PART III

CHAPTERS 1300 – 3700

POLICIES
AND
PROCEDURES
FOR
COMPREHENSIVE SUPPORTS WAIVERS PROGRAM (COMP):

Adult Occupational Therapies Services, Adult Physical Therapy Services, Adult Speech and Language Therapy Services, Adult Nutrition Services, Additional Staffing Services, Behavioral Supports Level 1 and Level 2, Community Access Services, Community Guide Services, Community Living Supports Services, Community Residential Alternative Services, Environmental Accessibility Services, Financial Support Services, Individual Directed Goods and Services, Interpreter Services, Natural Supports Training Services, Nursing Services, Prevocational Services, Respite Services, Supported Employment Services, Specialized Medical Supplies Services, Specialized Medical Equipment Services, Transportation Services and Vehicle Adaptation Services, Assistive Technology Services

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAID

Revised: July 1, 2023

NUMBER	REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE	REASON FOR CHANGE
				A=Added D= Deleted M= Modified	(Revision required by Regulation, Legislation, Etc.
1.	7.1.23	Manual Cover Page	Change date from April 1, 2023 to July 1, 2023.	M	N/A
2.	7.1.2023	1307	Added Co-payment towards other insurance sources as a non-covered payment	M	Modification to non-covered service definition
3.	7.1.2023	1407	Added Co-payment towards other insurance sources as a non-covered payment	M	Modification to non-covered service definition
4.	7.1.2023	1507	Added Co-payment towards other insurance sources as a non-covered payment	M	Modification to non-covered service definition
5.	7.1.2023	2206	Added allowance for CLS to be provided in individual or family owned home when the employee is a family caregiver hire as established in Chapter 900 and 1200 Part II NOW/COMP	A	Unwinding PHE
6.	7.1.2023	3005 7.	Added a minimum of two (2) monthly contacts for Supported Employment Group and Supported Employment Individual services	A	Clarification of service expectation
7.	7.1.2023	Appendix A	Updated Interpreter Services unit amounts to align with COMP renewal	M	COMP Renewal edit
8.	7.1.2023	Appendix A	Updated Appendix A to align with current rate structure	M	Clarification of rate structure
9.	7.1.2023	Appendix C	Update Personal Assistance Retainer Billing	M	Update for Clarification

The following defines each column:

1. Revision Date – the manual date of the change
2. Section. – The section of the document to which the comment applies.

3. Revision Description. – The paragraph for which the changes are occurring.
4. Revision Type
    a. A – The revision is an addition to the Policy
    b. D – The revision is a Deletion of the Policy
    c. M – The revision is modifying (changing) a portion of the Policy
5. Reason for the Change: Is the change needed because of a change in Regulation or Legislation, etc…..

PART III
POLICIES AND PROCEDURES

FOR
COMPREHENSIVE SUPPORTS WAIVER PROGRAM
(COMP)

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PART III - CHAPTER 1300

SPECIFIC PROGRAM REQUIREMENT
FOR
ADULT OCCUPATIONAL THERAPY SERVICES

SCOPE OF SERVICES

1301 General

Rev 07 2016

Adult Occupational Therapy Services (OT) cover 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) specified in the Individual Service Plan.

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 COMP Program, Adult Occupational Therapy Services providers must meet the following requirements:

Rev. 07 2010

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.

2. **Documentation Requirement**: Providers must document the following in the record of each individual receiving Adult Occupational Therapy Services:

   - Specific evaluation, training or therapeutic assistance provided;

- Date and the beginning and ending time when the service was provided;

- Location where the service was delivered;

- Verification of service delivery, including first and last name and title of the person providing the service and his or her signature;

- Progress towards the individual's independence as documented in the individual's ISP

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

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*.

4. **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 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 COMP Program, Adult Occupational Therapy Services provider agencies must meet the following requirements:

a.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.

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

a. Accredited or Certified DD Service Agencies;

b. Home Health Agencies.

c. Specialized Therapy Agencies

Rev 01 2013

c. Staffing Qualifications and Responsibilities:

a. **Accredited or Certified DD Service Agencies** rendering Adult Occupational Therapy Services must have staffing that meets the following requirements:

1) 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**.**

2) 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.

i. 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 Services.

3) Duties of the occupational therapists include all covered services in Section 1306.

b. **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.

4. **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 refer to *Part II Policies and Procedures for COMP*.

5. **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:

A. Specific evaluation, training or therapeutic assistance provided;

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

C. Location where the service was delivered;

D. Verification of service delivery, including first and last name and title of the person providing the service and his or her signature;

E. Progress towards the individual's independence as documented in the individual's ISP.

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

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 COMP, Chapter 1200*.

7. **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.

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

1303 Licensure

A. Adult Occupational Therapy Services are provided by a licensed Occupational Therapist in accordance with the applicable Georgia license as required under O.C.G.A. § 43-28-7.

B. 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

Adult Occupational Therapy Services are not available until the waiver individual's 21st birthday.

The need for Adult Occupational Therapy Services must be reflected in the Intake and Evaluation Team approved Individual Service Plan (ISP).

There is a reasonable expectation by the licensed occupational therapist that the individual can achieve the goals in the necessary time frame.

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 ISP 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:

1. Occupational therapy evaluation.

2. Therapeutic activities to improve functional performance.

3. Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands.

4. Individual /family education.

1307 Non-Covered Services

1. 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.

2. Transportation to and from these service delivery site may not be billed as part of the service.

3. Group Therapy Activities.

4. Not covered for conditions not related to DD diagnosis.

5. Services that have not been ordered by a physician.

6. Services in a hospital.

Rev 01 2013

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.

8. Co-payment towards other insurance sources.

1308 Basis for Reimbursement

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

The rate cannot exceed the established Medicaid rates for the Children Intervention Services Program.

1309 Participant-Direction Options

1. Individuals can choose the self-direction option with Adult Occupational Therapy Services.

2. An individual serving as a representative for a waiver individual in self-directed services is not eligible to be a participant-directed provider of Adult Occupational Therapy Services.

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

1310 Telehealth Options

Rev 10 2022

A. 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.

B. 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

C. 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.

D. 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.

E. 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).

Rev 10 2022

F. For more information regarding telehealth guidance, please refer to the telehealth guidance, located at www.mmis.georgia.gov, Click Provider Information-Provider Manuals.

PART III - CHAPTER 1400

SPECIFIC PROGRAM REQUIREMENTS FOR ADULT PHYSICIAL THERAPY SERVICES

SCOPE OF SERVICES

1401 General

Rev 07 2016

Adult Physical Therapy Services (PT) cover 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 a 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) specified in the Individual Service Plan.

1402 Special Requirements of Participation

a. 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 and COMP Program, Adult Physical Therapy Services providers must meet the following requirements:

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.

2. **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:

   i. Specific evaluation, training or therapeutic assistance provided;

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

   iii. Location where the service was delivered;

   iv. Verification of service delivery, including first and last name and title of the person providing the service and his or her signature;

   v. Progress towards the individual's independence as documented in the individual's ISP.

   vi. Adult Physical Therapy providers maintain documentation for: the identified need of therapies, frequency and duration of therapy, interventions to be provided, and Physical Therapy goal(s) addressing therapies.

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*.

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 and COMP Program, Adult Physical Therapy Services provider agencies must meet the following requirements:

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.

Types of Agencies: Agencies that provide Adult Physical Therapy Services are:

- Accredited or Certified DD Service Agencies
- Home Health Agencies
- Specialized Therapy Agencies

Staffing Qualifications and Responsibilities:

Rev 01 2013

a. **Accredited or Certified DD Service Agencies** rendering Adult Physical Therapy Services must have staffing that meets the following requirements:

i) 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.

ii) 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.

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

b. **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.

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 refer to *Part II Policies and Procedures for NOW and COMP*.

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:

   a. Specific evaluation, training or therapeutic assistance provided;

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

   c. Location where the service was delivered;

   d. Verification of service delivery, including first and last name and title of the person providing the service and his or her signature;

   e. Progress towards the individual's independence as documented in the individual's ISP.

   f. Adult Physical Therapy providers maintain documentation for: the identified need of therapies, frequency and duration of therapy, interventions to be provided, and Physical Therapy goal(s) addressing therapies.

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 and COMP, Chapter 1200*.

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.

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 (see *Part II Policies and Procedures for NOW and COMP, Chapter 603).*

1403 Licensure

1. Adult Physical Therapy Services are provided by a licensed Physical Therapist in accordance with the applicable Georgia license as required under O.C.G.A. § 43-33-19.

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

A. Adult Physical Therapy Services are not available until the waiver individual's 21st birthday.

B. The need for Adult Physical Therapy Services must be reflected in the Intake and Evaluation Team approved Individual Service Plan (ISP).

C. There is a reasonable expectation by the licensed physical therapist that the individual can achieve the physical therapy goal(s) in the necessary time frame.

D. 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 ISP 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:

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

1407 Non-Covered Services

1. 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.
2. Transportation to and from these services is not included in the rate.
3. Group Therapy Activities.
4. Not covered for conditions not related to DD diagnosis.
5. Services that have not been ordered by a physician.
6. Services in a hospital.

Rev 01 2013

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

8. Co-payment towards other insurance sources.

1408 Basis for Reimbursement

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

The rate cannot exceed the established Medicaid rates for the Children Intervention Services Program.

1409 Participant-Direction Options

A. Individuals can choose the self-direction option with Adult Physical Therapy Services.

B. An individual serving as a representative for a waiver individual in self-directed services is not eligible to be a participant-directed provider of Adult Physical Therapy Services.

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

1410 Telehealth Options

Rev 10 2022

A. 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.

B. 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

C. 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.

D. 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.

E. 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)

F. For more information regarding telehealth guidance, please refer to the telehealth guidance, located at www.mmis.georgia.gov, Click Provider Information-Provider Manuals.

PART III - 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 a 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) specified in the Individual Service Plan.

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 and COMP Program, Adult Speech and Language Therapy Services providers must meet the following requirements:

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.

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:

    a. Specific evaluation, training or therapeutic assistance provided;

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

    c. Location where the service was delivered;

    d. Verification of service delivery, including first and last name and title of the person providing the service and his or her signature;

    e. Progress towards the individual's independence as documented in the individual's ISP.

    f. Adult Speech and Language Therapy providers maintain documentation for: the identified need of therapies, frequency and duration of therapy, interventions to be provided, and Adult Speech and Language Therapy goal(s) addressing therapies.

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*.

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 COMP Program, Adult Speech and Language Therapy Services provider agencies must meet the following requirements:

A. 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.

B. Types of Agencies: Agencies that provide Adult Speech and Language Therapy Services are:

a. Accredited or Certified DD Service Agencies;

b. Home Health Agencies

c. Specialized Therapy Agencies

Rev 01 2013

a. Staffing Qualifications and Responsibilities

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

i) A designated **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.

ii) 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.

iii) 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.

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

b. **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 NOW and COMP PART II, Chapter 600 Policies and Procedures for Home Health Services.

4. **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 refer to *Part II Policies and Procedures for NOW and COMP*.

5. **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:

   a. Specific evaluation, training or therapeutic assistance provided;

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

c. Location where the service was delivered;

d. Verification of service delivery, including first and last name and title of the person providing the service and his or her signature;

e. Progress towards the individual's independence as documented in the individual's ISP.

f. Adult Speech and Language Therapy providers maintain documentation for: the identified need of therapies, frequency and duration of therapy, interventions to be provided, and Speech and Language Therapy goal(s) addressing therapies.

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 COMP and NOW Chapter 1200*.

7. **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.

1503 Licensure

a. 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 O.C.G.A. § 43-44-7.

b. 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

A. Adult Speech and Language Therapy Services are not available until the waiver individual's 21st birthday.

B. The need for Adult Speech and Language Therapy Services must be reflected in the Intake and Evaluation Team approved Individual Service Plan (ISP).

C. There is a reasonable expectation by the licensed speech and language pathologist that the individual can achieve the goals in the necessary time frame.

D. 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

1. 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:

2. Evaluation of speech language, voice, and language communication, auditory processing, and/or aural rehabilitation.

3. Individual treatment of speech, language, voice, communication, and/or auditory processing.

4. Therapeutic services for the use of speech-generating device, including programming and modification.

5. Individual/family education.

1507 Non-Covered Services

A. 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.

B. Transportation to and from these services is not included in the rate.

C. Group Therapy Activities.

D. Not covered for conditions not related to DD diagnosis.

E. Services that have not been ordered by a physician.

F. Services in a hospital.

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G. 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.

H. Payment is not made for feeding and swallowing evaluation and treatment via any telehealth modality.

I. Co-payment towards other insurance sources,

J.

1508 Basis for Reimbursement

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

The rate cannot exceed the established Medicaid rates for the Children Intervention Services Program.

1509 Participant-Direction Options

a. Individuals can choose the self-direction option with Adult Speech and Language Therapy Services.

b. An individual serving as a representative for a waiver individual in self-directed services is not eligible to be a participant-directed provider of Adult Speech and Language Therapy Services.

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

1510 Telehealth Options

Rev 10 2022

A. 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.

B. 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

C. 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.

D. 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.

E. 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)

F. 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.

G. For more information regarding telehealth guidance, please refer to the telehealth guidance, located at www.mmis.georgia.gov, Click Provider Information-Provider Manuals.

PART III – CHAPTER 1600

SPECIFIC PROGRAM REQUIREMENTS FOR ADULT NUTRITION SERVICES

SCOPE OF SERVICES

1601 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.

1602 Special Requirements of Participation

Licensure

4. Adult Nutrition Services are provided by a licensed Dietitian in accordance with the applicable Georgia license requirements under O.C.G.A. § 43-11A-16.

5. Home Health Agencies providing Adult Nutrition services must have a Home Health Agency License as required under O.C.G.A. § 31-7-151.

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:

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

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

    a) Specific evaluation, training or therapeutic assistance provided;

    b) Date and the beginning and ending time when the service was provided;

    c) Location where the service was delivered;

    d) Verification of service delivery, including first and last name and title of the person providing the service and his or her signature;

    e) Progress towards the individual's independence as documented in the individual's ISP..

    f) 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.

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*.

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.

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 COMP Program, Adult Nutrition Services provider agencies must meet the following requirements:

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

Types of Agencies: Agencies that provide Adult Nutrition Services are:

Accredited or Certified DD Service Agencies;

Home Health Agencies.

Staffing Qualifications and Responsibilities:

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

1) 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

2) 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.

3) Provider agencies must have available a sufficient number of employees or professionals under contract that are Georgia licensed dietitians to provide Adult Nutrition Services.

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.

- **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* and NOW.

- **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 waiver services may not receive these services at the same time of the same day.

- **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 and NOW, Chapter 603*).

1603 Special Eligibility Conditions

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

A medical condition or diagnosis:

For which a special therapeutic diet or dietary plan has been ordered by a physician, physician assistant or nurse practitioner; **or**
Which has resulted in the individual's inability to maintain adequate nutrition or hydration; **or**
Which involved pressure ulcers, non-healing skin lesions, or wounds **or**

The individual is obese with a body mass index (BMI) of 30 or greater[1] **or**
The individual has had an unplanned weight gain orloss of 10% in the past six months.

$$\text{BMI} = \frac{weight\ in\ pounds}{(height\ in\ inches)^2} \times 703 \quad or \quad \frac{weight\ in\ kilograms}{(height\ in\ meters)^2}$$

Adult Nutrition Services are not available until the waiver individual's 21st birthday.

[1] $\text{BMI} = \frac{weight\ in\ pounds}{(height\ in\ inches)^2} \times 703 \quad or \quad \frac{weight\ in\ kilograms}{(height\ in\ meters)^2}$

The need for Adult Nutrition Services must be reflected in the Intake and Evaluation Team approved Individual Service Plan (ISP).

There is a reasonable expectation by the licensed dietitian that the individual can achieve the goal(s) in the necessary time frame.

All services must be ordered by a physician.

1604 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.

1605 Covered Services

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

Nutrition evaluation.

Individual/family/staff education.

1606 Non-Covered Services

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.

2) Transportation to and from these service delivery site may not be billed as part of the service.

3) Not covered for conditions not related to DD diagnosis.

4) Services that have not been ordered by a physician.

5) Services in a hospital.

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.

1607 Documentation Requirement: Providers, except for providers of participant-directed services, must document the following in the record of each individual receiving Adult Nutrition Services:

a. Specific evaluation, training or therapeutic assistance provided;

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

c. Location where the service was delivered;

d. Verification of service delivery, including first and last name and title of the person providing the service and his or her signature;

e. Progress towards the individual's independence as documented in the individual's ISP.

f. 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.

1608 Basis for Reimbursement

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

The rate cannot exceed the established Medicaid rates for the Children Intervention Services Program.

1609 Participant-Direction Options

Individuals can not choose the self-direction option with Adult Nutrition Services.

An individual serving as a representative for a waiver individual 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*.

1610 Telehealth Options

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A. All components of Adult Nutrition Services can be safely provided via telehealth modalities in accordance with the applicable Georgia license requirements under O.C.G.A. § 43-11A-16 for Licensed Dietitians.

B. Adult Nutrition providers 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.

C. 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. All Adult Nutrition provider wishing to use telehealth modalities to deliver evaluation or treatment services must obtain valid signed consent from the individual or their legal decision-maker.

D. 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.

E. 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)

F. For more information regarding telehealth guidance, please refer to the telehealth guidance, located at www.mmis.georgia.gov, Click Provider Information-Provider Manuals.

PART III - CHAPTER 1700

SPECIFIC PROGRAM REQUIREMENTS
FOR
ADDITIONAL STAFFING SERVICES

SCOPE OF SERVICES

Section 1701 General Description of AS services

Rev 07 2017

Additional Staffing services are provided on behalf of individuals with a high level of functional, medical or behavioral needs who require direct support or oversight beyond the level provided within traditional service descriptions. Clinically indicated additional staffing can be utilized as an enhanced staffing option in conjunction with clinically indicated Community Living Supports Services, Community Access Group, or Community Residential Alternative Services. AS services may be authorized to provide a higher ratio of staff to waiver individual support, additional hours of service on a temporary basis in response to individual or family crisis, or to assist with transition services from institutional or acute care to community settings.

Note: If authorized for institutional transition support, AS is authorized temporarily for stabilization assistance with periodic reviews post transition to confirm continued need for additional staffing.

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Please reference Appendix H in PART II CHAPTERS 600 – 1200 POLICIES AND PROCEDURES FOR COMP and NOW for more information regarding Additional Staffing Services.

Section 1702 <u>Special Requirements of Participation</u>

G. **DD Service Agencies** rendering Services must have staffing that meets the following requirements:

H. **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.

1. Duties of the Agency Director include, but are not limited to:
   a. Oversees the day-to-day operation of the agency;

   b. Manages the use of agency funds;

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

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

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

I. **A Developmental Disability Professional (DDP)** (for definition, *Provider Manual for Community Developmental Disability Providers* at http://dbhdd.org/files/Provider-Manual-DD.pdf

The agency director who meets the qualifications of a Developmental Disability Professional may serve both roles provided the staff members meets the professional qualifications for each role.

J. **Direct Care Staff** who must:

a. Be 18 years or older;

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b. Have a high school diploma or equivalent (General Educational Development or GED) or have a minimum score of 75 on the Short Test of Functional Health Literacy for Adults (STOFHLA) or Test of Functional Health Literacy for Adults (TOFHLA).

c. Meet transportation requirements in COMP and NOW, Part II Chapter 900, section 905 if transporting individuals.

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

e. The purpose and scope of the service to be delivered, including related policies and procedures;

f. Confidentiality of individual information, both written and spoken;

g. Rights and responsibilities of individuals;

i. h. Requirements for recognizing and reporting suspected abuse, neglect, or exploitation of any individual:

i. To the Department of Behavioral Health and Developmental Disabilities;

ii. Within the organization;

iii. To appropriate regulatory or licensing agencies; and

iv. To law enforcement agencies

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 service.

The type and number of all other staff associated with the organization (such as contract staff, consultants) are:

a. Properly trained or credentialed in the professional field as required;

b. Present in numbers to provide services and supports to individuals as required; and

c. Experienced and competent in the services and support they provide.

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 pursuant to DBHDD Policy 04-104 and all policy outlined in *Part I Policies and Procedures For Medicaid/PeachCare For Kids.*

Provider agencies must have available a sufficient number of employees or professionals under contract as specified.

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

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.

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 NOW and COMP, Chapter 603*).

Licensure

Additional Staffing is provided by agencies enrolled to provide CLS or CRA services. License requirements for those services apply to services delivered under AS.

Supervision and Direct Support Staff Duties

Supervision of Direct Support Staff

All agency providers must comply with staff supervision requirements as defined in Private Home Care licensure Rules, Community Living Arrangement licensure Rules and policy requirements outlined in CAG, CLS. and CRA service descriptions.

Duties of Additional Staff include, but are not limited to:

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

B. Provide personal care and protective oversight and supervision;

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

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.

Additional Staffing services must be provided by an employee of an enrolled CLS, CAG or CRA provider agency or by an individual obtained through an employment agency.

Section 1703 Special Eligibility Conditions

1. Waiver individual receives either Community Access Group, Community Residential Alternative or Community Living Support Services, and

2. Waiver individual exhibits current high-level needs as evidenced by:

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   a. HRST healthcare level 5 or 6 indicating high medical and/or functional needs verified by DBHDD staff and
   b. A DBHDD conducted assessment indicating a need for enhanced staffing; or

c. Exceptional behavioral needs identified in at least one of the below items i-v and a DBHDD conducted assessment indicating a need for enhanced staffing:
    i. HRST score of 2 or higher on Item F. Self-Abuse
    ii. HRST score of 2 or higher on Item G. Aggression Toward Others or Property
    iii. HRST score of 3 or higher on Item U. Emergency Room Visits (documentation must indicate behavioral challenges as the clinical issue)
    iv. HRST score of 2 or higher on Item V. Hospital Admissions (documentation must indicate behavioral challenges as the clinical issue)
    v. SIS score of 7 or higher on Total Score for Section 3B: Behavioral Supports Needed; or:

3. A Communication Assessment performed by DBHDD Office of Deaf Services indicating the need for additional or a specialized staff proficient in communication with individuals who are deaf or hard of hearing.

