

VERMONT

MEDICAID MANUAL

FOR

DEVELOPMENTAL DISABILITIES

SERVICES

November 2017



Department of Disabilities, Aging and Independent Living
Developmental Disabilities Services Division

280 State Drive
Waterbury, VT 05671-2030

TABLE OF CONTENTS

GENERAL INFORMATION

1.0	INTRODUCTION	1
1.1	FOCUS AND SCOPE OF MANUAL	1
1.2	REVISIONS TO MANUAL.....	2
1.3	BENEFICIARY INFORMATION.....	2
1.4	THIRD PARTY LIABILITY	2
1.5	ELIGIBLE PROVIDERS	3
1.6	INDIVIDUALIZED SUPPORT AGREEMENT (ISA)	4
1.7	PHYSICIAN PRESCRIPTION	4
1.8	WORKER QUALIFICATIONS.....	5
1.9	QUALIFIED DEVELOPMENTAL DISABILITIES PROFESSIONAL (QDDP) QUALIFICATIONS	6
1.10	HEALTH AND SAFETY.....	6

GENERAL DOCUMENTATION REQUIREMENTS

2.0	AGENCY RECORDS	7
2.1	HANDWRITTEN NOTES	7
2.2	PAPER RECORDS.....	7
2.3	ELECTRONIC RECORDS	7
2.4	REIMBURSABLE SERVICES.....	7

BILLING

3.0	SUBMITTING CLAIMS.....	8
3.1	PAYMENT RATES	8
3.2	HCBS BILLING EXEMPTIONS.....	8
3.3	FUNDING EXEMPTIONS.....	8
3.4	SERVICE UNITS NOT DEFINED BY CPT CODE	8
3.5	DOCUMENTATION OF SERVICE UNITS	9
3.6	REIMBURSABLE SERVICES IN THE SAME DAY	9
3.7	PROVIDER NUMBERS	9
3.8	BILLING TIMEFRAME	9
3.9	ALLOWABLE SERVICES BILLED	9

3.10 COMPARABLE BILLING TERMS	10
3.11 MEDICAID – TITLE XIX	10

HOME AND COMMUNITY BASED DEVELOPMENTAL DISABILITIES SERVICES

4.0 INTRODUCTION	11
4.1 SERVICE PLANNING AND COORDINATION	11
4.2 COMMUNITY SUPPORTS.....	12
4.3 EMPLOYMENT SUPPORTS	13
4.4 RESPITE.....	14
4.5 CLINICAL SERVICES	14
4.6 CRISIS SERVICES	15
4.7 HOUSING AND HOME SUPPORTS.....	16
4.8 SUPPORTIVE SERVICES	18
4.9 GENERAL BILLING GUIDELINES FOR ALL HCBS.....	19

OTHER COVERED SERVICES

5.0 CLINICAL AND REHABILITATIVE SERVICES	23
5.1 SPECIALIZED DAY SERVICES (FORMERLY NURSING FACILITY DAY REHABILITATION).....	31
5.2 TARGETED CASE MANAGEMENT	32
5.3 BRIDGE CARE COORDINATION	34
5.4 FAMILY MANAGED RESPITE	37

AUDITS

6.0 AUDIT/REVIEW	38
------------------------	----

APPEALS AND GRIEVANCES

7.0 SERVICE DISAGREEMENTS.....	39
--------------------------------	----

SANCTIONS

8.0 DHVA MEDICAID COVERAGE RULES.....	39
---------------------------------------	----

GENERAL INFORMATION

1.0 Introduction

Medicaid Services in Vermont are provided under Global Commitment for Health 1115 Medicaid Waiver an agreement with Centers for Medicare and Medicaid Services. It is a matching entitlement program that provides medical care to aged, blind, or disabled persons and low-income families with limited resources. It is financed by a combination of both federal and state dollars. The Vermont General Assembly appropriates the state funds.

1.1 Focus & Scope of the Manual

This manual pertains to developmental disabilities services offered through the Vermont Developmental Disabilities Services Division. It is intended to provide guidance to Designated Agencies and Specialized Services Agencies (SSA), Supportive Intermediary Service Organization (ISO) and Fiscal Employer/Agent (FE/A) regarding eligible service activity, procedures for billing and documentation requirements.

All federal regulations and procedures supersede the Developmental Disabilities Services Division procedures and must be followed unless expressly waived by the approved Special Terms and Conditions (STCs) of the Global Commitment to Health Section 1115 Demonstration.

This manual only outlines requirements for reimbursement of Title XIX developmental disabilities services. Approaches to quality of service and the principles and values underlying those services are contained in the *Developmental Disabilities Act and the Regulations Implementing the Developmental Disabilities Act, State System of Care Plan for Developmental Disabilities*, as well as other guidance such as the *Guidelines for Quality Services, Individual Support Agreement Guidelines, Behavior Support Guidelines, and the Health and Wellness Guidelines*. A complete list of guidance and policy can be found in the appendix.

Please note: Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) are governed by a separate set of regulations.

The contents do not represent an inclusive reference directory for all possible questions or clarifications that may be necessary to comply with Medicaid requirements. Providers are responsible for seeking clarification regarding services or activities and eligibility for reimbursement when services or billing is in question. As a general principle, when in doubt about provisions contained in this provider manual, first contact your DS Specialist for technical assistance.

The most current version of this Medicaid Manual is available on the DDS website <http://ddsd.vermont.gov/sites/ddsd/files/documents/dds-medicaid-procedures.pdf>.

All requests for variances should be submitted to the Developmental Disabilities Services Division. For more information, see variances and background check policies here: <http://ddsd.vermont.gov/resources/policies>.

1.2 Revisions to the Manual

This Medicaid Manual shall be updated regularly, and notification of any changes shall be sent to providers. All changes shall be recorded in Addendum.

Ongoing revisions to this manual shall be communicated as needed through update memorandums. As noted in the Master Grant Agreement between the State and providers, agencies shall have a reasonable period of time to implement any required changes, not to exceed 90 days, unless a shorter period is required by law.

Manual updates and billing update memorandums are available on the DDS D website at www.ddsd.vermont.gov.

1.3 Beneficiary Information

People seeking developmental disabilities services must qualify for Vermont Medicaid. Applications for Medicaid are processed by the Vermont Department of Health Access (DVHA). This is the link to access Medicaid applications. The webpage also has a contact phone number for Green Mountain Care at DVHA. <http://www.greenmountaincare.org/apply-online-health-insurance>

Many individuals will need to use the application labeled “**Choices for Care, Long-Term Care**” (202LTC). This Medicaid program also applies to people in need of Developmental Disabilities Home and Community Based Services (DD HCBS). Before submitting the application, write **DD HCBS – LONG TERM CARE** on the front page.

Intake coordinators at the Designated Agencies can help with questions about Medicaid and filling out Medicaid applications. Or you may call the Developmental Disabilities Services Division - 802 241-0304 – for assistance.

1.4 Third Party Liability

Medicaid is the payer of last resort. Medicaid payment shall be made only after all third party medical resources have been applied. A third party is defined as one having an obligation to meet all or any portion of the medical expense incurred by the recipient for the time such service was delivered. Such obligation is not discharged by virtue of being undiscovered or underdeveloped at the time a Medicaid claim is paid; it then becomes an issue of recovery.

For more information, see DVHA Medicaid Covered Services policy at <http://humanservices.vermont.gov/on-line-rules/dvha/medicaid-covered-services-7100-7700/view>.

Medicaid Exceptions:

There is also the opportunity to request an exception to current Medicaid coverage limitations if there are any non-covered services, items or medications for which a beneficiary wants to request coverage. The beneficiary can submit a Beneficiary Request Form and have at least one Medicaid-enrolled doctor submit a Medical Need Form. These specific forms, as well as a copy of the rules can be found here:

<http://www.greenmountaincare.org/sites/gmc/files/Exception%20Request%20form.docx%202.pdf>

1.5 Eligible Providers

In order for a provider to be eligible to provide Developmental Disabilities Services under the Medicaid State Plan, it must agree to comply with appropriate federal regulations and to perform and bill for services, maintain records, and adhere to the supervision, regulations, standards, procedures, and this manual's requirements of the Commissioner of the Department of Disabilities, Aging and Independent Living pursuant to 18 VSA, Chapter 207, Section 8907 through 8913.

Medicaid payment for covered services is limited to Commissioner-designated agencies (DA) Specialized Services Agencies (SSA), Supportive Intermediary Service Organization (SISO), and contracted Fiscal Employer/Agent (FE/A), that are established for the purpose of providing and supporting developmental disabilities services.

