and CPR certifications to assure having at least one staff person with these certifications on duty during the provision of services.

Training and/or experience requirements for CLS services are defined in Rules and Regulations for Private Home Care Providers, Section 111-8-65-.09 (5)(c), (d) and #6 in the same section found at <http://dch.georgia.gov/hfr-laws-regulations>.

CLS services must be provided by an employee of the enrolled CLS provider agency or by a family-selected employee under the participant-directed model.

1903. Special Eligibility Conditions

- 1903.1. CLS services are provided only to individuals who require in-home supports.
- 1903.2. The need for CLS services must be reflected through assessed needs described as tasks or activities in the approved Individual Support Plan (ISP).
- 1903.3. In order to remain eligible for CLS services, and as a condition of participation in those services, a individual must allow visits by his or her Support Coordinator for all purposes for which Support Coordinator visits are permitted by DCH and/or DBHDD policies and standards. Repeated refusals to allow visits by his or her Support Coordinator may result in the individual's loss of eligibility for CLS services and the consequent loss of those services.

1904. Prior Approval

Community Living Support Services must be authorized prior to service delivery by the applicable DBHDD Field Office at least annually in conjunction with reevaluation of need, development of the initial and annual Individual Support Plan and with any ISP version changes. completed based upon a change in condition or circumstances.

1905. Covered Services

Reimbursable Community Living Support Services include the following based on the assessed need of the individual.

- 1905.1. Social and leisure skills development that assists the individual in planning and engaging in social and leisure activities as a part of home living.
- 1905.2. Adaptive skills development that assists the individual in community activities that are a part of home living in a community, such as communication, community navigation, mobility, understanding community signs/clues, and safety in the community.
- 1905.3. Personal care and protective oversight and supervision in the person's own or family home as a component part of the services.
- 1905.4. CLS protective oversight and supervision that are services provided by staff present in the individual's own or family home, which include protective care and watchful monitoring activities of individual's functioning, the making and reminding a individual of medical appointments, and intervention if a crisis arises.
- 1905.5. Training in and personal care/assistance with activities of daily living (ADLs), such as bathing, dressing, toileting, and transferring, and with instrumental activities of daily living (IADLs), such as personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, and medication and money management.
- 1905.6. Medically related services that are not required to be provided by a licensed professional under State law, rules, and regulations. Examples of medically-related services include basic first aid, arranging and transporting individuals to medical appointments, accompanying individuals on medical appointments, documenting an individual's food and/or liquid intake or output, supervision in the area of nutrition and self-administration of medications and other medically related services including health maintenance activities.
- 1905.7. Implementation of the behavioral support plan of a individual to reduce inappropriate and/or maladaptive behaviors and to acquire alternative adaptive skills and behaviors.
- 1905.8. Transportation required for individuals living in their own home to facilitate the individual's participation in grocery or personal shopping, banking, and other community activities that support continued home living. Georgia's Non-Emergency Transportation System may be used for medical appointment transportation with proper supervision and assistance by the CLS provider or family.
- 1905.9. CLS services may be provided in the following living environments:
 - 1905.9.1. The waiver individual's owned or leased home
 - 1905.9.2. the home of a family member or other natural/informal supporter

1906. Non-Covered Services

- 1906.1. Community Living Support services may not be delivered to a person living in a home leased or owned by the service delivery agency, by an employee or contractor of the service delivery agency, or by support staff hired under the participant-direction model with the exception of Family Relative/Family Caregiver Hire as set forth in PART II CHAPTERS 600 – 1200 POLICIES AND PROCEDURES FOR COMP & NOW Chapters 900 and 1200.
- 1906.2. Community Living Support services may not be delivered in a rental room/apartment/home for the individual where access to the kitchen is restricted and there is no access to at least one bathroom.
- 1906.3. Community Living Support services may not be delivered in foster homes, host homes, personal care homes, community living arrangements, or any other home/residence other than the individual's own or family home. but in no instance, can the individual's own home or family home be a licensed Personal Care Home, a licensed Community Living Arrangement, or a host home/life sharing arrangement that provides Community Residential Alternative Services.
- 1906.4. Educational and related services needed by children for whom the Department of Education is responsible.
- 1906.5. CLS services that duplicate or are provided at the same time of the same day as Community Access or Supported Employment services.
- 1906.6. Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement.
- 1906.7. Payment is not made, directly or indirectly, to members of the individual's immediate family, except as approved as indicated in Part II Policies and Procedures for COMP and NOW, Chapter 900.
- 1906.8. Medically related services that cannot be provided by non-licensed persons according to State law, rules, and regulations.
- 1906.9. Payment is not made for Personal Assistance Retainer outside of scheduled days and units per day for Community Living Support Services.
- 1906.10. Payment of Personal Assistance retainer is not allowable for absences due to services that are reimbursable as other waiver and Medicaid State Plan services except for admissions to a general hospital or nursing facility in accordance with requirements specified below in Section 1908, Basis for Reimbursement.
- 1906.11. Payment of Personal Assistance retainer beyond allowable days indicated below in Section 1908, Basis for Reimbursement.
- 1906.12. Non-covered health maintenance activities are defined the Rules and Regulations for Proxy Caregivers Used in Licensed Healthcare Facilities, Chapter 111-8-100.
- 1906.13. Payment is not made for those goods and services covered by the State Medicaid Plan

except where an individual's need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.

1907. Documentation

- 1907.1. Documentation of CLS services must include the following elements in the record of each individual.
 - 1907.1.1. Specific activity, training, or assistance provided;
 - 1907.1.2. Date and the beginning and ending time of day when the service was delivered;
 - 1907.1.3. Location where the service was delivered;
 - 1907.1.4. Verification of service delivery, including first and last name and title (if applicable) of the person providing the service and his or her signature;
 - 1907.1.5. Supervisory note documenting licensure-level required supervision of the direct support personnel;
 - 1907.1.6. Progress towards moving the individual towards his or her goal(s) and meeting the needs identified in the individual ISP.
- 1907.2. Personal Assistance Retainer Documentation: Providers must document the following in the record of each individual for whom a personal assistance retainer is a component of Community Living Support Habilitation Services:
 - 1907.2.1. Beginning and end date of absence.
 - 1907.2.2. Reason for absence.
 - 1907.2.3. Scheduled days and units per day for Community Living Support Habilitation Services.
 - 1907.2.4. Statement that the staff member has not been reassigned to another waiver individual during the absence.

Note: As of 4/1/17 providers must use the procedure code specified for Personal Assistance Retainer reimbursement.
- 1907.3. Participant-Directed Services Documentation and other Requirements: Documentation, including Personal Assistance Retainer documentation and other requirements for participant-directed services are specified in Part II Policies and Procedures for COMP and NOW, Chapter 1200.

1908. Basis for Reimbursement

Reimbursement rates for CLS services are found in Appendix A.

Transportation is included in the rate for CLS services but does not prevent the use of Georgia's

Non-emergency Transportation Service for medical appointments.

1909. Participant-Direction Options

- 1909.1. Participants can choose the self-direction or co-employer options for delivery of CLS services.
- 1909.2. An individual serving as a representative for a waiver participant in self-directed services is not eligible to be a participant-directed provider of CLS services.
- 1909.3. For details on participant-direction, see Part II Policies and Procedures for NOW and COMP, Chapter 1200.
- 1909.4. All CLS services, including CLS delivered through the participant-directed model are provided within the annual maximum.

Chapter 2000: Specific Program Requirements for Environmental Accessibility Adaptation Services Scope of Services

2001. General

Environmental Accessibility Adaptation Services include adaptations and technical assistance to individually or family owned private residences which are designed to enable individuals to interact more independently with their environment thus enhancing their quality of life and reducing their dependence on physical support from others. These services include physical adaptations to the individual's or family's home which are necessary to ensure the health, welfare and safety of the individual, or enable the individual to function with greater independence in the home and without which, the individual would require institutionalization. Environmental Accessibility Adaptations consist of the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the individual and are of direct medical or remedial benefit to the individual.

Any item billed under Environmental Accessibility Adaptation Services must not be available under the State Medicaid Plan. These services must also be documented to be the payer of last resource. The NOW does not cover items that have been denied through the DME and other programs for lack of medical necessity.

2002. Special Requirements of Participation

2002.1. Individual Provider

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and PART II, Chapter 600 Policies and Procedures for the NOW Program, individual providers of Environmental Accessibility Adaptations must meet the following requirements:

- 2002.1.1. Documentation Requirement: Providers, except for providers of participant-directed services, must document the following in the record of each individual receiving Environmental Accessibility Adaptation Services:
 - 2002.1.1.1. The efforts of the individual's Support Coordinator to substantiate payer of last resource, including available community, State Plan, or other resources.
 - 2002.1.1.2. Verification of Environmental Accessibility Adaptation service delivery, including date, location, and specific environmental accessibility adaptations provided.
 - 2002.1.1.3. Associated administration costs for Environmental Accessibility Adaptation service delivery that delineates line item sources of costs; billing of associated administration costs cannot exceed eight to ten (8 to 10)

percent of any billing for Environmental Accessibility Adaptation services.

- 2002.1.2. Participant-Directed Services Documentation and other Requirements: Documentation and other requirements for individual providers of participant-directed services are specified in Part II Policies and Procedures for NOW, Chapter 1200.

2002.2. Provider Agencies

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and PART II, Chapter 600 Policies and Procedures for the NOW Program, Environmental Accessibility Adaptation Services provider agencies must meet the following requirements:

- 2002.2.1. Documentation Requirement: Providers, except for providers of participant-directed services, must document the following in the record of each individual receiving Environmental Accessibility Adaptation Services:
- 2002.2.1.1. The efforts of the individual's Support Coordinator to substantiate payer of last resource, including available community, State Plan, or other resources.
 - 2002.2.1.2. Verification of Environmental Accessibility Adaptation service delivery, including date, location, and specific environmental accessibility adaptations provided.
 - 2002.2.1.3. Associated administration costs for Environment Accessibility Adaptation services delivery that delineates line item sources of cost; billing of associated administration costs cannot exceed Eight to ten (8 to 10) percent of billing for Environment Accessibility Adaptation services.
 - 2002.2.1.4. Participant-Directed Services Documentation and other Requirements: Documentation and other requirements for individual providers of participant-directed services are specified in Part II Policies and Procedures for NOW, Chapter 1200
 - 2002.2.1.5. DBHDD Contract/LOA and MHDDD Community Service Standards: Providers must adhere to DBHDD Contract Standards, DBHDD Core Requirements for All Providers and all other applicable DBHDD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DBHDD (see Part II Policies and Procedures for NOW, Chapter 603).

2003. Licensure

Environmental Accessibility Adaptations are made by building, plumbing or electrical contractors with applicable Georgia license (OCGA 43-14-2 or 43-41-2) or individual builders, plumbers or electricians with applicable Georgia business license as required by the local, city or county government in which the services are provided.

2004. Special Eligibility Conditions

- 2004.1. The need for Environmental Accessibility Adaptation services must be related to the individual disability and specified in the Evaluation Team approved Individual Service Plan (ISP).
- 2004.2. When a individual only receives specialized services, there must be a goal specialized services, which includes Environmental Accessibility Adaptation.
- 2004.3. Medical Necessity for Environmental Accessibility Adaptation Services must be documented through an order by the Georgia Licensed Physician.

2005. Prior Approval

- 2005.1. Environmental Accessibility Adaptation Services must relate to specific individual goal(s) and must be required to meet the needs of the individual.
- 2005.2. Environmental Accessibility Adaptation Services must be authorized prior to service delivery by the applicable DBHDD Field Office at least annually in conjunction with the ISP development and any ISP version changes.

2006. Covered Services

Reimbursable Environmental Accessibility Adaptation Services include the following based on the assessed need of the individual.

- 2006.1. Environmental Accessibility Adaptation Services consist of physical adaptations to the individual 's or family's home in which the individual resides and which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the individual would require institutionalization.
- 2006.2. Environmental Accessibility Adaptations consist of the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the individual and are of direct medical or remedial benefit to the individual.

2007. Non-Covered Services

- 2007.1. Environmental Accessibility Adaptation Services will not be approved for modifications made to homes that are licensed by the State as Personal Care Homes or Community Living Arrangements.

- 2007.2. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).
- 2007.3. Adaptations that are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc.
- 2007.4. Adaptations that are made to leased property.
- 2007.5. Comfort, convenience, or recreational adaptations.
- 2007.6. Installations or adaptations for alarm systems, chairlifts, elevators, burglar bars, security cameras, personal emergency response systems, deadbolt locks, fences, hot tubs, whirlpool tubs, portable pools and spas, lap pools, and indoor ceiling lift systems.
- 2007.7. Payment is not made, directly or indirectly, to members of the individual's immediate family, except as approved as indicated in Part II Policies and Procedures for NOW, Chapter 900.
- 2007.8. Payment is not made for those goods and services covered by the State Medicaid Plan except where an individual's need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.

2008. Basis for Reimbursement

- 2008.1. Reimbursement rate for Environmental Accessibility Adaptation is the lower of three price quotes or the lifetime maximum. The reimbursement rates for all specialized services are found in Appendix A.

2009. Participant-Direction Options

- 2009.1. Participants may choose the self-direction option with Environmental Accessibility Adaptation.
- 2009.2. For details on participant-direction, see Part II Policies and Procedures for NOW, Chapter 1200.

Chapter 2100: Specific Program Requirements for Financial Support Services Scope of Services

2101. General

Financial Support Services (FSS) are designed to perform fiscal and related finance functions for the participant or representative who elects the participant-direction option for service delivery and supports. FSS assure that the funds to provide services and supports, outlined in the Individual Service Plan (ISP) and to be implemented through a self-directed approach, are managed and distributed as intended.

Financial Support Services are provided by a Fiscal Intermediary Agency (FIA) established as a legally recognized entity in the United States, qualified and registered to do business in the state of Georgia and approved as a Medicaid provider by the Department of Community Health (DCH).

Financial Support Services are mandatory and integral to participant-direction (budget authority).

2102. Special Requirement of Participation

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and PART II, Chapter 600 Policies and Procedures for the NOW Program, Financial Support Services providers must meet the following:

2102.1. Provider Qualifications:

- 2102.1.1. Be a Fiscal Intermediary Agency;
- 2102.1.2. Be approved by the IRS under procedure 70-6 and meet requirements and functions as established by IRS code, Section 3504;
- 2102.1.3. Hold and execute Medicaid provider agreements and function as an Organized Health Care Delivery System (OHCDS) or as authorized under a written agreement with the Department of Community Health;
- 2102.1.4. Understand the laws and rules that regulate the expenditure of public resources;
- 2102.1.5. Have at least two years of basic accounting and payroll experience;
- 2102.1.6. Have a surety bond issued by a company authorized to do business in the State of Georgia in an amount equal to or greater than the monetary value of the participants' business accounts managed but not less than \$250,000;
- 2102.1.7. Be approved by the IRS (under IRS Revenue Procedure 70-6) and meet requirements and functions as established by the IRS code, section 3504;
- 2102.1.8. Not be enrolled to provide any other Medicaid services in the State of Georgia.

- 2102.2. Service Delivery Requirements:
- 2102.2.1. Receive and disburse funds for the payment of participant-directed services under an agreement with the Department of Community Health, the State Medicaid agency.
 - 2102.2.2. File claims through the Medicaid Management Information System (MMIS) for participant directed goods and services.
 - 2102.2.3. Utilize accounting systems that operate effectively on a large scale and have the capacity to track individual budgets;
 - 2102.2.4. Adhere to the timelines for payment that meet the individual participant's needs within Department of Labor standards;
 - 2102.2.5. Develop, implement and maintain an effective payroll system that adheres to all related tax obligations for both payment and reporting;
 - 2102.2.6. Maintain separate, individual accounts for each participant's funds to be used for participant-directed waiver services;
 - 2102.2.7. Establish procedures for conducting and paying for up to five (5) local and national criminal background checks, and for completing age verification on service support workers;
 - 2102.2.8. Establish procedures for generating service management, and statistical information and reports during each payroll cycle;
 - 2102.2.9. Develop materials for startup training and technical assistance to participants, their representatives, and others as required to include, but not limited to, timesheets and payroll forms.
 - 2102.2.10. Establish procedures for processing and maintaining all unemployment records;
 - 2102.2.11. Provide an electronic process for reporting and tracking timesheets and expense reports;
 - 2102.2.12. Establish procedures to execute and hold the Medicaid provider agreements as authorized under a written agreement with the Department of Community Health, the State Medicaid Agency.
 - 2102.2.13. Monitor expenditures of individual budgets on a regular basis to ensure that payments to not exceed the total units amount and the total dollar amount allocated for each participant in the participant's approved budget;
 - 2102.2.14. Provide all necessary employment and budget forms to Participants (employers) to include but not limited to timesheets, W-2s and a financial orientation package;

- 2102.2.15. Provide financial instruction and technical assistance to Participants (employers);

2103. Licensure

Provider agencies that render Financial Support Services must hold the applicable business license as required by the local, city, or county government in which the services are provided.

2104. Special Eligibility Conditions

- 2104.1. Only participants who opt for participant-direction of services are eligible to receive Financial Support Services.
- 2104.2. The need for Financial Support Services must be reflected in the Individual Service Plan approved by the Intake and Evaluation Team.
- 2104.3. Financial Support Services are not available to participants or representatives who choose the Co-Employer model for self-directed services and supports.

2105. Prior Approval

Financial Support Services must be authorized prior to service delivery by the applicable DBHDD Field Office at least annually in conjunction with the Individual Service Plan development and revisions.

2106. Covered Services

Based on the assessed need of the participant and as specified in the approved ISP, the Financial Support Services Provider:

- 2106.1. Conducts and pays for criminal background checks (local and national) and completes age verification on service support workers.
- 2106.2. Receives and disburses funds for payment of participant-directed services, in accordance with all related tax obligations, unemployment records, and worker compensation on earned income.
- 2106.3. Generates service management, statistical information, and reports during each payroll cycle.
- 2106.4. Provides startup training and technical assistance to participants, their representatives, and others as required.
- 2106.5. Process and maintain all unemployment records.

2107. Non-Covered Services

- 2107.1. Supplies and maintenance for fax machine.

- 2107.2. The FSS provider can only provide Financial Support Services and must not be enrolled to provide any other Medicaid services in Georgia.
- 2107.3. Financial Support Services are not available to participants or representatives who choose the Co-Employer model for self-directed services and supports.
- 2107.4. Payment is not made for those goods and services covered by the State Medicaid Plan except where a participant's need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.

2108. Basis for Reimbursement

- 2108.1. The reimbursement rate for Financial Support Services is found in Appendix A.

2109. Participant-Direction Options

- 2109.1. Financial Support Services is a mandatory and non-negotiable for participants who choose the participant-directed option for service delivery.
- 2109.2. When the participant is the employer of record, the FSS provider is the Internal Revenue Service approved Fiscal Employer Agent (FEA).
- 2109.3. For details on participant-direction, see Part II Policies and Procedures for NOW and COMP, Chapter 1200.

Chapter 2200: Specific Program Requirements for Individual Directed Goods and Services Scope of Services

2201. General

Individual Directed Goods and Services are goods and services not otherwise provided through the NOW or the Medicaid State Plan but are identified by the waiver participant/representative who opts for participant direction and the Support Coordinator or interdisciplinary team. These services are available only for participants who choose the participant-direction option for service delivery. Individual Directed Goods and Services must be clearly linked to an assessed need of the individual participant due to his or her disability and be documented in the participant's Individual Service Plan.

Individual Directed Goods and Services are purchased from the participant-directed budget and cover services that include improving and maintaining the participant's opportunities for full membership in the community. Goods and services purchased under this coverage may not circumvent other restrictions on NOW services, including the prohibition against claiming for the costs of room and board. Individual Directed Goods and Services must be authorized by the operating agency prior to service delivery.

The Individual Directed Goods and Services must:

Decrease the need for other Medicaid services; AND

Not be available through another source, including the participant not having the funds to purchase the item or service; AND

Promote inclusion in the community; OR

Increase the participant's safety in the home environment;

The participant/representative must submit a request to the Support Coordinator for the goods or service to be purchased that includes the supplier/vendor name and identifying information and the cost of the service/goods. A paid invoice or receipt that provides clear evidence of the purchase must be on file in the participant's records to support all goods and services purchased.

Authorization for these services requires Support Coordinator documentation that specifies how the Individual Directed Goods and Services meet the above-specified criteria for these services.

Participants receiving flexible support coordination are required to follow these same procedures.

2202. Special Requirements of Participation

2202.1. Individual Provider

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and PART II, Chapter 600 Policies and Procedures for the NOW Program, Individual Directed Goods and Services providers must meet the following requirements:

- 2202.1.1. Individual Providers of Individual Directed Goods and Services must:
 - 2202.1.1.1. Must be 18 years or older;
 - 2202.1.1.2. Have a minimum of a high school diploma or GED Equivalent;
 - 2202.1.1.3. Must have two years of professional work experience in the area of purchasing or related experience; OR
 - 2202.1.1.4. Have an applicable business license for goods provided.
- 2202.1.2. Authorization Documentation: The vendor for Individual Directed Goods and Services assures receipt of a copy of the required Support Coordinator documentation for authorization of these services prior to service provision.
- 2202.1.3. Participant-Directed Services Documentation and other Requirements: Documentation and other requirements for individual providers of participant-directed services are specified in Part II Policies and Procedures for NOW, Chapter 1200.
- 2202.1.4. Documentation of Services and Goods Purchased: A paid invoice or receipt that provides clear evidence of the purchase must be on file in the participant's records to support all goods and services purchased.
- 2202.2. Provider Agencies

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and PART II, Chapter 600 Policies and Procedures for the NOW Program, Individual Directed Goods and Services provider agencies must meet the following requirements:

 - 2202.2.1. Agency Providers of Individual Directed Goods and Services must:
 - 2202.2.1.1. Have employees providing services that meet the above requirements for individual providers; OR
 - 2202.2.1.2. Have an applicable business license for goods provided.
 - 2202.3. Authorization Documentation: The agency vendor for Individual Directed Goods and Services assures receipt of a copy of the required Support Coordinator documentation for authorization of these services prior to service provision.
 - 2202.4. Participant-Directed Services Documentation and other Requirements: Documentation and other requirements for providers of participant-directed services are specified in Part II Policies and Procedures for NOW, Chapter 1200.
 - 2202.5. Documentation of Services and Goods Purchased: A paid invoice or receipt that provides clear evidence of the purchase must be on file in the participant's records to

support all goods and services purchased.

2203. Licensure

Individual Directed Goods and Services are provided by vendors with the applicable Georgia business license as required by the local, city or county government in which the services are provided.

2204. Special Eligibility Conditions

- 2204.1. Individual Directed Goods and Services are only for participants who opt for participant-direction.
- 2204.2. The specific goods and services provided under Individual Directed Goods and Services must be clearly linked to an assessed need of the individual participant due to his or her disability and be documented in the participant's Intake and Evaluation approved Individual Service Plan (ISP).
- 2204.3. The participant/representative must submit a request to the Support Coordinator for the goods or service to be purchased that will include the supplier/vendor name and identifying information and the cost of the service/goods.

2205. Prior Approval

- 2205.1. Authorization for these services requires Participant-Directed Representative documentation that specifies how the Individual Directed Goods and Services meet the requirements for purchase of this coverage specified below:
 - 2205.1.1. The goods or services are not covered through the NOW Program or Medicaid State Plan; AND
 - 2205.1.2. The participant does not have the funds to purchase the item or service or the item or service is not available through another source; AND
 - 2205.1.3. The item or service would decrease the need for other Medicaid services; AND
 - 2205.1.4. Promote inclusion in the community; OR
 - 2205.1.5. Increase the participant's safety in the home environment.
- 2205.2. The Participant-Directed Representative provides a copy of the above documentation to the vendor prior to service provision.
- 2205.3. The above authorization procedures for the Participant-Directed Representative must be followed for participants receiving flexible support coordination.
- 2205.4. Individual Directed Goods and Services must be authorized prior to service delivery by the applicable DBHDD Field Office at least annually in conjunction with the ISP development and any ISP version changes.

2206. Covered Services

Reimbursable Individual Directed Goods and Services include the following based on the assessed need of the participant.

- 2206.1. Goods that specifically relate to the participant's needs due to his or her disability and are not otherwise provided through the NOW or the Medicaid State Plan.
- 2206.2. Services that specifically relate to the participant's needs due to his or her disability and are not otherwise provided through the NOW or the Medicaid State Plan.