4. Waiver individual has an active court order which requires specific staffing requirements beyond the scope of traditional CLS, CAG, or CRA services, or

5. Waiver individual has documented history of challenging behavior(s) that present significant risk to him/herself or others, or

6. Waiver individual has transitioned from an ICF-ID or other institution within the past six months and transition needs may necessitate additional staffing, or

7. Waiver individual has transitioned from a crisis home or other crisis setting and has an assessed need for additional staffing.

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Section 1704 Prior Approval

Additional Staffing Services must be authorized prior to service delivery. AS services require DBHDD Field Office 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. Additionally, AS services are subject to second level review by DBHDD clinical staff.

1705 **Covered Services**

Reimbursable AS Services include the following based on the assessed need of the individual

Adaptive skills development that assists the individual in community activities that support home living in the community, such as communication, community navigation, mobility, understanding community signs/clues, and safety in the community.

Personal care and protective oversight and supervision,

Protective oversight and supervision which include protective care and watchful monitoring activities of individual's functioning, the making and reminding an individual of medical appointments, intervention if a crisis arises.

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.

Medically related services, such as basic first aid, arranging and transporting individual 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.

Implementation of the behavioral support plan of an individual to reduce inappropriate and/or maladaptive behaviors and to acquire alternative adaptive skills and behaviors.

Escort with other staff during transportation in the community to events, medical appointments, and other activities.

Section 1706 **Non-Covered Services**

- Additional staffing is not available in family homes or individual's' own homes unless authorized with regular review for stabilization purposes in response to family, condition, environmental or service crisis or institutional transition.

- Additional staffing is not reimbursable for the purpose of 24-hour support in a family or waiver individual's own home unless assessed need or history corroborates that attempts to share staff with other waiver individuals have been unsuccessful.

- Additional staffing is not available to individuals served in settings unable to provide documentation of current staffing levels (in the form of time sheets, payroll records, or other documentation) and subject to DCH and DBHDD review.

Section 1707 Documentation

Documentation of AS services must include the following elements in the record of each individual:

- Weekly staff schedule noting beginning and ending time of day of all AS staff
- Specific activity, training, or assistance provided;
- Date and the beginning and ending time of day when the service was delivered;
- Location where the service was delivered;
- Verification of service delivery, including first and last name and title (if applicable) of the person providing the service and his or her signature;
- Supervisory note documenting licensure-level required supervision of the direct support personnel;
- Progress towards moving the individual towards his or her goal(s) and meeting the needs identified in the individual ISP and Individual 360. Documentation of all information relevant to the particular area of focused need.

Section 1708 Basis for Reimbursement

Additional Staffing, Basic
Additional Staffing, Enhanced

Rev 04 2020

The enhanced rate may only be accessed by individuals with specific needs and by staff with specific qualifications, as outlined in Appendix A. Basic and Enhanced rates represent 15-minute units.

Reimbursement rates for CRA, CAG, CLS services are found in Appendix A.

Section 1709 Participant-Direction Options

A. Additional Staffing Services are not eligible for the self-direction option.

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

PART III - CHAPTER 1800
SPECIFIC PROGRAM REQUIREMENTS
FOR
BEHAVIOR SUPPORT SERVICES-
LEVEL 1 & LEVEL 2
SCOPE OF SERVICES

Rev. 07 2020

1801 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 a 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.

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.

1802 Requirements for Enrollment and 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 COMP Program, Positive Behavioral Supports Services individual providers must meet the following requirements:

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

Education/Training

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

Or

Licensure/certification in one of the following categories:

Licensure:
Psychologist (O.C.G.A. § 43-39-7)
Licensed Professional Counselor (O.C.G.A. § 43-10A-7)
Licensed Clinical Social Worker (O.C.G.A. § 43-10A-7)
Psychiatrist (O.C.G.A. § 43-1-32)

Or

Certification:
Board Certified Behavior Analyst (certified through the Behavior Analyst Certification Board)

Other Standard:

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

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

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

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

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.

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

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.*

ii. **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)**

Education/Training

Minimum of a Master' Degree in psychology, education, counseling, or social work and two years' experience;

Or

Licensure/certification in one of the following categories:

Licensure:
Psychologist (O.C.G.A. § 43-39-7)
Licensed Professional Counselor (O.C.G.A. § 43-10A-7)
Licensed Clinical Social Worker (O.C.G.A. § 43-10A-7)
Psychiatrist (O.C.G.A. § 43-1-32)
Licensed Master Social Worker (O.C.G.A. § 43-10A-7)
Licensed Associate Professional Counselor (O.C.G.A. § 43-10A-7)
Or

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

Other Standard:

c. 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.

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

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

f. 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.

g. 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

h. 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.

1802.2 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:

1802.2.1 Types of Agencies

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

1803 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.

1804 <u>Documentation Requirements</u>

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

- Specific task/activity or assistance provided including assessment, plan development, intervention and methods outline, data tracking methods, analysis and intervention outcomes, training, and monitoring;
    - Date, beginning and ending time when the service was delivered;
    - Location where the service was delivered;
- Description of behaviors in observable, measurable terms with frequency, precipitating events, and tracking methods;
    - Progress toward individual goal(s), desired outcomes in the individual's action plan;

- 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.

- Attestation of service delivery through signature and legible, printed first and last name and title/description of the person providing the service.

1805 <u>Waiver Individual Eligibility Criteria</u>

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

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:

- HRST score of 2 or higher on Item E. Clinical Issues Affecting Daily Life (documentation must indicate behavioral challenges as the clinical issue)
- HRST score of 2 or higher on Item F. Self-Abuse
- HRST score of 2 or higher on Item G. Aggression Toward Others or Property
- HRST score of 3 or higher on Item U. Emergency Room Visits (documentation must indicate behavioral challenges as the clinical issue)
- HRST score of 2 or higher on Item V. Hospital Admissions (documentation must indicate behavioral challenges as the clinical issue)
- HRST score of 4 on Item Q. Treatments (documentation must indicate 1:1 staffing need due to behavioral issues)
- Placement in Crisis Home in the last 12 months (documentation must indicate that placement was due to behavioral challenges)
- Provision of In-Home Mobile Crisis Services in the last 12 months
- Admission to a Crisis Stabilization Unit in the last 12 months
- Arrest, detention, or intervention by law enforcement in the last 12 months
- SIS score of 7 or higher on Total Score for Section 1B: Behavioral Supports Needed

1806 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 version changes

1807 Covered Services

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

a. Functional assessment of behavior and other diagnostic assessment of behavior.

b. 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.

c. Training and coaching paid and unpaid supporters on recommended interventions and outcomes tracking.

d. Intervention modalities related to the identified behavioral needs of the individual.

e. Individual specific skills or replacement behavior acquisition training.

f. Family and/or direct support staff education and training on Positive Behavior Supports.

1808 Non-Covered Services

Services that duplicate any family education or training provided through Natural Supports Training (NST) Services.

Services that occur simultaneously or on the same day as NST Services.

Services in a hospital.

Restrictive behavioral interventions, including chemical or mechanical restraints and seclusion, prohibited by state law or regulations.

Transportation to and from these services is not included in the rate.

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

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.

Services provided by a staff member not qualified under Section 1802.

1809 Basis for Reimbursement

See Appendix A for Basis for Reimbursement

1810 Participant-Direction Option

Positive Behavioral Supports Services Level 1 and Level 2 will no longer be available under the self-direction model after February 28, 2023. Individuals in the self-direction model with an ISP that includes Positive Behavioral Supports Services Level 1 or Level 2 must receive a new ISP with an end date no later than February 28, 2023, to confirm that they are authorized to continue to receive Positive Behavioral Support Services through the traditional model.

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

1811 Telehealth Option

Rev 10 2022

A. 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:

a. Indirect assessment component for functional behavior assessment;
b. Follow up or refresher staff training for behavior support plans;
c. Additional fidelity monitoring of plan implementation and oversight;
d. Distant site observations of the individual for the purposes of consultation, modeling, and recommendations for interventions to staff/caregivers in real time;
e. Team meetings for the purpose of gathering feedback related to behavior support plans effectiveness; and
f. Review of data analysis summaries and behavior graphing.

B. 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

C. 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.

D. The Behavior Support Service provider must obtain signed consent to render a service via telehealth from the individual or designated representative as applicable.

E. 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.

F. 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.

G. 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…).

G. For more information regarding telehealth guidance, please refer to the telehealth guidance, located at www.mmis.georgia.gov, Click Provider Information-Provider Manuals.

PART III – CHAPTER 1900

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PART III - CHAPTER 2000

SPECIFIC PROGRAM REQUIREMENTS FOR COMMUNITY ACCESS SERVICES

SCOPE OF SERVICES

2001 **General**

Rev 01 2013

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. Community Access services cannot be provided in the individual's home or family home, personal care home, community living arrangement, or group home.

Community Access Individual (CAI) services are provided to an individual, with a one-to-one staff to individual ratio. CAI services are linked to goal(s) 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 provided to groups of individuals, with a staff to individual ratio of one to two or more. The direct care staff to individual ratio for Community Access Group services cannot exceed one (1) to ten (10) and is determined based on individual need level of the individuals in the 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. CAG services may be provided in a facility or a community as appropriate for the skill being taught or specific activity supported.

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 individual.

Transportation to and from activities and settings primarily utilized by people with disabilities is included in Community Access services. This transportation is provided through Community Residential Alternative services for individuals receiving these services. Transportation provided through Community Access Services is included in the cost of doing business and incorporated in the administrative overhead cost. When transportation is to and from other community destinations, separate payment for transportation only occurs when the COMP's distinct Transportation Services are authorized.

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 or Transportation services. An individual serving as a representative for a waiver individual 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. s.

The COMP Program is intended for those goods and services that are not covered by the State Medicaid Plan or those instances in which individual'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 individuals served and specified in the individual's Individual Service Plans.

2002 Special Requirements of Participation

Rev. 07 2009

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

2002.1 Individual Provider

Rev 01 2009

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/NOW Program, Community Access Services providers must meet the following requirements:

1. **Individual providers of Community Access services must:**

   a. Be 18 years or older;

   b. Have current CPR and Basic First Aid certifications;

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

   Direct Support Professional (DSP) certification; ***or*** Copy of high school diploma/transcript or General Education Development (GED) diploma; and at least six (6) months of experience providing behavioral health related services to individuals with Intellectual and Developmental Disabilities (I/DD), or documented experience providing specific supports to individuals with disabilities.

   d. Agree to or provide required documentation of a criminal records check, prior to providing Community Access services.

Rev. 04 2009

   e. Meet transportation requirements in COMP/NOW Part II Chapter 900, Section 905 if transporting individuals.

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:

a. Specific activity, training, or assistance provided;

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

c. Location where the service was delivered;

d. Verification of service delivery, including first and last name and title (if applicable) of the person providing the service and his or her signature;

Rev. 10 2009

e. Progress towards the individual's independence as documented in the individual's ISP. 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/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 COMP Program, Community Access Services provider agencies must meet the following requirements:

Rev 01 2013

A. Staffing Qualifications and Responsibilities

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

a. 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

b. Duties of the Agency Director 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.

1. At least one agency employee or professional under contract with the agency must:

   a. Be a Developmental Disability Professional (DDP) (for definition, see *Part II Policies and Procedures for COMP, Appendix I);*

   b. Have responsibility for overseeing the delivery of Community Access Services to individuals.

2. The same individual may serve as both the agency director and the Developmental Disability Professional

A Developmental Disability Professional (DDP) (for definition, *Provider Manual for Community Developmental Disability Providers* at http://dbhdd.org/files/Provider-Manual-DD.pdf

f. 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 everyone (1) individual served in Individual Community Access Services;

g. Direct Care Staff must:

- Be 18 years or older;

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- Have a high school diploma or equivalent (General Educational Development or GED) or have a minimum score of 75 on the Short Test of Functional Health Literacy for Adults (STOFHLA) or Test of Functional Health Literacy for Adults (TOFHLA);

Rev. 04 2009

- Meet transportation requirements in COMP and NOW, Part II Chapter 900, section 905 if transporting individuals.

Rev. 01 2009

- Be provided with a basic orientation prior to direct contact with individuals and show competence in:
  1) The purpose and scope of Community Access Services, including related policies and procedures;

  2) Confidentiality of individual information, both written and spoken;

  3) Rights and responsibilities of individuals;

  4) Requirements for recognizing and reporting suspected abuse, neglect, or exploitation of any individual:

     i. To the Department of Behavioral Health and Developmental Disabilities;

     ii. Within the organization;

     iii. To appropriate regulatory or licensing agencies; and

     iv. To law enforcement agencies

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

D. Provides direct assistance in self-help, socialization, and adaptive skills training, retention and improvement to individual individuals and groups of individuals;

E. Provides direct assistance in training, retraining or improving the access to and use of community resources by individual individuals or groups of individuals;

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

G. Provides active support and direct assistance in individuals' participation in community social, recreational and leisure activities;

H. Provides individual-specific assistance, such as assistance with personal care and self-administration of medications.

j. 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.

j. The type and number of all other staff associated with the organization (such as contract staff, consultants) are:

6. Properly trained or credentialed in the professional field as required;

7. Present in numbers to provide services and supports to individual as required;

8. Experienced and competent in the services and support they provide.

k. 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.

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 refer to *Part II Policies and Procedures for COMP and NOW*.

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:

I. Specific activity, training, or assistance provided;

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

K. Location where the service was delivered;

L. Verification of service delivery, including first and last name and title (if applicable) of the person providing the service and his or her signature;

Rev. 10 2009

M. Progress towards the individual's independence as documented in the individual's ISP. 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 COMP and NOW, Chapter 1200.*

5. **Co-Employer Provider Agencies**: Co-Employer Provider Agencies cannot provide facility-based Community Access Service.

6. **Community Access and Other Services in the Same Facility**:

   a. 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.

   b. 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.

7. Providers, except for providers of participant-directed services, must utilize methods, materials, and settings that meet the following:

   a. 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;

   b. Facilitate the provision of individual-specific supports through a supports network;

   c. Are appropriate to the chronological age of individuals;

d. Are culturally normative.

8. **Providers must meet the following requirements for staff-to-** individual **ratios:**

Rev. 04 2009

i. 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 more intense than the upper limit allowed; the actual ratio must be as indicated by the individualized needs of the individuals.

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

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 DBHDD (see *Part II Policies and Procedures for COMP and NOW, Chapter 603*).

10. **Physical Environment**

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

a. **Accessibility:** Is accessible to and usable by individuals and meets Americans with Disabilities Act (ADA) accessibility requirements for facilities.

b. **Building Construction and Maintenance:** Is constructed, arranged, and maintained so as to provide adequately for health, safety, access, and wellbeing of the individuals.

c. **Building Codes:** Is in compliance with all local building codes and other applicable codes;

d. **Lighting:** Provides adequate lighting for individuals' activities and safety;

e. **Ventilation:** Is adequately ventilated at all times by either mechanical or natural means to provide fresh air and the control of unpleasant odors;

f. **Floor Space:** Has adequate floor space to safely and comfortably accommodate the number of individuals for all activities and services provided in that space;

g. **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.

h. **Environmental/Sanitation**: Is in good repair and clean inside and outside of the facility, including being free from liter, extraneous materials, unsightly or injurious accumulations of items and free from pest and rodents;

i. **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:

j. **Equipment Maintenance:** Maintains all essential mechanical, electrical, and individual activity, care and support equipment in safe operating condition;

k. **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;

l. **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;

m. 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;

n. **Medication Storage:** Assures that medications are:

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;

2) Kept in original containers with original labels intact or in labeled bubble packs from a pharmacy;

3) Handled in accordance with current applicable State laws and regulations.

o. **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.

p. **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.

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

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.

Rev. 01 2009

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.

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.

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.

Rev. 04 2010

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 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.

Rev 07 2013

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.

2003 Special Eligibility Conditions

4) 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).

5) The need for Community Access Services must be related to the individual disability services and be therapeutic in nature.

2004 Prior Approval

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.

2005 Covered Services

Rev 01 2013

Reimbursable Community Access Services for the distinct categories include the following based on the assessed need of the individual and as specified in the approved ISP:

Community Access Group

1. Services in facility-based and community-based settings outside the individual's own or family home or any other residential setting

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.

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.

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.

5. Provision of oversight and assistance with daily living, socialization, communication, and mobility skills building and supports in a group.

6. Implementation of behavioral support plans to reduce inappropriate and/or maladaptive behaviors and to acquire alternative adaptive skills and behaviors.

7. Recreational and leisure activities that support the individual's active, local community participation) and 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 a individual in community recreational and leisure activities.

8. Facilitating volunteer roles in the community and participation in self-advocacy type activities.

Rev. 07 2011
Rev. 10 2011

9. Other related, individual-specific assistance, such as assistance with personal care and self-administration of medication, and nursing services and health maintenance activities as indicated in the approved Individual Service Plan.

Rev. 04 2009
Rev. 04 2010

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.

Rev 01 2013

<u>Community Access Individual</u>

1. Services in non-facility, community-based settings take place outside the individual's own or family home or any other residential setting.

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.

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.

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.

5. Individual-specific teaching and coaching of skills for access to the community, including communication, mobility, money management, and shopping skills.

6. Implementation of behavioral support plans to reduce inappropriate and/or maladaptive behaviors and to acquire alternative adaptive skills and behaviors.

7. Teaching and coaching a individual how to participate in and take advantage of community social and recreational activities.

8. Facilitating volunteer roles in the community and participation in self-advocacy type activities.

9. Other related, individual-specific assistance, such as assistance with personal care and self-administration of medications, and nursing services, and health maintenance activities as indicated in the approved Individual Service Plan.

Community Access Participant-Directed Activity

1402 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.

2006 **Non-Covered Services**

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.

2. Activities, training, or services provided in the individual's 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."

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

4. Admission fees, Memberships, Subscriptions, Donations, or related items.

5. Registration Fees unless participant-directed services.

6 Out of state camps.

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.

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 COMP and NOW, Chapter* 900.

Rev. 07 2010

9. Community Access Services may not be delivered to an individual by the same staff person who also provides the individual Community Residential Alternative Services or by the individual/family providing the individual a host home/life sharing arrangement.

Rev. 10 2011

10. Non-covered health maintenance activities are defined in the Rules and Regulations for Proxy Caregivers Used in Licensed Healthcare Facilities, Chapter 111-8-100.

Rev 01 2013

11. 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.

2007 Basis for Reimbursement

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

2008 Participant-Direction Options

A. Individuals can choose the self-direction or co-employer options with Community Access Services.

B. An individual serving as a representative for a waiver individual in self-directed services is not eligible to be a participant-directed provider of Community Access Services.

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

PART III - CHAPTER 2100

SPECIFIC PROGRAM REQUIREMENTS FOR COMMUNITY GUIDE SERVICES

SCOPE OF SERVICES

2101 General

Community Guide Services are direct assistance to individuals in skills building and information in meeting participant-direction responsibilities. These services are available ***only*** for individuals who choose the participant-direction option for service delivery. The individual, 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 individual are specified in the Individual Service Plan. Individuals may elect to receive Community Guide Services, and when elected, individuals choose their Community Guide.

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

Community Guides assist and train individuals 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 individual'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 individuals. Community Guide Services providers offer (or arrange when needed) any of the standard services listed in section 2105 – Covered Services that are needed by the individuals served and specified in the individual's Individual Service Plans.

2102 Special Requirements of Participation

2102.1 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, Community Guide Services providers must meet the following requirements:

1. **Individual Providers of Community Guide Services must:**

   - Be 18 years or older;
   - 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;
   - Agree to or provide required documentation of a criminal records check, prior to providing Community Guide services;
   - Be knowledgeable about resources in any local community in which the provider is a Community Guide;
   - Have demonstrated connections to the informal structures of any local community in which the provider is a Community Guide;
   - 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;

- Attend all mandatory, DBHDD training.

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 COMP, Chapter 1200.*

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

2102.2 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 and COMP Program, Community Guide Services provider agencies must meet the following requirements:

Rev 01 2013

A. Staffing Qualifications and Responsibilities

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

a. 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.

b. Duties of the Agency Director 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.

c. At least one agency employee or professional under contract with the agency must:

H. Be a Developmental Disability Professional (DDP) (for definition, see *Part II Policies and Procedures for NOW and COMP*, Appendix I);

I. Have responsibility for overseeing the delivery of Community Guide Services to individuals.

d. The same individual may serve as both the agency director and the Developmental Disability Professional;

1. **A Developmental Disability Professional (DDP)** (for definition, *Provider Manual for Community Developmental Disability Providers* at http://dbhdd.org/files/Provider-Manual-DD.pdf

e. 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 individuals served and specified in the individual's Individual Service Plans.

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

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 refer to *Part II Policies and Procedures for COMP*.

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 COMP,* Chapter 1200.

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 DBHDD (see *Part II Policies and Procedures for COMP and NOW, Chapter 603*).

2103 Special Eligibility Conditions

1. Community Guide Services are only for individuals who opt for participant-direction.

2. The individual determines the amount of Community Guide Services, if any, and the specific services that the Community Guide will provide.

3. The specific Community Guide Services for the individual are specified in the Individual Service Plan.

4. Individuals may elect to receive Community Guide Services, and when elected, individuals choose their Community Guide.

5. The need for Community Guide Services must be related to the individual disability in the approved Individual Service Plan (ISP).

2104 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.

2105 Covered Services

Reimbursable Community Guide Services include the following based on the assessed need of the individual and as specified in the approved ISP:

- Direct assistance to individuals in exploring and brokering available community resources.

- Direct assistance to individuals in meeting their participant-direction responsibilities.

- Information and assistance that helps the individual in problem solving and decision-making.

- Information and assistance that helps the individual in developing supportive community relationships and other resources that promote implementation of the Individual Service Plan.

- Assistance with developing and managing the individual budget;

- Assistance with recruiting, hiring, training, managing, evaluating, and changing employees;

- Assistance with scheduling and outlining the duties of employees;

- Training the individual to be an effective employer of support workers;

- Information and assistance in understanding provider qualifications, record keeping and other participant-direction requirements.