A provider is responsible for re-certifying with DXC Technologies Enrollment every year.

To receive funds administered by the Department to provide services or supports to people with developmental disabilities, providers shall be certified to enable the Department to ensure that an agency can meet certain standards of quality and practice. For Additional information, see Regulations Implementing the DD Act here:

<http://humanservices.vermont.gov/on-line-rules/health-care-administrative-rules-hcar/final-clean.ddact-regulations-10-01-2017.pdf>

An agency is considered enrolled for participation in the Developmental Disabilities Services program when it has signed a Master Grant Agreement for services with the Developmental Disabilities Services Division. The FE/A and the Supportive ISO are considered enrolled based on their agreements with the Department.

Status of non-designated providers:

- A. Any non-designated entity or organization that provides services or supports to individuals with funds administered by the Department must be a subcontractor of an agency (DA/SSA). This requirement does not apply to persons employed as

- independent direct support providers. The decision to subcontract with an entity or organization is at the discretion of the agency.
- B. The Department quality service reviews shall be responsible for including people served by subcontracted providers to verify that they meet quality review standards.
 - C. Any subcontract shall contain provision for operations in accordance with all applicable state and federal policies, rules, guidelines and regulations that are required of agencies.
 - D. Agencies shall require the following through all of its subcontracts: reserve the right to conduct inquiries or investigations without prior notification in response to incidents, events or conditions that come to its attention that raise concerns as to person-specific allegations regarding safety, quality of supports, the well-being of people who receive services or any criminal action. Further, the Department may conduct audits without advanced notice.
 - E. Having a subcontract does not terminate an agency receiving funds under Vermont's Medicaid program from its responsibility to ensure that all activities and standards under their Master Grant Agreement with AHS are carried out by their subcontractors.

1.6 Individual Support Agreement (ISA)

All services require a care plan. The agency is responsible for the development of an ISA, consistent with the Individual Support Agreement Guidelines or the Bridge Program Care Coordination Guidelines, which can be found on the division website here: http://ddsd.vermont.gov/sites/ddsd/files/documents/ISA_Guidelines.pdf

1.7 Physician Prescription

A physician signature is required for Clinic and Rehabilitation Services including Specialized Day Services, Individual Psychotherapy, Group Therapy, Medication Management, Emergency Care, and Transportation Services.

For reimbursement by Medicaid for one of the services listed above, it must be prescribed by a Vermont Medicaid enrolled physician. A physician prescription may consist of the physician's approval, documented by his/her signature, on the Individual Support Agreement (ISA) or documented verbal consultation (including a telephone consultation).

Physician prescription is NOT required for HCBS, Targeted Case Management (TCM) or Diagnostic and Evaluation (D&E).

- A. In instances where a verbal consultation constitutes a physician prescription of a plan, the following documentation must appear in the case record:

- 1) An entry which makes clear that the physician was consulted and that he/she approved the plan. This entry may be written by an agency staff member; and,
 - 2) A counter signature by the physician on the entry must be made within fourteen (14) calendar days of the verbal consultation.
- B. It is not reasonable to expect that all services be prescribed before the delivery of any new service; however, physician input must occur early in the program planning process. There must be a full ISA, signed by a physician when required as noted above, within thirty (30) calendar days of the first day of billable service. Under exceptional circumstances, for individuals new to services, a short-term ISA (e.g. 60-120 days) could be created with specific goals/outcomes for the funded areas the individual and team are ready to start supports and also have specific outcomes to gain the knowledge & understanding to address the other areas by the time the ISA expires (60 to 120 days).
- C. All ISA's that require a physician's prescription must be signed prior to their implementation (with the exception of new services as stated above).
- D. Clinic and Rehabilitation services require a physician signature at least once per ISA term or annually whichever is less, or when services change.
- E. Targeted Case Management, Bridge Care Coordination, Family-managed Respite and Home and Community-based Services, do not require a physician's prescription or signature on plan.

For more information on ISA signature requirements, see ISA Guidelines at http://ddsd.vermont.gov/sites/ddsd/files/documents/ISA_Guidelines.pdf

1.8 Worker Qualifications

- A. Anyone paid with Medicaid funds must, at a minimum, be at least eighteen years of age, possess a high school education or equivalent and must be monitored by appropriate agency staff or employers of record.
- B. Any additional qualifications or variations are included in each service definition. Qualifications, degrees and titles of all agency staff and contractors must be on file at the agency.
- C. Shared Living Providers must be at least twenty-one (21) years of age, possess a high school education or equivalent, and the residential service must be monitored by appropriate agency staff.
- D. Background checks consistent with the requirements outlined in the *DAIL Background Check Policy* are required for all workers paid with funds administered by DAIL. The current policy can be found here: http://dail.vermont.gov/sites/dail/files/documents/BackgroundCheckPolicy_v2_0.pdf

- E. Payment will not be made for services furnished by:
- Legal Guardian or spouse/domestic partner/civil union partner of legal guardian
 - Individual's parent, step-parent or adoptive parent
 - Domestic partner or civil union partner of the parent
 - Spouse, domestic partner or civil union partner of the individual
 - Payment will not be made to the spouse/domestic partner/civil union partner of a home provider for respite.
 - Payment *may* be made to the spouse/domestic partner/civil union partner of the home provider for Community Supports, In-Home residential supports at the discretion of the contracting DS agency.

1.9 Qualified Developmental Disabilities Professional (QDDP) Qualifications

To perform the roles and responsibilities of a Qualified Developmental Disabilities Professional (QDDP) in Vermont an individual must meet either the federal or state definition of a QDDP as well as additional qualifications outlined by the Developmental Disabilities Services Division. Qualified Developmental Disabilities Professionals may either work for designated or specialized service agencies or a Supportive ISO or act independently being hired or contracted by individuals with developmental disabilities and/or their family members.

For information on QDDP requirements and responsibilities, please consult the QDDP Policy here: http://ddsd.vermont.gov/sites/ddsd/files/documents/QDDP%20Protocol_11.9.16.pdf

- A. Exclusions for a QDDP:
A QDDP cannot be the individual, or the individual's spouse, domestic partner, civil union partner, parent, adoptive parent, step-parent, legal guardian or paid home provider.

1.10 Health and Safety

Individuals who receive Home and Community-Based services OR twenty-four (24) hour residential services OR whose services support and/or monitor medical care AND whose services are reimbursed through Medicaid funds must have documentation of an annual physical on file, except as specified in the *Health and Wellness Guidelines*.

All services must be delivered consistent with the *Health and Wellness Guidelines* found here: <http://ddsd.vermont.gov/sites/ddsd/files/documents/health-and-wellness-standards-and-guidelines.pdf>

GENERAL DOCUMENTATION REQUIREMENTS

2.0 Agency Records

All documents in the agency record must be dated with the month, day and year and include the signature (at least the first initial and last name) of the individual documenting the services.

2.1 Handwritten Notes

All handwritten notes must be legible.

2.2 Paper Records

The use of white-out in the paper clinical record is prohibited. The use of cross-outs to alter information that has been entered into the clinical record is the only acceptable method of changing information. Information to be altered should have a single line through the information and must be accompanied by the initials of the staff making the alterations, date and time.

2.3 Electronic Records

All electronic documentation should be locked when complete. If a change is needed after an electronic note has been locked, the agency should assure compliance with its policies regarding this and be able to identify change, time of change, and signature of person making the change.

2.4 Reimbursable Services

For a service to be reimbursable (except for some diagnosis and evaluation (D&E) services), there must be on file:

- A. An evaluation by a qualified evaluator documenting a Developmental Disability as specified in the Regulations Implementing the DD Act; evaluation should include ICD (current version) code.
- B. An ISA (or Bridge CCP) complete with all required components and signatures as indicated in the ISA Guidelines, within 30 days of the first billable service.

BILLING

3.0 Submitting Claims

Providers shall submit claims based upon the approved rate on file or the actual cost of service, whichever is less. In the case of services for which the rate on file is noted as “pay as billed”, the amount billed shall be amount authorized by the Division, or the actual cost of services, whichever is less. Medicaid payment for developmental disability services will be made at the approved rate on file or the amount billed whichever is less. The provider must accept, as payment in full, the amounts received from Medicaid.

3.1 Payment Rates

The Department of Disabilities, Aging and Independent Living retains sole authority to set payment rates. Clinic, Targeted Case Management, Rehabilitation Service Rates, etc. are set and published annually by the Department of Disabilities, Aging and Independent Living.

