

UR Desktop Reference

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How to use this reference

This Utilization Review (UR) Desk Reference is divided into three main sections. The first includes descriptions of the purpose and general practice of utilization review. The second section includes specific information related to services that can be funded through the various Medicaid Waivers. This is the largest section and is intended to provide guidance and clarification related to when it might be appropriate or inappropriate to recommend approval for the request. The third section contains other information about requests that could come before an UR committee, including autism project funding. The third section also includes frequently asked questions related to UR.

There are some situations where specific services are available only in a particular waiver or where services generally available in other waivers are precluded from being funded through a particular waiver. These include services termed “residential” (Individualized Supported Living, Group Home, and Shared Living) that are available only under the Comprehensive Waiver, and services targeted for adults (such as Day Habilitation and employment services) that are unavailable in waivers that are specifically targeted for children (Autism and MOCDDS/Lopez). In these and similar situations, the restrictions will be noted near the beginning of the material for that service. As of the date of this writing, the definitions for the Comprehensive and Community Support waiver funded services have been updated while the service definitions for the remaining waivers have not. When the remaining waivers are formally renewed the UR/DR will be updated to reflect those changes.

Intent of UR Process

Utilization Review (UR) in the Division of Developmental Disability system is intended to ensure that all necessary information is appropriately documented for any approved services funded through state or federal tax dollars. In essence, it is a check to confirm that an external audit would find no fault with the expenditure of tax funds for the service.

In order to meet this expectation the UR lead must be intimately familiar with the language of the service definitions, the philosophy of the Home and Community-Based Services (HCBS) rule, and the meaning of person-centered planning. Those three elements are the standards which the Division would be expected to meet in the event of an external review. When a recommendation for approval is made to the Regional Director or designee, the UR Committee is taking the position that the Individual Support Plan (ISP) as currently written contains all the necessary elements to pass such a review. Similarly, an URC recommendation for denial of some or part of the requested services means that the Committee believes some or multiple parts of the request would not pass an external review. UR, then, serves a “pre-audit function” in the Division of DD process.

The UR process is not and cannot be expected to be the “truth police,” meaning that it serves as a reviewer of the documentation and not as a determiner of whether or not the facts as presented are actually true. If there is a situation where personal knowledge of a situation leads someone on the committee to question the honesty anyone involved in the ISP development, that concern shouldn’t be ignored, but should be brought to the administration of the Regional Office and/or Targeted Case Management (TCM) organization. The review of the ISP and requested services should be solely based, though, on the details of the documentation presented.

Universal questions to be answered within the documentation for waiver-funded services:

What specific supports are needed?

Why are these supports needed?

Is there documentation that the supports are needed for the individual rather than the staff or family? Whose life is being improved?

What does the individual being served think of these supports?

When are the supports needed?

Where will the supports be provided?

How will the supports be delivered?

Are natural supports available to meet this need?

Does the plan document what other alternative services or supports have been considered?

Role of the Utilization Review Lead

The general role of the Utilization Review Leads is to make sure that the Individual Support Plans (ISP's) are ready to be presented to the Utilization Review Committee (URC), and then to let the Regional Director (or designee) know of the recommendation of the URC. In order to accomplish this, UR Leads:

- 1) Review the plans received from Support Coordinators and Targeted Case Managers for each element associated with the plan, including the description of the service, the justification for the service, the recommendation of the provider(s), and the plan's budget before they are presented to the UR Committee.
- 2) Have a comprehensive knowledge of what kinds of services can be accessed, and how to access them.
- 3) Understand the regulations involved with use of State, County, and Federal tax money, and can explain this information to others.
- 4) Review budgets for accuracy and relevance to requested services and identified needs, and help the Support Coordinator or Targeted Case Manager make adjustments when needed.
- 5) Examine the proposed plan and head off any minor problems before the plan is presented to the Utilization Review Committee.
- 6) Provide suggestions, when appropriate, to the Support Coordinators or Targeted Case Managers regarding reoccurring problems.
- 7) Present Individual Support Plans to the UR Committee
- 8) When there are other staff members who can help review the proposed plan discussions, such as Behavior Resource Team leads or Autism Coordinators, the UR Lead might invite them to the Committee meetings. On the other hand, UR Leads make sure that individual's privacy rights are respected and limit those in the UR Committee to people who really need to be there.
- 9) Reviewing Priority of Need scores and maintaining service wait lists. (This makes sure that the Division of Developmental Disability complies with the law that says we provide services to those with the greatest need first.)
- 10) For Division UR Leads, present the recommendation of the URC to the Regional Director (or designee). The Regional Director is in charge of approving services that require the use of State and Federal money and programs, and they rely on the opinion of the UR Lead and the UR Committee in making those decisions. The Regional Director often designates this responsibility to others.