2106 Non-Covered Services

a. Community Guide services cannot duplicate Support Coordination services.

b. Community Guides cannot provide other direct waiver services, including Support Coordination, to any waiver individual.

c. Community Guide agencies cannot provide Support Coordination services.

d. 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.

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

Rev 01 2013

2107 Basis for Reimbursement

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

2108 Participant-Direction Options

Community Guide Services will no longer be available under the self-direction service model after February 28, 2023. Individuals in the self-direction model with an ISP that includes Community Guide Services must receive a new ISP with an end date no later than February 28, 2023, to confirm that they are authorized to continue to receive Community Guide Services through the traditional model.

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

PART III - CHAPTER 2200

SPECIFIC PROGRAM REQUIREMENTS FOR COMMUNITY LIVING SUPPORT (CLS) SERVICES

SCOPE OF SERVICES

2201 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. 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:

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

2202 Special Requirements of Participation

Rev 04 2018

A. DD Service Agencies rendering Services must have staffing that meets the following requirements:

◊ **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.

◊ **Developmental Disability Professional (DDP)** (for definition, *Provider Manual for Community Developmental Disability Providers* at http://dbhdd.org/files/Provider-Manual-DD.pdf

The agency director who meets the qualifications of a Developmental Disability Professional may serve both roles provided the staff members meets the professional qualifications for each role

◊ **Direct Care Staff** who must:

a. Be 18 years or older;

b. Have a high school diploma or equivalent (General Educational Development or GED) or have a minimum score of 75 on the Short Test of Functional Health Literacy for Adults (STOFHLA) or Test of Functional Health Literacy for Adults (TOFHLA).

Rev 04 2022
Rev 10 2022

c. Meet transportation requirements in COMP and NOW Part II Chapter 900, section 905 if transporting individuals.

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

1. The purpose and scope of the service to be delivered, including related policies and procedures;

2. Confidentiality of individual information, both written and spoken;

3. Rights and responsibilities of individuals;

4. Requirements for recognizing and reporting suspected abuse, neglect, or exploitation of any individual:

i. To the Department of Behavioral Health and Developmental Disabilities;

a. ii. Within the organization;

b. iii. To appropriate regulatory or licensing agencies; and

c. iv. To law enforcement agencies

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 service.

The type and number of all other staff associated with the organization (such as contract staff, consultants) are:

a. Properly trained or credentialed in the professional field as required;

b. Present in numbers to provide services and supports to individuals as required; and

c. Experienced and competent in the services and support they provide.

A CLS provider may not provide CLS services in any residential site which is owned, leased, or managed by any of the following:

a. a person or entity (including a partnership, trust, or unincorporated association) with whom the provider, or any owner (whether direct or indirect), officer, principal, agent, or employee of the provider, has a contractual relationship of any kind;
b. an entity (including a partnership, trust, or unincorporated association) in which the provider, or any owner (whether direct or indirect), officer, principal, agent, or employee of the provider, has an ownership interest (whether direct or indirect) or financial interest;
c. an entity (including a partnership, trust, or unincorporated association) in which any relative (including relatives by marriage) within four degrees of kinship of any owner (whether direct or indirect), officer, or principal, or agent of the provider, is
    i. an owner (whether direct or indirect) of the entity;
    ii. an officer or principal of the entity; or
    iii. an agent of the entity with authority to bind the entity;
d. a person who is a relative (including relatives by marriage) within four degrees of kinship of any owner (whether direct or indirect), officer, or principal of the provider.

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 pursuant to DBHDD Policy 04-104 and all policy outlined in *Part I Policies and Procedures For Medicaid/PeachCare For Kids.*

Provider agencies must have available a sufficient number of employees or professionals under contract.

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

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.

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 and NOW, Chapter 603*).

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 http://dch.georgia.gov/hfr-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*

Supervision and Direct Support Staff Duties

Supervision of Direct Support Staff

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

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

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

O. Provide personal care and protective oversight and supervision;

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

Q. 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.

R. Provide assistance in completing Outcomes and Goal(s) according to the current Individual Support Plan.

Other Requirements

Rev 07 2017

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.

Rev 01 2018

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.

2203 Special Eligibility Conditions

1. CLS services are provided only to individuals who require in-home supports.

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

Rev 04 2019

3. In order to remain eligible for CLS services, and as a condition of participation in those services, an 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.

2204 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.

2205 Covered Services

Reimbursable Community Living Support Services include the following based on the assessed need of the individual and as specified and described in the approved ISP:

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.

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.

3. Personal care and protective oversight and supervision in the person's own or family home as a component part of the services.

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 an individual of medical appointments, and intervention if a crisis arises.

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.

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.

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.

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.

9. CLS services may be provided in the following living environments:
a. The waiver individual's owned or leased home
b. the home of a family member or other natural/informal supporter

Rev 07 2023

2206 <u>Non-Covered Services</u>

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.
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.

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 with the exception of a setting that is pending approval by DBHDD or DCH to be licensed and approved as a Community Living Arrangement.

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3. Educational and related services needed by children for whom the Department of Education is responsible.

4. CLS services that duplicate or are provided at the same time of the same day as Community Access or Supported Employment services.

5. Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement.

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.*

7. Medically related services that cannot be provided by non-licensed persons according to State law, rules, and regulations.

8. Payment is not made for Personal Assistance Retainer outside of scheduled days and units per day for Community Living Support Services as specified in the ISP.

9. 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.

10. Payment of Personal Assistance retainer beyond allowable days indicated below in Section 1908, Basis for Reimbursement.

11. Non-covered health maintenance activities are defined the Rules and Regulations for Proxy Caregivers Used in Licensed Healthcare Facilities, Chapter 111-8-100.

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.

Individuals receiving Community Residential Alternative services may not receive CLS services. Exceptions may be authorized through the DBHDD Division of Developmental Disabilities DBHDD Field Offices on a case by case basis documented by an approval letter and maintained by the provider in the individual's record. Exceptions to combination of CLS and residential services may be approved for individuals who are in the process of transitioning from Community Living

04/01/2018

Support Services to Community Residential Alternative Services due to the individual's transition to adulthood, the aging of the individual's caregivers, and/or to allow the individual to remain in his or her family home for as long as possible. These exceptions are granted on an individual basis with justification and documentation as above. **The provision of Community Living Support Services and Community Residential Alternative Services on the same day is never allowed.**

2207 Documentation

1. Documentation of CLS services must include the following elements in the record of each individual:

    a. Specific activity, training, or assistance provided;

    b. Date and the beginning and ending time of day when the service was delivered;

    c. Location where the service was delivered;

    d. Verification of service delivery, including first and last name and title (if applicable) of the person providing the service and his or her signature;

    e. Supervisory note documenting licensure-level required supervision of the direct support personnel;

    f. Progress towards the individual's independence as documented in the individual's ISP.

- **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:

    a. Beginning and end date of absence.

    b. Reason for absence.

    c. Scheduled days and units per day for Community Living Support Habilitation Services.

    d. 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.

- **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*.

2208 Basis for Reimbursement

Reimbursement rates for CLS include the following:
CLS Basic – 1-person
CLS Extended – 1-person
CLS Shared – 2-person
CLS Shared – 3-person
CLS Participant-directed

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.

2209 Participant-Direction Options

A. Individuals can choose the self-direction or co-employer options for delivery of CLS services.

B. An individual serving as a representative for a waiver individual in self-directed services is not eligible to be a participant-directed provider of CLS services.

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

D. All CLS services, including CLS delivered through the participant-directed model are provided within the annual maximum.

PART III - CHAPTER 2300

SPECIFIC PROGRAM REQUIREMENTS FOR COMMUNITY RESIDENTIAL ALTERNATIVE (CRA) SERVICES

SCOPE OF SERVICES

2301 General Description of CRA Services

Community Residential Alternative (CRA) services are targeted for individuals who require formal support 24 hours/day, 7 days/week. CRA services provide a range of interventions with a particular focus on training and support in one or more of the following areas: eating and drinking, toileting, personal grooming and health care, dressing, communication, interpersonal relationships, mobility, home management, and use of leisure time. CRA services are individually planned and tailored to meet the specific needs of the individual and to accommodate fluctuations in his or her needs for various supports in the areas of functional, healthcare or behavioral services. CRA services are delivered according to level of need which correspond to rate categories which reflect the fact that individuals with more significant needs require more intensive supports. Levels of need, expectations for providers based on level of need, and rate categories are described in greater detail below.

CRA services include assistance with and/or training in activities of daily living, such as bathing, dressing, grooming, other personal hygiene, feeding, toileting, transferring, and other similar tasks. CRA services may also include training and/or assistance in household care, such as meal preparation, clothes laundering, bed-making, housecleaning, simple home repair, yard care, and other similar tasks designed to increase waiver individuals' independence in self-care skills.

CRA services consist of medically related services that are not required to be provided by a licensed professional under State laws, rules, and regulations. Examples include basic first aid, arranging and transporting individuals to medical appointments, assisting with therapeutic exercises, and assisting with or supervising self-administration of medication. 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*.) CRA activities may also include implementing positive behavioral support plans individually designed to reduce inappropriate and/or maladaptive behaviors and to acquire alternative adaptive skills and behaviors.

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CRA Services include transportation to all other waiver services specified in the Individual Service Plan and as needed to facilitate the individual's participation in personal shopping, recreation and other community activities.

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Individuals receive CRA services in small group settings of four or fewer, in host home/life sharing situations for adults 18 years and above, or foster homes for individuals under the age of 18 years through an approved foster home operating under a licensed Child Placing Agency.

CRA Services may not be provided to persons living in their own or family homes.

2302 Special Requirements of Participation

1.DD Service Agencies rendering Services must have staffing that meets the following requirements:

2. 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.

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

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

ii. Manages the use of agency funds;

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

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

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

3.A Developmental Disability Professional (DDP) (for definition, *Provider Manual for Community Developmental Disability Providers* at http://dbhdd.org/files/Provider-Manual-DD.pdf

The agency director who meets the qualifications of a Developmental Disability Professional may serve both roles provided the staff members meets the professional qualifications for each role

4.Direct Care Staff must:

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a. Be 18 years or older;

b. Have a high school diploma or equivalent (General Educational Development or GED) or have a minimum score of 75 on the Short Test of Functional Health Literacy for Adults (STOFHLA) or Test of Functional Health Literacy for Adults (TOFHLA).

c. Meet transportation requirements in COMP Part II Chapter 900, section 905 if transporting individuals.

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

1.The purpose and scope of the service to be delivered, including related policies and procedures;

2.Confidentiality of individual information, both written and spoken; and

3. Rights and responsibilities of individuals including but not limited to;

i. Requirements for recognizing and reporting suspected abuse, neglect, or exploitation of any individual:

ii. To the Department of Behavioral Health and Developmental Disabilities;

iii. Within the organization; To appropriate regulatory or licensing agencies; and

iv. to law enforcement agencies

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 service.

The type and number of all other staff associated with the organization (such as contract staff, consultants) are:

a. Properly trained or credentialed in the professional field as required;

b. Present in numbers to provide services and supports to individuals as required; and

c. Experienced and competent in the services and support they provide.

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 pursuant to DBHDD Policy 04-104 and all policy outlined in *Part I Policies and Procedures For Medicaid/PeachCare For Kids.*

Provider agencies must have available a sufficient number of employees or professionals under contract.

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

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.

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*).

Licensure and Delivery Settings

Setting	License Required	Citation Source
Community Living Alternative	Yes	http://dch.georgia.gov/hfr-laws-regulations
*Personal Care Home	Yes	http://dch.georgia.gov/hfr-laws-regulations
Child Placing Agency	Yes	https://dhs.georgia.gov/child-placing-agencies-cpa
Host Home	No	* N/A

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

Personal Care Home: provider-operated residence with license capacity approval of four or fewer residents.
*Personal Care Home licenses are no longer accepted for CRA enrollment as of 7/1/2010

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

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*

Supervision and Direct Support Staff Duties

Supervision of Direct Support Staff

CRA providers must comply with staff supervision and training requirements as defined in licensure Rules and DBHDD policy for Host Home/Life Sharing Sites.

Enrolled CRA 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 CRA 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.*

The type and number of all other staff associated with the organization (such as contract staff, consultants) are:

A. Properly trained, licensed and/or credentialed in the professional field as required;

B. Present in numbers to provide services and supports to individuals as required;

C. Experienced and competent in the services and support they provide.

Direct Care Staff

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

S. 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;

T. Accompanying individuals and facilitating participation in visits for medical care, therapies, personal shopping, recreation and other community activities;

U. Training or assistance in household care, such as meal preparation, clothes laundering, bed-making, housecleaning, shopping, simple home repair, yard care, and other similar tasks;

V. Assisting with therapeutic exercises, supervising self-administration of medication and performing health maintenance activities;

W. Implementing positive behavioral support plans of individuals to reduce inappropriate and/or maladaptive behaviors and to acquire alternative adaptive skills and behaviors.

Other Requirements

In 24 hour or residential care 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.

5. **Community Residential Alternative Facility Capacity Limit:**

   A. Community Residential Alternative Services can only occur in a facility that serves no more than four (4) individuals at a time.

   B. Exceptions to the facility capacity are considered by DBHDD for short stays in circumstances with no other available options. In such circumstances, the DBHDD Field Office evaluates the setting for factors that might influence the safety of the new resident or other residents in the home, continues to seek other options, and works with support coordination staff through frequent monitoring of all residents in the home until the occupancy is reduced. In no circumstance can the excess capacity exceed one year.

6. **Host Home/Life Sharing Arrangement Requirements:**

a. Providers (i.e., the individual/family providing the individual the host home/life sharing arrangement) rendering Community Residential Alternative Services must comply with the DDBHDD Operational Standards for Host Home/Life Sharing.

b. Community Residential Alternative Services can only occur in a host home/life sharing arrangement that serves no more than two adult individuals.

c. Host home/life sharing for an individual under the age of 18 years can only occur in an approved foster home operating under a licensed Child Placing Agency. These foster homes can only serve a maximum of two (2) individuals under the age of 18 years at a time and can only serve individuals receiving services through the COMP Waiver.

Rev. 04 2009 ider agency can subcontract with a specific host home/life sharing site.

e. Administrative Costs and Payment to Host Home Provider. The following are requirements for administrative costs of the CRA provider agency and the agency's payment to the host home individual/family (i.e., the individual/family providing the individual the individual the host home/life sharing arrangement):

*The minimum share of the CRA rate that agencies must pass-through to the home providers is 60 percent.

f. Host home individual/family may not manage the day-to-day operations of another residential location.

1. Staffing allocations consistent with Rate Categories:

Levels – 4-person residence	**Allocated Staff Hours Per Week**
Category 1	45.3 per person
Category 2	55.3 per person
Category 3	66.5 per person
Category 4	80.5 per person
Levels – 3-person residence	**Allocated Staff Hours Per Week**
Category 1	53.7 per person
Category 2	60.3 per person
Category 3	73.7 per person
Category 4	88.7 per person

Staffing Levels:

The staff allocation table above describes the average staffing level determined to be necessary to support waiver individuals in each category. Staffing levels are based on average needs within each category and are not required to be delivered on a weekly basis. Staffing hours may fluctuate to accommodate greater or less need by the individual but should be used as a general guide to determine overall household staffing requirement. Any request for additional staffing will be based on the weekly hours outlined above as the baseline minimum requirement prior to consideration for additional staffing.

Floating Hours

"Floating" FTE hours are intended to accommodate members who participate in day programs less frequently than assumed, require more one-to-one support, etc. The residential rate categories include 40 "floating hours" per week per household.

Host Home Expectations

It is expected that Host home providers supporting members with the most extensive needs (Category 2) will be able to demonstrate specific training, experience, and/or expertise. Further, CRA Providers must be able to demonstrate a greater level of support to homes providing services to waiver individuals whose needs fall within the scope of Category 2 homes.

8.Termination of Contract between the Host Home/life Sharing Site and CRA Provider Agency

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

9. **Relocation of I**ndividual**:** A individual must not be relocated without documented prior approval from the DBHDD Field office, a minimum of thirty (30) days prior to the move except in documented and regionally approved emergencies, and with subsequent adjustments to the ISP and Prior authorization (PA) prior to relocation except with confirmed regional approval. The relocation of an individual after a disaster damages or destroys a CRA site must be according to the disaster plan for that CRA site. The disaster plan for that site must be available for review by DBHDD and DCH.

- **Individual Site Enrollment:** Each individual Community Residential Alternative site must be individually enrolled.

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12. **Actions Due to Critical Health and Safety Risks:** If a CRA service site is determined by DBHDD to have critical health and safety risk, DBHDD will take immediate action to remove the individual(s).

13. **Requirements for Employees Residing at Employer's CRA Site:** The provider agency must abide by the Fair Labor Standards Act requirements for sleep time when employees reside at the employer's CRA site.

14. **Requirements to Accompany Individuals to Emergency Rooms or Hospitals:** CRA provider agency staff must accompany individuals who are transported to an emergency room or hospital.

2303 Special Eligibility Conditions

c. CRA services are provided to individuals who require 24-hour support.

d. The need for CRA services is determined through assessment and described in the Intake and Evaluation Team approved Individual Service Plan (ISP).

e. Individuals who receive CRA services in a group setting live in small group settings which offer individualized support and training in all aspects of daily life including but not limited to activities of daily living, instrumental activities of daily living, socialization, leisure activities and events, spiritual activities and events, and work-related activities as desired.

f. Supports are designed commensurate with each waiver individual's level of need as determined by the Health Risk Screening Tool and the Supports Intensity Scale along with other specialized assessments or evaluations. Categories of need are determined using the level 1 – 4 with Category 1 waiver individuals requiring comparatively mild support needs and Category 4 having much more complex needs, particularly in the areas of exceptional medical and/or behavioral needs. Detailed description of the assessed levels and correlation to need categories can be reviewed at: https://dbhdd.georgia.gov/residential-and-respite-cost-study.

2304 Prior Approval

Community Residential Alternative 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 Individual Service Plan and with any ISP version changes.

2305 Covered Services

Reimbursable Community Residential Alternative Services include the following based on the assessed need of the individual and as specified in the approved ISP:

1. Assistance with, and/or training in, activities of daily living, such as bathing, dressing, grooming, other personal hygiene, feeding, toileting, transferring and other similar tasks.

2. Accompanying individuals and facilitating their participation in visits for medical care, therapies, personal shopping, recreation and other community activities. This category includes staff to serve as interpreters and communicators and transportation costs to provide the service.

3. Training or assistance in household care, such as meal preparation, clothes laundering, bed-making, housecleaning, shopping, simple home repair, yard care and other similar tasks.

4. Assisting with therapeutic exercises, supervising self-administration of medication, basic first aid, arranging and transporting individuals to medical appointments, documenting an individual's food and/or liquid intake or output, reminding individuals to take medication, and performing other medically related services including health maintenance activities.

5. Training and support in the areas of social, emotional, physical and special intellectual development. This category includes mobility training, life skills training, self-awareness, and positive behavior support to reduce inappropriate or maladaptive behaviors.

6. Transportation is included in the cost of Community Residential Arrangement services and is thus required to and from waiver and other services specified in the Individual Service Plan. Georgia's Non-Emergency Transportation System may be used for medical appointment transportation with proper supervision and assistance by the CRA provider.

7. Implementation of behavioral support plans to reduce inappropriate behavior and to acquire alternative skills and behaviors.

2306 Non-Covered Services

A. CRA services delivered in the individual's own or family home or in any residence in which Community Living Support services are provided to an individual including any family-owned licensed personal care home, licensed community living arrangement, or host home/life sharing arrangement.

B. Services in a facility/home that does not meet licensed capacity approved by Georgia Healthcare Facilities Regulation
.

C. Reimbursement over 344 days/year based on the waiver individual's annual ISP dates.

D. Any absence from the home that requires an overnight stay including hospitalization, overnight camp, family visits or vacations. The only exception is for the individual living in a host home who accompanies a host family on vacation as long as the vacation does not exceed 30 days in the ISP year.

E. An extended overnight visit with family or friends that exceeds 12 hours in a 24 hour period.

F. Medically related services that are not allowable by State law, rules, and regulations unless fully compliance with Proxy Caregiving Rules.

G. Restrictive behavioral interventions, including chemical or mechanical restraints and seclusion, prohibited by state law or regulations.

H. 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*.

Rev 10 01 2021

Environmental Accessibility Adaptation Services, Vehicle Adaptation Services and Transportation Services cannot be authorized when an individual is authorized Community Residential Alternative Services

I. Individuals receiving Community Residential Alternative services cannot receive Community Living Support Services unless

provided as an alternative in lieu of CRA services during family visits or other overnight excursions outside the residential setting. Exception is also allowed for individuals who are in the process of transitioning from Community Living Support Services to Community Residential Alternative Services due to such circumstances as the aging of the individual's caregivers, and/or to allow the individual to remain in his or her family home for as long as possible. Exceptions to the authorization of a combination of Community Residential Alternative Services and Community Living Services must reflect an assessed need and be described in the waiver individual's ISP. The delivery of Community Living Support Services and Community Residential Alternative Services on the same day is not allowed.

J. Non-covered health maintenance activities as defined in the *Rules and Regulations for Proxy Caregivers Used in Licensed Healthcare Facilities, Chapter 111-8-100.*

K. 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.

2307 <u>Documentation</u>

Documentation of CRA services must include the following elements in the record of each individual:

1. Daily logs with beginning and ending time of day of all staff and contractors delivering services in the home to include:
    i. Shift or PRN direct support staff
    ii. Supervisors or residential managers
    iii. Agency employed or contracted nurse consultants
    iv. Any approved Additional Staff
    v. Professional staff such as therapists, nurses, home health care professionals, behavioral support consultants or service providers

2. Consultation or other activity provided by the agency's nurse in response to request or ad hoc.

3. Specific activity, training, or assistance provided;

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;

5. Supervisory/management note documenting supervision, training and administrative support of the direct support personnel;

6. Progress towards the individual's independence as documented in the individual's ISP.

7. Coordination and/or transportation to other waiver services or community-based services, leisure activities, social events or other activities supporting community inclusion.