2207. Non-Covered Services

- 2207.1. Services or goods not related to the needs of the individual participant due to his or her disability.
- 2207.2. Experimental or prohibited treatments.
- 2207.3. Costs for room and board and other restrictions on NOW services.
- 2207.4. Services otherwise provided through the NOW or the Medicaid State Plan, including additional units or costs beyond the maximum allowable for any NOW or Medicaid State Plan service.
- 2207.5. Items denied through the Durable Medical Equipment and other Medicaid State Plan programs due to the lack of medical necessity.
- 2207.6. Educational services otherwise available through a program funded under 20 USC Chapter 3, section 1400 of the Individuals Education Act (IDEA), including private school tuition, Applied Behavior Analysis (ABA) in schools, school supplies, tutors, and home schooling activities and supplies.
- 2207.7. Services that are available under a program funded under section 110 of the Rehabilitation Act of 1973.
- 2207.8. Incentive payments, subsidies, or unrelated vocational training expenses.
- 2207.9. Supervisory activities rendered as a normal part of the business setting.
- 2207.10. Medically related services that are not allowable by State law, rules, and regulations.
- 2207.11. Admission fees, Memberships, Subscriptions, Donations, or related items.
- 2207.12. Training paid caregivers.
- 2207.13. Services in a hospital.
- 2207.14. Any item listed as non-covered for the NOW Specialized Medical Supplies, Specialized Medical Equipment, Vehicle Adaptations, and Environmental Accessibility Adaptation Services.
- 2207.15. Services reimbursable by any other source.

- 2207.16. Costs of travel, meals and overnight lodging for families and natural support network members to attend a training event or conference.
- 2207.17. Payment is not made, directly or indirectly, to members of the individual's immediate family, except as approved as indicated in Part II Policies and Procedures for NOW, Chapter 900.

2208. Basis for Reimbursement

The reimbursement rate is the lower of three price quotes or the annual maximum. The reimbursement rate for Individual Directed Goods and Services is found in Appendix A.

2209. Participant-Direction Options

- 2209.1. Individual Directed Goods and Services are only for participants who opt for the self-direction option.
- 2209.2. An individual serving as a representative for a waiver participant in self-directed services is not eligible to be a participant-directed provider of Individual Directed Goods and Services.
- 2209.3. For details on participant-direction, see Part II Policies and Procedures for NOW and COMP, Chapter 1200.

Chapter 2300: Specific Program Requirements for Interpreter Services Scope of Services

2301. General

Interpreter Services provide sign language interpretation support services that are not otherwise reimbursed through Medicaid State Plan Services. Interpreter services is intended to facilitate communication to aid in the development of ISPs through informed assessment and full participation in planning by the individual and treatment team members. Interpreter services are also intended to provide training to direct support staff in various community settings including but not limited to CLA, CLS and Community Access. Sign Language Interpreting Services are provided by a certified interpreter who is certified with the Registry of Interpreters for the Deaf (RID). Interpreter Services include the development of communication guidelines consistent with the individual's communication assessment, observation to gather information about the individual's communication skills and abilities, training and education of the individual, family, and staff in compliance with communication assessment. Any recommendations made by the certified interpreter that alter the original communication assessment must be supported by the communication specialist before implementation.

2302. Special Requirements of Participation

2302.1. Individual Provider

In addition to those conditions of participation in Section 106 (General Conditions of Participation), and Part II Chapter 6000 Policies and Procedures for the NOW/COMP program, Sign Language Interpreter Services providers must meet the following requirements:

- 2302.1.1. Service Provision: Interpreter Services are provided by a certified sign language interpreter in accordance with Registry of Interpreters for the Deaf (RID).
- 2302.1.2. Documentation Requirement: Providers must provide a documentation record of the services provided to each individual:
 - 2302.1.2.1. Specific services provided interpreting and translation/training or other communication assistance provided;
 - 2302.1.2.2. Date and the beginning and ending time when the service was provided;
 - 2302.1.2.3. Location where the service was delivered;
 - 2302.1.2.4. Verification of service delivery, including first and last name and title of the person providing the service and his or her signature.
 - 2302.1.2.5. Progress towards the goal(s) established in the individual's communication assessment report (CAR).

2302.1.2.6. Sign Language Interpreter Providers must maintain documentation for the identified need of communication supports. Copies of documentation or educational materials in support of the communication needs of the individual must be part of the documentation of a residential or other setting as training tools.

2302.1.3. Participant-Directed Services Documentation and other Requirements: Documentation and other requirements for individual providers of participant-directed services are specified in Part II Policies and Procedures for NOW/COMP, Chapter 1200.

2302.2. Provider Agencies

In addition to those conditions of participation in Section 106 (General Conditions of Participation), and PART II, Chapter 600 Policies and Procedures for the COMP and NOW Program, Interpreter Services provider agencies must meet the following requirements:

Service Interpreter Services are provided by a RID certified interpreter and supported by the individual's communication assessment report.

2302.3. Types of Agencies:

2302.3.1. Agencies that provide Sign Language interpreter Services are:

2302.3.1.1. Sign Language Interpreting Agencies

2302.3.1.1.1. Staffing Qualifications and Responsibilities:

Sign Language Interpreting Agencies rendering Sign Language Interpreter Services must have staffing that meets the following requirements:

2302.3.1.1.1.1. Employees or Contractors must hold current certification with Registry of Interpreters for the Deaf (RID)

2302.3.1.1.1.2. An Agency Director. Additional information regarding director qualifications can be found in DBHDD Policy Recruitment and Application to Become a Provider of Developmental Disability Services, 02-

701.

Duties of the Agency Director include, but are not limited to:

2302.3.1.1.1.3. Oversees the day-to-day operation of the agency;

2302.3.1.1.1.4. Manages the use of agency funds;

2302.3.1.1.1.5. Ensures the development and updating of required policies of the agency;

2302.3.1.1.1.6. Manages the employment of staff and professional contracts for the agency;

2302.3.1.1.1.7. Designates another agency staff member to oversee the agency, in his or her absence.

Provider agencies must have available a sufficient number of employees or professionals under contract that are certified sign language interpreters to provide Sign Language Interpreter Services.

2302.3.1.2. Agency Policies and Procedures:

2302.3.1.2.1. Each provider agency must develop written policies and procedures to govern the operations of Sign Language Interpreter Services, which follow the Standards for the Georgia Department of Behavioral Health and Developmental Disabilities refer to Part II Chapters 600-1200 Policies and Procedures for COMP and NOW General Manual

2302.3.1.3. DBHDD Contract/LOA and DBHDD Community Service Standards:

2302.3.1.3.1. Providers must adhere to DBHDD Contract/LOA, DBHDD Community

Service Standards and all other applicable DBHDD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the Department of Behavioral Health and Developmental Disabilities (see Part II Policies and Procedures for COMP and NOW).

2303. Licensure

- 2303.1. Interpreter Services are provided by a “qualified interpreter” or “intermediary interpreter” in accordance with the applicable Georgia code O.C.G.A. 24-9-101

2304. Special Eligibility Conditions

- 2304.1. In addition to the communication assessment, an individual must have one of the following conditions:
- 2304.1.1. A medical condition or diagnosis:
 - 2304.1.1.1. For which a communication assessment has been required; or
 - 2304.1.1.2. which has resulted in the patient’s inability to communicate in spoken language to others.
 - 2304.1.2. The individual is considered Deaf or has a hearing loss so seriously impaired as to prohibit the person from understanding oral communications when spoken in a normal conversational tone.
 - 2304.1.3. The individual’s communication preference is to communicate in sign language.
 - 2304.1.4. All services must be reflected on the communication assessment report.
- 2304.2. Documentation Requirement: Providers must document the following in the record of each individual receiving Interpreter Services:
- 2304.2.1. Specific interpreting, training or communication assistance provided;
 - 2304.2.2. Date and the beginning and ending time when the service was provided;
 - 2304.2.3. Location where the service was delivered; and
 - 2304.2.4. Verification of service delivery, including first and last name and title of the person providing the service and his or her signature;
 - 2304.2.5. Progress towards the individual’s communication needs as documented in the individual’s ISP.

- 2304.2.6. Sign Language Interpreter Providers must maintain documentation for the identified need of therapies, frequency and duration of interpreting, interventions to be provided, and goal(s) addressing communication needs.

2305. Prior Approval

Interpreter Services must be authorized prior to service delivery by the DBHDD in conjunction with the Individual Service Plan development and with any ISP version changes. The need for Sign Language Interpreter Services must be an identifiable assessed need in the CAR and in the ISP directly related to the disability.

2306. Covered Service

2306.1. Reimbursable Interpreter Services include the following based on the assessed need of the individual and as specified in the approved ISP:

- 2306.1.1. Evaluation and assessment
- 2306.1.2. Individual Service Planning
- 2306.1.3. Individual Family/Staff education

2307. Non-Covered Services

Sign Language Interpreter Services are not provided for other services/agencies that are not considered to be DBHDD services.

2308. Basis for Reimbursement

The reimbursement rates for Sign Language Interpreter Services are found in Appendix A.

2309. Participant-Direction Options

Participants cannot choose the self-direction option with Sign Language Interpreter Services. An individual serving as a representative for a waiver participant in self-directed services is not eligible to be a participant-directed provider.

For details on participant-direction, see Part II Policies and Procedures for COMP and NOW, Chapter 1200.

Chapter 2400: Specific Program Requirements for Natural Support Training Services Scope of Services

2401. General

Natural Support Training (NST) Services provide training and education to individuals who provide unpaid support, training, companionship or supervision to individuals. For purposes of this service, individual is defined as any person, family member, neighbor, friend, companion, or co-worker who provides uncompensated care, training, guidance, companionship or support to a person served on the waiver. These services must relate to the individual's needs due to his or her disability. All training for individuals who provide unpaid support to the individual provided through NST Services must be included in the individual's ISP.

NST Services include individualized training of families and members of the individuals' natural support networks for the acquisition or enhancement of their ability to support the waiver individual. This training consists of instruction about treatment regimens and other services included in the ISP. NST Services comprise training on the use of equipment. These services may include updates in training required to maintain the individual safely at home. NST Services encompass the costs of registration and training fees associated with formal instruction in areas relevant to the individual's disability needs. These services do not include the costs of travel, meals, and overnight lodging to attend a training event or conference.

NST Services are provided by Developmental Disability Professionals (see Appendix A for definition). These services may be provided in an individual's own or family home, the Developmental Disability Professional's office, outpatient clinics, Supported Employment work sites, or other community settings specific to community-based Natural Support Training goal(s) specified in the Individual Service Plan. Natural Support Training Services Providers offer (or arrange when needed) any of the standard services listed in section 2406 – Covered Services that are needed due to the disability of the individuals served and specified in the individuals' Individual Service Plans.

2402. Special Requirements of Participation

2402.1. Individual Provider

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and PART II, Chapter 600 Policies and Procedures for the NOW Program, Natural Support Training providers must meet the following requirements:

- 2402.1.1. Individual Providers of Natural Support Training Services must meet the requirements for a Developmental Disability Professional (DDP). For definition of DDP, see Part II Policies and Procedures for NOW and COMP.
- 2402.1.2. Documentation Requirement: Providers, except for providers of participant-directed services, must document the following in the record of each individual receiving Natural Support Training Services:

- 2402.1.2.1. Specific activity, training, or assistance provided;
- 2402.1.2.2. Date and the beginning and ending time when the service was provided;
- 2402.1.2.3. Location where the service was delivered;
- 2402.1.2.4. Verification of service delivery, including first and last name and title (if applicable) of the person providing the service and his or her signature;
- 2402.1.2.5. Verification of registration and certificate of attendance at any formal training;
- 2402.1.2.6. Progress towards moving the individual towards independence by meeting the individual ISP.
- 2402.1.3. Participant-Directed Services Documentation and other Requirements: Documentation and other requirements for individual providers of participant-directed services are specified in Part II Policies and Procedures for NOW, Chapter 1200.

2402.2. Provider Agencies

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and PART II, Chapter 600 Policies and Procedures for the NOW Program, Natural Support Training Services provider agencies must meet the following requirements:

2402.2.1. Staffing Qualifications and Responsibilities

Provider agencies rendering Natural Support Training Services must have staffing that meets the following requirements:

- 2402.2.1.1. A designated agency director. Additional information regarding director qualifications can be found in DBHDD Policy Recruitment and Application to Become a Provider of Developmental Disability Services, 02-701.
- 2402.2.1.2. Duties of the Agency Director include, but are not limited to:
 - 2402.2.1.2.1. Oversees the day-to-day operation of the agency;
 - 2402.2.1.2.2. Manages the use of agency funds;
 - 2402.2.1.2.3. Ensures the development and updating of required policies of the agency;

- 2402.2.1.2.4. Manages the employment of staff and professional contracts for the agency;
 - 2402.2.1.2.5. Designates another agency staff member to oversee the agency, in his or her absence.
 - 2402.2.1.3. At least one agency employee or professional under contract with the agency must:
 - 2402.2.1.3.1. Be a Developmental Disability Professional (DDP) (for definition, see Part II Policies and Procedures for NOW and COMP);
 - 2402.2.1.3.2. Have responsibility for delivering Natural Support Training Services to individual s.
 - 2402.2.1.4. The same individual may serve as both the agency director and the Developmental Disability Professional;
 - 2402.2.1.5. Provider agencies must have available a sufficient number of employees or professionals under contract that meet the DDP definition to provide Natural Support Training Services.
 - 2402.2.1.6. Provider agencies must assure that employees or professionals under contract providing NST services hold applicable professional licenses as required by Georgia Code Title 43.
- 2402.2.2. Agency Policies and Procedures - Each provider agency must develop written policies and procedures to govern the operations of Natural Support Training services, which follow the Standards for the Division of Mental Health, Developmental Disabilities and Addictive Diseases as stated in Part II Policies and Procedures for NOW.
- 2402.2.3. Documentation Requirement: Providers, except for providers of participant-directed services, must document the following in the record of each individual receiving Natural Support Training Services:
 - 2402.2.3.1. Specific activity, training, or assistance provided;
 - 2402.2.3.2. Date and the beginning and ending time when the service was provided;
 - 2402.2.3.3. Location where the service was delivered;
 - 2402.2.3.4. Verification of service delivery, including first and last name and title (if applicable) of the person providing the

service and his or her signature;

2402.2.3.5. Progress towards moving the individual towards independence by meeting the individual ISP.

2402.2.4. Participant-Directed Services Documentation and other Requirements: Documentation and other requirements for providers of participant-directed services are specified in Part II Policies and Procedures for NOW, Chapter 1200.

2402.2.5. DBHDD Contract/LOA and DBHDD Community Service Standards: Providers must adhere to DBHDD Contract/LOA, DBHDD Core Requirements for All Providers and all other applicable DBHDD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DBHDD (see Part II Policies and Procedures for NOW, Chapter 603).

2403. Licensure

The Developmental Disability Professional (DDP) providing NST services must have any applicable professional license as required by Georgia Code Title 43, for:

2403.1. Psychologist (OCGA 43-39-1); or

2403.2. Physician (OCGA 43-34-20); or

2403.3. Physician Assistant (OCGA 43-34-21); or

2403.4. Advanced Practice or Registered Nurse (OCGA 43-26-3); or

2403.5. Social Worker or Professional Counselor (OCGA 43-10-A-1); or

2403.6. Physical Therapist (OCGA 43-33-1); or

2403.7. Occupational Therapist (OCGA 43-28-1); or

2403.8. Speech and Language Pathologist (OCGA 43-44-1).

2404. Special Eligibility Conditions

The need for NST services must be related to the individual 's disability.

2405. Prior Approval

NST services must be authorized prior to service delivery by the applicable DBHDD Field Office at least annually in conjunction with the ISP development and any ISP version changes.

2406. Covered Services

Reimbursable Natural Support Training Services include the following based on the assessed need of the individual.

2406.1. Individualized, direct training of families and natural support networks for acquisition or enhancement of their ability to support the waiver individual.

- 2406.2. Instruction about treatment regimens and other services included in the ISP.
- 2406.3. Training on the use of equipment.
- 2406.4. Updates in training required to maintain the individual safely at home.
- 2406.5. The costs of registration and training fees associated with formal instruction in areas relevant to the individual's needs due to his or her disability.

2407. Non-Covered Services

- 2407.1. Training paid caregivers.
- 2407.2. Services reimbursable by any other source.
- 2407.3. Costs of travel, meals and overnight lodging to attend a training event or conference.
- 2407.4. Services not related to the needs of the individual due to his or her disability.
- 2407.5. NST Services must not duplicate any family education or training provided through Adult Physical Therapy Services, Adult Occupational Therapy Services, Adult Speech and Language Therapy Services, or Behavioral Supports Consultation Services.
- 2407.6. NST Services may not occur simultaneously or on the same day as Professional Therapeutic Services or Behavioral Supports Consultation Services.
- 2407.7. Payment is not made for those goods and services covered by the State Medicaid Plan except where an individual's need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.

2408. Basis for Reimbursement

The reimbursement rate for Natural Support Services is found in Appendix A. NST Services include the costs of registration and training fees associated with formal instruction only in areas relevant to the individual's needs due to his or her disability and as identified in the Individual Service Plan.

2409. Participant-Direction Options

- 2409.1. Participants can choose the self-direction option with Natural Support Training Services.
- 2409.2. An individual serving as a representative for a waiver participant in self-directed services is not eligible to be a participant-directed provider of Natural Support Training Services.
- 2409.3. For details on participant-direction, see Part II Policies and Procedures for NOW and COMP, Chapter 1200.

Chapter 2500: Specific Program Requirements for Prevocational Services Scope of Services

2501. General

Prevocational Services prepare an individual for competitive integrated employment. For the purposes of this section, “competitive integrated employment” has the same meaning as defined by the United States Department of Labor. These services are for the individual not expected to be able to join the general work force within one year as documented in the Individual Service Plan. Individuals are paid in accordance with the requirements of Part 525 of the Fair Labor Standards Act. The individual’s compensation must be in accordance with the 2025 “Dignity and Pay Act” and O.C.G.A Sections 34-4-4 and 34-6A-4.

Prevocational Services occur in facility-based settings or at community sites outside the facility for small groups of individuals, called mobile crews, who travel from the facility to these community sites. Mobile crews receive Prevocational Services by performing tasks, such as cleaning or landscaping, at community sites other than the individual’s home or family home or any residential setting.

The emphasis of Prevocational Services is directed to habilitative rather than explicit employment objectives. These services include teaching individuals concepts necessary to perform effectively in a job in the community. Activities included in these services are directed at teaching concepts such as rule compliance, attendance, task completion, problem solving, endurance, work speed, work accuracy, increased attention span, motor skills, safety, and appropriate social skills.

The intended outcome of these services is to prepare the individual for competitive integrated employment through increased skills. Prevocational Services are individually planned to meet the individual’s needs for preparation for competitive integrated employment. These services are provided either facility-based or at community sites other than the individual’s home or family home or any other residential setting. If the individual is not interested in competitive integrated employment, their choice must be documented in the ISP.

Prevocational Services are provided to groups of individuals at a facility or to small groups of individuals who travel to sites outside the facility, referred to as mobile crews. The staff to individual ratio for facility-based Prevocational Services cannot exceed one (1) to ten (10). The staff to individual ratio for Mobile Crew Prevocational Services cannot exceed one (1) to six (6). Prevocational Services Providers offer (or arrange when needed) any of the standard services listed in section 2505 – Covered Services that are needed by the individuals served and specified in the individual Service Plans.

2502. Special Requirements of Participation

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and PART II, Chapter 600 Policies and Procedures for the NOW Program, Prevocational Services providers must meet the following requirements:

2502.1. Staffing Qualifications and Responsibilities

Provider agencies rendering Prevocational Services must have staffing that meets the following requirements:

- 2502.1.1. A designated agency director. Additional information regarding director qualifications can be found in DBHDD Policy Recruitment and Application to Become a Provider of Developmental Disability Services, 02-701.least two of these years serving in a supervisory capacity; or
- 2502.1.2. Duties of the Agency Director include, but are not limited to:
 - 2502.1.2.1. Oversees the day-to-day operation of the agency;
 - 2502.1.2.2. Manages the use of agency funds;
 - 2502.1.2.3. Ensures the development and updating of required policies of the agency;
 - 2502.1.2.4. Manages the employment of staff and professional contracts for the agency;
 - 2502.1.2.5. Designates another agency staff member to oversee the agency, in his or her absence.
- 2502.1.3. At least one agency employee or professional under contract with the agency must:
 - 2502.1.3.1. Be a Developmental Disability Professional (DDP) (for definition, see Part II Policies and Procedures for NOW, Chapter 1200);
 - 2502.1.3.2. Have responsibility for overseeing the delivery of Prevocational Services to individuals.
- 2502.1.4. The same individual may serve as both the agency director and the Developmental Disability Professional;
- 2502.1.5. A minimum of one (1) direct care staff member for every ten (10) individuals served in facility-based Prevocational Services and a minimum of one (1) direct care staff members for every six (6) individuals served in Prevocational Services provided as mobile crews;
- 2502.1.6. Direct Care Staff must:
 - 2502.1.6.1. Be 18 years or older;
 - 2502.1.6.2. Have a high school diploma or equivalent (General Educational Development or GED) or have a minimum score of 75 on the Test of Functional Health Literacy for Adults (TOFHLLA) or Short Test of Functional Health Literacy for Adults (STOFHLLA).

- 2502.1.6.3. Meet transportation requirement NOW Part II Chapter 900, Section 905 if transporting individuals.
- 2502.1.6.4. Be provided with a basic orientation prior to direct contact with individuals and show competence in:
 - 2502.1.6.4.1. The purpose and scope of Prevocational Services, including related policies and procedures;
 - 2502.1.6.4.2. Confidentiality of individual information, both written and spoken;
 - 2502.1.6.4.3. Rights and responsibilities of individuals;
 - 2502.1.6.4.4. Requirements for recognizing and reporting suspected abuse, neglect, or exploitation of any individual:
 - 2502.1.6.4.4.1. To the DBHDD;
 - 2502.1.6.4.4.2. Within the organization;
 - 2502.1.6.4.4.3. To appropriate regulatory or licensing agencies; and
 - 2502.1.6.4.4.4. To law enforcement agencies
- 2502.1.7. Duties of the Direct Care Staff include, but are not limited to:
 - 2502.1.7.1. Provides direct assistance in teaching such concepts as rule compliance, attendance, task completion, problem solving, endurance, work speed, work accuracy, increased attention span, motor skills, and safety to groups of individuals;
 - 2502.1.7.2. Provides direct assistance in training appropriate social interaction skills required in the workplace to groups of individuals;
 - 2502.1.7.3. Implements the behavioral support plans of individuals to reduce inappropriate and/or maladaptive behaviors and to acquire alternative adaptive skills and behaviors;
 - 2502.1.7.4. Provides individual-specific assistance, such as assistance with personal care and self-administration of

medications.

- 2502.1.8. The agency has adequate direct care staff with First Aid and CPR certifications to assure having at least one staff person with these certifications on duty during the provision of facility-based or mobile crew Prevocational Services.
- 2502.1.9. The type and number of all other staff associated with the organization (such as contract staff, consultants) are:
 - 2502.1.9.1. Properly trained or credentialed in the professional field as required;
 - 2502.1.9.2. Present in numbers to provide services and supports to individuals as required;
 - 2502.1.9.3. Experienced and competent in the services and support they provide.
- 2502.1.10. National criminal records check (NCIC) documentation for all employees and any volunteers who have direct care, treatment, or custodial responsibilities for individuals served by the agency.
- 2502.2. Agency Policies and Procedures - Each provider agency must develop written policies and procedures to govern the operations of Prevocational Services, which follow the Standards for the Georgia Department of Behavioral Health and Developmental Disabilities as stated in Part II Policies and Procedures for NOW.
- 2502.3. Documentation Requirement: Providers must document the following in the record of each individual receiving Prevocational Services:
 - 2502.3.1. Specific activity, training, or assistance provided;
 - 2502.3.2. Date and the beginning and ending time when the service was provided;
 - 2502.3.3. Location where the service was delivered;
 - 2502.3.4. Verification of service delivery, including first and last name and title (if applicable) of the person providing the service and his or her signature;
 - 2502.3.5. Progress towards moving the individual towards independence by meeting the individual ISP.
- 2502.4. Prevocational Services and Other Services in the Same Facility:
 - 2502.4.1. Providers rendering facility-based Prevocational Services and other services (e.g., Community Access Services and adult therapy services) can provide these services in the same facility; however, the services must be documented and billed separately, and any waiver individual receiving multiple services may not receive these services at the same

time of the same day.