3.2 HCBS Billing Exemptions

A provider may not bill HCBS (H2022) for an individual on the same day as Clinic and Rehabilitation Services (90791,90792, H2011, H2019, H2032, 99213,99214), Bridge Program (T2022), Targeted Case Management (T1017), PASRR Specialized Services (T2021) or ICF/DD services.

3.3 Funding Exemptions

Medicaid developmental disabilities funding does not cover room and board, vacation expenses, clothing, or personal effects.

3.4 Service Units Not Defined by CPT Code

For service units of time not defined by CPT code, the following description of units of time must be used. (e.g., targeted case management, specialized day services, etc.).

1 minute to 14 minutes	= 1 unit (not billable)
15 minutes to 30 minutes	= 2 units
31 minutes to 45 minutes	= 3 units
46 minutes to 60 minutes	= 4 units
61 minutes to 75 minutes	= 5 units
76 minutes to 90 minutes	= 6 units
91 minutes to 105 minutes	= 7 units
106 minutes to 120 minutes	= 8 units (etc.)

3.5 Documentation of Service Units

Each unit of service billed must be documented in the individual's case record. There are times when documentation may be in a separate file or in another provider's files, (i.e., psychotherapy notes kept in provider's office for confidentiality purposes), but must be available to Medicaid auditors and must be referred to in the individual's record.

3.6 Reimbursable Services In the Same Day

Clinic, Rehabilitation, Transportation and Targeted Case Management services may be reimbursed during the same day within the parameters set forth in this document.

3.7 Provider Numbers

Providers must use the appropriate provider numbers for each service billed.

3.8 Billing Timeframe

Billing must occur within six months from the date of service.

3.9 Allowable Services Billed

Billing is allowed for services provided by staff and contractors of the agency. Billing is allowed for services provided by students/interns, provided that the student/intern is supervised by a qualified staff of the designated agency/entity, is subject to all designated agency/entity policies and procedures, and that the designated agency/entity assumes responsibility for the work performed. Behavioral health services provided by students/interns must adhere to the Supervised Billing requirements. For more information, refer to *Section 8.4 – Supervised Billing for Behavioral Health Services* in the Vermont Medicaid Provider Manual, located at <https://www.vtmedicaid.com/downloads/manuals/New%20Consolidated%20Manual/VTMedicaidProviderManual.pdf>

Billing for work performed by persons other than agency staff is allowed providing the individual meets the qualifications necessary for that particular service and the provision of such service is monitored by an agency staff.

Billing for services provided by contracted individuals is also allowed providing the designated agency or SSA is responsible for billing and monitoring of the contracted individual (except for contracted physicians). Contracts must be available for review during Title XIX audits.

A) Contracts require provisions showing:

- With whom the contract is made, stating specific individuals and their

- qualifications;
- What specific Title XIX services the contracted person(s) will provide;
- Person on DA or SSA staff responsible to monitor the services provided by the contracted individual(s).
- All contracting and subcontracting must be consistent with the requirements outlined in the DD Regulations and DA and SSA Master Grants Agreements.

3.10 Comparable Billing Terms

Per Federal Law, all clients must be treated similarly in terms of billing for all services. For example, if a non-Medicaid client is being transported with other clients whose services are being reimbursed by Medicaid, the non-Medicaid client must also be billed. (This does not preclude the use of sliding fee scales.)

3.11 Medicaid – Title XIX

The Federal Government (Medicaid – Title XIX) will not reimburse for services to a Medicaid eligible individual if a non-Medicaid individual receives the same service free of charge. This does not preclude the use of sliding fee scales.

HOME AND COMMUNITY-BASED DEVELOPMENTAL DISABILITIES SERVICES

4.0 Introduction

Individual HCBS budgets may comprise any or all of the services and supports defined in this document and are included in an all-inclusive daily rate (H2022 1 unit = 1 day) that combines all applicable services and supports provided to the individual.

The daily rate may include:

<u>Code</u>	<u>Service</u>
A01	Service Coordination
B01	Community Supports
C01 - C04	Employment Supports
D01 - D02	Respite
E01 - E07	Clinical Services
G01 - G02	Crisis Services
H01 - H06	Home Supports
N01 - N02	Supportive Services

This section includes descriptions of service definitions, worker qualifications, billing guidance and documentation for specific service.

See section 1.9 for general staff qualifications

See section 3.0 for general billing procedures

All HCBS services and supports are provided in accordance with the person’s Individual Support Agreement (ISA) and applicable State and Federal requirements, including health and safety, training and emergency procedures. Services and supports are funded in accordance with the guidance outlined in the Vermont State System of Care Plan for Developmental Disabilities Services.

4.1 A01 Service Planning and Coordination

Service Coordination: assistance to recipients in planning, developing, choosing, gaining access to, coordinating and monitoring the provision of needed services and supports for a specific individual. Service Coordination responsibilities include, but are not limited to, developing, implementing and monitoring the ISA, coordinating medical and clinical services; establishing and maintaining a case record; reviewing and signing off on critical incident reports; and providing general oversight of services and supports. The provision of Service Coordination will be consistent with the HCBS requirements for conflict-free case management.

Worker Qualifications:

Must meet requirements for all staff as described in minimum qualifications section and some responsibilities of the service coordinator must be done by a Qualified Developmental Disabilities Professional (QDDP) who must either work for the provider agency or must have been endorsed by the State of Vermont.

Billing Requirements:

- The maximum rate for service coordination managed through a DA/SSA shall be published in the DAIL Medicaid Claim Codes and Reimbursement Rates.
- If actual costs are less than the published rate, the actual cost must be billed.
- The maximum cost for service coordination for individuals who self/family-manage shall also be published by DAIL.
- When an individual transfer from a DA/SSA to self/family-managed, the difference between the DA/SSA's service coordination rate and the rate for individuals who self/family-manage is transferred to the Supportive ISO to pay their administrative costs.
- These services are billed under the inclusive daily rate of H2022.

Required Documentation:

Service Coordinator notes (home visit forms/notes) and QDDP summaries.

4.2 Community Supports

B01 Individual Support provided to assist individuals to develop skills and social connections. The supports may include teaching and/or assistance in daily living, support to participate in community activities, and building and sustaining healthy personal, family and community relationships. Community Supports may involve individual supports or group supports (see below...two or more people). Supports must be provided in accordance with the desires of the individual and their Individual Support Agreement and take place within settings that afford opportunities for choice and inclusion that are consistent with federal home and community-based services rules.

B02 Group Support Any community supports meeting the above definition, in which the service is provided at less than a 1:1 ratio.

Worker Qualifications:

Must meet requirements for all staff as described in minimum qualifications section 1.9 of this manual.

Billing Guidance:

- Must be suspended if a projected or actual gap in services exceeds 14 days.
- The services are billed under the inclusive daily rate of H2022.
- Provider must bill either the authorized rate or the actual cost of providing the service, whichever is less.

Required Documentation:

At least one outcome for each funded service area must be included in the individual's ISA. Service notes and timesheets are also required.

4.3 Employment Supports

Employment Supports are provided to assist transition age youth and adults in establishing and achieving work and career goals.

Environmental modifications and adaptive equipment are component parts of supported employment and, as applicable, are included in the daily rate paid to providers. Transportation is a component part of Employment Supports that is separately identified and included in the total hours of Employment Supports.

E01 Employment assessment involves evaluation of the individual's work skills, identification of the individual's preferences and interests, and the development of personal work goals.

E02 Employer and Job Development assists an individual to access employment and establish employer development and support. Activities for employer development include identification, creation or enhancement of job opportunities, education, consulting, and assisting co-workers and managers in supporting and interacting with individuals.

E03 Job Training assists an individual to begin work, learn the job, and gain social inclusion at work.

E04 Ongoing Support to Maintain Employment involves activities needed to sustain paid work by the individual. These supports and services may be given both on and off the job site, and may involve long-term and/or intermittent follow-up. Transportation to and from the job may be included as an employment activity.

Worker Qualifications:

Must meet requirements for all staff as described in minimum qualifications section 1.9 of this manual.

Billing Guidance:

- Must be suspended if a projected or actual gap in services exceeds 14 days.
- Reimbursement will not be made for incentive payments or subsidies to employers, or as a pass through to the individual.
- Funding cannot be used for sheltered workshops or enclaves.
- The services are billed under the inclusive daily rate of H2022.
- Provider must bill either the authorized rate or the actual cost of providing the service,

whichever is less.

Required Documentation:

At least one outcome for each funded service area must be included in the individual's ISA. Service notes and timesheets are also required.

