MEDICAID MANUAL
FOR
DEVELOPMENTAL
DISABILITIES SERVICES

2024

Department of Disabilities, Aging, and Independent Living

Developmental Disabilities Services Division

280 State Drive

Waterbury, Vermont 05671

REVISION LOG

Page left blank intentionally for future use, including updates related to DS payment reform and HCBS conflict of interest.

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GENERAL INFORMATION

1.0 INTRODUCTION

Medicaid Services in Vermont are provided under Global Commitment for Health 1115 Medicaid Waiver, an agreement with the federal 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 AND SCOPE OF MANUAL

This manual pertains to developmental disabilities services (DDS) offered through the Vermont Developmental Disabilities Services Division (DDSD). It is intended to provide guidance to Designated Agencies and Specialized Services Agencies (SSA), Supportive Intermediary Service Organization (ISO) and Fiscal/Employer Agent (F/EA) 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. The information in this guidance represents current coding constructs as of the date this document was published. Coding constructs can and do change on regularly occurring cycles, and it is the responsibility of Medicaid enrolled providers to stay up to date with current coding.

This manual only outlines requirements for reimbursement of Title XIX (Medicaid) 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 Developmental Disabilities Services Regulations (Health Care Administrative Rule 7.100), Vermont State System of Care Plan for Developmental Disabilities Services, 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 DDS guidance and policies can be found on the DDSD website: Policies and Guidelines | Developmental Disabilities Services Division

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 are in question. As a general principle, when in doubt about provisions contained in this provider manual, first contact your DDSD Specialist for technical assistance.

Medicaid follows the National Coding Convention Initiative (NCCI) and information published by the American Medical Association (AMA) always takes precedence over information in this program manual. For more information, consult the AMA Current Procedural Terminology (CPT) and Health Care Procedure Coding System (HCPCS) Manuals.

The most current version of this Medicaid Manual is available on the DDSD website: Medicaid Manual for Developmental Disabilities Services

1.2 REVISIONS TO THE MANUAL

This 2024 version of the Medicaid Manual represents a comprehensive revision from the 2017/2018 version. This Medicaid Manual shall be updated regularly as needed, and notification of any changes shall be sent to providers. All changes shall be recorded in the Revision Log.

Ongoing revisions to this manual shall be communicated as needed through update memorandums and/or notifications. As noted in the Provider Agreements, 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.

1.3 PAYMENT REFORM

The Department of Disabilities, Aging and Independent Living (DAIL) and the Department of Vermont Health Access (DVHA) are collaborating on a complex and comprehensive payment and delivery system reform project to improve data on services provided, ensure consistent assessment of individuals' needs, and transition from the current Developmental Disabilities Services (DDS) home and community based services (HCBS) payment method to a new form of payment for HCBS for individuals with developmental disabilities. The goal is to create a transparent, effective, and operationally feasible payment model for DDS that aligns with AHS' broader health care reform goals. Any changes to the Medicaid Manual under Payment Reform will be captured in future versions.

1.4 ELECTRONIC VISIT VERIFICATION

Electronic Visit Verification (EVV) is a telephone and computer-based system that records specific information about services provided to Medicaid recipients who receive personal care services. EVV is not encounter data. When an EVV in-scope service is provided, direct support workers use an electronic device (smartphone, computers) to record the following information:

- Type of service provided
- Person receiving the service
- Location where the service was provided

- Person providing the service
- Time the service begins and ends

Once the visit information is captured, it will match with the corresponding HCBS encounter data or fee for service claim to verify the visit

EVV is required for in-home services that are provided inside the care recipient's home by a provider that is not a live-in caregiver. Live-in caregivers are defined as care-providers that live in the same residence or dwelling as the care recipient. When the in-home service is provided inside the care recipients home by a non-live-in care provider, EVV is required for the following services:

- S5135 Supervised Living
- S5150 Respite Supports, HCBS & Family Managed Respite; per 15 minutes
- S5151 Respite Supports, HCBS & Family Managed Respite; daily
- T2017 In-home Family Supports
- T2017 Shared Living, Hourly Supports

For billing guidance, please refer to the DDSD Encounter Data Submission Guidance for Home and Community-based Services

For general EVV information, visit the Department of Vermont's Health Access EVV webpage.

1.5 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).

Many individuals will need to use the application labeled "Application for Long-Term Care Medicaid" on the DVHA website:

Long-Term Care | Department of Vermont Health Access

This Long-Term Care application also applies to people in need of Developmental Disabilities Home and Community Based Services (DD HCBS).

Intake coordinators at the Designated Agencies can help with questions about Medicaid and filling out Medicaid applications. The Developmental Disabilities Services Division (802 241-0304) may also be contacted for assistance.

Medicaid Exceptions:

People enrolled in Medicaid may 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 on the DVHA website:

Coverage Exceptions | Department of Vermont Health Access

1.6 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. Examples of third parties include Medicare and other health insurers.

For more information, see the Covered-Services-Rules policy 7108.

For most of the services funded by DDSD, there is no third-party liability. For those services that may have a third party liable for payment, it is noted in the “Billing Requirements” section for the applicable service.

1.7 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 8914

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 (F/EA), that are established for the purpose of providing and supporting developmental disabilities services.

A provider is responsible for re-validation with Gainwell Technologies Enrollment every three to five years depending on provider type and assigned risk level. Enrollment and re-validation instructions can be found on the Vermont Medicaid Portal: Provider Enrollment and Revalidation

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. More information about certification can be found in section 7.100.11 of the Developmental Disabilities Services Regulations.

A DA or SSA is considered certified to provide developmental disability services when it has been designated by the Commissioner and has a signed Provider Agreement for services with DAIL.

The F/EA is considered an eligible provider based on their signed agreement with the Department. The Supportive ISO is considered an eligible provider based on meeting the Supportive ISO Provider Standards .

Non-designated providers:

Services may be provided by non-designated providers under a subcontract with designated providers according to the rules outlined in the Developmental Disabilities Services Regulations section 7.100.11(f) and Provider Agreements.

1.8 INDIVIDUALIZED SUPPORT AGREEMENT

All services (except fee for service Crisis, Family Managed Respite and Clinical Assessment) require a care plan. The agency (DA/SSA) is responsible for the development of an Individual Support Agreement (ISA), consistent with the Individual Support Agreement (ISA) Guidelines or a Care Coordination Plan (CCP) consistent with The Bridge Program: Care Coordination for Children with Developmental Disabilities Guidelines . For people who choose to self/family-manage their services, the individual or family must develop the ISA. The Supportive ISO has the responsibility for ensuring that the individual has a current ISA.

1.9 PHYSICIAN PRESCRIPTION

A physician prescription is required for Clinical (Non-HCBS) Services including, Individual Therapy, Family Therapy, Group Therapy, Medication & Medical Support and Consultation Services, and PASRR Specialized Day 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 their signature, on the Individual Support Agreement (ISA)/plan of care or documented verbal consultation (including a telephone consultation).

Physician prescription is NOT required for HCBS, Targeted Case Management (TCM),

Clinical Assessment, Bridge Care Coordination, Crisis Services or Family Managed Respite.

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 approved the plan. This entry may be written by an agency staff member; and,
   (2) The signature of the physician must be obtained 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/plan of care, 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 outcomes for the funded areas of support. The short-term ISA allows extra time to gain knowledge about the individual's needs and develop specific outcomes to address these areas by the expiration date of the short-term ISA.
C. All ISAs/plans of care that require a physician's prescription must be signed prior to their implementation (with the exception of new services as stated above).
D. Clinical (non-HCBS) services that require a physician signature, must be signed by the physician 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, Clinical Assessment, Crisis and Home and Community-based Services do not require a physician's prescription or signature on the plan.

For more information on ISA signature requirements, see the Individual Support Agreement (ISA) Guidelines.

1.10 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 on the DDSD website: Policies, Guidelines and Field Memos | Developmental Disabilities Services Division (vermont.gov)

E. Payment will not be made for services furnished by:
   (1) Legal Guardian or spouse/domestic partner/civil union partner of legal guardian
   (2) Individual's parent, stepparent, or adoptive parent
   (3) Domestic partner or civil union partner of the parent
   (4) Spouse, domestic partner, or civil union partner of the individual
   (5) Payment will not be made to the spouse/domestic partner/civil union partner of a home provider for respite.
   (6) Payment may be made to the spouse/domestic partner/civil union partner of the home provider for Community Supports, and/or in-Home residential supports at the discretion of the contracting DS agency.

F. Variance requests may be made related to some of these qualifications. Follow the process outlined in the Variance Procedures for Direct Support Workers .

1.11 QUALIFIED DEVELOPMENTAL DISABILITIES PROFESSIONAL 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, found here: QDDP Protocol .

The QDDP for an individual may not be any of the following:

- Legal Guardian or spouse/domestic partner/civil union partner of legal guardian
- Individual's parent, stepparent, or adoptive parent
- Domestic partner or civil union partner of the parent
- Spouse, domestic partner, or civil union partner of the individual

- Home provider or spouse/domestic partner/civil union partner of a home provider.

1.12 HEALTH AND WELLNESS

An annual physical is required for all individuals receiving Home and Community-Based Services. Documentation of medical services varies depending on the type of supports received. Please see the Health and Wellness Guidelines for specific requirements.

All services must be delivered consistent with the Health and Wellness Guidelines .

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. Electronic signatures are allowable when consistent with the Vermont statute for Uniform Electronic Transactions Act.

2.1 HANDWRITTEN NOTES

All handwritten notes should be legible and must adhere to requirements stated in the Agency Records section.

2.2 PAPER RECORDS

The use of white-out in a 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 the change, time of the change, and signature of the person making the change.

