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CHAPTER IV

COVERED SERVICES AND LIMITATIONS

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CHAPTER IV COVERED SERVICES AND LIMITATIONS

INTRODUCTION

Home and community-based Mental Retardation/Intellectual Disability (MR/ID) Waiver services described in this chapter are covered under the Medicaid Program through a Section 1915(c) Waiver. The Community Services Board (CSB) or Behavioral Health Authority (BHA) screens for the waiver. Individuals being screened and their family/caregiver, as appropriate, make a choice between receiving services in an intermediate care facility for persons with MR/ID (ICF/MR) or in the community through the MR/ID Waiver. Community-based services must be determined to be an appropriate service alternative to exit from, delay, or avoid placement in an ICF/MR.

Services must be provided in accordance with the criteria defined in this chapter and in conjunction with the current assessment of the individual's support needs and Individual Support Plan developed for that individual by the individual and his or her support team.

If the individual has a guardian, the guardian shall act for the individual consistent with the parameters of his or her appointment. Throughout this chapter, references to "individual" will be inclusive of the individual's guardian when one has been named. A primary caregiver is the primary person who consistently assumes the role of providing direct care and support of the individual to live successfully in the community without compensation for providing such care.

Waiver services will be based on the concept of "person-centered planning," which is a variety of approaches or tools to organize and guide life planning with individuals with disabilities, their families, and friends. It is rooted in what is important to the individual while taking into account all other factors that affect his or her life, including effects of the disability and issues of health and safety. Focusing on the person in person-centered planning ensures that the service planning team moves beyond program planning for the individual and looks at the whole picture of the individual's life.

A provider is reimbursed only for the amount and type of services included in the Plan for Supports authorized by the Department of Behavioral Health and Developmental Services (DBHDS) and documented in the individual's record. MR/ID Targeted Case Management services described in this chapter are covered under the Medicaid State Plan Option.

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For any MR/ID Waiver service, a qualified case manager employed by or contracted with the CSB/BHA must complete the Individual Support Plan. The Individual Support Plan is the combination of a current assessment of the individual's needs in all life areas and a description of the services and supports necessary available under the MR/ID Waiver to address these needs. The Plans for Supports developed by individual service providers (including case management) describe the manner in which they will meet the individual's needs and are incorporated into the Individual Support Plan. Service providers, the individual and his or her family/caregiver, as appropriate, must be invited to the meeting and participate in the development of the Individual Support Plan. Providers must submit copies of their Plans for Supports to the case manager for review, approval and retention in the individual's case management file.

Unless otherwise noted, providers of Day Support Waiver services must meet the provider qualifications in Chapter II and shall provide services in accordance with the service criteria in Chapters IV and VI, as well as in conjunction with the current assessment of the individual's support needs and the Individual Support Plan.

MENTAL RETARDATION/INTELLECTUAL DISABILITY (MR/ID) WAIVER SERVICES

The MR/ID Waiver is targeted to provide home- and community-based services to individuals with MR/ID and children less than the age of six years at developmental risk who have been determined to require the level of care provided in an ICF/MR. These individuals may currently reside in an ICF/MR, nursing facility, or hospital or may be in the community at the time of assessment for MR/ID Waiver services.

MR/ID Waiver services may include various types of person-centered supports that empower an individual living with family or in another community residence in developing his or her desired lifestyle. The Individual Support Plan must clearly document the areas in which supports are needed and to be provided. Services that may not stand alone are environmental modifications, assistive technology, crisis stabilization, and therapeutic consultation services (other than behavior or psychological consultation). Behavior or psychological consultation may be offered in the absence of any other MR/ID Waiver service when the consultation is determined necessary to prevent institutionalization.

The case manager must present the individual with a choice of types of services: agency-directed or consumer-directed (or a combination of the two). When the individual chooses the type of services to meet his or her needs, the case manager offers the individual a choice of providers for each service.

Individuals residing in Medicaid-covered therapeutic foster care placements are not eligible to receive any MR/ID Waiver services, but may be placed on the MR/ID

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Statewide Waiting List. Individuals residing in assisted living facilities (ALFs) licensed by the Department of Social Services (DSS) are ineligible to receive congregate residential support, agency-directed or consumer-directed personal assistance, agency-directed or consumer-directed respite, environmental modifications, or personal emergency response services (PERS).

COORDINATION OF SERVICES

A team approach should be used to best ensure the individual's health and welfare and optimal service delivery. The team consists of the individual and family/caregiver as applicable, the case manager, provider(s), and any other person requested by the individual. The individual should be supported as needed to lead his or her own meeting, should he or she so desire. All team members work on behalf of the individual.

The case manager serves as the team facilitator and is responsible for the development of the Individual Support Plan as well as for ensuring that all team members have had input into the planning process. During team meetings, the individual is encouraged to discuss his or her needs and preferences, and desired outcomes and activities are identified. Agreed-upon outcomes and activities are documented on the Individual Support Plan.

The team approach is the basis for decision-making. Modifications should not be made to the individual's Individual Support Plan or service location without previous communication to the case manager and agreement by the team. Service quality and individual satisfaction are shared responsibilities and are accomplished through effective and consistent communication among the case manager, service providers, and other team members.

COVERED SERVICES

The MR/ID Waiver offers the following services:

- Assistive technology
- Companion services (agency- and consumer-directed)
- Crisis stabilization/crisis supervision
- Day support
- Environmental modifications
- Personal assistance (agency- and consumer-directed)
- Personal emergency response systems (PERS)
- Prevocational services
- Residential support

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- Respite (agency- and consumer-directed)
- Services Facilitation
- Skilled nursing
- Supported employment
- Therapeutic consultation
- Transition services

The Day Support (DS) Waiver offers:

- Day support services
- Prevocational services
- Supported employment services

FORMS

Forms referenced in this chapter may be found on the Department of Medical Assistance Services (DMAS) website at www.dmas.virginia.gov, with the exception of those beginning with “DMH” and other forms that are DBHDS forms, including samples of the Individual Support Plan and Plan for Supports. Those forms can be located on the DBHDS website at www.DBHDS.virginia.gov/.

REQUIRED TRAINING FOR AGENCY-DIRECTED SERVICE PROVIDERS

Providers must assure that persons providing residential support, personal assistance, day support, and prevocational services have received training in the characteristics of MR/ID and appropriate interventions, training strategies, and other methods of supporting individuals with functional limitations prior to providing MR/ID Waiver direct care services. This shall be accomplished through the *Staff Orientation Workbook*, the College of Direct Support (CDS), or other DBHDS-approved curriculum. See the DBHDS website at www.DBHDS.virginia.gov for more details about approved training options.

ELIGIBILITY FOR MR/ID WAIVER SERVICES

Diagnostic Eligibility

Individuals six years of age or older must have a psychological evaluation completed by a licensed professional that indicates a diagnosis of MR/ID. The psychological evaluation must reflect the individual’s current level of functioning and support the diagnosis of

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MR/ID as defined by the American Association on Intellectual and Developmental Disabilities (AAIDD):

“Mental retardation/intellectual disability is a disability characterized by significant limitations in both intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. This disability originates before age 18.”

Five assumptions essential to the application of the definition include:

1. Limitations in present functioning must be considered within the context of community environments typical of the individual’s age, peers, and culture;
2. Valid assessment considers cultural and linguistic diversity as well as differences in communication, sensory, motor and behavioral factors;
3. Within an individual, limitations often co-exist with strengths;
4. An important purpose of describing limitations is to develop a profile of needed supports; and
5. With appropriate personalized supports over a sustained period, the life functioning of the person with MR/ID generally will improve.

The psychological evaluation or accompanying documentation must address intellectual functioning, adaptive behavior and age of onset.

Individuals less than age six must have a psychological or standardized developmental evaluation that reflects the child’s current level of functioning and that states that the child has a diagnosis of MR/ID or is at developmental risk. Developmental risk is defined in the state regulations as:

“The presence before, during, or after birth of conditions typically identified as related to the occurrence of a developmental disability and for which no specific developmental disability is identifiable through available diagnostic and evaluative criteria.”

Functional Eligibility

Individuals receiving MR/ID Waiver services must meet the ICF/MR level of care. This is established by meeting the indicated dependency level in two or more of the categories on the Level of Functioning (LOF) Survey, which must be completed by the case

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manager with input from the individual, the family/caregiver, and providers, as appropriate. The LOF may not be completed in its entirety by either the individual's family or service providers. Guidance to assist in the interpretation of the LOF for children may be found in the "Developmental Milestones" chart available on the DMAS website at www.dmas.virginia.gov/ltc-home.htm.

Financial Eligibility and Patient Pay

Local departments of social services (LDSS) determine an individual's eligibility for Medicaid. Some individuals not otherwise eligible for Medicaid may be eligible to receive MR/ID Waiver services.

Additionally, some individuals may also have a patient pay responsibility. Virginia reduces its payment for MR/ID Waiver services by the amount of the individual's income remaining after all allowable deductions are made "personal maintenance needs," Special Earnings Allowance for earned income. The amount of the individual's income that remains after all deductions are made is known as the individual's patient pay. The individual is responsible for giving the designated provider the patient pay as payment for services. Individuals will pay the provider the full amount due for waiver services when the patient pay equals or exceeds the cost of waiver services. DMAS will reimburse the providers only for services that are not covered by the patient pay.

SLOT ALLOCATION

Individuals are enrolled into the MR/ID Waiver when a slot becomes available to the CSB/BHA. This may occur through attrition or through the allocation of new slots to the CSB/BHA. Waiver slots will be allocated to CSBs/BHAs based on the percentage of individuals each CSB/BHA has on the Statewide Urgent Waiting List. The CSB/BHA is responsible for assigning any available waiver slot to an individual who meets urgent criteria. DBHDS will confirm that the waiver slot is available to the CSB/BHA and that the individual has previously been included on the Statewide Urgent Waiting List or newly meets the urgent criteria. The CSB/BHA will determine, from among the individuals included in the urgent category, who should be served first, based on the immediate needs of the individual at the time a waiver slot becomes available using the statewide criteria as specified in the DBHDS guidance documents and not on any predetermined numerical or chronological order. Only after all individuals in the Commonwealth who meet the urgent criteria have been served can individuals in the non-urgent category be served. This decision process must be documented and available to DMAS and DBHDS for review.

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DBHDS may maintain a separate pool of waiver slots for individuals who choose discharge from state-operated facilities. The Office of Developmental Services (ODS) at DBHDS will track individuals discharged from state-operated facilities into waiver slots. If the individual is readmitted to a state-operated facility within 12 months of discharge, and the admission is a long-term admission, the waiver slot will revert to the statewide pool for state-operated facility discharges. If the discharged individual resides in the community for 12 consecutive months following discharge, the waiver slot will revert to the CSB/BHA providing case management services during the 12th month of community residence.

Reassignment of Slots

In the event that a CSB/BHA has a vacant slot and does not have an individual who meets the urgent criteria, the slot can be held by the CSB/BHA for 90 days from the date it is identified as vacant in case someone in an urgent situation is identified. If no one meeting the urgent criteria is identified within 90 days, the slot will be made available for allocation to another CSB/BHA in the Health Planning Region (HPR). If there is no urgent need at the time that the HPR is to make a regional reallocation of a waiver slot, DBHDS will, within 30 days, reallocate the slot to another HPR or CSB/BHA where there is unmet urgent need.

Transferring Case Management/Slots

If case management for an individual receiving waiver services is transferred from one CSB/BHA to another, the waiver slot for that individual will also be transferred to the new CSB/BHA and becomes part of its pool of available waiver slots. (Refer to the “Virginia Case Management Transfer Procedures for Persons with Intellectual Disabilities” found at www.dmas.virginia.gov/ltc-home.htm, then go to “Manuals and Forms.”) The transferring CSB/BHA will transfer case management responsibility within 90 days of residency in another service area unless one of the following conditions is met:

1. The individual and family/caregiver, as appropriate, has expressed a choice to continue case management services with the current CSB/BHA, and the current CSB/BHA is willing and able to provide or contract for case management and can demonstrate the capacity to handle emergency situations. If the CSB/BHA of the individual’s residence must provide MR/ID emergency/crisis services (vs. mandated mental health emergency/crisis services) at any time, case management

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and the waiver slot will be transferred within 30 days to the CSB/BHA in which the individual resides. In this instance, the current CSB/BHA will be deemed unable to provide case management services; or

2. The placement in another CSB/BHA service area is temporary (90 days or less).

When an individual receiving waiver services requests or it otherwise becomes necessary to change case management providers, the “referring” case management provider notifies, by telephone, the “receiving” case management provider of the expected date of transfer. A follow-up letter formally informs the “receiving” case management provider of the planned move. The letter must contain:

- The individual’s name;
- Medicaid number;
- Date of transfer;
- A listing of current services, providers and approved funding for services; and
- Any changes in providers or service levels that will occur with the move.

The “receiving” case management provider submits to DBHDS:

- A copy of the referring case management provider’s letter;
- A new Plan of Care Summary form; and
- Individual Service Authorization Request (ISAR) forms (if there are service level/provider changes).

Transitioning Individuals Less than Six Years of Age from the MR/ID Waiver to the Individual and Family Developmental Disabilities Support (IFDDS) Waiver

MR/ID Waiver individuals who attain the age of six years of age, who are determined to not have a diagnosis of MR/ID, and who meet all IFDDS Waiver eligibility criteria, shall be eligible for transfer to the IFDDS Waiver effective up to their seventh birthday. Psychological evaluations (or standardized developmental assessment for children under six years of age) confirming diagnoses must be completed less than one year prior to transferring to the IFDDS Waiver. These individuals transferring from the MR/ID Waiver will automatically be assigned a slot in the IFDDS Waiver, subject to the approval of the slot by CMS.

Annually each MR/ID case manager will identify children receiving MR/ID Waiver services who will be six years of age the following year. If the case manager notifies DBHDS that a psychological evaluation, completed no earlier than six months prior to

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the individual's sixth birthday, indicates that the child does not have MR/ID, DBHDS will simultaneously notify DMAS of the child's need to transfer to the IFDDS Waiver. The case manager will submit the current LOF, Individual Support Plan, and psychological evaluation to DMAS for review.

If DMAS determines the individual does not meet IFDDS Waiver eligibility requirements, DMAS will notify the family, the case manager, and DBHDS and provide written appeal rights to the individual. Additionally, the MR/ID case manager will notify the individual/family in writing of the impending termination of the waiver and services and provide appeal rights.

After confirming the individual meets IFDDS Waiver eligibility requirements, DMAS will notify the case manager, the family, and the individual, and DBHDS in writing. The case manager will plan with the child and his or her family for transfer to the IFDDS Waiver and will provide the family with a list of IFDDS Waiver case managers from DMAS. The MR/ID Waiver slot will be held by the CSB until the child has successfully transitioned.

The IFDDS waiver case manager notifies the MR/ID waiver case manager of the proposed effective date of the child's IFDDS waiver Plan for Supports. Case managers will be reimbursed for no more than one month of overlapping services. The MR/ID Waiver case manager will submit a DMAS-225 to the LDSS, DBHDS, and DMAS ending MR/ID Waiver services and issue appeal rights at least 10 days prior to the action. DBHDS will disenroll the child from the MR/ID Waiver. Once the time frame for filing an appeal has passed, the child's MR/ID Waiver slot will become available to the CSB for reassignment.

WAITING LIST

Description of Waiting Lists

CSBs/BHAs will be responsible for maintaining their own waiting list consisting of three categories for the MR/ID and DS Waivers. DBHDS will maintain the MR/ID Waiver Statewide Waiting List to include the CSBs' urgent and non-urgent lists. The urgent category consists of those who meet the diagnostic and functional criteria for the waiver, need services within 30 days and meet the urgent criteria. The CSB/BHA must maintain documentation with the reasons the individual meets the urgent criteria. The non-urgent category consists of those who meet the diagnostic and functional criteria for the waiver, need services within 30 days, but who do not meet the urgent criteria. Each individual on the Statewide Waiting List is given a "date of need," which is the permanent date assigned to reflect the individual has been determined eligible for the waiver and is willing to begin services within 30 days. The planning list is maintained solely by the CSB/BHA and is comprised of the names of the individuals who are potentially waiver

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eligible and interested in receiving services at some point more distant than the next 30 days. Individuals on the planning list are not currently eligible for a waiver slot.

The urgency of need of individuals on the CSB's/BHA's waiting list is to be evaluated quarterly by the case manager, who will make additions and deletions to the urgent and non-urgent categories as needed and forward to DBHDS any modifications to the MR/ID Waiver Urgent or Non-urgent Statewide Waiting List. Annually the case manager will contact all individuals that he or she supports on the Statewide Waiting List (and family/caregiver, as appropriate) for an update of status and a renewal of the choice between institutional placement and waiver services (documented on the DMAS 459-C). The date of this contact is forwarded to DBHDS.

It is permitted for an individual living out-of-state to remain or be placed on the Urgent or Non-urgent MR/ID Waiver Waiting List, as long as the individual has received a face-to-face screening by a case manager in the CSB region where the individual expects to reside. This screening must be no different than that for individuals residing in-state and must be done prior to placing the individual on the waiting list.

Individuals who reside in NFs or other institutions or who are enrolled in the Elderly or Disabled with Consumer Direction (EDCD) Waiver and who qualify for the MR/ID Waiver may be on the MR/ID Waiver Waiting List.

Children under six years of age who are on the MR/ID Waiver Statewide Waiting List must have a diagnosis of MR/ID when they turn six in order to be accepted into the waiver.

Placement on the Statewide Waiting List

The following documentation is needed for placement of eligible individuals on either the MR/ID Waiver Urgent or Non-urgent Statewide Waiting List:

1. "Fax Cover for any Submission Effecting a Waiting List Change" (DMH 885E 1213), indicating Urgent or Non-Urgent Status;
2. The completed "Enrollment Request" (DMAS-437) form; and
3. The signed "Documentation of Recipient Choice between Institutional Care or Home and Community-Based Services" (DMAS 459-C) form.

DBHDS will notify the appropriate CSB/BHA that the individual has been added to the Urgent Statewide Waiting List or the Non-Urgent Waiting List and maintain the documentation that the individual meets functional eligibility for the MR/ID Waiver, the "date of need" and that the individual has been added to a statewide waiting list. The case manager must notify the individual in writing within 10 business days of receiving

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notification from DBHDS that he or she has been placed on the Statewide Urgent Waiting List, or the Non-Urgent Waiting List, and of his or her appeal rights (see the “Individual’s Right to Appeal and Fair Hearing” section of Chapter VI for details).

Subsequent changes to an individual’s Statewide Waiting List status are communicated to DBHDS by the case manager via the “Fax Cover for any Submission Effecting a Waiting List Change” (DMH 885 E 1213) form. In addition, the individual and family member/caregiver must be notified in writing by the case manager of appeal rights.

Urgent Criteria

Assignment to the urgent category may be requested by the individual, his or her legally responsible relative, or primary caregiver. The individual, the individual’s spouse or the parent of an individual who is a minor child must confirm that they would accept the requested MR/ID Waiver service if offered.

Satisfaction of one or more of the following criteria shall indicate that the individual should be placed on the Urgent Need of Waiver Services Waiting List:

1. Both primary caregivers are 55 years of age or older, or if there is one primary caregiver, that primary caregiver is 55 years of age or older;
2. The individual is living with a primary caregiver who is providing the service, without pay and indicates that he or she can no longer care for the individual;
3. There is a clear risk of abuse, neglect, or exploitation;
4. A primary caregiver has a chronic or long-term physical or psychiatric condition or conditions which significantly limits the abilities of the primary caregiver to care for the individual with MR/ID;
5. The individual is aging out of a publicly funded residential placement or otherwise becoming homeless (exclusive of children who are graduating from high school); or
6. The individual with MR/ID lives with the primary caregiver and there is a risk to the health or safety of the individual, primary caregiver, or other individual living in the home due to either of the following conditions:
 - a. The individual’s behavior or behaviors present a risk to himself or others which cannot be effectively managed by the primary caregiver even with typical or specialized support arranged or provided by the CSB/BHA; or

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- b. There are physical care needs (such as lifting or bathing) or medical needs that cannot be managed by the primary caregiver even with generic or specialized supports arranged or provided by the CSB/BHA.