4.4 Respite

Alternative caregiving arrangements for family members or home providers/foster families and the individual being supported, on an intermittent or time limited basis, because of the absence of or need for relief of those persons normally providing the care to the individual, when the individual needs the support of another caregiver.

Respite care may be provided in the following locations: an individual's home or place of residence; private home of a respite provider; foster home; or, other non-institutional location approved by Division of Disability and Aging Services (i.e. camp).

D01 Respite Supports provided by the hour.

D02 Respite Supports provided for a 24-hour period.

Worker Qualifications:

Must meet requirements for all staff as described in minimum qualifications section 1.9 of this manual.

Billing Guidance:

- The services are billed under the inclusive daily rate of H2022.
- Provider must bill either the authorized rate or the actual cost of providing the service, whichever is less.

Required Documentation:

Timesheets are required.

4.5 Clinical Services

Assessment; individual, family and group therapy; and medication or medical services provided by clinical or medical staff, including a qualified clinician, therapist, psychiatrist or nurse. Clinical Services are medically necessary services and equipment (such as dentures, eyeglasses, assistive technology) that cannot be accessed through the Medicaid State Plan.

E01 Clinical Assessment services evaluate individuals' and families' strengths, needs, existence and severity of disability(s), and functioning, across environments. Assessment services may include evaluation of the support system's and community's strengths and availability to the individual and family.

E02 Individual Therapy is a method of treatment that uses the interaction between a therapist and the individual to facilitate emotional or psychological change and to alleviate distress.

E03 Family Therapy is a method of treatment that uses the interaction between a therapist, the individual, and family members to facilitate emotional or psychological change and to alleviate distress.

E04 Group Therapy is a method of treatment that uses the interaction between a therapist, the individual, and peers to facilitate emotional or psychological change and to alleviate distress.

E05 Medication and Medical Support and Consultation Services include evaluating the need for, prescribing and monitoring medication, and providing medical observation, support and consultation for an individual's health care.

[E06 intentionally missed used by DMH. E07 moved to Supportive Services below]

E08 Other Clinical Services are services and supports not covered by Medicaid State Plan, including medically necessary services provided by licensed clinicians and equipment (such as dentures, eyeglasses, assistive technology).

Worker Qualifications: Must meet requirements for all staff as described in minimum qualifications section 1.9 of this manual.

Billing Guidance:

- Must be suspended if a projected or actual gap in services exceeds 14 days.
- The services are billed under the inclusive daily rate of H2022.
- Provider must bill either the authorized rate or the actual cost of providing the service, whichever is less.

Required Documentation:

- At least one outcome for each funded service area must be included in the individual's ISA.
- Service notes and timesheets are also required.

4.6 Crisis Services

Time-limited, intensive supports provided for individuals who are currently experiencing, or may be expected to experience, a psychological, behavioral, or emotional crisis. Crisis Services may include crisis assessment, support and referral or crisis beds and may be individualized, regional or statewide. Services may also be provided to the individual's or family's immediate support system. These services are available 24 hours a day, 7 days a week.

G01 Emergency/Crisis Assessment, Support and Referral includes initial information gathering, triage, training and early intervention, supportive counseling, consultation, referral and crisis planning. In addition, supports include: outreach and stabilization, clinical diagnosis and evaluation, treatment and direct support, and integration/discharge planning back to the person's home or alternative setting. Assessment may also include screening for inpatient psychiatric admission.

G02 Emergency/Crisis Beds offer emergency, short-term, 24-hour residential supports in a setting other than the person's home.

Worker Qualifications:

Must meet requirements for all staff as described in minimum qualifications section 1.9 of this manual. Clinical evaluation and consultation activities must be performed by a Master's level graduate with a degree in a related human services field.

Billing Guidance:

- The services are billed under the inclusive daily rate of H2022.
- Provider must bill either the authorized rate or the actual cost of providing the service, whichever is less.

Required Documentation:

- Service notes and timesheets are also required.

4.7 Housing and Home Supports

Services, supports and supervision provided for individuals in and around their residences up to 24 hours a day, seven days a week (24/7). Services include support for individuals to acquire and retain life skills and improve and maintain opportunities and experiences for individuals to be as independent as possible in their home and community. Services include maintaining health and safety and home modifications required for accessibility related to an individual's disability, including cost-effective technology that promotes safety and independence in lieu of paid direct support. Home supports must be in compliance with HCBS rules which emphasize choice, control, privacy, tenancy rights, autonomy, independence and inclusion in the community.

H01 Supervised Living are regularly scheduled, or intermittent hourly supports provided to an individual who lives in his or her home or that of a family member. Supports are provided on a less than full time (not 24/7) schedule.

H02 Staffed Living are provided in a home setting for one or two people that is staffed on a full-time basis.

H03 Group Living are supports provided in a licensed home setting for three to six people that is staffed full time by providers.

H04 Shared Living (licensed) supports are provided for one or two children in the home of a shared living provider/foster family that is licensed. Shared living providers/foster families are contracted home providers and are generally compensated through a “Difficulty of Care” foster care payment.

H05 Shared Living (not licensed) supports are provided to one or two people in the home of a shared living provider/foster family. Shared living providers/foster families are contracted home providers and are generally compensated through a “Difficulty of Care” foster care payment.

H06 ICF/DD (Intermediate Care Facility for people with Developmental Disabilities) is a highly structured residential setting for up to six people which provides needed intensive medical and therapeutic services.

A. Shared Living Arrangements are individualized living arrangements for individuals, offered within a home provider’s home. Shared Living provider’s are contracted workers and are not considered staff in their role as contracted provider.

- 1) All shared living homes must meet the Housing Safety and Accessibility Guidelines. The home provider or applicable landlord is responsible for all costs to follow the housing safety guidelines.
- 2) Funding for environmental modifications for physical accessibility may be available. See the System of Care Plan for more specific information.
- 3) Shared living arrangements cannot be self/family managed.
- 4) Transportation for reasonable expenses can be built into the daily rate, including a stipend to contribute towards the cost of an accessible vehicle (i.e. van with lift).

Worker Qualifications:

- Must meet requirements for all staff as described in minimum qualifications section 1.9 of this manual.
- Any residential provider who resides with the individual must be a minimum of twenty-one (21) years of age.

Billing Guidance:

- Must be suspended if a projected or actual gap in services exceeds 14 days (excluding home providers).
- The services are billed under the inclusive daily rate of H2022.
- Provider must bill either the authorized rate or the actual cost of providing the service, whichever is less.
- Housing and Home supports cannot be used to pay for room and board costs for an individual, including the cost of vacations.
- There may be instances when the costs of a paid care giver may be covered. See State System of Care Plan for more details.

Required Documentation:

- At least one outcome for each funded service area must be included in the individual's ISA.
- Service notes and timesheets are also required (Excluding home providers).

4.8 Supportive Services

Supportive Services means therapeutic services, that cannot be accessed through State Plan Medicaid. These are therapeutically or medically appropriate services, that do not necessarily require a licensed clinician to provide, that include behavior support and consultation; assessment, consultation and training for communication supports; skills-based training such as dialectical behavior therapy skills group or sexuality groups. This includes other therapeutic or medically appropriate services not covered under State Plan Medicaid when provided by licensed or certified individuals (such as therapeutic horseback riding).

E07 Behavioral Support, Assessment, Planning and Consultation Services

include evaluating the need for, monitoring and providing support and consultation for positive behavioral interventions/emotional regulation.

N01 Communication Support means assessment, consultation and training that cannot be accessed through State Plan Medicaid to assist a team to support a person to increase his/her ability to communicate.

N02 Other Supportive Services include skills-based training such as dialectical behavior therapy skills groups or sexuality groups not provided by licensed clinicians. They also include other services that cannot be accessed through State Plan Medicaid but must be provided by licensed or certified individuals (such as therapeutic horseback riding).

Worker Qualifications:

Must meet requirements for all staff as described in minimum qualifications section 1.9 of this manual.

Billing Guidance:

- Must be suspended if a projected or actual gap in services exceeds 14 days.
- The services are billed under the inclusive daily rate of H2022.
- Provider must bill either the authorized rate or the actual cost of providing the service, whichever is less.

Required Documentation:

- At least one outcome for each funded service area must be included in the individual's ISA.
- Service notes and timesheets are also required.

4.9 General Billing Guidelines for All HCBS

An individual approved for Home and Community Based Developmental Disability Services is assigned a procedure code which designates a daily rate, encompassing all services.