2.4 REIMBURSABLE SERVICES

For a service to be reimbursable (except for - clinical assessment services, Family Managed Respite (see section 5.0 below regarding eligibility documentation) and some crisis supports), there must be on file:

A. An evaluation by a qualified evaluator documenting a developmental disability as specified in the Developmental Disabilities Services Regulations; the evaluation should include International Classification of Functioning Disability and Health (ICD) (current version) code for the developmental disability.
B. An ISA complete with all required components and signatures as indicated in the Individual Support Agreement (ISA) Guidelines, within 30 days of the first day of billable service/supports or authorized start date for HCBS or a Bridge CCP consistent with The Bridge Program: Care Coordination for Children with Developmental Disabilities Guidelines .

SUBMISSION OF PAID AND ZERO-PAID ENCOUNTER CLAIMS

3.0 SUBMITTING CLAIMS

Fee For Service:

Providers may submit fee for service claims based upon the approved rate on file (see DDSD Medicaid Claim Codes & Reimbursement Rates or the actual cost of service. In the case of Specialized Day Services and Bridge Care Coordination, for which the rate on file is noted as “pay as billed”, the amount billed shall be amount authorized by the DDSD, or the actual cost of services, whichever is less. For Psychiatric Diagnostic Evaluation, providers may submit the actual cost of services. Claims for Family Managed Respite must be within the approved rate ranges on file and reflect the actual cost of services.

Home and Community Based Services:

Submitting paid claims for Home and Community Based Services (HCBS) should follow the per member/per month (PMPM) billing process outlined in Appendix A. Claims cannot exceed the monthly rate authorized by DAIL.

Zero-paid encounter claims must also be submitted for each HCBS individual service category delivered.

Guidance for submitting zero paid encounter claims can be found in the DDSD Encounter Data Submission Guidance for Home and Community-based Services.

3.1 PAYMENT RATES

The Department of Disabilities, Aging and Independent Living retains sole authority to set payment rates. Rates are set and published annually by the Department of Disabilities, Aging and Independent Living. Medicaid Reimbursement Rates can be found on the DVHA Vermont Medicaid Portal and on DDSD websites: DDSD Medicaid Claim Codes & Reimbursement Rates.

For fee for service claims:

- Provider may bill either the authorized rate as indicated on the DDSD Medicaid Claims and Reimbursement Rates sheet or the actual cost of providing the service. However, the service will be reimbursed at no more than the rate on file, including after third party insurance payments are made.
- For services that are “pay as billed”, for which there is an approved rate on file (Specialized Day Services, Bridge Care Coordination) provider may bill no more than the Division’s approved rate on file.
- For Psychiatric Diagnostic Evaluation, which is “pay as billed”, the provider may bill the actual cost of services. However, reimbursement will be adjusted after third party liability payments have been applied.
- For Family Managed Respite, the rates on the claim must be within the rate range specified on the DDSD Medicaid Claim Codes and Reimbursement Rates sheet.

For HCBS claims:

- Providers must bill the authorized per member per month rate. Providers must adjust individual budgets as noted in Appendix A and the Vermont State System of Care Plan for Developmental Disabilities Services.
- Adjustments to rates in individual budgets must follow all guidance in the Vermont State System of Care Plan for Developmental Disabilities Services.
- For applicable services, rates reflected on individual budgets must be within the minimum and maximum rates noted on the DDSD Medicaid Claim Codes and Reimbursement Rates sheet.

For all services, the provider must accept, as payment in full, the amounts received from Medicaid.

3.2 HCBS BILLING EXCLUSIONS

A provider may not bill HCBS (99199 HW) for an individual on the same day as (non-HCBS) fee for service Clinical Services (90791, 90792, 90832, 90834, 90837, 90846, 90847, 90853, 96130, 96131, 96136, 96137, 99211, 99212, 99213, 99214, 99215, H2011), Family Managed Respite

(S5150, S5151), Bridge Program (T2022), Targeted Case Management (T1017), or Specialized Day Services (T2021).

A provider may not bill HCBS (99199 HW) when an individual is in a correctional facility, nursing facility, ICF/DD, level 1 psychiatric bed or other institutional placement that does not meet the federal HCBS setting rules for being considered community based.

3.3 FUNDING EXCLUSIONS

Medicaid developmental disabilities funding does not cover room and board, vacation expenses, clothing, or personal effects for individuals. There may be instances when the costs of a paid care giver accompanying a person on a vacation may be covered. See Vermont State System of Care Plan for Developmental Disabilities Services.

3.4 DOCUMENTATION OF SERVICE UNITS

Each unit of service billed or encountered must be documented in the individual's case record as outlined by individual service documentation requirements listed by service below. There are times when documentation may be in a separate file or in another provider's files, (e.g., 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. Reportable actions to calculate service units for HCBS can be found in the DDSD Encounter Data Submission Guidance for Home and Community-based Services.

3.5 BILLING PROVIDER IDENTIFICATION NUMBER

Providers must use the appropriate billing provider identification numbers for each service billed or encountered based on their provider type and specialty. The agency's provider ID associated with type 42, specialty 25 should be used when submitting paid and encounter claims for HCBS. The provider ID associated with type 38, specialty 13 should be used when submitting fee for service claims.

Providers must ensure that they are enrolled as the correct provider type and specialty, including correct National Provider Identifier (NPI) and taxonomy to allow for the processing of all claims.

3.6 CLAIM SUBMISSION TIMEFRAME

All paid and zero paid encounter claims must be submitted according to timely filing rules found on the DVHA website: Timely Filing for Claims | Department of Vermont Health Access. Initial claims must be submitted within 180 days of the date of service. See the above timely filing rules regarding processes for claims outside this window.

3.7 ALLOWABLE SERVICES BILLED

Submission of zero paid claims or fee for service billing is allowed for services provided by staff, contractors of the agency, and services paid through the Fiscal/Employer Agent (F/EA). Zero paid claims and fee for service billing are allowed for services provided by students/interns or clinicians working toward licensure, provided that the student/intern or clinician is supervised by a qualified staff of the designated agency/entity, is subject to all designated agency/entity, state, and federal 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 8.5 – "Supervised Billing for Behavioral Health Services" in the Vermont Medicaid Provider Manual .

Submission of zero paid claims or fee for service 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 or the employer of record.

Submission of zero paid claims or fee for service billing for services provided by contracted individuals is allowed provided the agency is responsible for claim submission and monitoring of the contracted individual (except for contracted physicians). Contracts must be available for review during Title XIX audits.

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;
- DA or SSA staff or role responsible to monitor the services provided by the contracted individual(s).

All contracting and subcontracting must be consistent with the requirements outlined in the Developmental Disabilities Services Regulations and the DA and SSA Provider Agreements.

For Self and Family Managed services, the employer of record is responsible for oversight of contracted services, e.g. camps, therapeutic horseback riding, therapy, etc.

3.8 SUBMISSION OF ENCOUNTER CLAIMS

Encounter claims must be reported for all services delivered to a person corresponding to the time period a provider agency is billing HCBS. Encounter claims should not be submitted for people for time periods when the agency is not submitting paid claims for HCBS. Submission of both paid claims and encounter data must follow the Medicaid rules for timely filing. It is not necessary to hold the submission of encounter claims until the monthly bundled claims are

billed. For complete information on encounter data submission, refer to the DDSD Encounter Data Submission Guidance for Home and Community-based Services.

HOME AND COMMUNITY-BASED SERVICES (HCBS)

4.0 INTRODUCTION

Individual Home and Community-Based Services (HCBS) budgets may comprise any or all the services and supports defined in this section and are included in an all-inclusive monthly rate (99199 HW 1 unit = 1 month) that combines all applicable services and supports provided to the individual. Submitting claims for HCBS must follow the Per Member Per Month billing process outlined in Appendix A.

The Billing Requirements listed for each service included in HCBS below refer to the amounts and rates of service for each individual submitted on the agency's monthly HCBS spreadsheet to DAIL for approval. These services are not billed separately but are all included in the monthly rate.

All services that are delivered must be reported as zero paid encounter claims using the codes listed for each service and consistent with the DDSD Encounter Data Submission Guidance for Home and Community-based Services.

This section includes descriptions of service definitions, worker qualifications, billing requirements, and documentation for a specific service. A list of the service definitions is also included in Appendix B.

See section 1.10 for general staff qualifications.

See section 3.0 for general billing procedures.

General Billing Guidelines for all HCBS

All HCBS services and supports must be provided in accordance with a person's Individual

Support Agreement (ISA) and applicable State and Federal requirements, including health and safety, training, and emergency procedures.

An individual is approved for an individualized Home and Community Based Services budget that is paid according to the Per Member Per Month (PMPM) methodology, included in Appendix A.

All budgets must be approved by the Department prior to billing. Adjustments to an individual's HCBS budget must follow the rules for suspensions and terminations and reflect the actual start

date of services as outlined in the Vermont State System of Care Plan for Developmental Disabilities Services. The authorized rate for each individual's services is reflected on the monthly HCBS spreadsheets approved by the Department.

When an individual transfers 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 for DDS, 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.

All funded services must be addressed within the ISA. The ISA must document the amount, duration, and scope of services. Each funded category of service must be reflected in the ISA either as an outcome or mentioned in the section related to other services that will be provided or coordinated (see each service category below for specific requirements).

For payment rate information and billing exclusions related to HCBS, see section 3.2 and 3.3 in this manual.

Home and community-based services can only be billed through one HCBS program on the same dates of service (e.g., DDSD, TBI, Choices for Care, DMH). For further information regarding billing for HCBS services, see the Vermont State System of Care Plan for Developmental Disabilities Services for the following areas:

- Billing when there is a vacancy in a group home.
- Limitations regarding billing of allowable services on the same date of service.
- Reasonable transportation expenses.

4.1 SERVICE PLANNING AND COORDINATION

T1016 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; oversight and coordination of services, phone calls/emails on behalf of the person, accompanying the person to appointments, planning, developing, and monitoring the ISA, including all attachments, coordinating medical and clinical services, 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 1.10. Some responsibilities of the service coordinator related to development and oversight of the ISA 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. See section 1.11 above for qualifications of a QDDP.

