2022

Waiver Provider Manual

FOR SPECIALIZED SERVICE PROVIDER NETWORK

KAREN COFFEY, DIRECTOR OF SYSTEM MANAGEMENT

ALABAMA DEPARTMENT OF MENTAL HEALTH |

Contents

Introduction 4
OCCUPATIONAL THERAPY 5
Occupational Therapy Services 5
Occupational Therapy Services Requirements 5
Occupational Therapy Documentation 5
Recertification Requirements 6
License Renewals 6
Recertification Documents Required 6
Additional Requirements 6
PHYSICAL THERAPY 7
Physical Therapy Service 7
Physical Therapy Services Requirements 7
Documentation Requirements 8
Recertification Requirements 8
License Renewals 8
Recertification Documents Required 8
Additional Requirements 8
SPEECH LANGUAGE THERAPY 9
Speech Language Therapy Service 9
Speech and Language Service Requirements 9
Documentation Requirements 10
Recertification Requirements 10
License Renewals 10
Recertification Documents Required 10
Additional Requirements 11
ASSISTIVE TECHNOLOGY 11
Assistive Technology Services 11
Service Requirements 12
Recertification Requirements 13
License Renewals 13
Recertification Documents Required 13

Additional Requirements 13
ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS 14
Environmental Accessibility Adaptations 14
Service Requirement 14
Documentation Requirements 15
Recertification Requirements 15
License Renewals 15
Recertification Documents Required 15
Additional Requirements 15
PERSONAL EMERGENCY RESPONSE SYSTEM (PERS) 16
INSTALLATION AND MONTHLY MONITORING 16
PERS Service 16
PERS Service Requirements 16
PERS Documentation Requirement 17
Recertification Requirements 17
License Renewals 17
Recertification Documents Required 17
Additional Requirements 18
POSITIVE BEHAVIOR SUPPORTS (PBS) 18
Positive Behavior Support Service 18
Positive Behavior Supports Requirements 19
Documentation Requirements 20
Recertification Requirements 20
License Renewals 20
Documents Required 21
Additional Requirements 21
REMOTE SUPPORT SERVICE 21
Remote Support Service 21
Remote Support Requirements 23
Recertification Requirements 24
License Renewals 24
Recertification Documents Required 24

Additional Requirements 24
SPECIALIZED MEDICAL SUPPLIES (SMS) 25
Specialize Medical Supplies Service 25
Specialized Medical Supplies Requirements 25
Recertification Requirements 26
License Renewals 26
Recertification Documents Required 26
Additional Requirements 26
Audits 27
Contact 29
Attachments: 30

Introduction

Waiver Services are designed to provide participants the care needed to remain in communities and avoid institutional placement while simultaneously assuring health and welfare are protected. The provider network that helps participants meet goals are key to the successful implementation of the waiver programs. We appreciate your dedication to serve waiver participants.

This manual's intent is to assist the provider to know what is needed in the provision of waiver services by describing those services in detail.

Providers will apply to become a provider and will be notified once that process is complete. Each provider will submit billing through ADMH/DDD data management system. The financial manager at the ADMH/DDD Regional Office closest to the provider physical location will make contact once approval is obtained to set up training in the Alabama Division of Intellectual Disabilities Information System (ADIDIS). There is no cost associated with the use of ADIDIS and there will be contact people with ADMH for assistance. All providers are required to have a National Provider Identification Number (NPI). Log onto https://nppes.cms.hhs.gov in order to bill for services and application cannot be processed without it.

Once a provider is approved for services, the name of the company and the service(s) to be provided will be added to the provider list in the area chosen in the application. When a participant chooses your company as the one to provide the service, the participant's support coordinator will contact you and you will be provided an authorization explaining the begin date for service.

OCCUPATIONAL THERAPY

Occupational Therapy Services

Occupational therapy is the application of occupation-oriented or goal-oriented activity to achieve optimum functioning, to prevent dysfunction, and to promote health. The term occupation as used in occupational therapy refers to any activity engaged in for evaluation, specifying, and treating problems interfering with functional performances. Services include assisting in the evaluation of an individual to determine level of functioning by applying diagnostic and prognostic tasks and guiding and treating individuals in the prescribed therapy to secure and/or obtain necessary functioning. Provision of this service will prevent institutional placement. Therapist may also provide consultation and training to staff or caregivers (such as clients family and /or foster family). Consultation/Training Services to direct caregivers will be allowed when the service to caregivers is for the direct benefit of the recipient and is necessary to enable the recipient to be cared for outside of an institution.

Occupational Therapy Services Requirements

Occupational Therapy requires a physician's prescription and documentation in the form of an initial assessment and development of a treatment plan with established goals that must be present in the case record and must justify the need for service. Services must be listed on the care plan and be provided and billed in 15-minute units of service. Occupational therapy is limited to no more than 50 hours or 200 units for the initial plan. If it appears that more therapy is needed, the OT will re-evaluate and submit another treatment plan that includes goals and outcomes, to the Support Coordinator who will complete a request for action to the Community Service Director at the Regional Office to approve. No more than an additional 50 hours, or 200 units will be allowed per occurrence per individual. The OT should teach the primary caregiver how to continue needed exercises for the participant. Occupational therapy under the waiver is not available to children under the age of 21 when provided as the result of an EPSDT screening, because that service is covered under the State Plan and not available to adults when the service is covered under the State Plan. Group therapy is not allowed.

Occupational Therapy Documentation

Providers of service must maintain the original prescription from the participant's physician, evaluation and results, the therapy plan and a service log that documents specific days on which occupational therapy services were delivered. Occupational therapists must document each therapy session in a treatment note and must sign each note denoting whether progress is made. Case notes should be sent to the individual's Support Coordination within 10 days of the service rendered dates. A case file for each waiver participant should be made and all required documents and any correspondence related to the participant included for auditing purposes.

Recertification Requirements

License Renewals

Occupational therapy providers must submit license at the time of the renewal. The new license may be sent by fax, scan, or email to the Director of System Management.