An individual's home and community-based services funding may be suspended for up to a maximum of 6 months. If a suspension exceeds 6 months, services must be terminated and the funding returned to the appropriate fund (Equity and Public Safety). A notification must be sent to the individual informing him or her of the right of appeal. The same provision applies to services approved and funded, but not implemented within 6 months of receiving funding. The Division may grant additional time for exceptional circumstances.

Services, in whole or in part, must be suspended for the following reasons:

- A. Incarceration – When an individual enters a correctional facility (pre- or post-sentencing) and is expected to stay no more than 6 months – all HCBS must be suspended.
- B. Nursing Facility – When an individual enters a nursing facility and is expected to stay no more than 6 months – all HCBS must be suspended. *With approval of the state, some funds may be shifted to Specialized Day Services.*
- C. ICF/DD – When an individual admitted to an ICF/DD and is expected to stay no more than 6 months – all HCBS must be suspended.
- D. Psychiatric Hospitalization – Level 1: When an individual is admitted to a Level 1 psychiatric bed – all HCBS must be suspended.
- E. Other Hospitalization – When an individual is temporarily hospitalized in other than an inpatient Level 1 psychiatric bed, HCBS funding can be used to provide personal care type services. Agencies can be reimbursed for an individual's daily rate for home supports, service planning and coordination and administration for up to 30 days of hospitalization.
- F. Gap in Service Provision – When there is a gap in the provision of any of an individual's authorized HCBS that exceeds 14 days – billing for those HCBS services that are not being delivered must be suspended until services are resumed. Services that are provided on an intermittent basis (service coordination, respite, individual crisis and transportation for a van payment only), that can be expected to be used within the fiscal year, may continue without suspension for gaps over 14 days. Billing for shared living may continue when an individual is temporarily away from home for no more than 30 days, such as when visiting family, on vacation, at respite or at camp. In most instances, a shared living provider is considered to be on-call and may be expected to be available in

the event of an emergency. It is at the discretion of the DA/SSA to determine under what circumstances they continue to pay a shared living provider. Services do not need to be suspended when a person is in an agency's local crisis bed or accessing VCIN level III services.

Because there are some challenges in predicting whether agency delivered services and services paid through the Fiscal/Employer Agent will be utilized by the end of the fiscal year, paid claims may not be consistent with the amount of service delivered. Agencies will conduct an end of year audit of paid claims and compare that to service utilization for each individual for the FY. The agency will provide an accounting of when paid claims exceeded the amount of services delivered and when the amount of services delivered exceeded paid claims. The agency will pay back funds received in excess of 3.0% of total HCBS claims reimbursed after reconciling individual budgets. The calculation of the amount of services delivered exceeding paid claims will be based on additional units of service beyond what the agency was reimbursed multiplied by the most recent authorized rate for the service for the individual. Additional guidance on reconciliation will be provided to agencies.

- G. Visits outside of Vermont – When an individual leaves Vermont temporarily but continues to need services, home and community-based services funding may be continued for a period not to exceed 6 months. Those services that are not being delivered during this time must be suspended.
- H. Leaves Services – When an individual drops out of services without notice and is unable to be contacted – all HCBS must be suspended.
- I. Other circumstances – When an individual is not expected to receive services within a 6-month period – all HCBS must be suspended.

An individual's home and community-based services funding must be terminated for the following reasons.

- A. Incarceration – When an individual's stay in a correctional facility exceeds, or is expected to exceed, 6 months.
- B. Nursing Facility – When an individual's stay in a nursing facility exceeds, or is expected to exceed, 6 months.
- C. ICF/DD – When an individual's stay in an ICF/DD exceeds, or is expected to exceed, 6 months.
- D. Extended Visit Out of State – When an individual's temporary visit out of state exceeds 6 months.

- E. Moved Out-of-State – When an individual makes a permanent move out of state. Exceptions for people who are living out-of-state for the purposes of receiving treatment (shared living in a NH, MA or NY border town)
- F. Declines Services – When an individual voluntarily chooses to no longer receive services.
- G. Prolonged Suspension – When a suspension exceeds 6 months.
- H. Death – when an individual die. Termination of funding date is the day after the individual died.

If the start date for newly approved HCBS (in whole or in part) is delayed, the start date for each delayed service must reflect (or, if previously submitted to DAIL, be amended to) the actual date services were started.

If an individual in a group living situation moves out or dies, the funding allocated to that individual may be spread across the budgets for the remaining people in the home for up to 30 days without prior approval. Requests to extend the funding beyond 30 days must be made to the Equity Funding Committee or Public Safety Funding Committee and cannot extend beyond 90 days in total.

Approval from the Division must occur prior to initial billing. Individual budgets are reviewed and updated at least annually. If a significant change to services occurs during the fiscal year, a new budget must be developed, and the ISA updated to reflect the changes.

Billing may be submitted weekly, at the discretion of the provider. For new service recipients or new services approved for existing recipients, billing may not occur until services have been implemented; however, partial billing may occur for plans that are partially implemented.

Specific components of or the individual's entire Home and Community Based Developmental Disability Services may be suspended for up to six (6) months as outlined above. At the conclusion of the six months, the Home and Community Based Developmental Disability Services shall be terminated unless a written request is made to the Division outlining the specific reasons why the Home and Community Based Developmental Disability Services or portion thereof should not be terminated. If a Home and Community Based Developmental Disability Services is terminated, the person receiving services must be notified and appropriate appeal rights must be communicated to the individual by the agency, in writing.

Billing may not occur when an individual has been admitted to an ICF/MR, correctional facility or nursing facility or when a person dies or permanently moves to another state. (Individuals may live temporarily in an adjoining state for the purposes of treatment.)

When an individual transfer to another agency, funding related to an individual's home and community-based services budget, as allowed in the Vermont State System of Care Plan, is

transferred to the receiving agency. Billing at the discharging agency ends on the last day of service and billing at the receiving agency begins on the following day.

Home and Community Based Developmental Disability Services (H2022) are all inclusive. No other Medicaid service may be billed, except for special situations where children's mental health services may be provided to a Home and Community Based Developmental Disability Services recipient. This includes Flexible Family Funding, Targeted Case Management, etc.

All funded services must be addressed within the ISA. The ISA must document the amount, duration and scope of services.

The maximum cost for service coordination managed through a DA/SSA shall be published in the DAIL Medicaid Claim Codes and Reimbursement Rates. If actual costs are less than the published rate, the actual cost must be billed. The maximum cost for service coordination for individuals who self/family-manage shall also be published by DAIL. When an individual transfers from a DA/SSA to self/family-managed, the difference between the DA/SSA's service coordination rate and the rate for individuals who self/family-manage is transferred to the Supportive ISO to pay their administrative costs.

The DDSD Rate Sheet may be found at the DDSD website here: <http://ddsd.vermont.gov/>

Reasonable transportation expenses to provide access to the community may be funded, including payments toward the cost of accessible vehicles when used as the primary means of transportation for the individual with developmental disabilities. The maximum per person payment for accessible vehicles shall be published in the DAIL Medicaid Claim Codes and Reimbursement Rates. This maximum applies to all funding, including shifts from other service lines, and cannot be exceeded.

A provider may not bill HCBS (H2022) for an individual on the same day as Clinic and Rehabilitation Services (90791,90792, H2011, H2019, H2032, 99213,99214), Bridge Program (T2022), Targeted Case Management (T1017), PASRR Specialized Day Services (T2021) or ICF/DD services.

Home and community-based services can only be billed through one HCBS program on the same day (e.g., DDSD, TBI, Choices for Care, DMH).

OTHER COVERED SERVICES

5.0 Clinical and Rehabilitative Services

Clinic and Rehabilitation services can be provided within a community mental health or developmental disability service setting as well as community based settings.

There are five reimbursable clinic and rehabilitation services:

- **90791/90792** **Diagnosis and Evaluation (D & E)**
- **H2019** **Individual Psychotherapy**
- **H2032** **Group Therapy**
- **H2011** **Emergency Care**
- **99213/99241** **Medication Evaluation, Management and Consulting Services
(Medication Management, Med-Check)**

A. Reimbursable activities billed to these services are as follows:

90791-90792 Diagnosis and Evaluation (D&E):

Service limitations for all Diagnosis and Evaluation:

Reimbursement is limited to a minimum of fifteen (15) minutes (two units) per session

D & E services may not be billed on the same day as H2022 (HCBS)).

1) ISA Development

The development of an ISA is reimbursable under D & E. An ISA includes all components as outlined in the Individual Support Agreement Guidelines found here http://ddsd.vermont.gov/sites/ddsd/files/documents/ISA_Guidelines.pdf . At a minimum, the ISA team must include the individual, the guardian (when applicable) and a Qualified Developmental Disability Professional (QDDP).