If the individual is NOT ALREADY IN THE REQUESTED WAIVER

- SC implements process to verify eligibility for waiver if requesting waiver services that are to be authorized or wait listed.
 - I/A staff review the waiver eligibility request

After Waiver Eligibility is established, SC must submit the following documents to UR Chair at least 1 month prior to planned start (or renewal) of services:

- PON (if not currently enrolled in the specific waiver)
- ISP (Specific outcomes and justification included)
- ISL budget & Staffing Pattern (when appropriate)
- Usage of service being increased or changed, with explanation
- Natural Home Budget and Budget Authorization for services
- If Amended Plan, include additional justification/explanation

If UR Chair reviews packet and finds that the information is incomplete, packet will be returned to the SC for correction without further review. UR timelines do not apply to incomplete packets.

When a complete packet is received:

UR Chair presents the complete packet to UR Committee within 6 days of receipt.

UR Committee reviews all documents in accordance with the UR Checklist, and determines:

- if the plan reflects a Want or a Need
 - if the Division can fund the request
 - if Service Need should be placed on the Waiting List
- UR Committee then makes a recommendation for Approval, Denial or Amendment of the ISP

Within 6 business days, the UR Chair completes the Recommendation Form and forwards the packet to the RO Director for the final decision, who has 5 business days to make the decision.

If Approved

- UR Lead notifies SC and Provide.
- SC informs individual/guardian
- UR Lead confirms approval by letter to individual/guardian
- New/Increased services entered into wait list by RO UR Lead
- After assignment of Waiver Slot or approval for alternate funding, services are authorized through the Auth System in CIMOR

If Partially Approved

- UR Notified SC of decision
- SC has 10 days to amend the plan and resubmit to the UR Chair
- If amended as recommended, the plan is forwarded directly from UR chair to RO Director: Process then continues as if Approved

If Denied

- UR Chair returns all documents to SC with recommendation.
- SC informs individual/ guardian,
- RO UR Chair mails recommendation form and denial letter to ind/ guardian
- UR chair sends denial to provider
- SC can make changes and resubmit within 10 days
- Individual/guardian may appeal within 30 days

Services by Waiver

Waiver Services X=Included	Comprehensive Waiver Services	Support Waiver Services	MOCDD Waiver Services	Partnership for Hope Services
Applied Behavior Analysis Service **	X	X	X	X
Assistive Technology	X	X	X	X
Career Planning	X	X	NO	X
Community Integration	X	X	X	X
Community Specialist (Allows self-directed option)	X	X	X	X
Community Transition	X	X	NO	X
Counseling	X	X	NO	NO
Crisis Intervention	X	X	X	NO
Day Habilitation	X	X	X	X
Dental	NO	NO	NO	X
Environmental Accessibility Adaptations-Home/Vehicle Modifications	X	X	X	X
Group Home	X	NO	NO	NO
Individualized Skill Development	X	X	X	X
Individualized Supported Living	X	NO	NO	NO
Job Development	X	X	NO	X
Occupational Therapy	X	X	NO	X
Personal Assistant (Allows self-directed option)	X	X	X	X
Person Centered Strategies Consultation (PCSC)	X	X	X	X
Physical Therapy	X	X	NO	X
Pre-Vocational Services	X	X	NO	X
Professional Assessment and Monitoring	X	X	X	X
Respite Care, In-Home	X	X	X	NO
Respite Care, Out-of-Home	X	X	X	
Shared Living: Host Home/Companion	X	NO	NO	NO
Support Broker	X	X	X	X
Supported Employment	X	X	NO	X
Temporary Residential Services	NO	NO	NO	X
Transportation	X	X	X	X

** For individuals without a diagnosis of Autism Spectrum Disorder (ASD)

**Process and Document Checklist for
Waiver-Funded Service Requests**

- ☐ Justification in ISP
- ☐ Waiver eligible and documented in LOC in CIMOR
- ☐ Choice of Provider Form
- ☐ ISP signatures
- ☐ Budgets completed and accurate for all services
- ☐ Ensure that services noted on the budget have a corresponding justification in the plan, and vice versa
- ☐ Budgets over funding cap for that waiver has justification and exceptions form completed

Additional information required for some types of services

- ☐ For SME: Bids (two, or credible documentation for why only one bid was practical)
- ☐ For EAA: OT/PT evaluations, Bids (two, or credible documentation for why only one bid was practical)
- ☐ For OT/PT/Speech Therapy: Doctor's orders
- ☐ For Medical Exception Day Habilitation: Doctor's orders
- ☐ For Behavioral Exception Day Habilitation: Evidence that the individual is participating in ABA

<i>Notes:</i>

“Bridging the gap” vs. “Narrowing the gap”

The differences between PA, ISD and CI

Individuals with disabilities often experience gaps between their current skill level and the level of skills necessary to engage in certain activities. The type of activity that is sought and the way in which we address the gaps will determine which waiver service is most appropriate.

Individual Skills Development (ISD) and Community Integration (CI) are services intended to “narrow the gap” between current abilities and those abilities needed to more independently meet the expectations of the environment. In contrast, Personal Assistance (PA) is intended to “bridge the gap” by doing for the individuals what they cannot do for themselves. If the goal is to bridge the gap, whether at home or in the community, the appropriate service would be PA.