- 2502.4.2. Providers may grant access to other Medicaid providers for the provision of services at the facility; however, the services must be documented and billed separately, and any waiver individual receiving multiple waiver services may not receive these services at the same time of the same day.
- 2502.5. Providers must meet the following requirements for staff-to-individual ratios:
 - 2502.5.1. Facility-Based Prevocational Services: a staff to individual ratio of one to two or more, not to exceed one (1) to ten (10).
 - 2502.5.2. Mobile Crew Prevocational Services: a staff to individual ratio of one to two or more, not to exceed one (1) to six (6).
 - 2502.5.3. The staff to individual ratio may be smaller than the upper limit indicated above; the actual ratio must be as indicated by the individualized needs of the individual.
- 2502.6. DBHDD Contract/LOA and DBHDD Community Service Standards: Providers must adhere to DBHDD Contract/LOA, DBHDD Community Service Standards and all other applicable DBHDD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DBHDD (see Part II Policies and Procedures for NOW, Chapter 603).
- 2502.7. Fair Labor Standards Act Requirements: Providers must adhere to the requirements of Part 525 of the Fair Labor Standards Act as follows:
 - 2502.7.1. Meet all requirements for time rates, piece rates, commensurate wages and fair business practices.
 - 2502.7.2. Maintain Department of Labor certificates appropriate to the program provided and/or the individual if sub minimum wage employment is provided.
 - 2502.7.3. Determine Special Minimum Wage as specified in the Fair Labor Standards Act.
- 2502.8. Prevocational Services are time-limited and must not exceed two (2) years. If the individual has received at least a year (12 months) of Prevocational Services justification must document the following assessment of necessity and adequacy of the continuation of Prevocational Services for the individual:
 - 2502.8.1. Consideration of the following by the support coordinator and interdisciplinary team developing the ISP:
 - 2502.8.1.1. Amount of time receiving Prevocational Services.
 - 2502.8.1.2. Progress on any or all Prevocational Services goal(s)
 - 2502.8.1.3. Interest of the individual in working in competitive

integrated employment.

- 2502.8.1.4. Any current or prior receipt of Supported Employment Services through the Georgia Vocational Rehabilitation Agency (GVRA) or DBHDD.
- 2502.8.1.5. Determination by the support coordinator and interdisciplinary team of continuance or discontinuance of Prevocational Services for the individual based on the above assessment.
- 2502.8.1.6. The provider of Prevocational Services for any individual for whom this section is applicable must maintain a copy of the required documentation in the individual's record.

2502.8.2. Physical Environment

Providers who render facility-based Prevocational Services must provide these services in a facility that meets the following requirements:

- 2502.8.2.1. Accessibility: Is accessible to and usable by participants and meets Americans with Disabilities Act (ADA) accessibility requirements for facilities.
- 2502.8.2.2. Building Construction and Maintenance: Is constructed, arranged, and maintained so as to provide adequately for health, safety, access, and wellbeing of the individual.
- 2502.8.2.3. Building Codes: Is in compliance with all local building codes and other applicable codes;
- 2502.8.2.4. Lighting: Provides adequate lighting for individuals' activities and safety;
- 2502.8.2.5. Ventilation: Is adequately ventilated at all times by either mechanical or natural means to provide fresh air and the control of unpleasant odors;
- 2502.8.2.6. Floor Space: Has adequate floor space to safely and comfortably accommodate the number of individuals for all activities and services provided in that space;
- 2502.8.2.7. Furnishings: Has sufficient furniture for use by individuals, which provide comfort and safety; are appropriate for population served, including any individuals with physical, visual, and mobility limitations; and provide adequate seating and table space for individual activities in the facility, including dining if applicable; Is accessible to and usable by individuals and meets Americans with Disabilities Act (ADA)

accessibility requirements for facilities.

- 2502.8.2.8. Environmental/Sanitation: Is in good repair and clean inside and outside of the facility, including being free from litter, extraneous materials, unsightly or injurious accumulations of items and free from pest and rodents;
- 2502.8.2.9. Temperature Conditions: Has an adequate central heating and cooling system or its equivalent at temperature ranges that are consistent with the individual health needs and comfort of individuals;
- 2502.8.2.10. Equipment Maintenance: Maintains all essential mechanical, electrical, and individual activity, care and support equipment in safe operating condition;
- 2502.8.2.11. Drinking Fountain: Must have drinking fountain(s) approved by the Georgia Department of Behavioral Health and Developmental Disabilities, Division of Public Health or provide access to single disposable cups to individuals, with individuals disposing of the used cups immediately after use;
- 2502.8.2.12. Restrooms: Has a minimum of at least two toilets and lavatories available, with accessibility for individuals with physical and mobility limitations, including installed grab bars;
- 2502.8.2.13. Individual Activities and Dining Space: Has one or more clean, orderly, and appropriate furnished rooms of adequate size designated for individual activities and, if applicable, dining. If the facility has a single room for individual activities and dining, the room provides sufficient space to accommodate both activities without interfering with each other.
- 2502.8.2.14. Medication Storage: Assures that medications are:
 - 2502.8.2.14.1. Stored under lock and key at all times. A staff member may keep medications needed for frequent or emergency use. The provider stores medications that require refrigeration in a locked container in the refrigerator;
 - 2502.8.2.14.2. Kept in original containers with original labels intact or in labeled bubble packs from a pharmacy;
 - 2502.8.2.14.3. Handled in accordance with current applicable State laws and regulations.

- 2502.8.2.15. Documentation of Self-Administration of Medications: The facility maintains documentation of all self-administration of medications supervised by facility staff. The documentation record must include the name of the medication, dosage, date, time, and name of the staff person who assists the individuals in the self-administration of medications by the individual.
- 2502.8.2.16. Evacuation Plan: The facility formulates a plan for evacuation of the building in case of fire or disaster. This plan is posted in a clearly visible place in each room. All employees are instructed and kept informed of their duties under the plan.
- 2502.8.2.17. Food Services: The following only apply if the facility stores, prepares, or distributes food:
- 2502.8.2.17.1. The facility observes and complies with all of the Rules of Georgia Department of Behavioral Health and Developmental Disabilities, Public Health, Chapter 290-5-14, Food Service and any local health ordinances when engaged in the storage, preparation, and distribution of food.
- 2502.8.2.17.2. Meals and snacks are prepared either on site or under subcontract with an outside vendor who agrees to comply with the food and nutritional requirements. The facility posts its current Food Service Permit and inspection report or the subcontracted vendor's current Food Service Permit and inspection report.
- Note. The Department will allow the facility to be exempted from the Food Service Permit requirement if all the facility does is use a microwave to heat up food participants bring to the facility. This exception is allowed only if:
- The microwave oven is clean, in good repair, and free of unsanitary conditions
- The microwave oven is allowed for warming of permitted foods and beverages based on the provider's internal policies and procedures.
- All food and utensils are handled in a

sanitary manner.

2502.8.2.17.3. The facility has a designated kitchen area for receiving food, facilities for warming or preparing cold food, and

2502.8.2.17.4. clean-up facilities including hot and cold running water. The facility provides palatable, nutritious and attractive meals and snacks that meet the nutritional requirements of each member.

2502.8.3. Transportation: The individual's family or representative may choose to transport the member to the Prevocational Services facility.

2502.8.4. Individual Site Enrollment: Part I Policies and Procedures for Medicaid/Peachcare for Kids require that each provider enroll at each location where services are provided to Medicaid members. Each individual, facility-based Prevocational Services site must be individually enrolled.

2503. Special Eligibility Conditions

- 2503.1. Prevocational Services are available only for individuals for whom the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Documentation is maintained in the file of each individual receiving Prevocational Services that these services are not available through any of these programs.
- 2503.2. Prevocational Services are for individuals not expected to be able to join the general work force within one year as documented in the Individual Service Plan.
- 2503.3. The need for Prevocational Services must be related to the individual disability and services must be therapeutic in nature.

2504. Prior Approval

Prevocational Services must be authorized prior to service delivery by the applicable DBHDD Field Office at least annually in conjunction with the Individual Service Plan (ISP) development and with any ISP version changes.

2505. Covered Services

Reimbursable Prevocational Services include the following based on the assessed need of the individual:

- 2505.1. Teaching such concepts as rule compliance, attendance, task completion, problem

solving, endurance, work speed, work accuracy, increased attention span, motor skills, and safety.

2505.2. Instruction in appropriate social interaction skills required in the workplace.

2505.3. Individual-specific assistance, such as assistance with personal care and self-administration of medications, as identified in the Individual Service Plan.

2505.4. Facility-based training and/or assistance.

2505.5. Mobile crews, which consist of a group of individuals who engage in prevocational services by performing tasks, such as cleaning or landscaping, at community sites at sites outside the facility.

2505.6. Transportation is required to and from the facility site (a reasonable amount of transportation, defined as up to one hour per day, is billable).

2506. Non-Covered Services

2506.1. Prevocational Services are distinct from and do not occur at the same time of day as Community Access or Supported Employment services.

2506.2. Services that are available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

2506.3. Medically related services that are not allowable by State law, rules, and regulations.

2506.4. Prevocational Services may not be delivered in an individual's own or family home or any residential site.

2506.5. Payment is not made, directly or indirectly, to members of the individual's immediate family, except as approved as indicated in Part II Policies and Procedures for NOW, Chapter 900.

2506.6. Payment is not made for those goods and services covered by the State Medicaid Plan except where an individual's need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.

2507. Basis for Reimbursement

2507.1. The reimbursement rate for Prevocational Services is found in Appendix A.

Transportation provided through these services is included in the cost of doing business and incorporated in the administrative overhead cost.

2508. Participant-Direction Options

2508.1. Prevocational Services are not eligible for any participant-direction option.

2508.2. For details on participant-direction, see Part II Policies and Procedures for NOW and COMP, Chapter 1200.

Chapter 2600: Specific Program Requirements for Respite Services Scope of Services

2601. General Description of Respite Services

Respite Services provide brief periods of support or relief for family or other unpaid caregivers of individuals with disabilities. Respite is provided in the following situations:

- 2601.1. When families or other unpaid caregivers are in need of support or relief in order to leave the home for periods during the day or overnight;
- 2601.2. When the individual needs relief or a break from the caregiver;
- 2601.3. When relief from caregiving is necessitated by unavoidable circumstances, such as a family emergency.

Planned respite provides brief periods of support or relief for caregivers or individuals. Respite Services might also be needed to respond to family emergency situations. Respite is intended to be a short term service for a individual who requires a period of structured support, or when respite services are necessitated by unavoidable circumstances, such as a family emergency. Respite may be provided as in-home support Provider agencies approved by DBHDD for in home respite (in the individual's home) and/or out-of-home (individual receives service outside of their home). Approved providers may deliver out of home respite services in a host home managed by a Community Residential Alternative provider or in a licensed Personal Care Home or Community Living Arrangement.

Respite services are provided in the following configurations which may be used interchangeably by family members responsive to need:

In-Home Respite-15-Minute Unit	1 Member
In-Home Respite-15-Minute Unit	2 Members
In-Home Respite-15-Minute Unit	3 Members
Out of Home Respite-15-Minute Unit	1 Member Only
Respite-Daily	Category 1
Respite-Daily	Category 2

2602. Special Requirements of Participation

- 2602.1. In-Home Respite Services Provider

- 2602.1.1. Licensure

Provider agencies that render In-home Respite Services must hold a current Private Home Care Provider License from the Department of Community Health, Healthcare Facilities Regulation Division (HFR). Licensure level must be commensurate with the level of service delivered:
personal care tasks; and/or companion or sitter tasks

Please refer to <https://dch.georgia.gov/divisionsoffices/hfrd/hfrd-laws-regulations> for information about specific licensure regulations.

For more information about provider enrollment, please refer to Part II, Chapters 600 – 1200, Policies and Procedures For Comprehensive Supports Waiver Program (Comp) and New Options Waiver Program (Now) General Manual.

2602.1.2. Supervision and Direct Support Staff Duties

2602.1.2.1. Supervision of Direct Support Staff

All agency providers must comply with staff supervision requirements as defined in Private Home Care licensure Rules.

2602.1.2.2. Duties of Direct Support Staff

Duties of direct support Respite staff include, but are not limited to:

2602.1.2.2.1. Provide direct assistance to the individual in self-help, socialization, and adaptive skills training, retention and improvement;

2602.1.2.2.2. Provide personal care and protective oversight and supervision;

2602.1.2.2.3. Implement the behavioral support plans of individuals to reduce inappropriate and/or maladaptive behaviors and to acquire alternative adaptive skills and behaviors;

2602.1.2.2.4. Provide assistance and training on independent community living skills, such as personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, and medication and money management.

2602.1.2.2.5. Provide assistance in completing

Outcomes and Goal(s) according to the current Individual Support Plan.

2602.1.2.3. Other Requirements

The agency has adequate direct care staff with First Aid and CPR certifications to assure having at least one staff person with these certifications on duty during the provision of services.

Respite services must be provided by an employee of the enrolled Respite provider agency, by an individual obtained through an employment agency or by a family-selected employee under the participant-directed model.

2602.2. Out-of-Home Respite Services Provider

Providers who render Respite Services outside the individual's own or family home must meet the following requirements:

2602.2.1. Provider Agencies of Out-of-Home Respite Services

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and Part II, Chapter 600 Policies and Procedures for the COMP Program, provider agencies who render out-of-home Respite Services must meet the following requirements:

2602.2.1.1. An agency Director-Additional information regarding director qualifications can be found in DBHDD Policy Recruitment and Application to Become a Provider of Developmental Disability Services, 02-701.

DDP-At least one agency employee or professional under contract with the agency must:
Be a Developmental Disability Professional (DDP) (for definition, see Part II Policies and Procedures for NOW and COMP, Chapter 1200);

2602.2.2. Licensure and Delivery Settings

<u>Setting</u>	<u>License Required</u>	<u>Citation Source</u>
Community Living Arrangement	yes	https://dbhdd.georgia.gov/be-connected/licensure-information
Child Placing Agency	yes	https://dhs.georgia.gov/child-placing-agencies-cpa
Host Home	no	* N/A
Personal Care Home	yes	https://dch.georgia.gov/divisionsoffices/hfrd/hfrd-laws-regulations

Community Living Arrangement: provider-operated residence with license capacity approval of four or fewer residents.

Child Placing Agency: provider-operated residence licensed for residential support of all waiver individuals under age 19.

Host Home/Life Sharing Site: private residence in which the occupant owner or lessee provides residential services to one or two persons.

* Refer to DBHDD policy 02-704 Process for Enrolling, Matching, and Monitoring Host Home/Life-Sharing Sites for DBHDD Developmental Disability Community Service Providers

2602.2.3. Supervision and Direct Support Staff Duties

2602.2.3.1. Supervision of Direct Support Staff

Respite providers delivering out-of-home services must comply with staff supervision and training requirements as defined in licensure Rules and DBHDD policy for Host Home/Life Sharing Sites.

Enrolled Respite provider agencies provide nursing consultation and oversight through direct employment status or through contracted nursing services. Consultative nursing provides support to direct care staff and managers on an as needed basis and is available to respite staff to assist with healthcare decisions, training direct care staff, and communication with physicians and other healthcare providers.

Consultative nursing does not replace direct nursing services if required to treat, evaluate or monitor specific conditions. Policies and Procedures for Nursing Services directly reimbursed through the COMP Waiver Program are outlined in Part III Policies and Procedures for Comprehensive Supports Waivers Program.

2602.2.3.2. Direct Care Staff

Duties of the Direct Care Staff include, but are not limited to:

- 2602.2.3.2.1. Providing individual-specific assistance and training in activities of daily living, such as bathing, dressing, grooming, other personal hygiene, feeding, toileting, transferring, and other similar tasks;

- 2602.2.3.2.2. Accompanying individuals and facilitating participation in visits for medical care and other community activities if needed;
 - 2602.2.3.2.3. Assistance in household care, such as meal preparation, clothes laundering, bed-making, housecleaning, shopping, and other similar tasks;
 - 2602.2.3.2.4. Assisting with therapeutic exercises, supervising self-administration of medication and performing health maintenance activities;
 - 2602.2.3.2.5. Implementing positive behavioral support plans of individuals to reduce inappropriate and/or maladaptive behaviors and to acquire alternative adaptive skills and behaviors.
- 2602.2.3.3. Other Requirements
- In respite service settings, at least one staff trained in Basic Cardiac Life Support (BCLS) and first aid is on duty at all times on each shift
- Providers must comply with DBHDD Policy 04-104 relative to Criminal History Records Checks as well as all criminal background checks required by the applicable licensure Rules.
- 2602.2.4. Overnight Respite Home Site Inspections: With the exception of providers of participant-directed services, individual providers who render out-of-home, Overnight Respite Services must meet the following requirements:
- 2602.2.5. Initial Site Inspection: Designated DBHDD Field Office staff conduct the initial inspection for the above Physical Standards requirements of private residences of an individual provider prior to the rendering of Overnight Respite Services and send approval documentation to the DBHDD Regional Coordinator or designee.
- 2602.2.6. Re-Inspections of Site: CRA providers who deliver out-of-home Respite Services must re-inspect semiannually the host home site for the standards requirements, document the meeting of these requirements, and make available documentation for review by Support Coordinators, and DBHDD and DCH staff.
- 2602.2.7. DBHDD Contract/LOA and DBHDD Community Service Standards:

Agency providers must adhere to DBHDD Contract/LOA, DBHDD Community Service Standards and all other applicable DBHDD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DBHDD (see Part II Policies and Procedures for COMP, Chapter 600, Section 603).

2603. Special Eligibility Conditions

Waiver individual lives with and receives support from unpaid caregivers.

The need for Respite services must be reflected through assessed needs described as tasks or activities in the approved Individual Support Plan (ISP).

2604. Prior Approval

Respite Services must be authorized prior to service delivery by the applicable DBHDD Field Office at least annually in conjunction with reevaluation of need, development of the initial and annual Individual Support Plan and with any ISP version changes completed based upon a change in condition or circumstances.

2605. Covered Services

Reimbursable Respite Services include the following based on the assessed need of the individual:

- 2605.1. Planned or scheduled respite that provides brief periods of support or relief for caregivers or individuals (1) when families or the usual caregivers are in need of additional support or relief; or (2) when the individual needs relief or a break from the caregiver.
- 2605.2. Short-term Respite that provides a period of structured support for a individual due to unavoidable circumstances, such as a family emergency.
- 2605.3. Respite Services are short-term services during a day or overnight that include but are not limited to:
 - 2605.3.1. Individual-specific assistance, such as assistance with activities of daily living, self-administration of medications, and health maintenance activities, personal care and protective oversight.
 - 2605.3.2. Direct assistance including transportation as needed to facilitate individuals' routine engagement in community social, recreational and leisure activities during absence from the family or natural home;
 - 2605.3.3. Implementation of the behavioral support plans of individuals to reduce inappropriate and/or maladaptive behaviors and to acquire alternative adaptive skills and behaviors;

2606. Non-Covered Services

- 2606.1. Services delivered in a personal care home or community living arrangement serving more than four individuals.
- 2606.2. Services provided in hospitals, ICF/ID facilities, assisted living facilities, and nursing homes.
- 2606.3. Services that duplicate or are provided at the same time of the same day as Community Living Support, Community Access or Supported Employment services.
- 2606.4. In-home Respite Services may not be delivered in foster homes, host homes, personal care homes, community living arrangements, or any other home/residence other than the individual's family home;
- 2606.5. Payment is not made, directly or indirectly, to members of the individual's immediate family.
- 2606.6. Medically related services that are not allowable by State law, rules, and regulations except health maintenance activities provided as defined in the Rules and Regulations for Proxy Caregivers Used in Licensed Healthcare Facilities, Chapter 111-8-100.
- 2606.7. Payment is not made for those goods and services covered by the State Medicaid Plan except where an individual's need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.

2607. Documentation

- 2607.1. Documentation of In-home Respite services must include the following elements in the record of each individual:
 - 2607.1.1. Specific activity, training, or assistance provided;
 - 2607.1.2. Date and the beginning and ending time of day(s) when the service was delivered;
 - 2607.1.3. Verification of service delivery, including first and last name and title (if applicable) of the person providing the service and his or her signature;
 - 2607.1.4. Supervisory note documenting licensure-level required supervision of the direct support personnel;
 - 2607.1.5. Progress in moving the individual towards his or her goal(s) and supporting the family. Relevant sections of the ISP include: person-centered goal(s) and desired outcomes in the individual's action plan, the amount/type of assistance/support in the ISP.

2608. Basis for Reimbursement

Reimbursement rates for Respite services are found in Appendix A.

For out-of-home Respite billed on a daily basis, there are two rate categories based on an

individual's assessed needs.

For out-of-home Respite billed on a daily basis, there are two rate categories based on an individual's assessed needs as shown below:

Levels 1 through 4 = Rate Category 1

Level 5 through 7 = Rate Category 2

2609. Participant-Direction Options

- 2609.1. Participants can choose the self-direction option with Respite Services.
- 2609.2. An individual serving as a representative for a waiver participant in self-directed services is not eligible to be a participant-directed provider of Respite Services.
- 2609.3. For details on participant-direction, see Part II Policies and Procedures for COMP, Chapter 1200.

Chapter 2700 : Specific Program Requirements for Specialized Medical Equipment Services Scope of Services

2701. General

Specialized Medical Equipment (SME) Services include various devices, controls or appliances which are designed to enable individuals to interact more independently with their environment thus enhancing their quality of life and reducing their dependence on physical support from others. SME services also include assessment or training needed to assist individuals with mobility, seating, bathing transferring, security or other skills such as operating a wheelchair, locks, door openers, or side lyers. These services additionally consist of customizing a device to meet an individual's needs. The NOW is intended for those goods and services that are not covered by the State Medicaid Plan or those instances in which an individual's needs exceed State Plan coverage limits and exceptions to the coverage limits are not available.

The NOW is the payer of last resource for items that are covered through the Durable Medical Equipment (DME), Orthotics and Prosthetics, and Hearing Services programs and other Medicaid State Plan programs. All items covered through these programs must be requested through the respective programs. Specialized Medical Equipment services must be documented to be the payer of last resource. The DME program prior approval process is used to determine medical necessity for medical equipment. The NOW does not cover items that have been denied through the DME and other programs for lack of medical necessity.

Providers for Specialized Medical Equipment should refer to Part II, Policies and Procedures for Durable Medical Equipment, Part II, Policies and Procedures for Orthotics and Prosthetics and Part III, Hearing Services for additional information about coverage of these services.

2702. Special Requirements of Participation

2702.1. Individual Vendor or Dealer

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and Part II, Chapter 600 Policies and Procedures for the NOW Program, individual vendors and dealers in Specialized Medical Equipment must meet the following requirements:

2702.1.1. Documentation Requirement: Documentation of administration costs for SME services delivery, that delineates lines item sources of cost; billing of associated administration cost cannot exceed eight of ten (8 to 10) percent of original billing for SME services. Providers, except for providers of participant-directed services, must document the following in the record of each individual receiving SME services:

2702.1.1.1. The efforts to substantiate payer of last resource, including available community, State Plan, or other resources by the individual's support coordinator.

2702.1.1.2. State Plan denial of coverage documentation received by

the DME Program.

- 2702.1.1.3. Verification of SME service delivery, including date, location, and specific equipment and assessment, training, customizing, or special circumstances repair of equipment provided.

- 2702.1.2. Participant-Directed Services Documentation and other Requirements: Documentation and other requirements for individual providers of participant-directed services are specified in Part II Policies and Procedures for NOW, Chapter 1200.

2702.2. Provider Agencies

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and Part II, Chapter 600 Policies and Procedures for the NOW Program, Specialized Medical Equipment Services provider agencies must meet the following requirements:

- 2702.2.1. Documentation Requirement: Documentation of providers, except for providers of participant-directed services, must document the following in the record of each individual receiving SME services:
 - 2702.2.1.1. The efforts to substantiate payer of last resource, including available community, State Plan, or other resources by the individual's support coordinator.
 - 2702.2.1.2. State Plan denial of coverage received by the DME Program.
 - 2702.2.1.3. Verification of SME service delivery, including date, location, and specific equipment and assessment, training, customizing, or special circumstances repair of equipment provided. Documentation of associated administration costs for SME service delivery that delineates line item sources of costs; billing of associated administration costs cannot exceed eight of ten (8 to ten) percent of any billing for SME services.
- 2702.2.2. Participant-Directed Services Documentation and other Requirements: Documentation and other requirements for individual providers of participant-directed services are specified in Part II Policies and Procedures for NOW, Chapter 1200.
- 2702.2.3. DBHDD Contract/LOA and MHDDD Community Service Standards: Providers must adhere to DBHDD Contract Standards, DBHDD Core Requirements for All Providers and all other applicable DBHDD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DBHDD (see Part II Policies and Procedures for NOW, Chapter 603).

2703. Licensure

Specialized Medical Equipment vendors must hold the applicable Georgia business license as required by the local, city or county government in which the services are provided.

2704. Special Eligibility Conditions

- 2704.1. The need for SME services must be related to the individual disability and specified in the Intake and Evaluation Team approved Individual Service Plan (ISP).
- 2704.2. Medical necessity for SME services must be documented through an order by a Georgia licensed physician.