*(Write up time is included in the cost of the service and is **not billable**.)*

a) Preparation time:

Preparation Time is defined as, but is not limited to, contact with the individual, family members, and guardian regarding the upcoming ISA meeting; gathering and organizing information to be utilized during the meeting; and, coordinating with members of the ISA Team.

b) Meeting time:

Meeting time is defined as the actual time spent by the ISA team in the development of a plan and time spent in the ISA meeting as defined in the ISA Guidelines.

c) **Post-Meeting Activities:**
Post-meeting activities are defined as time spent devoted to the refinement of expectations, outcomes, and support strategies.

d) **ISA Reviews:**
ISA reviews are time spent monitoring the implementation of the ISA and ensuring it continually reflects the individual's desires and needs.

An ISA review must specifically document current status of the goals/outcomes of the ISA and be signed by a QDDP.

e) **ISA Modifications:**
ISA modifications include time spent making changes to the ISA

A modification which makes significant changes to the ISA **must** document the nature of the change **and** include appropriate signatures of approval and prescription when required.

Billing Guidelines:

Reimbursement of ISA activities is allowed for prep time, meeting time and post-meeting activities up to sixty (90) calendar days prior to ISA implementation date.

Required documentation:

- Documentation of eligibility as required in Regulations Implementing the Developmental Disabilities Act of 1996.
- ISA which meets the ISA Guidelines, including reviews and modifications.
- Service Documentation: date, location, description of activity, amount of time and signature of staff.

Staff Qualifications:

Must be signed by a Qualified Developmental Disability Professional (QDDP).

2) **Psychological Evaluation and Consultation:**

a) **Diagnostic Evaluation:**
Diagnostic evaluations are necessary for all individuals to determine eligibility for all developmental disability services. The requirements for determining eligibility are stated in the Regulations Implementing the DD Act.

b) **Clinician Qualifications:**
A Vermont licensed or Ph.D. psychologist, or a master's level professional who is under the supervision of a Vermont licensed or Ph.D. psychologist.

Documentation Requirements:

Documentation of a diagnostic evaluation must contain the date of evaluation, location; amount of time and the signature of the evaluator. The completed diagnostic evaluation must include a summary of the evaluation session, the results of standardized testing of IQ or required components for ASD assessment and adaptive behavior, conclusions and a diagnosis including current ICD code and must be signed by the qualified evaluator.

Psychological Consultation:

A Psychological consultation obtains information pertinent to program development and the determination of necessary supports. It must include at least one face-to-face session. Standardized tests are not required; however, the documentation must provide recommendations for services.

a) Psychologist Qualifications:

A Vermont licensed or Ph.D. psychologist, or a master's level professional who is under the supervision of a Vermont licensed or Ph.D. psychologist.

b) Required Documentation:

Documentation of a Psychological consultation must contain the date of consultation, location; amount of time and the signature of the evaluator.

1) Person's Story:

At least one comprehensive person's story must be obtained upon entry into services and updated annually; and at the time of significant life events (move, death of family member, etc).

The initial person's story must include, but is not limited to:

- prenatal history
- family history
- developmental history (e.g. significant events: walked, talked, toileted, etc.)
- a summary of educational and residential history
- summary of programs the individual has previously participated in
- notation of significant persons and events in the individual's life.

Billing Guidelines:

For billing purposes, billing is only allowable for Non-HCBS. Billing can include the amount of time spent in accessing and interpreting information may be submitted. Write up time is included in the cost of the service and is not billable.

Required Documentation:

A completed person's story, documentation of the date, amount of time spent and the signature of the author is required to bill for this **service**.

- 2) **Guardianship Evaluations for Individuals with Developmental Disabilities:**
 A guardianship evaluation is an assessment of a person's current decision-making capacity, their support network, and availability of alternatives to guardianship for the individual. Evaluators generate an informative report for court that is based on the guardianship evaluation recommendations specific to areas of supervision contained in 14 VSA Section 3067 (private guardianship) and 18 VSA Section 9306 (public guardianship).

Billing Guidelines:

- Providers should bill Fee for Service Medicaid using the agency specific Developmental Services provider ID number.
- Diagnosis and Evaluation (D&E) is included in the *Psychiatric Diagnostic and Evaluation (no medical service)* code 90791.
- Write up time is not billable under fee for service Medicaid. The unreimbursed expenses are available for direct invoice to DAIL per the Guardianship Evaluation Billing Procedures.

Documentation Requirements:

A completed Comprehensive Evaluation, the date, location and amount of time of the evaluation session and the signature of the QDDP is required in order to bill for this service.

Comprehensive Evaluator Qualifications:

An evaluation for public or private guardianship must be completed by a Qualified Developmental Disability Professional (QDDP) who has specific training and demonstrated competence to evaluate individuals with developmental disabilities.

For more information, please refer to the Guardianship Evaluation Guidelines and the Guardianship Evaluation Billing Procedures. Both are available from the DDS website and upon request from the Office of Public Guardian, <http://ddsd.vermont.gov>

B. H2019 Individual Psychotherapy

Individual psychotherapy is a method for treating an individual's personal problems using the interaction between a therapist and the individual to promote emotional, behavioral or psychological well-being. This service must be specifically indicated in an ISA.

- 1) The ISA or separate annual treatment plan must include the following:
- A diagnosis relating to psychotherapy needs;
 - Goals for future therapy sessions;
 - The signature of individual providing psychotherapy and their qualified supervisor (as needed).

- 2) Notes of therapy sessions must be maintained which summarize the following:
 - Issues discussed or addressed relating to the individual's goals for psychotherapy;
 - The clinician's assessment of issues;

Worker Qualifications:

A Vermont licensed or Ph.D. psychologist or psychiatrist or a master's level individual with specialized training in providing psychotherapy who is under the direction of a Vermont licensed or Ph.D. psychologist or psychiatrist.

Billing Guidelines:

1. Psychotherapy sessions need to be face-to-face. Phone psychotherapy is not a billable service.
2. Only one charge may be made for psychotherapy regardless of the number of therapists present.
3. Write up time is included in the cost of the service and is not billable.
4. Couple's therapy or family therapy should be billed as individual psychotherapy. The primary recipient of care should be billed for the entire allowable rate. If no primary recipient is defined, participants should be billed a proportional share of the allowable rate.
5. Psychotherapy with a non-Medicaid eligible family member cannot be reimbursed by Medicaid with the exception of (f).
6. In family therapy, when the only Medicaid eligible individual is a child, the parents may be seen without the child present, for up to five hours per fiscal year as long as the focus of the session is the child's problems.
7. A progress note must be maintained for each session. For instance, documentation of two, one-half hour sessions on the same day, but at different times requires two notes.

The following services cannot be billed as individual psychotherapy:

- Social support;
- An Individual Support Agreement meeting;
- Consultation to other centers, or other staff of community
- Mental health centers or other designated providers;
- Vocational counseling.

Service limitations:

Reimbursement is limited to a minimum of one-half hour and a maximum of two hours per day, and no more than seven hours per week per individual.

Documentation Requirements:

- A psychological evaluation with adaptive behavior assessment documenting eligibility consistent with criteria outlined in the Regulations Implementing the Developmental Disabilities Act is required. A psychological evaluation with a developmental assessment may be grandfathered in for those in service prior to the implementation of the DD Act of 1996.
- ISA or a treatment plan

- Therapy goals
- Therapy note with:
 - a description of the session
 - date
 - location
 - amount of time
 - signature of therapist.

C. H2032 Group Therapy

Group therapy is a method of treating an individual's personal problems using the interaction between a therapist(s) and two to six individuals to promote emotional, psychological or behavioral change to alleviate the presenting condition(s). In addition, group therapy may focus on the person's adaptation skills involving social interaction and emotional reactions to reality situations. Group therapy also includes multiple family therapy or multiple couple therapy.

Billing Guidelines:

- Sessions are limited to a maximum of six people per group.
- Only one charge may be made for group therapy regardless of the number of therapists present.
- Write up is included in the cost of the service and is not billable.
- A separate note must be written for each individual in the group.

Service limitations:

Reimbursement is limited to a minimum of one hour per session and a maximum of two hours per day, and no more than ten hours per week per individual.

Documentation Requirements:

Group therapy must be specifically indicated in an ISA. The ISA or separate annual treatment plan must include the following:

- A diagnosis relating to group therapy needs
- Goals for future therapy sessions
- The signature of individual providing group therapy and his/her qualified supervisor (as needed).