If the goal is for the individual to manage his or her household and access services in the community more independently (such as tracking the type and amount of food in the home, making a menu, budgeting, buying the week’s groceries, replace worn clothing, or learning to access transportation independently) then the appropriate service would be ISD. In this case, we would be trying to narrow the gap between the person’s current abilities and what is needed to meet those universal household needs independently.

If the goal of the services is to teach the person to better and more independently participate in social and personal interest activities in the community, then the appropriate service would be CI. In this case, we would be narrowing the gap between the person’s current skills and the skills needed to meet his or her unique social and community interests. The intent of CI is to set goals for greater independence in social interaction, analyze what skills are missing or inadequately developed, and then working on those skills to better enable the person to participate in community activities on their own.

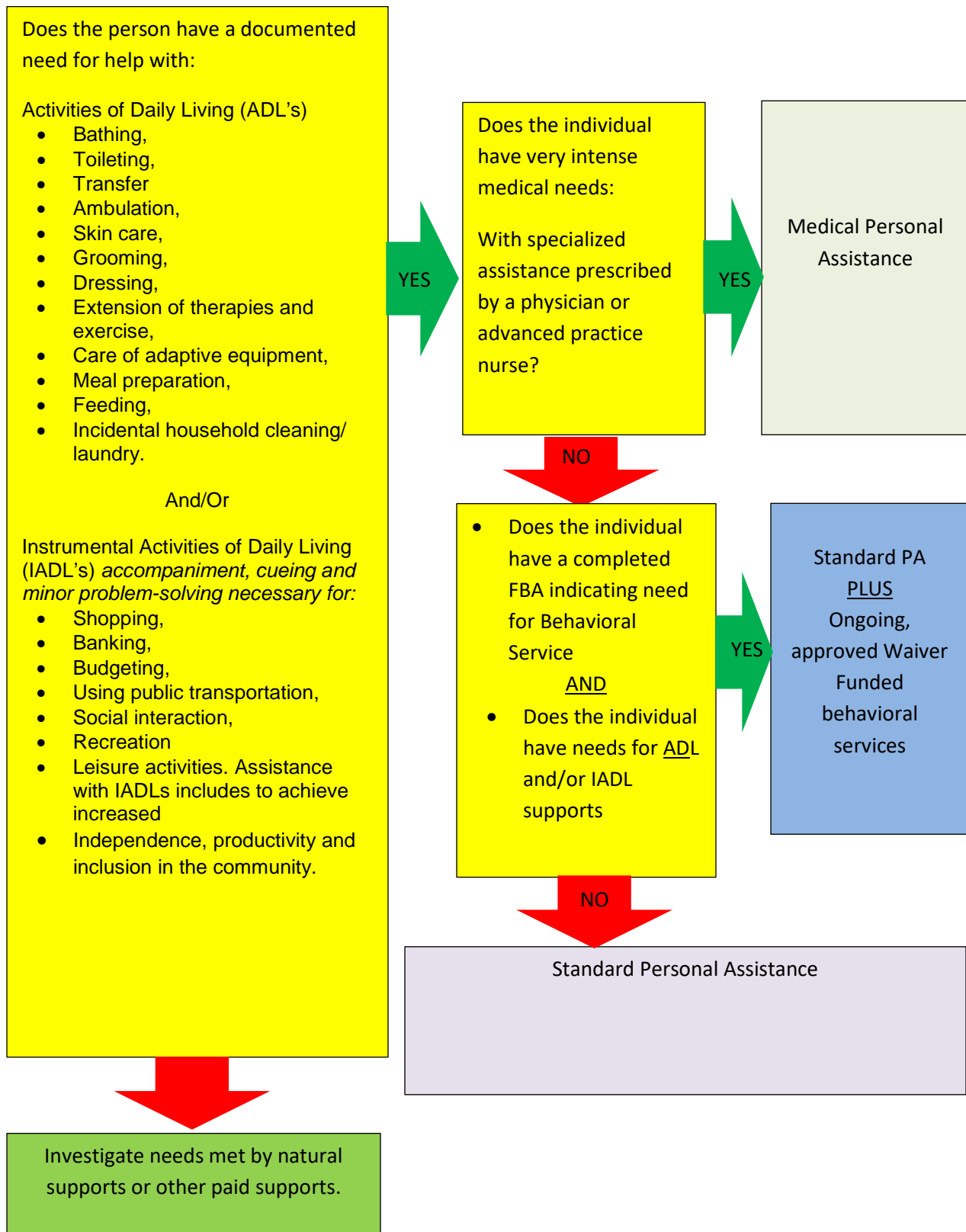
PA=Assisting an individual to do what they can’t do on their own.

ISD=Teaching a specific skill for independent living

CI= Teaching an individual to more independently be integrated into society.