2705. Prior Approval

- 2705.1. Individual receives recommendation in writing from physician stating a need for SME
- 2705.2. Individual takes recommendation in writing to a DME vendor.
 - 2705.2.1. Support Coordination may assist with locating/accessing an appropriate DME vendor.
- 2705.3. DME vendor submits a prior approval request to the Department of Community Health using the prior approval process outlined in the policy manual for Durable Medical Equipment, Section 803, found on the web portal at www.mmis.georgia.gov
- 2705.4. The Department's contractor approves or denies prior approval based on medical necessity criteria and notifies DME through electronic format of determination.
 - 2705.4.1. If there is not enough information to make the determination, the Department's contractor will request additional documentation from the appropriate party.
 - 2705.4.2. If approved as a State Plan Service, the DME vendor then submits a claim and provides the medically necessary equipment to the individual.
 - 2705.4.3. If denied for not meeting medical necessity criteria, the waiver will not pay for the SME.
 - 2705.4.4. If denied for reasons other than medical necessity criteria, the waiver will pay for the SME. Some DME items are allowable but only through the prior approval process described in Chapter 800 of the DME Program Policy Manual. (Section 802 of this chapter reviews which items require prior approval. The following sections of the chapter describe the procedures for obtaining prior approval. Denial of prior approval for these items allows for billing to the waiver).
 - 2705.4.5. If the DME vendor is unable to submit a prior authorization or obtain a denial because the medically necessary item is not a State Plan covered item, the provider maintains in the individual record a copy of the DME

Policy Manual Section 902, 903, 904, or 905, substantiating the item as non-covered. This documentation will be accepted in lieu of a formal denial for the equipment. With this documentation, the item can be purchased through the waiver

- 2705.5. If the waiver will pay for the SME, the SME services must be authorized prior to service delivery by the applicable DBHDD Field Office agency at least annually in conjunction with the Individual Service Plan development and with any ISP revision.

2706. Covered Services

Reimbursable SME services include the following based on the assessed need of the individual:

- 2706.1. Purchase of equipment or the lease of equipment when cost effective.
- 2706.2. Devices, controls or appliances specified in the Individual Service Plan, which enable individuals to increase their abilities to perform activities of daily living and to interact more independently with their environment, including costs of assessment or training needed to assist individuals with use of devices, controls, or appliances, such as operating a wheelchair, locks, door openers, or side lyers.
- 2706.3. Applications, scanning communicators, speech amplifiers, control switches, electronic control units, wheelchairs, locks, door openers, or side lyers.
- 2706.4. Customizing a device to meet an individual's needs.
- 2706.5. Replacement or repair of equipment is covered in cases of special circumstances (e.g., from fire), normal wear and tear, or when the individual's condition changes.

2707. Non-Covered Services

- 2707.1. Equipment that has been denied through the DME and other programs for lack of medical necessity.
- 2707.2. Equipment covered under the Durable Medical Equipment (DME), Orthotics and Prosthetics, and Hearing Services programs and other Medicaid non-waiver programs.
- 2707.3. Environmental control equipment (e.g., air conditioners, dehumidifiers, air filters or purifiers).
- 2707.4. Comfort or convenience equipment (e.g., vibrating beds, over-the-bed trays, chair lifts).
- 2707.5. Institutional-type equipment (e.g., cardiac or breathing monitors).
- 2707.6. Equipment designed specifically for use by a physician and trained medical personnel (e.g., EKG monitor, oscillating bed and laboratory testing equipment).
- 2707.7. Physical fitness equipment (e.g., exercise cycle, exercise treadmill).
- 2707.8. Furnishing-type equipment (e.g., infant cribs).
- 2707.9. Home security items, (e.g., alarm systems, burglar bars, security cameras, personal

- emergency response systems and deadbolt locks).
- 2707.10. Elevators, chair lifts, and indoor ceiling lift systems.
 - 2707.11. Equipment considered experimental or under investigation by the Public Health Service.
 - 2707.12. Equipment associated with experimental medical practices or treatments.
 - 2707.13. Infant and child car seats.
 - 2707.14. Blood pressure monitors and weight scales.
 - 2707.15. iPads, Computers, such as desktop and personal computers.
 - 2707.16. Cell phones and minutes.
 - 2707.17. Hot tubs, spas, and whirlpool tubs.
 - 2707.18. Items that add value to a property, such as a fence.
 - 2707.19. Equipment commonly used for recreational purposes, including but not limited to bicycles, trampolines, swimming pools, swing sets, slides, stereos, radios, televisions, and MP3 players.
 - 2707.20. Equipment for education and related services by children for whom the Department of Education has primary responsibility (i.e., private schools, ABA in school, home-schooling, tutors).
 - 2707.21. Equipment replacement or repair that is necessitated by individual neglect, wrongful disposition, intentional misuse or abuse. Equipment will not be replaced due to the individual's negligence and/or abuse (e.g., a wheelchair left outside). Equipment will not be replaced before its normal life expectancy has been attained unless supporting medical documentation of change in the physical or developmental condition of the individual.
 - 2707.22. Extended warranties and/or maintenance agreement.
 - 2707.23. Payment is not made, directly or indirectly, to members of the individual's immediate family, except as approved as indicated in Chapter 900.
 - 2707.24. Payment is not made for those goods and services covered by the State Medicaid Plan except where an individual's need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.

2708. Basis for Reimbursement

The reimbursement rate for the purchase, replacement or repair for Specialized Medical Equipment is the established Medicaid rate, or in the absence of a Medicaid rate, the lower of three price quotes or the annual maximum. Price quotes are not required for purchases, replacements, or repairs under \$200.00. The reimbursement rate is inclusive of equipment and any necessary technical assistance in its usage. The reimbursement rates for all specialized services are found in Appendix A.

2709. Participant-Direction Options

- 2709.1. Participants may choose the self-direction option with Specialized Medical Equipment Services.
- 2709.2. If the participant (or representative, if applicable) opts for participant direction of SME services, then this equipment will be purchased through participant-directed service delivery.
- 2709.3. For details on participant-direction, see Part II Policies and Procedures for NOW and COMP, Chapter 1200.

Chapter 2800: Specific Program Requirements for Specialized Medical Supplies Services Scope of Services

2801. General

Specialized Medical Supplies (SMS) Services include various supplies that enable individuals to interact more independently with their environment and contribute to an enhanced quality of life, as well as a reduced dependence on physical support from others. SMS includes items such as food supplements, special clothing, diapers, bed wetting protective chucks, and other supplies that are specified in the approved Individual Service Plan and are not available under the other Medicaid non-waiver programs. Ancillary supplies necessary for the proper functioning of approved devices are also included in this service. The NOW is intended for those goods and services that are not covered by the other Medicaid programs or those instances in which an individual's needs exceed coverage limits in the other Medicaid programs and exceptions to the coverage limits are not available.

Medical supplies can be obtained through the waiver if the supplies needed are not offered through the Durable Medical Equipment (DME) program (e.g. diapers and formula for individual 21 or older). When the medical supplies are not covered by the DME program it is not necessary to first submit a request to the DME program before requesting SMS.

The NOW Waiver Program is the payer of last resort for items that are covered through the Durable Medical Equipment (DME), Orthotics and Prosthetics (O&P), and Hearing Services programs and other Medicaid non-waiver programs. All items covered through Medicaid non-waiver programs (e.g. dental, DME services, etc.) must be requested through the respective programs, Medicare or private insurance where eligible and coverable. DME and other specialized medical supplies services require prior approval through the related Medicaid Program. If the specialized medical supplies services are non-covered through the related Medicaid Program, the services being requested through the NOW must be supported by:

- 2801.1. Documentation of COMP as payor of last resort as evidenced by:
- 2801.2. Documented phone calls to DME vendors to determine coverage through other healthcare funding sources
- 2801.3. Documented review of the DME policy manual found at <https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx>
- 2801.4. Documentation that service coverage has been exhausted in the other potential healthcare funding sources including State Plan Medicaid.
- 2801.5. The need for the services is documented through clinical evaluation.

The NOW does not cover items that have been denied through the DME or other Medicaid programs for lack of medical necessity. Supplies requested through the State DME program must comply with the guidelines outlined in Chapter 700 & 900 of Part II Policies and Procedures of Durable Medical Equipment.

For specific benefit coverage and limitations, providers of DME or other specialized medical supplies and services should refer to Part II, Policies and Procedures for Durable Medical Equipment (DME), Part II, Policies and Procedures for Orthotics and Prosthetics (O&P) and Part III, Hearing

Services found at

<https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx>.

Note: Pursuant to 42 CFR 440.70(b)(3)(i), “Supplies are health care related items that are consumable or disposable, or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness, or injury.”

2802. Special Requirements of Participation

2802.1. Individual Vendor or Dealer

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and Part II, Chapter 600 Policies and Procedures for the NOW Program, individual vendors and dealers in Specialized Medical Supplies must meet the following requirements:

2802.1.1. Documentation Requirement: Providers must document the following in the record of each individual receiving SMS services:

2802.1.1.1. The efforts to substantiate payer of last resource, including available community, State Plan, or other resources by the individual’s support coordinator.

2802.1.1.2. State Plan non-coverage of a particular item or items as evidenced by:

2802.1.1.2.1. Documented phone calls to DME vendors to determine coverage through other healthcare funding sources

2802.1.1.2.2. Documented review of the DME policy manual found at <https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx>

The following items do not require State Plan denial of coverage documentation for adults over age 21:

2802.1.1.2.2.1. Diapers

2802.1.1.2.2.2. Chucks (used to line the bed for incontinent people)

2802.1.1.2.2.3. Diaper wipes

- 2802.1.1.2.2.4. Nutritional supplements for adults
- 2802.1.1.2.2.5. Medication not covered by Medicaid
- 2802.1.1.2.2.6. Hearing aides
- 2802.1.1.2.2.7. Eye glasses
- 2802.1.1.2.2.8. Condom catheters
- 2802.1.1.2.2.9. Bibs
- 2802.1.1.2.2.10. Med Cups
- 2802.1.1.3. Verification of SMS service delivery, including date, location, and specific supplies provided.
- 2802.1.1.4. Documentation of associated administration costs for SMS service delivery that delineates line item sources of costs; billing of associated administration costs cannot exceed eight to ten (8 to 10) percent of the cost of Specialized Medical Supplies.
- 2802.1.2. Participant-Directed Services Documentation and other Requirements: Documentation and other requirements for individual providers of participant-directed services are specified in Part II Policies and Procedures for NOW, Chapter 1200.
- 2802.1.3. Transfer of Specialized Medical Supplies with Transition to New Provider: Specialized Medical Supplies billed for a individual must transfer with the individual when the individual transitions to a new waiver provider (e.g., SMS purchased in bulk for the individual for the entire quarter or year). This transfer of SMS includes all Specialized Medical Supplies billed for the individual but not yet provided to or used by the individual.
- 2802.2. Provider Agencies

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and Part II, Chapter 600 Policies and Procedures for the NOW Program, Specialized Medical Supplies Services provider agencies must meet the following requirements:

 - 2802.2.1. Documentation Requirement: Providers must document the following in the record of each individual receiving SMS services:
 - 2802.2.1.1. The efforts to substantiate payer of last resource, including available community, State Plan, or other

resources by the Individual's support coordinator.

2802.2.1.2. State Plan non-coverage of a particular item or items as evidenced by:

2802.2.1.2.1. Documented phone calls to DME vendors to determine coverage through other healthcare funding sources

2802.2.1.2.2. Documented review of the DME policy manual found at
<https://www.mmis.georgia.gov/portal/PublicAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx>

The following items do not require State Plan denial of coverage documentation for adults over age 21:

2802.2.1.2.2.1. Diapers

2802.2.1.2.2.2. Chucks (used to line the bed for incontinent people)

2802.2.1.2.2.3. Diaper wipes

2802.2.1.2.2.4. Nutritional supplements for adults

2802.2.1.2.2.5. Medication not covered by Medicaid

2802.2.1.2.2.6. Hearing aides

2802.2.1.2.2.7. Eye glasses

2802.2.1.2.2.8. Condom catheters

2802.2.1.2.2.9. Bibs

2802.2.1.2.2.10. Med Cups

2802.2.1.3. Verification of SMS service delivery, including date, location, and specific supplies provided.

2802.2.1.4. Documentation of associated administration costs for SMS service delivery that delineates line item sources of costs; billing of associated administration costs cannot exceed eight to ten (8 to 10) percent of the cost of Specialized Medical Supplies.

- 2802.2.2. Participant-Directed Services Documentation and other Requirements: Documentation and other requirements for individual providers of participant-directed services are specified in Part II Policies and Procedures for NOW, Chapter 900.
- 2802.2.3. DBHDD Contract/LOA and MHDDD Community Service Standards: Providers must adhere to DBHDD Contract Standards, DBHDD Core Requirements for All Providers and all other applicable DBHDD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DBHDD (see Part II Policies and Procedures for NOW, Chapter 603).
- 2802.2.4. Transfer of Specialized Medical Supplies with Transition to New Provider: Specialized Medical Supplies billed for a individual must transfer with the individual when the individual transitions to a new waiver provider (e.g., SMS purchased in bulk for the individual for the entire quarter or year). This transfer of SMS includes all Specialized Medical Supplies billed for the individual but not yet provided to or used by the individual.

2803. Licensure

Specialized Medical Supplies vendors must hold the applicable Georgia business license as required by the local, city or county government in which the services are provided.

2804. Special Eligibility Conditions

- 2804.1. The need for SMS services must be related to the individual's disability and verified through clinical evaluation.
- 2804.2. Medical necessity for SMS services must be documented through an order by a Georgia licensed physician, except for incontinent supplies which are approved by the Clinical Reviewer Nurse in the review of the ISP. Pharmacy generated confirmation of prescriptions is an acceptable practice.

2805. Prior Approval

- 2805.1. Individual receives recommendation in writing from physician stating a need for SMS, except for incontinent supplies which are approved by the Clinical Reviewer Nurse in the review of the ISP and related documentation.
- 2805.2. SMS provider attempts to procure the items through a DME vendor through all available healthcare coverage sources including but not limited to: private insurance, Medicare, and/or State Plan Medicaid.

Note: Representatives/individuals self-directing SMS are required to attempt to access SMS items through a DME vendor using all available healthcare coverage sources including but not limited to: private insurance, Medicare, and/or State Plan Medicaid.

- 2805.2.1. Support Coordination will assist with locating/accessing an appropriate

DME vendor

- 2805.3. DME vendor provides the item/items through authorization and reimbursement through a non-waiver fund source, or verifies that the item/items are not reimbursed through any other healthcare fund source.
- 2805.3.1. Items covered by State Plan Medicaid are processed as outlined in the policy manual for Durable Medical Equipment, Section 803, found on the web portal at www.mmis.georgia.gov.
- 2805.4. The DME vendor may be required to seek additional information for prior approval such as clear physician orders or other medical necessity documentation.
- 2805.4.1. If denied for not meeting medical necessity criteria, the waiver will not pay for the SMS.
- 2805.4.2. If denied for reasons other than medical necessity criteria, the waiver will authorize the item(s) under SMS.
- 2805.4.3. If the DME vendor is unable to submit a prior authorization or obtain a denial because the medically necessary item is not a State Plan covered item, the provider maintains in the individual record a copy of the DME Policy Manual Section 902, 903, 904, or 905, substantiating the item as non-covered. This documentation will be accepted in lieu of the formal denial for the supplies. With this documentation, the item can be purchased through SMS waiver funds.
- 2805.5. SMS services must be authorized prior to service delivery by the applicable DBHDD Field Office agency at least annually in conjunction with the Individual Service Plan development and with any ISP revision. A current prescription, including a pharmacy generated prescription, is an acceptable form of documentation. The date of the prescription does not have to align with the date of the ISP.

NOTE: Prior approval through the DME Program will not be required for items listed above in 2801.1b and 2802.1 (1b).

The following items do not require State Plan denial of coverage documentation:

- 2805.5.1. Diapers
- 2805.5.2. Chucks (used to line the bed for incontinent people)
- 2805.5.3. Diaper wipes
- 2805.5.4. Nutritional supplements for adults
- 2805.5.5. Medication not covered by Medicaid
- 2805.5.6. Hearing aides
- 2805.5.7. Eye glasses

2805.5.8. Condom catheters

2805.5.9. Bibs

2805.5.10. Med Cups

2806. Covered Services

Reimbursable SMS services include the following based on the assessed need of the individual:

- 2806.1. Specialized Medical Supplies are various supplies, which enable individuals to interact more independently with their environment thus enhancing their quality of life and reducing their dependence on physical support from others.
- 2806.2. Nutritional supplements, such as Ensure, Isomil, and Boost, for individuals 21 years of age or older.
- 2806.3. Nutritional supplements, such as Ensure, Isomil, and Boost, for individuals under the age of 21 years only if insurance benefits and/or State Plan coverage is exhausted.
- 2806.4. Special clothing, such as specially designed vests to assist with wheelchair transfers and re-positioning, adaptive clothing for individuals with limited mobility, clothing designed with G-tube access openings, and other easy access clothing specifically designed for individuals with disabilities.
- 2806.5. Diapers, bed wetting protective chucks, and other continence supplies.
- 2806.6. Other supplies with documented medical necessity that are related to the individual's disability, such as supplies for ongoing medical or nursing care of the individual.
- 2806.7. Ancillary supplies necessary for the proper functioning of approved devices are also included in this service.
- 2806.8. Infection control supplies, such as non-sterile gloves, aprons, masks and gowns, when services are provided by an individual. Supplies used by agencies are customarily included in the agency's reimbursement rate for services. However, when supplies are required in quantity, for recurring need and are included in the ISP for a specific individual, these supplies would be considered as a separate billable item under this program. Supplies that are considered as separate billable items must meet the following criteria:
 - 2806.8.1. The supply is directly identifiable to an individual.
 - 2806.8.2. The item furnished at the direction of the individual's physician and is specifically identified in the ISP and only used by that Individual.
- 2806.9. Over-the-counter (OTC) medications when prescribed by a physician and related to a diagnosed condition.
- 2806.10. Medications not covered by the Medicaid State Plan when written documentation from the pharmacy for non-coverage of the medication through the State Medicaid Plan is in

the individual's record.

2807. Non-Covered Services

- 2807.1. Items covered under the Durable Medical Equipment (DME), Orthotics and Prosthetics, and Hearing Services programs and other Medicaid non-waiver programs.
- 2807.2. Items that have been denied through the DME and other programs for lack of medical necessity.
- 2807.3. Environmental control items (e.g., air conditioners, dehumidifiers, air filters or purifiers).
- 2807.4. Comfort or convenience items.
- 2807.5. Physical fitness items (e.g., exercise cycle, exercise treadmill).
- 2807.6. Supplies considered experimental.
- 2807.7. Experimental medicines, practices, or treatments.
- 2807.8. Infant and child car seats.
- 2807.9. Blood pressure monitors and weight scales.
- 2807.10. Computer supplies (printers, cartridges, speakers and other supplies).
- 2807.11. Cell phones and minutes.
- 2807.12. Ancillary supplies for the proper functioning of non-approved devices or equipment.
- 2807.13. Supplies for education and related services by children for whom the Department of Education has primary responsibility (i.e., private schools, ABA in school, home-schooling, tutors).
- 2807.14. Vitamins, herbal supplement, nutritional oils, and other non-nutritional supplements are not covered except when prescribed by a physician and related to a diagnosed condition.
- 2807.15. Payment is not made, directly or indirectly, to members of the individual's immediate family, except as approved as indicated in Part II Policies and Procedures for NOW, Chapter 900.
- 2807.16. Payment is not made for those goods and services covered by the State Medicaid Plan except where an individual's need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.
- 2807.17. Medications covered by the Medicaid State Plan are not allowed.
- 2807.18. Co-pays for medications.
- 2807.19. Bicycles, trampolines, swimming pools, swing sets, slides, stereos, radios, televisions,

and MP3 players.

2808. Basis for Reimbursement

Reimbursement rate for Specialized Medical Supplies is individual specific up to the annual maximum. The reimbursement rates for all specialized services are found in Appendix A.

2809. Participant-Direction Options

2809.1. Participants may choose the self-direction option with Specialized Medical Supplies Services.

2809.2. If the participant (or representative, if applicable) opts for participant direction of SMS services, then these supplies will be purchased through participant-directed service delivery.

For details on participant-direction, see Part II Policies and Procedures for NOW, Chapter 1200.

Chapter 2900

Now found in PART III POLICIES AND PROCEDURES FOR SUPPORT COORDINATION SERVICES AND INTENSIVE SUPPORT COORDINATION SERVICES (COMP & NOW) Waiver Programs

Chapter 3000: Specific Program Requirements for Supported Employment Services Scope of Services

3001. General

Supported Employment services are ongoing supports that enable individuals, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. Supported Employment services are conducted in a variety of settings, particularly work sites where persons without disabilities are employed. The scope and intensity of Supported Employment supports may change over time, based on the needs of the individual. Supported Employment services are conducted in a variety of settings, particularly work sites where persons without disabilities are employed. Individuals who receive Supported Employment services must require long-term, direct or indirect job-related support in job supervision, adapting equipment, adapting behaviors, transportation assistance, peer support, and/or personal care assistance during the work day.

Supported Employment has four distinct categories: Job Maintenance, Individual Job Coaching, Individual Job Development, and Group.

Supported Employment Job Maintenance services consist of activities needed to sustain paid work by individuals, including supervision, training, and services and supports that assist individuals in achieving self-employment through the operation of a business, including helping the individual, identifying the supports that are necessary for the individual to operate a business, and ongoing assistance, counseling and guidance once the business has been launched. These services do not include the supervisory activities rendered as a normal part of the business setting. Individuals authorized for Job Maintenance activities typically require occasional support and generally do not need support for every hour they work. To be authorized for Job Maintenance, an individual must work at least 60 hours per month.

Supported Employment Individual Job Coaching services consist of activities needed to sustain paid work by individuals, including supervision, training, and services and supports that assist individuals to advance in their careers or achieve self-employment through the operation of a business. This service is distinguished from Job Maintenance in that individuals authorized for Job Coaching typically require more direct, face-to-face support on an ongoing basis.

The planned outcomes of these services are to increase the hours worked by each individual toward the goal of forty hours per week and to increase the wages of each individual toward the goal of increased financial independence. Supported Employment services are based on the individual's needs, preferences, and informed choice. These services allow for flexibility in the amount of support an individual receives over time and as needed in various work sites.

Supported Employment Individual Job Development services consist of activities needed to obtain paid work by individuals, including job location, prospective employer outreach, assistance with resume development, and job interview preparation, as well as services and supports that assist individuals in achieving self-employment through the establishment of a business. Job Development services can only be authorized when not available through the Georgia Vocational Rehabilitation Agency (GVRA).

Supported Employment Group services are provided to groups of individuals, with a staff to individual ratio of one to two or more. The staff to individual ratio for Supported Employment Group services cannot exceed one (1) to ten (10).

Supported Employment Services Providers offer (or arrange when needed) any of the standard services listed in section 2905 – Covered Services that are needed by the individuals served and specified in the Individual Service Plans.

3002. Special Requirements of Participation

3002.1. Individual Provider

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and Part II, Chapter 600 Policies and Procedures for the NOW Program, Supported Employment Services providers must meet the following requirements:

3002.1.1. Individual providers of Supported Employment services must meet the following requirements for Supported Employment Specialists:

3002.1.1.1. Be 18 years or older;

3002.1.1.2. Have current CPR and Basic First Aid certifications;

3002.1.1.3. Have the experience, training, education or skills necessary to meet the individual's needs for Supported Employment services as demonstrated by:

3002.1.1.3.1. Direct Support Professional (DSP) certification, and at least six (6) months of experience in supported employment of individuals with disabilities; or

3002.1.1.3.2. Copy of high school diploma/transcript or General Education Development (GED) diploma and at least six (6) months of experience in supported employment of individuals with disabilities and fifteen (15) hours of training in providing supported employment of individuals with disabilities; or high school diploma or GED and one (1) year experience in providing supported employment to individuals with disabilities; or documented experience providing specific supports to individuals with disabilities related to the supported employment of those individuals.

3002.1.1.4. Agree to or provide required documentation of a criminal records check prior to providing Supported Employment services.

- 3002.1.1.5. Meet transportation requirements in NOW Part II Chapter 900, Section 905 if transporting individuals.
- 3002.1.2. Documentation Requirement: Providers, except for providers of participant-directed services, must document the following in the record of each individual receiving Supported Employment Services:
 - 3002.1.2.1. Specific activity, training, or assistance provided;
 - 3002.1.2.2. Date and the beginning and ending time when the service was provided;
 - 3002.1.2.3. Location where the service was delivered;
 - 3002.1.2.4. Verification of service delivery, including first and last name and title (if applicable) of the person providing the service and his or her signature;
 - 3002.1.2.5. Progress towards moving the individual towards independence by meeting the individual ISP.
- 3002.1.3. Participant-Directed Services Documentation and other Requirements: Documentation and other requirements for individual providers of participant-directed services are specified in Part II Policies and Procedures for NOW and COMP, Chapter 1200.