Notes of therapy sessions must be maintained which summarize the following:

- Issues discussed or addressed relating to the individual's goals for group therapy
- The clinician's assessment of issues
- If there is a change in approach toward the issues, it must be described.

Other documentation required includes:

- A psychological evaluation with adaptive behavior assessment documenting eligibility consistent with criteria outlined in the Regulations Implementing the Developmental Disabilities Act is required. A psychological evaluation with a

developmental assessment may be grandfathered in for those in service prior to the implementation of the DD Act of 1996.

- ISA or treatment plan
- Therapy Goals
- Therapy notes describing the session, date, location, amount of time, and the signature of the therapist.

Group Therapist Qualifications:

A Vermont licensed or Ph.D. psychologist or psychiatrist or a master's level individual with specialized training in providing psychotherapy who is under the direction of a Vermont licensed or Ph.D. psychologist or psychiatrist.

D. H2011 Emergency Care

Emergency care is a service provided to people experiencing an acute emotional crisis as evidenced by:

- A. A sudden change or potential change in behavior with negative consequences for well-being; and/or
- B. A loss of usual coping mechanisms; and/or
- C. Him/her presenting a danger to self or others.

Emergency care includes services such as assessment of the individual and the circumstances leading to the crisis, crisis counseling, screening for hospitalization, referral and follow-up.

Services are intensive, time limited and are intended to resolve or stabilize the immediate crisis.

Emergency care services must include, as one component, a face-to-face contact with the individual. Both direct treatment or indirect service, such as support services to significant others, arrangement of other more appropriate resources, and phone calls are also billable.

Billing Guidelines:

- There is a two hours/day limitation on psychotherapy and a three hour/day limitation on emergency care services. These may be combined into a maximum of five hours of reimbursable services per day in emergency situations, up to the allowable maximum per individual.
- Documentation must include a separate note per twenty-four (24) hour period documenting all emergency services provided. Emergency services must be clearly labeled as such.
- Write-up is included in the cost of the service and is not billable.

Service Limitations:

Reimbursement is limited to a minimum of one-half hour and a maximum of three hours per day and no more than twelve (12) hours per week per individual.

Required Service Documentation:

- A psychological evaluation with adaptive behavior assessment documenting eligibility consistent with criteria outlined in the Regulations Implementing the Developmental Disabilities Act is required. A psychological evaluation with a developmental assessment may be grandfathered in for those in service prior to the implementation of the DD Act of 1996.
- Emergency care note including:
 - date
 - location
 - amount of time
 - summary of service
 - signature of qualified staff/clinician.

E. 9913/99214 Medication Management

Medication Management is a face-to-face interaction by a physician, physician's assistant or qualified nurse and an individual, who evaluates him/her in terms of symptoms, medication history, diagnosis and appropriateness of medication being prescribed or continued, and/or the monitoring and assessment of the individual's reaction (favorable or unfavorable) to the medication.

Furthermore, the reaction of the individual to the medication is not only in terms of physical reaction (side effects) but also any mental status change at which the medication management is aimed. This requires both pharmacological and mental health psychiatric skills. A nurse may provide medication management if the physician prescribed treatment plan so specifies.

Billing Guidelines:

- The administration of medication is not considered billable as Medication Management.
- Medication Management may not be done in group sessions.
- Individual notes must be written for each individual.

Service limitations:

Reimbursement is limited to one session per day, and no more than four sessions per week. A session must be a minimum of fifteen minutes in duration.

Documentation Requirements:

Required service documentation for Medication Management includes:

- A psychological evaluation with adaptive behavior assessment documenting eligibility consistent with criteria outlined in the Regulations Implementing the Developmental Disabilities Act is required. A psychological evaluation with a developmental assessment may be grandfathered in for those in service prior to the

- implementation of the DD Act of 1996.
- ISA within 30 days
- Annual Physical
- Service note which includes:
 - date
 - location
 - description of service
 - amount of time
 - signature of clinician.

Qualifications:

A Vermont licensed physician, physician's assistant, APRN or qualified nurse (as defined in the Nurse Practice Act) designated by the physician.

5.1 T2021 Specialized Day Services (formerly Nursing Facility Day Rehabilitation)

Pre -Admission Screening and Resident Review (PASRR) Funding Specialized Day Services are available to individuals living in a nursing facility and who needs additional services related to their developmental disability (e.g., social, behavior, communication) that are beyond the scope of the nursing facility.

These services are prior authorized on an individual basis by DDS. Allocations for individuals currently receiving Specialized Day Services are reviewed on an annual basis by DDS. Funding for Specialized Day Services is allocated from the revolving PASRR fund unless the individual was receiving HCBS funding prior to admission to the nursing facility, in which case a portion (up to 25 hours) of his or her HCBS funding is converted to Specialized Day Services funding to pay for Specialized Day Services. DDS is legally mandated to provide these services, therefore, if the PASRR Fund is depleted, funding is allocated through New Caseload Funding or Returned Caseload Funding.

If an individual receiving Specialized Day Services moves out of a nursing facility, the individual's funding is converted to HCBS funding to support the individual's community based services. Any additional HCBS funding approved for an individual moving from a nursing facility to a community placement comes from the New Caseload Funding or Returned Caseload Funding. If an individual dies or stops receiving Specialized Day Services, the funds are returned to the revolving PASRR Fund or to the Returned Caseload Fund if there are sufficient resources to cover current and anticipated Specialized Day Services needs.

An ISA for Specialized Day Services is required and should be submitted to the PASRR Coordinator within 30 days, including all relevant signatures/approvals. Specialized Day Services may be based in or outside a facility, including within an agency or a nursing facility.

Billing Guidelines:

- Specialized Day Services for children under the age of eighteen are not billable.
- Medical and other services routinely provided through the nursing facility must not be duplicated through Specialized Day Services.

Service Limitations:

- Specialized Day Services are reimbursed on a per unit basis. A session must last at least two units (15 minutes). Individuals can receive a maximum of 25 hours per week of Specialized Day Services.
- The PASRR Coordinator will determine whether Specialized Day Services are applicable and appropriate in the course of the PASRR Level II determination.
- Transportation and case management services are included in the per unit billing and can not be billed separately.
- Unit reimbursement rate is established by the PASRR Coordinator on an individual basis.

Documentation Requirements:

Required service documentation for Specialized Services includes:

- ISA within 30 days of the first date of service, including physician signature
- A service note which includes:
 - date
 - location
 - amount of time
 - summary of the service provides
 - signature of the staff providing the service

5.2 T1017 Targeted Case Management

Targeted Case Management (TCM) is a Medicaid service that provides assessment, care planning, referral and monitoring. Services are provided by the DA/SSA and designed to assist adults and children to gain access to needed services.

Reimbursable Services:

Assessment of an individual to determine the need for any medical, educational, social or other services. These assessment activities include:

- Taking client history
- Identifying the individual's needs and completing related documentation
- Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

Development of a specific care plan:

- Based on the information collected through the assessment

- Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual
- Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals
- Identifies a course of action to respond to the assessed needs of the eligible individual.

Referral and related activities:

- To help an eligible individual obtain needed services including activities that help link an individual with:
 - Medical, social, educational providers; or
 - Other programs and services capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

Monitoring and follow-up activities:

- Activities, and contact, necessary to ensure the care plan is implemented and adequately addressing the individual's needs.
- These activities, and contact, may be with the individual, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary.

Activities and contact must include at least one annual review to ensure the following conditions are met:

- Services are being furnished in accordance with the individual's care plan
- Services in the care plan are adequate
- If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and to service arrangements with providers.

Billing Guidelines:

TCM may not be billed when a person is receiving Developmental Disabilities Services funded through the Home and Community Based Developmental Disability Services, ICF/DD, or Specialized Day Services.

TCM may be billed for persons receiving other clinic or rehabilitation services including individual psychotherapy, group therapy, emergency care and medication management.

TCM may not be billed for an individual residing in a correctional facility, hospital, psychiatric facility, residential school, rehabilitation facility, or crisis facility *except* for the purposes of discharge planning when the service does not duplicate the facility's services and when provided thirty (30) calendar days or less prior to discharge.

TCM may not be billed for case management activities occurring between staff of the same agency.

A. TCM Conversion from HCBS:

Providers should submit a written request to DDS Director asking to convert HCBS funds to TCM. Provider must include the client budget the funds would be coming out of, the

effective date, and the amount. DDS Director will allow or disallow the requested conversion. If approved, DDS staff will provide a copy of the approval to the business office. The business office will confirm the provider makes the appropriate adjustments on their monthly spreadsheet and move forward with increasing the provider's TCM allocation on their Exhibit B.