Recertification Documents Required

The following documentations is required every two years for Occupational Therapy service continuation with ADMH/DDD.

- Copy of licensure by the State of Alabama
- Proof of Liability Insurance at least $1 million dollars

If another Occupational Therapist (s) who provides service to a waiver participant is employed by the agency, the following must be included in each personnel record:

- Background Screen
- License issued by the State of Alabama
- Documentation of monthly debarment

Additional Requirements

To become an Occupational Therapy provider, ADMH/DDD will conduct searches at the U.S. Office of Inspector General (OIG), System for Award Management (SAM), and the Alabama Medicaid Agency website to ensure the therapist has not been debarred from providing services to Medicaid eligible participants.

ADMH/DDD will apply for enrollment to the Alabama Medicaid Agency on behalf of your agency, so that you will become a waiver service provider once the initial application has been checked and is complete. This application allows the business to submit claims for services rendered by tying your National Provider Identification number with ADMH/DDD waiver numbers. Medicaid will issue your agency a Medicaid Payee Number that will be entered into the ADMH/DDD electronic system. *Please Note: This number will not allow you to bill for Medicaid patients who are not waiver participants. To be able to perform services for the general Medicaid population, a separate application is required.*

Once ADMH/DDD has the approval from Medicaid, your information will be entered into the division's electronic system called ADIDIS, or Alabama Division of Intellectual Disabilities Information System.

Re-enrollment in the Medicaid billing system is required every two years and will be initiated by ADMH/DDD after receiving the information from Medicaid.

After all information is entered into ADIDIS, the Regional Office closest to the physical location of the providing agency will be notified. The financial manager at that Regional Office will contact you to provide training on accessing and claims billing.

PHYSICAL THERAPY

Physical Therapy Service

Physical therapy is treatment of an individual by the employment of effective properties of physical measures and the use of therapeutic exercises and rehabilitative procedures with or without assistive devices, for the purpose of preventing, correcting, or alleviating a physical or mental disability. Services must begin with the PT evaluation that, if necessary, results in the development of a treatment plan. The treatment plan should outline the frequency of service, goals of therapy, and outcomes or milestones to be reached by the participant. The PT may recommend exercises to the participant/family that will be completed at home that will help to ensure maximum potential is reached. The evaluation of an individual to determine level of functioning by applying diagnostic and prognostic tasks and providing treatment training programs that are designed to: preserve and improve abilities for independent function, such as range of motion, strength, tolerance, coordination and facility performing activities of daily living; and prevent irreducible progressive disabilities through means such as the use of orthotic and prosthetic appliances, assistive and adaptive devices, positioning, behavior adaptations and sensory stimulation.

Therapist may also provide consultation and training to staff or caregivers (such as client's family and/or another caregiver). Services to direct caregivers will be allowed when the service to caregivers is for the direct benefit of the recipient and is necessary to enable the recipient to be cared for outside of an institution.

Physical Therapy Services Requirements

Physical Therapy requires a physician's prescription and documentation in the form of an initial assessment and development of a treatment plan with established goals that must be present in the case record and must justify the need for service. Services must be listed on the care plan and be provided and billed in 15-minute units of service. Physical therapy is limited to no more than 5O hours or 200 units for the initial plan. If it appears that more therapy is needed, the PT will re-evaluate and submit another treatment plan that includes goals and outcomes, to the case manager who will complete a request for action to the CSD to approve. No more than an additional 50 hours, or 200 units will be allowed per occurrence per individual. The PT should teach the primary caregiver how to continue ROM exercises for the participant. Physical therapy under the waiver is not available to children under the age of 21 when provided as the result of an EPSDT screening,

because that service is covered under the State Plan, and is not available to adults when the service is covered under the State Plan. Group therapy is not allowed.

Documentation Requirements

Providers of service must maintain the original prescription from the participant's physician, evaluation and results, the therapy plan and a service log that documents specific days on which physical therapy services were delivered. Physical therapists must document each therapy session in a treatment note and must sign each note denoting whether progress is made. Case notes should be sent to the individual's Support Coordination within 10 days of the service rendered dates. A case file for each waiver participant should be made and all required documents and any correspondence related to the participant included for auditing purposes.

Recertification Requirements

License Renewals

Physical therapy providers must submit license at the time of the renewal. The new license may be sent by fax, scan, or email to the Director of System Management.

Recertification Documents Required

The following documentations is required every two years for Physical Therapy service continuation with ADMH/DDD.

- Copy of licensure by the State of Alabama
- Proof of Liability Insurance at least $1 million dollars

If another Physical Therapist (s) who provides service to a waiver participant is employed by the agency, the following must be included in each personnel record:

- Background Screen
- License issued by the State of Alabama
- Documentation of monthly debarment checks of the OIG, Alabama Medicaid website, and SAM.

Services may not be provided by physical therapy assistant.

Additional Requirements

To become a Physical Therapy provider, ADMH/DDD will conduct searches the U.S. Office of Inspector General (OIG), System for Award Management (SAM), and the Alabama Medicaid Agency website to ensure the therapist has not been debarred from providing services to Medicaid eligible participants.

ADMH/DDD will apply for enrollment to the Alabama Medicaid Agency on behalf of your agency, so that you will become a waiver service provider once the initial

application has been checked and is complete. This application allows the business to submit claims for services rendered by tying your National Provider Identification number with ADMH/DDD waiver numbers. Medicaid will issue your agency a Medicaid Payee Number that will be entered into the ADMH/DDD electronic system. *Please Note: This number will not allow you to bill for Medicaid patients who are not waiver participants. To be able to perform services for the general Medicaid population, a separate application is required.*

Once ADMH/DDD has the approval from Medicaid, your information will be entered into the division's electronic system called ADIDIS, or Alabama Division of Intellectual Disabilities Information System.

Re-enrollment in the Medicaid billing system is required every two years and will be initiated by ADMH/DDD after receiving the information from Medicaid.