8. Any overnight absences from the home including reason for absence.

2308 Basis for Reimbursement

Reimbursement rates for CRA include the following:

Community Residential Alternative-Group Home
4-Person Residence, Category 1 (Level 1)
4-Person Residence, Category 2 (Level 2)
4-Person Residence, Category 3 (Level 3, 4)
4-Person Residence, Category 4 (Level 5, 6, 7)

3-Person Residence, Category 1 (Level 1)
3-Person Residence, Category 2 (Level 2)
3-Person Residence, Category 3 (Level 3, 4)
3-Person Residence, Category 4 (Level 5, 6, 7)

Community Residential Alternative-Host Home
Category 1 (Levels 1, 2, 3, 4)
Category 2 (Level 5, 6, 7)

Reimbursement rates for CRA services are found in Appendix A.

A. The unit of service for CRA services is daily.

D. Transportation is included in the rate for CRA services but does not prevent the use of Georgia's Non-emergency Transportation Service for medical appointments.

E. Rates for Community Residential Alternative - Group Home and Host Home include an absence factor that adds a premium to the daily rate (based on a 365-day year). Thus, rates represent annualized annual reimbursement over 344 billing days.

C. The annual maximum number of CRA daily units is 344 daily per year.

2309 Participant-Direction Options

Rev 10 01 2021

A. Community Residential Alternative Services cannot be participant-directed.

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

PART III - CHAPTER 2400

SPECIFIC PROGRAM REQUIREMENTS FOR ENVIRONMENTAL ACCESSIBILITY ADAPTATION SERVICES

SCOPE OF SERVICES

2401 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 COMP does not cover items that have been denied through the DME and other programs for lack of medical necessity.

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 COMP Program, individual providers of Environmental Accessibility Adaptations must meet the following requirements:

a. **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:

- The efforts of the individual's Support Coordinator to substantiate payer of last resource, including available community, State Plan, or other resources.

- Verification of Environmental Accessibility Adaptation service delivery, including date, location, and specific environmental accessibility adaptations provided.

Rev. 07 2009

- Associated administration costs for Environmental Accessibility Adaptation service delivery that delineates line item sources of costs; billing of associated administration costs can not exceed eight to ten (8 to 10) percent of any billing for Environmental Accessibility Adaptation services.

a) **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.*

2402.2 <u>Provider Agencies</u>

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, Environmental Accessibility Adaptation Services provider agencies must meet the following requirements:

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:

   (a) The efforts of the individual's Support Coordinator to substantiate payer of last resource, including available community, State Plan, or other resources.

(b) Verification of Environmental Accessibility Adaptation service delivery, including date, location, and specific environmental accessibility adaptations provided.

Rev. 04 2009

(c) 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.

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 COMP and NOW, Chapter 1200.*

3. 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 DBHDD (see *Part II Policies and Procedures for COMP and NOW, Chapter 603*).

2403 Licensure

Environmental Accessibility Adaptations are made by building, plumbing or electrical contractors with applicable Georgia license (O.C.G.A. § 43-14-8 or 43-41-6) 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.

2404 Special Eligibility Conditions

Rev. 10 2009

1. The need for Environmental Accessibility Adaptation services must be related to the individual disability and specified in the Intake and Evaluation Team approved Individual Service Plan (ISP).

Rev. 10 2009

2. Medical Necessity for Environmental Accessibility Adaptation Services must be documented through an order by the Georgia Licensed physician.

2405 Prior Approval

1. Environmental Accessibility Adaptation Services must relate to specific individual goal(s) and must be required to meet the needs of the individual.

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.

2406 Covered Services

Reimbursable Environmental Accessibility Adaptation Services include the following based on the assessed need of the individual and as specified in the approved ISP:

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.

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.

2407 Non-Covered Services

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.

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).

3. Adaptations that are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc.

4. Adaptations that are made to leased property.

5. Comfort, convenience, or recreational adaptations.

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.
7. Individuals cannot receive Environmental Accessibility Adaptation Services if receiving Community Residential Alternative Services.

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 COMP and NOW, Chapter 900*.

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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.

2408 Basis for Reimbursement

A. Lifetime maximum is $10,400 per individual.

B. Reimbursement Rate:
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.

2409 Participant-Direction Options

A. Individuals may choose the self-direction option with Environmental Accessibility Adaptation.

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

III - CHAPTER 2500

SPECIFIC PROGRAM REQUIREMENTS FOR FINANCIAL SUPPORT SERVICES

SCOPE OF SERVICES

2501 General

Financial Support Services (FSS) are designed to perform fiscal and related finance functions for the individual 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).

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 COMP Program, Financial Support Services providers must meet the following:

1) **Provider Qualifications:**

   a. Be a Fiscal Intermediary Agency;

   b. Be approved by the IRS under procedure 70-6 and meet requirements and functions as established by IRS code, Section 3504;

c. 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;

d. Understand the laws and rules that regulate the expenditure of public resources;

e. Have at least two years of basic accounting and payroll experience;

f. 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 individual's business accounts managed but not less than $250,000;

g. Be approved by the IRS (under IRS Revenue Procedure 70-6) and meet requirements and functions as established by the IRS code, section 3504;

h. Not be enrolled to provide any other Medicaid services in the State of Georgia.

2. **Service Delivery Requirements:**

a. Receive and disburse funds for the payment of participant-directed services under an agreement with the Department of Community Health, the State Medicaid agency.

b. File claims through the Medicaid Management Information System (MMIS) for participant-directed goods and services.

c. Utilize accounting systems that operate effectively on a large scale and have the capacity to track individual budgets;

d. Adhere to the timelines for payment that meet the individual's needs within Department of Labor standards;

e. Develop, implement and maintain an effective payroll system that adheres to all related tax obligations for both payment and reporting;

f. Maintain separate, individual accounts for each individual's funds to be used for participant-directed waiver services;

g. 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;

h. Establish procedures for generating service management, and statistical information and reports during each payroll cycle;

i. Develop materials for startup training and technical assistance to individuals, their representatives, and others as required to include, but not limited to, timesheets and payroll forms.

j. Establish procedures for processing and maintaining all unemployment records;

k. Provide an electronic process for reporting and tracking timesheets and expense reports;

l. 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.

m. 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 individual in the participant's approved budget;

n. Provide all necessary employment and budget forms to Participants (employers) to include but not limited to timesheets, W-2s and a financial orientation package;

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

2503 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.

2504 Special Eligibility Conditions

A. O*nly* individuals who opt for participant-direction of services are eligible to receive Financial Support Services.

B. The need for Financial Support Services must be reflected in the Individual Service Plan approved by the Intake and Evaluation Team.

C. Financial Support Services are not available to individuals or representatives who choose the ***Co-Employer*** model for self-directed services and supports.

2505 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.

2506 Covered Services

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

1. Conducts and pays for criminal background checks (local and national) and completes age verification on service support workers.

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.

3. Generates service management, statistical information, and reports during each payroll cycle.

4. Provides startup training and technical assistance to individuals, their representatives, and others as required.

5. Process and maintain all unemployment records.

2507 Non-Covered Services

A. Supplies and maintenance for fax machine.

B. The FSS provider can only provide Financial Support Services and must not be enrolled to provide any other Medicaid services in Georgia.

C. Financial Support Services are not available to individuals or representatives who choose the ***Co-Employer*** model for self-directed services and supports.

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

2508 Basis for Reimbursement

A. One unit per month per member.

B. Reimbursement Rate
The reimbursement rate for Financial Support Services is found in Appendix A.

2509 Participant-Direction Options

c. Financial Support Services is a mandatory and non-negotiable for individuals who choose the participant-directed option for service delivery.

d. When the individual is the employer of record, the FSS provider is the Internal Revenue Service approved Fiscal Employer Agent (FEA).

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

PART III - CHAPTER 2600

SPECIFIC PROGRAM REQUIREMENTS FOR INDIVIDUAL DIRECTED GOODS AND SERVICES

SCOPE OF SERVICES

2601 General

Individual Directed Goods and Services are goods and services not otherwise provided through the COMP or the Medicaid State Plan but are identified by the waiver individual/representative who opts for participant-direction and the Support Coordinator or interdisciplinary team. These services are available ***only*** for individuals 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 due to his or her disability and be documented in the individual'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 individual's opportunities for full membership in the community. Goods and services purchased under this coverage may not circumvent other restrictions on COMP 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:

A. Decrease the need for other Medicaid services; AND

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

C. Promote inclusion in the community; OR

D. Increase the individual's safety in the home environment;

The individual/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 individual'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. Individuals receiving flexible support coordination are required to follow these same procedures.

2602 Special Requirements of Participation

2602.1 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, Individual Directed Goods and Services providers must meet the following requirements:

1. **Individual Providers of Individual Directed Goods and Services must:**

    1. Must be 18 years or older;

    2. Have a minimum of a high school diploma or GED Equivalent;

    3. Must have two years of professional work experience in the area of purchasing or related experience; OR

    4. Have an applicable business license for goods provided.

        b. **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.

        c. **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 and NOW,* Chapter 1200.

        d. **Documentation of Services and Goods Purchased:** A paid invoice or receipt that provides clear evidence of the purchase must be on file in the individual's records to support all goods and services purchased.

2602.2 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 COMP Program, Individual Directed Goods and Services provider agencies must meet the following requirements:

1. **Agency Providers of Individual Directed Goods and Services must**:

    1. Have employees providing services that meet the above requirements for individual providers; OR

    2. Have an applicable business license for goods provided.

2. **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.

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 COMP*, Chapter 1200.

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 individual's records to support all goods and services purchased.

2603 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.

2604 Special Eligibility Conditions

Individual Directed Goods and Services are only for individual who opt for participant-direction.

The specific goods and services provided under Individual Directed Goods and Services must be clearly linked to an assessed need of the individual individual due to his or her disability and be documented in the individual's Intake and Evaluation approved Individual Service Plan (ISP).

The individual/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.

2605 Prior Approval

Authorization for these services requires Support Coordinator documentation that specifies how the Individual Directed Goods and Services meet the requirements for purchase of this coverage specified below:

The goods or services are not covered through the COMP Program or Medicaid State Plan; AND

The individual does not have the funds to purchase the item or service or the item or service is not available through another source; AND

The item or service would decrease the need for other Medicaid services; AND

Promote inclusion in the community; OR

Increase the individual's safety in the home environment.

The Support Coordinator provides a copy of the above documentation to the vendor prior to service provision.

The above authorization procedures for the Support Coordinator must be followed for individuals receiving flexible support coordination.

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.

2606 Covered Services

Reimbursable Individual Directed Goods and Services include the following based on the assessed need of the individual and as specified in the approved ISP:

a. Goods that specifically relate to the individual's needs due to his or her disability and are not otherwise provided through the COMP or the Medicaid State Plan.

b. Services that specifically relate to the individual's needs due to his or her disability and are not otherwise provided through the COMP or the Medicaid State Plan.

2607 Non-Covered Services

a. Services or goods not related to the needs of the individual due to his or her disability.

b. Experimental or prohibited treatments.

c. Costs for room and board and other restrictions on COMP services.

d. Services otherwise provided through the COMP or the Medicaid State Plan, including additional units or costs beyond the maximum allowable for any COMP or Medicaid State Plan service.

e. Items denied through the Durable Medical Equipment and other Medicaid State Plan programs due to the lack of medical necessity.

f. 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.

g. Services that are available under a program funded under section 110 of the Rehabilitation Act of 1973.

h. Incentive payments, subsidies, or unrelated vocational training expenses.

i. Supervisory activities rendered as a normal part of the business setting.

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

k. Admission fees, Memberships, Subscriptions, Donations, or related items.

l. Training paid caregivers.

m. Services in a hospital.

n. Any item listed as non-covered for the COMP Specialized Medical Supplies, Specialized Medical Equipment, Vehicle Adaptations, and Environmental Accessibility Adaptation Services.

a. Services reimbursable by any other source.

b. Costs of travel, meals and overnight lodging for families and natural support network members to attend a training event or conference.

c. 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.

2608 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.

2609 Participant-Direction Options

- Individual Directed Goods and Services are only for individuals who opt for the self-direction option.

- An individual serving as a representative for a waiver individual in self-directed services is not eligible to be a participant-directed provider of Individual Directed Goods and Services.

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

PART III - CHAPTER 2700

SPECIFIC PROGRAM REQUIREMENTS FOR INTERPRETER SERVICES

SCOPE OF SERVICES

2701 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.

2702 Special Requirements of Participation

2702.1 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:

8. Service Provision: Interpreter Services are provided by a certified sign language interpreter in accordance with Registry of Interpreters for the Deaf (RID).
9. Documentation Requirement: Providers must provide a documentation record of the services provided to each individual:

a. Specific services provided interpreting and translation/training or other communication assistance provided;
b. Date and the beginning and ending time when the service was provided:
c. Location where the service was delivered;
d. Verification of service delivery, including first and last name and title of the person providing the service and his or her signature.
e. Progress towards the goal(s)established in the individual's communication assessment report (CAR).

f. 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.

10. 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.

2702.2 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.
Types of Agencies: Agencies that provide Sign Language interpreter Services are:
Sign Language Interpreting Agencies

Staffing Qualifications and Responsibilities:

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

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

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.

3) 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.

- Agency Policies and Procedures: 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*

- 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 and NOW*).

2703 Licensure

A. Interpreter Services are provided by a "qualified interpreter" or "intermediary interpreter" in accordance with the applicable Georgia code O.C.G.A. § 24-6-651

2704 Special Eligibility Conditions

In addition to the communication assessment, an individual must have one of the following conditions:
1. A medical condition or diagnosis:
a. For which a communication assessment has been required; or
b. which has resulted in the patient's inability to communicate in spoken language to others.
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.
3. The individual's communication preference is to communicate in sign language.
4. All services must be reflected on the communication assessment report.

Documentation Requirement: Providers must document the following in the record of each individual receiving Interpreter Services:

1. Specific interpreting, training or communication assistance provided;

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

3. Location where the service was delivered; and

4. Verification of service delivery, including first and last name and title of the person providing the service and his or her signature;

5. Progress towards the individual's communication needs as documented in the individual's ISP.

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.

2705 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.

2706 Covered Service

Reimbursable Interpreter Services include the following based on the assessed need of the individual and as specified in the approved ISP:
Evaluation and assessment
Individual Service Planning
Individual Family/Staff education

2707 Non-Covered Services

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

2708 Basis for Reimbursement

The reimbursement rates for Sign Language Interpreter Services are found in Appendix A of this manual- the rate cannot exceed the established rates for the Waiver Services Program.

2709 Participant-Direction Options

Individuals can not choose the self-direction option with Sign Language Interpreter Services.
An individual serving as a representative for a waiver individual 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.*

Rev 10 2022 2710 Telehealth Options

All components of Interpreter Services may be provided via a telehealth modality. Service provision a via telehealth modality will be considered on an individual basis taking into consideration the most effective communication mode and preferences of the

individual. Individuals who are Deaf have various levels of language use, comprehension, abstract thinking ability, and temporal relation. Each individual's level of language use and preferences are considered when the individual determines telehealth is the most effective option for that individual during the Individual Service Plan (ISP) planning process. The DBHDD Office of Deaf Services is available for assistance with service planning and access to COMP Interpreter Services and can be contacted at deafservices@dbhdd.ga.gov.

For other COMP services being rendered via a telehealth delivery model, the interpreter may also join the COMP service provider remotely at the preference of the individual and the individual's designated representative as applicable.

All Interpreting services are required to adhere to HIPAA and state privacy law. Providers are required to use HIPAA compliant platforms while offering telehealth services. In addition to being HIPAA compliant, all certified interpreters are also required to adhere to the Registry of Interpreter for the Deaf's (RID) Code of Professional Conduct (CPC).

Interpreter telehealth services shall be rendered in a quiet, private environment with attendance limited to those participating in the event.

H. For more information regarding telehealth guidance, please refer to the telehealth guidance, located at www.mmis.georgia.gov, Click Provider Information-Provider Manuals.

PART III - CHAPTER 2800

SPECIFIC PROGRAM REQUIREMENTS
FOR
NATURAL SUPPORT TRAINING SERVICES

SCOPE OF SERVICES

2801 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 and tie to a specific goal in the Individual Service Plan. 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 as specified in the ISP. There 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 identified in the ISP. 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 *Part II Policies and Procedures for NOW and COMP* 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).. 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.

2802 Special Requirements of Participation

2802.1 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, Natural Support Training providers must meet the following requirements:

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 COMP, Appendix I.*

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:

    a. Specific activity, training, or assistance provided;

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

    c. Location where the service was delivered;

    d. Verification of service delivery, including first and last name and title (if applicable) of the person providing the service and his or her signature;

    e. Verification of registration and certificate of attendance at any formal training;

    f. Progress towards moving the individual towards independence by meeting the individual ISP, which includes person-centered goal(s), desired outcomes in the individual's action plan, and the amount/type of assistance/support in the ISP.

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 and NOW, Chapter 1200.*

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 COMP Program, Natural Support Training Services provider agencies must meet the following requirements:

1. **Staffing Qualifications and Responsibilities**

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

a. 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.

b. Duties of the Agency Director 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.

c. At least one agency employee or professional under contract with the agency must:

a. Be a Developmental Disability Professional (DDP) (for definition, see *Part II Policies and Procedures for NOW and COMP, Appendix I);*

b. Have responsibility for delivering Natural Support Training Services to individuals.

d. The same individual may serve as both the agency director and the Developmental Disability Professional;

A Developmental Disability Professional (DDP) (for definition, *Provider Manual for Community Developmental Disability Providers* at http://dbhdd.org/files/Provider-Manual-DD.pdf

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.

Provider agencies must assure that employees or professionals under contract providing NST services hold applicable professional licenses as required by Georgia Code Title 43.

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 DBHDD as stated in *Part II Policies and Procedures for NOW and COMP*.

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:

   a. Specific activity, training, or assistance provided;

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

   c. Location where the service was delivered;

   d. Verification of service delivery, including first and last name and title (if applicable) of the person providing the service and his or her signature;

   e. Progress towards moving the individual towards independence by meeting the individual ISP, which includes person-centered goal(s), desired outcomes in the individual's action plan, and the amount/type of assistance/support in the ISP.

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 COMP*, Chapter 1200.

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 COMP and NOW*,

Chapter 603).

2803 Licensure

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

- Psychologist (O.C.G.A. § 43-39-7); or
- Physician (O.C.G.A. § 43-1-32); or
- Physician Assistant (O.C.G.A. § 43-34-103); or
- Advanced Practice or Registered Nurse (O.C.G.A. § 43-26-10); or
- Social Worker or Professional Counselor (O.C.G.A. § 43-10A-7); or
- Physical Therapist (O.C.G.A. § 43-33-19); or
- Occupational Therapist (O.C.G.A. § 43-28-7); or
- Speech and Language Pathologist (O.C.G.A. § 43-44-7).

2804 Special Eligibility Conditions

The need for NST services must be related to the individual's disability in the Intake and Evaluation Team approved Individual Service Plan (ISP).

2805 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.

2806 Covered Services

Reimbursable Natural Support Training Services include the following based on the assessed need of the individual and as specified in the approved ISP:

1. Individualized, direct training of families and natural support networks for acquisition or enhancement of their ability to support the waiver individual.
2. Instruction about treatment regimens and other services included in the ISP.
3. Training on the use of equipment specified in the ISP.

4. Updates in training required to maintain the individual safely at home.

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 and as identified in the ISP.

2807 Non-Covered Services

1. Training paid caregivers.

2. Services reimbursable by any other source.

3. Costs of travel, meals and overnight lodging to attend a training event or conference.

4. Services not related to the needs of the individual due to his or her disability.

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 Services Level 1 and Level 2.

6. NST Services may not occur simultaneously or on the same day as Adult Therapy Services or Behavioral Supports Services Level 1 and Level 2.

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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.

2808 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.

2809 Participant-Direction Options

Natural Support Services will no longer be available under the self-direction model after February 28, 2023. Individuals in the self-direction model with an ISP that includes Natural Support Services must receive a new ISP with an end date no later than February 28, 2023, to confirm that they are authorized to continue to receive Natural Support Services through the traditional model.

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

PART III - CHAPTER 2900

SPECIFIC PROGRAM REQUIREMENTS FOR NURSING SERVICES

SCOPE OF SERVICES

Policies and procedures in this Chapter apply to all Nursing Services delivered by enrolled providers with a Private Home Care or Community Living Arrangement license. This Chapter must be used in conjunction with the manuals and policies listed below:

Part I – Policies and Procedures for Medicaid/Peach Care for Kids, Chapters 100 through 500
Part II – Chapters 600-1200 Policies for Procedures for NOW and COMP Medicaid Waiver Programs
Rules and Regulations for Private Home Care Providers, Chapter 290-5-54
Rules and Regulations for community Living Arrangements, Chapter 290-9-37
DBHDD Policy Recruitment and Application to Become a Provider of Developmental Disability Services, 02-701.

2901 General

This policy is intended to outline the parameters of the practice of licensed nursing within the waiver. Clinical nursing services are indicated when the individual has a clinical diagnosis which requires ongoing complex assessment and intervention for the purpose of health restoration or prevention of further deterioration of the health of the individual.
Nursing care is the assessment and treatment of human responses to actual or potential health problems as identified through the nursing process. Thusly, nursing services are the provision of this level of care via the process of assessment, assignment of nursing diagnosis, planning, implementation/intervention and continued evaluations directed by the Georgia Nurse Practice Act and generally accepted standards of practice.

Nursing Services may be provided by licensed private home care or community living arrangement provider in the community. Private home care and community living arrangement providers, in accordance with O.C.G.A. § 31-7-300 et seq., and community living arrangements in accordance with O.C.G.A. § 31-7 et seq. and 37-1-22, must be licensed by the Georgia Department of Community Health, and Health Care Facility Regulations Division. Private Home rules are stated in Chapter 290-5-54. Community living arrangement rules are found in Chapter 290-9-37. In accordance with Section 105A of Part I Policies and Procedures for Medicaid/PeachCare for Kids, providers must be fully licensed without restriction. 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. All nursing services provided under a Community Living

Arrangement license require site-specific nursing enrollment.