Service Limitations:

Reimbursement is limited to a minimum of two units (15 minutes) of service per individual. The rate of reimbursement for a unit is established annually by the Business Office of the Department of Disabilities, Aging and Independent Living (DAIL) based on the cost of service.

Documentation Requirements:

- A psychological evaluation with adaptive behavior assessment documenting eligibility consistent with criteria outlined in the Regulations Implementing the Developmental Disabilities Act is required. A psychological evaluation with a developmental assessment may be grandfathered in for those in service prior to the implementation of the DD Act of 1996.
- A completed ISA (within 30 days of first billable service) consistent with the ISA Guidelines.
- A service note which includes:
 - Date
 - Description of the activity
 - Amount of time spent
 - Service location
- Staff signature (Only one note would be needed for a period of continuous service, e.g. 2 hours, even if multiple activities were being completed.)

5.3 T2022 BRIDGE CARE COORDINATION

The Bridge Program is an Early Periodic Screening, Diagnosis and Treatment (EPSDT) service that provides support to families in need of Care Coordination to help them access and/or coordinate medical, educational, social or other services for their children with developmental disabilities under the age of 22. The Bridge Program offers care coordination to assist families of children under 22 with developmental disabilities.

The Bridge Program provides a goal-driven service which will:

- Help families determine what supports or services are needed,
- Help families access needed medical, educational, social or other services to address their child's needs,
- Help families coordinate multiple community-based services and develop a coordinated plan to address assessed needs.

Billing Guidelines:

Reimbursable activities include assessment, care plan development, referral and monitoring as defined below:

Assessment of an individual to determine the need for any medical, educational, social or other services. These assessment activities include:

- Taking client history;
- Identifying the individual's needs and completing related documentation;
- Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

Development of a specific care plan that:

- Is based on the information collected through the assessment;
- Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- Identifies a course of action to respond to the assessed needs of the eligible individual.

Referral and related activities:

- To help an eligible individual obtain needed services including activities that help link an individual with:
 - Medical, social, educational providers; or
 - Other programs and services capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

Monitoring and follow-up activities:

- Activities, and contact, necessary to ensure the care plan is implemented and adequately addressing the individual's needs. These activities, and contact, may be with the individual, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary; including at least one annual monitoring to assure following conditions are met:
 - Services are being furnished in accordance with the individual's care plan;
 - Services in the care plan are adequate; and
 - If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and to service arrangements with providers.

Services are billed on a monthly per child case rate. The case rate is the individually determined rate for the designated agency. Billing may occur for a child as long as services were provided for at least 15 minutes during the month.

Limitations:

Bridge Care Coordination cannot be billed when a person is receiving Developmental Disabilities Services funded through the Home and Community-based Developmental Disability Services, ICF/DD, Targeted Case Management or Specialized Day Services.

Bridge Care Coordination may not be billed for children who are receiving care coordination, case management or service coordination from another Agency of Human Services funded source

including any Home and Community-Based Services (Choices for Care, Children's Mental Health), Family, Infant and Toddler Program, Hi-Tech Nursing Services, children's or adult mental health, foster care, etc.

Bridge Care Coordination may be billed for persons receiving other clinic services including individual psychotherapy, group therapy, emergency care and chemotherapy.

Bridge Care Coordination may be billed for an individual residing in a correctional facility, hospital, psychiatric facility, nursing home, residential school, rehabilitation facility, or crisis facility only for the purposes of discharge planning when the service does not duplicate the facility's services and when provided thirty (30) calendar days or less prior to discharge.

The cost of conducting assessments for eligibility for this service are included in the monthly case rate and may not be billed separately for those receiving Bridge Care Coordination.

Documentation Requirements:

A psychological and developmental assessment documenting eligibility consistent with criteria outlined in the *Regulations Implementing the Developmental Disabilities Act of 1996*.

Bridge Service Agreement (BSA). Because of the more limited nature of this service, a care plan known as a Bridge Services Agreement, will be used rather than the Individual Service Agreement format used for all other Developmental Disabilities Services.

The BSA must include:

- Designated Agency
- Beginning and end dates of the BSA term, not to exceed one year
- Service goals
- Linkage plan describing what activities the care coordinator will engage in to reach the service goal
- Anticipated timeframe for completion (extension if needed)
- Description of outcome achieved and date achieved
- Frequency of review of BSA (minimum once per term)
- Documentation of BSA review
- Approval of individual (not required for those under 18), parent or guardian, Care Coordinator and Qualified Developmental Disability Professional (QDDP)

Additional Documentation Requirements:

A service note for each time the service is provided which includes:

- the date
- description of the activity
- time spent
- service location
- staff signature.

(Only one note would be needed for a period of continuous service, e.g. 2 hours, even if multiple activities were being completed.)

5.4 Family Managed Respite

Family Managed Respite (FMR) funding is allocated by DAs to provide families with a break from caring for their child with a disability, up to age 21. Respite can be used as needed, either planned or in response to a crisis. Additional information regarding Family Managed Respite can be found in the Family Managed Respite program guidelines:

http://ddsd.vermont.gov/sites/ddsd/files/documents/Family_Managed_Respite_Guidelines.pdf

Billing Guidelines:

Billing cannot exceed the maximum allowable daily rate established by the Department.

Service Limitations:

- Respite may be used during a family member's employment hours but it is not intended to support caregiver employment.
- FMR can only be used for direct care provided by a person hired by the family.
- FMR cannot be used to pay for camp or to pay an organization, agency, or facility.
- FMR cannot be used to purchase goods or items.

Documentation Requirements:

A time sheet for each date the service is provided which includes:

- the date
- time spent
- staff signature

Audits

6.0 Audit/Review

To ensure program integrity, the division is responsible for oversight of billing and utilization of Medicaid funded services to eliminate fraud, waste and abuse and ensure the use of state and federal dollars are maximized for the benefit of the people receiving services. An essential component of this oversight is review of paid claims, monthly services report (MSR) data and documentation of services provided. All service providers should expect periodic audits of billing and utilization to ensure proper payments resulting from the following:

- Payment for services rendered
- Payment supported by documentation
- Services provided in compliance with *Vermont Medicaid Manual for Developmental Disabilities Services, Vermont State System of Care Plan, and Regulations Implementing the DD Act of 1996.*
- Payment for services included in a current approved ISA.

Medicaid audits for all DDS services will be performed at least annually. A random sample of paid claims will be drawn and compared to MSR data, FE/A and traced to the service documentation, time records and/or EMR equivalent documentations. The sample size will vary for each service provider based on the entire number of transactions that were billed and paid during the fiscal year. The clinical and fiscal (billing records and documents) findings will be compared to each other to verify agreement. Ten percent (10%) will be the allowable error rate. Any non-adherence to the policies listed above would be considered an error.

A post-audit reconciliation and correction of all identified errors must be completed with the fiscal agency (DXC Technology) within 30 days unless a formal appeal is in process.

A copy of the reconciliation materials must be sent to DDS within 45 days.

Errors must be refunded or adjustments made immediately upon realization that an error in billing has occurred.

If an error rate exceeds the allowable 10%, the service provider must develop a plan of correction, addressing the errors identified, and submit to DDS within 45 days.

The service provider has a right to appeal the results of an audit. The provider has 15 days from receipt of the audit findings to submit to DDS any documentation to support its stance that proper payment was made. The submitted documentation will be reviewed, and a subsequent determination will be issued within 30 days.

The provider agency has 30 days after receiving the subsequent determination to appeal to the Commissioner of the Department of Aging and Independent Living. The Commissioner will

review the appeal and respond, either upholding the DDS determination or issuing a new determination.

The decision made by the Commissioner of the Department of Aging and Independent Living is final.

Appeals and Grievances

7.0 Service Disagreements

These Medicaid services are funded by agreement between the Federal and Vermont State governments. Under this agreement, the State is required to have an internal grievance and appeal process for resolving service disagreements between recipients/applicants and the State or its provider agencies. These policies can be found here: <http://ddsd.vermont.gov/grievance-appeals>

Sanctions

8.0 DVHA Medicaid Coverage Rules

Agencies must comply with current federal and state laws and rules, state procedures, licensure and state contractual agreements. If there is a failure to comply, sanctions may be imposed. For more information, please see the DVHA Medicaid Coverage Rules Section 7106 Violations of Provider Responsibility.

<http://humanservices.vermont.gov/on-line-rules/dvha/medicaid-covered-services-7100-7700/view>