3002.2. Provider Agencies

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and Part II, Chapter 600 Policies and Procedures for the NOW Program, Supported Employment Services provider agencies must meet the following requirements:

3002.2.1. Staffing Qualifications and Responsibilities

Provider agencies rendering Supported Employment Services must have staffing that meets the following requirements:

- 3002.2.1.1. A designated agency director. Additional information regarding director qualifications can be found in DBHDD Policy Recruitment and Application to Become a Provider of Developmental Disability Services, 02-701
- 3002.2.1.2. Duties of the Agency Director include, but are not limited to:
 - 3002.2.1.2.1. Oversees the day-to-day operation of the agency;
 - 3002.2.1.2.2. Manages the use of agency funds;

- 3002.2.1.2.3. Ensures the development and updating of required policies of the agency;
- 3002.2.1.2.4. Manages the employment of staff and professional contracts for the agency;
- 3002.2.1.2.5. Designates another agency staff member to oversee the agency, in his or her absence.
- 3002.2.1.3. At least one agency employee or professional under contract with the agency must:
 - 3002.2.1.3.1. Be a Developmental Disability Professional (DDP) (for definition, see Part II Policies and Procedures for NOW and COMP);
 - 3002.2.1.3.2. Have responsibility for overseeing the delivery of Supported Employment Services to individuals.
- 3002.2.1.4. The same individual may serve as both the agency director and the Developmental Disability Professional;
- 3002.2.1.5. Must have a minimum of one (1) employee that meets the Supported Employment Specialist experience, training, education or skills qualifications specified above for Individual Providers for every five (5) direct care staff members.
- 3002.2.1.6. Duties of the Supported Employment Specialist include, but are not limited to:
 - 3002.2.1.6.1. Provides direct supervision of Direct Care Staff in their performance of Supported Employment services for individuals;
 - 3002.2.1.6.2. Develops, acquires, and maintains work opportunities for individuals;
 - 3002.2.1.6.3. Conducts necessary additional assessments at the work site;
 - 3002.2.1.6.4. Helps individuals choose appropriate jobs or a specific employment option;
 - 3002.2.1.6.5. Applies training techniques which enhance the social and vocational functioning of individuals;

- 3002.2.1.6.6. Monitors wages, hours, and productivity of individuals on an ongoing basis;
- 3002.2.1.6.7. Assists the individual, if applicable, in achieving self-employment through the operation of a business by:
 - 3002.2.1.6.7.1. Aiding the individual to identify potential business opportunities;
 - 3002.2.1.6.7.2. Assisting in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business;
 - 3002.2.1.6.7.3. Identifying the supports that are necessary for the individual to operate a business;
 - 3002.2.1.6.7.4. Providing ongoing assistance, counseling and guidance once the business has been launched.
- 3002.2.1.7. A minimum of one (1) direct care staff member or Supported Employment Specialist for every ten (10) individuals served in Group Supported Employment Services and minimum of one (1) direct care staff member or Supported Employment Specialist for every one (1) individual served in Individual Supported Employment Services;
- 3002.2.1.8. Direct Care Staff must:
 - 3002.2.1.8.1. Be 18 years or older;
 - 3002.2.1.8.2. Have a high school diploma or equivalent (General Educational Development or GED) or have a minimum score of 75 on the Test of Functional Health Literacy for Adults (TOFHLA) or the Short Test of Functional Health Literacy for Adults (STOFHLA)

- 3002.2.1.8.3. Meet transportation requirements in NOW Part II Chapter 900, Section 905 if transporting individuals.
- 3002.2.1.8.4. Be provided with a basic orientation prior to direct contact with participants and show competence in:
 - 3002.2.1.8.4.1. The purpose and scope of Supported Employment Services, including related policies and procedures;
 - 3002.2.1.8.4.2. Confidentiality of individual information, both written and spoken;
 - 3002.2.1.8.4.3. Rights and responsibilities of individuals;
 - 3002.2.1.8.4.4. Requirements for recognizing and reporting suspected abuse, neglect, or exploitation of any individual;
 - 3002.2.1.8.4.5. To the DBHDD;
 - 3002.2.1.8.4.6. Within the organization;
 - 3002.2.1.8.4.7. To appropriate regulatory or licensing agencies; and
 - 3002.2.1.8.4.8. To law enforcement agencies
- 3002.2.1.9. Duties of the Direct Care Staff include, but are not limited to:
 - 3002.2.1.9.1. Provides direct assistance in activities needed for the individual or a group of individuals to sustain work, including job coaching, supervision and training;

- 3002.2.1.9.2. Provides direct assistance in training, retraining or improving the social and vocational functioning of the individual worker or groups of individual workers;
- 3002.2.1.9.3. Implements the behavioral support plans of individuals to reduce inappropriate and/or maladaptive behaviors and to acquire alternative adaptive skills and behaviors;
- 3002.2.1.9.4. Provides active support and direct assistance in facilitating natural supports at the work site;
- 3002.2.1.9.5. Provides other support services at or away from the work site, such as transportation and personal assistance services.
- 3002.2.1.10. The type and number of all other staff associated with the organization (such as contract staff, consultants) are:
 - 3002.2.1.10.1. Properly trained or credentialed in the professional field as required;
 - 3002.2.1.10.2. Present in numbers to provide services and supports to individuals as required;
 - 3002.2.1.10.3. Experienced and competent in the services and support they provide.
- 3002.2.1.11. National criminal records check (NCIC) documentation for all employees and any volunteers who have direct care, treatment, or custodial responsibilities for individuals served by the agency.
- 3002.2.1.12. Agency Policies and Procedures - Each provider agency must develop written policies and procedures to govern the operations of Supported Employment services, which follow the Standards for the Georgia Department of Behavioral Health and Developmental Disabilities refer to Part II Policies and Procedures for NOW.
- 3002.2.1.13. Documentation Requirement: Providers, except for providers of participant-directed services, must document the following in the record of each individual receiving Supported Employment Services:
 - 3002.2.1.13.1. Specific activity, training, or assistance

- provided;
- 3002.2.1.13.2. Date and the beginning and ending time when the service was provided;
- 3002.2.1.13.3. Location where the service was delivered;
- 3002.2.1.13.4. Verification of service delivery, including first and last name and title (if applicable) of the person providing the service and his or her signature;
- 3002.2.1.13.5. Progress towards moving the individual towards independence by meeting the individual ISP.
- 3002.2.1.14. Participant-Directed Services Documentation and other Requirements: Documentation and other requirements for providers of participant-directed services are specified in Part II Policies and Procedures for NOW and COMP, Chapter 1200.
- 3002.2.1.15. Providers must meet the following requirements for staff-to individual- ratios:
 - 3002.2.1.15.1. Group Supported Employment Services: a staff to individual ratio of one to two or more, not to exceed one (1) to ten (10).
 - 3002.2.1.15.2. Individual Supported Employment Services: a one-to-one staff to individual ratio.
- 3002.2.1.16. Providers must develop and plan Supported Employment services and supports:
 - 3002.2.1.16.1. Based on the individual's needs, preferences, and informed choice;
 - 3002.2.1.16.2. To allow for flexibility in the amount of support a individual receives over time and as needed in various work sites;
 - 3002.2.1.16.3. With attention to the health and safety of the individual;
 - 3002.2.1.16.4. In accordance with the Fair Labor Standards Act, if applicable, to include documentation of sub-minimum wage;

3002.2.1.16.5. With planned outcomes, which include:

3002.2.1.16.5.1.Increases in hours worked by each individual toward the goal of 40 hours per week;

3002.2.1.16.5.2.Frequent opportunities for each individual to interact with non-disabled peers during the normal performance of the job and/or during breaks, lunch periods, or travel to and from work;

3002.2.1.16.5.3.Increases in wages of each individual toward the goal of increased financial independence.

3002.2.1.16.6. DBHDD Contract/LOA and DBHDD Community Service Standards: Agency providers must adhere to DBHDD Contract/LOA, DBHDD Community Service Standards and all other applicable DBHDD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DBHDD (see Part II Policies and Procedures for NOW, Chapter 603).

3003. Special Eligibility Conditions

3003.1. Supported Employment Services are available only for individuals for whom the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Documentation is maintained in the file of each individual receiving Supported Employment Services that these services are not available through any of these programs.

3003.2. The need for Supported Employment Services must be related to the individual disability.

3004. Prior Approval

Supported Employment Services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan (ISP) development and with

any ISP version changes.

3005. Covered Services

Reimbursable Supported Employment Services include the following based on the assessed need of the individual:

- 3005.1. Assisting the individual to locate a job or develop a job on behalf of the individual.
- 3005.2. Activities needed to sustain paid work by individuals, including supervision and training.
- 3005.3. Services and supports that assist the individual in achieving self-employment through the operation of a business and may include:
- 3005.4. Aiding the individual to identify potential business opportunities;
- 3005.5. Assistance in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business;
- 3005.6. Identification of the supports that are necessary for the individual to operate the business; and
- 3005.7. Ongoing assistance, counseling and guidance once the business has been launched. Payment is not made to defray the expenses associated with starting up or operating a business.
- 3005.8. Adaptations, supervision, and training required by individuals receiving Supported Employment services as a result of their disabilities, when these services are provided in a work site where persons without disabilities are employed.
- 3005.9. Transportation of two or more individuals to the same community work site is provided by the Supported Employment provider as an administrative cost in Supported Employment Group services.
- 3005.10. Job Maintenance activities to maintain an individual in 60 to 80 or more hours of work per month.
- 3005.11. There is a monthly minimum requirement of two (2) in-person contacts for the purposes of billing Supported Employment Individual and Job Maintenance.

3006. Non-Covered Services

- 3006.1. Incentive payments, subsidies, or unrelated vocational training expenses such as the following:
 - 3006.1.1. Incentive payments made to an employer to encourage or subsidize the employer's participation in Supported Employment program;
 - 3006.1.2. Payments that are passed through to users of Supported Employment programs; or
 - 3006.1.3. Payments for training that is not directly related to an individual's

Supported Employment program.

- 3006.2. Supervisory activities rendered as a normal part of the business setting.
- 3006.3. Supported Employment Services are distinct from and do not occur at the same time of the same day as Community Access, Prevocational or Transportation Services, with the exception of non-face-to-face Supported Employment job development. The exception for Supported Employment job development must be documented sufficiently to demonstrate no duplication of services for an individual and a service provided in preparation for transition of an individual to Supported Employment Services.
- 3006.4. Services that are available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).
- 3006.5. Payment is not made, directly or indirectly, to members of the individual's immediate family, except as approved as indicated in Part II Policies and Procedures for NOW, Chapter 900.
- 3006.6. Supported Employment Services do not include sheltered work or other similar types of vocational services furnished in specialized facilities, such as service centers for individuals with intellectual/developmental disabilities.
- 3006.7. Payment is not made for those goods and services covered by the State Medicaid Plan except where an individual's need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.

3007. Basis for Reimbursement

The reimbursement rate for Supported Employment Services is found in Appendix A

Separate authorization of transportation services may be made for NOW individuals to facilitate access to community work sites but must be provided by a vendor enrolled to provide transportation services or through participant direction.

- 3007.1. Supported Employment Job Maintenance
 - 3007.1.1. Supported Employment Job Maintenance is billed as actual hours worked from 60 hours up to a maximum of 80 hours per month, even if the individual works more than 80 hours.
 - 3007.1.2. Supported Employment Job Maintenance is billed under Supported Employment Group 1: 10 ratio from 240 units up to a maximum of 320 units per month.

Supported Employment Group Services other than Job Maintenance cannot be billed in any month in which Supported Employment Job Maintenance is billed. Supported Employment Individual Services cannot be billed in any month in which Supported Employment Job Maintenance is billed.

- 3007.2. Supported Employment Group payment rates vary based on the staffing ratio, with separate rates for:

3007.2.1. 1:8 (one-to-eight) to 1:10 (one-to-ten)

3007.2.2. 1:5 (one-to-five) to 1:7 (one-to-seven)

3007.2.3. 1:3 (one-to-three) to 1:4 (one-to-four)

3007.2.4. 1:2 (one-to-two)

3008. Participant-Direction Options

3008.1. Individuals can choose the self-direction or co-employer options with Supported Employment Services.

3008.2. An individual serving as a representative for a waiver participant in self-directed services is not eligible to be a participant-directed provider of Supported Employment Services.

3008.3. For details on participant-direction, see Part II Policies and Procedures for NOW and COMP, Chapter 1200.

3009. Telehealth Options

3009.1. Supported Employment providers are expected to use synchronous audio/video technology for remote direct support services.

3009.2. All contracted waiver providers are covered entities and obligated to abide by HIPAA and state privacy law. Providers are required to use only HIPAA compliant platforms while offering remote direct support services. All contracted providers must sign business associate agreements with the operating agency, as required by HIPAA. All Supported Employment providers wishing to use remote modalities to deliver direct support services must obtain valid signed consent from the individual or their legal decision-maker.

3009.3. Remote direct support services must be rendered in quiet environment with attendance limited to the individual and whoever is assisting the employment specialist during the session as informant and/or following hands-on direction.

3009.4. The provision of remote direct support services does not supersede the expectation or requirement that Supported Employment providers must conduct a minimum of two in-person visits per month to the individual.

3009.5. For more information regarding remote guidance visit the DCH “Telemedicine Guidance” manual at <https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx>.

Chapter 3100: Specific Program Requirements for Transportation Services

3101. General

Transportation Services enable waiver individuals to access non-medical services, activities, resources, and organizations typically utilized by the general population. These services are only provided as independent, stand-alone waiver services when transportation is not otherwise included as an element of another waiver service. Transportation services are not intended to replace available formal or informal transit options for individuals. Whenever possible, family, neighbors, friends or community agencies, which can provide this service, without charge, are to be utilized. The need for Transportation Services and the unavailability of other resources for transportation must be documented in the Individual Service Plan (ISP).

Transportation Services provide transportation for the individual to waiver services and other community services, activities, resources, and organizations typically utilized by the general population. These services include:

3101.1. One-way or round trips provided by Georgia licensed drivers and/or DD Service Agencies;

and

3101.2. Transit by commercial carrier available to the community at large.

Transportation Services must not be available under the Medicaid Non-Emergency Transportation Program, State Plan, Individual with Disabilities Education Act (IDEA), or the Rehabilitation Act. These services do not include transit provided through Medicaid non-emergency transportation. Transportation Services are not available to transport an individual to school (through 12th grade). These services do not include transportation that is included as an element of another waiver service as follows:

3101.3. Community Living Support Services

3101.4. Prevocational Services

3101.5. Supported Employment Group Services

3101.6. Community Access Individual Services

3101.7. Community Access Group for activities and settings primarily utilized by people with disabilities, such as transportation to and from a developmental disability service center or other day center.

Transportation Services are only for individuals who do not have formal or informal transit options available. The type and amount of Transportation Services provided are specific to the individual and detailed in his or her Individual Service Plan. Transportation Services providers offer any of the standard services listed in section 3106—Covered Services that are needed by the individuals served and specified in the individuals' Individual Service Plans.

3102. Special Requirements of Participation

3102.1. Individual Provider

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and Part II, Chapter 600 Policies and Procedures for the NOW Program, Transportation Services providers must meet the following requirements:

- 3102.1.1. Transportation Provided: Individual providers rendering Transportation Services provide one-way or round trip transportation for participants.
- 3102.1.2. Individual providers of Transportation must:
 - 3102.1.2.1. Be 18 years or older;
 - 3102.1.2.2. Have a valid, Class C license as defined by the Georgia Department of Driver Services;
 - 3102.1.2.3. Have current mandatory insurance;
 - 3102.1.2.4. Have no more than two chargeable accidents, moving violations, or any DUI's in a three (3) year period within the last five (5) years of the seven (7) year Motor Vehicle Record (MVR) period;

NOTE: The Department will allow an exception to Out-of-State Driver's License and MVP record under the following circumstances: (1) the individual is on active duty in Georgia; (2) the individual is a college student enrolled at a Georgia college or university; or (3) the individual's place of residence is a neighboring state on the border of Georgia. For individual to be granted this exception, he or she must:

Have a valid, Class C license

Have no convictions for substance abuse, sexual crime or crime of violence for five (5) years prior to providing the service

Have current, valid insurance
 - 3102.1.2.5. Have evidence of an annual health examination with signed statement from a physician, nurse practitioner, or physician assistant that the person is free of communicable disease;
 - 3102.1.2.6. Agree to or provide required documentation of a criminal records check, prior to providing Transportation Services.

- 3102.1.3. Documentation Requirement: Providers, except for providers of participant-directed services, must document the following in the record of each individual receiving Transportation Services:
 - 3102.1.3.1. Specific type and purpose of transportation provided;
 - 3102.1.3.2. Date and the beginning and ending time when the service was provided;
 - 3102.1.3.3. Location of origin and that for destination of transportation services;
 - 3102.1.3.4. Verification of service delivery, including first and last name and title (if applicable) of the person providing the service and his or her signature;
 - 3102.1.3.5. Progress towards moving the individual towards independence by meeting the individual ISP.
- 3102.1.4. Participant-Directed Services Documentation and other Requirements: Documentation and other requirements for individual providers of participant-directed services are specified in Part II Policies and Procedures for NOW and COMP, Chapter 1200.

3102.2. Transportation Broker Provider Agencies

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and Part II, Chapter 600 Policies and Procedures for the NOW Program, Transportation Broker Provider Agencies must meet the following requirements:

- 3102.2.1. Community Commercial Carrier: Transportation Broker Provider Agencies rendering Transportation Services must provide commercial carrier services to the community at large or broker these services.
- 3102.2.2. Agency Policies and Procedures: Each Transportation Broker Provider Agency must develop written policies and procedures to govern the operations of Transportation Services.
- 3102.2.3. Documentation Requirement: Providers, except for providers of participant-directed services, must document the following in the record of each individual receiving Transportation Services:
 - 3102.2.3.1. Specific type and purpose of transportation provided;
 - 3102.2.3.2. Date and the beginning and ending time when the service was provided;
 - 3102.2.3.3. Location of origin and that for destination of transportation services;

- 3102.2.3.4. Verification of service delivery, including first and last name and title (if applicable) of the person providing the service and his or her signature;
- 3102.2.3.5. Progress towards moving the individual towards independence by meeting the individual ISP.
- 3102.2.4. Participant-Directed Services Documentation and other Requirements: Documentation and other requirements for providers of participant-directed services are specified in Part II Policies and Procedures for NOW, Chapter 1200.
- 3102.2.5. DBHDD Provider Requirements: Transportation Broker Provider Agencies must adhere to DBHDD Contract/LOA, and any other applicable DBHDD Standards refer to Part II Policies and Procedures for NOW.
- 3102.3. DD Service Agencies

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and Part II, Chapter 600 Policies and Procedures for the NOW Program, DD Service Agencies rendering Transportation Services must meet the following requirements:

 - 3102.3.1. Transportation Provided: DD Service Agencies rendering Transportation Services provide one-way or round trip transportation for individuals.
 - 3102.3.2. Staffing Qualifications and Responsibilities

DD Service Provider agencies rendering Transportation Services must have staffing that meets the following requirements:

 - 3102.3.2.1. Driver Staff must:
 - 3102.3.2.1.1. Be 18 years or older;
 - 3102.3.2.1.2. Be legally licensed in the State of Georgia with the class of license appropriate to the vehicle operated as follows:
 - 3102.3.2.1.2.1. Have a valid, Class C license as defined by the Georgia Department of Driver Services for any single vehicle with a gross vehicle weight rating not in excess of 26,000 pounds.

3102.3.2.1.2.2. Have valid, Commercial Driver's License (CDL) as defined by the Georgia Department of Driver Services if the vehicle operated falls into one of the following three classes:

3102.3.2.1.2.3. If the vehicle has a gross vehicle weight rating of 26,001 or more pounds or such lesser rating as determined by federal regulation; or

3102.3.2.1.2.4. If the vehicle is designated to transport 16 or more passengers, including the driver.

3102.3.2.1.3. Have no more than two chargeable accidents, moving violations, or any DUI's in a three (3) year period within the last five (5) years of the seven (7) year Motor Vehicle Record (MVR) period;

NOTE: The Department will allow an exception to Out-of-State Driver's License and MVP record under the following circumstances: (1) the individual is on active duty in Georgia; (2) the individual is a college student enrolled at a Georgia college or university; or (3) the individual's place of residence is a neighboring state on the border of Georgia. For individual to be granted this exception, he or she must:

Have a valid, Class C license

Have no convictions for substance abuse, sexual crime or crime of violence for five (5) years prior to providing the service

Have current, valid insurance

3102.3.2.1.4. Be provided with a basic orientation prior to direct contact with individuals and show competence in:

- 3102.3.2.1.4.1. The purpose and scope of Transportation Services, including related policies and procedures;
- 3102.3.2.1.4.2. Confidentiality of individual information, both written and spoken;
- 3102.3.2.1.4.3. Rights and responsibilities of individuals;
- 3102.3.2.1.4.4. Requirements for recognizing and reporting suspected abuse, neglect, or exploitation of any individual:
- 3102.3.2.1.4.5. To the DBHDD;
- 3102.3.2.1.4.6. Within the organization;
- 3102.3.2.1.4.7. To appropriate regulatory or licensing agencies; and
- 3102.3.2.1.4.8. To law enforcement agencies
- 3102.3.2.1.5. Duties of the Driver Staff include, but are not limited to:
 - 3102.3.2.1.5.1. Provides transportation for the individual to waiver services and other community services, activities, resources, and organizations;
 - 3102.3.2.1.5.2. Provides assistance to the individual in entering or exiting the vehicle.
 - 3102.3.2.1.5.3. Ensures transportation from the designated

pick up point to the designated drop off point.

- 3102.3.2.1.6. The agency has adequate driver staff with First Aid and CPR certifications to assure having at least one staff person with these certifications on duty during the provision of services.
- 3102.3.2.1.7. The type and number of all other staff associated with the organization (such as contract staff, consultants) are:
 - 3102.3.2.1.7.1. Properly trained or credentialed in the professional field as required;
 - 3102.3.2.1.7.2. Present in numbers to provide services and supports to individuals as required;
 - 3102.3.2.1.7.3. Experienced and competent in the services and support they provide.
- 3102.3.2.1.8. National criminal records check (NCIC) documentation for all employees and any volunteers who have direct care, treatment, or custodial responsibilities for individuals served by the agency.
- 3102.3.2.2. Agency Policies and Procedures: Each DD Service Provider Agency must develop written policies and procedures to govern the operations of Transportation Services, which follow the Standards for the Georgia Department of Behavioral Health and Developmental Disabilities refer to Part II Policies and Procedures for NOW.
- 3102.3.2.3. Documentation Requirement: Providers, except for providers of participant-directed services, must document the following in the record of each individual receiving Transportation Services:
 - 3102.3.2.3.1. Specific type and purpose of transportation provided;

- 3102.3.2.3.2. Date and the beginning and ending time when the service was provided;
- 3102.3.2.3.3. Location of origin and that for destination of transportation services;
- 3102.3.2.3.4. Verification of service delivery, including first and last name and title (if applicable) of the person providing the service and his or her signature;
- 3102.3.2.3.5. Progress towards moving the individual towards independence by meeting the individual ISP.

3102.3.2.4. DHS Vehicle Requirements

DD Service Agency Providers who render Transportation Services in a vehicle owned by, titled to, or otherwise controlled by DHS must meet the policies and procedures for transportation and vehicle management in the DHS Transportation Manual, which is available at the following website:
<https://dhs.georgia.gov/organization/about/division-offices/operations/office-facilities-support-services/transportation>.

3102.3.2.5. Participant-Directed Services Documentation and other Requirements: Documentation and other requirements for providers of participant-directed services are specified in Part II Policies and Procedures for NOW, Chapter 1200.

3102.3.2.6. DBHDD Contract/LOA and DBHDD Community Service Standards: DD Service Agency Providers must adhere to DBHDD Contract/LOA, DBHDD Community Service Standards and all other applicable DBHDD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DBHDD (see Part II Policies and Procedures for NOW, Chapter 603).

3103. Licensure

- 3103.1. Individual Providers rendering Transportation Services must hold a valid Class C license as defined by the Georgia Department of Driver Services.
- 3103.2. DD Service Provider Agency driver staff providing Transportation Services must hold the class of license appropriate to the vehicle operated as defined by the Georgia Department of Driver Services.

3104. Special Eligibility Conditions

- 3104.1. The need for Transportation services must be reflected in the Intake and Evaluation Team approved Individual Service Plan (ISP).
- 3104.2. The unavailability of other resources for transportation must be documented in the ISP.