Nursing services are approved when there is the requirement to meet the healthcare needs of the member and may be delivered in a variety of settings including but not limited to the member's home, relative's home, or other location where no duplicative serves are available.
Individuals admitted to the NOW and COMP Waiver Programs are screened using the Health Risk Screening Tool (HRST) (see Health Risk Screening Tool, Policy 02-803 for additional detail). A baseline nursing assessment will be performed for individuals with nursing services authorized after October 1, 2015 for the purpose of identification of healthcare risks. The nursing assessment will result in documentation of the individual's indicated and/or performed nursing supports, services and/or needs.

2902 Waiver Individual Eligibility

2902.1 Eligibility for Nursing Services

1. Nursing services are available to individuals who meet the following criteria:
    - Are over age 21; and
    - Have the following scores on an appropriately completed HRST with review and signature by a Georgia-licensed registered nurse:

a. An HRST score of 3 or above on eating or toileting
b. A rating of a 4 on treatments in the HRST category 3I (physiological)
c. A rating of 4 or more ratings of 4 overall An HRST score of 3 or higher on item U, emergency room visits (documentation must indicted clinical health needs).
d. An HRST score of 2 or higher on item V, hospital admissions (documentation must indicate healthcare issues as the clinical need.
e. A SIS score of 2 or higher on the total score for section 3B, exceptional medical supports needed.
f. Any and/all healthcare needs as assessed by the Registered Nurse that healthcare plans such as skincare, diabetes, hypertension, bowel function, nutritional needs, weight monitoring, etc.
g. Preventative healthcare maintenance activities as required based on risk score of HRST; **OR**
    - Have specific skilled nursing needs, as indicated in an appropriately completed HRST completed within the previous 90 days and supported by a nursing assessment completed by a registered nurse employed by DBHDD.

2902.2 Determination of Approved Hours

1. The number of hours for which approval will be granted is based on specific medical and/or treatment needs of the member confirmed by available medical information assessed and documented by a qualified professional who is knowledgeable about the individual's clinical needs.
2. Documentation:

N. For individuals who currently receive nursing services funded through an HCBS waiver or through GAPP, hours will not be allocated without:
    3506 A nursing assessment completed by a licensed registered nurse;
    3507 written orders from a licensed physician, physician assistant, or nurse practitioner order;
    3508 an appropriately completed HRST; and
    3509 documentation evidencing implementation of physician (or physician extender's) order

O. For individuals who are being assessed for nursing services funded through an HCBS waiver or through GAPP for the first time, hours will not be allocated without:
    3506 A nursing assessment completed by a licensed registered nurse;
    3507 written orders from a licensed physician, physician assistant, or nurse practitioner order; and
    3508 an appropriately completed HRST

3. Nursing assessments are performed by DBHDD field office staff and provide documented assessment of diagnosis, risk, indicated preventative maintenance needs of the individual, and indicated or ordered skilled nursing tasks required to treat, mitigate risk, or comply with the schedule of care.
4. Approval of specific hours is determined by use of a standardized methodology for determination of skilled nursing support. The standardized methodology allocates time needed for skilled nursing tasks identified in assessments and validated screenings.
    N. The standardized methodology tool does not include allocation for unskilled support needs.
    O. Hours are allocated based only on current skilled need, not projected needs.
    P. 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.
    Q. Approval for 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 will be granted for the lowest level of professional licensure appropriate to serve the medically necessary needs of the individual.

2903 Nursing Services Provider Qualifications and Scope of Services

Nursing Services are performed by a Registered Nurse, or under certain circumstances a licensed practical nurse, both of whom are licensed to practice in the State of Georgia; both having at least two years of home health, long term care or acute care nursing experience. Complex or high-risk waiver individuals may require nursing care by individuals with specific training, for example, pulmonary, gastroenterology, or wound care skills. In such cases, DBHDD will determine and specify the skills and experience required. Professional nursing oversight and care is provided according to laws and standards of practice found in the:

A. Official Code of Georgia Annotated § 43-26-3, ET. seq.
B. Georgia Board of Nursing Rules and Regulations, Chapter 410
C. American Nurses Association [ANA] Professional Standards
D. Developmental Disabilities Nurses Association [DDNA] Aspirational Standards of Developmental Disabilities Nursing Practice

2903.1 Qualifications for Registered Professional Nurse

A. Successful completion of an approved nursing education program as defined in Code Section 43-26-3.
B. Successful passing of a board recognized licensing examination.
C. Successful completion of the initial orientation and competency-based training provided by the provider agency and the State of Georgia.

Preferred Qualification

1. Minimum of 4000 hours of RN nursing experience within the past five (5) years. (DDNA).

2903.2 Services by a Registered Nurse include (but are not limited to):

1. Assessment of individual's nursing needs
2. Initial healthcare plan(s) development *(based upon assessed needs, risks, and active conditions)*
3. Development of teaching plan and caregiver(s) competency checklist;
4. Implementation of ordered/indicated clinical and nursing interventions
5. Preparation of clinical progress notes
6. Coordination of healthcare services
7. Informing the physician, support coordination and other personnel of changes in the patient's condition or needs
8. Patient and family teaching
9. Supervision (to be performed by RN) and teaching of other provider personnel (clinical and other direct support staff)
10. Administering medications and treatments as prescribed by a physician in accordance with currently accepted standards of nursing practice
11. Other services in accordance with and as outlined in the Georgia Registered Professional Nurse Practice Act

2903. 3 Qualifications for Licensed Practical Nurse

Licensed Practical Nurses function by law in a dependent role at the direction of a Registered Professional Nurse or other select authorized health care providers. Under such direction, the Licensed Practical Nurse may administer medication, provide nursing treatments, gather data, signs and symptoms that can be utilized by the RN in his/her decisions about the care of specific individuals. The scope of practice does not include assessment, independent interpretation of clinical data or independent action on such data, triage, creation, initiation or establishment of nursing healthcare plans or the alteration of nursing care goal(s). Supervising RNs must provide an appropriate degree of clinical supervision which is determined by the specific assessed needs of the individual care to be provided. Providers and employers must assure that such on-site direct supervision is readily available when hiring LPNs.

A. Successful completion of a formal educational program in practical nursing approved by the Georgia Board of Nursing.
B. Successful passing of the National Council Licensure Examination for Practical Nurses and a current Georgia issues license.
C. Successful completion of orientation and competency-based training provided by the provider agency and the State of Georgia.

Preferred Qualification

1. Minimum of 4000 hours (2 years) of practical nursing experience within the past five (5) years (DDNA).

2903.4 Services which may be provided by Licensed Practical Nurse include:

- Collecting data and collaborating in the assessment of the health status of a patient
- Collaborating in the development and modification of the registered professional nurse's or advanced practice nurse's comprehensive nursing plan of care for all types of patients.
- Implementing aspects of the plan of care as delegated.
- Participating in health teaching and counseling to promote, attain, and maintain the optimum health levels of patients, as delegated.
- Serving as an advocate for the patient by communicating and collaborating with other health services personnel, as delegated.
- Participating in the evaluation of patient responses to interventions
- Communicating and collaborating with other health care professionals, as delegated
- Providing input into the development of policies and procedures to support patient safety. (Section 55-30 of the Act)

Services which may not be provided by a Licensed Practical Nurse include:

a. The initial evaluation or complex assessment of a waiver individual
b. Initial development of the healthcare plan
c. Supervisory responsibilities

2903.5 Duties of the RN providing oversight (*include but are not limited to*):

a. Provision of appropriate degree of clinical supervision, is determined by the specific assessed needs of the individual receiving care.
b. Monitoring and supervising the healthcare of individuals receiving nursing services.
c. Reviewing referrals, evaluating the individual's needs during initial and subsequent visits, and identifying and assigning the appropriate staff to provide support needed.
d. Developing and revising the healthcare plan as appropriate and reviewing the content of healthcare plans during each supervisory visit and communicating all revisions to appropriate staff
e. Supervising functions of direct support staff, CNAs and licensed practical nurses.
f. Completing supervisory assessments to include observation of each CNA or LPN providing support.

g. Arranging for orientation of each CNA or LPN to each individual for whom they are providing care.

2903.6 Contracted Services

Enrolled providers must maintain adequate and appropriate 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.

2903.7 Subcontracting

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

1. Names of all parties entering into contract
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.
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.
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 is amended.
5. A stipulation that the persons delivering services meet the staff requirements
6. A stipulation that the subcontractor will participate as needed in the nursing agency's case conferences to coordinate support or care.

2903.8 Care That May Not Be Delegated Under This Policy

Healthcare needs that require the training and skill level of a Registered Professional Nurse and are not delegable nursing tasks (without physician or physician extender order and documentation of training) or are not predictable or able to be scheduled may include but are not limited to the following:

1. Ventilator Care
2. Tracheostomy care
3. Deep/endo-tracheal suctioning

4. Wound Vac care
5. Wound Care
6. IV medication administration
7. IM medication administration
8. Irrigation of wound, orifices and catheters
9. Physical
10. Chest Physical therapy (CPT)
11. Cough Assist vest
12. Oxygen administration above 6L/minute
13. Insertion of indwelling catheter/tube
14. Medication calculation

Regardless of delegation of other tasks to unlicensed personnel, the Department of DBHDD considers these care interventions to be non-delegable to unlicensed staff.

2904 Provider Policy and Procedure Requirements

The nursing service provider will have written policies and procedures, which are reviewed at least annually and address, at a minimum:

1. Scope of services offered
a. Method of oversight of offered services (supervision)
2. Procedures for admission and discharge
3. Healthcare plans stipulating emergency procedures for active conditions
4. Onsite clinical records management, including clinical note format and schedule of record retention (consistent with state and federal policies).
5. Administrative, Personnel, and the Training records of staff
6. Use and maintenance of supplies and equipment (if applicable); and training of the use of indicated equipment.
7. The role of the RN in the coordination of care with physicians and other providers and Support Coordination staff.

2905 Documentation

2905.1 On–Site Record Review

Providers must agree to periodic on-site reviews and financial audits by authorized representatives of the Department of Behavioral Health and Developmental Disabilities, the Department of Community Health Program Integrity Unit, Center for Medicare and Medicaid Services (CMS), Office of Inspector General (OIG), and Alliant Georgia Medical Care Foundation.

The Department of Behavioral Health and Developmental Disabilities' procedure for reviewing providers may involve the use of sampling a percentage of records of full and complete review of all records. When sampling is used, the Department or its agents will utilize a generally accepted statistically valid sampling methodology for selecting the sample or records to be reviewed.

2905.2 Record Management and Maintenance of Clinical Records

Providers must maintain records pertaining to the provision of nursing services in accordance with the standards in this policy and with accepted professional standards and practices, including but not limited to actual times of services provided; i.e., date with the beginning and ending time when the service was provided to the member. Records must be available as requested for a period of six (6) years following the date of service in compliance with *PART I POLICIES AND PROCEDURES FOR MEDICAID/PEACHCARE FOR KIDS,* Section 106. *General Conditions of Participation*. The provider must maintain a copy of all service records at the Medicaid enrolled provider site(s). Records must be maintained in a manner that assures security, accuracy, confidentially, and accessibility.

In accordance with 45 CFR Part 17, state and federal governments shall have access to any pertinent books, documents, papers and records for the purpose of making audit examinations, excerpts, and transcripts and copies as needed. If any litigation, claim, or audit is initiated before the expiration of the ten (10) year period the provider must retain records until all litigation, claims, or audit findings involving the records are resolved. All original documents should be maintained in the member record at the agency. The agency is to maintain the nurses' signed time sheets on file for a period no less than three (3) years.

2905.3 The Clinical Record

The nurse agency must establish and maintain at the agency's office and at the service delivery site, a current clinical record for all waiver individuals admitted to the agency. There must be eighteen months of clinical records available on site. While the member is receiving services, the following records (below), marked with an asterisk, should be maintained securely at the site where the individual receives nursing services. These records shall be kept in accordance with currently accepted standards of medical practice, be readily available to facilitate coordination of healthcare services, and must include at minimum:

1. Appropriate patient identifying information, including current directions to the service delivery site from the provider's site
2. The name of the individual's primary care physician with current contact information*
3. Signed and dated progress notes written the day of service, by the providing member of the health team, to include at a minimum:
    a. All logs as applicable according to the healthcare plan*
    4. Current healthcare plan* (signed and dated by the preparing provider)
    5. A current copy of the completed DMA-6/7
6. Copies of summary reports sent to the physician to correspond with physician visits and provide report
    7. Discharge summary when applicable
    8. Hospital discharge notes and instructions
9. Detailed teaching plan and skills check for all staff providing tasks through proxy caregiver status. This document should be maintained at the service delivery site and updated as necessary

10. Supervisory assessment dated and signed by the R.N. when applicable
11. A current ISP which reflects approved nursing services with duration and frequency; to include goal(s).
12. Current clinical assessments relevant to the holistic healthcare plan

2905.4 Clinical Notes

The clinical record must include written progress notes detailing specific tasks provided to the individual. The notes should be written by all personnel delivering support. The written notes should include all information pertaining to the waiver individual. Any problems reported by an individual, support staff member or family must be addressed in the notes. The notes should include on-going evaluation regarding the progress made toward identified goal(s). Progress notes must be maintained on a continuous basis and should also include daily documentation of all treatments and medications administered by the nurse. Signed and dated clinical notes, written by the close of the business day of the day the service was rendered by the providing member of the health team, and incorporated in the office record no less often than weekly. Original clinical notes will remain on site.

Services must be performed and documented according to the physicians' orders and the healthcare plan. See templates for specific protocols and risk reduction or management strategies available at www.gadbhdd.policystat.com.

Logs (i.e., seizure/bowel/intake & output) are to reflect date and time, and description of the activity assessed, duration, intervention/s required and individual response.

2905.5 Summary Report

The summary report is a report of the individual's condition, change or progress, new problems identified, vital signs, complaints, description of wound, etc. (Applicable on to Licensed Private Care Homes) The summary report must be sent to the physician with each physician visit with returned instructions as appropriate.

2905.6 Healthcare Plan

The health risk screening tool identifies the risks and triggers further assessment for the purpose of diagnosis and recommendations of treatment. The healthcare plan addresses the identified risks and outlines interventions necessary to mitigate them. It must indicate the disciplines to be involved and individualized teaching plans to be utilized as well as provide updates regarding the accomplishments of goal(s). It must be formulated, signed and dated by the provider RN. It should be reviewed and revised as often as the severity of the individual's condition requires (i.e., change in medication, treatment, or condition) or at a minimum of annually (in conjunction with the ISP review).

2906 Non-covered Services

Waiver-funded Nursing Services does not include:

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.

2. Services that have not been ordered/approved by a physician or physician extender licensed to provide such orders.

3. Services provided to individuals receiving concurrent nursing services through home health, hospice.

4. Services to individuals under the age of 21.

5. Services provided in a hospital or other institution.

6. Payment is not made for those goods and services covered by the State Medicaid Plan.

2907 Basis for Reimbursement

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Reimbursement for Nursing Services is based on a fixed rate per unit (15 – minute). Reimbursement for employee travel time and expenses to and from the member's home is included in the reimbursement rate for skilled nursing visits.

RN – nursing services (T1002-U1)
Unit = 15 minutes
Maximum rate per unit = $10.00
LPN – nursing services (T1003-U1)
Unit = 15 minutes
Maximum rate per unit = $8.75

2908 Participant-Direction Options

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

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

2909 Essential Elements of Healthcare Plan

- Demographic information
- Effective Date
- Diagnosis(s)
- Description of Symptoms or Exacerbation of Condition

- Nursing Diagnosis (s)
- Goal(s) and Objection(s) (standards of care)
- Nursing Interventions
- Documentation Requirements
- Evaluation of Progress
- Signature of approving RN

2910 Annual Health Screening Recommendations

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ALL ADULTS		**1. Date of last screen 2. N/A 3. Does this need to be done?**	***Questions / Notes***
Height / Weight / BMI	Annually		
Colorectal Cancer Screen	1. Fecal Occult Blood Testing ages 50+ **OR** 2. FOBT + Sigmoidoscopy every 5 years ages 50+ **OR** 3. Colonoscopy every 10 years at ages 50+, per HCP recommendation or if above screens not performed		
Skin Cancer Screen	1. Total skin examination every 3 years from 20–39. 2.Annually age 40 and older.		
Hypertension	At least Annually		
Cholesterol	Every 5 years or at HCP discretion.		
Diabetes [Type II]	1. HgbA1c or fasting plasma glucose screen at least every 5 years until age 45 if at high risk. 2. Every 3 years after age 45.		
Osteoporosis	Consider Bone Mineral Density (BMD) testing ages 19-59 when risk factors are present (including medications, mobility impairment, hypothyroid). BMD testing for others age 60-65.		
Dysphagia and Aspiration	Annually assess for swallowing problems and symptoms of GERD		
STDs	Annual screen if at risk		

HIV	Periodic testing if at risk		
Hepatitis B and C	Periodic testing if at risk		
Tuberculosis	Skin testing every two years if at risk		
Depression	Screen annually for sleep, appetite disturbance, weight loss, general agitation.		
Dementia	Monitor for problems in performing activities of daily living		
MEN		**1. Date of last screen 2. N/A 3. Does this need to be done?**	***Questions / Notes***
Testicular Exam	Annually		
Prostate cancer screen (PSA or DRE)	1. Discuss screen age 40-49 if at risk. 2. Discuss risks and benefits of screen age 50-75, based on presence of symptoms and clinician/patient discretion.		
WOMEN		**1. Date of last screen 2. N/A 3. ?Does this need to be done?**	***Questions / Notes***
Clinical Breast Exam	Annually		
Mammogram	1. Annually ages 50-69. 2. Earlier at HCP discretion.		

Pap Smear	1. Every 2 years through age 29. 2. Every 3 years ages 30-65, depending on risk factors.		
IMMUNIZATIONS		**1. Date of last screen** **2. N/A** **3. ?Does this need to be done?**	***Questions / Notes***
Tetanus-Diptheria [Tdap]	1. Three doses given once. 2. TD booster every 10 yrs.		
Influenza Vaccine	Annually		
Pneumococcal Vaccine **Hepatitis B**	One time [booster at age 65] One series of 3 vaccinations. Reevaluate antibody status every 5 years.		
HPV Vaccine	Three doses for unvaccinated adults ages 9-26.		
VISION AND HEARING		**1. Date of last screen** **2. N/A** **3. ?Does this need to be done?**	***Questions / Notes***

Eye Examination	Ophthalmologist or optometrist should guide vision care plan and eye examination schedule, to include: 1. Glaucoma assessment at least once by age 22; and if diabetic 2.Annual eye exams.		
Hearing Assessment	Annually. Re-evaluate if hearing problem reported or change in behavior noted.		
GENERAL COUNSELING / GUIDANCE		**1. Date of last screen 2. N/A 3. ?Does this need to be done?**	***Questions / Notes***
Prevention Counseling	Annually. Includes but not limited to accident/fall prevention, fire/burns, choking.		
Abuse or neglect	Annually. Monitor for behavioral and physical signs of abuse and neglect.		
Healthy Lifestyle	Annually. Includes but no limited to diet/nutrition, physical activity, & substance abuse.		
Pre- conception Counseling	As appropriate to situation. Genetic counseling, folic acid supplementation, discussion of parenting capability.		
Menopause Management	As age and situation appropriate. Counsel on change and symptom management		
SPECIFIC POPULATIONS		**1. Date of last screen 2. N/A 3. ?Does this need to be done?**	***Questions / Notes***

Individuals with Downs Syndrome	1. Thyroid function test every 3 yrs (sensitive TSH) 2. Obtain baseline of cervical spine x-ray to rule out atlanto-axial instability; recommend repeat if symptomatic, or 30 years from baseline. 3. Baseline echocardiogram if no records of cardiac function are available. 4. Annual screen for dementia after age 40		
Hepatitis B Carrier	Annual liver function test		
Other Screening or questions to be considered at this appointment			***Questions / Notes***

DATE	**Signature of Family / Advocate / Staff Present at Annual Appointment**	**Relationship / Title**

PART III - CHAPTER 3000

SPECIFIC PROGRAM REQUIREMENTS FOR PREVOCATIONAL SERVICES

SCOPE OF SERVICES

3001 General

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Prevocational Services prepare a individual for paid or unpaid employment. 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. If compensated, individuals are paid in accordance with the requirements of Part 525 of the Fair Labor Standards Act.

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 individual 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 paid or unpaid employment through increased skills. Prevocational Services are individually planned to meet the individual's needs for preparation for paid or unpaid 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.

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 individuals' Individual Service Plans.

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3002 **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 COMP Program, Prevocational Services providers must meet the following requirements:

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Staffing Qualifications and Responsibilities

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

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

b. Duties of the Agency Director 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.

1. At least one agency employee or professional under contract with the agency must:

   a. Be a Developmental Disability Professional (DDP) (for definition, *Provider Manual for Community Developmental Disability Providers* at http://dbhdd.org/files/Provider-Manual-DD.pdf

   b. Have responsibility for overseeing the delivery of Prevocational Services to individuals.

d. The same individual may serve as both the agency director and the Developmental Disability Professional;

f. 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;

g. Direct Care Staff must:

- Be 18 years or older;

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- Have a high school diploma or equivalent (General Educational Development or GED) or have a minimum score of 75 on the Short Test of Functional Health Literacy for Adults (STOFHLA) or Test of Functional Health Literacy for Adults (TOFHLA);

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- Meet transportation requirements in COMP Part II chapter 900, Section 905 if transporting individuals.
- Be provided with a basic orientation prior to direct contact with individuals and show competence in:

1) The purpose and scope of Prevocational Services, including related policies and procedures;

2) Confidentiality of individual information, both written and spoken;

3) Rights and responsibilities of individuals;

4) Requirements for recognizing and reporting suspected abuse, neglect, or exploitation of any individual:

1.To the DBHDD;

2.Within the organization;

3.To appropriate regulatory or licensing agencies; and

4.To law enforcement agencies

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

X. 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;

Y. Provides direct assistance in training appropriate social interaction skills required in the workplace to groups of individuals;

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

AA. Provides individual-specific assistance, such as assistance with personal care and self-administration of medications.

i. 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.

j. The type and number of all other staff associated with the organization (such as contract staff, consultants) are:

1) Properly trained or credentialed in the professional field as required;

2) Present in numbers to provide services and supports to individuals as required;

3) Experienced and competent in the services and support they provide.

k. 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.