APPLICATION FOR MR/ID WAIVER SERVICES

Waiver services shall not be furnished to individuals who are inpatients of a hospital, NF, ICF/MR, or inpatient rehabilitation facility. Individuals with MR/ID who are inpatients of these facilities may receive case management services through the CSB, if they qualify, and the case manager may recommend waiver services that would promote exiting from the institutional placement. However, Medicaid reimbursement for waiver and case management services shall not be provided until the individual has exited the institution.

The case manager's responsibilities are as follows:

1. Meets with the individual (and family/caregiver, as appropriate), in a timely manner following the individual's request for a Medicaid-covered service, and determines the individual's needs and supports necessary to provide appropriate services to the individual.
2. Provides the individual (and family/caregiver, as appropriate) with appeals information.
3. Obtains the individual's (and family/caregiver's, as appropriate), consent and signature(s) on a Health Insurance Portability and Accountability Act (HIPAA) compliant consent form in order to gather information from other sources and communicate to DMAS.
4. Determines diagnostic and functional eligibility by obtaining or completing the following:
 - a. A psychological evaluation or a standardized developmental evaluation for children under six years of age; and
 - b. An ICF/MR LOF Survey, which must be completed within 45 days of the individual's date of request. To aid in interpretation of the LOF for children under six years of age, the appropriate section of the "Developmental Milestones Assessment for Children Under the Age of Six and at Developmental Risk" form may be used. This form is found on the DMAS website at www.dmas.virginia.gov/ltc-home.htm.
5. Recommends MR/ID Waiver services only if they are determined to be an appropriate service alternative to delay or avoid placement in an ICF/MR or

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promote exiting from either an ICF/MR or other institutional setting. If the case manager can recommend MR/ID Waiver services, he or she informs the individual and family/caregiver, as appropriate of all the MR/ID Waiver services available for which he or she is eligible (including consumer- and agency-directed services) and documents the individual's choice of waiver services or institutional care by signatures on the "Documentation of Recipient Choice between Institutional Care or Home and Community-Based Services" (DMAS 459-C) form.

6. Determines if the individual meets one or more of the urgent criteria.
7. Informs the individual (and family/caregiver, as appropriate) of non-MR/ID Waiver services for which he or she is eligible.
8. If the individual selects MR/ID Waiver and meets the urgent or non-urgent criteria, submits required documentation to DBHDS for enrollment or placement on the Statewide Waiting List.
9. If the individual selects ICF/MR placement, assists the individual with this option. If the individual chooses ICF/MR placement and is placed on a waiting list, he or she may be placed on either the MR/ID Waiver Urgent or Non-urgent Statewide Waiting List (depending on need) at the same time.
10. Annually, each MR/ID case manager will identify children receiving MR/ID Waiver services who will be six years of age the following year. A referral is made to the IFDDS Waiver if the child does not have an MR/ID diagnosis.

DBHDS REVIEW FOR ENROLLMENT IN THE MR/ID WAIVER

The following documentation is required by DBHDS for enrollment (unless previously submitted for placement on the Waiting List and still current):

1. "Slot Change/New Assignment Fax Cover" (DMH 885E 1202R) with documentation of slot availability;
2. The completed "Enrollment Request" form. Note: The LOF Survey must have been completed no earlier than six months prior to enrollment;
3. The signed "Documentation of Recipient Choice between Institutional Care or Home and Community-Based Services" (DMAS 459-C) form; and
4. The DMAS-225 for the individual who vacated the slot, if applicable.

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DBHDS will notify the CSB/BHA that the individual has been enrolled as requested or that additional information is needed. Once enrollment is complete, DBHDS will forward the approved “Enrollment Request” and the “MR/ID Waiver Level of Care Eligibility” (DMH 885E 1164) forms to the case manager.

AUTHORIZATION OF MR/ID WAIVER SERVICES

Responsibilities of the Case Manager

Following receipt of notification (i.e., written or electronic) from DBHDS that the individual has been enrolled in the MR/ID Waiver, the case manager takes the following actions:

1. Obtains a medical examination that is completed no more than one year prior to the initiation of waiver services.
2. Determines that the psychological evaluation, or standardized developmental evaluation for those less than six years of age, reflects the individual’s current status and meets the criteria stated in the “Diagnostic Eligibility” section above.
3. Ensures that the LOF is completed no more than six months prior to enrollment and that the individual meets the criteria to be eligible for the waiver.
4. Obtains input from the individual and family/caregiver, as appropriate, and others involved in the individual’s life. This information is used to complete the Essential Information, Personal Profile, and the Virginia Supports Intensity Scale™ (SIS) (or other DBHDS-approved assessment for those not yet scheduled for the SIS), thereby determining the supports needed and appropriate services for meeting the individual’s needs. The Personal Profile must be completed no more than one year prior to enrollment. See the DBHDS website for more information of the SIS.

The SIS form’s use shall be phased-in across all CSBs/BHAs with completion effective by July 2012. During the phase-in process, CSBs/BHAs may use alternative assessment forms with the approval of DBHDS. This provision for the phase-in process of the use of the SIS shall sunset effective July 1, 2012, except if otherwise noted in agency guidance documents.

5. Identifies and provides a list to the individual and family/caregiver, as appropriate, of the names of available service providers.

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6. Arranges for visits or interviews with the providers, as desired by the individual and family/caregiver, as appropriate.
7. Confirms that any interested provider, including the CSB/BHA, has a current DMAS Participation Agreement as an MR/ID Waiver provider of the specific service under consideration.
8. Documents in writing the individual's choice of MR/ID Waiver providers on the "Virginia Home and Community-Based Waiver Choice of Providers" (DMAS-60) form.
9. Completes the identifying information on the "MR/ID Waiver Level of Care Eligibility" form (DMH 885E 1164), along with the DMAS-225 (entering the NPI/API number of the provider that will be responsible for collecting patient pay, if an amount is designated), and forwards them to the LDSS for MR/ID Waiver financial eligibility determination and patient pay responsibilities.
10. Contacts chosen service providers in sufficient time so that services can be initiated within 30 days of the date that financial eligibility was determined.
11. Coordinates a meeting with the individual, service providers, the individual's chosen planning partner, family/caregiver, as appropriate, and significant others, within 30 calendar days of receipt of written notification of Medicaid eligibility by the LDSS and written confirmation of enrollment from DBHDS. At the planning meeting, the team reviews the individual's existing supports and support needs, as documented on the SIS (or other DBHDS-approved assessment for those not yet scheduled for the SIS) and Personal Profile and Essential Information, along with relevant results of any other assessments, such as the LOF Survey, psychological evaluation, and medical examination. The assessment information and the preferences of the individual and family/caregiver, as appropriate, inform the development of the Individual Support Plan. The Individual Support Plan development process identifies the services to be rendered to individuals, the frequency of services, the type of service providers(s) and a description of the services to be offered.
12. Reviews the Plans for Supports developed by the team as a result of the planning meeting. The Plan for Supports from each waiver service provider shall be incorporated into the Individual Support Plan along with the steps for risk mitigation as indicated by the risk assessment (Part IV of the Virginia SIS). (As the SIS is to be completed every three years for each individual, during the years when it is not scheduled, Section IV the SIS will be completed and used to develop any needed risk mitigation strategies in the Individual Support Plan.)

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The case manager confirms that the Plans for Supports meet the following requirements:

- a. Designate supports agreed to by the team, which are based upon input from the individual and noted in the assessment information;
- b. Include outcomes which are specific and measurable;
- c. Include a schedule of when the provider will offer supports and services;
- d. Include activities that are allowable for the service, as well as staff instructions based on the preferences of the individual;
- e. Indicate the total weekly hours or units;
- f. Indicate the correct start date; and
- g. Indicate the person-centered review (formerly quarterly review) due dates, which correspond to the case management review dates.

If these requirements are not met, the case manager must:

- 1) Telephone the provider to explain the concern(s);
- 2) Follow-up with a letter if needed, giving a five-day response time;
- 3) Then, if the concern(s) is not resolved, forward the request (Plan for Supports and ISAR) to DBHDS preauthorization staff along with the relevant correspondence (including any from the provider) describing the concern(s).

12. Submits to DBHDS the following documents:

- The “Plan of Care Summary” (DMAS-438) form; and
- ISARs consistent with the information on the Plans for Supports that have been signed by the case manager.

Delay in Service Initiation

If MR/ID Waiver services are not initiated within 60 days of receipt of enrollment confirmation, for individuals not assigned a facility slot, the case manager must complete the “Retain or Reassign Slot for Individual Not Currently Receiving MR/ID Waiver Services” (DMH 885E 1197) form, demonstrating why more time is needed to initiate

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services. This is submitted to DBHDS and copied to the individual or individual's family. DBHDS has the authority to approve the request in 30-day extensions, up to a maximum of four consecutive extensions, or deny the request. DBHDS shall provide a written response to the case manager indicating denial or approval of the extension within 10 working days of the receipt of the request. Additional requests for an extension may be submitted to DBHDS and copied to the individual and the individual's family/caregiver, as appropriate, by using the same form.

Individual Service Authorization Request (ISAR)

It is the responsibility of the case manager to review, approve and submit ISARs to DBHDS to begin services, to modify the amount or type of services, or to end services. The ISAR must clearly describe the reason for the action and include the signature of the case manager indicating review. All requests will be reviewed under the health and safety standard. This standard means that an individual needs the service, based on appropriate assessment criteria and a written Plan for Supports and that services can safely be provided in the community. A narrative describing the individual's need for the service may be submitted along with the ISAR. Final recommendation for authorization of MR/ID Waiver services is the responsibility of DBHDS. DMAS has the final authority on all approvals.

The authorized start date of services will not be prior to the date of receipt by DBHDS of a correct, complete authorization request for an eligible individual. To assure the provider that the individual is eligible and that services are authorized as requested, it is recommended that the required documents be submitted at least 30 working days prior to the requested start of services. All authorization requests will be acted upon (i.e., review of the documentation to determine the need for MR/ID Waiver eligibility and appropriateness of services, followed by approval, denial, or pended) within 10 working days following receipt by DBHDS.

When services are approved by DBHDS, the case manager will be notified via a returned ISAR. For all services a DMAS-generated Notice of Approval of Pre-Authorized Services will be sent to the individual and the specified service provider notifying them of the action taken by DBHDS and the approved hours/units and authorized start date of services. Only MR/ID or DS Waiver services authorized on the Individual Support Plan by DBHDS according to DMAS policies and commencing on or after the start date on the Notice of Approval of Pre-Authorized Services will be reimbursed by DMAS.

If the requested services are denied, the case manager will be notified by DBHDS and a DMAS notification letter will be sent to the individual and provider notifying them of the reason for the denial and explaining the individual's appeal rights. Any requests for services that are denied may be resubmitted at a later date if additional justification is obtained.

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If DBHDS pends approval of services, notification will be sent to the service provider and case management provider, explaining the reason for this action and any additional information or action that is required of the provider or case manager. DBHDS is responsible for assuring that the documentation received supports the request. The case manager must immediately forward this notification to the provider, and is responsible for submitting the requested information to DBHDS within 30 calendar days. If the requested information is submitted within the required time period services may be approved as of the requested start date on the ISAR. If the requested information is not received within the 30-day time period, the request will be rejected and the provider, via the case manager, will have to resubmit the request. Whenever services are rejected, a new ISAR must be submitted with a new start date and the required justification for reconsideration by DBHDS.

60-Day Assessments ISAR

A 60-day assessment ISAR may be authorized for the Individual Support Plan year or only for the assessment period, in which case a new ISAR will be needed to continue services. In either case, an annual plan, developed with the involvement of the individual, must be forwarded to the case manager for review and approval prior to the end of the 60 days.

Modifications to Services

To change the amount or type of service previously authorized, a revised Plan for Supports must be developed with the individual and approved by the case manager. The provider must submit a new ISAR for review and approval by the case manager and final authorization by DBHDS.

Multiple Providers

If the individual will be receiving the same service from more than one provider, the case manager should clearly describe the circumstances to DBHDS on the Plan of Care Summary during preauthorization. If changes occur during the Individual Support Plan year, the circumstances should be clearly described on the ISARs.

Changing Providers

To change a provider for an approved service, the case manager must submit to DBHDS an ISAR to terminate the services of the existing provider and an ISAR to begin services with the new provider.

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Family Members Providing Waiver Services

Some waiver services (i.e., residential support, personal assistance, respite, and companion services) specify that payment may not be made for services rendered by family members who live under the same roof as the individual receiving services unless there is objective written documentation as to why there are no other providers available to provide the supports. Family members who are reimbursed to provide these services shall meet the same applicable standards and policies as providers who are unrelated to the individual. Examples of situations meeting the criteria of no other providers available might include when:

- Individuals are living in a remote area unserved or underserved by other providers; or
- Other providers have been unsuccessful at appropriately supporting the individual.

In these cases, the case manager shall review and document that service delivery by the family member best meets the individual's preferences and support needs, that the family member is qualified and able to provide the supports, and that the individual's choice of providers has been honored. Concerns that these intents will not or have not been fulfilled must be discussed with DBHDS staff.

Ending Service(s)

When services from a single MR/ID Waiver provider cease, an ISAR including the detailed reason for terminating services must be submitted to DBHDS. When all MR/ID Waiver services end, this constitutes either an interruption or a discharge from MR/ID Waiver. Neither of these situations requires the submission of ISARs.

PATIENT PAY

If the individual receiving MR/ID Waiver services has a patient-pay amount, a provider shall use the electronic patient pay process. The LDSS will enter data regarding an individual's patient pay amount obligation in to the Medicaid Management Information System (MMIS) at the time action is taken regarding an individual either as a result of an application for Waiver services, redetermination of eligibility, or reported change in an individual's situation.

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Verification of an individual's patient pay obligation will be available through the web-based ARS system and telephone-based MediCall system. Responsible providers, as designated by the case manager, must monitor the ARS/MediCall systems for Medicaid Waiver individuals in order to determine the appropriate amount of patient pay to collect. DMAS offers a web-based Internet option (ARS) to access information regarding Medicaid eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification. The website to enroll for access to this system is <http://virginia.fhsc.com>. The MediCall voice response system will provide the same information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider. Information regarding how to access these systems is included in Chapter 1 of each provider manual.

The DMAS-225 will be used to advise the LDSS staff which provider is responsible for collecting the individual's patient pay obligation. The case manager, ~~or~~ should complete the Provider NPI# (or API) data field on the DMAS-225. The DMAS-225, when completed by the LDSS, will then be used to inform the case manager of the individual's eligibility status.

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

Only the cost of medically necessary, individual-specific, customized, non-covered items or services may be deducted from patient pay.

MEDICAID LTC COMMUNICATION DOCUMENT (DMAS-225)

For communication of information other than patient pay, the DMAS-225 will be used by the case manager, to report changes in an individual's situation. This form is available on the DMAS website.

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Once a responsible provider is identified, the case manager forwards a copy of the MR/ID Waiver Level of Care Eligibility Form received from DBHDS, with the DMAS-225 with the top portion completed, to the LDSS indicating that the individual has met the level of care requirements and providers have been selected. Following verification that the individual has been screened and approved to receive MR/ID Waiver services, the LDSS eligibility worker will determine the individual's Medicaid eligibility, complete the LDSS portion of the DMAS-225 and return it to the case manager with the bottom section completed, showing confirmation of the individual's Medicaid identification number and the date on which the individual's Medicaid eligibility was effective.

In the event that the DMAS-225 is not received by the case manager in a timely manner, the case manager may monitor the ARS/MediCall systems for financial eligibility and patient pay obligations. DSS is responsible for notifying the case manager if the individual no longer meets eligibility requirements and for updating the case manager of changes to an individual's eligibility.

The DMAS-225 is also used by the case manager and the LDSS to exchange information that may affect the eligibility status of an individual. The case manager must complete an updated DMAS-225 and forward it to the LDSS eligibility worker whenever an individual experiences any of the following changes:

- A new address;
- A different provider of case management services;
- An increase or decrease in monthly income;
- Change in collector of patient pay;
- Discharge from all MR/ID Waiver services;
- An interruption in all MR/ID Waiver services for more than 30 days; or
- Death.

The case manager must update the DMAS-225 and submit it to the LDSS as soon as possible following any of these changes. The exact change in circumstances and reason for the change must be clearly noted on the DMAS-225. .

Pending Medicaid Eligibility

DBHDS will notify the case manager if an ISAR cannot be processed due to a pending Medicaid number. Once the Medicaid number has been issued by the LDSS, the case manager must notify DBHDS by telephone or fax to complete the authorization process. Providers cannot be paid until the Medicaid number has been given to DBHDS.

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INTERRUPTION OF SERVICES

Temporary Interruption with Continued Eligibility

Whenever all waiver services are interrupted on a temporary basis (e.g., temporary loss of financial eligibility, health and safety at risk in current situation, temporary placement in a rehabilitation hospital, NF, or ICF/MR), for more than 30 consecutive days, the case manager must notify the LDSS via a DMAS-225. DSS determines if the individual continues to meet all eligibility requirements for Medicaid.

For an interruption that continues for more than 60 consecutive days, the case manager sends the DMAS-225 to DBHDS. A Retain or Reassign Slot form (DMH 885E 1197E) must be submitted to the DBHDS Community Resource Consultant and copied to the individual and family/caregiver, as appropriate. DBHDS has the authority to approve or deny the request in 30-day extensions.

Temporary Interruption with Loss of Financial Eligibility

When DSS determines that the individual is no longer eligible, the case manager must forward the DMAS-225 to DBHDS. DBHDS will discharge the individual from the MR/ID Waiver and end all active service authorizations. If it is a temporary discharge (no more than 60 days), the case manager must indicate such on the DMAS-225. Individuals who are not financially eligible for Medicaid will not receive Medicaid funding for MR/ID Targeted Case Management.

Individual Enters an ICF/MR, NF, or Rehabilitation Hospital

When services are interrupted due to the individual's entering an ICF/MR, NF, or rehabilitation hospital for temporary services, the case manager must immediately notify the LDSS eligibility worker by telephone and forward a DMAS-225 to the LDSS and DBHDS explaining the reason for the temporary discharge. A Retain or Reassign Slot form (DMH 885E 1197E) is required if this interruption continues for more than 60 days. To return to MR/ID Waiver services, the case manager forwards a copy of the revised DMAS-225 to the LDSS and DBHDS, indicating the start date. In the event that the DMAS-225 is not received by the case manager in a timely manner, the case manager may monitor the ARS/MediCall systems for financial eligibility and patient pay obligations. New ISARs are required only if there has been a change in service, service level, or provider.

DISCHARGING AN INDIVIDUAL FROM MR/ID WAIVER SERVICES

Reasons to discharge an individual from the MR/ID Waiver are:

- Death;

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- Individual moves to another state;
- Individual declines MR/ID Waiver services;
- Individual no longer meets diagnostic or functional eligibility;
- Individual enters an ICF/MR, NF, or rehabilitation hospital;
- The LDSS determines that the individual is no longer financially eligible;
- Home and community-based care services are not the critical alternative to prevent or delay ICF/MR placement;
- The individual's environment does not provide for his or her health and safety; or
- An appropriate and cost-effective Individual Support Plan cannot be developed.

The case manager must complete a DMAS-225 to discharge the individual from the MR/ID Waiver, which terminates all MR/ID Waiver services, and must notify all providers. The DMAS-225 is sent to the LDSS and DBHDS, clearly noting the date of discharge and the reason for the discharge. Once an individual is discharged from the MR/ID Waiver the individual must reapply to receive MR/ID Waiver services again.

A Retain or Reassign Slot form must be submitted to DBHDS (with a copy sent to the individual and family/caregiver, as appropriate) to request reassignment of the vacated slot, unless the reason for the slot's vacancy is the individual's death.

INDIVIDUAL SUPPORT PLAN

An Individual Support Plan must be developed for each individual receiving MR/ID Targeted Case Management Services and MR/ID Waiver services. The Individual Support Plan must be updated whenever changes in services are required and at least annually. The Individual Support Plan organizes and describes the services and supports necessary for attaining an individual's vision of "a good life" and desired outcomes for living successfully in the community. An individualized approach should be utilized to assure that needed supports are identified, as well as the individual's desired outcomes; this is coordinated by the case manager, but is a responsibility shared with the individual, family member/caregiver, as appropriate, and service providers. Factors to be considered when developing this plan may include the individual's age, primary disability, and level of functioning.