Billing Requirements

- The maximum rates for service coordination managed through a DA/SSA or self/family-managed will be published in the DDSD Medicaid Claim Codes & Reimbursement Rates.
- If actual costs are less than the published rate, the actual cost must be billed.
- 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. If an individual transfers back to a DA/SSA from self/family management, the DA/SSA rate is applied.

Required Documentation

- Service notes are required indicating what actions were taken on behalf of the individual for each date of service. Time completing reportable actions can be rolled up for the day to calculate units of service and these actions can be included in one note per day.
- Service Coordinator summaries (may be monthly or other frequency).
- QDDP ISA outcome review of progress (frequency is as noted in the individual's ISA)
- Home visit forms/notes for people in Shared Living.
- Service Coordinator Summaries, QDDP outcome reviews, and home visit notes may be combined into one document.
- Zero paid encounter data claim submissions.

4.2 COMMUNITY SUPPORTS

T2021 Community Supports, 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. 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. Transportation is a component part of Community Supports that is separately identified and included in the total hours of Community Supports.

Provided to an individual on a 1:1 or 2:1 basis, T2021 HW with U1 or U2 modifier only.

T2021 Community Supports, Group: 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. 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. Transportation is a component part of Community Supports that is separately identified and included in the total hours of Community Supports.

Provided to a group of 2-3 people per staff person, T2021 HW with UN or UP modifiers only.

T2021 Community Supports, Group Facility Based: 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. 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. Transportation is a component part of Community Supports that is separately identified and included in the total hours of Community Supports.

Provided to a group in a facility (agency operated location or adult day center).

T2021 HW, no additional modifiers U3, U4 and U5 are for future use. Use POS codes 39 for Adult Day Care and 53, Community Mental Health Center, for agency location.

Worker Qualifications

- Must meet requirements for all staff as described in minimum qualifications section 1.10 of this manual.

Billing Requirements

- Must follow Vermont State System of Care Plan for Developmental Disabilities Services requirements regarding billing and suspension if there is a gap in services.
- The rate for adult day services under HCBS may not exceed the DVHA rate on file.

Required Documentation

- There must be at least one outcome in the ISA related to Community Supports when it is a funded service.
- Documentation must reflect requirements outlined in the Individual Support Agreement (ISA) Guidelines.
- Documentation must reflect what is specified in the individual's ISA for collection of information and frequency of review to monitor progress for each outcome.
- Zero paid encounter data claim submissions

4.3 EMPLOYMENT SUPPORTS

Employment Supports means support provided to assist transition age youth and adults in establishing and achieving work and career goals. Employment Supports include assessment, employer and job development, job training and ongoing support to maintain employment, and may include environmental modification, adaptive equipment, and transportation, as necessary.

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

For all employment services, the following applies

Worker Qualifications

Must meet requirements for all staff as described in minimum qualifications section 1.10 of this manual.

Billing Requirements

- Must follow Vermont State System of Care Plan for Developmental Disabilities Services requirements regarding billing and suspension if there is a gap in services.
- 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.

H2023 Employer and Job Development assists an individual to access employment and establish employer development and support through employer contact on behalf of the individual. 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.

Required Documentation

- Documentation must reflect requirements outlined in the Individual Support Agreement (ISA) Guidelines.
- When this service has an outcome in the ISA, documentation must reflect what is specified in the individual's ISA for collection of information and frequency of review to monitor progress for each outcome.
- When this service does not have an outcome in the ISA, monthly service notes are required in each month the service is delivered.

- Zero paid encounter data claim submissions

H2024 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.

Required Documentation

- Documentation must reflect requirements outlined in the Individual Support Agreement (ISA) Guidelines.
- The results of the assessment must be documented in the record
- Monthly notes are required in each month assessment activities are performed
- Zero paid encounter data claim submissions

H2025 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.

Required Documentation

- There must be at least one outcome in the ISA related to Ongoing Support to Maintain Employment when it is a service delivered. Documentation must reflect requirements outlined in the Individual Support Agreement (ISA) Guidelines.
- Documentation must reflect what is specified in the individual's ISA for collection of information and frequency of review to monitor progress for each outcome.
- Zero paid encounter data claim submissions

T2012 Post-secondary Education and Technical Training: Support to assist transition age youth to engage in typical college experiences through self-designed education plans leading to competitive employment and independent living or support to participate in technical training for career development. Support must be provided in DAIL approved programs.

Required Documentation

- There should be at least one outcome on the ISA related to Post-secondary Education and Technical Training support when it is a Medicaid funded service.
- Documentation must reflect requirements outlined in the Individual Support Agreement (ISA) Guidelines.
- Documentation must reflect what is specified in the individual's ISA for collection of information and frequency of review to monitor progress for each outcome.
- Zero paid encounter data claim submissions

T2019 Job Training assists an individual to begin work, learn the job, and gain social inclusion at work.

Required Documentation

- Documentation must reflect requirements outlined in the Individual Support Agreement (ISA) Guidelines.
- When this service has an outcome in the ISA, documentation must reflect what is specified in the individual's ISA for collection of information and frequency of review to monitor progress for each outcome.
- When this service does not have an outcome in the ISA, monthly service notes are required in each month the service is delivered.
- Zero paid encounter data claim submissions

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 camp. All locations must comply with HCBS Settings Rule.

S5150 Respite Supports; per 15 minutes: 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. Provided to an individual on a 1:1 or 2:1 basis or small group of 2-3 individuals.

S5151 Respite Supports; daily: 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. Provided to an individual on a 1:1, 2:1 or 1:2 basis.

T2036 Camp, Overnight consists of attendance at a session of an overnight camp when it serves the same function as respite in providing an alternative caregiving arrangement for primary caregivers. A session is the full span of days, e.g., 1-2 weeks.

T2037 Camp, Day includes attendance at a session of a day camp when it serves the same function as respite in providing an alternative caregiving arrangement for primary caregivers. Cost of the camp session should be included on the encounter claim, up to amount equal to the typical cost of respite paid by 15-minute units times the number of hours attending the session. (e.g.: 25-hour session (100 units) X $15.00/hr. = $375).

Worker Qualifications

- Must meet requirements for all staff as described in minimum qualifications section 1.10 of this manual (except camps, who have their own worker qualifications).

Billing Requirements

- Billing should follow the Vermont State System of Care Plan for Developmental Disabilities Services for gaps in service when it cannot be expected that the funding will be utilized.
- Hourly respite must be used when provided less than 24 hours of continuous service.
- When hourly and daily respite overlap on the same date of service, please refer to the DDSD Encounter Data submission guidance (vermont.gov) for specific claims submission guidance.
- Daily respite can be used for respite provided for a continuous 24-hour period of which up to 8 hours of sleep time is excluded. See link to Department of Labor for full guidelines: Exclusion of Sleep Time from Hours Worked by Domestic Service Employees | U.S. Department of Labor (dol.gov)

Required Documentation

- Zero paid encounter data claim submissions.
- EVV, when applicable.
- Invoices for camps, which include the name of the camp, address, contact information, dates attended and cost.

4.5 CLINICAL SERVICES

Clinical Services means 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 that cannot be accessed through the Medicaid State Plan. Clinical services include Clinical Assessment, Individual Therapy, Family Therapy, Group Therapy, and Medication or Medical Support and Consultation.

General Worker Qualifications for Clinical Services:

For Master's level, or Bachelor's level intern providing clinical services through a formal internship as part of a clinical advanced degree program, non-licensed, rostered clinical staff, Supervised Billing rules apply. For more information refer to Section 3.6 – Supervised Billing for Behavioral Health Services in the Vermont Medicaid General Billing and Forms Manual on the DVHA website.

For information about covered telemedicine clinical services, including telehealth and audio-only services, please refer to the DVHA Medicaid Telehealth Rule.

Clinical Assessment services evaluate individuals' 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. Clinical Assessment includes the following services:

90791 Psychiatric Diagnostic Evaluation without Medical Services includes Clinical Assessment services to evaluate individuals' strengths; needs; existence and severity of disability(s); and functioning across environments. Assessment services may include evaluation of the support systems and community's strengths and availability to the individual and family. Psychiatric/psychological diagnostic interview without medical services, when not prescribing medications.

90792 Psychiatric Diagnostic Evaluation with Medical Service includes Clinical Assessment services to evaluate individuals' strengths; needs; existence and severity of disability(s); and functioning across environments. Assessment services may include evaluation of the support systems and community's strengths and availability to the individual and family. Psychiatric diagnostic interview with medical services when prescribing medications.

96130 Psychological and Neuropsychological Testing Evaluation Services; first hour Psychological testing evaluation services by a physician or other qualified health care professional, including integration of the person's data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the person, family members or caregivers, when performed. First hour only.

96131 Psychological and Neuropsychological Testing Evaluation Services; each additional hour Psychological testing evaluation services by a physician or other qualified health care professional, including integration of the person's data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and

interactive feedback to the person, family members or caregivers, when performed. Each hour after 96130.

96136 Psychological or Neuropsychological Test Administration and Scoring; First 30 minutes Psychological or neuropsychological test administration and scoring by a physician or other qualified health care provider, two or more tests, any method, first 30 minutes.

96137 Psychological or Neuropsychological Test Administration and Scoring; Each additional 30 minutes Psychological or neuropsychological test administration and scoring by a physician or other qualified health care provider, two or more tests, any method, each additional 30-minute increment after 96136.

Worker Qualifications

Only the following Medicaid enrolled providers may bill for 90792 Psychiatric Diagnosis and Evaluation with Medical Services:

- Licensed physician certified in psychiatry by the American Board of Medical Specialties;
- Licensed nurse practitioner, including APRNs, working within their scope of practice.