3105. Prior Approval

Transportation Services must be authorized prior to service delivery by the applicable DBHDD Field Office agency at least annually in conjunction with the Individual Service Plan development and with any ISP version changes.

3106. Covered Services

Reimbursable Transportation Services include the following based on the assessed need of the individual:

- 3106.1. One-way trip provided by Georgia licensed drivers or DD Service Agencies to waiver services and other community, non-medical services, activities, resources, and organizations typically utilized by the general population.
- 3106.2. One-way trip provided by Georgia licensed drivers or DD Services Agencies of one individual to Supported Employment Services community work sites.
- 3106.3. Brokering or provision of commercial carrier services available to the community at large.

3107. Non-Covered Services

- 3107.1. Transportation of a waiver individual to school (through 12th grade).
- 3107.2. Transportation that is included as an element of another waiver service as follows:
 - 3107.2.1. Community Living Support Services
 - 3107.2.2. Prevocational Services
 - 3107.2.3. Supported Employment Group Services
 - 3107.2.4. Community Access Group or Individual Services, which entail activities and settings primarily utilized by people with disabilities, such as transportation to and from a developmental disability service center or other day center.
- 3107.3. Transit provided through Medicaid non-emergency transportation.
- 3107.4. Transportation available under the State Medicaid Plan, including transportation to medical services, Individuals with Disabilities Education Act (IDEA), or the Rehabilitation Act.

- 3107.5. Payment is not made, directly or indirectly, to members of the individual's immediate family, except as approved as indicated in Part II Policies and Procedures for NOW, Chapter 1200.
- 3107.6. Transportation services are not intended to replace available formal or informal transit options for individuals
- 3107.7. Payment for vehicle maintenance.

3108. Basis for Reimbursement

The reimbursement rate for transportation services is found in Appendix A.

3109. Participant-Direction Options

- 3109.1. Participants may choose the participant-direction or co-employer options with Transportation Services.
- 3109.2. An individual serving as a representative for a waiver participant in self-directed services is not eligible to be a participant-directed provider of Supported Employment Services.
- 3109.3. For details on participant-direction, see Part II Policies and Procedures for NOW and COMP, Chapter 1200.

Chapter 3200: Specific Program Requirements for Vehicle Adaptation Services Scope of Services

3201. General

Vehicle Adaptation Services include various adaptations and technical assistance to individually or family owned vehicles which are designed to enable individuals to interact more independently with their environment thus enhancing their quality of life and reducing their dependence on physical support from others. Vehicle Adaptations are limited to a individual's or his or her family's privately owned vehicle and include such things as a hydraulic lift, ramps, special seats and other interior modifications to allow for access into and out of the vehicle as well as safety while moving. The adapted or to be adapted vehicle must be the individual's primary means of transportation.

Any item billed under Vehicle Adaptation Services must not be available under the State Medicaid plan. These services must also be documented to be the payer of last resource. The NOW does not cover items that have been denied through the DME and other programs for lack of medical necessity.

3202. Special Requirements of Participation

3202.1. Individual Provider

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and Part II, Chapter 600 Policies and Procedures for the NOW Program, individual vendors and dealers in Vehicle Adaptations must meet the following requirements:

- 3202.1.1. Documentation Requirement: Providers, except for providers of participant-directed services, must document the following in the record of each individual receiving Vehicle Adaptation Services:
 - 3202.1.1.1. The efforts of the Individual's Support Coordinator to substantiate payer of last resource, including available community, State Plan, or other resources.
 - 3202.1.1.2. Verification of Vehicle Adaptation service delivery, including date, location, and specific vehicle adaptations provided.
- 3202.1.2. Participant-Directed Services Documentation and other Requirements: Documentation and other requirements for individual providers of participant-directed services are specified in Part II Policies and Procedures for NOW, Chapter 1200.

3202.2. Provider Agencies

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and Part II, Chapter 600 Policies and Procedures for the NOW Program, Vehicle

Adaptation Services provider agencies must meet the following requirements:

- 3202.2.1. Documentation Requirement: Providers, except for providers of participant-directed services, must document the following in the record of each individual receiving Vehicle Adaptation services:
 - 3202.2.1.1. The efforts of the Individual's Support Coordinator to substantiate payer of last resource, including available community, State Plan, or other resources.
 - 3202.2.1.2. Verification of Vehicle Adaptation service delivery, including date, location, and specific vehicle adaptations provided.
- 3202.2.2. Participant-Directed Services Documentation and other Requirements: Documentation and other requirements for individual providers of participant-directed services are specified in Part II Policies and Procedures for NOW, Chapter 1200.
- 3202.2.3. DBHDD Contract/LOA and MHDDD Community Service Standards: Providers must adhere to DBHDD Contract Standards, DBHDD Core Requirements for All Providers and all other applicable DBHDD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DBHDD (see Part II Policies and Procedures for NOW, Chapter 603).

3203. Licensure

Vehicle Adaptations are made by vendors with the applicable Georgia business license as required by the local, city or county government in which the services are provided.

3204. Special Eligibility Conditions

- 3204.1. The need for Vehicle Adaptation Services must be related to the individual disability and specified in the Intake and Evaluation Team approved Individual Service Plan (ISP).
- 3204.2. Medical necessity for Vehicle Adaptation Services must be documented through and order by a Georgia licensed physician.

3205. Prior Approval

- 3205.1. Vehicle Adaptation Services must relate to specific individual goal(s) and must be required to meet the needs of the individual.
- 3205.2. Vehicle Adaptation Services must be authorized prior to service delivery by the applicable DBHDD Field Office at least annually in conjunction with the ISP development and any ISP version changes.

3206. Covered Services

Reimbursable Vehicle Adaptation Services include the following based on the assessed need of the individual:

- 3206.1. Vehicle Adaptations are limited to a individual's or his or her family's privately owned vehicle.
- 3206.2. Vehicle Adaptations include such things as a hydraulic lift, ramps, special seats and other interior modifications to allow for access into and out of the vehicle as well as safety while moving.
- 3206.3. Vehicle Adaptation to the individual's primary means of transportation.
- 3206.4. Repair of a prior existing vehicle adaptation provided the repair is less than replacement.
- 3206.5. Replacement of a prior existing vehicle adaptation if replacement is less than a repair.

3207. Non-Covered Services

- 3207.1. Adaptation, repair or replacement costs for adaptations to provider-owned vehicles.
- 3207.2. Adaptation, repair or replacement costs for adaptations to leased vehicles.
- 3207.3. Vehicle adaptations will not be replaced in less than three years except in extenuating circumstances and authorized by the Division of Medical Assistance, Department of Community Health.
- 3207.4. Vehicle backup sensor and alarm systems.
- 3207.5. Comfort, convenience, or recreational adaptation.
- 3207.6. Adaptation, replacement or repair that is necessitated by individual's neglect, wrongful disposition, intentional misuse or abuse. Adaptations will not be replaced due to the individual negligence and/or abuse (e.g., before its normal life expectancy has been attained unless supporting medical documentation and change in the physical or developmental condition of the individual).
- 3207.7. Regularly scheduled upkeep and maintenance of the vehicle or its modifications.
- 3207.8. Adaptations of general utility that are not of direct medical or remedial benefit to the individual.
- 3207.9. Purchase or lease of vehicles.
- 3207.10. Extended warranties and/or maintenance agreements.
- 3207.11. Payment is not made, directly or indirectly, to members of the individual's immediate family, except as approved as indicated in Part II Policies and Procedures for NOW and COMP, Chapter 900.
- 3207.12. Payment is not made for those goods and services covered by the State Medicaid Plan

except where an individual's need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.

3208. Basis for Reimbursement

The reimbursement rates for all specialized services are found in Appendix A.

3209. Participant-Direction Options

3209.1. Participants may choose the self-direction option with Vehicle Adaptation.

3209.2. For details on participant-direction, see Part II Policies and Procedures for NOW and COMP, Chapter 1200.

Chapter 3300: Specific Program Requirements for Nursing Services Scope of Services

3301. General

This policy is intended to outline the parameters of the practice of licensed nursing within the waiver. Nursing Services is the provision of nursing care for the assessment and treatment of human responses to actual or potential health problems as identified through the nursing process. Nursing Services are indicated when the individual has a clinical diagnosis that requires ongoing complex assessment and intervention for the purpose of health restoration or prevention of further deterioration of the health of the individual.

Nursing Services provide intermittent skilled services to an individual for the purpose of restoring and maintaining the individual's maximal level of function and health. As described in the Georgia Nurse Practice Act, nursing services include the assessment, planning, intervention, evaluation, teaching and supervision of an individual either solely by a registered nurse or by a registered nurse in collaboration with other licensed or unlicensed personnel. The standards of nursing practice are based on the premise that the registered nurse is responsible for and accountable to the individual for the quality of nursing care rendered.

Nursing Services are provided by a registered nurse (RN) or licensed practical nurse (LPN) with a valid license in the state of Georgia or Nurse Licensure Compact. LPNs are required to provide services under the supervision of the RN.

Nursing services are approved when there is the requirement to meet the healthcare needs of the individual and may be delivered in an individual's place of residence, family home, relative's home, residential services, other community settings where no duplicative services are available.

3301.1. The following tasks, which require the training and skill level of a Registered Nurse, may be delegated to an LPN with a physician or physician extender order and documentation of training.

These tasks may never be delegated to unlicensed staff.

- 3301.1.1. Ventilator care
- 3301.1.2. Tracheostomy care
- 3301.1.3. Deep/endo-tracheal suctioning
- 3301.1.4. Wound Vac care
- 3301.1.5. Complex wound care
- 3301.1.6. IV medication administration
- 3301.1.7. Central line maintenance

- 3301.1.8. Irrigation of wound, orifices
- 3301.1.9. Chest Physical therapy (CPT) if nursing ordered to perform
- 3301.1.10. Insertion of supra pubic catheter/tube
- 3301.1.11. Medication calculation
- 3301.1.12. Other complex nursing designated task(s) with a physician or physician extender order

- 3301.2 Licensed Practical Nurse may not provide the following services:
 - 3301.1.13. The initial evaluation or complex assessment of a waiver individual
 - 3301.1.14. Development and training of the healthcare plan
 - 3301.1.15. Supervisory responsibilities

- 3301.3 For more information regarding tasks that may be delegated to unlicensed staff, refer to Rules and Regulations for Proxy Caregivers Used in Licensed Healthcare Facilities, Rule 111-8-100.

- 3301.4 Clinical nursing, oversight services, and care is provided according to laws and standards of practice found in the:
 - 3301.1.16. Official Code of Georgia Annotated § 43-26-3, ET. seq.
 - 3301.1.17. Georgia Board of Nursing Rules and Regulations, Chapter 410
 - 3301.1.18. American Nurses Association [ANA] Professional Standards
 - 3301.1.19. Developmental Disabilities Nurses Association [DDNA] Aspirational Standards of Developmental Disabilities Nursing Practice

- 3301.5 Each provider, individual or agency, must develop written policies and procedures to govern the operation of Nursing Services, which follow the standards for the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD).

- 3301.6 All waiver enrolled providers, individual or agency, must comply with DBHDD provider manuals, standards, and policies.

3302. Special Requirements of Participation

3302.1 Individual Provider

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/Peach Care for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and Part II, Chapter 600 Policies and Procedures for NOW and COMP Program, Nursing Services individual providers must meet the following requirements:

3301.1.20. Service Provision:

3301.1.20.1. Registered Nurse (RN) – Nursing Services are provided by a Registered Nurse who has a current license to practice in the State of Georgia.

3301.1.20.2. Licensed Practical Nurse (LPN) – Nursing Services are provided by a Licensed Practical Nurse who has a current license to practice in the State of Georgia.

3302.1.2 Nursing Services at Community Access, Prevocational Services, and in Residential Settings

Nursing Services may be provided at facilities or residential settings where no duplicative services are available. The RN and LPN services must be documented and billed separately.

3302.1.3 Subcontracting

Individual providers may not subcontract nursing services.

3302.2 Provider Agencies

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/Peach Care for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and Part II, Chapter 600 Policies and Procedures for NOW and COMP Program, Nursing Services provider agencies must meet the following requirements:

3302.2.1 Service Provision:

3301.1.20.2.1. Registered Nurse (RN) – Nursing Services are provided by a Registered

Nurse who has a current license to practice in the State of Georgia.

3301.1.20.2.2. Licensed Practical Nurse (LPN) – Nursing Services are provided by a Licensed Practical Nurse who has a current license to practice in the State of Georgia.

3302.2.2 Type of Agencies

Provider agencies must maintain adequate and appropriate RN and LPN staffing to render the approved services but may contract with other entities to provide nursing services. Such contracts must be maintained in the provider's office and must reflect the enrolled provider's total administrative responsibility, to include training and determining competency of contracted nurses, professional, supervisory, and billing responsibility. Providers must assure that the persons delivering services meet minimum staff requirements.

3302.2.3 Subcontracting

Provider agencies may subcontract for the provision of services as long as the subcontract contains, at a minimum, the following elements:

- 3302.2.3.1. Names of all parties entering into contract.
- 3302.2.3.2. A stipulation requiring subcontractors to perform in accordance with all conditions of participation which pertain to the service purchased under subcontract, requirements specific to nursing services policy and requiring the contractor to assume responsibility if the selected subcontractor fails to do so.
- 3302.2.3.3. A stipulation requiring contractor agency to maintain responsibility for, and assure the subcontractor's performance of administrative, supervisory, professional and service delivery responsibilities relative meeting all requirements of the program.
- 3302.2.3.4. A stipulation that the subcontractor will comply with local, state and federal laws, rules and regulations and will adhere to program policies and procedures as they now exist or may hereafter be amended.
- 3302.2.3.5. A stipulation that the persons delivering services meet

the staff requirements.

- 3302.2.3.6. A stipulation that the subcontractor will participate as needed in the nursing agency's case conferences to coordinate support or care.

3302.2.4 Nursing Services at Community Access, Prevocational Services, and in Residential Settings

Nursing Services may be provided at facilities or residential settings where no duplicative services are available. The RN and LPN services must be documented and billed separately.

- 3302.2.5 The provider must maintain the nurses' signed time sheets on file for a period no less than three (3) years.

3303. Documentation Requirements

- 3303.1 All Nursing Services Providers, both individual and agency, must document at minimum on a continuous basis the following in the record of each individual receiving Nursing Services:

- 3303.1.1. The specific services (tasks) performed according to the physicians' orders and the healthcare plan.
- 3303.1.2. Date, beginning and ending time when the service was delivered.
- 3303.1.3. Location where the service was delivered.
- 3303.1.4. Progress toward individual's goal(s), desired outcomes in the individual's service plan.
- 3303.1.5. Attestation of service delivery through signature and legible, printed first and last name, including the license of the person providing service.
- 3303.1.6. All other items as outlined in Part I Policies and Procedures for Medicaid Peachcare for Kids and Part II Chapters 600-1200 Policies and Procedures for Comprehensive Supports Waiver Program (COMP) and New Options Waiver Program (NOW) General Manual.

- 3303.2 Original Nursing Services notes must be maintained either on site and/or in an electronic format on the individual's record.

Individual providers and provider agencies must maintain a copy of Nursing Services

notes, healthcare plans, and other documentation of nursing services rendered.

- 3303.3 The full Clinical Record is maintained by the primary provider in accordance with the DBHDD Provider Manual.

3304. Licensure

3304.1. Individual Nursing Services Providers

3304.1.1 Registered Nurse (RN) - Nursing Services are provided by an Individual Nursing Provider for individual RN licensed nursing provider services in accordance with the applicable Georgia state license or Nurse Licensure Compact as required under the Official Code of Georgia Annotated (O.C.G.A.) § 43-26-7.

3304.1.2 Licensed Practical Nurse (LPN) – Nursing Services are provided by an Individual Nursing Provider for individual LPN licensed nursing provider services in accordance with the applicable Georgia state license or Nurse Licensure Compact as required under the Official Code of Georgia Annotated ((O.C.G.A.) § 43-26-32. LPN will need to contract with a waiver provider of RN services under the waivers for supervision of provided nursing services.

3304.2 Provider Agencies

3304.2.1 Private Home Care License with nursing – In accordance with O.C.G.A. § 31-7-300 et seq. must be licensed by the Georgia Department of Community Health, and Health Care Facility Regulations Division. Private Home Care Rules are stated in Chapter 290-5-54.

and/or

3304.2.2 Community Living Arrangement License with nursing –

In accordance with O.C.G.A. § 31-7 et seq. and 37-1-22, all nursing services provided under a CLA requires site specific nursing enrollment and must be licensed by the Georgia Department of Community Health, and Health Care Facility Regulations Division. Community Living Arrangement Rules are found in Chapter 290-9-37. Agencies providing nursing services at one site location may do so under the site's Community Living Arrangement license if enrolled to provide nursing services at that location.

3305. Special Eligibility Conditions

- 3305.1 Nursing Services are available to waiver individuals who meet the following criteria:
 - 3305.1.1 Are age 21 and over; and
 - 3305.1.2 Any specific skilled nursing support needs, and healthcare needs are identified and documented by the DBHDD RN in the Georgia DBHDD State Nursing Assessment
 - 3305.1.3 Written orders for skilled nursing tasks required to treat, mitigate risk, or comply with scheduled care from a licensed physician, physician assistant or nurse practitioner
- 3305.2 The need for Nursing Services must be reflected in the Georgia DBHDD Nursing Assessment completed by the DBHDD RN who provides documented assessment of diagnosis, preventative maintenance needs of the individual, and review of the written orders for skilled nursing tasks.
- 3305.3 Determination of Approved Hours
 - 3305.3.1 Standardized Methodology
 - 3305.3.1.1 A standardized methodology is used to determine the number of hours that are approved. The standardized methodology allocates time needed for skilled nursing tasks identified in assessments and validated screenings, as confirmed by available medical records documented by a qualified professional who is knowledgeable about the individual's clinical needs.
 - 3305.3.1.2 The standardized methodology tool does not include allocation for unskilled support needs.
 - 3305.3.1.3 Hours are allocated based only on current skilled need, not projected needs.
 - 3305.3.1.4 Hours are allocated based solely on medical necessity, taking into consideration the overall medical condition of the individual, the equipment, and the level of and frequency of care required for the individual, and do not consider social support needs.

3305.3.1.5 Approval of the utilization of a Registered Nurse versus a Licensed Practical Nurse is determined by the inherent complexity of the service, the condition of the individual, and accepted standards of medical and nursing practice. Approval is granted for the lowest level of professional licensure appropriate to serve the medically necessary needs of the individual.

3305.3.2 Special Review Process

The special review process is an in-depth analysis intended to serve as an exception to the standardized methodology in 2905.3.

3305.3.2.1 The special review process is available to waiver recipients who meet the following criteria:

3304.1.1.1.1. Have an active authorization for COMP waiver services;

3304.1.1.1.2. Have an active authorization for CLS services; and

3304.1.1.1.3. Have a calculated allocation using the standardized methodology (referenced in 2905.3) of 12 or more daily LPN hours.

3305.3.2.2 During the special review process, the DBHDD RN considers a combination of the following factors in making a determination if additional skilled nursing hours are required:

3304.1.1.1.4. The individual's diagnoses;

3304.1.1.1.5. The medical interventions detailed by their physician and reported by their family

and/or caregivers;

3304.1.1.1.1.6. Their overall health status, including their medical baseline, any history of medical complications and recurring issues, and the impact of new illnesses or fluctuating conditions (seasonal allergies, tachycardia, insomnia, etc.) that increase their need for nursing support

3305.3.2.3 Individuals who are determined to need additional skilled nursing hours following the special review process will receive direct communication from DBHDD outlining the DBHDD-calculated nursing hours. This communication will also include a clear pathway to provide a signed determination of medically necessary skilled nursing hours from their primary care physician or qualified extender. Barring a significant deviation from medically reasonable standards, the physician's determination of medically necessary skilled nursing hours will be adopted.

3306. Prior Approval

Nursing Services must be authorized prior to service delivery by the provider and require DBHDD Field Office RN evaluation of the waiver individual at least annually in conjunction with reevaluation of need, development of the Individual Service Plan, and with any ISP version changes related to Nursing Services.

3307. Covered Services

Covered nursing services include the following and are based on the assessed need of the individual:

3307.1. Monitoring the individual, collecting and reviewing medical data, and collaborating in

the assessment of the individual's health status;

- 3307.2. Nursing Assessment to determine health status and nursing needs;
- 3307.3. Clinical Review of the individual's needs;
- 3307.4. Healthcare plan(s) development and implementation with competency trainings;
- 3307.5. Medication and/or treatment administration as prescribed in accordance with currently accepted standards of nursing practice;
- 3307.6. Evaluating the individual's response to intervention and informing the physician, physician assistant, or nurse practitioner of changes in the individual's condition or needs;
- 3307.7. Communication and collaboration with other health care professionals; and
- 3307.8. Individual, family and/or direct support staff health education and counseling to promote, attain, and maintain the optimum health levels of individual.

3308. Non-Covered Services

- 3308.1. In-home services for the treatment of an illness or injury covered in Home Health Services under the Medicaid State Plan, Medicare, private health insurance or other fund sources.
- 3308.2. Services that have not been ordered/approved by a physician or physician extender licensed to provide such orders.
- 3308.3. Services provided to individuals receiving concurrent nursing services through home health.
- 3308.4. Services to individuals under the age of 21.
- 3308.5. Services provided in a hospital or other institution.
- 3308.6. Payment is not made for those good and services covered by the Medicaid State Plan.

3309. Basis for Reimbursement

See Appendix A for reimbursement.

3308. Participant-Direction Options

3308.1 Nursing Services are not eligible for any participant-direction option.

3308.2 For details on participant-direction, see Part II Policies and Procedures for COMP, Chapter 1200.

Chapter 3400: Specific Program Requirements for Adult Nutrition Services Scope of Services

3401. General

Adult Nutrition Services provide evaluation and dietary intervention services that are not otherwise reimbursed through Medicaid State Plan Services. Adult Nutrition Services include nutrition evaluation, education of individual, family, and support staff, and periodic monitoring and dietary intervention to improve nutrition-related health conditions. Adult Nutrition Services are provided by a Georgia Licensed Dietitian and by order of a physician, physician assistant, or nurse practitioner. These services may be provided in the individual's own home, family home, Licensed Dietitian's office, outpatient clinic, or facilities in which day services are provided.

Adult Nutrition Services include development of diet guidelines consistent with physician's order, mealtime observation to gather information about typical meal choices and preparation practices, development of sample menus, training and education of the individual, family, and staff in dietary compliance, and other clinically sound interventions judged necessary by the Licensed Dietitian, and not inconsistent with the physician's order. Any recommendations made by the Licensed Dietitian that alter the original order (e.g., modification to the prescribed diet, addition of supplements) must be ordered by the physician, physician assistant, or nurse practitioner before implementation.

3402. Special Requirements of Participation

3402.1. Licensure

3402.1.1. Adult Nutrition Services are provided by a licensed Dietitian in accordance with the applicable Georgia license as required under Title O.C.G.A. § 43-11A-18.

3402.1.2. Home Health Agencies providing Adult Nutrition services must have a Home Health Agency License as required under Title O.C.G.A. § 31-7-150.

3402.2. Individual Provider

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and PART II, Chapter 600 Policies and Procedures for the COMP Program, Adult Occupational Therapy Services providers must meet the following requirements:

3402.2.1. Service Provision: Adult Nutrition Services are provided by a Georgia licensed dietitian and by order of a physician.

3402.2.2. Documentation Requirement: Providers must document the following in the record of each individual receiving Adult Nutrition Services:

3402.2.2.1. Specific evaluation, training or therapeutic assistance provided;

- 3402.2.2.2. Date and the beginning and ending time when the service was provided;
- 3402.2.2.3. Location where the service was delivered;
- 3402.2.2.4. Verification of service delivery, including first and last name and title of the person providing the service and his or her signature;
- 3402.2.2.5. Progress towards moving the individual towards independence by meeting the individual ISP.
- 3402.2.2.6. Adult Nutrition Providers must maintain documentation for the identified need of therapies, frequency and duration of therapy, interventions to be provided, and goal(s) addressing therapies. Copies of documentation and/or educational material must be part of the documentation of a residential or other setting as training tools.

3402.2.3. Participant-Directed Services Documentation and other Requirements: Documentation and other requirements for individual providers of participant-directed services are specified in Part II Policies and Procedures for COMP, Chapter 1200.

3402.2.4. Adult Nutrition Services at Community Access and Prevocational Service Facilities: Providers can provide Adult Nutrition Services at facilities where Community Access and Prevocational Services are rendered; however, the services must be documented and billed separately, and any waiver individual receiving multiple services may not receive these services at the same time of the same day.