The Individual Support Plan means supports and actions to be taken during the year by each service provider to achieve the individual's desired outcomes. The Individual Support Plan is developed by the individual and partners chosen by the individual. It contains essential information and includes what is important to the individual on a day-to-day basis and in the future and what is important for the individual to keep healthy and safe as reflected in the Plans for Supports. The Individual Support Plan is known as the Consumer Service Plan in the Day Support Waiver.

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The Individual Support Plan includes:

1. The Essential Information (including risk assessment) and Personal Profile;
2. The individual's vision for a good life (formerly called primary goals) and desired outcomes (including risk mitigation);
3. A Plan for Supports for each MR/ID community service requested and received by the individual (including MR/ID Targeted Case Management and all MR/ID Waiver services) which outline the activities planned to assist in attaining the individual's desired outcomes, which include items that are important to him, as well as his health and safety needs;
4. A documentation of agreement (may be a signature page) by those individuals participating in the development and implementation of the Individual Support Plan; and
5. A begin and end date.

MONITORING AND RE-EVALUATION OF THE SERVICE NEED

The case manager must continuously monitor the appropriateness of the Individual Support Plan and make revisions as indicated.

The case management review process is as follows:

1. Case management person-centered reviews must be written and include a review of all MR/ID Waiver Services included in the Individual Support Plan. Person-centered reviews from the waiver service providers are reviewed and filed in the case management record. The person-centered review schedule for individual providers is based upon the start date of the Individual Support Plan and shall be completed quarterly.
2. Respite services (agency- or consumer-directed), assistive technology, environmental modification, and crisis stabilization are considered sporadic and temporary services and do not require a person-centered review from the provider.
3. Prior to the end of the Individual Support Plan year, the case manager meets with the individual and family/caregiver, as appropriate, and service providers to reassess service needs and develop a new Individual Support Plan, if services are to continue.

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4. This new annual Individual Support Plan must be completed prior to service delivery. However, the new Individual Support Plan would not need to take effect until the previous one expires.
5. If, at any time during the Individual Support Plan year, the individual's needs change or there is a request for changes in services, providers must make revisions to the Individual Support Plan, as follows:
 - a. If the individual agrees to the changes, in collaboration with the case manager, the Individual Support Plan is revised and an effective date for the change is stated on the Individual Support Plan. Details of the revision would be documented and discussed at the person-centered review;
 - b. If the total hours or units change at any time during the Individual Support Plan year, authorization is required. The case manager must receive a revised Plan for Supports and ISAR form from the provider and submit it to DBHDS within the required time frame;
 - c. There must be a current Personal Profile and Essential Information, an updated documentation of agreement, and a new "Virginia Home and Community-Based Waiver Choice of Providers" form, if needed;
 - d. A case manager can add a new service to an existing Individual Support Plan at any time during the Individual Support Plan year with DBHDS authorization; however, the end date and person-centered review dates shall coincide with the Individual Support Plan year; and
 - e. The individual must be notified of changes resulting in decreases or terminations in services. Individuals will be given the right to appeal.

ANNUAL REASSESSMENTS

The case manager will be responsible to maintain compliance with 1915c waivers by conducting an annual LOF Survey for each individual receiving waiver services. The results of this review will be sent to DBHDS. The case manager must complete an annual comprehensive reassessment (i.e., gather relevant social, psychological, medical and level of care information) in order to coordinate a new Individual Support Plan. This includes the annual completion of a risk assessment (Section IV of the Virginia SIS). As the SIS is to be completed every three years for each individual, during the years when it is not scheduled, Section IV the SIS will be completed and used to develop any needed risk mitigation strategies in the Individual Support Plan.

The Individual Support Plan must be developed and copies distributed to all team members prior to the end of the previous Individual Support Plan year. The current

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MR/ID Waiver services and non-waiver services are summarized on the updated Plan of Care Summary form.

Annual renewals of preauthorization (via ISARs) are required only for assistive technology, environmental modifications, therapeutic consultation, skilled nursing, personal emergency response system (PERS), crisis stabilization, and crisis supervision.

MR/ID TARGETED CASE MANAGEMENT SERVICES

Service Description

All individuals receiving MR/ID Waiver services must receive MR/ID Targeted Case Management Services. MR/ID Targeted Case Management Services covered under the Medicaid Program do not require preauthorization. The case management provider must meet all applicable standards and policies. It is the responsibility of the CSB/BHA to assure individuals' ongoing eligibility and need for MR/ID Targeted Case Management Services.

MR/ID Targeted Case Management Services are activities designed to assist an individual with MR/ID in accessing needed medical, psychiatric, social, educational, vocational, residential, and other supports essential for living in the community and in developing his or her desired lifestyle.

The allowable support activities include, but are not limited to:

1. Coordinating initial assessment and annual reassessment of the individual and planning services and supports, to include history-taking, gathering information from other sources, and the development of a Individual Support Plan. This does not include performing medical or psychiatric assessments, but may include referral for such assessment;
2. Coordinating services and supports planning with other agencies and providers. This includes making appointments;
3. Linking the individual to services and supports specified in the Individual Support Plan;
4. Assisting the individual directly for the purpose of locating, developing, or obtaining needed services and resources, including crisis supports;
5. Enhancing community integration through increasing the individual's community access and involvement;

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6. Making collateral contacts to promote implementation of the Individual Support Plan and allow the individual to participate in activities in the community;
7. Monitoring implementation of the Individual Support Plan through regular contacts with service providers, as well as periodic site visits and home visits;
8. Instruction and counseling which guides the individual in problem-solving and decision-making and develops a supportive relationship that promotes implementation of the Individual Support Plan. Counseling in this context is defined as problem-solving activities designed to enhance an individual's ability to live in the community. Allowed instructional activities would include discussion about the benefits of the activities listed in the service plan;
9. Monitoring the quality of services; and
10. Assisting the individual to secure services in an ICF/MR, if the individual or family member requests institutional placement.

Criteria

The assigned case manager must provide MR/ID Targeted Case Management Services as frequently and timely as the person needs assistance. There must be at least one documented contact, activity, or communication, as designated above, and relevant to the Individual Support Plan, during any calendar month for which MR/ID Targeted Case Management services are billed.

The activity of writing the Individual Support Plan, person-centered review, or case note is not considered a billable case management activity. Developing the Individual Support Plan through a team meeting or reviewing other providers' written materials in order to prepare the case management person-centered reviews are billable activities. Accompanying individuals to appointments or transporting them is not covered.

MR/ID Targeted Case Management Services may be provided to an individual who is eligible for Medicaid benefits and who is documented to have MR/ID as defined by the AAIDD.

Individuals with MR/ID and children less than six years of age who are at developmental risk and who are receiving MR/ID Waiver Services are eligible for and must also be receiving MR/ID Targeted Case Management Services during the months that MR/ID Waiver services are received.

To be eligible to receive MR/ID Targeted Case Management Services, the individual must need "active case management." An individual is considered to need "active case management" if a minimum of one face-to-face contact is required every 90 days. In

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addition, a minimum of one scheduled or unscheduled contact or communication by the case manager per month with the individual or with the family, service providers, or other organizations on behalf of the individual must typically be performed. The contact must be relevant to the individual's needs and Individual Support Plan.

MR/ID Targeted Case Management Services may not duplicate any other Medicaid or MR/ID Waiver service.

Service Units and Service Limitations

A unit of service is equal to a month of service. Billing for the service may begin with the first face-to-face contact and can be submitted only for months in which at least one direct or individual-related contact, activity, or communication occurs and is documented. Reimbursement is provided only for individuals receiving active MR/ID case management as previously described.

MR/ID Targeted Case Management services may be billed for services provided to Medicaid-eligible institutionalized individuals (including those in acute care hospitals, ICFs/MR, NFs, and psychiatric hospitals that are not institutions for mental diseases (IMDs) for individuals aged 22-64) during the 30 calendar days preceding discharge. The activities of the case manager may not duplicate the activities of the institutional discharge planner and may be billed no more than twice in a 12-month period.

Documentation Requirements

The following documentation is required to be completed by the case manager for the provision of MR/ID Targeted Case Management Services:

1. An Individual Support Plan which addresses the individual's support needs and desired outcomes, must be developed and reviewed and updated whenever changes in services are required and at least annually. The Individual Support Plan and any updates must be retained in the record, document the need for MR/ID Targeted Case Management and be approved, dated, and signed by the individual and case manager, at least annually.
2. The case manager must annually coordinate the completion of the Personal Profile, which is a person-centered assessment designed to help the team determine and respond to what works in the person's life and thus needs to be maintained or improved and what does not work and thus needs to be stopped or changed. The Personal Profile may be initiated by the individual's chosen planning partner and completed at the person-centered planning meeting, with the final version distributed to all team members following the meeting. The Personal Profile, along with other relevant social, psychological, psychiatric,

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medical, and level of care information serves as the basis for development of the Individual Support Plan and component Plans for Supports.

The Personal Profile summarizes the individual's vision of a good life, their talents and contributions, and "what's working/what's not working" in the following life areas:

- Home
- Community and interests
- Relationships
- Work and alternates to work
- Learning and other pursuits
- Money
- Transportation and travel
- Health and safety

Additionally, the case manager annually updates, as needed, the Essential Information, which includes:

- Contact Information
- Emergency contacts/representation
- Psychological or developmental evaluation
- Current Level of Functioning Survey (for those on MR/ID or DS Waivers)
- Support Coordination and provider contacts
- Communication and sensory supports
- Health, medications and physicals
- Summary of social/developmental/behavioral/family history/previous interventions and outcomes
- Summary of employment and educational background
- Exceptional support needs/risk assessment
- Ability to access services and supports
- Legal, financial, and advocacy issues

3. The MR/ID Targeted Case Management Plan for Supports (a component of the Individual Support Plan) outlines the case management support activities and instructions necessary to carry out the Individual Support Plan.
4. Documentation, in the form of case or progress notes, must indicate the dates and nature of MR/ID Targeted Case Management services rendered. Documentation of a face-to-face contact every 90 days (with a 10-day grace period permitted) must be in the record. This documentation must clearly state that the case manager was in the presence of the individual, assessed and documented his or her satisfaction with services, determined any unmet needs, evaluated the individual's status, and assisted with adjustments in the services and supports as

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appropriate. All entries must be signed (first initial and last name minimum) and dated with month, day, and year.

5. The Individual Support Plan must be reviewed every three months (at a minimum) and modified as appropriate. Person-centered review documentation must include any revisions to the Individual Support Plan, as well as significant events, progress toward reaching each desired outcome, and individual or family/caregiver, as appropriate, satisfaction with services received under the Individual Support Plan. This person-centered review must include reviewing the written person-centered review of each provider. A 30-day grace period to complete the person-centered review of the Individual Support Plan will be permitted. The day the person-centered review is actually completed does not affect the due date for the next review.
6. A new or revised Individual Support Plan must be developed within 365 days (366 in a leap year) of the effective date of the previous Individual Support Plan.
7. The case manager must send a letter to the individual notifying him or her of appeal rights if the individual is denied or found ineligible for MR/ID Targeted Case Management, MR/ID Waiver services or ICF/MR services, placed on the Statewide Waiting List, moved from the Urgent to Non-urgent status on the Statewide Waiting List or services are decreased or terminated.
8. All relevant communication with the individual, family/caregiver, providers, DBHDS, DMAS, DSS, Department of Rehabilitative Services (DRS), or other related parties must be documented in the record.

In addition to the above, for individuals receiving MR/ID Waiver services, the case manager is responsible for the following:

1. Coordination and maintenance of the individual's required medical, psychological, psychiatric, triennial Virginia SIS, annual risk assessment (Section IV of the Virginia SIS) and Personal Profile, as well as the annual ICF/MR Level of Functioning (LOF) Survey. The Virginia SIS will be phased in across all CSBs/BHAs with completion effective July 2012. Those for whom a SIS has not been completed will continue to have DBHDS-approved assessments completed, and this information will help to inform the development of their person-centered plans. After July 2012, all individuals will have a Virginia SIS completed every three years, or more frequently if the individual has undergone significant changes. A new psychological assessment must be obtained at such time as the existing assessment fails to reflect the individual's current psychological status, cognitive abilities, and adaptive functioning. Medical reassessment must be completed as needed for adults and for children less than age 21, in accordance with Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT).

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2. Consent to Exchange Information form (a form developed by the provider that serves this purpose) completed to initiate waiver services and updated as required thereafter.
3. The Documentation of Recipient Choice Between Institutional Care or Home and Community-Based Services (DMAS 459-C), indicating the individual's desire for MR/ID Waiver services over institutional services, required at the initiation of services and should be maintained in the individual's case management record.
4. Documentation that the choice of provider(s) has been offered on the "Virginia Home and Community-Based Waiver Choice of Providers" (DMAS-460) form when MR/ID Waiver services are initiated, when there is a request for a change in provider(s), when additional services are initiated, or when the individual is dissatisfied with the current provider.
5. Documentation in the case management record that the individual has been presented with all feasible alternatives of available agency- and consumer-directed services for which he or she is eligible under the MR/ID Waiver (this is done on the Recipient Choice form).
6. All providers' Plans for Supports, reviewed to assure that they fulfill all requirements for the particular service offered and address the identified outcomes and support needs before being approved and maintained by the case manager.
7. The Plan of Care Summary (DMAS-438) form, completed by the case manager, stating the desired outcomes for the individual, assessment results, the full range of services and supports the individual receives and other information needed for DBHDS to preauthorize services upon initial enrollment in the waiver. This form must be updated annually and sent to DBHDS for review. The individual and family member/caregiver, as appropriate, must also receive a copy annually.
8. A copy of the MR/ID Waiver Level of Care Eligibility Form (DMH 855E 1164) and the (DMAS-225), as needed. Each update of the DMAS-225 must be in the individual's file maintained by the case manager.
9. Making monthly onsite visits to individuals receiving any MR/ID Waiver services who reside in assisted living facilities (ALFs), or adult foster care (AFC) homes. Quarterly visits to individuals receiving MR/ID Waiver services who reside in DBHDS-licensed sponsored residential homes are recommended. The visits are to occur when the individual is present. For each individual, the following must be documented in the case notes:
 - Any issues related to the individual's health and safety;

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- Individual satisfaction with service delivery and place of residence; and
 - Staff interactions and types of services the individual is receiving while the case manager is present.
10. Responding to any health and safety concerns and reporting unresolved health and safety concerns to DBHDS. Concerns about ALFs must be reported to the DSS Division of Licensing, and concerns about AFCs must be reported to the local DSS where the home is located.
 11. Suspicions of an individual's abuse, neglect, or exploitation must be reported immediately to the local DSS Adult Protective Services (APS) or Child Protective Services (CPS) units, as appropriate, or to the DSS 24-hour toll-free APS or CPS Hotline, as appropriate, which is available on the DSS website. This information must be summarized in the quarterly review.

90-Day MR/ID Case Management Screening

An abbreviated, screening Plan for Supports may be written and utilized up to a maximum of 90 days for individuals who have not previously received MR/ID Targeted Case Management Services from any CSB/BHA and who do not have diagnostic information necessary to determine eligibility for MR/ID Community services. The standard 90-day screening case management Plan for Supports may be used (DMAS-451A/B). The 90-day screening case management documentation should:

1. Include referral information; and
2. Describe the reason for suspecting the presence of MR/ID (or cognitive and adaptive delays in a child less than six years of age) and indicate the probable need for ongoing active MR/ID case management services.

The 90-day screening case management Plan for Supports may begin no earlier than the date of the initial face-to-face contact with the individual and must end when the assessment information is obtained, but no later than 90 days after the start date. However, only three months of billing are permitted. An annual plan (Individual Support Plan) must be developed at the point in time during the 90-day screening period when it is determined that the individual meets eligibility requirements and is in need of active MR/ID case management. The Individual Support Plan year will then begin. Person-centered reviews are based upon the start date of the Individual Support Plan. The 90-day screening case management Plan for Supports does not require a person-centered review; however, a final case note must indicate the results of the 90-day service. Billing for 90-day MR/ID Targeted Case Management must end when it is determined that the individual is not eligible.

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Continued Review

The case manager is responsible for continuous monitoring of the appropriateness of the individual's Individual Support Plan. At a minimum, the case manager must review the Individual Support Plan every three months to determine whether desired outcomes are being achieved and whether any modifications to the Individual Support Plan are necessary.

If there is evidence of serious problems revealed upon MR/ID Targeted Case Management review, including, but not limited to:

- 1) The individual, family, or primary caregiver is dissatisfied with services;
- 2) Services are not delivered as described in the Individual Support Plan; or
- 3) The individual's health and safety are at risk, the case manager must take necessary actions and document in the individual's appropriate record(s).

Actions may include:

- 1) Requesting a written response from the provider;
- 2) Reporting the information to the appropriate licensing, certifying, or approving agency;
- 3) Reporting the information to DBHDS or DMAS;
- 4) Informing the individual of other providers of the service in question; and
- 5) As a last resort, after all other options have been exhausted, informing the individual that his or her eligibility for services may be in jeopardy should he or she choose to continue receiving services from a provider who cannot ensure health and safety or other requirements. Any time abuse, neglect, or exploitation of a waiver individual is suspected, the case manager, as a mandated reporter, is required to inform APS or CPS at DSS, as appropriate, and DBHDS.

In addition to a person-centered review, the case manager must make a face-to-face contact with the individual at least once every 90-day period. The purpose of the face-to-face contact is for the case manager to observe the individual's status, to verify that services are being provided as described in the Individual Support Plan, to assess the individual's satisfaction with services, and to identify any unmet needs or to determine changes needed to the Individual Support Plan. It is not required that the face-to-face contact occur at the same time as the person-centered review. It is recommended that the face-to-face contacts occur in a variety of service settings. At least one face-to-face

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contact per year will be conducted in the individual's home so that supports present in that setting may be assessed.

The individual's continued eligibility and need for MR/ID Targeted Case Management Services must be reviewed and documented by the case manager at least annually.

ASSISTIVE TECHNOLOGY

Service Description: Assistive Technology

Assistive technology is specialized medical equipment, supplies, devices, controls, and appliances, not available under the State Plan for Medical Assistance, which enable individuals to increase their abilities to perform activities of daily living (ADLs), or to perceive, control, or communicate within the environment in which they live. This service also includes items necessary for life support, ancillary services, and equipment necessary to the proper functioning of such items.

The equipment and activities include:

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

Criteria: Assistive Technology

This service is available to individuals who are receiving at least one other MR/ID Waiver service, in addition to MR/ID Targeted Case Management Services. Assistive technology may be provided in residential and non-residential settings. Items will not be approved for purposes of convenience of the caregiver or restraint of the individual.

To qualify for assistive technology, the individual must have a demonstrated need for equipment or modification for remedial or direct medical benefit primarily in the individual's home, vehicle, community activity setting, or day program to specifically serve to improve the individual's personal functioning.

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The cost of no more than a one-year maintenance contract at the time of the initial purchase of the assistive device may be covered.

Equipment or supplies already covered by the State Plan for Medical Assistance may not be purchased under the MR/ID Waiver. A copy of the DME and Supplies list is available from DMAS and should be used to ascertain whether an item is covered through the State Plan for Medical Assistance before requesting it through the MR/ID Waiver. All questionable items should be verified as covered items with the DMAS HELPLINE (800-552-8627 or 800-852-6080) prior to billing. DME information can also be found on the DMAS website by reviewing the DME Provider Manual at www.dmas.virginia.gov.

Equipment and supplies must be purchased from a DME provider, if available. Any equipment, supplies, or technology not available through a DME provider may be purchased by the CSB/BHA and billed to DMAS for reimbursement. Thirty percent mark-ups, customarily taken by DME providers, are not permitted in the MR/ID Waiver. Reimbursement shall not exceed usual and customary charge to the general public or manufacturer suggested retail price.

Children (under age 21) who are on the MR/ID Waiver and who require items not funded through DME or the MR/ID Waiver should be assisted in seeking funding for the items through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. See the Medicaid EPSDT Manual, Supplement B, at dmas.virginia.gov for more information.