Only the following Medicaid enrolled providers may bill for Psychiatric Diagnosis and Evaluation without Medical Services:

- Licensed physician certified in psychiatry by the American Board of Medical Specialties;
- Licensed psychiatric nurse practitioner;
- Licensed psychologist;
- Licensed marriage and family therapist;
- Licensed clinical mental health counselor; and
- Licensed clinical social worker
- Licensed alcohol and drug abuse counselors

Psychological and Neuropsychological Testing Evaluation Services (96130 and 96131) must be provided by a Medicaid enrolled:

- Licensed physician with appropriate training and expertise in neuropsychological evaluation
- Licensed psychologist with appropriate training and expertise in neuropsychological evaluation
- Psychological or Neuropsychological Test Administration and Scoring (96136 and 96137) must be provided by:

- Licensed physician with appropriate training and expertise in neuropsychological evaluation
- Licensed psychologist with appropriate training and expertise in neuropsychological evaluation or
- Technician under the supervision of a licensed physician or psychologist with appropriate training and expertise in neuropsychological evaluation

For licensure requirements for clinicians diagnosing Intellectual Disability or Autism Spectrum Disorder to determine eligibility for DDS, please see section 7.100.3 of the Developmental Disabilities Services Regulations.

Billing Requirements

- Agencies must bill insurers other than Medicaid, or other third parties, first when applicable. See section 1.6 of this document for more information. Revenues from third parties must be accounted for on the agencies monthly HCBS spreadsheet.
- Provider may bill either the authorized rate or the actual cost of providing the service.
- While telehealth is allowable for codes 90791/90792, in many cases it would not be best practice given the cognitive and communication challenges of people with DD. It should only be used when the clinician has determined that it will be clinically effective.

Required Documentation

- An evaluation report which includes:
    - Date of evaluation
    - location
    - amount of time
    - summary of the assessment session
    - results and interpretation of any assessment tools administered
    - conclusions
    - diagnosis including current ICD code, when making a diagnosis
    - signature of the evaluator
- Zero paid encounter data claim submissions
- If clinical assessment is completed for the purposes of determining eligibility for Developmental Disabilities Services, documentation requirements for those evaluations are listed in the Developmental Disabilities Services Regulations

Individual, Family and Group Therapy

90832 (30 Min), 90834 (45 Min), 90837 (60 Min) 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.

90846 (without patient), 90847 (with patient) Family Therapy 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.

90853 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.

Worker Qualifications

Only the following Medicaid enrolled providers may bill for Individual Therapy, Family Therapy, or Group Therapy:

- Licensed physician certified in psychiatry by the American Board of Medical
- Specialties;
- Licensed psychiatric nurse practitioner;
- Licensed psychologist;
- Licensed marriage and family therapist;
- Licensed clinical mental health counselor; and
- Licensed clinical social worker
- Licensed alcohol and drug abuse counselors

Billing Requirements

- Agencies must bill insurers other than Medicaid or other third parties first, when applicable. See section 1.6 of this document for more information. Revenues received from third parties must be accounted for on the Agencies monthly HCBS spreadsheet.
- Provider may bill either the authorized rate or the actual cost of providing the service.
- Billing must be suspended if a projected or actual gap in services exceeds 14 days, except for intermittent services annualized in the individual budget (bi-weekly is not considered intermittent for this purpose).
- Psychotherapy sessions may be face-to-face, or via Telehealth when following the DVHA Medicaid Telehealth Rule and should include the appropriate corresponding telephonic location code or modifier, where applicable
- Only one charge may be made for a psychotherapy session regardless of the number of therapists present.
- Write-up time is included in the cost of the service and is not billable.
- 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. The service may be billed under the child's name.
- Group therapy is limited to no more than 3 sessions per week. Reimbursement is limited to one session per day, per group.

Required Documentation

- Treatment plan or plan of care outlined in ISA which includes:
  - A diagnosis relating to psychotherapy needs;
  - Goals for future therapy sessions;
  - The signature of clinician providing psychotherapy and their qualified supervisor when needed.
- Documentation must reflect requirements outlined in the [Individual Support Agreement (ISA) Guidelines] when included in the ISA.
- Documentation must reflect what is specified in the individual's ISA for collection of information and frequency of review to monitor progress for each outcome.
- Service/progress notes are required each time therapy is provided.
- Progress notes must include issues addressed, progress towards treatment goals and any needed follow-up.
- Zero paid encounter data claim submissions.

99211 - 99215 Medication and Medical Support and Consultation Services

- 99211 (5-9 minutes, delivered face-to-face or via telemedicine)
- 99212 (10-19 minutes, delivered face-to-face or via telemedicine)
- 99213 (20-29 minutes, delivered face-to-face or via telemedicine)
- 99214 (30-39 minutes, delivered face-to-face or via telemedicine)
- 99215 (40-54 minutes, delivered face-to-face or via telemedicine)
- 99441 (5-10 minutes, delivered telephonically)
- 99442 (11-20 minutes, delivered telephonically)
- 99443 (21-30 minutes, delivered telephonically)

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

- Psychiatric medication checks and nursing oversight for already established individuals.
- Psychiatric medication checks provided on a 1:1 basis.
- Nursing oversight may include support in-person or on behalf of the person to provide medical observation, support, and consultation for an individual's health care.
- Providing training and/or delegation on special care procedures to direct care staff (with person present).

Worker Qualifications

Only the following Medicaid enrolled providers may bill 99211-99215 and 99441-99443 Medication or Medical Support and Consultation services for psychiatric medication checks:

- Licensed physician certified in psychiatry by the American Board of Medical
- Specialties;
- Licensed nurse practitioner, including APRNs, working within their scope of practice.
- Nursing oversight and training/delegation of special care procedures may be provided by:
- Licensed nurse (APRN, RN or LPN)

Billing Requirements

- Agencies must bill insurers other than Medicaid or other third parties first, when applicable. See section 1.6 of this document for more information. Revenues received from third parties must be accounted for on the Agencies monthly HCBS spreadsheet.
- Provider may bill either the authorized rate or the actual cost of providing the service.
- May be provided face-to-face, or via Telehealth when following the DVHA Medicaid Telehealth Rule, when applicable.
- When providing services telephonically, use the corresponding “telephonic only” codes listed above.
- Billing must be suspended if a projected or actual gap in services exceeds 14 days except for intermittent services annualized in the individual budget such as quarterly med checks (bi-weekly is not considered intermittent for this purpose).

Required Documentation

- Treatment plan/plan of care (including special care procedures plan, when needed)
- signed by clinician/nurse.
- Documentation must reflect requirements outlined in the DDS Health and Wellness Guidelines.
- Service notes are required each time these services are provided.
- Zero paid encounter data claim submissions.

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.

H0046 Emergency/Crisis Beds offer emergency, short-term, 24-hour supports in a community setting other than the person’s home.

Worker Qualifications

- Must meet requirements for all staff as described in minimum qualifications section 1.10 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 Requirements

- Providers may continue to bill the PMPM while a person is in an emergency or crisis bed (this includes all crisis beds).
- Required Documentation
- Daily Notes are required.
- Visit Summary, including documentation of clinical evaluation and consultation activities, if completed.
- Zero paid encounter data claim submissions
- Medication administration records

Specific documentation requirements related to stays the **Vermont Crisis Intervention Network** crisis beds:

- Daily notes
- Written discharge plan, including recommendations.
- Copies of communication evaluation or recommendations, if completed
- Copies of Shared Risk Assessment, if completed
- Medication administration records, including medication change orders.
- Zero paid encounter data claim submissions

Specific documentation requirements related to stays in **Intensive Transition Supports (ITS)** beds:

- Assessment of the presenting behavioral challenges
- A Behavior Support Plan prior to discharge.
- Sending agency must have a plan for transition back to the community placement that must be reviewed and updated during the person's stay.
- The sending agency will also need to continue to follow an updated ISA, required documentation, and all documentation of medical services.

H2011 Emergency/Crisis Assessment, Support, and Referral includes include initial information gathering; triage; training and early intervention; supportive counseling; consultation; referral; crisis planning; outreach and stabilization; clinical diagnosis and evaluation; treatment and direct support.

Worker Qualifications

Must meet requirements for all staff as described in minimum qualifications section 1.10 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.

Required Documentation

- Daily service notes are required for each crisis response.
- Zero paid encounter data claim submissions

4.7 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.

For all Home Supports

Worker Qualifications

- Must meet requirements for all staff as described in minimum qualifications section 1.10 of this manual.
- Shared Living Providers must be a minimum of twenty-one (21) years of age.
- Billing Requirements
- Billing must be suspended if a projected or actual gap in services exceeds 14 days, except as noted in the Vermont State System of Care Plan for Developmental Disabilities Services.
- 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 accompanying a person on a vacation may be covered. See Vermont State System of Care Plan for Developmental Disabilities Services for more details.
- Costs for installation and testing of an emergency response system or home modifications must be removed from individual budgets once the item/service has been fully paid for.

S5135 Supervised Living are regularly scheduled, or intermittent hourly supports provided to an individual who lives in his or her own home or apartment. Supports are provided on a less than full time (not 24/7) schedule. May be provided 1:1, 2:1 or 1:2. Support in the community is allowable.

Required Documentation

- There must be at least one outcome for this service included in the individual's ISA when it is a funded service.
- Documentation must reflect the requirements outlined in the Individual Support Agreement (ISA) Guidelines.
- Documentation must reflect what is specified in the individual's ISA for collection of information and frequency of review to monitor progress for each outcome.
- Zero paid encounter data claim submissions
- EVV, when applicable

S5140 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.

Required Documentation

- There must be at least one outcome for this service included in the individual's ISA when it is a funded service.
- Documentation must reflect the requirements outlined in the Individual Support Agreement (ISA) Guidelines.
- Documentation must reflect what is specified in the individual's ISA for collection of information and frequency of review to monitor progress for each outcome.
- Home visit forms/notes for people in Shared Living.
- Service Coordinator Summaries, QDDP outcome reviews, and home visit notes may be combined into one document.
- Documentation must reflect requirements outlined in the Health and Wellness Guidelines.
- Zero paid encounter data claim submissions

S5145 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.