After all information is entered into ADIDIS, the Regional Office closest to the physical location of the providing agency will be notified. The financial manager at that Regional Office will contact you to provide training on accessing and claims billing. Physical Therapy is reimbursed in 15 minute units.

SPEECH LANGUAGE THERAPY

Speech Language Therapy Service

Speech and language therapy include diagnostic, screening, preventive, corrective services provided on an individual basis, when referred by a physician (M.D., D.O.). These services may include: Screening and evaluation of individuals, speech and hearing functions and comprehensive speech and language evaluation; participation and may include swallowing therapy in the continuing interdisciplinary evaluation of individuals for purposes of implementing, monitoring and following up on individuals habilitation programs; and treatment services as an extension of the evaluation process that include: consulting with others working with the individual for speech education and improvement, designing specialized programs for developing an individual communication skills comprehension and expression. Provision of this service in the community is an alternative to an institutional level of care. Therapist may also provide training to staff and caregivers (such as a client's family and/or foster family). Services to direct caregivers will be allowed when the service to caregivers is for the direct benefit of the recipient and is necessary to enable the recipient to be cared for outside of an institution. Speech Therapy is expected to be therapeutic with outcomes and goals based on the therapist evaluation.

Speech and Language Service Requirements

Services must be listed on the care plan and prescribed by the participant's physician and related to a participant's particular diagnosis. An evaluation is required by the speech therapist to determine the need for service. If there is a

need for service, the Speech Therapist must develop the treatment plan outlining the frequency of service and length of time expected to meet outlined goals and expected outcomes. The need for service must be documented in the case record and the outcome is expected improvement for the waiver participant. Speech and Language Therapy is limited 30 visits in any one planned therapy program. The service is expected to terminate when the goals of the developed treatment plan are met or when no further progress is anticipated. However, a request for an extension of therapy, up to an additional 30 visits, complete with proper justification showing the progress toward the goal(s) must be submitted by the case manager to the CSD for approval following the regular RFA established process. Services shall be provided and billed as an encounter unit of service and with only one encounter daily. Documentation of service provided by the Speech Therapist is required for each encounter and each note must be signed by the therapist. Notes must be maintained in the client file. Speech/Language Therapy must be due to an acute episode and should terminate once therapy becomes maintenance in nature. When provided as the result of an EPSDT screening, children under the age of 21 should utilize services covered under the State Plan. Speech therapy is available to adults when the service is not covered under the State Plan. Group therapy will not be reimbursed.

Documentation Requirements

Providers of service must maintain a service log that documents specific days on which speech and language therapy services were delivered and detailed documentation of what the service entailed. Therapist must keep notes and document participant progress toward the planned goals. Documentation of progress toward specific goals are required. Providers of service must maintain the original prescription from the participant's physician, evaluation and results, and the therapy plan. A case file for each waiver participant should be made and all required documents and any correspondence related to the participant included for auditing purposes.

Recertification Requirements

License Renewals

Speech/language therapy providers must submit license at the time of the renewal. The new license may be sent by fax, scan, or email to the Director of System Management.

Recertification Documents Required

The following documentations is required every two years for Speech/Language Therapy service continuation with ADMH/DDD.

- Copy of licensure by the State of Alabama
- Proof of Liability Insurance at least $1 million dollars

If another Speech/Language Therapist (s) who provides service to a waiver participant is employed by the agency, the following must be included in each personnel record:

- Background Screen
- License issued by the State of Alabama
- Documentation of monthly debarment checks of the OIG, Alabama Medicaid website, and SAM.

Services may not be provided by speech/language therapy assistant.

Additional Requirements

To become a Speech/Language Therapy provider, ADMH/DDD will conduct searches the U.S. Office of Inspector General (OIG), System for Award Management (SAM), and the Alabama Medicaid Agency website to ensure the therapist has not been debarred from providing services to Medicaid eligible participants.

ADMH/DDD will apply for enrollment to the Alabama Medicaid Agency on behalf of your agency, so that you will become a waiver service provider once the initial application has been checked and is complete. This application allows the business to submit claims for services rendered by tying your National Provider Identification number with ADMH/DDD waiver numbers. Medicaid will issue your agency a Medicaid Payee Number that will be entered into the ADMH/DDD electronic system. *Please Note: This number will not allow you to bill for Medicaid patients who are not waiver participants. To be able to perform services for the general Medicaid population, a separate application is required.*

Once ADMH/DDD has the approval from Medicaid, your information will be entered into the division's electronic system called ADIDIS, or Alabama Division of Intellectual Disabilities Information System.

Re-enrollment in the Medicaid billing system is required every two years and will be initiated by ADMH/DDD after receiving the information from Medicaid.

After all information is entered into ADIDIS, the Regional Office closest to the physical location of the providing agency will be notified. The financial manager at that Regional Office will contact you to provide training on accessing and claims billing. Speech Therapy is reimbursed as an encounter rate.

ASSISTIVE TECHNOLOGY

Assistive Technology Services

Assistive technology means an item, piece of equipment to include Specialized Durable Medical Equipment (including any equipment not covered by Medicaid

State Plan Services), service animal or product system, whether acquired commercially, modified, or customized that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assist an individual in the selection, acquisition, or use of an assistive technology device that may include:

(A) the evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant.

(B) services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants.

(C) services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices.

(D) coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan.

(E) training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and

(F) training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants. Providers of this service must maintain documentation of items purchased for everyone.

Service Requirements

A prescription from the participant's physician is required for this service. The provider must send a copy of the RX to the Support Coordinator along with any evaluation/assessment completed, a price quote providing breakdown of the individual items recommended for purchase and the cost of each, training plans, maintenance policy and applicable warranty on the item. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the recipient. Payment is for the cost of the item provided. There is a $5,000 per year, per individual maximum cost limitation. For children under 21 years of age, State Plan Services available through EPSDT are utilized prior to expending waiver funds. A file should be kept for each waiver participant. Any additional information or correspondence regarding the purchase of Assistive Technology should be placed in the case file.