Assistive technology items must be recommended and determined appropriate to meet the individual's needs by the following professionals, prior to approval by DBHDS:

Examples of Assistive Technology Devices (not a comprehensive list)	Professional Assessment Required
Organizational Devices	Occupational Therapist, Psychologist, or Psychiatrist
Computer/Software or Communication Device	Speech Language Pathologist or Occupational Therapist
Orthotics, such as braces	Physical Therapist or Physician
Writing Orthotics	Occupational Therapist or Speech Language Pathologist
Support Chairs	Physical Therapist or Occupational Therapist
Specialized Toilets	Occupational Therapist or Physical Therapist
Other Specialized Devices/Equipment	Physician, Speech Language Pathologist, Behavioral Consultant, Psychologist, Psychiatrist, Physical Therapist or Occupational Therapist (depending on the device or equipment)

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Specially Designed Utensils for Eating	Occupational Therapist or Speech Language Pathologist
Weighted Blankets/Vests	Physical Therapist, Occupational Therapist, Psychologist, or Behavioral Consultant

For items not included above, contact DBHDS for assistance with determining the appropriate professional required to make the recommendation and determination.

A rehabilitation engineer or certified rehabilitation specialist (CRS) may be utilized if, for example:

- The assistive technology will be initiated in combination with environmental modifications involving systems which are not designed to go together; or
- An existing device must be modified or a specialized device must be designed and fabricated.

Service Units and Service Limitations: Assistive Technology

The service unit for items and supplies is the total cost of the item and any supplies. The amount billed must not exceed the cost of the item actually provided to the individual. The service unit for rehabilitation engineering or a CRS is one hour under either therapeutic consultation or incorporated in the cost of the assistive technology.

The maximum Medicaid-funded expenditure for assistive technology is \$5,000 per Individual Support Plan year. Assistive technology shall be covered in the least expensive, most cost-effective manner. The cost for assistive technology cannot be carried over from one Individual Support Plan year to the next and must be preauthorized each Individual Support Plan year. Prior authorization must be obtained prior to technology being obtained. Assistive technology received without prior authorization will not be retroactively reimbursed.

Assistive technology shall not be approved for the purchase or down payment for the purchase of an automotive vehicle.

Documentation Requirements: Assistive Technology

The following documentation is required:

1. The assistive technology ISAR form, to be completed by the case manager, may serve as the Plan for Supports, provided it adequately documents the need for the service, the process to obtain this service (contacts with potential vendors or contractors, or both, of service, costs, etc.); and the time frame during which the service is to be provided. This includes a separate notation of evaluation or

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- design, or both, labor, and supplies or materials, or both. The Plan for Supports/ISAR must include documentation of the reason that a rehabilitation engineer/CRS is needed, if one is to be involved. A rehabilitation engineer/CRS may be involved if disability expertise is required that a general contractor will not have. The ISAR must be submitted to DBHDS for authorization to occur;
2. Written documentation regarding the process and results of ensuring that the item is not covered by the State Plan for Medical Assistance as DME and supplies and that it is not available from a DME provider when purchased elsewhere;
 3. Documentation of the recommendation for the item by a qualified professional;
 4. Documentation of the date services are rendered and the amount of service needed;
 5. Any other relevant information regarding the device or modification;
 6. Documentation in the case management record of notification by the individual or individual's representative of satisfactory completion or receipt of the service or item;
 7. Instructions regarding any warranty, repairs, complaints, or servicing that may be needed; and
 8. The following accompanying information, as applicable:
 - a. Drawings or pictures of the items being requested;
 - b. An itemized invoice or estimate;
 - c. The DME denial letter for assistive technology items otherwise covered by DME;
 - d. A description of the individual requiring the item or modification to include age and pertinent disability(ies) beyond MR/ID (e.g., items that might be appropriate for a child with autism that would not be appropriate for adults with solely an MR/ID diagnosis);
 - e. A clearly stated "reason for request" on the ISAR. Attach another sheet if more space is needed for the explanation; and
 - f. A professional assessment or recommendation for the assistive technology items according to the chart under the Assistive Technology Criteria section listed previously.

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CRISIS STABILIZATION/CRISIS SUPERVISION SERVICES

Service Description: Crisis Stabilization

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

The allowable activities include, but are not limited to:

1. Psychiatric, neuropsychiatry, and psychological assessment, and other assessments and stabilization techniques;
2. Medication management and monitoring;
3. Behavior assessment and positive behavior support;
4. Intensive care coordination with other agencies and providers to assist the planning and delivery of services and supports to enable the individual to remain in the community;
5. Training of family members and other caregivers and service providers in positive behavioral supports to maintain the individual in the community; and
6. Temporary crisis supervision (as a separate billable service) to ensure the safety of the individual and others.

Criteria: Crisis Stabilization

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

Medicaid reimbursement is available only for crisis stabilization allowable support activities that are authorized and provided according to an approved Plan for Supports, when a qualified provider is providing the services.

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

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1. Is experiencing marked reduction in psychiatric, adaptive, or behavioral functioning;
2. Is experiencing extreme increase in emotional distress;
3. Needs continuous intervention to maintain stability; or
4. Is causing harm to self or others.

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

1. Psychiatric hospitalization;
2. Emergency ICF/MR placement;
3. Immediate threat of loss of a community service due to a severe situational reaction (e.g., change in schedule/staff/medication); or
4. Causing harm to self or others.

Crisis stabilization services may only be authorized following a documented face-to-face assessment conducted by a qualified mental retardation professional (QMRP). If appropriate, the assessment will be conducted jointly with a licensed mental health professional or other appropriate professional(s), or both. The actual service units per episode will be based on the documented clinical needs of the individual being served. Extension of services, beyond the 15-day limit per authorization, may be authorized following a documented face-to-face reassessment conducted by a QMRP. If appropriate, the reassessment will be conducted jointly with a licensed mental health professional or other appropriate professional(s), or both.

The case manager may request a change in the amount of authorized hours for crisis stabilization services on the Plan for Supports at any time this is justified by individual need. Requests for authorization of additional periods of crisis stabilization must be accompanied by a summary of the previous 15-day period's activities and results, as well as the reason for continued need and planned strategies for the next 15-day period. No more than four 15-day authorizations will be approved per Individual Support Plan year.

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

1. The home of an individual who lives with family, friends, or other primary caregiver(s);

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2. The home of an individual who lives independently or semi-independently to augment any current services and support;
3. A community-based residential program to augment current services and supports;
4. A day program or setting to augment current services and supports;
5. A respite setting to augment current services and supports; or
6. Any combination of the settings in this list.

Crisis Supervision

Crisis supervision is an optional component of crisis stabilization in which one-to-one supervision of the individual in crisis is provided by agency staff in order to ensure the safety of the individual and others in the environment. Crisis supervision may be provided as a component of this service only if clinical or behavioral interventions allowed under this service are also provided during the authorized period.

Crisis supervision must be provided one-to-one and face-to-face with the individual. The same qualified provider of crisis stabilization clinical or behavioral services or a different provider may provide it.

Service Units and Service Limitations: Crisis Stabilization

MR/ID crisis stabilization clinical or behavioral services are billed in hourly service units and may be authorized for provision during a maximum of 15 days. Crisis supervision, if provided within the authorized period as a component of this service, is separately billed in hourly service units. A combination of these services can be provided no more than 60 days in a calendar year. No more than four 15-day authorizations will be approved per Individual Support Plan year.

While it is permissible for crisis supervision to be billed simultaneously with another MR/ID Waiver service (e.g., crisis supervision and residential support may be billed during the same hour), this requires the presence of one staff person to deliver crisis supervision and another staff person to implement the Plan for Supports for the other MR/ID Waiver service.

Documentation Requirements: Crisis Stabilization

The documentation must contain:

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1. The need for service or extension of service which must be clearly documented following a documented face-to-face assessment or reassessment, or both, by a QMRP.
2. A crisis stabilization Plan for Supports and ISAR, which must be developed (or revised, if requesting an extension) and submitted to the case manager for submission to DBHDS within 72 business hours of the requested start date for authorization. The standard crisis stabilization Plan for Supports may be used for this purpose. The Plan for Supports must contain, at a minimum:
 - a. The individual's strengths and required or desired supports;
 - b. The individual's desired outcomes;
 - c. Services to be rendered and the frequency of services to accomplish the above outcomes;
 - d. A timetable for the accomplishment of the individual's outcomes;
 - e. The estimated duration of the individual's needs for services; and
 - f. The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports.
3. The dates and times of crisis stabilization services, the amount and type of service provided, and specific information regarding the individual's response to the services and supports as agreed to in the Plan for Supports.
4. The qualifications of providers, which must be maintained for review by DBHDS or DMAS staff.

DAY SUPPORT & PREVOCATIONAL SERVICES

Service Description: Day Support & Prevocational Services

Day support services include skill building or supports for the acquisition, retention, or improvement of self-help, socialization, community integration and adaptive skills. Day support provides opportunities for peer interactions, community integration and enhancement of social networks. Supports may be provided to ensure an individual's health and safety.

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These services take place in non-residential settings, separate from the individual's home. Day support services should be coordinated with any physical, occupational, or speech/language therapies listed in the Individual Support Plan. Services are normally furnished one or more hours per day on a regularly scheduled basis for one or more days per week.

Prevocational services are defined as services aimed at preparing an individual for paid employment or volunteer work, but which are not job task-oriented. They are aimed at a more generalized result. Prevocational services are provided to individuals who are not expected to join the regular work force without supports or participate in a transitional sheltered workshop program within a year (excluding supported employment programs).

Allowable day support activities include, but are not limited to:

1. Developing problem-solving skills;
2. Support with personal care tasks;
3. Developing self, social, and environmental awareness skills;
4. Developing sensory, gross, and fine motor skills;
5. Skill development and support as needed in communication and personal care;
6. Skill development and support as needed in positive behavior, the use of community resources, community safety, positive peer interactions, and social skills;
7. Safety supports to ensure the individual's health and safety;
8. Staff coverage for transportation of the individual between service activity sites;
and
9. Opportunities to use developing skills in community settings.

Allowable prevocational activities include, but are not limited to:

1. Developing skills required for paid employment or volunteer work in community settings (e.g., attending to the task at hand, improved dexterity/movement, responding appropriately to supervision, maintaining consistent attendance, completion of assigned tasks, problem-solving and safety);
2. Support with personal care tasks;

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3. Safety supports to ensure the individual's health and safety; and
4. Staff coverage for transportation of the individual between service activity sites.

Criteria: Day Support & Prevocational Services

Medicaid reimbursement is available only for allowable support activities that are authorized and provided according to the Plan for Supports and the approved ISAR, when the individual is present and when a qualified provider is providing the services.

The Plan for Supports must provide an estimate of the amount of day support or prevocational services required by the individual. These services, either alone, together, or in combination with group supported employment services shall be limited to 780 units per Individual Support Plan year or its equivalent under the DMAS fee schedule.

In order to qualify for prevocational services, the individual shall have a demonstrated need for support in skills that are aimed towards preparation of paid employment.

Suspension of Day Support or Prevocational Services

Day support or prevocational services may only be suspended for an authorized individual if: (1) the individual is receiving behavioral or psychological consultation services and suspension is an agreed upon consequence stipulated in the individual's support plan, or (2) if the temporary removal of the individual from the day support/prevocational site is necessary to ensure the health and safety of the individual or others within that setting.

In the event that day support or prevocational services are suspended according to the above guidelines, the provider initiating the suspension must do the following:

1. Immediately notify the individual, in person, and the case manager and primary caregiver by telephone to inform each why the suspension has occurred and describe the terms of the suspension; and
2. Send a completed copy of the notification/right to appeal letter with the individual as he or she is leaving the program. The provider must also send a copy of this letter to the case manager and the primary caregiver.

The provider shall maintain documentation in the individual's record of the reason for the suspension, what notification was given and to whom (copies of the letters or documented telephone calls), and the terms of the suspension with any follow-up that was conducted.

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Safety Supports

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

As safety supports are typically provided in a 1:1 fashion, the provider must have sufficient staff to implement the activities for each individual for whom this is a component of the Plan for Supports. The ongoing need for and utilization of this component of day support or prevocational services should be included in providers' person-centered reviews.

60-Day Assessment

An assessment must be conducted to evaluate the individual's support needs, personal preferences, and desires in his or her day support/prevocational environment or community setting. A provider may use a 60-day assessment period for evaluating the individual's need for specific skill building, supports and safety supports. If a provider utilizes a 60-day assessment period prior to developing an annual Plan for Supports, a preliminary Plan for Supports, based on information in the Personal Profile, must be developed with the team and include the areas to be evaluated and a schedule of services to be provided. Prior to the last day of the assessment period, if services are to continue, the provider, with the involvement of the individual, must develop an annual Plan for Supports, forward it to the case manager for review, approval and reauthorization if required. The start date of the annual Plan for Supports must be no later than day 61 and the end date must correspond to the end date of the annual Individual Support Plan.

Types and Levels of Day Support & Prevocational Services

There are two types of day support and prevocational services: 1) center-based, which is provided primarily in a single location, or 2) non-center-based, which is provided primarily in community settings.

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Both types of day support and prevocational services may be provided at either: 1) intensive or 2) regular levels. The individual who requires intensive level services must receive a greater level of staff involvement than those at the regular level of need and service delivery. To be authorized at the intensive level, the individual must meet at least one of the following criteria:

- The individual must require physical assistance to meet the basic personal care needs (toileting, feeding, etc.);
- The individual must have extensive disability-related difficulties and requires additional, ongoing support to fully participate in programming and to accomplish individual service goals; or
- The individual must require extensive personal care or constant supports to reduce or eliminate behaviors that preclude full participation in the program. In this case, a written behavioral objective(s) in the Plan for Supports is required to address behaviors such as, but not limited to, withdrawal, self-injury, aggression, or self-stimulation.

Service Sites

Day support cannot be regularly or temporarily (e.g., due to inclement weather or illness of the individual) provided in an individual's home or other residential setting without written, prior approval from DBHDS. In this situation, the Plan for Supports must clearly indicate the specific time frame and designate specific day support activities provided in the individual's home or other residential setting. Some examples include:

- An individual's day support Plan for Supports includes allowable support activities at a residential site (e.g., learning or practicing skills related to grounds maintenance), provided these activities are not routinely performed by residents of that home;
- A new individual, or one with serious emotional/behavioral challenges, requires a temporary "phase-in period," expected duration to be clearly indicated on the Plan for Supports, to become accustomed to staff, a schedule and routine, riding in a van or car, etc. Only one unit of day support services provided at the individual's home may be billed; and
- Individuals return from community settings to a residence for lunch. The "lunch location" and amount of time allotted for lunch (including preparation and clean-up) must be specified on the day support Plan for Supports.

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Other Allowances

Non-center-based day support and prevocational services must be separate and distinguishable from either in-home residential support, or personal assistance services. There must be separate, supporting documentation for each service and each must be clearly differentiated in documentation and corresponding billing. If the same record is used to document both services, each must be clearly differentiated in documentation and corresponding billing.

Vocational services may not be included in an MR/ID Waiver prevocational services plan for Medicaid reimbursement. Vocational services are job task-oriented with service activities primarily directed at teaching specific job skills. Examples of non-allowable vocational services include focusing on increasing productivity or teaching an individual to operate a specific type of equipment to perform a job (e.g., a floor buffer for a janitorial position).

Providers for persons eligible for or receiving prevocational services funded under § 110 of the Rehabilitation Act of 1973 (through DRS) or §§ 602(16)(17) of the Individuals with Disabilities Education Act (IDEA) (through special education services) cannot receive payment for this service through MR/ID Waiver services. The case manager must assure that prevocational services are not available through these sources and document the finding in the individual's case management record. When services are provided through these sources, the Individual Support Plan will not include them as a requested MR/ID Waiver service.

Prevocational services are available only for persons whose compensation is less than 50 percent of minimum wage.

Service Units and Service Limitations: Day Support & Prevocational Services

Billing is in accordance with the DMAS fee schedule.

In instances where the provider is billing Medicaid for transportation (a non-MR/ID Waiver service) and staff is required to ride in addition to the driver to and from day support and prevocational activities, billing for this time cannot exceed 25 percent of the total time spent in the day support or prevocational activity for that day.

Periodic support hours may be included in the Plans for Supports of individuals participating in day support or prevocational services minimally (such as after school) during the school year who desire to participate for a full day during school closures and breaks. The Plan for Supports should detail activities that may be provided during these additional hours and detail the specific activities that will occur during those times when periodic support units will be used. Periodic support units must be submitted on the

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ISAR for authorization by DBHDS. The recommended form for documenting the need for periodic support hours in a day support or prevocational setting is “Determining Periodic Support Units.”

Documentation Requirements: Day Support & Prevocational Services

The provider documentation requirements are:

1. If available, a copy of the DBHDS-approved assessment (the Virginia SIS, or documentation of a request to obtain the SIS, or other DBHDS-approved assessment for those not yet scheduled for the SIS), in addition to other assessment information that was used by the provider, to identify the individual’s support needs and aid in developing the Plan for Supports. If a 60-day assessment period is utilized, the Personal Profile and Essential Information may serve as the assessment for that timeframe.
2. A Plan for Supports is developed by the team, which includes the individual, his or her family/caregiver as applicable, and others selected by the individual. The Plan for Supports is based on the results of the assessment and the individual’s desired outcomes. The Plan for Supports contains, at a minimum, the following elements:
 - a. The individual’s needs and preferences, strengths, desired outcomes, which include items that are important to him or her as well as his or her health and safety needs, as indicated by the assessment information, and required and/or desired supports.
 - b. A description of the areas in which the individual will build skills, require supports and receive safety supports, based on his or her assessed support needs and desired outcomes, while also ensuring that his or her basic needs of health, safety and quality of life are met. The Plan for Supports should clearly describe the expected outcome, the role of staff as well as natural supports, duration of activity and target completion date for each activity. The Plan for Supports will also include plans to provide supports to address challenging behavior and/or communication, if applicable.
 - c. A timetable of activities and the services/supports provided to accomplish the desired outcomes as described in the Plan for Supports/.
 - d. The estimated duration of the individual’s needs for services, including begin and end dates.
 - e. The provider staff responsible for the overall coordination and integration of the services specified in the plan.

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- f. It shall be signed and dated, at a minimum, by the person responsible for implementing the plan, the individual receiving services and/or the family member/caregiver, as applicable.
3. The appropriate ISAR must be completed and submitted to the case manager with the Plan for Supports for authorization by DBHDS. Following the annual planning meeting, at which time the Individual Support Plan for the next year is discussed, the provider must provide a copy of the revised Plan for Supports to the case manager even if a new ISAR is not required.
4. Documentation (including that for the 60-day assessment period) must confirm the individual's attendance and amount of time in services and provide specific information regarding the individual's response to various settings and supports as agreed to in the Plan for Supports. Documentation must confirm center or non-center based services and for high-intensity services, documentation must indicate the individual's ongoing needs, specific staff supports, and the reasons they are needed. The data or assessment information that is gathered may vary in type, intensity, methodology, and frequency according to the description in the Plan for Supports. Sixty-day assessment results should be available in at least a daily note or a weekly summary. Documentation typically takes the following forms:
 - a. A narrative which describes the major activities or events of the day including specific responses to the implementation of the Plan for Supports which are unusual or may signal a need to review the plan;
 - b. Daily documentation of supports provided to meet the needs of health, safety and quality of life. Supports should be documented each time they are provided. This can be accomplished through a checklist format, support log entry, or a progress note describing the assistance/support provided and the individual's response;
 - c. Documentation of the implementation of skill building activities, data collected and/or progress toward meeting the desired outcomes, or documentation of circumstances that prevented implementation of the activity; and
 - d. Documentation of safety supports, if applicable, must detail the specific intervention performed by staff that directly relates to the health and safety needs of the individual as reflected in the assessment and the Plan for Supports. Safety supports must be documented each time they are provided. If the provider chooses to utilize a checklist, it is imperative to also include narrative notes as needed to describe unusual circumstances, amount of time, and interventions performed during safety supports delivery.