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 refer to *Part II Policies and Procedures for COMP and NOW.*

3. **Documentation Requirement**: Providers must document the following in the record of each individual receiving Prevocational Services:

BB. Specific activity, training, or assistance provided;

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

DD. Location where the service was delivered;

EE. Verification of service delivery, including first and last name and title (if applicable) of the person providing the service and his or her signature;

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

4. **Prevocational Services and Other Services in the Same Facility**:

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a. 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.

b. 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.

5. **Providers must meet the following requirements for staff-to-individual ratios:**

- Facility-Based Prevocational Services: a staff to individual ratio of one to two or more, not to exceed one (1) to ten (10).

- Mobile Crew Prevocational Services: a staff to individual ratio of one to two or more, not to exceed one (1) to six (6).

- The staff to individual ratio may be more intense than the upper limit indicated above; the actual ratio must be as indicated by the individualized needs of the individuals.

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a. **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 and COMP, Chapter 603*).

b. **Fair Labor Standards Act Requirements:** Providers must adhere to the requirements of Part 525 of the Fair Labor Standards Act as follows:

a. Meet all requirements for time rates, piece rates, commensurate wages and fair business practices.

b. Maintain Department of Labor certificates appropriate to the program provided and/or the individual if sub-minimum wage employment is provided.

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c. Determines Special Minimum Wage as specified in the Fair Labor Standards Act.

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1) Continuation of Prevocational Services: Effective July 1, 2009, any Individual Services Plan (ISP) for an individual who has a birthday on or after November 1st. 2009 and has received at least a year (12 months) of Prevocational Services must document the following assessment of necessity and adequacy of the continuation of Prevocational Services for the individual:

a. Consideration of the following by the support coordinator and interdisciplinary team developing the ISP:

ount of time receiving Prevocational Services.

(2) Progress on any or all Prevocational Services goal(s);
(3) Interest of individual in working; and
(4) Any prior receipt of Supported Employment Services.

b. Determination by the support coordinator and interdisciplinary team of continuance or discontinuance Services for the individual bases on the above assessment.

c. 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.

9. **Physical Environment**

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

a. **Accessibility:** Is accessible to and usable by individuals and meets Americans with Disabilities Act (ADA) accessibility requirements for facilities.

b. **Building Construction and Maintenance:** Is constructed, arranged, and maintained so as to provide adequately for health, safety, access, and wellbeing of the individuals.

c. **Building Codes:** Is in compliance with all local building codes and other applicable codes;

d. **Lighting:** Provides adequate lighting for individuals' activities and safety;

e. **Ventilation:** Is adequately ventilated at all times by either mechanical or natural means to provide fresh air and the control of unpleasant odors;

f. **Floor Space:** Has adequate floor space to safely and comfortably accommodate the number of individuals for all activities and services provided in that space;

g. **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.

h. **Environmental/Sanitation**: Is in good repair and clean inside and outside of the facility, including being free from liter, extraneous materials, unsightly or injurious accumulations of items and free from pest and rodents;

i. **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:

j. **Equipment Maintenance:** Maintains all essential mechanical, electrical, and individual activity, care and support equipment in safe operating condition;

k. **Drinking Fountain:** Must have drinking fountain(s) approved by the Georgia Department of Human Services (DHS), Division of Public Health or provide access to single disposable cups to individuals, with individuals disposing of the used cups immediately after use;

l. **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;

m. **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;

n. **Medication Storage:** Assures that medications are:

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;

2. Kept in original containers with original labels intake or in labeled bubble packs from a pharmacy;

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

o. **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.

p. **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.

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

i. 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.

ii. 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.

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iii. 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.

10. **Transportation:** The family or representative may choose to transport the member to the Prevocational Services facility.

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 individuals 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.

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- **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.

3003 Special Eligibility Conditions

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.

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.

3. The need for Prevocational Services must be related to the individual disability and services must be therapeutic in nature.

3004 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.

3005 Covered Services

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

1. Teaching such concepts as rule compliance, attendance, task completion, problem solving, endurance, work speed, work accuracy, increased attention span, motor skills, and safety.

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

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

4. Facility-based training and/or assistance.

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.

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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).

3006 Non-Covered Services

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

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.).

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

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

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 COMP and NOW, Chapter 900*.

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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.

3007 Basis for Reimbursement

Reimbursement Rate: 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.

3008 Participant-Direction Options

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

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

PART III - CHAPTER 3100

SPECIFIC PROGRAM REQUIREMENTS FOR RESPITE SERVICES

SCOPE OF SERVICES

3101 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:

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;
2) When the individual needs relief or a break from the caregiver;
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 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, Community Living Arrangement, or Child Caring Institution.

3102 Special Requirements of Participation

1. **DD Service Agencies** rendering Services must have staffing that meets the following requirements:

2. **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.

   Duties of the Agency Director include, but are not limited to:
   i. Oversees the day-to-day operation of the agency;
   ii. Manages the use of agency funds;
   iii. Ensures the development and updating of required policies of the agency;

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

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

3. **A Developmental Disability Professional (DDP)** (for definition, *Provider Manual for Community Developmental Disability Providers* at http://dbhdd.org/files/Provider-Manual-DD.pdf

The agency director who meets the qualifications of a Developmental Disability Professional may serve both roles. provided the staff members meets the professional qualifications for each role

4. **Direct Care Staff** who must:
   1. Be 18 years or older;

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2. Have a high school diploma or equivalent (General Educational Development or GED) or have a minimum score of 75 on the Short Test of Functional Health Literacy for Adults (STOFHLA) or Test of Functional Health Literacy for Adults (TOFHLA).

3. Meet transportation requirements in COMP Part II Chapter 900, section 905 if transporting individuals.

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

a. The purpose and scope of the service to be delivered, including related policies and procedures;

b. Confidentiality of individual information, both written and spoken;

c. Rights and responsibilities of individuals;

d. Requirements for recognizing and reporting suspected abuse, neglect, or exploitation of any individual:

i. To the Department of Behavioral Health and Developmental Disabilities;

ii. Within the organization;

iii. To appropriate regulatory or licensing agencies; and

iv. To law enforcement agencies

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 service.

The type and number of all other staff associated with the organization (such as contract staff, consultants) are:

a. Properly trained or credentialed in the professional field as required;

b. Present in numbers to provide services and supports to individuals as required; and

c. Experienced and competent in the services and support they provide.

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 pursuant to DBHDD Policy 04-104 and all policy outlined in *Part I Policies and Procedures For Medicaid/Peachcare For Kids.*

Provider agencies must have available a sufficient number of employees or professionals under contract.

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

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.

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*).

3102.1 In-Home Respite Services Provider

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 http://dch.georgia.gov/hfr-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.*

Supervision and Direct Support Staff Duties

Supervision of Direct Support Staff

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

Duties of Direct Support Staff

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

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

HH. Provide personal care and protective oversight and supervision;

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

JJ. 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.

KK. Provide assistance in completing Outcomes and Goal(s) according to the current Individual Support Plan.

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.

3102.2 Out-of-Home Respite Services Provider

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

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 NOW and COMP Program, provider agencies who render out-of-home Respite Services must meet the following requirements:

Licensure and Delivery Settings

Setting	License Required	Citation Source
Community Residential Arrangement	yes	http://dch.georgia.gov/hfr-laws-regulations
Child Placing Agency	yes	https://dhs.georgia.gov/child-placing-agencies-cpa
Host Home	no	* N/A

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 age appropriate waiver individuals.

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*

Supervision and Direct Support Staff Duties

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.*

Direct Care Staff

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

LL. 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;

MM. Accompanying individuals and facilitating participation in visits for medical care and other community activities if needed;

NN. Assistance in household care, such as meal preparation, clothes laundering, bed-making, housecleaning, shopping, and other similar tasks;

OO. Assisting with therapeutic exercises, supervising self-administration of medication and performing health maintenance activities;

PP. Implementing positive behavioral support plans of individuals to reduce inappropriate and/or maladaptive behaviors and to acquire alternative adaptive skills and behaviors.

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.

Out of Home Respite Home Site Inspections: With the exception of providers of participant-directed services, individual providers who render out-of-home respite services must meet the following requirements:

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 Service Administrator or designee.

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.

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 600, Section 603*).

3103 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).

3104 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.

3105 Covered Services

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

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.

2. Short-term Respite that provides a period of structured support for a individual due to unavoidable circumstances, such as a family emergency.

3. Respite Services are short-term services during a day or overnight that include but are not limited to:

    a. Individual-specific assistance, such as assistance with activities of daily living, self-administration of medications, and health maintenance activities, personal care and protective oversight.

b. 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;

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

3106 Non-Covered Services

a. Services delivered in a personal care home, community living arrangement, or child caring institution serving more than four individuals.

b. Services provided in hospitals, ICF/ID facilities, assisted living facilities, and nursing homes.

c. Services that duplicate or are provided at the same time of the same day as Community Living Support, Community Access or Supported Employment services.

d. 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;

e. Payment is not made, directly or indirectly, to members of the individual's immediate family.

f. 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.*

g. 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.

3107 Documentation

1. Documentation of In-home Respite services must include the following elements in the record of each individual:

   a. Specific activity, training, or assistance provided;

b. Date and the beginning and ending time of day(s) when the service was delivered;

c. Verification of service delivery, including first and last name and title (if applicable) of the person providing the service and his or her signature;

d. Supervisory note documenting licensure-level required supervision of the direct support personnel;

e. 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.

3108 Basis for Reimbursement

Reimbursement Rate: Reimbursement rates for Respite services are found in Appendix A.

- The unit of service is 15 minutes, daily/ or $1 =1 unit for self directed
- Respite services delivered during 7.5 hours (30 units) in one day must be billed as a daily unit.
- Cap of daily units = 30 annually
- The maximum allowable amount for respite services includes either in-home, daily or a combination of the two reimbursement unit types.
- Once a individual uses the annual maximum of units, no additional Respite Services are billable for that individual for the remainder of the individual's ISP year.

3109 Participant-Direction Options

A. Individuals can choose the self-direction option with Respite Services.

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

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

PART III - CHAPTER 3200

SPECIFIC PROGRAM REQUIREMENT FOR SPECIALIZED MEDICAL EQUIPMENT SERVICES

SCOPE OF SERVICES

3201 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, or door openers. These services additionally consist of customizing a device to meet an individual's needs. The COMP 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 COMP 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 COMP 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.

3202 Special Requirements of Participation

3202.1 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 COMP Program, individual vendors and dealers in Specialized Medical Equipment must meet the following requirements:

A. **Documentation Requirement:** Providers, except for providers of participant-directed services, must document the following in the record of each individual receiving SME services:

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

b. State Plan denial of coverage documentation received by the DME Program.

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

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d. Documentation of associated administrative costs for SME 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 Specialized Medical Equipment.

B. **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.*

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 COMP Program, Specialized Medical Equipment Services provider agencies must meet the following requirements:

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A. **Documentation Requirement: Documentation of associated administration ts for SME service delivery that delineates line item sources of costs; ing of associated administration cost can not exceed eight to ten (8 to ten) cent of any 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:

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

b. State Plan denial of coverage received by the DME Program.

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

B. **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*.

C. **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 COMP, Chapter 603*).

3203 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.

3204 Special Eligibility Conditions

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1. The need for SME services must be related to the individual disability and specified in the Intake and Evaluation Team approved Individual Services Plan (ISP).
2. When a individual only receives specialized services, a specific goal must be in the ISP for specialized services, which includes SME.

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3. Medical necessity for SME services must be documented through an order by a Georgia licensed physician.

3205 Prior Approval

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1. Individual receives recommendation in writing from physician stating a need for SME.

2. Individual takes recommendation in writing to a DME vendor.
    a. Support Coordination may assist with locating/accessing an appropriate DME vendor

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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.

4. The Department's contractor approves or denies prior approval based on medical necessity criteria and notifies DME through electronic format of determination
    a. If there is not enough information to make the determination, the Department's contractor will request additional documentation from the appropriate party.

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    b. If approved as a State Plan Service, the DME vendor then submits a claim and provides the medically necessary supplies to the individual.
    c. If denied for not meeting medical necessity criteria, the waiver will not pay for the SME.

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    d. If denied for reasons other than medical necessity criteria, the waiver will pay for the SME. Some DME items allowable but only through the prior approval process described in Chapter 800 of the DME Program Manual (Section 802 of this chapter reviews which items requires prior approval. The following sections of this chapter describe the procedures for obtaining prior approval. Denial of prior approval for these items allows for billing of the waiver.

Rev. 04 2010

    e. 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 is non-covered. This documentation will be accepted in lieu of a formal denial for supplies. With this documentation, the item can be purchased through the waiver.

Rev. 04 2010

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 version changes.

3206 Covered Services

Reimbursable SME services include the following based on the assessed need of the individual and as specified in the approved ISP:

- Purchase of equipment or the lease of equipment when cost effective.

- 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.

Rev 01 2017

- Applications, scanning communicators, speech amplifiers, control switches, electronic control units, wheelchairs, locks, door openers, or side lyers.

- Customizing a device to meet an individual's needs.

- 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.

3207 Non-Covered Services

1. Equipment that has been denied through the DME and other programs for lack of medical necessity.

2. Equipment covered under the Durable Medical Equipment (DME), Orthotics and Prosthetics, and Hearing Services programs and other Medicaid non-waiver programs.

3. Environmental control equipment (e.g., air conditioners, dehumidifiers, air filters or purifiers).

4. Comfort or convenience equipment (e.g., vibrating beds, over-the-bed trays, chair lifts).

5. Institutional-type equipment (e.g., cardiac or breathing monitors).

6. Equipment designed specifically for use by a physician and trained medical personnel (e.g., EKG monitor, oscillating bed and laboratory testing equipment).

7. Physical fitness equipment (e.g., exercise cycle, exercise treadmill).

8. Furnishing-type equipment (e.g., infant cribs).

9. Home security items, (e.g., alarm systems, burglar bars, security cameras, personal emergency response systems and deadbolt locks).

10. Elevators, chair lifts, and indoor ceiling lift systems.

11. Equipment considered experimental or under investigation by the Public Health Service.

12. Equipment associated with experimental medical practices or treatments.

13. Infant and child car seats.

14. Blood pressure monitors and weight scales.

15. IPads, Computers, such as desktop and personal computers.

16. Cell phones and minutes.

17. Hot tubs, spas, and whirlpool tubs.

18. Items that add value to a property, such as a fence.

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.

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).

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.

22. Extended warranties and/or maintenance agreement.

23. 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, Chapter 900*.

Rev 01 2013

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.

3208 Basis for Reimbursement

a. Lifetime maximum is $13,474.76 per individual.

b. Annual maximum is $5,200.

c. Reimbursement Rate
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.

3209 Participant-Direction Options

A. Individuals may choose the self-direction option with Specialized Medical Equipment Services.

B. If the individual (or representative, if applicable) opts for participant-direction of SME services, then this equipment will be purchased through participant-directed service delivery.

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

PART III - CHAPTER 3300

SPECIFIC PROGRAM REQUIREMENTS FOR SPECIALIZED MEDICAL SUPPLIES SERVICES

SCOPE OF SERVICES

3301 General

Rev. 04 2010

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 COMP is intended for those goods and services that are not covered by other Medicaid programs or those instances in which an individual's needs exceed coverage limits in 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 DME program before requesting SMS.

The COMP Waiver Program is the payer of last resource for items that are covered through the Durable Medical Equipment (DME), Orthotics and Prosthetics (O&P), and Hearing Services programs and other non-waiver Medicaid 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 are non-covered through the related Medicaid Program, the services being requested through the COMP must be supported by:

1. Documentation of COMP as payor of last resort as evidenced by:

a. Documented phone calls to DME vendors to determine coverage through other healthcare funding sources
b. Documented review of the DME policy manual found at https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx

2. Documentation that service coverage has been exhausted in the other potential healthcare funding sources including State Plan Medicaid. The need for the services is documented through clinical evaluation.

Rev. 01 2011

The COMP 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 for Durable Medical Equipment.

For specific benefit coverage and limitations, providers of DME and specialized medical supplies and services should refer to Part II Policies and Procedures manual 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.

Rev.07 2018

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."

3302 Special Requirements of Participation

3302. 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 COMP Program, individual vendors and dealers in Specialized Medical Supplies must meet the following requirements:

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

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

Rev. 01 2009
Rev. 04 2010
4/1/2018

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

i. Documented phone calls to DME vendors to determine coverage through other healthcare funding sources
ii. Documented review of the DME policy manual found at https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx

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

Rev. 07 2009
Rev. 07 2010

d. 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.

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 and COMP, Chapter 1200*.

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.

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/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, Specialized Medical Supplies Services provider agencies must meet the following requirements:

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

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

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4/1/2018

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

i. Documented phone calls to DME vendors to determine coverage through other healthcare funding sources
ii. Documented review of the DME policy manual found at https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx

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

Diapers
Chucks (used to line the bed for incontinent people)
Diaper wipes
Nutritional supplements for adults
Medication not covered by Medicaid
Hearing aides
Eye glasses

Rev. 04 2010

Condom catheters

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

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4/1/2018

h. 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.

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 COMP, Chapter 1200*.

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 COMP, Chapter 603*).

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.

3303 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.

3304 Special Eligibility Conditions

Rev 10 2009

i. The need for SMS services must be related to the individual's disability and verified through clinical evaluation.

Rev 04 2018

Rev. 10 2009
Rev. 01 2022

Medical necessity for SMS services must be documented through an order by a Georgia licensed physician, except for continence supplies which are approved by the Clinical Reviewer in the review of the ISP. Pharmacy generated confirmation of prescriptions is an acceptable practice.

3305 Prior Approval

Rev. 01 2009 Rev. 04 2010

A. Individual receives recommendation in writing from physician stating a need for SMS, except for continence supplies which are approved by the Clinical Reviewer in the review of the ISP and related documentation.

B. 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.

a. Support Coordination will assist with locating/accessing an appropriate DME vendor

Rev. 4/1/2018

C. 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.

a. 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.

D. The DME vendor may be required to seek additional information for prior approval such as clear physician orders or other medical necessity documentation.

Rev. 04 2010

a. If denied for not meeting medical necessity criteria, the waiver will not pay for the SMS.

b. If denied for reasons other than medical necessity criteria, the waiver will authorize the item(s) under SMS.

Rev. 04 2010

c. 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.

Rev. 04 2010

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E. 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 version changes.

NOTE: Prior approval through the DME Program will not be required for items listed above in 2501.1b and 2502.1 (1b).

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

Diapers
Chucks (used to line the bed for incontinent people)
Diaper wipes
Nutritional supplements for adults
Medication not covered by Medicaid
Hearing aides
Eye glasses
Condom catheters

Rev. 04 2010

Rev 04 2018

3306 Covered Services

Reimbursable SMS services include the following based on the assessed need of the individual and as specified in the approved ISP:

A. 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.

B. Nutritional supplements, such as Ensure, Isomil, and Boost, for individuals 21 years of age or older.

C. 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.

D. 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.

E. Diapers, bed wetting protective chucks, and other continence supplies.

F. 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.

G. Ancillary supplies necessary for the proper functioning of approved devices are also included in this service.

H. 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:

- The supply is directly identifiable to an individual.
- The item furnished at the direction of the individual's physician and is specifically identified in the ISP and only used by that individual.

Rev 10 2013

9. Over-the-counter (OTC) medications when prescribed by a physician and related to a diagnosed condition.

Rev 10 2013

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.

3307 <u>Non-Covered Services</u>

1. Items covered under the Durable Medical Equipment (DME), Orthotics and Prosthetics, and Hearing Services programs and other Medicaid non-waiver programs.
2. Items that have been denied through the DME and other programs for lack of medical necessity.
3. Environmental control items (e.g., air conditioners, dehumidifiers, air filters or purifiers).
4. Comfort or convenience items.
5. Physical fitness items (e.g., exercise cycle, exercise treadmill).
6. Supplies considered experimental.
7. Experimental medicines, practices, or treatments.
8. Infant and child car seats.

9. Blood pressure monitors and weight scales.

10. Computer supplies (printers, cartridges, speakers and other supplies).

11. Cell phones and minutes.

12. Ancillary supplies for the proper functioning of non-approved devices or equipment.

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).

Rev 10 2013

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.

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 COMP, Chapter 900*.

Rev 01 2013

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.

Rev 10 2013

17. Medications covered by the Medicaid State Plan are not allowed.

Rev 10 2013

d. Co-pays for medications.

Rev. 01 2016

e. Bicycles, trampolines, swimming pools, swing sets, slides, stereos, radios, televisions, and MP3 players.

3308 **<u>Basis for Reimbursement</u>**

A. $3,800 annual maximum.

a. Reimbursement Rate
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.

3309 Participant-Direction Options

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

- If the individual (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 and COMP, Chapter 1200*.

PART III – CHAPTER 3400

SPECIFIC PROGRAM REQUIREMENTS FOR SUPPORTED EMPLOYMENT SERVICES

SCOPE OF SERVICES

3401 General

Rev. 01 2011
Rev. 07 2011

Supported Employment services are ongoing supports that enables individuals, for whom competitive employment as 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. 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 services consist of activities needed to obtain and sustain paid work by individuals, including job location, job development, supervision, training, and services and supports that assist individuals in achieving self-employment through the operation of a business, including helping the individual identify potential business opportunities, assisting in the development of a business plan, 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.

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 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 Individual services are provided to an individual, with a one-to-one staff to

individual ratio. Supported Employment Services Providers offer (or arrange when needed) any of the standard services listed in section 3305 – Covered Services that are needed by the individuals served and specified in the individuals' Individual Service Plans.

3402 Special Requirements of Participation

Rev 01 2009

3402.1 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, Supported Employment Services providers must meet the following requirements:

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

   a. Be 18 years or older;
   b. Have a high school diploma or equivalent (General Educational Development or GED) or have a minimum score of 75 on the Short Test of Functional Health Literacy for Adults (STOFHLA) or Test of Functional Health Literacy for Adults (TOFHLA).

Rev. 04 2022
Rev 10 2022

   c. Have current CPR and Basic First Aid certifications;

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

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

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

Rev. 04 2009

f. Meet transportation requirements in COMP Part II Chapter 900 Section 905 if transporting individuals.