Self-Directed Assistive Technology is only available to those participants who are self-directing personal care, companion and/or LPN/RN services.

Recertification Requirements

License Renewals

At any time during the year the AT provider receives a new license, it can be sent in at that time.

Recertification Documents Required

AT providers must be recertified yearly. Documentation includes a copy of the latest business license, proof of liability insurance and requirements outlined in the Alabama Code 34-14C:1-8. Providers of this service must meet the same standards required for the providers under the Alabama State Plan which is in the Alabama Medicaid Provider Manual Chapter 14 and the Medicaid's Administrative Code Chapter 13. Providers must also adhere to the Department of Mental Health guidelines found in the Alabama Administrative Code 580-3023, 580-3-25, 580-3-26, 580-5-30 and the Division of Developmental Disabilities Operational Guidelines. All documents are included in the manual.

Additional Requirements

To become an Assistive Technology provider, ADMH/DDD will conduct searches the U.S. Office of Inspector General (OIG), System for Award Management (SAM), and the Alabama Medicaid Agency website to ensure the therapist has not been debarred from providing services to Medicaid eligible participants.

ADMH/DDD will apply for enrollment to the Alabama Medicaid Agency on behalf of your agency, so that you will become a waiver service provider once the initial application has been checked and is complete. This application allows the business to submit claims for services rendered by tying your National Provider Identification number with ADMH/DDD waiver numbers. Medicaid will issue your agency a Medicaid Payee Number that will be entered into the ADMH/DDD electronic system. *Please Note: This number will not allow you to bill for Medicaid patients who are not waiver participants. To be able to perform services for the general Medicaid population, a separate application is required.*

Once ADMH/DDD has the approval from Medicaid, your information will be entered into the division's electronic system called ADIDIS, or Alabama Division of Intellectual Disabilities Information System.

Re-enrollment in the Medicaid billing system is required every two years and will be initiated by ADMH/DDD after receiving the information from Medicaid.

After all information is entered into ADIDIS, the Regional Office closest to the physical location of the providing agency will be notified. The financial manager at that Regional Office will contact you to provide training on accessing and claims

billing. A participant/guardian should sign that the service was received prior to billing. The reimbursement rate is by the item, ut cannot exceed $5000.00 per waiver participant per waiver year.

ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS

Environmental Accessibility Adaptations

Those physical adaptations to the home, required by the individual plan of care, which are necessary to ensure the health, welfare, and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the recipient would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the recipient, but shall exclude those adaptations or improvements to the home which are of general utility and not of direct medical or remedial benefit to the waiver client, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit. An evaluation by a Physical Therapist may be necessary to assist in the determination of structural requirements and need for the EAA service. All services shall be provided in accordance with applicable State or local building codes as well as ADA Standards.

Service Requirement

Rental and leased property are excluded from modifications as it the landlord's responsibility for ensuring property is accessible, however, if costs prohibit adaptations, some modification could be considered, such as, modular ramps or any that could be moved if the individual changes residence. Adaptations to the work environment covered by the Americans with Disabilities Act, or those that are the responsibility of other agencies, are not covered. Covered adaptations of rented or leased homes should be those extraordinary alterations that are uniquely needed by the individual and for which the property owner would not ordinarily be responsible.

Payment is for the cost of material and labor. The unit of service would be the job. Total costs of environmental accessibility adaptations shall not exceed $5,000 per year, per individual. This service does not require a prescription from the participant's physician. All other community resources should be explored and exhausted prior to expending waiver funding. A file should be kept for each waiver participant. Any additional information or correspondence regarding the purchase of EAA should be placed in the case file.

Self-Directed Environmental Accessibility Adaptations are only available to those participants who are self-directing personal care, companion and/or LPN/RN services.

All construction, wiring, and plumbing provided must meet applicable building codes.

Documentation Requirements

Providers of service must maintain a service log that documents specific days on services were delivered and detailed documentation of what the service entailed. Any evaluation performed and provided to the EAA provider. A quote for the cost of materials and labor sent to the participant's support coordinator. A case file for each waiver participant is suggested and should be made and all required documents and any correspondence related to the participant included for auditing purposes.

Recertification Requirements

License Renewals

License issued Alabama Licensing Board for General Contractors must be sent to the ADMH/DDD at the time of the initial enrollment and annually thereafter. Providers must meet all applicable State (Alabama Code 230-X-1) and Local Licensure requirements. (See attachment)

Recertification Documents Required

Current license by the state of Alabama Board of General Contractors

Additional Requirements

Once receiving conditional approval to become an EAA provider, ADMH/DDD will conduct searches the U.S. Office of Inspector General (OIG), System for Award Management (SAM), and the Alabama Medicaid Agency website to ensure the therapist has not been debarred from providing services to Medicaid eligible participants.

ADMH/DDD will apply for enrollment to the Alabama Medicaid Agency on behalf of your agency, so that you will become a waiver service provider once the initial application has been checked and is complete. This application allows the business to submit claims for services rendered by tying your National Provider Identification number with ADMH/DDD waiver numbers. Medicaid will issue your agency a Medicaid Payee Number that will be entered into the ADMH/DDD electronic system. *Please Note: This number will not allow you to bill for Medicaid patients who are not waiver participants. To be able to perform services for the general Medicaid population, a separate application is required.*

Once ADMH/DDD has the approval from Medicaid, your information will be entered into the division's electronic system called ADIDIS, or Alabama Division of Intellectual Disabilities Information System.

Re-enrollment in the Medicaid billing system is required every two years and will be initiated by ADMH/DDD after receiving the information from Medicaid. The reimbursement rate is $5,000.00 per participant per waiver year.

PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

INSTALLATION AND MONTHLY MONITORING

PERS Service

Personal emergency response system (PERS) is a service that provides a direct telephonic or other electronic communications link between someone living in the community and health professionals to secure immediate assistance in the event of a physical, emotional, or environmental emergency. This service may include installation, monthly fee (if applicable), upkeep and maintenance of devices or systems as appropriate. As with any service, an assessment should be administered to the participant to ensure appropriateness of the device and that the participant demonstrates the capabilities to use the devices as intended.

The use of these technologies requires assurance that safeguards are in place to protect privacy, provide informed consent, and that documented needs are addressed in the least restrictive manner. The person-centered plan should identify options available to meet the need of the individual in terms of preference while also ensuring health, safety, and welfare. Personal risk factors should be discussed, information regarding data collection should be discussed, customized list of individuals/providers to be notified of alerts should be customized, who will be allowed access to data (service provider/staff), and choice should be afforded between providers of both equipment and monitoring. The person-centered plan should also include the purpose of the PERS, back-up system for PERS in times of electronic outages or failure, training of caregiver (paid and unpaid), provider/caregiver response time for different events, safeguards for protection of the person's privacy related to remote support and data collection.

PERS Service Requirements

Emergency Response System installation and testing is approximated to cost $500.00; Emergency Response Monthly Service Fee (excludes installation and testing) is approximated to cost no more than $83.00/month; Emergency Response system purchase is approximated to cost $1,500.00. The maximum cost for all PERS per year is $3000.00

This service will not be authorized for person's receiving residential habilitation. PERS will not replace supervision and monitoring of activities of daily living which are provided to meet requirements of another service (i.e., personal care; day habilitation).

The PERS provider should assure that these devices, where applicable, meet Federal Communication Commission standards or Underwriters Laboratory standards or the equivalent.

The installation of PERS systems should be done by qualified installers representing the health agency managing the personal emergency response system. In the event these installers are not available the agency should seek experienced technicians to complete necessary line adaptations. The minimum requirements for PERS:

1) Provide an alert button or other mechanism that can be activated by the person to indicate the needs for emergency assistance and/or utilize technology to detect a possible adverse event indicating the need for immediate response.

2) Immediately transmit/communicate the alert to a central clearinghouse that maintains 24/7 immediate/real time recognition of and response to the alert and includes a "failsafe" procedure that assures that every alert for assistance is responded to in a timely manner as defined in the person's person-centered plan or PERS parameters.

3) A call tree that reflects the person's needs and preferences.

4) Assurance that any agency or individual who creates, collects, records, maintains, stores, or discloses any individually identifiable participant data complies with the Health Insurance Portability and Accountability Act (HIPAA) and all other data privacy laws and requirements.

5) Address the documented risk factors and preferences of the person.

Self-Directed PERS are only available to those participants who are self-directing personal care, companion and/or LPN/RN services.

PERS Documentation Requirement

A quote for the monitoring system and the monthly monitory fee must be submitted to the participant's support coordinator along with any assessment performed to determine the appropriateness of the PERS for the participant. Monthly fees for service must be maintained in the participant's case file along with any correspondence with the participant and/or support coordinator.

Recertification Requirements

License Renewals

At any time during the year the PERS provider receives a new license, it can be sent to the central office at that time.

Recertification Documents Required

PERS providers must be recertified every two years. Documentation includes a copy of the latest business license, proof of liability insurance Manual Chapter 14 and the Medicaid's Administrative Code Chapter

Additional Requirements

To become an EAA provider, ADMH/DDD will conduct searches the U.S. Office of Inspector General (OIG), System for Award Management (SAM), and the Alabama Medicaid Agency website to ensure the therapist has not been debarred from providing services to Medicaid eligible participants.

ADMH/DDD will apply for enrollment to the Alabama Medicaid Agency on behalf of your agency, so that you will become a waiver service provider once the initial application has been checked and is complete. This application allows the business to submit claims for services rendered by tying your National Provider Identification number with ADMH/DDD waiver numbers. Medicaid will issue your agency a Medicaid Payee Number that will be entered into the ADMH/DDD electronic system. *Please Note: This number will not allow you to bill for Medicaid patients who are not waiver participants. To be able to perform services for the general Medicaid population, a separate application is required.*

Once ADMH/DDD has the approval from Medicaid, your information will be entered into the division's electronic system called ADIDIS, or Alabama Division of Intellectual Disabilities Information System.

Re-enrollment in the Medicaid billing system is required every two years and will be initiated by ADMH/DDD after receiving the information from Medicaid.

POSITIVE BEHAVIOR SUPPORTS (PBS)

Positive Behavior Support Service

Positive Behavior Support (PBS) is a set of researched-based strategies that combines behavioral and biomedical science with person-centered, valued outcomes and systems change to increase quality of life and decrease problem behaviors by teaching new skills and making changes in a person's environment. The strategies take into consideration all aspects of the person's life and are intended to enhance positive social interactions across work, academic, recreational, and community settings while reducing actions that are not safe or that lead to social isolation, loneliness, or fearfulness. PBS provides framework for approaches that emphasize understanding the person, strengthening environment that build on individual strengths and interests, and decreasing interventions that focus on controlling problematic behavior to fit the person's environment. Billable tasks include conducting functional behavior assessments, behavior support plan (BSP) development, training to implement the BSP, data entry/analysis/graphing, monitoring effectiveness of BSP, writing progress notes/reports, etc. BSP may include consultation provided to families, other caretakers, and habilitation services providers. BSP shall place primary emphasis on the development of desirable adaptive behavior rather than merely the elimination or suppression of undesirable

behavior. A behavior support plan may only be implemented after positive behavioral approaches have been tried, and its continued use must be reviewed every thirty days with reports due quarterly.