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5. The Plan for Supports must be reviewed by the provider when the individual's needs change significantly and at least every three months. Person-centered review documentation must include any revisions to the Plan for Supports and also address significant events and individual's and family/caregiver's, as appropriate, satisfaction with services. The due date for the person-centered review is determined by the effective date of the Individual Support Plan and communicated to the provider by the case manager. A 10-day grace period is permitted, after which the provider should immediately forward the person-centered review to the case manager.
6. For the annual review and in cases where the Plan for Supports is modified, the team must work collaboratively to implement changes needed or desired by the individual. All significant changes to outcomes occurring at the annual or at any point during the Plan for Supports year must be documented and signed by the individual, family member/caregiver, as appropriate, all affected providers and the case manager.
7. The record must contain all correspondence and significant contacts made with the individual, family/caregiver, physicians and all other professionals, formal and informal service providers, case manager, DMAS, and DBHDS.
8. Documentation of delivery of periodic support units, if applicable, must include: a) the date periodic supports were provided; b) the reason the individual did not participate in normally scheduled activities; c) the services and supports provided to the individual; and d) the number of periodic support units provided.
9. Documentation must be maintained to verify that billing for day support or prevocational staff coverage during transportation (i.e., travel time between the individual's home and the initial or final program site) does not exceed 25 percent of total time spent in day support or prevocational services on that day.
10. For prevocational services, the lack of DRS or special education funding for the service must be documented in the individual's record, as applicable. If the individual is older than 22 years and, therefore, not eligible for special education funding, documentation is required only for lack of DRS funding. Acceptable documentation would include a copy of a letter from DRS or the local school system or a record of a telephone call (the name, date, and person contacted) documented in the case manager's case notes. Unless the individual's circumstances change, the original verification can be forwarded into the current record, through documentation on the annual Individual Support Plan or Essential Information.

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ENVIRONMENTAL MODIFICATIONS

Service Description: Environmental Modifications

Environmental modifications are physical adaptations to an individual's home or community residence, vehicle, and, in some instances, a workplace when the modification exceeds the reasonable accommodation requirements of the Americans with Disabilities Act (ADA), which provide direct medical or remedial benefit to the individual. Environmental modifications are typically permanently installed fixtures or modifications that change a site's structure. These adaptations are necessary to ensure the health and safety of the individual, or enable the individual to function with greater independence in the home or work site. Without these adaptations the individual would require institutionalization.

Modifications and activities are:

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

Criteria: Environmental Modifications

This service is available to individuals who are receiving at least one other MR/ID Waiver service, in addition to MR/ID Targeted Case Management Services. This service shall encompass those items not otherwise covered in the State Plan for Medical Assistance or through another program.

In order to qualify for these services, the individual must have a demonstrated need for equipment or modifications of a remedial or medical benefit offered in an individual's primary home, primary vehicle used by the individual, community activity setting or day program to specifically improve the individual's personal functioning.

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One modification may require the collaboration of up to three different providers:

1. A rehabilitation engineer or CRS may be used in cases where structural modifications of the primary residence are requested to evaluate the individual's needs and subsequently act as project manager, assuring functionality of the environmental modification through quality assurance inspections once the project is finished. Alternatively, the rehabilitation engineer may actually design and personally complete the modification. A physical therapist or occupational therapist, available through the State Plan for Medical Assistance or MR/ID Waiver therapeutic consultation, may also be utilized to evaluate the needs for environmental modifications, when appropriate. (NOTE: Under the State Plan for Medical Assistance, physical and occupational therapy services must be preauthorized by DMAS' contractor if more than five visits have been provided to the individual. Visits are individual-specific, not provider-specific.);
2. A building contractor may design and complete the structural modification; and
3. A vendor who supplies the necessary materials may be separately reimbursed, or supplies may be included in the bill of the building contractor or rehabilitation engineer.

A rehabilitation engineer/CRS may be required if (for example):

- The environmental modification involves combinations of systems which are not designed to go together.
- The structural modification requires a project manager to assure that the design and functionality meet ADA accessibility guidelines.
- Where structural modifications of the primary residence are requested to ensure the residence is structurally sound for the modifications.

Service Units and Service Limitations: Environmental Modifications

The service unit for Rehabilitation Engineering or a CRS is an hour, paid as either therapeutic consultation, or incorporated in the cost of the environmental modification. Building contractor services are individually contracted and shall include supplies, or the total cost of supplies may be billed separately. Delivery costs are not covered.

The maximum Medicaid-funded expenditure for environmental modifications is \$5,000 per Individual Support Plan year. Costs for environmental modifications cannot be carried over from one Individual Support Plan year to the next, and must be preauthorized each Individual Support Plan year. The prior authorization must be

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obtained prior to the modification being performed. Modifications performed without prior authorization will not be retroactively reimbursed.

Exclusions to this service are those modifications, adaptations or improvements to the home which are of general utility and are not intended to provide a direct medical or remedial benefit to the individual (i.e., carpeting, roof repair, central air conditioning, etc.). Further, environmental modifications may not be used to bring a substandard dwelling up to minimum habitation standards. Also excluded are modifications that are reasonable accommodation requirements of the ADA, Virginians with Disabilities Act, and the Rehabilitation Act. Modifications, adaptations or improvements, which add to the total square footage of the home, are not allowable expenditures except when necessary to complete an adaptation, as determined through preauthorization. All modifications must meet current building code.

Environmental modifications may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services. The purchase or lease of a vehicle and regularly scheduled upkeep and maintenance of the modifications are excluded. Payments may not be made to adapt vehicles that are owned or leased by paid providers of waiver services.

Documentation Requirements: Environmental Modifications

The following documentation is required:

1. The environmental modification ISAR form, to be completed by the case manager, may serve as the Plan for Supports, provided it adequately documents the need for the service, the process to obtain the service (contacts with potential contractors of service, costs, etc.), and the time frame during which the service is to be provided. This includes a separate notation of the evaluation, design, labor, and supplies or materials, or both. The Plan for Supports/ISAR must include documentation of the reason that a rehabilitation engineer is needed, if one is to be involved. The ISAR must be submitted to DBHDS for authorization to occur.
2. Documentation of the date services are rendered and the amount of services and supplies.
3. Any other relevant information regarding the environmental modification.
4. Documentation that the case manager, upon completion of each modification, met face-to-face with the individual and the family/caregiver, as appropriate, to ensure that the modification was completed satisfactorily and is able to be used by the individual.

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5. Instructions regarding any warranty, repairs, complaints, and servicing that may be needed.
6. The following accompanying information, as applicable:
 - a. Drawings or pictures of the items being requested or modifications to be made;
 - b. An itemized invoice or estimate;
 - c. A description of the individual requiring the item or modification to include age and pertinent disability(ies) beyond MR/ID (e.g., items that might be appropriate for a child with autism that would not be appropriate for adults with solely an ID/MR diagnosis); and
 - d. A clearly stated “reason for request” on the ISAR. Attach another sheet if more space is needed for the explanation.

PERSONAL ASSISTANCE, RESPITE, & COMPANION SERVICES (AGENCY-DIRECTED)

Service Description: Agency-Directed Personal Assistance, Respite, and Companion Services

Personal assistance services provide direct support with personal assistance, activities of daily living (ADLs), instrumental activities of daily living, community access, assistance with medication and other medical needs, and, with the exception of companion services, monitoring health status and physical condition. These services may be provided in home and community settings to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities.

Respite services are specifically designed to provide temporary, substitute care for that which is normally provided by the family or other unpaid, primary caregiver of an individual. Services are provided on a short-term basis because of the emergency absence or need for routine or periodic relief of the primary caregiver and are provided in an individual’s home, community residence or in other community sites.

Companion services provide non-medical care, socialization, or support to adults. This service is provided in an individual’s home or at various locations in the community.

Allowable support activities for these services are described in the table below.

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Allowable Support Activities	Personal Assistance	Respite	Companion
Support with ADLs such as: bathing or showering, toileting, routine personal hygiene skills, dressing, transferring, etc.	Yes	Yes	No
Support with monitoring health status and physical condition	Yes	Yes	No
Support with medication	Yes	Yes	Yes, self-administered
Support with medical needs	Yes	Yes	No
Support with preparation and eating of meals	Yes	Yes	Yes
Support with housekeeping activities, such as bed-making, dusting and vacuuming, laundry, grocery shopping, etc.	Yes *	Yes *	Yes *
Support to assure the safety of the individual	Yes	Yes	Yes
Support needed by the individual to participate in social, recreational, or community activities	Yes	Yes	Yes
Support with bowel/bladder programs, range of motion exercises, routine wound care that does not include sterile technique, and external catheter care when properly trained and supervised by an RN**	Yes	Yes	No
Accompanying the individual to appointments or meetings	Yes	Yes	Yes
Activities for the specific purpose of building the individual's skills	No	No	No
Services performed for the convenience of other members of the household (e.g., cleaning rooms used by all family members, cooking meals for the family, washing dishes, family laundering, etc.)	No	No	No
<i>* When specified in the individual's Plan for Supports and essential to the individual's health and welfare.</i>			
<i>** Must be ordered by a physician.</i>			

Criteria: Agency-Directed Personal Assistance, Respite, and Companion Services

For personal assistance, the individual shall require assistance with ADLs. In addition, the individual shall have a need for assistance with IADLs, community access, self-administration of medications, or monitoring of health status or physical condition. Personal assistance does not include either practical or professional nursing services or those practices regulated in Chapter 30 of Title 54.1 of the *Code of Virginia*. This service does not include skilled nursing services with the exception of skilled nursing tasks that may be delegated pursuant to the Nurse Practice Act §54.1-3000 *et seq.* of the *Code of Virginia*.

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The individual receiving personal assistance must have a back-up plan (e.g., a family member, neighbor, or friend willing and available to assist the individual) in case the personal assistant does not come to work as expected. The provider is not responsible for providing back-up support. This is the responsibility of the individual and family/caregiver. The back-up plan must be identified in the Plan for Supports. Individuals who do not have a back-up plan are not eligible for these services.

To qualify for companion services, the individual shall have a need for assistance with light housekeeping, community access, medication self-administration or support to assure safety. The provision of companion services does not entail hands-on nursing care and is provided in accordance with a therapeutic outcome in the Plan for Supports.

Respite services may only be offered to individuals who have an unpaid primary caregiver living in the home who requires temporary relief to avoid institutionalization of the individual.

Personal assistance, respite, and companion services are reimbursed based on allowable support activities that are authorized and provided according to an approved Plan for Supports when the individual is present and when a qualified provider is providing the services to the individual.

The registered nurse (RN) supervisor (for DMAS-enrolled personal care/respite providers) or designated residential services supervisor (for DBHDS-licensed agencies) must make an initial home visit prior to the start of services for purposes of assessment and service planning for all new individuals admitted to personal assistance, companion and respite services. The designated supervisor must also perform any subsequent reassessments or changes to the supporting documentation.

Supervisory Visits

The supervisor must make home visits as often as needed to ensure both quality and appropriateness of services. Based on continuing evaluations of the assistant's/companion's performance and individual's needs, the supervisor shall identify any gaps in the assistant's/companion's ability to function competently and shall provide training as indicated.

The minimum frequency of these visits for personal assistance is every 30-90 days, depending on the individual's needs. The minimum frequency of follow-up home visits to monitor companion services is quarterly.

When respite services are received on a routine basis, the minimum acceptable frequency of these supervisory visits shall be every 30-90 days based on the needs of the individual.

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When respite services are not received on a routine basis, but are episodic in nature, the supervisor is not required to conduct a supervisory visit every 30-90 days. Instead, the supervisor must conduct the initial home visit with the respite assistant immediately preceding the start of services and make a second home visit within the respite service period.

When respite services are routine in nature and offered in conjunction with personal assistance, the 30-90 day supervisory visit conducted for personal assistance may serve as the visit for respite. However, the supervisor must document supervision of respite services separately. For this purpose, the same individual record may be used with a separate section for respite services documentation.

60-Day Assessment

A DBHDS-approved assessment (the Virginia SIS or other DBHDS-approved assessment for those not yet scheduled for the SIS) must be used by the provider to identify the individual's support needs and aid in developing the Plan for Supports.

A personal assistance provider may use a 60-day assessment period while evaluating the individual's need for specific assistance and supports. If a 60-day assessment period is utilized, the Personal Profile and Essential Information may act as the assessment for that timeframe. A preliminary Plan for Supports must be developed with the team and include the areas to be evaluated and a schedule of services to be provided. Supports and objectives must be tailored to the individual's known needs. Prior to the last day of the assessment period, the provider, with the involvement of the individual, must develop an annual Plan for Supports and forward it to the case manager for review, approval and authorization. The start date of the annual Plan for Supports must be no later than day 61 and the end date must correspond to the end date of the annual Individual Support Plan.

The case manager may request a change in the amount of authorized hours for personal assistance, respite and companion services on the Plan for Supports at any time this is justified by individual need.

Restrictions with Other Services

Personal assistance services are available for individuals for whom skills skill-building is not the primary objective or is received in another service or setting. This service may not supplant an appropriate skill-building service when an individual has the capacity to gain increased independence.

Personal assistance services may not be authorized for an individual who receives MR/ID Waiver congregate residential support or who is living in a licensed ALF.

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Personal assistance services may not be provided during the same billable hours as other MR/ID Waiver services. Limited exceptions may be requested of DBHDS and will be reviewed on a case-by-case basis.

Respite services may not be provided by a DSS-approved AFC provider to an individual residing in that setting. Respite services shall not be provided to relieve group home, sponsored residential, or ALF staff where residential services are provided in shifts. Skill-building is not provided with respite services.

Companion services are only available to adults aged 18 and older. A companion shall not be permitted to provide the care associated with ventilators, continuous tube feedings, or suctioning of airways.

Companion services shall not be provided to individuals residing in AFC homes.

Attending to Personal Assistance Needs of Individuals Who Work or Attend Post-Secondary School or Both

The personal assistant may help prepare and accompany the individual to work/post-secondary school and assist him or her with ADLs while the individual is at work or school and upon return home. DBHDS will review the individual's needs when determining the services that will be provided to the individual in the workplace or school. The assistant may not perform any functions related to the individual completing his or her job or school functions or for supervision time during work or school.

DMAS will not provide reimbursement for personal assistance services that are required as a reasonable accommodation as a part of the ADA or the Rehabilitation Act of 1973. For example, if the individual's only need were for assistance during lunch, DMAS would not pay for the assistant for any time extending beyond lunch. For an individual whose speech is such that he or she cannot be understood without an interpreter (not translation of a foreign language), or the individual is physically unable to speak or make him or her understood even with a communication device, the assistant's services may be necessary all day. Documentation must clearly specify the need and what services are rendered.

Service Units and Service Limitations: Agency-Directed Personal Assistance, Respite, and Companion Services

The unit of service for personal assistance, respite, and companion services is one hour.

The amount of personal assistance services that can be authorized is determined by the individual's assessed needs and required supports.

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Respite services are limited to 720 hours per calendar year. Individuals who are receiving both consumer-directed and agency-directed respite services cannot exceed 720 hours per calendar year combined.

Companion services may not exceed eight hours per 24-hour day. This applies to agency or consumer-directed or a combination of the two.

No more than two unrelated individuals who live in the same home are permitted to share the authorized work hours of the assistant/companion. When two individuals who live in the same home request personal assistance, companion or respite services, the provider will assess the needs of all authorized individuals independently and determine the amount of time required for each individual for those tasks which must be provided independently, such as assistance with self-medication, bathing, dressing, ambulating, etc. The amount of time for tasks that could and should be provided for both individuals simultaneously (such as meal preparation, cleaning rooms, laundry, and shopping) must be combined and the hours split between the individuals.

For bowel and bladder programs, a written physician's order in the individual's file must specify the method and type of digital stimulation and frequency of administration. The supervisor must document that the assistant has received special training in bowel and bladder program management, has knowledge of the circumstances that require immediate reporting to a RN, and a RN has observed the assistant performing this function. The assistant's continuing understanding and ability to perform bowel and bladder programs must also be documented in the routine visit note.

Periodic support hours may be included in the personal assistance Plan for Supports and personal assistance ISAR when it is anticipated that additional hours will be needed due to semi-predictable events, such as illness of the individual, inclement weather, closing of a day program. The regular Plan for Supports activities may be provided during these additional hours; however, the Plan for Supports should confirm this or add a specific support activity that would apply to those times when periodic support hours would be used. Personal assistance periodic support hours must be individually determined and documented for each individual. The recommended form for documenting the need for periodic support hours is "Determining Periodic Support Hours."

Documentation Requirements: Agency-Directed Personal Assistance, Respite, and Companion Services

The provider documentation requirements are:

1. A copy of the DBHDS-approved assessment (the Virginia SIS or DBHDS-approved assessment other for those not yet scheduled for the SIS) that was used by the provider to aid in developing the Plan for Supports. If a 60-day assessment period is utilized for personal assistance, a copy of the Personal Profile and

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Essential Information used to help develop the Plan for Supports should be in the record.

2. A provider-designed Plan for Supports, the Provider Agency Plan of Care form (DMAS-97A/B), or the DBHDS-developed Plan for Supports is required. If the provider is a DBHDS-licensed residential services provider, a Plan for Supports consistent with DBHDS licensing regulations is required. This plan is developed by the team, which includes the individual, his or her family/caregiver, as applicable and others selected by the individual. It should be based on the results of the assessment and the individual's desired outcomes. Otherwise the Plan for Supports must contain, at a minimum, the following elements:
 - a. The individual's desired outcomes;
 - b. The support activities to be rendered and their frequency to accomplish the desired outcomes;
 - c. Estimated duration of the individual's needs for supports and the amount of hours needed; and
 - d. The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports.
3. The appropriate ISAR must be completed and submitted to the case manager with the Plan for Supports for authorization by DBHDS. Following the annual planning meeting at which the Individual Support Plan for the next year is discussed, the provider must provide a copy of the revised Plan for Supports to the case manager even if a new ISAR is not required.
4. Documentation indicating the dates and times (arrival and departure) of the assistants/companions and amount and type of service provided must be in the individual's record. The Aide Record form (DMAS-90) may be used for this purpose. Other formats for documentation of services should be reviewed by DBHDS staff prior to use. Documentation should also include comments or observations about the individual's status and his or her response to services.
5. All correspondence and contacts with the individual, family/caregiver, case manager, DMAS and DBHDS, and other relevant persons or providers involved in the individual's support must be included in the individual's record.
6. Documentation (including that for the 60-day assessment period for personal assistance) must confirm the individual's participation and amount of time in

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services and provide specific information regarding the individual's response to various settings and supports as agreed to in the Plan for Supports.

7. Providers of personal assistance services must document delivery of periodic support hours, as appropriate. Documentation must include: a) the date, b) the reason the individual did not participate in normally scheduled day activities, c) the assistance or general supervision provided to the individual, and d) the number of periodic support hours provided.
8. The designated supervisor's written summaries of supervision visits must note any contacts with the assistant/companion, individual and family/caregiver, as appropriate. Supervisory visit summaries must also include:
 - a. Whether personal assistance, respite or companion services continue to be appropriate;
 - b. Whether the plan is adequate to meet the need or changes are indicated in the plan;
 - c. Any suspected abuse, neglect, or exploitation and to whom it was reported;
 - d. For respite or personal assistance, any special tasks performed by the assistant (e.g., assistance with bowel/bladder programs, range of motion exercises, etc.), his or her qualifications to perform these tasks;
 - e. The individual's and family/caregiver's, as appropriate, satisfaction with the service;
 - f. Any hospitalization or change in medical condition or functioning status;
 - g. For personal assistance or respite, other services received and their amount; and
 - h. The presence or absence of the assistant/companion in the home during the supervisor's visit.
9. All correspondence and significant contacts made with the individual, family/caregiver, physicians and all other professionals, formal and informal service providers, case manager, DMAS and DBHDS.
10. Reassessments and any changes to supporting documentation made during the provision of services.

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11. For individuals not receiving services in a congregate residential setting, the assistant's/companion's record must contain:
 - a. The specific services delivered to the individual, dated the day of service delivery, and the individual's response;
 - b. The assistant/companion's arrival and departure time;
 - c. Comments or observations recorded weekly about the individual. Assistant/companion comments must include, at a minimum, observation of the individual's physical and emotional condition, daily activities, and the individual's response to services rendered;
 - d. The signature of the assistant/companion and the individual or family/caregiver, as appropriate, once each week to verify that personal assistance/respite/companion services have been rendered; and
 - e. Signature, time and dates shall not be placed in the record prior to the date that the services are delivered.

12. For individuals' receiving personal assistance and respite services in a congregate residential setting, the record must contain:
 - a. The specific services delivered to the individual, date the day services were provided, the number of hours as outlined in the Plan for Supports, the individual's responses and observations of the individual's physical and emotional condition; and
 - b. At a minimum, monthly verification by the residential supervisor of the services and hours and quarterly verification as outlined in the "Residential" section of this chapter.