Required Documentation

- There must be at least one outcome for this service included in the individual's ISA when it is a funded service.
- Documentation must reflect the requirements outlined in the Individual Support Agreement (ISA) Guidelines.
- Documentation must reflect what is specified in the individual's ISA for collection of information and frequency of review to monitor progress for each outcome.
- Home visit notes.
- Documentation must reflect requirements outlined in the Health and Wellness Guidelines.
- Zero paid encounter data claim submissions.

S5160 Emergency Response System; Installation and Testing of a personal emergency response system (Example: Safety Connection). The system could be used by one or two individuals in the same home.

Required Documentation

- Invoices are required.
- Zero paid encounter data claim submissions.

S5161 Remote Support includes monthly access to remote support using technology for people living in their own home. Support may include access to support around activities of daily living, medication reminders, emotional support, counseling, problem solving, wellbeing check-ins, connection to emergency services, and/or in-person support.

Required Documentation

- Service notes are required. Notes may be per service or a monthly summary.
- Documentation must reflect the requirements outlined in the Individual Support Agreement (ISA) Guidelines. Must be included in the ISA as an outcome or listed as an additional support to be provided or coordinated.
- When this service has an outcome in the ISA, documentation must reflect what is specified in the individual's ISA for collection of information and frequency of review to monitor progress for each outcome.
- Zero paid encounter data claim submissions.

S5165 Home Modifications to a person's home needed for accessibility related to an individual's disability, including cost effective technology that promotes safety and independence in lieu of paid direct support. Examples of home modifications include ramps,

widening doors, accessible bathrooms for physical disabilities; visual fire alarm for a person who is deaf; plexiglass windows or alarms systems for safety.

Required Documentation

- Invoices are required
- Must be listed in the ISA as an additional support to be provided or coordinated.
- Zero paid encounter data claim submissions

T2016 Staffed Living supports are provided in a home setting for one or two people that is staffed on a fulltime basis by providers. Services in and about the person's residence. Support in the community is allowable. Service may be provided 1:1, 2:1 or 1:2.

Required Documentation

- There must be at least one outcome on the ISA related to Staffed Living when it is a funded service.
- Documentation must reflect the requirements outlined in the Individual Support Agreement (ISA) Guidelines.
- Documentation must reflect what is specified in the individual's ISA for collection of information and frequency of review to monitor progress for each outcome.
- Documentation must reflect requirements outlined in the Health and Wellness Guidelines.
- Zero paid encounter data claim submissions.

T2017 In-home Family Supports are regularly scheduled, or intermittent hourly supports provided to an individual who lives in the home of unpaid family caregivers. Supports are provided on a less than full time (not 24/7) schedule. May be provided 1:1, 2:1 or in a small group of 2-3 living in the same home. Support in the community is allowable.

Required Documentation

- There must be at least one outcome on the ISA related to in-home family supports when it is a funded service.
- Documentation must reflect the requirements outlined in the Individual Support Agreement (ISA) Guidelines.
- Documentation must reflect what is specified in the individual's ISA for collection of information and frequency of review to monitor progress for each outcome.
- Zero paid encounter data claim submissions
- EVV, when applicable.

T2017 Shared Living, Hourly Supports are regularly scheduled, or intermittent hourly supports provided to an individual who lives in Shared Living. May be provided 1:1, 2:1 or 1:2. Support in the community is allowable. Note: If this service is provided at the same time as the shared living provider is providing support, the staffing ratio should be coded as 1:1 as shared living will be reported separately.

Required Documentation

- Separate ISA outcomes are not required for Shared Living, Hourly; however, there must be documentation as required by the Individual Support Agreement (ISA) Guidelines when implementing an ISA outcome related to Shared Living (licensed or unlicensed).
- Zero paid encounter data claim submissions.
- EVV, when applicable.

T2033 Group Living supports provided in a licensed home setting for three to six people that is staffed full time by providers.

Required Documentation

- There should be at least one outcome on the ISA related to group living when it is a funded service.
- Documentation must reflect the requirements outlined in the Individual Support Agreement (ISA) Guidelines.
- Documentation must reflect what is specified in the individual's ISA for collection of information and frequency of review to monitor progress for each outcome.
- Documentation must reflect requirements outlined in the Health and Wellness Guidelines.
- Zero paid encounter data claim submissions.

4.8 TRANSPORTATION SERVICES

T2039 Transportation Services, Vehicle Modifications; acquisition and maintenance of accessible transportation for an individual living with a home provider or family member.

S0215 Transportation Services, Mileage reimbursement for mileage for transportation to access Community Supports or Employment Supports for non-agency workers paid through Fiscal/Employer Agent (ARIS).

Billing Requirements

- Suspension of billing for Vehicle Modifications should follow the guidance in the Vermont State System of Care Plan for Developmental Disabilities Services for gaps in service provision.

- The maximum annual cost for accessible transportation is published in the DDSD Medicaid Claim Codes & Reimbursement Rates sheet on the DDSD website.
- For T2039 Transportation Services, Vehicle Modifications add up all costs per date of service when submitting an encounter claim.

Required Documentation

- Invoices are required.
- For Vehicle modifications, documentation must reflect requirements outlined in the Individual Support Agreement (ISA) Guidelines. Must be listed in the ISA as an additional support to be provided or coordinated.
- Zero paid encounter data claim submissions.

4.9 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).

H2019 Behavioral Support, Assessment, Planning and Consultation Services include evaluating the need for, monitoring, and providing support and consultation for positive behavioral interventions/emotional regulation. Encounter data may only be reported for this service when it is provided by a behavioral consultant.

Worker Qualifications

- Must meet requirements for all staff as described in minimum qualifications section 1.10 of this manual. In addition, this service must be provided by a behavior consultant (which is described in the Behavior Support Guidelines as a person with training and skills in behavior analysis and positive behavior supports).

Billing Requirements

- Must be suspended if a projected or actual gap in services exceeds 14 days, except as noted in the Vermont State System of Care Plan for Developmental Disabilities Services.

Required Documentation

- Service notes are required

- A Behavior Support Plan consistent with the requirements outlined in the Behavior Support Guidelines is required. Must note the behavior consultant involved in developing the plan.
- Documentation must reflect the requirements outlined in the Individual Support Agreement (ISA) Guidelines.
- Documentation must reflect what is specified in the person's Behavior Support Plan for collection of information and frequency of review to monitor progress.
- Zero paid encounter data claim submissions.

H2032 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 1.10 of this manual. In addition, other supportive services that are provided by licensed or certified individuals and cannot be accessed through the State Plan, must be provided by individuals who are licensed or certified in their field.

Billing Requirements

- Group size does not need to be reported. May be reported as 1:1 for individualized service.
- Must be suspended if a projected or actual gap in services exceeds 14 days, except as noted in the Vermont State System of Care Plan for Developmental Disabilities Services.

Required Documentation

- Invoices are required for services paid through the F/EA or sub-contracted by providers. Invoices must include name of provider, address and contact information of the provider, a description of the service provided, number of service units provided, dates of service, and billing amount.
- Documentation must reflect the requirements outlined in the Individual Support Agreement (ISA) Guidelines. Must be included in the ISA as an outcome or listed as an additional support to be provided or coordinated.
- When this service has an outcome in the ISA, documentation must reflect what is specified in the individual's ISA for collection of information and frequency of review to monitor progress for each outcome.
- Zero paid encounter data claim submissions

T2025 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 their ability to communicate.

Worker Qualifications

- Must meet requirements for all staff as described in minimum qualifications section 1.10 of this manual. In addition, this service must be provided by a Licensed Speech Language Pathologist with expertise in Augmentative and Alternative Communication or a person with the following knowledge and experience in:
    A. Providing direct support to people with developmental disabilities.
    B. Assessing individuals with developmental disabilities who have complex communication support needs.
    C. Developing individualized communication support plans.
    D. Providing consultation, coaching, and training to individuals and their teams.
    E. Providing necessary support for an individual that is completed with and/or without the person present (e.g., technology support such as programming and modification of tools for communication).

Billing Requirements

- Must be suspended if a projected or actual gap in services exceeds 14 days, except as noted in the Vermont State System of Care Plan for Developmental Disabilities Services.

Required Documentation

- Service notes are required indicating what actions were taken on behalf of the individual for each date of service. Time completing reportable actions can be rolled up for the day to calculate units of service and these actions can be included in one note per day.
- Documentation must reflect the requirements outlined in the Individual Support Agreement (ISA) Guidelines.
- Documentation must reflect what is specified in the individual's ISA for collection of information and frequency of review to monitor progress.
- Zero paid encounter data claim submissions

OTHER COVERED SERVICES (NON-HCBS)

The following is a list of other covered services that are non-Home and Community-Based Services. HCBS 99199 HW and these fee for service non-HCBS services may not be billed on the same date of service. These services are billable under the DA/SSA's DDS fee for service billing provider ID, provider type 038 and specialty S13.

5.0 CLINICAL (NON-HCBS) SERVICES

Clinical services billed through fee for service (non-HCBS) can be provided within a community mental health or developmental disability service setting as well as community-based settings.

Clinical Services means 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 include Clinical Assessment, Individual Therapy, Family Therapy, Group Therapy, and Medication or Medical Support and Consultation.

General Worker Qualifications for Clinical Services

For Master's level, or Bachelor's level intern providing clinical services through a formal internship as part of a clinical advanced degree program, non-licensed, rostered clinical staff, Supervised Billing rules apply. For more information refer to Section 3.6 – Supervised Billing for Behavioral Health Services in the Vermont Medicaid General Billing and Forms Manual .

For information about covered telemedicine clinical services, including telehealth and audio-only services, please refer to the DVHA Medicaid Telehealth Rule.

Clinical Assessment services evaluate individuals' 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. Clinical Assessment includes the following services:

90791 Psychiatric Diagnostic Evaluation without Medical Services includes Clinical Assessment services to evaluate individuals' strengths; needs; existence and severity of disability(s); and functioning across environments. Assessment services may include evaluation of the support systems and community's strengths and availability to the individual and family. Psychiatric/psychological diagnostic interview without medical services, when not prescribing medications.