Positive Behavior Supports Requirements

Positive Behavior Support (PBS) waiver service is comprised of two general categories of service tasks. These are (1) development of a Behavior Support Plan (BSP) and (2) implementation of a BSP. In addition, this waiver service has three service levels: two professional and one technical, each with its own procedure code and rate of payment. The service levels are distinguished by the qualifications of the service provider and by supervision requirements. Both professional and technical level service providers may perform tasks within both service categories, adhering to supervision requirements that are described under provider qualifications. The two professional service provider levels are distinguished by the qualifications of the person providing the service. Both require advanced degrees and specialization, but the top level also requires board certification in behavior analysis. The third service provider level is technical and requires that the person providing the service be under supervision to perform PBS tasks. Providers of this service is required to perform the required monthly exclusion lists, AMA, and OIG for all staff. Documentation of monthly checks are required.

The maximum units per year of both professional and technician level units in combination cannot exceed 1200 and the maximum units of any combination of professional level one (1) or two (2) cannot exceed 800. Maximum units of Technician level service are the balance between billed professional level one (1) and two (2) units and the combined maximum per year. Professional level providers may provide more than the 800-unit limit, but these additional units will be paid at the Technician level up to the 1200 max on total units. Providers of service must document which tasks are provided by date performed in addition to their clinical notes. There will be no accommodation for exceeding the overall cap of 1200 units for all three levels. The following do not qualify for billing under this waiver service: 1) individual or group therapy, 2) group counseling, 3) behavioral procedures not listed in a formal BSP or that do not comply with the current Behavioral Services Procedural Guidelines and Community Certification Standards, 4) non-traditional therapies, such as music therapy, massage therapy, etc., 5) supervision.

PBS service under the waiver is not available to children under the age of 21 when provided as the result of an Early Periodic Screening Diagnostic Testing (EPSDT) screening, because that service is covered under the State Plan.

Three levels of provider may provide Positive Behavior Support services. The qualifications are as follows:

Level 1: Providers must have either a Ph.D. or a master's degree and be certified and/or licensed as a Behavior Analyst (BCBA) by the Behavior Analysis Certification Board.

Level 2: Providers must have either a Doctoral or master's level degree in Behavior Analysis, Psychology, Special Education or a related field and three years' experience working with persons with Developmental Disabilities. Level 2 providers with a Doctorate do not require supervision.

Level 3: Providers must be either a QDDP (per the standard at 43 CFR 483.430) or be a Board-certified Assistant Behavior Analyst (BCaBA). Level 3 providers require supervision averaging at a minimum of one hour per week by either a Level 1 provider or a Level 2 Doctoral provider.

All PBS service providers must complete the Positive Behavior Supports (PBS) Orientation: Alabama Behavioral Services Procedural Guidelines provided by the Office of Psychological Behavioral Services. This will consist of training to ensure providers are aware of the minimum standards of practice outlined in the Behavioral Services Procedural Guidelines adopted by the Department. Providers must also complete any additional orientation training refresher courses when BSP Guidelines have been updated The DMH will maintain a registry of trained BPS providers and record of their orientation. The provider will maintain a record of the supervising the Level 3 provider and will make available upon request/audit.

Documentation Requirements

An evaluation/assessment is performed with the individual to determine the level of service needed. From the assessment, a PBS treatment plan is developed clearly identifying the goal(s) to be met, the strategies to be used, the professional who will provide the implementation of the plan and the supervision needed. Each time a PBS Provider meets with the participant to provide the PBS service, a note should be made describing the session, the outcome of the session and progress made toward the goal(s) identified in the plan. PBS supervisors must also document a review of the documentation in a case note. All case notes should be contained in the participant record. There should be a note for each session billed. Each level is reimbursed in 15 minute increments.

Recertification Requirements

License Renewals

At any time during the year the PBS provider receives a new license, it should be updated at the location where services are being provided and must be sent to the ADMH-Central Office.

Documents Required

PBS providers must be recertified every two years. A copy of the most recent license, proof of liability insurance and applicable certification renewals.

Additional Requirements

To become an PBS, ADMH/DDD will conduct searches the U.S. Office of Inspector General (OIG), System for Award Management (SAM), and the Alabama Medicaid Agency website to ensure the therapist has not been debarred from providing services to Medicaid eligible participants. For persons employed and delivering services to waiver participants, the provider must conduct monthly an initial background screen and check the OIG, SAM, and Alabama Medicaid for debarment. Evidence of monthly checks must be present at the time of the audit.

ADMH/DDD will apply for enrollment to the Alabama Medicaid Agency on behalf of your agency, so that you will become a waiver service provider once the initial application has been checked and is complete. This application allows the business to submit claims for services rendered by tying your National Provider Identification number with ADMH/DDD waiver numbers. Medicaid will issue your agency a Medicaid Payee Number that will be entered into the ADMH/DDD electronic system. *Please Note: This number will not allow you to bill for Medicaid patients who are not waiver participants. To be able to perform services for the general Medicaid population, a separate application is required.*

Once ADMH/DDD has the approval from Medicaid, your information will be entered into the division's electronic system called ADIDIS, or Alabama Division of Intellectual Disabilities Information System.

Re-enrollment in the Medicaid billing system is required every two years and will be initiated by ADMH/DDD after receiving the information from Medicaid.

REMOTE SUPPORT SERVICE

Remote Support Service

The provision of supports to a waiver participant who is 18 years of age or older, at their place of residence, by Remote Support staff housed at a remote location and who are engaged with the person through equipment with the capability for live, two-way communication. Remote Supports shall be provided in real time, not via a recording, by awake staff at a remote monitoring base using the appropriate stable, reliable connection.

While Remote Supports are being provided, the remote support staff shall not have duties other than remote support. Equipment used to meet this requirement may include but is not limited to one or more of the following components:

- Sensor Based System (e.g., motion sensors, doors, windows, personal pagers, smoke detectors, bed sensors etc.)
- Radio frequency identification
- Live video feed
- Live audio feed
- Web-based monitoring system
- Another device that facilitates live two-way communication
- Contact ID

Remote Supports are provided pursuant to the Person-Centered Plan (PCP) and required protocol(s) that are developed from, and support implementation of, the PCP. Remote Supports are intended to address a person's assessed needs in his/her residence and are to be provided in a manner that promotes autonomy, minimizes dependence on paid support staff, and reduces the need for in-person services that may be more intrusive. A person's team, including the person themselves, shall assess whether Remote Support is appropriate and sufficient to ensure the person's health and welfare assuming all appropriate protocols are in place to minimize risk as compared to the overall benefit of Remote Supports for the individual.