13. The personal assistance and companion provider must review the Plan for Supports when the individual's needs change significantly and at least every three months. Person-centered reviews are not required for respite services, as this service is typically delivered on an intermittent basis. However, respite providers should regularly communicate with the individual's case manager about service provision and related issues. Person-centered review documentation must include any revisions to the Plan for Supports and also address significant events, and the individual's and family/caregiver's, as appropriate satisfaction with services. The due date for the person-centered review is determined by the effective date of the Plan for Supports and communicated to the provider by the case manager. A 10-day grace period is permitted, after which the provider should immediately forward the person-centered review to the case manager.

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14. For the annual review and in cases where the Plan for Supports is modified, the team must work collaboratively to implement changes needed or desired by the individual. All significant changes to outcomes occurring at the annual or at any point during the Plan for Supports year must be documented and signed by the individual, family member/caregiver, as appropriate, all affected providers, and the case manager.

Inability of an Agency to Provide Services and Substitution of Personal/Respite Assistants

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

1. If a provider cannot supply an assistant to render authorized services, the provider may obtain a substitute assistant from another provider, if the lapse in coverage is expected to be less than two weeks in duration.
 - a. The prior authorized provider is responsible for providing the supervision for the substitute assistant.
 - b. The prior authorized provider must obtain a copy of the assistant's daily records, signed by the individual or family caregiver on his behalf and the substitute assistant, from the personal assistance provider employing the substitute assistant. All documentation of services rendered by the substitute assistant must be in the individual's record. The documentation of the substitute assistant's qualifications must also be obtained and recorded in the personnel files of the preauthorized provider.
 - c. Only the prior authorized provider may bill DMAS for services rendered by the substitute assistant.
 - d. The two providers are responsible for negotiating the financial arrangements of paying the substitute assistant.
2. If no other provider can supply an assistant, the provider shall notify the individual or family and case manager so that they may find another available provider of the individual's choice. Prior authorization by DBHDS is required in those cases in which the services are transferred to another provider.

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PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

Service Description: PERS

Personal Emergency Response System (PERS) is an electronic device that enables certain individuals to secure help in an emergency. PERS electronically monitors individual safety in the home and provides access to emergency crisis intervention for medical or environmental emergencies through the provision of two-way voice communication system that dials a 24-hour response or monitoring center upon activation and via the individual's home telephone line. When appropriate, PERS may also include medication-monitoring devices.

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

Criteria: PERS

PERS services are limited to those individuals who live alone, or are alone for significant parts of the day, have no regular caregiver for extended periods of time, or when there is no one else in the home who is competent or continuously available to call for help in an emergency. While medication-monitoring services are also available to those receiving PERS services, medication-monitoring units must be physician ordered and are not a stand-alone service.

Service Units and Service Limitations: PERS

There is a one-time reimbursement for installation of the unit(s) per individual, which shall include installation, account activation, individual and caregiver instruction, and removal of equipment. If the individual moves, DMAS will reimburse for the installation of the unit at the new location. A unit of service for PERS monitoring is the one-month rental price set by DMAS. A unit of service for PERS nursing services for the purpose of refilling the medication-monitoring device is one-half hour

In cases where the provider must fill medication-monitoring units, the person filling the unit must be a RN or a licensed practical nurse (LPN). The units can be refilled every 14 days.

The PERS provider is prohibited from direct-marketing activities to individuals who receive Medicaid.

All PERS equipment must be approved by the Federal Communications Commission and meet the Underwriters' Laboratories, Inc. (UL) safety standards. The UL listing mark on the equipment will be accepted as evidence of the equipment's compliance with such

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standard. The PERS device must be automatically reset by the response center after each activation, ensuring that subsequent signals can be transmitted without requiring manual reset by the individual.

PERS services shall be capable of being activated by a remote wireless device and be connected to the individual's telephone line. The PERS console unit must provide hands-free voice-to-voice communication with the response center. The activating device shall be waterproof, automatically transmit to the response center, have an activator low battery alert signal prior to the battery losing power, and be able to be worn by the individual.

The provider must furnish all supplies necessary to ensure that the system is installed and maintained in working order. The PERS installation shall include local seize line circuitry, which guarantees the unit to have priority over the telephone connected to the console unit should the telephone be off the hook or in use when the unit is activated. The PERS provider must have back-up monitoring capacity in case the primary system cannot handle incoming emergency signals. The provider shall replace or repair the PERS device within 24 hours of the individual's notification of a malfunction of the console unit, activating devices, or medication-monitoring unit while the original equipment is being repaired.

A PERS provider shall furnish education, data, and ongoing assistance to individual and family member or guardian and the case manager to familiarize them with the service, allow for ongoing evaluation, and refinement of the program.

The emergency response activator must be activated either by breath, by touch, or by some other means, and must be usable by persons who have a visual or hearing impairment or an intellectual or physical disability. The emergency response communicator must be capable of operating without external power during a power failure at the individual's home for a minimum period of 24-hours and automatically transmit a low battery alert signal to the response center if the back-up battery is low. The emergency response console unit must also be able to self-disconnect and redial the back-up monitoring site without the individual resetting the system in the event it cannot get its signal accepted at the response center.

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

- A primary receiver and a back-up receiver, which must be independent and interchangeable;

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- A back-up information retrieval system;
- A clock printer, which must print out the time and date of the emergency signal, the PERS individual's identification code, and the emergency code that indicates whether the signal is active, passive, or a responder test;
- A back-up power supply;
- A separate telephone service;
- A toll-free number to be used by the PERS equipment in order to contact the primary or back-up response center; and
- A telephone line monitor, which must give visual and audible signals when the incoming telephone line is disconnected for more than 10 seconds.

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

Documentation Requirements: PERS

1. The appropriate ISAR form, to be completed by the case manager, may serve as the Plan for Supports, provided it adequately documents the need for the service, the type of device to be installed and description of ongoing services, including training regarding the use of the PERS. The ISAR must be submitted to DBHDS for authorization to occur. Annual reauthorization of this service is required.
2. A PERS provider must maintain a data record for each individual utilizing PERS at no additional cost to DMAS. The record shall document all of the following:
 - Delivery date and installation date of the PERS;
 - Individual/caregiver signature verifying receipt of PERS device;
 - The PERS device is operational as verified, minimally, by a monthly test;
 - Updated and current individual responder and contact information, as provided by the individual, the individual's care provider or case manager; and
 - A case log documenting individual system utilization and individual, family/caregiver, case manager or responder contacts/communications.

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

RESIDENTIAL SUPPORT SERVICES

Service Description: Residential Support

Residential support services consist of supports, provided in an individual's home, community, or in a licensed or approved residence. These supports should enable the individual to improve or maintain his or her health/medical status, live at home and use the community, improve abilities and acquire new home living or community skills, and demonstrate safe and appropriate behavior for his or her community. Medicaid reimbursement is available only for residential support allowable activities that are authorized and provided according to an approved Plan for Supports, when the individual is present and when a qualified provider is providing the services. Residential support does not include room and board or general supervision. MR/ID Waiver residential services will not routinely be provided for a continuous 24-hour period.

Residential support services may be provided as in-home supports or as congregate residential support. Those services authorized for reimbursement under the MR/ID Waiver may not duplicate those that are funded or provided by another source.

In-home supports are typically provided in a private residence and are supplemental to the primary care provided by the individual, caregiver(s) or the parent(s). In-home supports may not supplant this primary care. In-home supports are delivered on an individualized basis, typically for less than a continuous 24 hours, according to the Plan for Supports and are delivered primarily with a 1:1 staff-to-individual ratio, except when training protocols require parallel or interactive intervention. Individuals who reside in a DSS-licensed ALF or local DSS approved adult foster care home may also receive in-home residential support, if a DBHDS-licensed residential support provider provides the service.

Congregate residential supports are typically provided to an individual living: 1) in a group home, 2) in the home of the MR/ID Waiver services provider (such as AFC or sponsored residential), or 3) in an apartment or other home setting, with others receiving MR/ID Waiver residential support simultaneously. Congregate residential supports services cannot be authorized unless the individual requires supports which exceed the room, board, and general supervision included in the individual's residential arrangement.

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The allowable support activities include, but are not limited to:

1. Skill-building related to personal care activities (toileting, bathing, and grooming; dressing; eating; mobility; communication; household chores; food preparation; money management; shopping, etc.);
2. Skill-building related to the use of community resources (transportation, shopping, dining at restaurants, participating in social and recreational activities, etc.);
3. Supporting the individual in developing the ability to replace challenging behavior with positive, accepted behavior for home and community environments, for example (not all inclusive):
 - Developing a circle of friends;
 - Handling social encounters with others; or
 - Redirecting challenging behavior.
4. Monitoring health and physical conditions and providing supports with medication or other medical needs;
5. Providing supports with personal care, ADLs, and use of community resources, for example (not all-inclusive):
 - Completing personal care or mealtime tasks when physically unable to do so; or
 - Completing daily tasks, such as laundry, meal preparation, using the bank, or other tasks essential to the individual's health and welfare.
6. Supporting with transportation to and from training sites and community resources; and
7. Providing safety supports to ensure the individual's health and safety.

Criteria: Residential Support

60-Day Assessment

A provider may use a 60-day assessment period for evaluating the individual's need for specific supports. If a provider utilizes an assessment period prior to development and integration of an annual Plan for Supports, a preliminary Plan for Supports must be

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developed with the team, based on information in the Personal Profile, Essential Information, the Virginia SIS or other DBHDS-approved assessment, in addition to other assessment information available to the provider. The Plan for Supports must include the areas to be evaluated and a schedule of services to be provided. Prior to the last day of the assessment period, the provider, with the involvement of the individual, must develop an annual Plan for Supports, and forward it to the case manager for review, approval and reauthorization if required. The start date of the annual Plan for Supports must be no later than day 61 and the end date must correspond to the end date of the annual Individual Support Plan.

General Supervision

General supervision consists of the need for staff presence without evidence of the need for individualized supports. General supervision may help assure that appropriate action is taken in an emergency or if an unanticipated incident occurs. However, routine staff activities, such as the examples described below, are not evidence of the need for individualized supports and are therefore considered to be general supervision that may not be billed to Medicaid.

- Awake staff coverage during nighttime hours if an individual generally sleeps through the night and has no documented medical or behavioral problems that indicate a need for individualized supports to ensure health and safety;
- Routine bed checks;
- Oversight of leisure activities;
- Asleep staff at night on the premises for security or safety reasons, or both; or
- Staff “on-call” during the day while individuals are at a day program or job site.

Safety Supports

Ongoing or intermittent safety supports may be provided to an individual to ensure his or her health and safety. DBHDS preauthorization staff may request assessment information, recent documentation of safety supports-related staff intervention (in the form of charts and/or progress notes) and/or staffing patterns in order to corroborate the individual’s need for and the provider’s ability to actually deliver safety supports. As safety supports are typically provided in a 1:1 fashion, the provider must schedule sufficient staff for each individual requiring them when in a home in which there are multiple individuals requiring safety supports during the night.

For Medicaid to reimburse for safety supports, the assessment must clearly document the individual’s ongoing need for safety supports. The Plan for Supports must indicate what

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safety supports activities the staff will provide and when. The amount of time included in the Plan for Supports must be based on the individual's assessed needs. Documentation should detail the staff's activities that relate to the individual's health and safety needs and indicate occurrences of the provision of those needed supports.

In the case of awake overnight staff supports in a residential support plan, safety supports may be delivered throughout the entire night, but only if assessment information documents ongoing night needs. In some cases, an individual may need staff intervention on a regular but unpredictable basis. For example, an individual who has a documented history of an active uncontrolled seizure disorder may need overnight safety supports in the form of staff assistance due to the unpredictable nature of the disorder, as well as active intervention when seizures occur. In such a case, safety supports may be included throughout the night. When an individual requires predictable supports, such as scheduled assistance with toileting each night, only the amount of time typically involved in providing assistance may be included in the residential support plan.

The ongoing need for and utilization of this component of residential support should be included in providers' quarterly reviews. If, over a 60-day period, the hours of safety supports actually provided are consistently less than the schedule upon which the average daily amount is determined, the provider must revise the residential support Plan for Supports and submit a revised ISAR to the case manager.

Other Criteria

Residential support services may be offered on a periodic basis. This service shall not be used solely to provide routine or emergency respite for the family caregiver with whom the individual lives.

Service Units and Service Limitations: Residential Support

Congregate residential support may be reimbursed on an average daily amount of hours established per individual according to the following procedures. Multiplying the total hours scheduled per week by 4.3 and dividing the results by 30 determine the average daily amount. The average daily amount is used for billing purposes only. No more than 30 days per month (28/29 days in February) may be billed when billing is based on the average daily amount.

The congregate residential support provider shall routinely deliver the scheduled amount of service hours as described in the Plan for Supports. It is recognized that occasionally unavoidable circumstances occur or unplanned opportunities present themselves (e.g., the individual becomes ill, a family member wishes to take the individual home or to a

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community event, the individual chooses not to participate in regularly scheduled activities). In those situations, whenever any portion of the services authorized in the residential support Plan for Supports is provided during a day, the average daily amount of services may be billed. Documentation of activities must be maintained by the provider in a daily format and should demonstrate that the individual is regularly receiving services as scheduled and described in the Plan for Supports.

If services do not match the Plan for Supports or the hours actually provided are consistently less, over a 90-day period, than the schedule upon which the average daily amount is determined, the provider must revise the residential support Plan for Supports and submit an adjusted ISAR to reflect this reduction. For example, if the Plan for Supports includes eight hours of service every Saturday, but every other Saturday morning the individual leaves to visit his or her family for the day, this time must be removed from the schedule before computing the average daily amount. This revision must be reviewed and approved by the case manager and authorized by DBHDS.

In-home supports are reimbursed on an hourly basis for the time the residential support staff is working directly with the individual. Total billing cannot exceed the total hours provided and authorized on the ISAR. When unavoidable circumstances occur so that a provider is at the individual's home at the designated time but cannot deliver part of the services due to individual or family related situations (such as unanticipated lateness or illness of the individual or family emergency), billing will be allowed for the entire number of hours scheduled for that day. The provider must maintain documentation of the date, times, services that were provided and specific circumstances, which prevented provision of all of the scheduled services. If fewer hours than scheduled in the Plan for Supports are delivered on a regular basis over a 90-day period, the provider must revise the residential support Plan for Supports and submit an adjusted ISAR. This revision must be reviewed and approved by the case manager and authorized by DBHDS.

Periodic support hours may be included in the residential Plan for Supports when it is anticipated that additional hours will be needed due to semi-predictable events, such as illness of the individual, inclement weather, or the closing of a day program. The Plan for Supports should detail activities that may be provided during these additional hours.

Providers of residential support services must document delivery of periodic support hours. Documentation must include: a) the date periodic support hours were used; b) the reason the individual did not participate in normally scheduled day activities or needed additional residential support; c) the services and supports provided to the individual; and d) the number of periodic support hours provided. Periodic support hours must be submitted on the ISAR for authorization by DBHDS. The recommended form for

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documenting the need for periodic support hours is “Determining Periodic Support Hours.”

The average daily amount is not changed when periodic support hours are also used. Any periodic support hours provided in the month are added to the total number of average daily hours for billing purposes. (See Chapter V for additional billing instructions.)

Documentation Requirements: Residential Support

The requirements are:

1. If available, a copy of the DBHDS-approved assessment (the Virginia SIS, or documentation of a request to obtain the SIS, or other DBHDS-approved assessment for those not yet scheduled for the SIS), in addition to other assessment information that was used by the provider to aid in developing the Plan for Supports may serve as the assessment for that timeframe. If a 60-day assessment period is utilized, a copy of the Personal Profile and Essential Information used to help develop the Plan for Supports should be in the record.
2. A Plan for Supports is developed by the team, which includes the individual, his or her family/caregiver, as applicable, and others selected by the individual. The Plan for Supports is based on the results of the assessment and the individual’s desired outcomes. The Plan for Supports contains, at a minimum, the following elements:
 - a. The individual’s needs and preferences, strengths, desired outcomes, which include items that are important to him or her, as well as his or her health and safety needs, as indicated by the assessment information and required and/or desired supports.
 - b. A description of the areas in which the individual will build skills, require supports and receive safety supports, based on his or her assessed needs and desired outcomes, while also ensuring that his or her basic needs of health, safety and quality of life are met. The Plan for Supports should clearly describe the expected outcome, the role of staff as well as natural supports, and the duration or target completion date for each objective. The Plan for Supports will also include plans to provide supports regarding challenging behavior and/or communication, if applicable.
 - c. A timetable of activities and the services/supports provided to accomplish the desired outcomes as described in the Plan for Supports.
 - d. The estimated duration of the individual’s need for services, including begin and end dates.

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- e. The provider staff responsible for the overall coordination and integration of the services specified in the plan.
 - f. At a minimum, signature and date of the person responsible for implementing the plan, the individual receiving services, and/or the family member/caregiver, as applicable.
3. The appropriate ISAR must be completed and submitted to the case manager with the Plan for Supports for authorization by DBHDS. Following the annual planning meeting at which the plan for the next year is discussed, a copy of the Plan for Supports will be provided to the case manager even if a new ISAR is not required.
 4. Documentation (including that for the 60-day assessment period) must confirm the individual's attendance and amount of time in services and provide specific information regarding the individual's response to various settings and supports as agreed to in the Plan for Supports. The data or assessment information that is gathered may vary in type, intensity, methodology, and frequency according to the description in the Plan for Supports. Sixty-day assessment results should be available in at least a daily note or a weekly summary. Documentation typically takes the following forms:
 - a. A narrative which describes the major activities or events of the day including specific responses to the implementation of the Plan for Supports that are unusual or may signal a need to review the plan.
 - b. Daily documentation of the routine supports delivered to meet the needs of health, safety and quality of life. Supports should be documented each time they are provided. This can be accomplished through a checklist format or a progress note or support log entry describing the support provided and the individual's response.
 - c. Documentation of the implementation of skill-building activities, data collected and/or progress toward meeting the desired outcome, or documentation of circumstances that prevented implementation of the activity.
 - d. Documentation of safety supports, if applicable, must detail the specific support performed by staff that directly relates to the health and safety needs of the individual as reflected in the assessment and the Plan for Supports. Safety supports should be documented each time supports are provided. If the provider chooses to utilize a checklist, it is imperative to also include narrative notes (i.e., progress note or support log entry) as needed to describe unusual

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circumstances and interventions performed during the delivery of safety supports.

5. The record must contain all correspondence and significant contacts made with the individual, family/caregiver, physicians and all other professionals, formal and informal service providers, case manager, DMAS, and DBHDS.
6. The Plan for Supports must be reviewed by the provider when the individual's needs change significantly and at least every three months. Person-centered review documentation must include any revisions to the Plan for Supports and address significant events, and individual and family/caregiver, as appropriate, satisfaction with services. The due date for the person-centered review is determined by the effective date of the Individual Support Plan and communicated to the provider by the case manager. A 10-day grace period is permitted, after which the provider should immediately forward the person-centered review to the case manager.
7. For the annual review and in cases where the Plan for Supports is modified, the team must work collaboratively to implement changes needed or desired by the individual. All changes occurring at the annual or at any point during the Plan for Supports year must be documented and signed by the individual and family member/caregiver, as appropriate. Changes in the Plan for Supports should be shared with the case manager and other participating providers, as appropriate.

SKILLED NURSING SERVICES

Service Description: Skilled Nursing Services

Skilled nursing services are those medical services that are ordered by a medical physician and that are required to prevent institutionalization, that are not otherwise available under the State Plan for Medical Assistance.

Skilled nursing is defined as part-time or intermittent care that may be provided concurrently with other services due to the medical nature of the supports provided as long as those services involve a distinctly different, non-nursing activity. Services listed in the Individual Support Plan must be within the scope of the State's Nurse Practice Act and are provided by a RN or licensed practical nurse (LPN) under the direct supervision of a RN. An RN or LPN must have a current license issued by the Virginia Board of Nursing or a current multistate licensure privilege to practice nursing in the Commonwealth as an RN or LPN, as applicable.

Skilled nursing services are those that do not meet home health criteria and are available to individuals with serious medical conditions and complex health care needs,. These

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services must be necessary to enable an individual to live in a non-institutional setting in the community and cannot be provided by non-nursing personnel. Services are provided in an individual's home or community setting, or both, on a regularly scheduled or intermittent need basis.