2. **Documentation Requirement**: Providers must document the following in the record of each individual receiving Supported Employment Services:

a. Specific activity, training, or assistance provided;

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

c. Location where the service was delivered;

d. Verification of service delivery, including first and last name and title (if applicable) of the person providing the service and his or her signature;

Rev. 10 2009

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

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

3402.2 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 COMP Program, Supported Employment Services provider agencies must meet the following requirements:

Rev 01 2013

1. Staffing Qualifications and Responsibilities

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

Supported Employment Specialists:

A. Be 18 years or older;

B. Have current CPR and Basic First Aid certifications;

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

(1) 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 (2) year experience in providing supported employment to individuals with disabilities.

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

Rev. 04 2009

e. Meet transportation requirements in COMP Part II Chapter 900 Section 905 if transporting individuals.

a. 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.

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

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

2) Manages the use of agency funds;

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

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

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

c. At least one agency employee or professional under contract with the agency must:

a. Be a Developmental Disability Professional (DDP) (*for definition, see Part II Policies and Procedures for COMP, Appendix I);*

b. Have responsibility for overseeing the delivery of Supported Employment Services to individuals.

d. The same individual may serve as both the agency director and the Developmental Disability Professional;

A Developmental Disability Professional (DDP) (for definition, *Provider Manual for Community Developmental Disability Providers* at http://dbhdd.org/files/Provider-Manual-DD.pdf

f. 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.

g. Duties of the Supported Employment Specialist include, but are not limited to:

1. Provides direct supervision of Direct Care Staff in their performance of Supported Employment services for individuals;

2. Develops, acquires, and maintains work opportunities for individuals;

3. Conducts necessary additional assessments at the work site;

4. Helps individuals choose appropriate jobs or a specific employment option;

5. Applies training techniques which enhance the social and vocational functioning of individuals;

6. Monitors wages, hours, and productivity of individuals on an ongoing basis;

7. Assists the individual, if applicable, in achieving self-employment through the operation of a business by:

   a. Aiding the individual to identify potential business opportunities;

   b. Assisting in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business;

   c. Identifying the supports that are necessary for the individual to operate a business;

   d. Providing ongoing assistance, counseling and guidance once the business has been launched.

h. 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;

i. Direct Care Staff must:

- 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 Short Test of Functional Health Literacy for Adults (STOFHLA) or Test of Functional Health Literacy for Adults (TOFHLA).

Rev. 01 2011

- Meet transportation requirements in NOW and COMP Part II Chapter 900, Section 905 in transporting individuals.

Rev. 04 2009

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

    1) The purpose and scope of Supported Employment Services, including related policies and procedures;

    2) Confidentiality of individual information, both written and spoken;
    3) Rights and responsibilities of individuals;

    4) Requirements for recognizing and reporting suspected abuse, neglect, or exploitation of any individual:

        a. To the DBHDD;

        b. Within the organization;

        c. To appropriate regulatory or licensing agencies; and
        d. To law enforcement agencies

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

QQ. Provides direct assistance in activities needed for the individual or a group of individuals to sustain work, including job coaching, supervision and training;

RR. Provides direct assistance in training, retraining or improving the social and vocational functioning of the individual worker or groups of individual workers;

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

TT. Provides active support and direct assistance in facilitating natural supports at the work site;

UU. Provides other support services at or away from the work site, such as transportation and personal assistance services.

k. The type and number of all other staff associated with the

organization (such as contract staff, consultants) are:

1) Properly trained or credentialed in the professional field as required;

2) Present in numbers to provide services and supports to individuals as required;

3) Experienced and competent in the services and support they provide.

l. 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.

2. **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 Department of Behavioral Health and Developmental Disabilities refer to *Part II Policies and Procedures for COMP.*

3. **Documentation Requirement**: Providers, except for providers of individual-directed services, must document the following in the record of each individual receiving Supported Employment Services:

VV. Specific activity, training, or assistance provided;

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

XX. Location where the service was delivered;

YY. Verification of service delivery, including first and last name and title (if applicable) of the person providing the service and his or her signature;

Rev. 10 2009

ZZ. Progress towards moving the individual towards independence by meeting the individual ISP, which includes person-centered goal(s), desired outcomes in the individual's action plan, and the amount/type of assistance/support in the ISP.

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 COMP, Chapter 1200*.

5. **Providers must meet the following requirements for staff-to-**individual **ratios:**

    a. Group Supported Employment Services: a staff to individual ratio of one to two or more, not to exceed one (1) to ten (10).

    b. Individual Supported Employment Services: a one-to-one staff to individual ratio.

6. **Providers must develop and plan Supported Employment services and supports**:

    a. Based on the individual's needs, preferences, and informed choice;

    b. To allow for flexibility in the amount of support a individual receives over time and as needed in various work sites;

    c. With attention to the health and safety of the individual;
    d. In accordance with the Fair Labor Standards Act, if applicable, to include documentation of sub-minimum wage;

    e. With planned outcomes, which include:

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

        ii. 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;

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

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 DBHDD (see *Part II Policies and Procedures for COMP, Chapter 603*).

3403 Special Eligibility Conditions

A. 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.

B. The need for Supported Employment Services must be related to the individual disability in the approved Individual Service Plan (ISP).

3404 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.

3405 Covered Services

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

1. Assisting the individual to locate a job or develop a job on behalf of the individual.

2. Activities needed to sustain paid work by individuals, including supervision and training.

3. Services and supports that assist the individual in achieving self-employment through the operation of a business and may include:

    a. Aiding the individual to identify potential business opportunities;

    b. Assistance in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business;

c. Identification of the supports that are necessary for the individual to operate the business; and

d. 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.

4. 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.

Rev. 07 2010

5. Transportation of two or more individuals to community work sites is provided for individuals receiving Supported Employment Group services.

Rev. 10 2009

6. Job Maintenance activities to maintain an individual in 60 to 80 or more hours of work per month.

7. There is a monthly minimum requirement of two (2) in-person contacts for the purposes of billing Supported Employment Individual and Supported Employment Group services.

3406 **<u>Non-Covered Services</u>**

1. Incentive payments, subsidies, or unrelated vocational training expenses such as the following:

   a. Incentive payments made to an employer to encourage or subsidize the employer's participation in Supported Employment program;

   b. Payments that are passed through to users of Supported Employment programs; or

   c. Payments for training that is not directly related to an individual's Supported Employment program.

2. Supervisory activities rendered as a normal part of the business setting.

Rev. 10 2009

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

time-limited, 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.

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.).

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 and COMP, Chapter 900*.

Rev. 07 2011

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

Rev 01 2013

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.

3407 Basis for Reimbursement

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

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

A. Supported Employment Job Maintenance

Rev. 10 2009

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.
2. Supported Employment Job Maintenance is billed under Supported Employment Group from 240 units up to a maximum of 320 units per month.

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

3408 Participant-Direction Options

Supportive Employment Services will no longer be available under the self-direction model after February 28, 2023. Individuals in the self-direction model with an ISP that includes Supportive Employment Services must receive a new ISP with an end date no later than February 28, 2023, to confirm that they are authority to continue to receive Supportive Employment Services through the traditional model.

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

3409 Telehealth Options

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

B. 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.

C. 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.

D. 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.

E. For more information regarding remote guidance visit [insert telehealth guidance link].

PART III - CHAPTER 3500

SPECIFIC PROGRAM REQUIREMENTS FOR TRANSPORTATION SERVICES

SCOPE OF SERVICES

3501 General

Rev 01 2018

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 individual s. Whenever possible, family, neighbors, friends or community agencies, which can provide this service, without charge, are to be utilized. Transportation Services may be used in areas where public transportation is not available and/or useable independently by the individual. 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:

(1) One-way or round trips provided by Georgia licensed drivers and/or DD Service Agencies; and

(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:

- Community Living Support Services
- Prevocational Services

- Community Access Group or Individual Services for activities and settings primarily utilized by people with disabilities, such as transportation to and from a 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 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.

3502 Special Requirements of Participation

Rev 01 2009

3502.1 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, Transportation Services providers must meet the following requirements:

a. **Transportation Provided:** Individual providers rendering Transportation Services provide one-way or round trip transportation for individuals.

b. Individual providers of Transportation must:

- Be 18 years or older;
- Have a valid, Class C license as defined by the Georgia Department of Driver Services;
- Have current mandatory insurance;
- 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;

Rev. 01 2009

NOTE: The Department will allow an exception to Out-of-State Driver's License and MVP record under the following circumstances: (1) the individuals 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:

1 Have a valid, Class C license

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

- 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;

f. Agree to or provide required documentation of a criminal records check, prior to providing Transportation Services.

3. **Documentation Requirement**: Providers, except for providers of participant-directed services, must document the following in the record of each individual receiving Transportation Services:

A. Specific type and purpose of transportation provided;

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

C. Location of origin and that for destination of transportation services;

D. Verification of service delivery, including first and last name and title (if applicable) of the person providing the service and his or her signature;

Rev. 10 2009

E. Progress towards moving the individual towards independence by meeting the individual's ISP.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*.

3502.2 **Transportation Broker Provider Agencies**

Rev 01 2018

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, Transportation Broker Provider Agencies must meet the following requirements:

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.

2. **Agency Policies and Procedures**: Each Transportation Broker Provider Agency must develop written policies and procedures to govern the operations of Transportation Services.

3. **Documentation Requirement**: Providers, except for providers of participant-directed services, must document the following in the record of each individual receiving Transportation Services:

1. Specific type and purpose of transportation provided;

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

3. Location of origin and that for destination of transportation services;

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;

Rev. 10 2009

5. Progress towards moving the individual towards independence by meeting the individual ISP-described goal(s).

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 COMP, Chapter 1200*.

5. **DBHDD Provider Requirements:** Transportation Broker Provider Agencies must adhere to DBHDD Contract/LOA, and

Rev 01 2009

any other applicable DBHDD Standards refer to *Part II Policies and Procedures for COMP.*

3502.3 DD Service Agencies

Rev 01 2018

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, DD Service Agencies rendering Transportation Services must meet the following requirements:

- **Transportation Provided:** DD Service Agencies rendering Transportation Services provide one-way or round trip transportation for individuals.

Rev 01 2013

- **Staffing Qualifications and Responsibilities**

  Driver Staff meets the following criteria:

  - Be 18 years or older;
  - Be legally licensed in the State of Georgia with the class of license appropriate to the vehicle operated as follows:

    A. 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.

    B. 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:

       1) 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

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

  - Have no more than two chargeable accidents, moving violations, or any DUI's in a three (3) year period

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within the last five (5) years of the seven (7) year Motor Vehicle Record (MVR) period;

Rev. 01 2009

NOTE: The Department will allow an exception to Out-of-State Driver's License and MVP record under the following circumstances: (1) the individuals is on active duty in Georgia; (2) the individual is a college student enrolled at a Georgia college or university; (3) the individual's place of residence is a neighboring state on the border of Georgia; or (4) the individual has moved to Georgia within the previous six months of employment date. For individual to be granted this exception, he or she must:

4 Have a valid, Class C license

5 Meet all requirements under criminal

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

  1) The purpose and scope of Transportation Services, including related policies and procedures;

  2) Confidentiality of individual information, both written and spoken;

  3) Rights and responsibilities of individuals;

  4) Requirements for recognizing and reporting suspected abuse, neglect, or exploitation of any individual:

     1) To the DBHDD;

     2) Within the organization;

     3) To appropriate regulatory or licensing agencies; and

     4) To law enforcement agencies

6. Duties of the Driver Staff include, but are not limited to:

AAA. Provides transportation for the individual to waiver services and other community services, activities, resources, and organizations;

BBB. Provides assistance to the individual in entering or exiting the vehicle.

CCC. Ensures transportation from the designated pick up point to the designated drop off point.

h. 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.

i. The type and number of all other staff associated with the organization (such as contract staff, consultants) are:

- Properly trained or credentialed in the professional field as required;
- Present in numbers to provide services and supports to individuals as required;
- Experienced and competent in the services and support they provide.

j. 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.

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 Division of Georgia Department of Behavioral Health and Developmental Disabilities refer to *Part II Policies and Procedures for NOW and COMP.*

3. **Documentation Requirement**: Providers must document the following in the record of each individual receiving Transportation Services:

- Specific type and purpose of transportation provided;
- Date and the beginning and ending time when the service was provided;
- Location of origin and that for destination of transportation services;

- Verification of service delivery, including first and last name and title (if applicable) of the person providing the service and his or her signature;

Rev. 10 2009

- Progress towards moving the individual towards independence by meeting the individual ISP-described outcomes.

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: www.odis@dhr.state.ga.us.

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 COMP, Chapter 1200*.

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 COMP, Chapter 603*).

3503 Licensure

a) Individual Providers rendering Transportation Services must hold a valid Class C license as defined by the Georgia Department of Driver Services.

b) 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.

3504 Special Eligibility Conditions

1. The need for Transportation services must be reflected in the Intake and Evaluation Team approved Individual Service Plan (ISP).

2. The unavailability of other resources for transportation must be documented in the ISP.

3505 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.

3506 Covered Services

Reimbursable Transportation services include the following based on the assessed need of the individual and as specified in the approved ISP:

Rev. 04 2009

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.

Rev. 04 2009

2. One-way trip provided by Georgia licensed drivers or DD Service Agencies of one individual to Supported Employment Services community work sites.

3. Brokering or provision of commercial carrier services available to the community at large.

3507 Non-Covered Services

1. Transportation of a waiver individual to school (through 12th grade).

2. Transportation that is included as an element of another waiver service as follows:

3. Community Living Support Services

4. Prevocational Services

5. Community Access Group or Individual Services which entail activities and settings primarily utilized by people with disabilities, such as transportation to and from an Intellectual or Developmental Disability Service Center or other day center.

Transit provided through Medicaid non-emergency transportation.

Transportation available under the State Medicaid Plan, including transportation to medical services, Individuals with Disabilities Education Act (IDEA), or the Rehabilitation Act.

Individuals cannot receive Transportation Services if receiving Community Residential Alternative Services

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, Chapter 900.*

Transportation services are not intended to replace available formal or informal transit options for individuals

Rev. 04 2009

Payment for vehicle maintenance.

3508 Basis for Reimbursement

Rev 01 2021

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

- 1 Unit= $1.00: encounter/one-way trip or commercial carrier/multipass.
- Annual maximum is 2797 units for encounter/one-way trip and commercial carrier/multipass
- Annual maximum for all Transportation Services, including encounter/one-way and commercial carrier/multipass, is $2,797 per individual.
- Mileage Rates are established by the provider agency but must use a methodology of comparable transportation rates.

Self-directed:
Unit of service: $1 = 1 unit

Annual limit is as authorized in the individual budget up to annual maximum for all self-directed Transportation Services of $2,797.

3509 Participant-Direction Options

1. Individuals may choose the participant-direction or co-employer options with Transportation Services.

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

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

PART III - CHAPTER 3600

SPECIFIC PROGRAM REQUIREMENTS FOR VEHICLE ADAPTATION SERVICES

SCOPE OF SERVICES

3601 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 COMP does not cover items that have been denied through the DME and other programs for lack of medical necessity.

3602 Special Requirements of Participation

A. **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, individual vendors and dealers in Vehicle Adaptations must meet the following requirements:

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:

    a. The efforts of the Individual's Support Coordinator to substantiate payer of last resource, including available community, State Plan, or other resources.

b. Verification of Vehicle Adaptation service delivery, including date, location, and specific vehicle adaptations provided.

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 COMP, Chapter 1200*.Refer to Section 3502.1 below.

3602.1 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 COMP Program, Vehicle Adaptation Services provider agencies must meet the following requirements:

3. **Documentation Requirement:** Providers, except for providers of participant-directed services, must document the following in the record of each individual receiving Vehicle Adaptation services:

    a. The efforts of the Individual's Support Coordinator to substantiate payer of last resource, including available community, State Plan, or other resources.

    b. Verification of Vehicle Adaptation service delivery, including date, location, and specific vehicle adaptations provided.

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 COMP, Chapter 1200*.

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 COMP, Chapter 603*)).

3603 Licensure

Rev. 10 2009

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.

3604 Special Eligibility Conditions

Rev. 10 2009

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).

Rev. 10 2009

2. Medical necessity for Vehicle Adaptation Services must be documented through and order by a Georgia licensed physician.

3605 Prior Approval

1. Vehicle Adaptation Services must relate to specific individual goal(s) and must be required to meet the needs of the individual.

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.

3606 Covered Services

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

1. Vehicle Adaptations are limited to an individual or his or her family's privately owned vehicle.

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.

3. Vehicle Adaptation to the individual's primary means of transportation.

4. Repair of a prior existing vehicle adaptation provided the repair is less that replacement.

5. Replacement of a prior existing vehicle adaptation if replacement is less than a repair.

3607 Non-Covered Services

A. Adaptation, repair or replacement costs for adaptations to provider-owned vehicles.

B. Adaptation, repair or replacement costs for adaptations to leased vehicles.

C. Vehicle adaptations will not be replaced in less than three years except in extenuating circumstances and authorized by the Division of Medicaid, Department of Community Health.

D. Vehicle backup sensor and alarm systems.

E. Comfort, convenience, or recreational adaptation.

F. 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's negligence and/or abuse (e.g., before its normal life expectancy has been attained unless supporting medical documentation and change I the physical or developmental condition of the individual).

G. Regularly scheduled upkeep and maintenance of the vehicle or its modifications.

H. Adaptations of general utility that are not of direct medical or remedial benefit to the individual.

I. Purchase or lease of vehicles.

J. Extended warranties and/or maintenance agreements.

K. 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.*

Rev 01 2013

L. 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.

3608 Basis for Reimbursement

i. Lifetime maximum is $6,240.00 per individual.

ii. Reimbursement Rate
Reimbursement rate for Vehicle Adaptation is the lower of three price quotes or the lifetime maximum. The reimbursement rates for all specialized services are found in Appendix A.

3609 Participant-Direction Options

1. Individuals may choose the self-direction option with Vehicle Adaptation.

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

PART III - CHAPTER 3700

SPECIFIC PROGRAM REQUIREMENTS FOR

ASSISTIVE TECHNOLOGY

SCOPE OF SERVICES

Section 3701 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 3709 of this chapter.

Section 3702 Special Requirements of Participation Section

3702.1

Provider Agency- Service

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 COMP Program, provider agencies of AT Services must meet the following requirements for evaluation and order:
    a. **Georgia Licensed Occupational Therapist; or**
    b. **Georgia Licensed Speech Therapist;**
    c. **Georgia Licensed Audiologist;**
    d. **Georgia License Physical Therapist; or**
    e. **Assistive Technology Professional (ATP) accredited by Rehabilitation Engineering, and Assistive Technology Society of North America (RESNA) or other accredited institution; or**
    f. **Georgia Licensed Physician**

Provider Agency - Good

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 COMP Program, provider agencies of AT Goods must meet the following requirements for goods distribution.
    a. 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 COMP, Chapter 603).

b. Registration with the Georgia Secretary of State for all providers excluding community service boards
c. 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.

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 COMP Program, provider agencies of AT Services must meet the following requirements for evaluation and order:

1. **Georgia Licensed Occupational Therapist; or**
2. **Georgia Licensed Speech Therapist;**
3. **Georgia Licensed Audiologist;**
4. **Georgia Licensed Physical Therapist;**
5. **Assistive Technology Professional (ATP) accredited by Rehabilitation Engineering, and Assistive Technology Society of North America (RESNA) or other accredited institution; or**
6. **Georgia Licensed Physicians.**

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

A. 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.

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

i. Medicaid denial letter; or

ii: 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

C. If applicable, evidence that AT goods/services are not covered under private insurance or other healthcare funding:

i. Documented phone calls to AT vendors to determine coverage;

ii. Notice of non-coverage of AT goods/services in a current schedule of benefits for a private insurance policy or other healthcare funding; or

iii. Denial letter from private insurance or other healthcare funding

D. Verification of AT service delivery, including date, location, specific supplies, and services provided.

E. Documentation of associated administration costs for AT 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 Assistive Technology

F. Provider will supply at least two (2) estimates of any AT device with cost in excess of $300.00

F. 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.

G. A fee of $25 is allowed for the provision of administrative services for each individual ISP year

2. 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 COMP, Chapter 603*).

3. 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.

3703 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.

3704 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 that is estimated at less than $300.00 (both service and good) must be identified in the Individual Service Plan and approved by the DBHDD Clinical Reviewer in the review of the ISP and related documentation.

3705 Prior Approval Section

1. Individual receives assessment and order from a qualified provider (as indicated above) for AT equipment and/or AT service(s).
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.
3. If all other funding sources have been exhausted and COMP 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)
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.
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.

3706 Covered Services Section

1. **Reimbursable AT Goods** are listed in 3709 of this Chapter

2. **Assistive Technology services and supports** include the following:

A. 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 qualified individual or agency services provider as specified (in section 3702 above) - where no other therapy assessment is available/ appropriate.

B. 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 3702above or qualified agency goods provider as specified in section 3702 above.

C. 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 3702 above)

D. 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

E. 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 3702 above

F. Maintenance and repair of the assistive technology. Maintenance and repair must be provided by a qualified agency goods provider as specified in section 3702above.

G. 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.

3707 Non-Covered Services Section

1. Items covered under the Durable Medical Equipment (DME), Orthotics and Prosthetics, and Hearing Services programs and other Medicaid non-waiver programs.

2. Items that have been denied through the DME and other programs for lack of medical necessity.

3.Massage equipment and exercise equipment

4. Equipment and devices considered experimental.

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.

7. 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).

8. Stereos, radios, televisions, and MP3 players.

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.

10. Services otherwise provided through the COMP or the Medicaid State Plan, including additional units or costs beyond the maximum allowable for any COMP or Medicaid State Plan service.

11. AT training that is already covered in the delivery/ installation of the product by the vendor.

12. Replacement or repair of AT goods under current manufacturer or extended warranty.

13. 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

3708 Basis for Reimbursement

A. Lifetime maximum is $18,000 per individual. B. Annual maximum is $1,279.80

B. Reimbursement Rate Reimbursement rate for AT is individual specific up to the annual maximum. The reimbursement rates for all services are found in Appendix A.