90792 Psychiatric Diagnostic Evaluation with Medical Service includes Clinical Assessment services to evaluate individuals' strengths; needs; existence and severity of disability(s); and functioning across environments. Assessment services may include evaluation of the support systems and community's strengths and availability to the individual and family. Psychiatric diagnostic interview with medical services when prescribing medications.

96130 Psychological and Neuropsychological Testing Evaluation Services; first hour
Psychological testing evaluation services by a physician or other qualified health care professional, including integration of the person's data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and

interactive feedback to the person, family members or caregivers, when performed. First hour only.

96131 Psychological and Neuropsychological Testing Evaluation Services; <u>each additional hour</u> Psychological testing evaluation services by a physician or other qualified health care professional, including integration of the person's data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the person, family members or caregivers, when performed. Each hour after 96130.

96136 Psychological or Neuropsychological Test Administration and Scoring; <u>First 30 minutes</u> Psychological or neuropsychological test administration and scoring by a physician or other qualified health care provider, two or more tests, any method, first 30 minutes.

96137 Psychological or Neuropsychological Test Administration and Scoring; <u>Each additional 30 minutes</u> Psychological or neuropsychological test administration and scoring by a physician or other qualified health care provider, two or more tests, any method, each additional 30-minute increment after 96136.

<u>Worker Qualifications</u>

Only the following Medicaid enrolled providers may bill for 90792 Psychiatric Diagnosis and Evaluation with Medical Services:

- Licensed physician certified in psychiatry by the American Board of Medical Specialties.
- Licensed nurse practitioner, including APRNs, working within their scope of practice.

Only the following Medicaid enrolled providers may bill for 90791 Psychiatric Diagnosis and Evaluation without Medical Services:

- Licensed physician certified in psychiatry by the American Board of Medical Specialties;
- Licensed psychiatric nurse practitioner;
- Licensed psychologist;
- Licensed marriage and family therapist;
- Licensed clinical mental health counselor; and
- Licensed clinical social worker
- Licensed alcohol and drug abuse counselors

Psychological and Neuropsychological Testing Evaluation Services (96130 and 96131) must be provided by a Medicaid enrolled:

- Licensed physician with appropriate training and expertise in neuropsychological evaluation
- Licensed psychologist with appropriate training and expertise in neuropsychological evaluation
- Psychological or Neuropsychological Test Administration and Scoring (96136 and 96137) must be provided by:
- Licensed physician with appropriate training and expertise in neuropsychological evaluation
- Licensed psychologist with appropriate training and expertise in neuropsychological evaluation or
- Technician under the supervision of a licensed physician or psychologist with appropriate training and expertise in neuropsychological evaluation

For licensure requirements for clinicians diagnosing Intellectual Disability or Autism Spectrum Disorder to determine eligibility for DDS, please see the section 7.100.3 of the Developmental Disabilities Services Regulations.

Billing Requirements

- Agencies must bill insurers other than Medicaid or other third parties first, when applicable. See section 1.6 of this document for more information.
- Provider may bill either the authorized rate as indicated on the DDSD Medicaid Claim Codes and Reimbursement Rates or the actual cost of providing the service. However, the service will be reimbursed at no more than the rate on file, including after third party payments are made.
- For services that are "pay as billed", provider may bill the actual cost of the service.
- While telehealth is allowable for codes 90791/90792, in many cases it would not be best practice given the cognitive and communication challenges of people with DD. It should only be used when the clinician has determined that it will be clinically effective.

Required Documentation

- An evaluation report which includes:
  - Date of evaluation
  - location
  - amount of time
  - summary of the assessment session
  - results and interpretation of any assessment tools administered
  - conclusions

  - diagnosis including current ICD code, when making a diagnosis
  - signature of the evaluator with their credentials

If clinical assessment is completed for the purposes of determining eligibility for Developmental Disabilities Services, documentation requirements for those evaluations are listed in Section 7.1.00.3 of the Developmental Disabilities Services Regulations.

Individual, Family and Group Therapy

90832 (30 Min), 90834 (45 Min), 90837 (60 Min) 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.

90846 (without patient), 90847 (with patient) 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.

90853 Group Therapy 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.

Worker Qualifications

Only the following Medicaid enrolled providers may bill for Individual Therapy, Family Therapy, or Group Therapy:

- Licensed physician certified in psychiatry by the American Board of Medical Specialties;
- Licensed psychiatric nurse practitioner;
- Licensed psychologist;
- Licensed marriage and family therapist;
- Licensed clinical mental health counselor; and
- Licensed clinical social worker
- Licensed alcohol and drug abuse counselors

Billing Requirements

- Agencies must bill insurers other than Medicaid or other third parties first, when applicable. See section 1.6 of this document for more information.
- Psychotherapy sessions can be face-to-face or via Telehealth, when following the DVHA Medicaid Telehealth Rule.
- Only one charge may be made for a psychotherapy session regardless of the number of therapists present.

- Write-up time is included in the cost of the service and is not billable.
- Provider may bill either the authorized rate as indicated on the DDSD Medicaid Claims and Reimbursement sheet or the actual cost of providing the service. However, the service will be reimbursed at no more than the rate on file, including after third party payments are made.
- Psychotherapy with a non-Medicaid eligible family member cannot be reimbursed by Medicaid with the exception of the bullet below.
- 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. The service is billed under the child's name.
- Group therapy is limited to no more than 3 sessions per week. Reimbursement is limited to one session per day, per group.

Required Documentation

- An evaluation documenting that the person has a developmental disability, consistent with criteria outlined in the Developmental Disabilities Services Regulations.
- Treatment plan or plan of care outlined in ISA which includes:
  - A diagnosis relating to psychotherapy needs;
  - Goals for future therapy sessions;
  - The signature of clinician providing psychotherapy and their qualified supervisor when needed.
- Documentation must reflect requirements outlined in the Individual Support Agreement (ISA) Guidelines when included in the ISA.
- When this service has an outcome in the ISA, documentation must reflect what is specified in the individual's ISA for collection of information and frequency of review to monitor progress for each outcome.
- Service/progress notes are required each time therapy is provided.
- Progress notes must include issues addressed, progress towards treatment goals and any needed follow-up

Medication and Medical Support and Consultation Services

This series is defined by specific time frames;

- **99211 5-9 Minutes**
- **99212 10-19 Minutes**
- **99213 20-29 Minutes**
- **99214 30-39 Minutes**
- **99215 40-54 Minutes**
- **99441 (5-10 minutes, delivered telephonically)**
- **99442 (11-20 minutes, delivered telephonically)**

- **99443 (21-30 minutes, delivered telephonically)**

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

- Psychiatric medication checks for already established individuals.
- Psychiatric medication checks provided on a 1:1 basis.
- Consultation regarding medication

Worker Qualifications

Only the following Medicaid enrolled providers may bill 99211-99215 and 99441-99443 Medication or Medical Support and Consultation services for psychiatric medication checks:

- Licensed physician certified in psychiatry by the American Board of Medical Specialties;
- Licensed nurse practitioner, including APRNs, working within their scope of practice.

Billing Requirements

- Agencies must bill insurers other than Medicaid or other third parties first, when applicable. See section 1.6 of this document for more information.
- Provider may bill either the authorized rate as indicated on the DDSD Medicaid Claim Codes and Reimbursement Rates or the actual cost of providing the service. However, the service will be reimbursed at no more than the rate on file, including after third party payments are made.
- May be provided face-to-face, or via Telehealth when following the DVHA Medicaid Telehealth Rule, when applicable.
- When providing services telephonically, use the corresponding "telephonic only" codes listed above.

Required Documentation

- An evaluation documenting that the person has a developmental disability, consistent with criteria outlined in the Developmental Disabilities Services Regulations.
- Treatment plan/plan of care which includes a diagnosis relating to the need for psychiatric medication, signed by the prescribing clinician;
- Documentation must reflect requirements outlined in the DDS Health and Wellness Guidelines.
- Service notes are required each time these services are provided with the signature of the prescribing clinician.

5.1 CRISIS SERVICES

Crisis Services are time-limited, intensive supports provided for individuals who are currently experiencing, or may be expected to experience, a psychological, behavioral, or emotional crisis.

H2011 Emergency/Crisis Assessment, Support, and Referral includes include initial information gathering; triage; training and early intervention; supportive counseling; consultation; referral; crisis planning; outreach and stabilization; clinical diagnosis and evaluation; treatment and direct support.

Worker Qualifications

Must meet requirements for all staff as described in minimum qualifications section 1.10 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 Requirements

- Provider must bill either the rate listed in DDSD Medicaid Claim Codes & Reimbursement Rates or the actual cost of providing the service, whichever is less.
- 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.
- A maximum of $1,600 per day may be billed when billing H2011, T1017 (TCM) or H2011 and T1017 combined.

Required Documentation

- Daily service notes are required for each crisis response. Clinician's signature when providing clinical evaluation or consultation.

5.2 PRE-ADMISSION SCREENING AND RESIDENT REVIEW SPECIALIZED DAY SERVICES

T2021 Pre-Admission Screening and Resident Review (PASRR) Specialized Day Services are available to individuals living in a nursing facility and who need additional services related to their developmental disability (e.g., social, behavior, communication) that are beyond the scope of the nursing facility.

Worker Qualifications

- Must meet requirements for all staff as described in minimum qualifications section 1.10 of this manual.

Billing Requirements

- This service must be prior authorized by DDS staff. The need for the service must be determined through a PASRR evaluation.
- The unit reimbursement rate is established by DDS staff for each agency.
- Specialized Day Services may be based in or outside a facility, including within an agency or a nursing facility.
- 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.
- Individuals can receive a maximum of 25 hours per week of Specialized Day Services.
- Transportation and case management services are included in the per unit billing rate and cannot be billed separately.