3402.3. Provider Agencies

In addition to those conditions of participation in the Medical Assistance Program as in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and PART II, Chapter 600 Policies and Procedures for the COMP Program, Adult Nutrition Services provider agencies must meet the following requirements:

- 3402.3.1. Service Provision: Adult Nutrition Services are provided by a Georgia licensed dietitian and by order of a physician.
- 3402.3.2. Types of Agencies: Agencies that provide Adult Nutrition Services are:
 - 3402.3.2.1. Accredited or Certified DD Service Agencies;
 - 3402.3.2.2. Home Health Agencies.
- 3402.3.3. Staffing Qualifications and Responsibilities:

- 3402.4. Accredited or Certified DD Service Agencies rendering Adult Nutrition Services must have staffing that meets the following requirements:
- 3402.5. A Clinical Services Supervisor (CSS). Additional information regarding CSS qualifications can be found in DBHDD Policy Recruitment and Application to Become a Provider of Developmental Disability Services, 02-701.
- 3402.6. Duties of the CSS include, but are not limited to:
 - 3402.6.1. Oversees the day-to-day operation of the agency;
Manages the use of agency funds;
Ensures the development and updating of required policies of the agency;
Manages the employment of staff and professional contracts for the agency;
 - 3402.6.2. Designates another agency staff member to oversee the agency, in his or her absence.
- 3402.7. Provider agencies must have available a sufficient number of employees or professionals under contract that are Georgia licensed dietitians to provide Adult Nutrition Services.
 - 3402.7.1. Home Health Agencies rendering Adult Nutrition Services must have staffing that meets the conditions of participation in the Medical Assistance Program as outlined in PART II, Chapter 600 Policies and Procedures for Home Health Services.
 - 3402.7.2. Agency Policies and Procedures: Each provider agency must develop written policies and procedures to govern the operations of Adult Nutrition services, which follow the Standards for the Georgia Department of Behavioral Health and Developmental Disabilities refer to Part II Policies and Procedures for COMP.
 - 3402.7.2.1. Adult Nutrition Services at Community Access and Prevocational Service Facilities: Providers can provide Adult Nutrition Services at facilities where Community Access and Prevocational Services are rendered; however, the services must be documented and billed separately, and any waiver participant receiving multiple waiver services may not receive these services at the same time of the same day.
 - 3402.7.2.2. DBHDD Contract/LOA and DBHDD Community Service Standards: Providers must adhere to DBHDD Contract/LOA, DBHDD Community Service Standards and all other applicable DBHDD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or

certification by the Department of Behavioral Health and Developmental Disabilities (see Part II Policies and Procedures for COMP, Chapter 603).

3403. Special Eligibility Conditions

In addition to a physician's order, a individual must have one of the following conditions:

- 3403.1. A medical condition or diagnosis:
 - 3403.1.1. For which a special therapeutic diet or dietary plan has been ordered by a physician, physician assistant or nurse practitioner; or
 - 3403.1.2. Which has resulted in the individual's inability to maintain adequate nutrition or hydration; or
 - 3403.1.3. Which involved pressure ulcers, non-healing skin lesions, or wounds or
- 3403.2. The individual is obese with a body mass index (BMI) of 30 or greater or
- 3403.3. The participant has had an unplanned weight gain or loss of 10% in the past six months.

$\text{BMI} = \frac{\text{weight in pounds}}{(\text{height in inches})^2} \times 703 \quad \text{or} \quad \frac{\text{weight in kilograms}}{(\text{height in meters})^2}$
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- 3403.4. Adult Nutrition Services are not available until the waiver individual's 21st birthday.
- 3403.5. The need for Adult Nutrition Services must be reflected in the Intake and Evaluation Team approved Individual Service Plan (ISP).
- 3403.6. There is a reasonable expectation by the licensed dietitian that the individual can achieve the goal(s) in the necessary time frame.
- 3403.7. All services must be ordered by a physician.

3404. Prior Approval

Adult Nutrition Services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any ISP version changes. The need for Adult Nutrition Services must be an identifiable assessed need in the ISP and directly related to the disability.

3405. Covered Services

Reimbursable Adult Nutrition Services include the following based on the assessed need of the individual:

- 3405.1. Nutrition evaluation.
- 3405.2. Individual/family/staff education.

3406. Non-Covered Services

$\text{BMI} = \frac{\text{weight in pounds}}{(\text{height in inches})^2} \times 703 \quad \text{or} \quad \frac{\text{weight in kilograms}}{(\text{height in meters})^2}$
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- 3406.1. Adult Nutrition Services do not include in-home therapeutic services for the treatment of an illness or injury that are covered in Home Health Services under the regular Medicaid State Plan.
- 3406.2. Transportation to and from these service delivery site may not be billed as part of the service.
- 3406.3. Not covered for conditions not related to DD diagnosis.
- 3406.4. Services that have not been ordered by a physician.
- 3406.5. Services in a hospital.
- 3406.6. Payment is not made for those goods and services covered by the State Medicaid Plan except where an individual's need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.

3407. Documentation Requirement:

Providers, except for providers of participant-directed services, must document the following in the record of each individual receiving Adult Nutrition Services:

- 3407.1. Specific evaluation, training or therapeutic assistance provided;
- 3407.2. Date and the beginning and ending time when the service was provided;
- 3407.3. Location where the service was delivered;
- 3407.4. Verification of service delivery, including first and last name and title of the person providing the service and his or her signature;
- 3407.5. Progress towards moving the individual towards independence by meeting the individual ISP.
- 3407.6. Adult Nutrition Providers must maintain documentation for the identified need of therapies, frequency and duration of therapy, interventions to be provided, and goal(s) addressing therapies.

3408. Basis for Reimbursement

The reimbursement rates for Adult Nutrition Services are found in Appendix A.

3409. Participant-Direction Options

Participants cannot choose the self-direction option with Adult Nutrition Services.

An individual serving as a representative for a waiver participant in self-directed services is not eligible to be a participant-directed provider.
For details on participant-direction, see Part II Policies and Procedures for NOW and COMP, Chapter 1200.

Chapter 3500: Specific Program Requirements for Assistive Technology Scope of Services

3501. General

Assistive Technology (AT) covers goods and services that are not otherwise covered by Medicaid State Plan services. These goods and services address the AT needs of the individual that result from his or her developmental disability. AT consists of any technology that is used to maintain or improve functional capabilities of waiver recipients by augmenting strengths and providing an alternative mode of performing a task. For a list of AT goods and services, refer to section 3509 of this chapter.

3502. Special Requirements of Participation Section

3502.1. Provider Agency- Service

3502.1.1. In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and Part II, Chapter 600 Policies and Procedures for the NOW/COMP Program, provider agencies of AT Services must meet the following requirements for evaluation and order:

3502.1.1.1. Georgia Licensed Occupational Therapist; or

3502.1.1.2. Georgia Licensed Speech Therapist;

3502.1.1.3. Georgia Licensed Audiologist;

3502.1.1.4. Georgia License Physical Therapist; or

3502.1.1.5. Assistive Technology Professional (ATP) accredited by Rehabilitation Engineering, and Assistive Technology Society of North America (RESNA) or other accredited institution; or

3502.1.1.6. Georgia Licensed Physician

3502.2. Provider Agency - Good

3502.2.1. In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and Part II, Chapter 600 Policies and Procedures for the NOW/COMP Program, provider agencies of AT Goods must meet the following requirements for goods distribution.

3502.2.1.1. DBHDD Contract/LOA and DBHDD Community Standards: Providers must adhere to DBHDD Contract Standards, DBHDD Core Requirements for All

Providers and all other applicable DBHDD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DBHDD (see Part II Policies and Procedures for NOW/COMP, Chapter 603).

- 3502.2.1.2. Registration with the Georgia Secretary of State for all providers excluding community service boards
- 3502.2.1.3. A minimum of 1-year prior experience as an AT goods or services provider (evidenced through invoicing, claims, bank summaries, or related practice) within the last 36 months or a letter of recommendation from manufacturer/publisher of product they represent.

3502.3. Individual Provider – Service

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and Part II, Chapter 600 Policies and Procedures for the NOW/COMP Program, provider agencies of AT Services must meet the following requirements for evaluation and order:

- 3502.3.1. Georgia Licensed Occupational Therapist; or
- 3502.3.2. Georgia Licensed Speech Therapist;
- 3502.3.3. Georgia Licensed Audiologist;
- 3502.3.4. Georgia Licensed Physical Therapist;
- 3502.3.5. Assistive Technology Professional (ATP) accredited by Rehabilitation Engineering, and Assistive Technology Society of North America (RESNA) or other accredited institution; or
- 3502.3.6. Georgia Licensed Physicians.

3502.4. Documentation Requirement:

Providers must document the following information in the individual's record regarding AT services:

- 3502.4.1. The efforts to substantiate DBHDD as payer of last resource, including available community, State Plan, or other resources by the individual's Support Coordinator or Intensive Support Coordinator.
- 3502.4.2. State Plan non-coverage of a particular item or items as evidenced by:
 - 3502.4.2.1. Medicaid denial letter; or

- 3502.4.2.2. Documentation of coverage exclusion by citation to Durable Medical Equipment Manual, Orthotic and Prosthetic Services Manual, Vision Care Manual, or Children's Intervention Service Manual
- 3502.4.3. If applicable, evidence that AT goods/services are not covered under private insurance or other healthcare funding:
 - 3502.4.3.1. Documented phone calls to AT vendors to determine coverage;
 - 3502.4.3.2. Notice of non-coverage of AT goods/services in a current schedule of benefits for a private insurance policy or other healthcare funding; or
 - 3502.4.3.3. Denial letter from private insurance or other healthcare funding
- 3502.4.4. Verification of AT service delivery, including date, location, specific supplies, and services provided.
- 3502.4.5. Documentation of associated administration costs for AT service delivery that delineates line-item sources of costs.
- 3502.4.6. Provider will supply at least two (2) estimates of any AT device with cost in excess of \$300.00.
- 3502.4.7. A sole source letter attesting to the unique aspects of the item is required when a provider is sole source for a particular item. This documentation shall be maintained in the individual's record.
- 3502.4.8. A fee of \$25 is allowed for the provision of administrative services for each individual ISP year.
- 3502.5. DBHDD Contract/LOA and DBHDD Community Service Standards: Providers must adhere to DBHDD Contract Standards, DBHDD Core Requirements for All Providers and all other applicable DBHDD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DBHDD (see Part II Policies and Procedures for NOW/COMP, Chapter 603).
- 3502.6. Transfer of Assistive Technology with Transition to New Provider: AT billed for an individual must transfer with the individual when the individual transitions to a new waiver provider (e.g., AT purchases of devices in the individual's possession acquired for the individual during the time receiving services). This transfer of AT includes all AT equipment/devised in possession as well as all AT billed for the individual but not yet provided to or used by the individual.

3503. Licensure

Individual and agency Assistive Technology providers must hold the applicable Georgia business license as required by the local, city or county government in which the services are provided.

3504. Special Eligibility Conditions Section

The need for assistive technology must be identified in the Individual Service Plan. Recommendations of AT (both service and good) of \$300.00 or more must be approved by a Georgia physician, Georgia Licensed Occupational Therapist, Georgia Licensed Speech Therapist, Georgia Licensed Audiologist, Georgia License Physical Therapist, RESNA ATP (Rehabilitation Engineering and Assistive Technology Society of North America Assistive Technology Professional), or other qualified professional whose signature indicates approval.

AT requests estimated at less than \$300 (total for both service and good) must be identified in the Individual Service Plan and need will be determine by the SC/ISC. AT requests estimated at \$300 and above must have an assessed need and be approved by the DBHDD Clinical Reviewer in the review of the ISP and related documentation provided.

3505. Prior Approval Section

- 3505.1. Individual receives assessment and order from a qualified provider (as indicated above) for AT equipment and/or AT service(s).
- 3505.2. The Support Coordination agency will attempt to procure all covered items through a DME vendor and any other available healthcare coverage sources – including, but not limited to: private insurance, Medicare, and/or State Plan Medicaid.
- 3505.3. If all other funding sources have been exhausted and NOW is payor of last resort, the ISP team will follow procedures for adding a new service as set forth in DBHDD policy found here: Viewing Service Changes via the Individual Service Plan and Requests for Clinical Review for NOW and COMP Waiver Participants, 02-444 (policystat.com)
- 3505.4. If the DME vendor is unable to submit a prior authorization or obtain a denial because the medically necessary item is not a State Plan covered item, the provider will maintain in the individual's record a copy of the DME Policy Manual Section (902, 903, 904, or 905) that substantiates the item as "non-covered." This documentation will be accepted in lieu of the formal denial for the supplies. With this documentation, the item can be purchased through AT waiver funds.
- 3505.5. AT services must be authorized prior to service delivery applicable DBHDD Field Office agency at least annually in conjunction with the Individual Service Plan development and with any ISP version changes.
- 3505.6. If an AT item is requested which does not appear on the approved AT reimbursable items list, DBHDD will consider the item, based on assessed need and cost, on a case-by-case basis.

3506. Covered Services Section

- 3506.1. Reimbursable AT Goods are listed in 3509 of this Chapter
- 3506.2. Assistive Technology services and supports include the following:

- 3506.3. Consultation and assessment to identify and address the Individual's needs as specified in the Individual Service Plan and/or other supporting documentation. Consultation & Assessment must be conducted by a qualified individual or agency services provider as specified (in section 3502 above) - where no other therapy assessment is available/appropriate.
- 3506.4. AT Demonstration- Individual and small group exploration of devices to increase awareness and knowledge of what is available. AT demonstration must be provided by either a qualified individual or agency services provider as specified in section 3502 above or qualified agency goods provider as specified in section 3502 above.
- 3506.5. Individual consultations to support device trials and assist in appropriate device selection. Individual consultations must be provided by qualified individual or agency services provider as specified (in section 3502 above)
- 3506.6. Individual and small group training on a specific device to support proper use. Small group training must be provided by either qualified individual or agency services provider as specified (above or qualified agency goods provider as specified
- 3506.7. Education and training for the Individual and family, guardian, and/or provider staff to aid the Individual in the use of the assistive technology Education and training must be provided by either qualified individual or agency services provider as specified (above or qualified agency goods provider as specified in section 3502 above.
- 3506.8. Maintenance and repair of the assistive technology. Maintenance and repair must be provided by a qualified agency goods provider as specified in section 3502 above.
- 3506.9. One-time Implementation training per order if needed and not provided by the vendor as part of delivery and installation. Additional therapy-related training should be recommended by the Doctor/ evaluator and have its own code.

3507. Non-Covered Services Section

- 3507.1. Items covered under the Durable Medical Equipment (DME), Orthotics and Prosthetics, and Hearing Services programs and other Medicaid non-waiver programs.
- 3507.2. Items that have been denied through the DME and other programs for lack of medical necessity.
- 3507.3. Massage equipment and exercise equipment
- 3507.4. Equipment and devices considered experimental.
- 3507.5. Off-the-shelf, non-customized cell phones and tablets that are purchased for standard use unrelated to the individual's disability; and that are not intended to maintain or improve functional capabilities of waiver members with disabilities by augmenting strengths and providing an alternative mode of performing a task⁶. Ancillary supplies for the proper functioning of non-approved devices or equipment.
- 3507.6. Equipment/devices for education and related services by children for whom the Department of Education has primary responsibility (i.e., private schools, ABA in

school, home-schooling, tutors).

- 3507.7. Stereos, radios, televisions, and MP3 players.
- 3507.8. Payment is not made for those goods and services covered by the State Medicaid Plan except where an individual's need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.
- 3507.9. Services otherwise provided through the NOW or the Medicaid State Plan, including additional units or costs beyond the maximum allowable for any NOW or Medicaid State Plan service.
- 3507.10. AT training that is already covered in the delivery/ installation of the product by the vendor.
- 3507.11. Replacement or repair of AT goods under current manufacturer or extended warranty.
- 3507.12. Educational services otherwise available through a program funded under 20 USC Chapter 3, section 1400 of the Individuals Education Act (IDEA), including private school tuition, Applied Behavior Analysis (ABA) in schools, school supplies, tutors, and homeschooling activities and supplies

3508. Basis for Reimbursement

- 3508.1. Reimbursement Rate Reimbursement rate for Assistive Technology (AT) is found in Appendix A.

3509. List of Reimbursable AT Goods

- 3509.1. Reimbursable AT Goods include the following based on the assessed need of the individual as specified in the approved ISP:

Ablenet JellyBean Twist; Ablenet Super Talker, Acrylic Mirror Sheet, Adapted Keyboard with TouchPad, Adaptive Cutting Board, Adaptive Scissors, Amazon Echo, Amazon Echo Dot, Amazon Echo Show, Bar Magnifier, Beams 723, Big Blue Switch, Big Mack, Blood Pressure Monitor, Boil Alert, Button Pusher, Double Keypad Door Lock, Freedom Wand, Furniture Risers, Go Talk 32, Go Talk 9+, Google Home, Google Home Mini, Gooseneck Mount with	Clamps & Adapter, GoTalk 32 Carry Stand, GoTalk 9 Carry Stand, Hickies Laces, Jellybean Twist, Jumbo Dry Erase Calendar , Liftware Level Starter Kit, Little Mack, Little Spill Drinking Cup, Long Handle Loofa, LumaWarm Heated Toilet Seat, MedELert, Medical Stepping Stool w/ railing, Med-ID USB Necklace/ Bracelet, modular hose, modular hose & phone holder, Modular Hose with Podium Mount, Modular Mounts and tray, One Handed Cutting Board, OT Vest, Penfriend2,	Plexiglass Eye-gaze Board, PocketTalk, PocketDresser, PowerLink 4, QuickTalker FT12, Reacher, Reizen RL-350 Braille Labeler, Ring Video Doorbell, Rocking T-Knife, SatinShave Razor, Seven Message Take n' Talk Go! Board, Stander Bed Rail, SuperTalker Progressive Communicator, Talking Pocket Wallet, Toto Washlet (Bidet), WatchMinder 3, Pocket Talker Ultra, ZoomText Large Print Keyboard.
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3509.2. Reimbursable AT Goods that must be specified in the approved ISP:

3"x3" Icon Holder Kit, Adult Bib, Anti-Scald Device, Automatic Pill Dispenser, Automatic Soap Dispenser, Automatic Toothpaste Dispenser, Bump dots, Button Aid, Button Hook, Clarity P300 Picture Phone, Clear Choice 2 Shower Dispenser, Clever Tongs, Colgate Electric Toothbrush, Cut Resistant Gloves, Digital Timer, Dignity Mug,, Divided Plate w/ Suction, Dycem Non-Slip Placemat, Epic ID, Ergonomic Bath Sponge, EZ PZ Happy Bowl, Fidget Balls, Fidget	Cube, Flipper Big Button Remote, Foam Grip Tubes, Freedom Dessert Bowl, LiveFine Automatic Pill Dispenser & Reminder, Long Arm Oven Mitt, No Tie Shoelaces, Norco Featherlite Reacher, Nosey Cups, Oasis Space Pill Reminder Box, One Handed Canister Set, Picture Care Phone, Pill box, Pocket-sized Communication Book, Potty Protector Shield, Reminder Rosie, Scoop Plate with Suction, Sensor Soap Dispenser, Shower Caddy, Shower Clock,	Shower Decals, Signature Guide, Slant Board, Snap Front Bra, Socks with Grips, SpeaksVolumz Cup, Swivel Spoon, Talking Photo Album, Talking Smoke and Carbon Monoxide Alarm, Tile Mate, Time Timer Plus, Toilet Safety Frame, Toothpaste Dispenser, Trio Shower Dispenser, Universal Cuff, Universal Cup Holder, Visual Recipes Cookbook, monitored medical alert system, seizure alarm.
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Appendix A
Reimbursement Rates for NOW Services

The reimbursement rates outlined below are the maximum amount that Medicaid may reimburse providers.

A. Adult Nutrition Services:

Service	Procedure Code	Modifier	Limits	Rate
Nutrition Evaluation	97802	U1	1 visit	\$28.09
Nutrition Follow Up	97803	U1	8 units/month (15-minute)	\$23.94

*Nutrition Evaluation is limited to 1 visit per year. 1 visit = 3 units.

Unit = 15-minute

Rate per unit = \$15.94

2,700 annual maximum for any Adult Nutrition Service procedure codes

Note: All adult therapy codes are subject to NCCI edits which cut back the allowable reimbursement to that noted below. CMS developed the National Correct Coding Initiative (NCCI) in 1997 which is included in the claims edits and cannot be overridden by the Georgia Department of Community Health.

B. Adult Occupational Therapy:

Procedure Name	Code	Modifier	Modifier	Modifier	Limit	Rate
Adult OT Evaluation – Low Complexity	97165				1 eval per year	\$71.98
Adult OT Evaluation – Low Complexity – self directed	97165	UC			1 eval per year	\$71.98
Adult OT Evaluation – Moderate Complexity	97166				1 eval per year	\$71.98
Adult OT Evaluation – Moderate Complexity – self directed	97166	UC			1 eval per year	\$71.98
Adult OT Evaluation – High Complexity	97167				1 eval per year	\$71.98
Adult OT Evaluation – High Complexity – self directed	97167	UC			1 eval per year	\$71.98
Adult OT Re-Evaluation	97168				1 unit per 180 days	\$47.55
Adult OT Re-Evaluation – self directed	97168	UC			1 unit per 180 days	\$47.55

Adult OT Therapeutic Services	97530	GO			<u>6 units per day</u>	\$30.23
Adult OT Therapeutic Services (self-directed)	97530	GO	UC		<u>6 units per day</u>	\$30.23
Adult OT Sensory Integrative Techniques	97533	GO			<u>4 units per day</u>	\$30.23
Adult OT Sensory Integrative Techniques (self-directed)	97533	GO	UC		<u>4 units per day</u>	\$30.23
Adult Orthotic and Prosthetic Fitting and Training	97760	GO			<u>6 units per day</u>	\$30.23
Adult Orthotic and Prosthetic Fitting and Training (self-directed)	97760	GO	UC		<u>6 units per day</u>	\$30.23
Prosthetic Training	97761	GO			<u>6 units per day</u>	\$30.23
Prosthetic Training (self-directed)	97761	GO	UC		<u>6 units per day</u>	\$30.23
Orthotic and Prosthetic Check Out	97763	GO			<u>6 units per day</u>	\$30.23
Orthotic and Prosthetic Check Out (self-directed)	97763	GO	UC		<u>6 units per day</u>	\$30.23
Occupational Therapy	97530	GO	U1			\$30.23
Occupational Therapy – Self-Directed	97530	GO	U1	<u>UC</u>		\$30.23

Only 97530-GO and 97530-GO-UC may be authorized after January 1, 2025.

Annual Limit for all combined Adult Therapies = \$10,800

C. Adult Physical Therapy:

Procedure Name	Code	Modifier	Modifier	Limit	Rate
Adult PT Evaluation – Low Complexity	97161	GP		1 eval per year	\$74.27
Adult PT Evaluation – Low Complexity – self directed	97161	GP	UC	1 eval per year	\$74.27
Adult PT Evaluation – Moderate Complexity	97162	GP		1 eval per year	\$74.27
Adult PT Evaluation – Moderate Complexity – self directed	97162	GP	UC	1 eval per year	\$74.27
Adult PT Evaluation – High Complexity	97163	GP		1 eval per year	\$74.27
Adult PT Evaluation –	97163	GP	UC	1 eval per	\$74.27

High Complexity - self directed				year	
Adult PT Re-evaluation	97164	GP		1 unit per 180 days	\$50.49
Adult PT Re-evaluation – self directed	97164	GP	UC	1 unit per 180 days	\$50.49
Adult PT Therapeutic Procedure	97110			<u>6 units per day</u>	\$30.23
Adult PT Therapeutic Procedure - self-directed	97110		UC	<u>6 units per day</u>	\$30.23
Neuro-Muscular Re-Education	97112	GO		<u>6 units per day</u>	\$39.23
Neuro-Muscular Re-Education (self-directed)	97112	GO	UC	<u>6 units per day</u>	\$30.23
Physical Therapy	97110	U1		<u>6 units per day</u>	\$30.23
Physical Therapy– Self-Directed	97110	U1	UC	<u>6 units per day</u>	\$30.23

Only 97110-U1 and 97110-U1-UC may be authorized after January 1, 2025.