1. 97755 – Assistive Technology Assessment $38.66 15 minute

2. 97755 (U1) - All other AT goods and services and training: $1 dollar = 1 unit.

a. The amount of funds per Assistive Technology purchase is the standard Medicaid reimbursement rate for the good or service, or, in the absence of a standard Medicaid rate, the lower of two price quotes unless evidence to support the good or service is only available through sole source letter. The annual maximum number of units is 1,279 unless there is approval to exceed the annual maximum up to the lifetime maximum due to assessed exceptional needs of the individual.

3709 List of Reimbursable AT Goods

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.

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.

APPENDIX A

Reimbursement Rates for COMP Services

Rev. 01 2018

Rev 04 2020

The reimbursement rates outlined below are the maximum amount that Medicaid may reimburse providers, unless an enhanced Support Service rate has been authorized by the DBHDD Field Office and the Office of Developmental Disabilities (see Part II, COMP Policies and Procedures, Appendix H for information on Enhanced Services rate approval). The Department of Behavioral Health and Developmental Disabilities assigns the individual provider rates.

Rates for extended plan services follow rates for the same or similar services found in the Medicaid State Plan.

Note: The reimbursement rates outlined below are the maximum amount that Medicaid will reimburse providers, unless an Enhanced Support Service rate has been authorized by the DBHDD Field Office and the Division of Developmental Disabilities.

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.

Rev 04 2018

1. Adult Occupational Therapy:

Procedure Name	Code	Modifier	Modifier	Limit	Rate
Adult OT Evaluation – Low Complexity	97165			1 eval per year	$67.21
Adult OT Evaluation – Low Complexity – self directed	97165	UC		1 eval per year	$67.21
Adult OT Evaluation – Moderate Complexity	97166			1 eval per year	$67.21
Adult OT Evaluation – Moderate Complexity – self directed	97166	UC		1 eval per year	$67.21
Adult OT Evaluation – High Complexity	97167			1 eval per year	$67.21
Adult OT Evaluation – High Complexity – self directed	97167	UC		1 eval per year	$67.21

Adult OT Re-Evaluation	97168			1 unit per 180 days	$44.40
Adult OT Re-Evaluation – self directed	97168	UC		1 unit per 180 days	$44.40
Adult OT Therapeutic Services	97530	GO		6 units per day	$28.23
Adult OT Therapeutic Services (self -directed)	97530	GO	UC	6 units per day	$28.23
Adult OT Sensory Integrative Techniques	97533	GO		4 units per day	$24.46
Adult OT Sensory Integrative Techniques (self-directed)	97533	GO	UC	4 units per day	$24.46
Adult Orthotic and Prosthetic Fitting and Training	97760	GO		6 units per day	$27.38
Adult Orthotic and Prosthetic Fitting and Training (self-directed)	97760	GO	UC	6 units per day	$27.38
Prosthetic Training	97761	GO		6 units per day	$24.98
Prosthetic Training (self-directed)	97761	GO	UC	6 units per day	$24.98
Orthotic and Prosthetic Check Out	97763	GO		6 units per day	$23.39
Orthotic and Prosthetic Check Out (self-directed)	97763	GO	UC	6 units per day	$23.39

Annual Limit for all combined Adult Therapies = $5,400.00

2. Adult Physical Therapy:

Rev 04 2018

Procedure Name	**Code**	**Modifier**	**Modifier**	**Limit**	**Rate**
Adult PT Evaluation – Low Complexity	97161	GP		1 eval per year	$69.34
Adult PT Evaluation – Low Complexity – self directed	97161	GP	UC	1 eval per year	$69.34
Adult PT Evaluation – Moderate Complexity	97162	GP		1 eval per year	$69.34
Adult PT Evaluation – Moderate Complexity – self directed	97162	GP	UC	1 eval per year	$69.34

Adult PT Evaluation – High Complexity	97163	GP		1 eval per year	$69.34
Adult PT Evaluation – High Complexity - self directed	97163	GP	UC	1 eval per year	$69.34
Adult PT Re-evaluation	97164	GP		1 unit per 180 days	$47.14
Adult PT Re-evaluation – self directed	97164	GP	UC	1 unit per 180 days	$47.14
Adult PT Therapeutic Procedure	97110			6 units per day	$25.91
Adult PT Therapeutic Procedure - self-directed	97110		UC	6 units per day	$25.91
Neuro-Muscular Re-Education	97112	GO		4 units per day	$27.07
Neuro-Muscular Re-Education (self-directed)	97112	GO	UC	4 units per day	$27.07

Annual Limit for all combined Adult Therapies = $5,400.00

Rev 04 2018

3. <u>Adult Speech and Language Therapy</u>:

Procedure Name	**Code**	**Modifier**	**Modifier**	**Limit**	**Rate**
Adult Speech Language Evaluation	92523			1 unit per 180 days	$163.81
Adult Speech Language Evaluation (self-directed)	92523		UC	1 unit per 180 days	$163.81
Adult Speech Language Therapy	92507	GN		1 session per day	$62.53
Adult Speech Language Therapy (self-directed)	92507	GN	UC	1 session per day	$62.53
Adult Speech Generating Device Evaluation	92607			2 evals per year	$109.28
Adult Speech Generating Device Evaluation (self-directed)	92607		UC	2 evals per year	$109.28
Adult Speech-Generating Device Therapy	92609			1 session per day	$54.75
Adult Speech-Generating Device Therapy (self-directed)	92609		UC	1 session per day	$54.75

Adult Swallowing/Feeding Therapy	92526			1 session per day	$44.66
Adult Swallowing/Feeding Therapy (self-directed)	92526		UC	1 session per day	$44.66
Adult Swallowing/Feeding Evaluation	92610			1 unit per 180 day	$117.54
Adult Swallowing/Feeding Evaluation (self-directed)	92610		UC	1 unit per 180 day	$117.54

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

Annual Maximum for all combined Adult Therapies = $5,400.00

4. Additional Staffing

Rev 01 2018, Rev 10 2019

Service	Unit	Procedure Code	Rate
Additional Staffing, Basic	15 min.	T2017-U6 Note: code change retroactive for CLS and CRA to 3/1/17 Note: code change retroactive for CAG effective 9/1/19.	$4.67
Additional Staffing, Enhanced	15 min.	T2017-U7 Note: code change retroactive for CLS and CRA to 3/1/17 Note: code change retroactive for CAG effective 9/1/19	$5.01

Used for billing additional staffing *approved by DBHDD*.
Not available through participant-direction.

The enhanced rate may only be accessed for individuals with specific needs and by staff with specific qualifications, as outlined below, unless otherwise specifically approved by DBHDD due to a DBHDD documented clinical extenuating circumstance. All requests for the enhanced staffing rate are subject to approval by DBHDD.

As of April 1, 2020 see below requirements for the Additional Staffing Enhanced Rate:

Individual Profile- the individual must have the following:

1. "Yes" to questions 2, 3, or 4 on the individual's current SIS-C and SIS-A supplemental questions, or
2. Exceptional Behavior Support Needs score of 7 or higher on the individual's current SIS-C and SIS-A

AND

Staff Profile – all staff billing at an enhanced rate must evidence the following:

1. Current Registered Behavior Technicians (RBT); and/or
2. Current Certification for Direct Support Professionals through National Association for Dually Diagnosed (NADD Certification); and/or

3. Current Positive Behavior Support Training Curriculum 3rd edition Completion (American Association on Intellectual and Developmental Disabilities (AAIDD)

5. Assistive Technology

Procedure Name	Code	Modifier	Modifier	Limit	Rate
Assistive Technology Assessment	97755			15 Min	$38.66
Assistive Technology Acquisition of Items	97755	U1		15 Min	$1.00

A. Lifetime maximum is $18,000 per individual.

B. Annual maximum is $1,279.80.

C. Reimbursement rate for AT is individual specific up to the annual maximum.

6. Behavioral Supports Services:

Rev. 07 2015
Rev. 01 2021

Behavioral Supports Services Level 2 (H2019-UB)
Behavioral Supports Services Level 2 Self-Directed (H2019-UB/UC)
Unit = 15 minutes
Maximum rate per unit- $23.56

Self-Directed
Limit: 1 unit = $1.00

Rev. 07 2014
Rev. 07 2015

Rev. 07 2015
Rev. 01 2021

Behavioral Supports Services Level 1 (H2019-UA)
Behavioral Supports Services Level 1 Self-Directed (H2019-UA/UC)

Unit = 15 minutes

Maximum rate per unit = $18.75

Self-Directed
Limit: 1 unit = $1.00

7. Community Living Support Services:

Service	Unit of Service	Procedure Code	Rate
Community Living Support (CLS) - Basic	15-minute Unit	T2025-U5	$6.35
CLS – Basic self-directed	1 Unit	T2025-U5-UC	$1.00
CLS – Basic co-employer	15-minute Unit	T2025-U5-UA	$6.35
Community Living Support - Extended	15-minute Unit	T2025-U4	$5.74
CLS- Extended self-directed	1 Unit	T2025-U4-UC	$1.00
CLS – Extended co-employer	15-minute Unit	T2025-U4-UA	$5.74
Community Living Support, 2 Members - Basic	15-minute Unit	T2025-U5-UN	$3.49
CLS Basic – 2 Members self-directed	1 Unit	T2025-U5-UN-UC	$1.00
CLS Basic – 2 Members co-employer	15-minute Unit	T2025-U5-UN-UA	$3.49
Community Living Support, 2 Members - Extended	15-minute Unit	T2025-U4-UN	$3.16
CLS Extended, 2 Members self-directed	1 Unit	T2025-U4-UN-UC	$1.00
CLS Extended, 2 Members co-employer	15-minute Unit	T2025-U4-UN-UA	$3.16
Community Living Support, 3 Members - Basic	15-minute Unit	T2025-U5-UP	$2.54
CLS Basic – 3 Members self-directed	1 Unit	T2025-U5-UP-UC	$1.00
CLS Basic – 3 Members co-employer	15-minute Unit	T2025-U5-UP-UA	$2.54
Community Living Support,	15-minute Unit	T2025-U4-UP	$2.30

3 Members - Extended			
CLS Extended – 3 Members self-directed	1 Unit	T2025-U4-UP-UC	$1.00
CLS Extended – 3 Members co-employer	15-minute Unit	T2025-U4-UP-UA	$2.30
Personal Assistance Retainer	15-minute Unit	T2025-U5-CG	$5.74
Personal Assistance Retainer self-directed	1 Unit	T2025-U5-CG-UC	$1.00
Personal Assistance Retainer co-employer	15-minute Unit	T2025-U5-CG-UA	$5.74

Total annual amount of all fifteen-minute CLS services billed can***not*** exceed $51,300 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 $51,300.

8. Community Access Services:

Community Access Group (T2025-HQ)
Community Access Group Self-Directed (T2025-HQ/UC)
Community Access Group Co-Employer (T2025-HQ/UA)
Unit = 15 minutes
Annual Limit = 5760 units
Rev 04 2015 Maximum rate per unit = $3.10

Community Access Individual (T2025-UB)
Community Access Individual Self-Directed (T2025-UB/UC)
Community Access Individual Co-Employer (T2025-UB/UA)
Unit = 15 minutes
Annual Limit = 1440 units
Rev 04 2015 Maximum rate per unit = $7.41

Rev. 07 2014 Self-Directed
Community Access Group Limits: 1 unit = $1.00
Annual limit is as authorized in the individual budget up to an annual maximum of $17,856.
Community Access Individual Limits: 1 unit = $1.00
Annual limit is as authorized in the individual budget up to an annual maximum of $10,670.

Rev. 07 2014 Self-Directed

Limit: 1 unit = $1.00
Annual limit is as authorized in the individual budget up to an annual maximum of $2,000.

9. Community Residential Alternative

Community Residential Alternative-Group Home				
Capacity	Category	Unit of Service	Procedure Code	Rate
5-Person Residence	N/A	1 Day	T2033-U5-UR	$158.67
4-Person Residence	Category 1 (Level 1	1 Day	T2033-U1-UQ	$154.74
4-Person Residence	Category 2 (Level 2)	1 Day	T2033-U2-UQ	$214.80
4-Person Residence	Category 3 (Level 3, 4)	1 Day	T2033-U3-UQ	$239.73
4-Person Residence	Category 4 (Level 5, 6, 7)	1 Day	T2033-U4-UQ	$254.36
3-Person Residence	Category 1 (Level 1)	1 Day	T2033-U1-UP	$178.53
3-Person Residence	Category 2 (Level 2)	1 Day	T2033-U2-UP	$235.05
3-Person Residence	Category 3 (Level 3, 4)	1 Day	T2033-U3-UP	$261.48
3-Person Residence	Category 4 (Level 5, 6, 7)	1 Day	T2033-U4-UP	$277.44
Community Residential Alternative-Host Home				
1-2 Person Residence	Category 1 (Level 1, 2, 3, 4)	1 Day	T2017-U1	$149.45
1-2 Person Residence	Category 2 (Level 5, 6, 7)	1 Day	T2017-U2	$185.25

Not available through participant-direction.
Reimbursement rates are annualized at 344 day per year. Claims reimbursement is limited to 344 days annually.

10. Environmental Accessibility Adaptation:

Environmental Accessibility Adaptation (S5165)
Environmental Accessibility Adaptation Self-Directed (S5165-UC)
Individual Specific rate

Lifetime maximum per individual= $10,400.00
The reimbursement rate is the lower of three price quotes or the lifetime maximum.

11. Financial Support Services:

Financial Support Services (T2040-UC)
Monthly maximum unit = 1
Maximum annual number of units = 12
Maximum rate per individual= $75.00 per month

Rev. 10 2011
Rev. 07 2014

12.Individual Directed Goods and Services:

Individual Directed Goods and Services (T2025-U7/UC)
Maximum Annual number of units = 1500
Annual maximum = $1,500.00

Limits: 1 unit = $1.00
$1,500 annual maximum

Rev. 10 2022
Rev. 10 2011

13. Interpreter Services:

Interpreter Services (T1013)
Unit=15 minutes
Maximum Annual number of units=245/ 61.25 hours
Maximum rate per unit= $24.99
Annual maximum= $6,122.55
245 15-minute units

14. Skilled Nursing Services:

RN – nursing services (T1002-U1)
Unit = 15 minutes
Rev. 10 2017 Maximum rate per unit = $10.00

LPN – nursing services (T1003-U1)
Unit = 15 minutes
Maximum rate per unit = $8.75
Rev. 04 2018

15. Adult Nutrition Services:

Service	Procedure Code	Modifier	Limits	Rate

Nutrition Evaluation	97802	U1	1 visit	$14.89
Nutrition Follow Up	97803	U1	8 units/month (15-minute)	$14.89

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

Unit = 15-minute
Rate per unit = $14.89
$1,800 total for any Adult Nutrition Service procedure codes

16. Prevocational Services:

Prevocational Services (T2015)
Unit = 15 minutes
Annual Limit = 5760 units
Rev. 04 2015 Maximum rate per unit = $3.10

17. Respite Services

Service	Unit	Procedure Code	Rate
Respite-15-Minutes 1 Member In Home	15 min	S5150	$4.83
Respite-15-Minutes 1 Member, self-directed In Home	1 unit	S5150-UC	$1.00
Respite-15-Minutes 1 Member, co-employer In Home	15 min	S5150-UA	$4.83
Respite-15-Minutes 2 Member In Home	15 min	S5150-UN	$2.66
Respite-15-Minutes 2 Member, self-directed In Home	1 unit	S5150-UN-UC	$1.00
Respite-15-Minutes 2 Member, co-employer In Home	15 min	S5150-UN-UA	$2.66
Respite-15-Minutes 3 Member In Home	15 min	S5150-UP	$1.93
Respite-15-Minutes 3 Member, self-directed In Home	1 unit	S5150-UP-UC	$1.00
Respite-15-Minutes 3 Member, co-employer In Home	15 min	S5150-UP-UA	$1.93
Respite-Daily Category 1 Out of Home	Daily	S5151-UJ	$153.61
Respite-Daily Category 1, self-directed Out of Home	Daily	S5151-UJ-UC	$153.61
Respite-Daily Category 1, co-employer Out of Home	Daily	S5151-UJ-UA	$153.61
Respite-Daily	Daily	S5151-U1-UJ	$209.51

Category 2 Out of Home			
Respite-Daily Category 2, self-directed Out of Home	Daily	S5151-U1-UJ-UC	$209.51
Respite-Daily Category 2, co-employer Out of Home	Daily	S5151-U1-UJ-UA	$209.51
Respite- 15 Minutes, Out of Home Category 1	15 min	S5150 U1	$4.83
Respite- 15 Minutes, Out of Home Category 1	15 min	S5150 U1-UC	$1.00
Respite- 15 Minutes, Out of Home Category 2	15 min	S5150 U3	$4.83
Respite- 15 Minutes, Out of Home Category 2	15 min	S5150 U3-UC	$1.00

Annual Limit Daily Out of Home Respite Category 1 = $4,608 maximum 30 units per year
Annual Limit Daily Out of Home Respite Category 2 = $6,285 maximum 30 units per year
Annual Limit 15 Minute Out of Home Respite Category 1= $4,608 maximum per year
Annual Limit 15 Minute Out of Home Respite Category 2= $6,285 maximum per year
Annual Limit In-Home Respite 15 Minute Category 1=$4608
Annual Limit In-Home Respite 15 Minute Category 2=$6,285

Self-Directed
Respite: 1 unit = $1.00
Applies to 15 minutes Respite

18. Specialized Medical Equipment:

Specialized Medical Equipment (T2029)
Specialized Medical Equipment Self-Directed (T2029-UC)
1 unit = $1.00
Annual maximum = $5,200.00

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 5,200 unless there is approval to exceed the annual maximum up to the lifetime maximum due to assessed exceptional needs of the individual.

Lifetime maximum per individual= $13,474.76

19. Specialized Medical Supplies:

Specialized Medical Supplies (T2028)
Specialized Medical Supplies Self-Directed (T2028-UC)
1 unit = $1.00
Annual maximum = $3,800.00

The annual maximum number of units is 3,800 unless there is approval to exceed annual maximum units due to assessed exceptional needs of the individual.

20. Supported Employment Services:

Rev 07 2019

Supported Employment Group (T2019-HQ)
Supported Employment Group Self-Directed (T2019-HQ/UC)
Supported Employment Group Co-Employer (T2019-HQ/UA)
Unit = 15 minutes

Rev. 04 2015
Rev. 07 2020

Maximum rate per unit = $2.02

Support Employment Individual (T2019-UB)
Support Employment Individual Self-Directed (T2019-UB/UC)
Support Employment Individual Co-Employer (T2019-UB/UA)
Unit = 15 minutes
Daily Limit = 40 units

Rev. 07 2019
Rev. 07 2020

Maximum rate per unit = $8.15

Annual Limit for Supported Employment Individual and Supported Employment Group combined = $10,454.00

Self-Directed
Supported Employment Group Limits: 1 unit = $1.00
Annual limit is as authorized in the individual budget.

Supported Employment Individual Limits: 1 unit = $1.00
Annual limit is authorized in the individual budget

Annual Limit for Supported Employment Individual and Supported Employment Group combined = $10,454.00

Rev. 07 2020

21. Transportation Services:

Rev 01 2021

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.

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 = $2,797.

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 $2,797.

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 $2,797.

22. Vehicle Adaptation Services:

Vehicle Adaptation (T2039)
Vehicle Adaptation Self-Directed (T2039-UC)
1 unit = $1.00
Lifetime maximum per individual= $6,240.00

APPENDIX B

GUIDELINES FOR SUPPORTING ADULTS WITH CHALLENGING BEHAVIORS IN COMMUNITY SETTINGS

Note: Appendix B deleted from this manual. The document is found on the DBHDD website in the Provider Tool Kit section.

APPENDIX C
Procedures for Billing and Documenting Personal Assistance Retainer

Rev 04 2016

A personal assistance retainer is a component of Community Living Support Services. The personal assistance allows continued payment for Community Living Support services while a 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.

Rev. 01 2016

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:

a) Beginning and end date of absence.

b) Reason for absence.

c) Scheduled days and units per day for Community Living Support Services as specified in the ISP.

d) Scheduled staff were 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 individual/representative who opts for participant-direction through a Co-Employer Agency must document the personal assistance retainer as above. The individual/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.

Personal Assistance Retainer Allowances and Exclusions:

1. 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.

1. ***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.

B. **Personal Assistance Retainer Exclusions**

The following exclusions apply to the personal assistance retainer:

a. Payment will not made for Personal Assistance Retainer in excess of the pre-authorized amount for Community Living Supports as specified in the Individual Service Plan.

b. 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.

c. Payment of Personal Assistance retainer beyond allowable days indicated below.

<u>Personal Assistance Retainer Billing</u>:

Providers must submit claims as follows for the personal assistance retainer:

A. Claims During Hospital Stays

Rev 01 2013
Rev 04 2016

a. Providers submit claims for each admission to a general hospital or nursing facility, including ICF/ID and skilled nursing facilities;

b. Providers submit claims for only scheduled days and units as specified in the individual's Individual Service Plan;

c. Providers bill ***a separate line for each day*** claimed during the hospital stay;

d. Providers list place of service on the claim as follows:

. 31 for Skilled Nursing Facility

i. 32 for Nursing Facility

ii. 54 for Intermediate Care Facility/MR

iii. 21 for Inpatient Hospital

Rev 04 2023

iv. 99 for vacations and family/relative visits

Note: Providers may not submit reimbursement for services provided in a nursing facility, hospital or ICF/ID.

Rev 01 2013

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 individual from his or her home.

B. Claims for Other Absences

Rev 01 2013

Rev 04 2016

a. 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 A. above and other absences of the individual from his or her home, such as vacations and family/relative visit, per calendar year;

b. Providers submit claims for only scheduled days and units (would have been provided except for the absence from the home) as specified in the Individual's Service Plan;

c. Providers may submit claims for other absences as standard (that is, in weekly, bi-weekly, or monthly spans)

Rev 07 2023

Note: Providers are required to submit timecard documentation of the vacations and family visits to mellis@dch.ga.gov for review.

Rev 07 2023

Note: Family hire caregivers are exempt from utilizing retainer payments when unavailable to render services to the member.