Personal Assistance

Decision Tree: Personal Assistance & Medical Personal Assistance



The goal of personal assistance (PA) is to support the individual with activities of daily living, either performed directly by staff or through training of the individual. The planning team determines the composition of the service and assures it does not duplicate, nor is duplicated by, any other service provided to the individual. Personal Assistant can occur in the person's home and/or community, including the work place.

PA Services include assistance with:

Activities of daily living (ADL's)

- bathing
- toileting,
- transfer and ambulation,
- grooming,
- dressing,
- extension of therapies and exercise,
- skin care,
- care of adaptive equipment,
- meal preparation,
- feeding,
- incidental household cleaning and laundry.

Instrumental activity of daily living (IADL's).

- shopping,
- banking,
- budgeting,
- IADLs also include accompaniment, cueing and minor problem-solving necessary to achieve increased independence, productivity and inclusion in the community.
- using public transportation,
- social interaction,
- recreation,
- leisure activities,

Medical Personal Assistance. To meet specialized medical needs for the individual as identified by the team and documented in the ISP, the following must be documented:

- A specific need for more intensive medical support (clearly explain why the intensive support is needed)
- An order from a physician or advanced practice nurse for the service (renewed annually)
- Depending on the scope of service, a registered professional nurse may be required to provide oversight

Medical PA limitations

- For minors living with parent or guardian, Med PA cannot supplant:
 - Support ordinarily provided by parents to children without disabilities,
 - Educational support that is the responsibility of local education authorities.
- This service may not be provided by a family member unless the family member has obtained the required and current certification and the individual receiving the care is over the age of 21.
- Payment is on a 15 minute, fee for service basis, with different rates for individual and small group services, and, when needed, for enhanced staff qualifications. The same qualifications noted in personal assistance apply for the use of state plan services.

PA/Med PA - General Notes and Limitations:

- Personal Assistant shall not be provided concurrently with or as a substitute for facility-based day habilitation services.
- Group PA: Assisting up to three (3) individuals (4-6 with written Regional Director approval) at a time is covered under the definition when it is determined that the needs of each person in the group can be safely met.
- The use of remote monitoring technology (the equipment itself is covered under the Assistive Technology service).
- Payment is on a 15 minute, fee for service basis, with different rates for individual and small group services, and, when needed, for enhanced staff qualifications (Med PA).
- PA needs through EPSDT, when applicable, must be exhausted before using DD waiver funding for PA.

Team collaboration: Team collaboration can be included in the individual budget up to 120 hours per plan year. A team meeting can be convened by the individual or their designated representative to discuss specific needs of the individual, progress towards outcomes, and other related concerns.

- For self-directed supports, Team Collaboration allows the individual's employees to:
 - Participate in the support plan and
 - Meet as a team to ensure consistency in its implementation.
- For agency-based personal assistant services, team collaboration is included in the unit rate.

Relatives as Providers

PA services may be provided to a person by a member(s) of his or her family when:

- The individual is not opposed to the family member providing services;
- The services to be provided are solely for the individual (not task household tasks expected to be shared with people living in family unit);
- The planning team determines the paid family member providing the service best meet the individual's needs;
 - A family member will only be paid for the hours authorized in the support plan, and never more than 40 hours per week.

Personal assistant services shall not be provided by:

- An individual's spouse,
- A parent (if the individual is under age 18), or
- An individual's guardian or power of attorney.

Relation to State Plan Personal Care Services

An individual will not be eligible for personal assistant services under the waiver when the need:

- Is strictly related to ADLs and
- Can be met through the MO HealthNet state plan personal care program

DD Waiver personal assistant may be authorized when:

- State plan limits on number of units for personal care are reached and more assistance with ADLs and/or IADLs is needed;
- The person requires personal assistance at locations outside of their residence;
- The individual has behavioral or medical needs requiring more highly-trained PA than is available under state plan.
- The PA worker is related to the individual;
- The individual or family is directing the service through the FMS contractor.

When waiver PA is authorized to adults also eligible for state plan personal care, the SC must consult and coordinate the waiver support plan with the DSDS service authorization system.

Day Habilitation

Goal of Day Habilitation:

- Assisting the individual to acquire, improve and retain the self-help, socialization and adaptive skills necessary to reside successfully in the community.
- Day Habilitation is not intended to be solely a facility-based service, but must also take place on a regular basis in the community and in real-world situations.
- This service does not provide basic child care (a.k.a. “baby sitting”).

Skills targeted for development include (but aren’t limited to):

- Proper behavior in public settings,
- Getting along with others
- Resolving conflicts
- Getting your needs met
- Using the public services available to everyone, such as post office, library,
- Recognition and use of money
- Proper clothing attire for the time and setting,

Day Habilitation Service vs Personal Assistant:

- Day Habilitation Services includes all personal assistance required by the individual during the provision of the service.