Annual Limit for all combined Adult Therapies = \$10,800

D. Adult Speech and Language Therapy:

Adult Speech Language Evaluation	92523			<u>1 unit per 180 days</u>	\$175.44
Adult Speech Language Evaluation (self-directed)	92523		UC	<u>1 unit per 180 days</u>	\$175.44
Adult Speech Language Therapy	92507	GN		<u>1 session per day</u>	\$66.97
Adult Speech Language Therapy (self-directed)	92507	GN	UC	<u>1 session per day</u>	\$66.97
Adult Speech Generating Device Evaluation	92607			2 evals per year	\$117.03
Adult Speech Generating Device Evaluation (self-directed)	92607		UC	2 evals per year	\$117.03
Adult Speech-Generating Device Therapy	92609			<u>1 session per day</u>	\$58.64
Adult Speech-Generating Device Therapy (self-directed)	92609		UC	<u>1 session per day</u>	\$58.64
Adult Swallowing/Feeding Therapy	92526			<u>1 session per day</u>	\$47.83
Adult Swallowing/Feeding Therapy (self-directed)	92526		UC	<u>1 session per day</u>	\$47.83
Adult Swallowing/Feeding	92610			<u>1 unit per</u>	\$125.89

Evaluation				<u>180 days</u>	
Adult Swallowing/Feeding Evaluation (self-directed)	92610		UC	<u>1 unit per 180 days</u>	\$125.89

Note: All reference to 2 evaluations/year indicates 1 evaluation/180 days.

Annual Maximum for all combined Adult Therapies = \$10,800

E. Assistive Technology:

Procedure Name	Code	Modifier	Modifier	Limit	Rate
Assistive Technology Assessment	T2029	UD		6 units/year (15-minute)	\$38.66
Assistive Technology Goods and Services	T2029	UD	U1	1 unit	\$1.00

- i. Annual maximum is \$2,000 (AT Assessment and AT Goods & Services combined) with no lifetime maximum.
- ii. AT Assessment is limited to 1 assessment per year. 1 assessment = 6 units.
- iii. AT Goods and Services annual maximum number of units is 2,000.
- iv. Reimbursement rate for AT is individual specific to the cost of the device up to the annual maximum.

F. Behavioral Supports Services:

Behavioral Supports Services Level 2 (H2019-UB)
Behavioral Supports Services Level 2 Self-Directed (H2019-UB/UC)
Unit = 15 minutes
Maximum rate per unit- \$36.68

Self-Directed
Limit: 1 unit = \$1.00

Behavioral Supports Services Level 1 (H2019-UA)
Behavioral Supports Services Level 1 Self-Directed (H2019-UA/UC)
Unit = 15 minutes
Maximum rate per unit = \$24.36

Self-Directed
Limit: 1 unit = \$1.00

G. Community Access Services:

Service	Unit	Procedure Code	Rate
Community Access-Group, Facility	15 minutes	T2025-HQ-U1-U6	\$3.65
Community Access-Group, Facility, Deaf and Hard of Hearing	15 minutes	T2025-HQ-U1-U6-UD	\$3.97
Community Access-Group, Community, Category 1	15 minutes	T2025-HQ-U1-U7	\$3.65
Community Access-Group, Community, Category 1, Deaf and Hard of Hearing	15 minutes	T2025- HQ-U1-U7-UD	\$3.81
Community Access-Group, Community, Category 2	15 minutes	T2025- HQ-U2-U7	\$4.18
Community Access-Group, Community, Category 2, Deaf and Hard of Hearing	15 minutes	T2025- HQ-U2-U7-UD	\$4.54
Community Access-Group, Community, Category 3	15 minutes	T2025- HQ-U3-U7	\$5.23
Community Access-Group, Community, Category 3, Deaf and Hard of Hearing	15 minutes	T2025- HQ-U3-U7-UD	\$5.71
Community Access-Group, Community, Category 4	15 minutes	T2025- HQ-U4-U7	\$7.42
Community Access-Group, Community, Category 4, Deaf and Hard of Hearing	15 minutes	T2025- HQ-U4-U7-UD	\$8.13
Community Access-Individual	15 minutes	T2025-UB	\$10.55
Community Access-Individual, Deaf and Hard of Hearing	15 minutes	T2025-UB-UD	\$11.74
Community Access-Group, Facility, Self-Directed	1 Unit	T2025-HQ-UC	\$1.00
Community Access-Group, Community – Category 1, Self-Directed	1 Unit	T2025-HQ-U1-U7-UC	\$1.00
Community Access-Group, Community – Category 2, Self-Directed	1 Unit	T2025-HQ-U2-U7-UC	\$1.00
Community Access-Group, Community – Category 3, Self-Directed	1 Unit	T2025-HQ-U3-U7-UC	\$1.00
Community Access-Group, Community – Category 4, Self-Directed	1 Unit	T2025-HQ-U4-U7-UC	\$1.00
Community Access-Individual, Self-Directed	1 Unit	T2025-UB-UC	\$1.00
Community Access-Group, Facility – Co-Employer	15 minutes	T2025-HQ-U1-U6-UA	\$3.65
Community Access-Group, Community – Category 1, Co-Employer	15 minutes	T2025-HQ-U1-U7-UA	\$3.65
Community Access-Group, Community – Category 2, Co-Employer	15 minutes	T2025-HQ-U2-U7-UA	\$4.18
Community Access-Group, Community – Category 3, Co-Employer	15 minutes	T2025-HQ-U3-U7-UA	\$5.23
Community Access-Group, Community	15 minutes	T2025-HQ-U4-U7-	\$7.42

– Category 4, Co-Employer		UA	
Community Access-Individual, Co-Employer	15 minutes	T2025-UB-UA	\$10.55

Community Access-Group (including Co-Employer) = 6,000 units

The annual maximum for community access group is in combination for the annual maximum for prevocational services

Community Access-Group, Self-Directed = \$21,900.00

Community Access-Individual (including Co-Employer) = \$15,192.00

Community Access-Individual, Self-Directed = \$15,192.00

H. Community Guide Services:

Community Guide Self-Directed (H2015-UC)

Community Guide Co-Employer (H2015-UA)

Unit = 15 minutes

Daily Limit = 32 units

Annual Limit = 224 units

Maximum rate per unit = \$9.57

Annual Maximum = \$2,144.00

Self-Directed

Limit: 1 unit = \$1.00

Annual limit is as authorized in the individual budget up to an annual maximum of \$2,144

I. Community Living Support Services:

Service	Unit	Procedure Code	Rate
Community Living Support (CLS) – Basic	15-minutes	T2025-U5	\$9.98
CLS – Basic, Deaf and Hard of Hearing	15-minutes	T2025-U5-UD	\$11.14
CLS – Basic self-directed	1 Unit	T2025-U5-UC	\$1.00
CLS – Basic co-employer	15-minutes	T2025-U5-UA	\$9.98
Community Living Support - Extended	15-minutes	T2025-U4	\$9.28
CLS – Extended, Deaf and Hard of Hearing	15-minutes	T2025-U4-UD	\$10.40
CLS- Extended self-directed	1 Unit	T2025-U4-UC	\$1.00
CLS – Extended co-	15-minutes	T2025-U4-UA	\$9.28

employer			
Community Living Support, 2 Members - Basic	15-minutes	T2025-U5-UN	\$5.49
CLS, 2 Members - Basic, Deaf and Hard of Hearing	15-minutes	T2025-U5-UN-UD	\$6.13
CLS Basic – 2 Members self-directed	1 Unit	T2025-U5-UN-UC	\$1.00
CLS Basic – 2 Members co-employer	15-minutes	T2025-U5-UN-UA	\$5.49
Community Living Support, 2 Members - Extended	15-minutes	T2025-U4-UN	\$5.10
CLS, 2 Members - Extended, Deaf and Hard of Hearing	15-minutes	T2025-U4-UN-UD	\$5.72
CLS Extended, 2 Members self-directed	1 Unit	T2025-U4-UN-UC	\$1.00
CLS Extended, 2 Members co-employer	15-minutes	T2025-U4-UN-UA	\$5.10
Community Living Support, 3 Members - Basic	15-minutes	T2025-U5-UP	\$3.99
CLS, 3 Members - Basic, Deaf and Hard of Hearing	15-minutes	T2025-U5-UP-UD	\$4.46
CLS Basic – 3 Members self-directed	1 Unit	T2025-U5-UP-UC	\$1.00
CLS Basic – 3 Members co-employer	15-minutes	T2025-U5-UP-UA	\$3.99
Community Living Support, 3 Members - Extended	15-minutes	T2025-U4-UP	\$3.71
CLS, 3 Members - Extended, Deaf and Hard of Hearing	15-minutes	T2025-U4-UP-UD	\$4.16
CLS Extended – 3 Members self-directed	1 Unit	T2025-U4-UP-UC	\$1.00
CLS Extended – 3 Members co-employer	15-minutes	T2025-U4-UP-UA	\$3.71
Personal Assistance Retainer	15-minutes	T2025-U5-CG	\$9.28
Personal Assistance Retainer, Deaf and Hard of Hearing	15-minutes	T2025-U5-CG-UD	\$10.40
Personal Assistance Retainer self-directed	1 Unit	T2025-U5-CG-UC	\$1.00

Personal Assistance Retainer co-employer	15-minutes	T2025-U5-CG-UA	\$9.28
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Total annual amount of all fifteen-minute CLS services billed cannot exceed \$65,000 annually.

Self-Directed

Community Living Support: 1 unit = \$1.00

Annual limit is as authorized in the individual budget up to an annual maximum of \$65,000.

J. Environmental Accessibility Adaptation:

Environmental Accessibility Adaptation (S5165)

Environmental Accessibility Adaptation Self-Directed (S5165-UC)

Maximum of \$15,000 per individual every five years

The reimbursement rate is the lower of three price quotes or \$15,000.

K. Financial Support Services:

Financial Support Services (T2040-UC)

Unit = 1 month

Maximum annual number of units = 12

Maximum rate per participant = \$101.75 per month

L. Individual Directed Goods and Services:

Individual Directed Goods and Services (T2025 U7/UC)

Maximum annual number of units = 1606

Limits: 1 unit = \$1.00

\$1,606.00 annual maximum.

M. Interpreter Services:

Interpreter Services (T1013)

Unit=15 minutes

Maximum Annual number of units= 245/61.25 hours annually

Maximum rate per unit= \$26.76

Annual maximum= \$6,556.20

N. Natural Support Training Services:

Natural Support Training (T2025-UD)

Natural Support Training Self-Directed (T2025-UD/UC)

Unit = 15 minutes

Maximum annual number of units = 86

Maximum rate per unit = \$22.26

Annual maximum = \$1,914.36

O. Nursing Services

RN – nursing services (T1002-U1)

Unit = 15 minutes

Maximum rate per unit = \$36.68

LPN – nursing services (T1003-U1)

Unit = 15 minutes

Maximum rate per unit = \$24.36

P. Prevocational Services:

Service	Unit	Procedure Code	Rate
Prevocational Services	15 minutes	T2015	\$3.33
Prevocational Services, Deaf and Hard of Hearing	15 minutes	T2015-UD	\$3.63

Annual Limit = 6,000 units

The annual maximum for prevocational services is in combination for the annual maximum for community access group.

Q. Respite Services

Service	Unit	Procedure Code	Rate
Respite-1 Member, In Home	15 min	S5150	\$9.38
Respite-1 Member, In Home, Self-Directed	1 unit	S5150-UC	\$1.00
Respite-1 Member, In Home, Co-Employer	15 min	S5150-UA	\$9.38
Respite-1 Member In Home, Deaf and Hard of Hearing	15 min	S5150-UD	\$10.50
Respite-2 Members, In Home	15 min	S5150-UN	\$5.16
Respite-2 Members, In Home, Self-Directed	1 unit	S5150-UN-UC	\$1.00
Respite-2 Members, In-Home, Co-Employer	15 min	S5150-UN-UA	\$5.16
Respite-2 Members In Home, Deaf and Hard of Hearing	15 min	S5150-UN-UD	\$5.77
Respite-3 Members, In Home	15 min	S5150-UP	\$3.75
Respite-3 Members, In Home, Self-Directed	1 unit	S5150-UP-UC	\$1.00
Respite-3 Members, In Home, Co-Employer	15 min	S5150-UP-UA	\$3.75
Respite-3 Members In Home, Deaf and Hard of Hearing	15 min	S5150-UP-UD	\$4.20
Respite-Out of Home, Category 1	Daily	S5151-UJ	\$184.72

Respite-Out of Home, Category 1, Self-Directed	Daily	S5151-UJ-UC	\$184.72
Respite-Out of Home, Category 1, Co-Employer	Daily	S5151-UJ-UA	\$184.72
Respite-Out of Home, Category 2	Daily	S5151-U1-UJ	\$248.94
Respite-Out of Home, Category 2, Self-Directed	Daily	S5151-U1-UJ-UC	\$248.94
Respite-Out of Home, Category 2, Co-Employer	Daily	S5151-U1-UJ-UA	\$248.94
Respite-Out of Home, Category 1	15 min	S5150 U1	\$9.38
Respite-Out of Home ,Category 1, Self-Directed	1 unit	S5150 U1-UC	\$1.00
Respite-Out of Home, Category 2	15 min	S5150 U3	\$9.38
Respite-Out of Home, Category 2, Self-Directed	1 unit	S5150 U3-UC	\$1.00

Respite services delivered during 7.5 hours (30 units in one day) must be billed as a daily unit.

Annual limits for all Respite services in combination:

Individuals in Levels 1 through 4 = \$5,541.60

Individuals in Levels 5 through 7 = \$7,468.20

R. Specialized Medical Equipment:

Specialized Medical Equipment (T2029)

Specialized Medical Equipment Self-Directed (T2029-UC)

1 unit = \$1.00

Annual maximum = \$5,569.00

The amount of funds per equipment purchase is the standard Medicaid reimbursement rate for the equipment or, in the absence of a standard Medicaid rate, the lower of three price quotes. The annual maximum number of units is 5,569 unless there is approval to exceed the annual maximum due to assessed exceptional needs of the individual.

S. Specialized Medical Supplies:

Specialized Medical Supplies (T2028)

Specialized Medical Supplies Self-Directed (T2028-UC)

1 unit = \$1.00

Annual maximum = \$4,069.00

The annual maximum number of units is 4,069 unless there is approval to exceed annual maximum units due to assessed exceptional needs of the individual.

Note: Revision to the annual maximum authorization for Specialized Medical Supplies was approved by CMS through NOW Waiver Renewal as of 03/2018 but omitted in error in the 40/2018 policy publication.

T. Supported Employment Services:

Service	Unit	Procedure Code	Rate
Supported Employment-Group, 1:8-1:10	15 minutes	T2019-HQ-U1	\$2.47
Supported Employment-Group, 1:8-1:10, Co-Employer	15 minutes	T2019-HQ-UA-U1	\$2.47
Supported Employment-Group, 1:8-1:10, Deaf and Hard of Hearing	15 minutes	T2019-HQ-UD-U1	\$2.63
Supported Employment-Group, 1:5-1:7	15 minutes	T2019-HQ-U2	\$3.38
Supported Employment-Group, 1:5-1:7, Co-Employer	15 minutes	T2019- HQ-UA-U2	\$3.38
Supported Employment-Group, 1:5-1:7, Deaf and Hard of Hearing	15 minutes	T2019- HQ-UD-U2	\$3.63
Supported Employment-Group, 1:3-1:4	15 minutes	T2019-HQ-U3	\$5.37
Supported Employment-Group, 1:3-1:4, Co-Employer	15 minutes	T2019- HQ-UA-U3	\$5.37
Supported Employment-Group, 1:3-1:4, Deaf and Hard of Hearing	15 minutes	T2019- HQ-UD-U3	\$5.78
Supported Employment-Group, 1:2	15 minutes	T2019-HQ-U4	\$8.95
Supported Employment-Group, 1:2, Co-Employer	15 minutes	T2019- HQ-UA-U4	\$8.95
Supported Employment-Group, 1:2, Deaf and Hard of Hearing	15 minutes	T2019- HQ-UD-U4	\$9.67
Supported Employment-Group, 1:2, Self-Directed	1 unit	T2019-HQ-UC-U4	\$1.00
Supported Employment-Group, 1:3-1:4, Self-Directed	1 unit	T2019- HQ-UC-U3	\$1.00
Supported Employment-Group, 1:5-1:7, Self-Directed	1 unit	T2019- HQ-UC-U2	\$1.00
Supported Employment-Group, 1:8-1:10, Self-Directed	1 unit	T2019- HQ-UC-U1	\$1.00
Supported Employment-Individual, Job Developer	15 minutes	T2019-UB-U1	\$17.92
Supported Employment-Individual, Job Developer, Deaf and Hard of Hearing	15 minutes	T2019-UB-UD-U1	\$19.26
Supported Employment-Individual, Job Developer, Co-Employer	15 minutes	T2019-UB-UA-U1	\$17.92
Supported Employment-Individual, Job Developer, Self-Directed	1 unit	T2019-UB-UC-U1	\$1.00
Supported Employment-Individual, Job Coach	15 minutes	T2019-UB-U2	\$15.06
Supported Employment-Individual, Job Coach, Deaf and Hard of Hearing	15 minutes	T2019-UB-UD-U2	\$16.37
Supported Employment-Individual, Job Coach, Co-employer	15-minutes	T2019-UB-UA-U2	\$15.06
Supported Employment-Individual, Job Coach, Self-Directed	1 unit	T2019-UB-UC-U2	\$1.00

U. Transportation Services

Transportation Encounter/Trip (T2003 U1)

Transportation Encounter/Trip Self-Directed (T2003-UC)

Transportation Encounter/Trip Co-Employer (T2003-UA)

1 Unit = \$1.00

Mileage Rates are established by the provider agency but must use a methodology of comparable transportation rates. Maximum rate per unit =

Transportation Commercial Carrier, Multi-Pass (T2004)

Transportation Commercial Carrier, Multi-Pass Self-Directed (T2004-UC)

Individual specific rate for local commercial carrier, multi-pass

Annual Maximum for Transportation Services = \$2,995

Self-Directed

Scheduled Encounter/Trip

1 Unit = \$1.00

Mileage Rates are established by the Vendor and/or the Representative but must use a methodology of comparable transportation rates.

Annual limit is authorized in the individual budget up to annual maximum for all self-directed

Transportation services of \$2,995.

Commercial Carrier/Multipass/Intermittent Trip

1 unit = \$1.00

Annual limit is as authorized in the individual budget up to annual maximum for all self-directed

Transportation Services of \$2,995.

V. Vehicle Adaptation Services:

Vehicle Adaptation (T2039)

Vehicle Adaptation Self-Directed (T2039-UC)

1 unit = \$1.00

Limit 15,000 every years

The reimbursement rate is the lower of three price quotes or the lifetime maximum.

Appendix B

Requirements for the Deaf and Hard of Hearing Rate Enhancement

A. Overview

The NOW Program includes enhanced provider payments rates for services provided to individuals who are deaf or hard of hearing (as determined through a Communications Assessment) by staff qualified in sign language or an alternative approved communication in accordance with the individual's Communication Assessment. The following services have enhanced rates:

- i. Community Living Support
- ii. Respite, 15-Minute
- iii. Supported Employment-Individual
- iv. Supported Employment-Group
- v. Prevocational Services
- vi. Community Access-Individual
- vii. Community Access-Group

DBHDD's policy regarding accessibility for services for individuals who are deaf and hard of hearing can be found under the DBHDD policy "Accessibility of Community Intellectual and Developmental Disabilities Services for Individuals Who are Deaf and Hard of Hearing, 15-115."

B. Participant Eligibility

To qualify for the deaf and hard of hearing rate enhancement, the participant must meet both of the following criteria, as confirmed by a Communication Assessment performed by a Communication Specialist from DBHDD's Office of Deaf Services:

- i. The participant must be deaf or hard of hearing.

"Deaf" means having hearing that is totally impaired or hearing that is so seriously impaired as to prohibit the individual from understanding oral communications spoken in a normal conversational tone (see O.C.G.A. § 30-1-1). This can be a self-identified classification regardless of the severity of the hearing loss or mode of manual communication preferred.

"Hard of hearing" means having a hearing loss, whether permanent or fluctuating, which may be corrected by amplification or other assistive technology or means but which nevertheless presents challenges in understanding oral communications spoken in a normal conversational tone through hearing.
- ii. The participant's preferred mode of communication must be American Sign Language (ASL) or words or gestures (sometimes referred to based on ASL).

Individuals who are believed to be deaf or hard of hearing must receive a Communications Assessment in accordance with DBHDD Policy “Accessibility of Community Intellectual and Developmental Disabilities Services for Individuals Who are Deaf and Hard of Hearing, 15-115.”

C. Provider and Staff Qualification Requirements

To bill an enhanced deaf and hard of hearing rate, the service must be delivered by direct care staff who both meet the standard requirements for the service and demonstrate fluency in American Sign Language (ASL). To demonstrate fluency, staff must take the Sign Language Proficiency Interview (SLPI) or its predecessor, the Signed Communication Proficiency Interview (SCPI), when those interviews are administered by a person or agency approved by DBHDD for SLPI or SCPI administration. The level of fluency that needs to be demonstrated by an ASL-fluent staff is determined by the Communication Assessment and the Individual Service Plan (ISP) for the individual served by that staff member.

For programs with multiple staff who may support the individual, such as a Community Access-Group program or Community Residential Alternative-Group Home, an ASL-fluent staff must be available to the individual at all times that active supports are being provided, which does not include hours when the individual is asleep.

Appendix C

Procedures for Billing and Documenting Personal Assistance Retainer

A personal assistance retainer is a component of Community Living Support Services. The personal assistance allows continued payment for Community Living Support services while an individual is hospitalized or otherwise away from the home to prevent reassignment of or otherwise stabilize staff known to the individual. Staff may not provide services in a hospital or nursing home setting but are retained in order to ensure stability of staff upon the individual's return home. This retainer allows continued payment to personal caregivers under the waiver for up to thirty (30) days per (Calendar year) for absences of individual from his or her home.

A. Personal Assistance Retainer Documentation:

Providers must document the following in the record of each individual for whom a personal assistance retainer is a component of Community Living Support Services:

- i. Beginning and end date of absence.
- ii. Reason for absence.
- iii. Scheduled days and units per day for Community Living Support Services.
- iv. Scheduled staff was not deployed to work at any other provider location, in home of another individual, or in an institutional setting (hospital or nursing facility).

The Co-Employer agency of any participant/representative who opts for participant-direction through a Co-Employer Agency must document the personal assistance retainer as above. The participant/representative who opts for participant-direction through a Financial Support Services Provider must maintain copies of CLS Personal Assistance Retainer Timesheet for any claims of this retainer for Community Living Support Services.

D. Personal Assistance Retainer Allowances and Exclusions:

- i. Personal Assistance Retainer Allowances

The personal assistance retainer allows continued payment to personal caregivers under the waiver for up to thirty (30) days per year for absences of the individual from his or her home, per calendar year.

Only for the scheduled days and amounts of Community Living Support services as indicated in the ISP (e.g., if an individual receives CLS services only on Tuesday, Wednesday, and Thursday for a total of 16 units per day, the personal assistance retainer may only be claimed for Tuesday, Wednesday, and Thursday for 16 units per day for any week for which the retainer provides continued payment). The provider must document specific days and units billed under the personal assistance retainer.

- ii. Personal Assistance Retainer Exclusions

The following exclusions apply to the personal assistance retainer:

1. Payment is not made for Personal Assistance Retainer outside of scheduled days and units per day for Community Living Support Services.
2. Payment of Personal Assistance retainer is not allowable for absences due to services that are reimbursable as other waiver and Medicaid State Plan services except for admissions to a general hospital or nursing facility as indicated below.
3. Payment of Personal Assistance retainer beyond allowable days indicated below.

E. Personal Assistance Retainer Billing:

Providers must submit claims as follows for the personal assistance retainer:

i. Claims During Hospital Stays

1. Providers submit claims for each admission to a general hospital or nursing facility, including ICF/ID and skilled nursing facilities;
2. Providers submit claims for only scheduled days and units.
3. Providers bill a separate line for each day claimed during the hospital stay;
4. Providers list place of service on the claim as follows:
 - (a) 31 for Skilled Nursing Facility
 - (b) 32 for Nursing Facility
 - (c) 54 for Intermediate Care Facility/MR
 - (d) 21 for Inpatient Hospital
 - (e) 99 for vacations and family/relative visits

Note: Providers may not submit reimbursement for services provided in a nursing facility, hospital or ICF/ID.

Note: For personal assistance retainer claims during hospital stays, the provider must bill a separate line for each day claimed during the hospital stay up to the allowable (30) days per calendar year for all absences of the participant from his or her home.

ii. Claims for Other Absences

1. Providers submit claims up to the allowable thirty (30) days per calendar year for all absences of the individual from his or her home, including hospital stays as in Section E.i. above and other absences of the individual from his or her home, such as vacations and family/relative visit, per calendar year;
2. Providers submit claims for only scheduled days and units (would have been provided except for the absence from the home).
3. Providers may submit claims for other absences as standard (that is, in weekly, bi-

weekly, or monthly spans)

Note: Providers are required to submit timesheets documentation of the vacations, hospitalizations, and family visits to mellis@dch.ga.gov for review.

Note: Family hire caregivers are exempt from utilizing retainer payments when unavailable to render services to the member.