Required Documentation

- ISA within 30 days of the first date of service, including physician signature
- Documentation must reflect requirements outlined in the Individual Support Agreement (ISA) Guidelines.
- Documentation must reflect what is specified in the individual's ISA for collection of information and frequency of review to monitor progress for each outcome.
- A service note which includes:
    - Date
    - Location
    - Amount of time
    - Summary of service provided
    - Signature of staff providing service

5.3 TARGETED CASE MANAGEMENT

T1017 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 to gain access to needed medical, social, educational and other services.

Reimbursable Services - The following are reimbursable activities for TCM:

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

- Taking client history, including the Person's Story component of the ISA
- Identifying the needs of the individual, 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 (and periodic revision) a specific care plan (ISA):

- 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 such as making referrals to providers for needed services and scheduling appointments for the individual that help link an individual with:
    - Medical, social, educational providers; or
    - Other programs and services capable of providing needed services to address identified needs and achieve goals specified in the care plan,

Monitoring and follow-up activities:

- Activities, and contact, necessary to ensure the care plan is effectively implemented and adequately addressing the individual's needs.
- These activities, and contact, may be with the individual, family members, service 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.

Worker Qualifications

- Must meet requirements for all staff as described in minimum qualifications section 1.10 of this manual. The ISA must be signed by a QDDP. If the case manager is not a QDDP, they must be supervised by one who will co-sign the ISA.

Billing Requirements

- TCM may be billed for any of the reimbursable activities listed above.
- TCM may not be billed for the direct provision of medical, social, educational, and other services.
- TCM may only be billed for adults 18 years of age or older.
- 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 not be billed when a person is receiving any Home and Community-Based Service funding (e.g TBI program, Choices for Care, DMH HCBS programs).
- TCM may be billed for persons receiving other non-HCBS clinical services including family managed respite (S5150, S5151), individual psychotherapy (90832, 90834, 90837), group therapy (90853), family therapy (90846, 90847), emergency care (H2011), psychiatric diagnostic evaluation (90791, 90792), Psychological and Neuropsychological Testing Evaluation Services (96130, 96131), Psychological or Neuropsychological Test Administration and Scoring (96136, 96137) and medication management (99211-99215).
- A maximum of $1,600 per day may be billed when billing H2011 (Crisis), T1017 or H2011 and T1017 combined.
- TCM may not be billed for an individual residing in a correctional facility or for adults age 22-64 residing in a level 1 psychiatric facility (Brattleboro Retreat, Vermont Psychiatric Care Hospital). TCM may be billed for those residing in a hospital, residential school, rehabilitation facility, or crisis facility for the purposes of discharge planning when the service does not duplicate the facility's services and when provided 180 calendar days or less prior to discharge.
- The case manager may not:
    - restrict access to any other Medicaid service,
    - authorize or deny services,
    - compel an individual to receive TCM as a condition of receiving other services or
    - compel an individual to receive other services as a condition to receive TCM.

Required Documentation

- A psychological evaluation with adaptive behavior assessment documenting eligibility consistent with criteria outlined in the Developmental Disabilities Services Regulations.
- A completed ISA (within 30 days of first billable service). The ISA must include the timeline for obtaining needed services.
- There must be at least one outcome in the ISA for TCM services.
- Documentation must reflect requirements outlined in the Individual Support Agreement (ISA) Guidelines.

- Documentation must reflect what is specified in the individual's ISA for collection of information and frequency of review to monitor progress for each outcome.
- A service note which includes:
    - Date
    - Description of all activities performed (one note per day is allowable) including whether goals specified in the ISA are being achieved
    - Amount of time spent (may roll up all time spent on TCM activities that day)
    - Service location
    - Staff signature

TCM Conversion from HCBS:

Providers may request to convert unused HCBS funds to TCM when there are insufficient TCM funds available at their agency. They should submit a written request to DDSD Director asking to convert HCBS funds to TCM. The provider must include the client budget the funds would be coming out of, the effective date, and the amount. DDSD Director will allow or disallow the requested conversion. If approved, DDSD 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.

5.4 THE BRIDGE PROGRAM: CARE COORDINATION FOR CHILDREN WITH DEVELOPMENTAL DISABILITIES

T2022 The Bridge Program: Care Coordination for Children with Developmental Disabilities 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 service description, worker qualifications, billing requirements and required documentation can be found on the DDSD website:

The Bridge Program: Care Coordination for Children with Developmental Disabilities Guidelines

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.

5.5 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 service description, worker qualifications, billing requirements and required documentation can be found on the DDSD website:

[Family Managed Respite (FMR) Program Guidelines]

S5150 Respite Supports; per 15 minutes: 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. Provided to an individual on a 1:1 or 2:1 basis or a small group of 2-3 individuals.

S5151 Respite Supports; daily: 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. Provided to an individual on a 1:1, 2:1 or 1:2 basis.

Billing Requirements

- Billing must be within the minimum and maximum allowable hourly or daily rate established by the Department. See DDSD Medicaid Claim Codes & Reimbursement Rates.

Required Documentation

- A time sheet from the respite worker for each date the service is provided which includes:
    - the date
    - time spent
    - respite worker's signature
    - employer of record's signature
- EVV, when applicable

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 to 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 zero paid encounter claims and paid claims. Audits may also include a comprehensive review of claim data information from the Medicaid Management Information System (MMIS) and documentation of services provided, when applicable. All service providers should expect periodic audits of billing and utilization to ensure proper payments resulting from the following:

- Monthly Per Member Per Month 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 Developmental Disabilities Services Regulations.
- Payment for services included in a current approved ISA.

The Division is in the process of developing audit procedures that will be utilized after the implementation of payment reform. In the interim, the Division will be conducting audits as described below:

Medicaid audits for DDSD HCBS services will be performed quarterly. The audit will review paid and zero paid claims from the DA/SSA, FEA and Supportive ISO. Audits will review claims that are at least 6 months (180 days) past the date of service. For example, a Q1 audit will occur after March 31st. The audit report will review the PMPM claims for each month in the quarter to ensure that there is a corresponding service that has met a minimum 1 billable unit threshold for the month, as described in Appendix A. If there is no corresponding one unit of service, the relevant HCBS spreadsheet will be checked to verify that suspension for PMPM billing for that month is documented. If there is a suspension documented on the HCBS spreadsheet, no further action will be taken as the annual allocation is adjusted to account for the amount billed. If there is no suspension documented on the HCBS spreadsheet, a report with findings will be shared with the provider. The provider will have 30 days to review the errors and communicate a plan and timeline for resolution to the Division. The provider must submit documentation of the resolution to the Division. The Division will verify the resolution and communicate outcomes to the provider. If the provider cannot resolve the error within 90 days of receiving the Division's notice, a report will be sent to the DAIL Business Office to reduce the Agency's annual allocation by the amount billed in error.

Effective Date: 5.21.24

Technical Correction: 6.6.24

Medicaid audits for DDSD Fee for Service claims will be performed quarterly and will review paid claims that are at least 6 months past the date of service. The audit report will check to ensure that claims billed and paid are approved services covered under the DA/SSA, FEA, and Supportive ISO for service billing provider ID, provider type 038 and specialty S13. The audit will additionally check to ensure that "pay as billed" claims are paid at the Provider's authorized rate. If there are non-approved services and/or unauthorized rates billed and paid, a report with findings will be shared with the Provider and the DAIL Business Office. Providers should follow the guidance outlined in section 3 of the Vermont Medicaid Provider Manual (vtmedicaid.com) for reimbursement, recoupment, and claims processing procedures. The service provider has the right to appeal the results of an audit of HCBS or Fee for Service claims.

The provider agency has 30 days after receiving the subsequent determination to appeal to the Commissioner of the Department of Disabilities, Aging and Independent Living. The Commissioner will review the appeal and respond, either upholding the DDSD determination or issuing a new determination.

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

SANCTIONS

7.0 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, located at Covered-Services-Rules-083123.pdf (vermont.gov) .

APPENDIX A

Developmental Disabilities Services Home and Community-Based Services

Per Member Per Month payment method

Effective 12.1.23

Below is a description of the Per Member Per Month (PMPM) payment method for Developmental Disabilities Services (DDS) Home and Community-Based Services (HCBS) which went into effect on July 1, 2020. This method was set up as an interim step while DDS payment reform continues. The structure of this method was proposed by DDS providers and the final process was a result of a collaboration between the Department and the providers.

The procedure code for billing DDS HCBS is 99199 with a modifier HW.

Providers continue to use the Monthly HCBS Spreadsheet according to the instructions in the HCBS Spreadsheet Manual (HCBS Spreadsheet Manual for TII) to document the individual budgets for each recipient.

Per Member Per Month (PMPM) Rate Setting - The initial PMPM billing rate for the fiscal year (FY) will be set by DAIL prior to each provider submitting their first set of FY claims at the beginning of August. This is NOT a prospective payment thus the monthly claims must be submitted after the prior month's dates of service have passed. Each provider will have a unique monthly per person rate set based on their individual DS HCBS allocations and caseload counts at that time (per the latest DAIL approved waiver spreadsheet). DAIL will continue to set provider specific monthly rates each month for the rest of the fiscal year with a final reconciliation done after the close of the fiscal year. Each subsequent monthly rate will be set accounting for Medicaid revenue collected to-date, the revised allocation, new client count, and number of remaining months in the fiscal year. Example of how the new monthly billing rate is calculated:

August 1st rate calculation for July billing –

FY estimated beginning allocation (sum of individual budgets, plus any adjustments) = $10,000,000

Clients served = 200

July rate = $10M/200 = $50K/ 12 months = $4,166 PMPM

Sept 1st rate calculation for August billing –

FY revised allocation (per waiver spreadsheet changes) = $10,250,000

Clients served = 205

August rate = $10.25M minus $833,200 (200 x 4,166) of prior month Medicaid revenue = $9,416,800/205 clients = $45,936/ 11 months = $4,176 PMPM

This process would continue each month. It is important to note that Medicaid claims reports will be run by DAIL to gather the Medicaid paid to date amounts and will not be provided to DAIL by each provider.