The allowable support activities include, but are not limited to:

1. Monitoring of an individual's medical status;
2. Administering medications and other medical treatment; or
3. Training, consultation, nurse delegation or oversight of family members, staff, and other persons responsible for carrying out an individual's Individual Support Plan for the purpose of monitoring the individual's medical status and administering medications and other medically related procedures consistent with the Nurse Practice Act [18VAC90-20-10 *et seq.*, by statutory authority of Chapter 30 of Title 54.1, *Code of Virginia*].

Criteria: Skilled Nursing Services

If an individual has skilled nursing needs that are short-term and intermittent in nature, the case manager must assist the individual in accessing skilled nursing services under the State Plan for Medical Assistance. The State Plan home health coverage provides short-term intermittent skilled nursing services for five visits without preauthorization. It must be accessed through a licensed home health agency that has a provider agreement with DMAS for skilled nursing services. Additional visits after the initial five visits require preauthorization from DMAS' preauthorization contractor.

If an individual has skilled nursing needs that are expected to be long-term in nature, the case manager may assist the individual in accessing skilled nursing services under the MR/ID Waiver. The individual's Individual Support Plan must state that this service is necessary in order to prevent or delay institutionalization in an ICF/MR or acute care facility.

The case manager is responsible for inquiring whether an individual is receiving home health services under the State Plan at the time that waiver services are in place. If the individual receives home health services that are comparable to services available under the MR/ID Waiver, the case manager must notify the individual and the home health provider. If the individual desires nursing services under the MR/ID Waiver, the case manager must facilitate the transfer of the nursing services to the MR/ID Waiver or identify another available provider of nursing services.

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Skilled nursing services under the MR/ID Waiver are those procedures that cannot be provided by non-nursing personnel, consistent with the Commonwealth's Nurse Practice Act.

The case manager may request a change in the amount of authorized hours for skilled nursing services on the Plan for Supports at any time this is justified by individual need and ordered by the individual's physician.

Medicaid reimbursement is available only for skilled nursing services provided when the individual is present (with the exception of family or staff consultation and training regarding the individual's medical needs) and when a qualified provider is providing the services.

Service Units and Service Limitations: Skilled Nursing Services

The unit of service is one hour. Skilled nursing services must be explicitly detailed in the Plan for Supports and must be specifically ordered by a physician as medically necessary to prevent or delay institutionalization.

Periodic support hours may be included in the Plan for Supports, when it is anticipated that additional hours of skilled nursing over and above those regularly scheduled will be needed due to semi-predictable events, such as illness of the individual, inclement weather, closing of a day program. The regular Plan for Supports activities may be provided during these additional hours; however, the Plan for Supports should confirm this or add a specific objective that would apply to those times when periodic support hours would be used.

The number of additional periodic support hours per month to be authorized by DBHDS is determined by estimating the maximum possible number of hours in any month an individual may need additional skilled nursing support. The number of hours for nursing, including periodic supports, cannot exceed the physician-ordered frequency or duration.

Documentation Requirements: Skilled Nursing Services

Documentation for skilled nursing services must include:

1. A Plan for Supports that notes the specific nursing services to be provided and the estimated amount of time required performing these services. A provider-designed Plan for Supports or the CMS-485 form may be used for this purpose. The Plan for Supports must specify any training of family or staff, or both, to be provided, including the individual(s) of the training and content of the training (consistent with the Nurse Practice Act).

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2. Initial, and, in subsequent years, annual documentation of medical necessity by a physician. This may be accomplished by having a physician sign the CMS-485 form or provider-designed Plan for Supports. Alternatively, the physician may provide a statement, which specifies skilled nursing services required by the individual. The need for the skilled services of an RN or LPN must be specified as well as the number of nursing hours needed and the duration of skilled nursing services according to the physician's order. This statement must be retained with the CMS-485 form or Plan for Supports.
3. The appropriate ISAR form must be completed and submitted to the case manager with the Plan for Supports for authorization by DBHDS to occur. Services are authorized for the length of time ordered by the physician; however, at least annual reauthorization of this service is required.
4. Documentation of nursing license/qualifications of providers.
5. Documentation indicating the dates and times of nursing services and the amount and type of service or training provided. It is suggested that the format for documentation of hours of services be reviewed by DBHDS staff prior to use.
6. When periodic support hours are used, the provider of skilled nursing services must document delivery of those hours. Documentation must include: a) the date; b) the reason the individual did not participate in normally scheduled day activities; c) the skilled nursing tasks provided to the individual; and d) the number of periodic support hours provided.
7. Documentation that changes to the Plan for Supports were ordered by a physician prior to implementation.
8. All correspondence and significant contacts made with the individual, family/caregiver, physicians and all other professionals, formal and informal service providers, case manager, DMAS, and DBHDS.
9. A review of the completed Plan for Supports by the provider when the individual's needs change significantly and at least quarterly with modifications made as appropriate. Person-centered review documentation must include any revisions to the Plan for Supports significant events, and individual and family/caregiver, as appropriate, satisfaction with services. The due date for the person-centered review is determined by the effective date of the Individual Support Plan/ Plan for Supports and communicated to the provider by the case manager. A 10-day grace period is permitted, after which the provider should immediately forward the person-centered review to the case manager.

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10. Documentation that the Plan for Supports has been reviewed and approved by a physician within 30 days of initiation of services, when any changes are made to the Plan for Supports, and also annually.

11. For the annual review and in cases where the Plan for Supports is modified, the team must work collaboratively to implement changes needed or desired by the individual. All significant changes to outcomes occurring at the annual or at any point during the Plan for Supports year must be documented and signed by the individual, family member/caregiver, as appropriate, all participating providers and the case manager.

SUPPORTED EMPLOYMENT

Service Description: Supported Employment Services

Supported employment services are job skills training in settings in which persons without disabilities are typically employed. This service is for individuals with developmental disabilities for whom competitive employment at or above the minimum wage is unlikely without on-going supports and who because of their disability need ongoing post-employment support to perform in a work setting.

The allowable support activities include, but are not limited to:

1. Individualized assessment and development of employment related outcomes and activities;
2. Individualized job development that produces an appropriate job match for the individual and the employer;
3. On-the-job training in work and work-related skills required to perform the job;
4. Ongoing evaluation, supervision, and monitoring of the individual's performance on the job which are required because of the individual's disabilities but which do not include supervisory activities rendered as a normal part of the business setting;
5. Ongoing supports necessary to assure job retention;
6. Safety supports to ensure the individual's health and safety;
7. Development of related skills essential to obtaining and retaining employment, such as the effective use of community resources and break/lunch areas and transportation systems; and

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8. Staff coverage for transportation between the individual's place of residence and the workplace when other forms of transportation are unavailable or inaccessible.

Criteria: Supported Employment Services

Models of Supported Employment

Supported employment can be provided in one of two models. Individual supported employment is defined as intermittent support, usually provided one-on-one by a job coach to an individual in a supported employment position who, during most of the time on the job site, performs independently. Group supported employment is defined as continuous support provided by staff to eight or fewer individuals with disabilities in an enclave, work crew, entrepreneurial model or benchwork model. An entrepreneurial model of supported employment is a small business employing fewer than eight individuals with disabilities and usually involves interactions with the public and with co-workers without disabilities. An example of the benchwork model is a small, nonprofit electronics assembly business that employs individuals without disabilities to work alongside eight or fewer individuals with significantly complex needs and provides daily opportunities for community integration. The individual's assessment and Individual Support Plan must clearly reflect the individual's need for skill-building and supports to acquire or maintain paid employment.

Restrictions with Other Services

Providers for persons receiving supported employment services funded under §110 of the Rehabilitation Act of 1973 (through DRS) or §§ 602(16)(17) of IDEA (through special education services) cannot receive payment for this service through MR/ID Waiver services. The case manager must assure that supported employment services are not available through these sources and document the findings in the individual's case management record. When services are provided through these sources, the Individual Support Plan will not include them as a requested waiver service. Supported employment under the MR/ID Waiver is usually a long-term service and is generally provided following time-limited DRS supported employment.

Only job development tasks that specifically include the individual are allowable job search activities under MR/ID Waiver supported employment and only after determining this service is not available from DRS.

60-Day Assessment

A DBHDS-approved assessment (the Virginia SIS or other DBHDS-approved assessment for those not yet scheduled for the SIS) must be used by the provider, to identify the individual's support needs and aid in developing the Plan for Supports. A provider may use a 60-day assessment period for evaluating the individual's need for specific skill-

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building, supports, and safety supports. If a provider utilizes a 60-day assessment period prior to developing an annual Plan for Supports, a preliminary Plan for Supports, based on information in the Personal Profile and Essential Information, must be developed by the team and include the areas to be evaluated and a schedule of services to be provided. Prior to the last day of the assessment period, if services are to continue, the provider, with the involvement of the individual, must develop an annual Plan for Supports, forward it to the case manager for review, approval and reauthorization if required. The start date of the annual Plan for Supports must be no later than day 61 and the end date must correspond to the end date of the annual Individual Support Plan.

Other Criteria

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

Suspension of Supported Employment Services

Supported employment services may only be suspended for an authorized individual if: 1) the individual is receiving behavioral or psychological consultation services and suspension is an agreed upon consequence stipulated in the individual's support plan, or 2) if the temporary removal of the individual from the supported employment site is necessary to ensure the health and safety of the individual or others within that setting. In the event that supported employment services are suspended according to the above guidelines, the provider initiating the suspension must do the following:

1. Immediately notify the individual, in person, and the case manager and primary caregiver by telephone to inform each why the suspension has occurred and describe the terms of the suspension;
2. Send a completed copy of the notification/right to appeal letter with the individual as he or she is leaving the program. The provider must send a copy of this letter to the case manager and the primary caregiver; and
3. Maintain documentation in the individual's record of the reason for the suspension, what notification was given and to whom (copies of the letters or documented telephone calls must be documented), and the terms of the suspension with any follow-up that was conducted.

Safety Supports

Safety supports provide staff presence to ensure an individual's health and safety. For Medicaid to reimburse for safety supports, the assessment must clearly document the individual's ongoing need. DBHDS preauthorization staff may request assessment

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information, recent documentation of related staff intervention (in the form of charts and/or progress notes) and/or staffing patterns in order to corroborate the individual's need for and the provider's ability to actually deliver safety supports. The Plan for Supports must indicate what safety support activities the staff will perform and when. Documentation should reflect specialized activities on the part of the staff that relate to the individual's health and safety needs and indicated occurrences of the provision of those needed supports. The intervention provided may be continuous or intermittent, and the amount of time included in the Plan for Supports must be based on the individual's assessed needs.

As safety supports are typically provided in a 1:1 fashion, the provider must have sufficient staff to implement the activities for each individual for whom this is a component of the Plan for Supports. The ongoing need for and utilization of this component of supported employment services should be included in providers' person-centered reviews.

Service Units and Service Limitations: Supported Employment Services

Supported employment for individual job placement will be billed on an hourly basis, not to exceed 40 hours per week. It may include transportation of the individual to and from work sites (not to exceed 25 percent of the total time billed).

Group models of supported employment, alone or in combination with day support and/or prevocational services, is limited to 780 units per Individual Support Plan year or its equivalent under the DMAS fee schedule. Billing is in accordance with the DMAS fee schedule.

In instances where the provider is billing Medicaid for transportation (a non-MR/ID Waiver service) and staff is required to ride in addition to the driver to and from supported employment activities, billing for this time cannot exceed 25 percent of the total time spent in the supportive employment activity for that day. Transportation restrictions do not include transportation reflected in the Plan for Supports for purposes of developing independence in this area.

Documentation Requirements: Supported Employment Services

The documentation requirements are:

1. Lack of DRS or special education funding for the service must be documented in the individual's record, as applicable. If the individual is older than 22 years, and, therefore not eligible for special education funding, documentation is required only for the lack of DRS funding. Acceptable documentation would include a

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copy of a letter from DRS or the local school system, or a record of a telephone call (the name, date, and person contacted) documented in the case manager's case notes. Unless the individual's circumstances change, the original verification can be forwarded into the current record, through documentation on the annual Individual Support Plan or Social Assessment.

As DRS is not responsible for "extended services" (or "follow along") in supported employment for people with MR/ID, documentation that an individual remains in extended services in supported employment with no change in circumstances would be sufficient. A change in circumstances, which might warrant a new verification of the lack of DRS funding, would include the loss of a supported employment placement or the need for a job change or upgrade, for which DRS-funded job development and initial on-the-job training could be available.

2. If available, a copy of the DBHDS-approved assessment (the Virginia SIS, or documentation of a request to obtain the SIS, or other for those not yet scheduled for the SIS) in addition to other assessment information that was used by the provider to aid in developing the Plan for Supports.
3. A Plan for Supports is developed by the team, which includes the individual, his or her family/caregiver as applicable, and others selected by the individual. The Plan for Supports is based on the results of the assessment and the individual's desired outcomes. The Plan for Supports contains, at a minimum, the following elements:
 - a. The individual's needs and preferences, strengths, desired outcomes, as indicated by the assessment information, and required and/or desired supports;
 - b. A description of the areas in which the individual will build skills, require supports and receive safety supports, based on his/her assessed needs and desired outcomes, while also ensuring that his or her basic needs of health, safety and quality of life are met. The Plan for Supports should clearly describe the expected outcome, the role of staff as well as natural supports, duration of activity and target completion date for each activity. The Plan for Supports will also include plans to provide supports regarding challenging behavior and/or communication, if applicable;
 - c. A timetable of activities and the services or supports provided to accomplish the desired outcomes as described in the Plan for Supports;
 - d. The estimated duration of the individual's needs for services;

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- e. The provider staff responsible for the overall coordination and integration of the services specified in the plan; and
 - f. It shall be signed and dated, at a minimum, by the person responsible for implementing the plan, the individual receiving services and/or the family member/caregiver, as applicable.
4. The appropriate ISAR must be completed and submitted to the case manager with the Plan for Supports for authorization by DBHDS. Following the annual review, the provider must provide a copy of the revised Plan for Supports to the case manager.
 5. Documentation (including that for the 60-day assessment period) must confirm the individual's participation and amount of time in services and provide specific information regarding the individual's response to various settings and supports as agreed to in the Plan for Supports. The data or assessment information that is gathered may vary in type, intensity, methodology, and frequency according to the description in the Plan for Supports. 60-day assessment results should be available in at least a daily note or a weekly summary. Documentation typically takes the following forms:
 - a. A narrative which describes the major activities or events of the day including specific responses to the implementation of the Plan for Supports which are unusual or may signal a need to review the plan;
 - b. Daily documentation of supports provided to meet the needs of health, safety and quality of life. Supports should be documented each time they are provided. This can be accomplished through a checklist format, support log entry, or a progress note describing the support provided and the individual's response;
 - c. Documentation of the implementation of skill building activities, data collected and/or progress toward meeting the desired outcome, or documentation of circumstances that prevented implementation of the activity; and
 - d. Documentation of safety supports, if applicable, must detail the specific intervention performed by staff that directly relates to the health and safety needs of the individual as reflected in the assessment and the Plan for Supports. Safety supports should be documented each time they are provided. If the provider chooses to utilize a checklist, it is imperative to also include narrative notes as needed to describe unusual circumstances and interventions performed during safety supports delivery.

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DBHDS staff should review the format for documentation of supported employment services prior to use.

6. The Plan for Supports must be reviewed by the provider when the individual's needs change significantly and at least every three months. Person-centered review documentation must include any revisions to the Plan for Supports and also address significant events, and individual's and family/caregiver's, as appropriate, satisfaction with services. The due date for the person-centered review is determined by the effective date of the Individual Support Plan and communicated to the provider by the case manager. A 10-day grace period is permitted, after which the provider should immediately forward the person-centered review to the case manager.
7. For the annual review and in cases where the Plan for Supports is modified, the team must work collaboratively to implement changes needed or desired by the individual. All significant changes to outcomes occurring at the annual or at any point during the Plan for Supports year must be documented and signed by the individual, family member/caregiver, as appropriate, all participating providers and the case manager.
8. All correspondence and significant contacts made with the individual, family/caregiver, physicians and all other professionals, formal and informal service providers, case manager, DMAS, and DBHDS.
9. An attendance log or similar document must be maintained which indicates the date, type of services rendered, and number of hours and/or units provided.
10. Documentation must be maintained to verify that billing for supported employment staff coverage during transportation of the individual to and from work sites does not exceed 25 percent of total time billed for supported employment for that day.

THERAPEUTIC CONSULTATION

Service Description: Therapeutic Consultation

Therapeutic consultation provides expertise, training, and technical assistance in the individual's home or community, in any of the following specialty areas to assist family members, caregivers, and other service providers in supporting the individual to facilitate implementation of the individual's desired outcomes as identified in the Individual Support Plan.

The specialty areas are:

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1. Psychology;
2. Behavioral consultation;
3. Therapeutic recreation;
4. Speech and language pathology;
5. Occupational therapy;
6. Physical therapy; and
7. Rehabilitation engineering.

Simple accommodations or modifications that may better support the individual may be identified merely by observing the individual's environment, daily routines and personal interaction, thereby eliminating the need for further, more complex interventions. If therapeutic consultation services are needed, the allowable activities are:

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

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Criteria: Therapeutic Consultation

The individual's Plan for Supports must clearly reflect the individual's needs, as documented in the Personal Profile, Essential Information and Virginia SIS (or other DBHDS-approved assessment for those not yet scheduled for the SIS) for specialized consultation provided to service providers or other family/caregivers in order to implement the Individual Support Plan effectively. MR/ID Waiver therapeutic consultation services may not include direct therapy provided to waiver individuals, nor duplicate the activities of other services that are available to the individual through the State Plan for Medical Assistance.

Only behavioral consultation may be provided in the absence of other MR/ID Waiver services when it is determined to be necessary to prevent institutionalization.

A supervisor at the provider agency receiving the therapeutic consultation should participate in meetings with the consultant, so that, in the event of a staff turnover, the consultation and support plan can be shared with new staff, and additional therapeutic consultation is not requested.

Service Units and Service Limitations: Therapeutic Consultation

The unit of service is one hour. The services must be explicitly detailed in an Plan for Supports. Travel time, telephone communications, and written preparation are in-kind expenses and are not billable as separate items. Therapeutic consultation may not be billed solely for purposes of monitoring.

Therapeutic consultation services must be preauthorized each Individual Support Plan year.

Documentation Requirements: Therapeutic Consultation

The documentation requirements are:

1. Plan for Supports for therapeutic consultation. This must contain:
 - a. Identifying Information. The individual's name and Medicaid number; provider name and provider number; responsible person and telephone number; effective dates for the Plan for Supports; and person-centered review dates, if applicable;
 - b. Targeted support activities and time frames related to the individual's desired outcomes;

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- c. Specific consultation activities (frequency; where; when; and to whom); and
 - d. The expected products (minimally, a written consultation support plan).
2. Ongoing documentation in the form of one of the following:
 - a. Contact-by-contact notes that detail:
 - (1) The date, location, and time of each consultative service contact;
 - (2) The type of activities and hours of service provided; and
 - (3) The persons to whom activities were directed.
 - b. Monthly notes that detail:
 - (1) A summary of consultative activities for the month;
 - (2) The dates, locations, and times of service delivery;
 - (3) The Plan for Supports activities addressed;
 - (4) Specific details of the activities;
 - (5) Services delivered as planned or modified; and
 - (6) The effectiveness of the support instructions and individual's and family's/caregivers', as appropriate, satisfaction with the service.
 3. Person-centered reviews are required of the service provider if consultation extends three months or longer. Any changes to the Plan for Supports must be reviewed with the individual or family/caregiver, as appropriate. Person-centered review documentation must include:
 - a. Any revisions to the therapeutic consultation Plan for Supports;
 - b. Activities related to the therapeutic consultation supporting documentation;
 - c. Individual status and satisfaction with services; and
 - d. Consultation outcomes or effectiveness of the consultation support plan.
 4. The due date for the person-centered review is determined by the effective start date of the Individual Support Plan, which is communicated to the provider by the case manager. A 10-day grace period is permitted, after which the provider should immediately forward the person-centered review to the case manager. If consultation services extend less than three months, the

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provider must forward the Final Disposition Summary to the case manager for the case management person-centered review.