Requirements:

- Individuals who receive Group Home or Individualized Supported Living, or Shared Living may receive Day Habilitation; their group home or ISL budget will clearly document no duplication in service.
- When services are provided to children the ISP must clearly document that:
 - Day Habilitation is medically necessary to support and promote the development of independent living skills of the child or youth, and
 - The need for support is over and above the need of a child of similar age without developmental disabilities.
- The ISP must document:
 - That Day Habilitation will be used to Reinforce skills or lessons taught in school, therapy or other settings and
 - Neither duplicates or supplants the services provided in school, therapy or other settings.
 - That the service is not supplanting the responsibilities of the primary caregiver.
 - The outcomes and action steps individualized to what the individual wishes to accomplish, learn and/or change
 - That, for minors, Day Habilitation services is not utilized in lieu of basic child care that would be provided to children without disabilities.
- Day habilitation services are provided at a stand-alone licensed or certified day program facility, which is not physically connected to the participant’s residence.
- Costs for transporting the participant from their place of residence to the day program site are not included in the day service rate, and waiver transportation may be provided and separately billed.

Day Habilitation - Medical Exception

Exceptional medical supports funding shall be utilized to provide enhanced services as prescribed to meet medical needs which require the following: services from a Certified Nursing Assistance (CNA), services from a licensed practical nurse, or registered nurse within their scope of practice as prescribed by the state, OR, for help with mobility needs, appropriately trained staff. A separate rate and code modifier is available for this service. This is to promote individuals ability to access community based services and integration to the fullest extent of their capabilities.

Requests for Exceptional medical supports shall be submitted to the Utilization Review Committee and include the following documentation:

- Written Support Plan which includes clinical outcome data with criteria for reduction of supports as relevant to the identified medical condition(s).
- Written documentation from the individual's medical practitioner noting the individual's assessed need for medical services or mobility assistance.

Day Habilitation - Behavior Exception

The goal:

- To promote individual's ability to access community-based services and to integrate to the fullest extent of their capabilities

When to use this variation of Day Hab:

- When an individual is accessing ABA services and
- Additional supervision is needed during the Day Habilitation time to support the teaching of necessary skills and to develop appropriate behaviors

General notes and exceptions:

- A separate rate and code modifier is available for this service.
- Requests must include the following documentation in the ISP:
 - Written documentation by a Board Certified Behavior Analyst or Qualified Health Care Professional noting the individual's assessed need for behavioral services.
 - Written documentation that Behavioral services have been authorized and secured for the individual in day habilitation setting.
 - If an ongoing request (not the first time Day Hab- Behavior Exception has been authorized), documentation must include a description of the progress made in the habilitation setting
 - Clinical outcome data with criteria for reduction of supports as relevant to the identified target behavior(s). (When will we know that this service isn't needed?)
 - Upon waiver approval, individuals and support coordinators will revise the individual support plan (ISP) during the annual plan development meeting to be reflective of the new service definitions. ISP will fully implement the revised service definitions within 18 months of waiver approval.

Individuals who receive Group Home, Individualized Support Living (ISL) and Shared Living may also receive this service.

Comparison between Day Habilitation and PA: Day Hab services include, but are not limited to, teaching the individual about etiquette skills at a restaurant, checking out a book at a library, mailing a letter, exchanging money for purchases, etc. PA may directly perform activities or may support the individual to learn how to perform ADLS and IADLS as part of the service. Day Habilitation Services includes all personal assistance needed by the individual.

Community Integration

Goals of CI:

- Assisting and teaching participation in community activities.
- Enabling individuals to engage directly with people who aren't paid to provide them with services
- Helping people to develop relationships with the broader community.
- Supporting a person to be a fully participating member of the community, including (but not limited to):
 - Participating as a member of social events/clubs,
 - Engaging in recreational activities,
 - Volunteering
 - Participating in organized worship or spiritual activities.

Limits:

- CI does not include assistance with activities of daily living (such as personal grocery or clothing shopping, getting a haircut, or paying bills) unless it happens to be combined with a community integration activity.
For example, personal weekly grocery shopping does not fit with the intent of CI, but shopping with other members of a club for a fund raising activity or party that would fit the intent of CI because it's part of the club activity.
- Transportation costs related to providing CI are included in the service rate and aren't to be billed separately.
- Personal assistance may be a component of community integration services, but may not comprise the entirety of the service.
- This service is limited to 25 hours a week
- Group CI may not be provided to more than 4 individuals in the group.

Comments from Fed Programs Unit: CI typically occurs in the community. The expectation with CI is that the individual interacts with the broader community on a regular basis, including community activities that enable individuals to engage directly, throughout the day, with people who are not paid to provide them with services. In addition, community activities should be organized for the benefit of the individuals to foster relationships with the broader community.

Here are some questions to ask about the CI service(s) that you are considering. If you can answer them with a, "Yes," then CI service could be justified and authorized:

- The CI is assisting and teaching participation in community activities?
- The CI is enabling individuals to engage directly with people who aren't paid to provide them with services?
- The CI is helping people to develop relationships with the broader community?
- The CI is supporting a person to be a fully participating member of the community, including (but not limited to):
 - Participating as a member of social events/clubs,
 - Engaging in recreational activities,
 - Volunteering
 - Participating in organized worship or spiritual activities.