The Remote Support staff shall have detailed and current written protocols for responding to a person's needs as specified in the PCP, including contact information for the backup support person(s) to assist when necessary. The PCP and written protocols shall also set forth the procedures to be followed should the person request that the equipment used for delivery of Remote Support be turned off. When a person needs assistance, but the situation is not an emergency, the Remote Support staff shall address the situation as specified in the individual's Remote Supports written protocol(s). If the protocol involves the Remote Support staff contacting backup support, the backup support person shall verbally acknowledge receipt of a request for assistance from the Remote Support staff and shall arrive at the person's location within a reasonable amount of time (as specified in the PCP, but no longer than one (1) hour) when a request for in-person assistance is made. If a known or reported emergency involving a person arises, the Remote Support staff shall immediately assess the situation and call emergency personnel first, if that is deemed necessary, and then contact the backup support person, who will respond to the emergency immediately. The Remote Support staff shall stay engaged with the person during an emergency, as appropriate to the situation, until emergency personnel or the backup support person arrives. The Remote Supports vendor shall provide initial and ongoing training to its staff to ensure they know how to use the monitoring base system and have training on the most recent versions of the written protocols for each person supported. The Remote Supports vendor shall ensure a

suitably trained person from their agency, or from another provider agency for the person, provides the person who receives Remote Supports with initial and ongoing training on how to use the remote support system as specified in the PCP. The Remote Supports vendor shall have a backup power system (such as battery power and/or generator) in place at the monitoring base in the event of electrical outages. The Remote Supports vendor shall have other backup systems and additional safeguards in place which shall include, but are not limited to, contacting the backup support person in the event the monitoring base system stops working for any reason. The Remote Supports vendor shall comply with all federal, state, and local regulations that apply to the operation of its business or trade, including but not limited to, 18 U.S.C. section 2510 to section 2522 as in effect on the effective date of this rule. The Remote Supports vendor shall have an effective system for notifying emergency personnel such as police, fire, emergency medical services, and psychiatric crisis response.

A backup support person is always identified, available and responsible for responding to the site of the person's residence whenever the person otherwise needs in-person assistance, including emergencies. Backup support may be provided on an unpaid basis by a family member, neighbor, friend, or other person selected by the individual, or on a paid basis by a local provider of waiver services. When backup support is provided on a paid basis by a local provider, that provider shall be the primary contact for the Remote Support vendor.

Remote Support Requirements

This service is available only to waiver participants who are age 18 or older. For those ages 18- 21 years, State Plan Services available through EPSDT are utilized to meet needs documented in the PCP prior to expending waiver funds.

- Remote Supports shall only be provided in waiver participants' places of residence when paid or unpaid sources of support are not present in the residence, except temporarily, if needed, when the Remote Supports are being initially introduced.

- In Supported Living or Residential Habilitation settings the reimbursement rate to the provider shall be adjusted to account for the use of Remote Supports and the provider's role in providing backup support for the waiver participant(s) in the residence.

- Camera systems located in communal areas of the home where the individual is likely to spend time and not places where an individual may wish to go to gain privacy (e.g., bathroom or bedroom). Systems are customizable and can be located wherever the individual prefers.

- When Remote Supports involve the use of audio and/or video equipment that permits remote support staff to view activities and/or listen to conversations in the

residence, the person who receives the service and each person who lives with the person shall consent in writing after being fully informed of what remote support entails including, but not limited to, that the remote support staff will observe their activities and/or listen to their conversations in the residence, where in the residence the remote support will take place, and whether or not recordings will be made. If the person or a person who lives with the person has a guardian, the guardian shall consent in writing. If a person moves into a residence with Remote Supports already in place, the person shall consent in writing, before the move-in date, after being fully informed of what remote support entails including, but not limited to, that the remote support staff will observe their activities and/or listen to their conversations in the residence, where in the residence the remote support will take place, and whether or not recordings will be made. If the person moving into the residence has a guardian, the guardian shall consent in writing, before the move-in date. The person's Support Coordinator shall keep a copy of each signed consent form with the PCP.

- A monitoring base shall not be located at the residence of a person who receives Remote Supports.

- A secure network system requiring authentication, authorization, and encryption of data that complies with applicable state laws currently in effect shall be in place to ensure that access to computer, video, audio, sensor, and written information is limited to authorized persons.

- If a Reportable Event as defined in the DDD Critical Incident Prevention and Management System occurs while a person is receiving Remote Supports, the Remote Supports provider shall retain, or ensure the retention of, any video and/ or audio recordings and any sensor and written information pertaining to the incident for at least seven years from the date of the incident.

- Where applicable, there must be a form of notice, informing visitors to the residence that they may be recorded. (See attached Remote Scope of Service)

Recertification Requirements

License Renewals

Applicable license should be sent to ADMH/DDD Central Office upon receipt.

Recertification Documents Required

Remote Support providers are certified annually. All providers must submit proof of insurance, current license and any certification held.

Additional Requirements

To become a Remote Supports, ADMH/DDD will conduct searches the U.S. Office of Inspector General (OIG), System for Award Management (SAM), and the Alabama Medicaid Agency website to ensure the therapist has not been debarred from

providing services to Medicaid eligible participants. For persons employed and delivering services to waiver participants, the provider must conduct monthly an initial background screen and check the OIG, SAM, and Alabama Medicaid for debarment. Evidence of monthly checks must be present at the time of the audit.