Date Range on Claims – Providers should submit claims for the authorized PMPM after the month in which the service was delivered. A claim may be submitted as long as the person received one unit of service during that month. In most circumstances the date range should be the first of the month to the last day of the month. The unit is "1". In some circumstances a person may have only received services for part of the month because they were exiting or entering HCBS services with an agency. In these circumstances, you should reflect the actual days of service. This will prevent denials if the person transitions to another service within your agency or transfers to another agency. A few examples:

1) A person was receiving targeted case management for the first 10 days of a month and then starts receiving HCBS on the 11th day. You would use the 11 to the last day of the month as the date range.

2) A person received HCBS services from provider A from the 1-15th and provider B from the 16 to the end of the month. Each provider can submit a claim for that month but must reflect the actual dates of service in order to prevent a denial.

3) Billing for Bridge Care Coordination and HCBS is not allowed in the same month because they are both monthly billing codes. Agencies will need to monitor transfers between these programs to prevent billing both services in the same month.

Submission of HCBS Spreadsheets

- Each agency will submit their HCBS spreadsheet, updated with all known and required adjustments (by the 15th of the month for the previous month (billing will be based on the allocation indicated). Adjustments (e.g. suspensions, terminations, moving funds) must be made according to the guidance in the Vermont State System of Care Plan for Developmental Disabilities Services, and the HCBS Spreadsheet Manual (HCBS Spreadsheet Manual for TII).
- DAIL will review spreadsheet and make any adjustments needed.
- DAIL will rename spreadsheet to indicate that it is the adjusted version.

- Agency will make any adjustments indicated by DAIL on the current working version.
- Process will continue each month.

Accounting for third party clinical insurance payments:

Each agency will need to account for revenue received from third party insurance payments by providing the amount to DAIL (as an additional year to date revenue recognition to be used in rate calculation), or in the waiver spreadsheet, which will adjust the total waiver allocation remaining to be billed.

End of FY reconciliation process

DAIL will reconcile payments to providers with services/budgets authorized via monthly HCBS spreadsheets for the FY. (Note: this is not a process to reconcile payments to services delivered as reported through encounter claims.)

- Final FY Allocation - $X,XXX,XXX (per June approved spreadsheet – which is not available until after the close of the FY)
- Minus Third Party insurance payments to providers for the FY - $XX,XXX (given to DAIL from provider agency)
- Minus Medicaid Paid-to-Date for dates of service 7/1 – 5/30 of the FY (11 months of service based on a newly run Medicaid report by DAIL)
- Remaining allocation is divided by number of active participants in June (# of participants might have to be worked out between DAIL and DA/SSA if there is a discrepancy)
- DA/SSA will then recoup all June claims and rebill at the newly approved monthly PMPM.

The reason that reconciliation is needed is that changes to providers' allocations through adjustments to individual budgets are not approved by DAIL until a month or two after the actual dates of service. For the other eleven months of the fiscal year, any adjustments to budgets from the previous months billed are addressed in the subsequent months' PMPM rate. This process allows for a clean close out of the FY.

APPENDIX B

DEVELOPMENTAL DISABILITIES SERVICES CODES AND DEFINITIONS FOR

HOME AND COMMUNITY-BASED SERVICES

Individual budgets may include any of the services and supports defined in this document as authorized by DAIL and are included in an all-inclusive monthly rate that combines all applicable services and supports provided to the individual. The service codes listed are used by providers to submit encounter claims in the Medicaid Management Information System to report the delivery of each category of service. See [DDSD Encounter Data Submission Guidance for Home and Community-based Services] for specific details regarding submission of encounter claims.

The tables on the next three pages list the allowable services which can be included in the monthly billed rate.

Service	Code
Service Coordination	T1016
Community Supports	T2021
Employment Supports	
Employment Assessment	H2024
Employer and Job Development	H2023
Job Training	T2019
Ongoing Support to Maintain Employment	H2025
Post-Secondary Education and Technical Training Support	T2012
Respite	
Respite Supports, per 15 minutes	S5150
Respite Supports, per day	S5151
Camp, overnight	T2036
Camp, Day	T2037
Clinical Services	
Clinical Assessment	90791, 90792,

	96130, 96131, 96136, or 96137
Individual Therapy	90832, 90834, or 90837
Family Therapy	90846, or 90847
Group Therapy	90853
Medication and Medical Support and Consultation Services	99211, 99212, 99213, 99214, or 99215
Crisis Services	
Emergency/Crisis Assessment, Support and Referral	H2011
Emergency/Crisis Beds	H0046
Home Supports	
In-Home Family Support	T2017
Supervised Living	S5135
Staffed Living	T2016
Group Living	T2033
Shared Living (licensed)	S5145
Shared Living (non-licensed)	S5140
Shared Living, Hourly Supports	T2017
Emergency Response System: Installation and Testing	S5160
Remote Supports	S5161
Home Modifications	S5165

Transportation	
Transportation Services – Vehicle Modifications	T2039
Transportation Services – Mileage (for non-agency Workers paid through ARIS for Community and Employment Services only.)	S0215
Supportive Services	
Behavioral Support, Assessment, Planning and Consultation Services	H2019
Communication Support	T2025
Other Supportive Services	H2032

Below are the full service definitions with corresponding encounter claim codes. Abbreviated service definitions are included in section 7.100.2 of the Developmental Disabilities Services Regulations.

Service 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.

Encounter claim code: T1016

Community Supports

Community Supports: 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 (two or more people). Community supports includes transportation to access the community. 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 HCBS rules.

Encounter claim code: T2021

Employment Supports

Employment Supports means support provided to assist transition age youth and adults in establishing and achieving work and career goals. Employment supports include assessment, employer and job development, job training and ongoing support to maintain a job, and may include environmental modification, adaptive equipment and transportation, as necessary.

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

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.

Encounter claim code: H2024

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.

Encounter claim code: H2023

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

Encounter claim code: T2019

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.

Encounter claim code: H2025

Employment Supports do not include incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or,

3. Payments for vocational training that are not directly related to individuals' supported employment program.

Post-Secondary Education and Technical Training Support

Post-Secondary Education and Technical Training Support are supports to assist transition age youth to engage in typical college experiences through self-designed education plans leading to competitive employment and independent living or support to participate in technical training for career development. Support must be provided in DAIL approved programs.

Encounter claim code: T2012

<u>Respite Supports</u>

Respite Supports means 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 Supports provided per 15 minutes.

Encounter claim code: S5150

Respite Supports provided for a 24-hour period.

Encounter claim code: S5151

Camp, Overnight means attendance at a session of an overnight camp when it serves the same function as respite in providing an alternative caregiving arrangement for primary caregivers.

Encounter claim code: T2036

Camp, Day means attendance at a session of a day camp when it serves the same function as respite in providing an alternative caregiving arrangement for primary caregivers.

Encounter claim code: T2037

<u>Clinical Services</u>

Clinical Services means 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.

Clinical Assessment services evaluate individuals' 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.

Encounter claim codes: 90791, 90792, 96130, 96131, 96136, or 96137

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.

Encounter claim codes: 90832, 90834 or 90837

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.

Encounter claim codes: 90846 or 90847

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.

Encounter claim code: 90853

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

Encounter claim codes: 99211, 99212, 99213, 99214 or 99215

Crisis Services

Crisis Services means 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.

Emergency/Crisis Assessment, Support and Referral include initial information gathering; triage; training and early intervention; supportive counseling; consultation; referral; crisis planning; outreach and stabilization; clinical diagnosis and evaluation; treatment and direct support.

Encounter claim code: H2011

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

Encounter claim code: H0046

Home Supports

Home Supports means 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 shall be in compliance with HCBS rules which emphasize choice, control, privacy, tenancy rights, autonomy, independence and inclusion in the community.

An array of services is provided for individuals, as appropriate, in accordance with an individual planning process that results in an Individual Support Agreement (ISA). When applicable, the costs for home modifications or cost-effective technology are included in the daily rate paid to providers. Costs for room and board cannot be included in the daily rate.

In-home Family Supports are regularly scheduled, or intermittent hourly supports, provided to an individual who lives in the home of unpaid family caregivers. Supports are provided on a less than full time (not 24/7) schedule.

Encounter claim code: T2017

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

Encounter claim code: S5135

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

Encounter claim code: T2016

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

Encounter claim code: T2033

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.

Encounter claim code: S5145

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.

Encounter claim code: S5140

Shared Living, Hourly Supports are regularly scheduled, or intermittent hourly supports provided to an individual who lives in Shared Living.

Encounter claim code: T2017

Emergency Response System: Installation and Testing is one that allows access to Remote Support using technology for people living in their own home.

Encounter claim code: S5160

Remote Supports (excluding Emergency Response System: Installation and Testing) are access to remote support through an emergency response system using technology to support people living in their own home. Includes monitoring and availability of operators to provide independent living support and emergency responses.

Encounter claim code: S5161

Home Modifications are modifications to a person's home needed for accessibility related to an individual's disability.

Encounter claim code: **S5165**

<u>Transportation Services</u>

Transportation Services means acquisition and maintenance of accessible transportation for an individual living with a home provider or family member or reimbursement for mileage for transportation to access Community Supports.

Transportation Services-Vehicle Modifications means acquisition and maintenance of accessible transportation for an individual living with a home provider or family member.

Encounter claim code: T2039

Transportation Services – Mileage means reimbursement for mileage for transportation to access Community Supports or Employment Supports for non-agency workers paid through the Fiscal/Employer Agent (ARIS).

Encounter claim code: S0215 (Note: Mileage for agency staff should not be reported using this code. Mileage will be included in both the Community Supports and Employment Supports rates.)

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).

Behavioral Support, Assessment, Planning and Consultation Services include evaluating the need for, monitoring and providing support and consultation for positive behavioral interventions/emotional regulation.

Encounter claim code: H2019

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 their ability to communicate.

Encounter claim code: T2025

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).

Encounter claim code: H2032