Individualized Skill Development (Formerly Home Skills Development)

Goals of ISD:

- Assisting the individual to acquire life skills necessary for independent living.
- Achieving maximum independence in home and community-based settings.
- Basing activities on what the individual wishes to accomplish, learn and/or change,

Skills targeted for development might include (but are not limited to):

- Cooking
- Laundry
- Shopping
- Budgeting
- Paying bills
- Accessing public transportation

ISD description of need in the ISP must include:

- Specific outcomes (clearly identified skill(s) or skill set(s))
- A task analysis for each identified learning objective (what each step of the task entails, and where the individual is at present).

Requirements:

- Only staff trained who are nationally or state credentialed in skill development can provide ISD.
- Payment is on a 15 minute, fee for service basis.
- Transportation costs related to the provision of this service in the community are included in the service rate
- When applicable, ISD should be completed in the community.

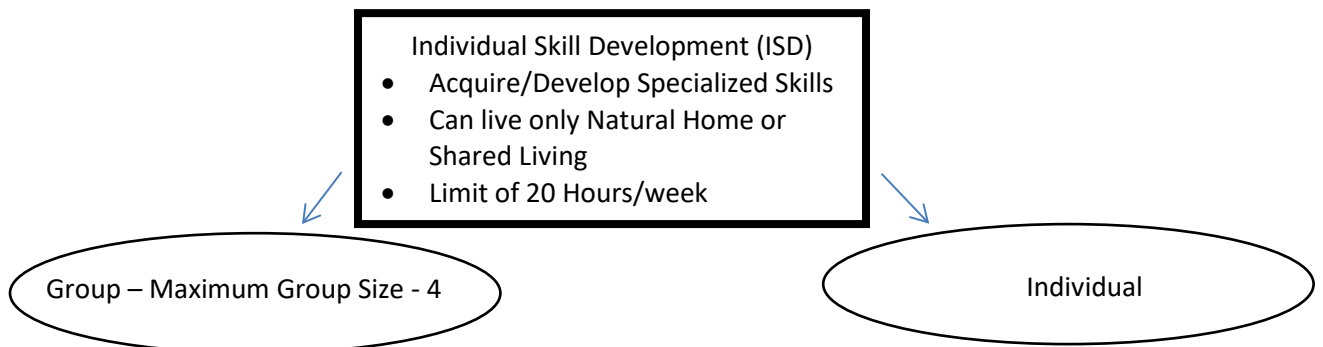
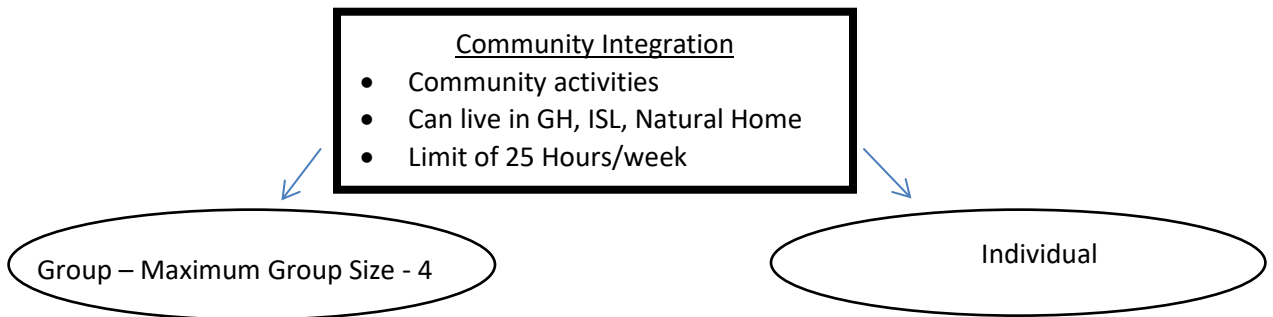
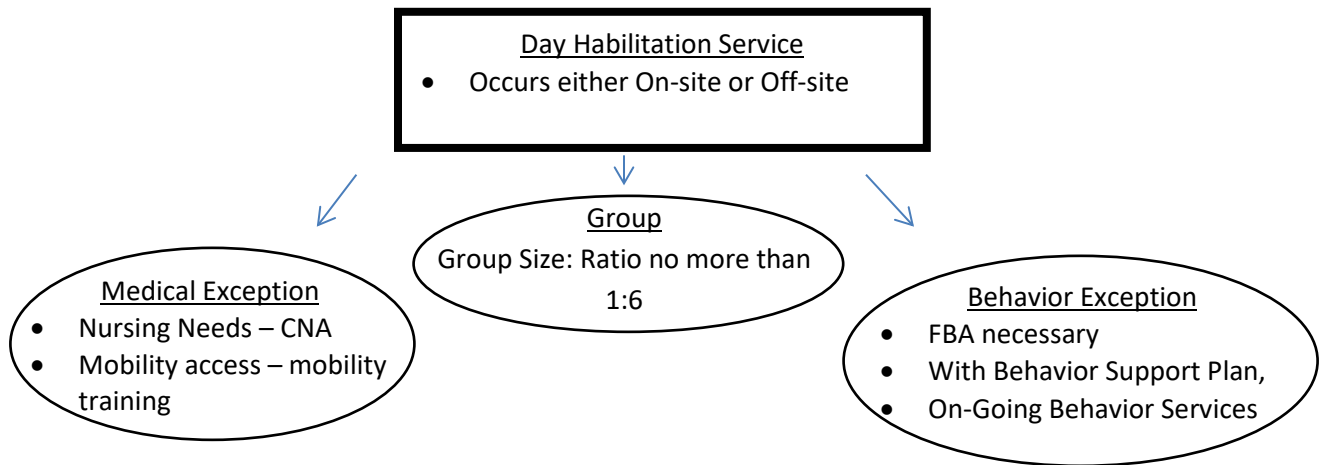
Limits:

- Not available for individuals who receive Group Home, Individualized Supported Living, or Shared Living services.
- No more than 20 hours a week
- Group Individualized Skill Development may not have more than 4 individuals in a group.
- Cannot supplant expected parental role for their minor children – don't use it for babysitting

Individualized Skill Development vs. Personal Assistant:

- ISD is a skill development service; it is focused on improving someone's ability to perform a skill. PA is a direct support service: it is focused on ensuring that the ADLS and IADLS needs are met today. Training can be a portion of the service, but it is not the primary intent.

Day Service, Community Integration, and Individual Skill Development Settings



Medical Personal Assistant (PA) & Medical Exception Day Hab Determination Guide

Through the Person Centered Planning Process individual health/medical needs are identified. The individual support plan (ISP) addresses what supports the individual needs to **ensure** that their health/medical needs are met.

To support the individual and team in this process, clinical consultation with the individual's health care provider and/or agency registered nurse (RN) and/ or contracted RN through Professional Assessment & Monitoring (PAM) Services may be utilized.

The clinical consultation provides the team with assessment of the level of medical support required to meet each identified need which may include the following:

- **Med PA**-what services and supports may be provided by a personal assistant(PA) independently
- **Med PA**-what services and supports may be provided by a medical personal assistant(Med PA) under the supervision and delegation of a medical professional in accordance with their scope of practice
- **Medical Exception Day Hab** -what services and supports may be provided by a direct care staff independently
- **Medical Exception Day Hab** -what services and supports may be provided by a Certified Nurse Aide(CNA) under the supervision and delegation of a medical professional in accordance with their scope of practice
- **Med PA and Medical Exception Day Hab** -what services and supports require a medical professional ie. Registered Nurse or Licensed Practical Nurse within their scope of practice in accordance with MO Nurse Practice Act RsMO Chapter 335.

Resources:

Delegation Decision Making Tool

<http://pr.mo.gov/boards/nursing/delegationtree.pdf>

MO State Board of Nursing Guidance on Unlicensed Assistive Personnel <http://pr.mo.gov/nursing-focus-unlicensed.asp>

RN Scope of Practice Statement

<http://pr.mo.gov/boards/nursing/RNSCOP1.pdf>

LPN Scope of Practice Statement

<http://pr.mo.gov/boards/nursing/lpnscop1.pdf>

MO State Board of Nursing Scope of Practice Decision Making Tool

<http://pr.mo.gov/boards/nursing/MODecision%20Making%20Model.pdf>

Once the individual and planning team receive the clinical consultation and/or assessment information then the plan is developed to identify the specific services and supports that are required including time parameters for monitoring of the service(s) and support(s)

The individual with the support of their **planning team determines the level of medical support that is required** to meet **each** identified need.

Standard UR and RO approval process is then followed

Employment Services

Career Planning (T2019)

The goal of Career Planning is a documented career objective and a career plan describing the steps and activities necessary to meet that objective.

Career planning:

- It is a focused, time limited service engaging an individual in self-discovery
- Can be used for individuals who are exploring employment, whether currently employed or not.
- When conducted with someone already employed, assists in the exploration of other competitive career objectives more consistent with the person's skills and interests.
- Like all waiver funded employment services, is focused on attainment of integrated, competitive employment at or above the state's minimum wage.
- Incorporates activities to help the individual evaluate interests, opportunities in the community, and to identify the employment skills and challenges they face through:
 - Job exploration,
 - Job shadowing,
 - Informational interviewing,
 - Assessment of interests,
 - Labor market research
 - Informal or formal assessment and consultation
- To the maximum extent possible takes place in the community with the individual both present and engaged.
- Is able to evaluate and communicate not only with the individual but also with caregivers, support team members, employers and others.
- May include social security benefits support, training, consultation and planning.
- Can be used in conjunction with
 - supported employment,
 - pre-vocational training,
 - residential and/or
 - day habilitation services

Notes and Restrictions:

- The ISP must document why Vocational Rehabilitation or other services could not be accessed.
- Transportation costs for Career Planning services are included in the unit rate, but costs for transporting to and from the residence are not included.
- Career Planning is intended to be time-limited.
- Services should be authorized based upon individualized assessed need not to exceed 240 quarter hour units of services within an annual support plan.