ADMH/DDD will apply for enrollment to the Alabama Medicaid Agency on behalf of your agency, so that you will become a waiver service provider once the initial application has been checked and is complete. This application allows the business to submit claims for services rendered by tying your National Provider Identification number with ADMH/DDD waiver numbers. Medicaid will issue your agency a Medicaid Payee Number that will be entered into the ADMH/DDD electronic system. *Please Note: This number will not allow you to bill for Medicaid patients who are not waiver participants. To be able to perform services for the general Medicaid population, a separate application is required.*

Once ADMH/DDD has the approval from Medicaid, your information will be entered into the division's electronic system called ADIDIS, or Alabama Division of Intellectual Disabilities Information System.

Re-enrollment in the Medicaid billing system is required every two years and will be initiated by ADMH/DDD after receiving the information from Medicaid.

SPECIALIZED MEDICAL SUPPLIES (SMS)

Specialize Medical Supplies Service

Specialized medical supplies are those which are specified in the plan of care and are necessary to maintain the individual's health, safety, and welfare, prevent further deterioration of a condition, or increase an individual's ability to perform activities of daily living. Specialized medical supplies are supplies that address the participant's physical health and any ancillary supplies. All items shall meet applicable standards of manufacture and design.

Providers of this service must maintain documentation of items purchased for each participant. State plan services must be utilized prior to the expenditure of waiver funds for medical supplies.

Specialized Medical Supplies Requirements

Supplies reimbursed under this service shall not include common over-the-counter personal care items, supplies otherwise furnished under the Medicaid State plan, and items which are not of direct medical or remedial benefit to the recipient and does not include items such as soap, cotton swabs, toothpaste, deodorant, shampoo, or sanitary items. Costs for medical supplies are limited to *$1800 per year, per individual and must be prescribed by the participant's physician. For participants

under the age of 21 years medical supplies covered through EPSDT should be utilized. *($2400 a year during the Public Health Emergency)

Self-directed medical supplies services are available to those participants who are also self-directing personal care and/or LPN/RN services.

Recertification Requirements

License Renewals

Applicable license should be sent to ADMH/DDD Central Office upon receipt.

Recertification Documents Required

Specialized Medical Supplies providers are certified annually. All providers must submit proof of insurance, current business license and any certification held.

Additional Requirements

Once receiving conditional approval to become a Specialized Medical Supplies, ADMH/DDD will conduct searches the U.S. Office of Inspector General (OIG), System for Award Management (SAM), and the Alabama Medicaid Agency website to ensure the therapist has not been debarred from providing services to Medicaid eligible participants. For persons employed and delivering services to waiver participants, the provider must conduct monthly an initial background screen and check the OIG, SAM, and Alabama Medicaid for debarment. Evidence of monthly checks must be present at the time of the audit.

ADMH/DDD will apply for enrollment to the Alabama Medicaid Agency on behalf of the provider agency, allowing the provide become a waiver service provider once the initial application has been checked and is complete. This application allows the business to submit claims for services rendered by tying the provider's National Provider Identification number with ADMH/DDD waiver numbers. Medicaid will issue your agency a Medicaid Payee Number that will be entered into the ADMH/DDD electronic system. *Please Note: This number will not allow you to bill for Medicaid patients who are not waiver participants. To be able to perform services for the general Medicaid population, a separate application is required.*

Once ADMH/DDD has the approval from Medicaid, your information will be entered into the division's electronic system called ADIDIS, or Alabama Division of Intellectual Disabilities Information System.

Re-enrollment in the Medicaid billing system is required every two years and will be initiated by ADMH/DDD after receiving the information from Medicaid.

Training for Billing

New providers will be trained to use the claims/billing feature in the ADMH/DDD billing system and will have a contact at the ADMH Regional Office, Fiscal Office who

will provide the training and be the contact for billing problems. A participant/guardian should sign that the service was received prior to billing.

Audits

ADMH/DDD assures Alabama Medicaid and the Centers for Medicaid and Medicare Services (CMS) that it will be good stewards of waiver funds so periodically, ADMH/DDD will conduct audits to assure all documentation requirements and billing components are correct and meet the standards outlined in the waiver document. The audit may be conducted remotely or in person. The auditor(s) will send thirty days (30) written notification to the provider informing them of the date and time of the audit. This written notification will include a list of the waiver participant records, as well as the documentation, to be reviewed. The number of waiver participants reviewed will be a representative sample based on the number served by the provider. For those serving less than ten (10) participants, one hundred percent (100%) will be reviewed. The audit will consist of a review of the required documentation in the participant file, to include any communication from the support coordinator. All billing and claims filed should be supported with a receipt signed by the waiver participant (medical supplies and assistive technology), a progress note signed by the provider (OT, PT, ST, and PBS), or attendance note signed by the Remote Support provider.

Billing and claims submitted for the participants listed in the notification will be reviewed during the audit. This review will ensure that all services rendered were delivered to the participant in the amount, frequency, duration, and scope outlined in the waiver. All service delivered must be correctly billed. Billing errors may have to be repaid or recouped.

At any time during the audit, ADMH/DDD retains the right to conduct a 100% review of participant records if there is evidence through those reviewed, that problems exist.

The provider will be informed of the results of the audit through the exit interview when the auditors have completed the review. The owner of the business and employee responsible for billing must be present at the exit interview. The provider may include any other key personnel in the exit interview.

The provider will receive a formal written findings of the auding within thirty-days (30) of the exit interview. Based on the findings of the audit, ADMH may recommend training on any issues identified during the audit, recoupment, or repayment of billing issues, or in extreme cases, removal of the provider from service delivery. ADMH/DDD is required to report any fraudulent activities found to the Alabama Medicaid Agency Program Integrity Unit for further review.

ADMH/DDD reserves the right to conduct a *for cause audit* of a provider at any time. Providers have the right to appeal any adverse actions based on the results of the audit and will be provided the procedure with the official written audit results.

Contact

This manual provides a lot of information for providers of specific waiver services. For assistance, please contact the Director of System Management at 334-242-3719.

Attachments:

Remote Supports Policy