5. If the consultation service extends beyond one year, and in cases where the Plan for Supports is modified, the Plan for Supports must be reviewed with the individual, and family/caregiver, as appropriate, other providers and the case manager.
6. A written consultation support plan, detailing the interventions or support strategies for providers and family/caregivers to use to better support the individual in the service.
7. The Final Disposition Summary is forwarded to the case manager within 30 days following the end of the service and must include:
 - a. Strategies utilized;
 - b. Support activities;
 - c. Unresolved issues; and
 - d. Consultant recommendations.

CONSUMER-DIRECTED SERVICES (PERSONAL ASSISTANCE, RESPITE, AND COMPANION SERVICES)

Service Description: CD Services

There are three consumer-directed (CD) services: personal assistance (PA), respite, and companion. The individual is the employer-of-record (EOR) and is responsible for hiring, training, supervising, and firing. An individual unable to manage his or her own CD services or individuals less than 18 years of age must have a family member/caregiver serve as the EOR. Specific employer duties include checking of references of assistants/companions, determining that they meet basic qualifications, training assistants/companions, supervising their performance and submitting timesheets to the fiscal agent on a consistent and timely basis.

The individual and his or her family/caregiver, as appropriate, must have a back-up plan in the event the assistant/companion does not show up for work as expected or terminates employment without prior notice. This is the responsibility of the individual and family/caregiver, as appropriate, and must be identified in the Plan for Supports/Individual Support Plan. Individuals who do not have a back-up plan are not eligible for these services.

The case manager shall document in the Individual Support Plan the individual's choice for the CD model and whether or not there is need for a family/caregiver to serve as the employer on behalf of the individual.

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CD personal assistance services enable an individual to maintain the health status and skills necessary to live in the community or participate in community activities. They include assistance with ADLs and instrumental activities of daily living (IADLs), access to the community, medication and other medical needs, and monitoring health status and physical condition.

CD respite services are specifically designed to provide temporary, substitute care for that which is normally provided by the family or other unpaid, primary caregiver of an individual. These services are provided on a short-term basis because of the emergency absence or need for periodic or routine relief of the primary caregiver to avoid institutionalization of the individual. This service is provided in an individual's home or at various locations in the community.

CD companion services provide non-medical care, social opportunities, or support to adults. This service is provided in an individual's home or at various locations in the community.

Criteria: CD Services

Services facilitation means a service that assists the individual (and the individual's family or caregiver, as appropriate) in arranging for, directing, and managing services provided through the consumer-directed model. Individuals choosing CD models of service delivery may receive support from a services facilitator (SF). This waiver service is used in conjunction with CD personal assistance, respite, or companion services. The SF will be responsible for assessing the individual's particular needs for a requested CD service, assisting in the development of the Plan for Supports, providing training to the individual and family/caregiver, as appropriate, on his or her responsibilities as an employer and providing ongoing support of the CD models of services.

If a services facilitator is not selected by the individual, the individual or the family/caregiver serving as the employer shall perform all of the duties and requirements identified within this section for services facilitation.

The SF cannot be the individual, the individual's case manager, direct service provider, spouse or parent of the individual who is a minor child or a family/caregiver employing the assistant/companion.

If an individual enrolled in CD services has a lapse in SF services for more than 90 consecutive days, the case manager must notify DBHDS, and CD services will either be

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discontinued or the individual or family/caregiver serving as employer may perform all duties and requirements related to services facilitation. In this section, references to tasks to be completed by the SF shall also mean the person other than an SF who is designated to perform services facilitation duties if an SF is not chosen. Services facilitation services must be performed for CD services.

The following are responsibilities of the SF:

1. **Comprehensive Visit:** The selected SF must make an initial comprehensive home visit prior to the start of services to collaborate with the individual and their family/caregiver, as appropriate, to identify the needs, assist in the development of the Plan for Supports and provide employee management training (utilizing the *Consumer-Directed Employer Management Manual* found on the DMAS website at www.dmas.virginia.gov/ltc-home.htm). The initial comprehensive home visit is done only once upon the individual's entry into the CD model of service regardless of the number or type of CD services that an individual chooses to receive. If an individual changes SFs, the new SF must complete a reassessment visit in lieu of a comprehensive visit.

The SF will ensure that the individual understands his or her rights and responsibilities in the program and signs all of the participation agreements. The SF shall explain how to complete the hiring packet reviewed with the individual or family member/caregiver.

2. **Development of the CD Services Plan for Supports:** Information gathered during the comprehensive visit should be used to develop the Plan(s) for Supports for the appropriate CD service(s) for the individual. A copy of the Plan(s) for Supports, along with a summary of the information gathered from the comprehensive visit, and the required ISAR(s) will be maintained by the case manager.
3. **Employee Management Training:** The SF, using the *CD Employer Management Manual*, must provide the individual with training on his or her responsibilities as employer either during the initial comprehensive home visit or within seven days of receipt of the authorization for services. Documentation must be present indicating the training has been received prior to the individual's employing an assistant or companion.
4. **Routine On-Site Visits:** After the comprehensive visit, the SF must conduct two onsite, routine visits within 60 days of the initiation of CD services (once per month) to monitor and ensure both the quality and appropriateness of the services being provided. After the first two routine onsite visits, the SF and individual can decide how frequent the routine onsite visits will be. However, a face-to-face meeting with the individual must be conducted at least every six months after the second of the initial two routine on-site visits to ensure appropriateness of

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services. These meetings should include times when services are scheduled to be delivered. The SF must record all significant contacts in the individual's file.

During visits with the individual, the SF must observe, evaluate and consult with the individual or family member/caregiver or both and document the adequacy and appropriateness of the CD services with regards to the individual's current functioning and cognitive status, medical and social needs. If a health and safety issue is noted by the SF during a visit, he or she must report this to the case manager and immediately to CPS or APS, as appropriate.

5. **Availability:** The SF must be available during normal workday hours by telephone to the individual receiving CD services.
6. **Attendance at meetings:** If requested by the individual, the SF will attend Individual Support Plan meetings. If the SF has questions about the services that have been designated in the individual's Individual Support Plan, the SF, with the permission of the individual, may contact the case manager to discuss the issues.
7. **Update Visit ("Reassessment Visit"):** Annually, the SF must meet with the individual or family member/caregiver, as appropriate, to review the individual's current medical, functional, and social support status, as related to consumer-directed services, provide the information to the case manager, and work together with the case manager to develop the annual Plan for Supports. The first annual update visit may be less than 12 months from the comprehensive visit, as the CD services must comply with the case manager's stated person-centered review and annual Individual Support Plan review schedule. Additionally, the SF should conduct an update visit for individuals who are transferring from another SF or who request a change in their CD services.
8. **Monitoring:** The SF is responsible for taking appropriate action to assure continued appropriate and adequate service to the individual. Appropriate actions may include: counseling or training an assistant or companion about the services to be provided to the individual (at the individual's request); counseling or training an individual regarding his or her responsibilities as an employer; submitting any changes in the Plan for Supports to the case manager, following consultation with the individual or family member/caregiver as needed; and discussing with the individual the need for additional CD services. Any time the SF is unsure of the action that needs to be taken, he or she should contact the case manager.
9. **Management Training:** The SF, upon the request of the individual or family member/caregiver, provides training. This may be additional management training for the individual or family member/caregiver or special training for the assistant or companion at the request of the individual. SFs can provide up to four

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hours of management training on behalf of an individual or family member/caregiver within any six-month period. Each hour of management training is billed as one unit. Management training can also be used to reimburse the SF for the costs of tuberculosis skin tests required of companions and assistants. SFs providers can bill DMAS for the costs of these requirements on behalf of the individual by billing for these costs in management training units and maintaining documentation of these costs in the individual's file.

10. **Criminal Record Check:** All CD assistants and companions must complete a criminal record check as a condition of employment within 15 calendar days of employment. The prospective employee must complete his/her portion of the "Criminal History Record Name Search Request" form (in the Employment Packet sent by the fiscal agent), have his/her signature notarized and return the form to the fiscal agent. If the individual receiving CD services is a minor (under age 18), a VDSS CPS Registry check form will also need to be completed by the prospective employee. The fiscal agent will submit the form(s) to the appropriate authorities and inform the individual and family/caregiver, as appropriate, of the results. If the CD employee has been convicted of a "barrier" crime pursuant to §37.2-416 of the *Code of Virginia*, continued Medicaid reimbursement is prohibited following results of the background check. The employer must terminate the employee; however, time sheets must be submitted to the fiscal agent up to the date of separation. If the CD employee has been convicted of a crime other than a barrier crime and continued employment is desired, the SF will assist the employer in completing the disclaimer form, "Individual/Employer Acceptance of Responsibility for Employment" and mail it to the fiscal agent, filing a copy in the individual's record.
11. **Verification of Timesheets:** The SF shall review copies of the timesheets during routine on-site visits or more often as needed, to ensure that the hours of service provided are consistent with the Plan for Supports. If discrepancies are identified in the timesheets, the SF must contact the individual or family member/caregiver to resolve discrepancies and must notify the fiscal agent. If an assistant or companion consistently has discrepancies in his or her timesheets and training has been offered, the SF must meet with the individual or family member/caregiver and case manager to determine if the individual or family member/caregiver can manage the services.
12. **Assistant/Companion Records:** The SF shall maintain records of willing assistants/companions to share with individuals and family/caregivers as needed. The records shall contain the names of persons who have interest or experience providing personal assistance, companion, or respite services. The record shall be maintained as a supportive source to obtain the names of potential assistants or companions. DMAS does not require SFs to verify an assistant's or companion's qualifications prior to enrollment in the records.

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13. **Transfer of services:** If an individual is consistently unable to hire and retain a CD assistant/companion, the SF will make arrangements with the case manager to have the services transferred to an agency-directed services provider or to discuss with the individual and their family/caregiver, as appropriate, other service options.

To qualify for CD personal assistance services, the individual must demonstrate a need for assistance with ADLs, community access, medication, or other medical needs, or monitoring health status, or physical condition. This service shall not include either practical or professional nursing services with the exception of tasks that may be delegated pursuant to the Nurse Practice Act.

To qualify for CD companion services, the individual must demonstrate a need for assistance with IADLs, light housekeeping, community access and activities, medication self-administration, or support to assure safety, during times when no other supporting individuals are available. The provision of companion services must be provided in accordance with a therapeutic outcome in the Plan for Supports.

CD respite services may only be offered to individuals who have an unpaid primary caregiver living in the home who requires temporary relief to avoid institutionalization of the individual.

An individual may receive CD services along with any other MR/ID Waiver service for which he or she is eligible, unless specifically prohibited. However, individuals cannot simultaneously (same billable hours) receive multiple services.

Reimbursement is only made for personal assistance, respite, and/or companion allowable support activities that are authorized and provided according to an approved Plan for Supports. The following table lists allowable support activities for CD services:

Allowable CD Support Activities	Personal assistance	Respite	Companion
Support with ADLs such as: bathing or showering, toileting, routine personal hygiene skills, dressing, transferring, etc.	Yes	Yes	No
Support with monitoring health status and physical condition	Yes	Yes	No
Support with medication	Yes	Yes	Yes, self-administered
Support with medical needs	Yes	Yes	No
Support with preparation and eating of meals	Yes	Yes	Yes
Support with housekeeping activities, such as bed-making,	Yes*	Yes*	Yes*

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dusting and vacuuming, laundry, grocery shopping, etc.			
Support to assure the safety of the individual	Yes	Yes	Yes
Support needed by the individual to participate in social, recreational, or community activities	Yes	Yes	Yes
Assistance with bowel/bladder programs, range of motion exercises, routine wound care which does not include sterile technique, and external catheter care when properly trained and supervised by an RN**	Yes	Yes	No
Accompanying the individual to appointments or meetings	Yes	Yes	Yes
Activities for the specific purpose of building the individual's skills	No	No	No
Attending training requested by the individual or family member caregiver that relates to services described in the Plan for Supports	Yes	Yes	Yes
Services performed for the convenience of other members of the household (e.g., cleaning rooms used by all family members, cooking meals for the family, washing dishes, family laundering, etc.)	No	No	No
<i>*When specified in the individual's Plan for Supports and essential to the individual's health and safety.</i>			
<i>** Must be ordered by a physician.</i>			

All CD services require the services of a fiscal agent and must be preauthorized by DBHDS.

The fiscal agent will perform certain tasks as an agent for the individual who is receiving CD services. The fiscal agent will provide a packet of employment information and necessary forms to the individual or family member/caregiver. The forms must be completed and returned to the fiscal agent before the assistant or companion can be employed. The fiscal agent will handle the payroll services for the individual. For more information, refer to the *Consumer-Directed Waiver Services Employer Manual* on the DMAS website.

CD personal assistance or respite services may not be authorized for an individual who receives MR/ID Waiver congregate residential support or resides in a licensed ALF.

CD companion services are available to adults only, age 18 and older. The provision of CD companion services does not entail hands-on nursing services. Therefore, a companion shall not be permitted or reimbursed to provide the care associated with ventilators, continuous tube feedings, or suctioning of airways.

Any individual signing a time sheet or hiring packet that contains false information may be removed from CD services and only given the choice of agency-directed services.

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Attending to Personal Assistance Needs of Individuals Who Work or Attend Post-Secondary School or Both

The CD personal assistant may help prepare and accompany the individual to work/post-secondary school and assist him/her with ADLs while the individual is at work/school and upon return home. DBHDS will review the individual's needs when determining the services that will be provided to the individual in the workplace/school. The assistant may not perform any functions related to the individual completing his or her job/school functions or for supervision time during work or school.

DMAS will not provide reimbursement for CD personal assistance services that are required as a reasonable accommodation as a part of the ADA or the Rehabilitation Act of 1973. For example, if the individual's only need were for assistance during lunch, DMAS would not pay for the assistant for any time extending beyond lunch. For an individual whose speech is such that he or she cannot be understood without an interpreter (not translation of a foreign language), or the individual is physically unable to speak or make himself or herself understood even with a communication device, the assistant's services may be necessary all day.

Service Units and Service Limitations: CD Services

Consumer-directed services are paid an hourly rate. The fiscal agent on behalf of the individual pays assistants/companions.

Periodic support hours may be included in the Plan for Supports for CD personal assistance, when it is anticipated that additional hours over and above those regularly scheduled will be needed due to semi-predictable events, such as illness of the individual, inclement weather, closing of a day program. Periodic support hours must be individually determined and documented for each individual. The recommended form for documenting the need for periodic support hours is "Determining Periodic Support Hours."

CD respite services are limited to 720 hours per individual per calendar year. Those who receive CD-respite and agency-directed respite services cannot receive more than 720 hours combined.

The amount of CD companion services, either as a stand alone service or combined with agency-directed services that may be included in the Plan for Supports may not exceed eight hours per 24-hour day.

CD companion services shall not be provided by adult foster care providers or any other paid caregivers.

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The hours authorized are based on individual need. No more than two unrelated individuals who are receiving waiver services and live in the same home are permitted to share the authorized work hours of the assistant or companion. When two individuals who live in the same home request CD services, the SF will assess the needs of all authorized individuals independently and determine the amount of time required for each individual for those tasks which must be provided independently, such as bathing, dressing, ambulating, etc. The amount of time for tasks that could and should be provided for both individuals simultaneously (such as meal preparation, cleaning rooms, laundry, and shopping) must be combined and the hours split between the individuals.

Documentation Requirements: CD Services

Documentation must clearly indicate the dates and times of CD personal assistance, CD respite, and CD companion services delivery (e.g., time sheets).

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

1. The Plan for Supports that includes the types of assistance (allowable support activities) that will be provided during the Individual Support Plan period and the approximate hours.
2. The appropriate ISAR must be completed and submitted to the case manager with the Plan for Supports and comprehensive or reassessment visit summary for authorization by DBHDS. At the annual review, the SF must provide a copy of the revised Plan for Supports to the case manager even if a new ISAR is not required.
3. A Consent to Exchange Information Form authorizing release and communication of confidential information to related providers.
4. The SF's documentation of the routine on-site visits may be in the form of a progress note or a standardized form. The documentation must include the following:
 - a. Whether CD services are adequate to meet the individual's needs and whether changes need to be made;
 - b. Any suspected abuse, neglect or exploitation and to whom it was reported;
 - c. Hospitalization or change in medical condition, functioning, or cognitive status;

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- d. The individual's and family/caregiver's, as appropriate, satisfaction with services;
 - e. The presence or absence of the assistant or companion in the home during the visit;
 - f. Any change in who is employed as the assistant or companion. The SF must note this in the individual's file; and
 - g. A review of time sheets. The SF must review the assistant's/companion's time sheets, which are submitted to the fiscal agent by the individual or family member/caregiver, to determine whether the assistant/companion and individual or family member/caregiver, as appropriate, are recording the number of hours worked and that this does not exceed the number of hours approved.
5. In addition to the typical information that must be documented in the SF's routine visit summary, there are several areas (such as bowel/bladder programs, range of motion exercises, catheter and wound care) that, when they are part of an individual's Plan for Supports due to physician's orders, require monitoring by the individual's primary health care professional and special documentation by the SF of their ongoing completion and the personal or respite assistant's qualifications to perform these tasks.
6. All correspondence and significant contacts made with the individual, family/caregiver, physicians and all other professionals, formal and informal service providers, case manager, DMAS, and DBHDS.
 7. Updates to information about the individual made during the provision of services.
 8. All training provided to the assistant or companion on behalf of the individual or family member/caregiver.
 9. All management training provided to the individual or family member/caregiver, including the individual's or family member's/caregiver's responsibility for the accuracy of the assistant's or companion's timesheets.
 10. All documents signed by the individual or the family member/caregiver that acknowledge the responsibilities for receipt of the services.
 11. The SF must review the CD personal assistance and companion services Plans for Supports and this review must be submitted to the case manager, at least quarterly, with modifications made, as appropriate. For the annual review and in

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cases where the Plan for Supports is modified, the Plan for Supports must be reviewed with the individual or family/caregiver. Person-centered review documentation must include any revisions to the Plan for Supports and also address significant events, and individual's and family member's/caregiver's, as appropriate, satisfaction with services. The due date for the person-centered review is determined by the effective date of the Individual Support Plan and communicated to the SF by the case manager. A 10-day grace period is permitted, after which the SF should immediately forward the person-centered review to the case manager.

12. A person-centered review is not required for CD Respite services. However, the SF will review the utilization of and individual and family member/caregiver satisfaction with CD Respite either every six months or upon the use of 300 respite hours, whichever comes first. This review must be submitted to the case manager.

Although the services facilitation does not require preauthorization, all criteria and documentation requirements must be met for the entire time that CD services are provided in order to be reimbursed by Medicaid.

Transportation

Transportation services not paid by the Medicaid program are coordinated between the assistant/companion and the individual. This includes transportation necessary to implement the CD services Plan for Supports. It is permissible for the assistant/companion to transport the individual in the assistant/companion's vehicle. It is advisable, but not a requirement of the Medicaid program, that the individual or family member/caregiver determine if the assistant/companion has vehicle insurance that covers the following.

The insurance should insure the insured or the other person:

1. Against loss from any liability imposed by law for damages;
2. Against damages for care and loss of services, because of bodily injury to or death of any person;
3. Against injury to or destruction of property caused by accident and arising out of the ownership, use, or operation of such motor vehicle or motor vehicles within the Commonwealth, any other state in the United States, or Canada;

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4. Subject to a limit of exclusive of interest and costs, with respect to each motor vehicle of \$25,000 because of bodily injury to or death of one person in any one accident and, subject to the limit for one person, to a limit of \$50,000 because of bodily injury to or death of two or more persons in any one accident; and
5. Subject to a limit of \$20,000 because of injury to or destruction of property of others in any one accident.

TRANSPORTATION FOR INDIVIDUALS IN THE MR/ID WAIVER

The following transportation services will be paid for eligible individuals through the DMAS transportation broker.

1. Transportation from the individual's place of residence or other designated location, such as school, to an enrolled Medicaid service provider (including medical appointments) and back.
2. Transportation to a respite location of an enrolled MR/ID Waiver provider and back to the residence or other designated location.

If a staff member, in addition to a driver, is required to supervise the individual, the staff member's time may include in the total hours/units billed (up to the limits described for each service in this chapter).

The broker will not arrange or pay service providers for transportation for community integration activities (trips made during the day after the individual has arrived at the center-based provider or after arrival at the first non-center based activity and before the last non-center-based activity).

The transportation broker may request the ISAR or a Broker Authorization Form to verify weekly schedules (i.e., which days are authorized for MR/ID Waiver services).