Prevocational Services (H2025)

The goal of Prevocational Services is to develop the individual's general, non-job-task-specific skills necessary to succeed in paid employment, including (but not limited to):

- Ability to communicate effectively with future supervisors, co-workers and customers;
- Generally accepted community workplace conduct and dress;
- Ability to follow directions;
- Ability to attend to tasks;
- Potential workplace problem solving skills and strategies;
- Potential general workplace safety and mobility training.

Prevocational Services:

- ISP describes the specific and measurable outcomes to occur over a defined period of time.
- Can be provided through one-to-one learning and group experiences.
- Like all waiver funded employment services, are focused on attainment of integrated, competitive employment at or above the state's minimum wage consistent with the individual's interests, strengths, priorities, abilities, and capabilities.
- Are not a required pre-requisite for supported employment.
- Only authorized when an individual is otherwise unable to directly enter the general workforce as a result of under or undeveloped general, non-job-task-specific skill(s).
- Must be provided in a community workplace setting or at a licensed, certified or accredited facility of a qualified employment service provider.

General Notes and Restrictions:

- Prevocational services can be provided in small groups not exceeding four (4) individuals at a time. Use of group must be meeting a documented need that can't be met in an individualized setting,
- A person receiving prevocational services may pursue employment opportunities at any time to enter the general work force.
- Personal assistance may be a component of prevocational services, but may not comprise the entirety of the service.
- Transportation costs for Prevocational Services are included in the unit rate, but costs for transporting to and from the residence are not included.
- Individuals who receive prevocational services may also receive supported employment and/or day habilitation services.
- Prevocational services may include volunteer work, such as volunteer learning and training activities that prepare a person for entry into the paid workforce. Keep in mind that the definition of "volunteer" is strictly governed by the US Dept., of Labor and that there can be serious consequences if used incorrectly.
- Units are based on need, and not to exceed 80 quarter-hour units per week. Prevocational Services must not exceed 6 months. Additional units or monthly increments beyond 6 months must be pre-authorized by the Division's Regional Director or designee.

Job Development (H0038)

The goal of Job Development is the acceptance by the individual of a job offer that meets the individual's personal and career goals.

Job Development may include:

- Application completion assistance with the individual,
- Job interviewing activities with the individual,
- Completion of task analysis with or without the presence of the individual, based upon individualized need,
- Negotiation with prospective employers and education of prospective employers of their role in promoting full inclusion with or without the presence of the individual based upon individualized need.

Job Development:

- Helps the individual find and obtain the specific job goal identified in the ISP.
- Focuses on developing the greatest degree of integration, independence and autonomy for the individual; *All the help required, and no more than is necessary.*
- Promotes integration into the workplace and interaction between individuals and people without disabilities in those workplaces
- Is limited to seeking only potential employers who would compensate at or above the minimum wage, not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

General Notes and Restrictions:

- Cannot supplant other services available outside of waiver funding.
- Can be used in conjunction, but not at the same time as other waiver funded services. Don't double bill.
- Transportation costs are not included in the job development fee, but specialized transportation is available as a separate service if necessary.
- There is a limit of 240 quarter hour units of services within an annual support plan. Additional units may be approved by the Division's Regional Director or designee in exceptional circumstances.

Supported Employment (H2023)

The goal of Supported Employment is sustained employment in a competitive and integrated setting. Models of service delivery include individual and group support.

Regardless of the model, Supported Employment:

- Is only available for support of employment in competitive, integrated settings.
- Is only available when there is a specific set of documented needs in the plan, and when it is the best option to promote integration, independence and autonomy.
- Uses on-the-job training in work and work-related skills; (i.e. job coaching) to facilitate
 - Initial training of the essential job skills
 - Ongoing performance of the essential functions of the job and
 - Development of natural supports.
- Can include ongoing supervision and monitoring of the person's performance on the job by:
 - promoting attendance
 - promoting social inclusion in the workplace
 - promoting use of community resources and public transportation
 - evaluating self-maintenance strategies,
 - evaluating work production and
 - evaluating the effectiveness of natural supports (i.e. fading)

Group Supported Employment services:

- Are intended to result in sustained, integrated and competitively-paid employment.
- Takes place in groups of 2-4
- Is provided in regular community business and industry, such as business-based work groups and/or mobile crews.
- Cannot be provided in facility-based work settings or non-integrated work
- Are not appropriate for individuals who demonstrate the capacity, ability and interest to work independently.

Individual Supported Employment services for self-employment:

Individual Supported Employment could be used to support self-employment, including ongoing assistance, counseling and guidance once the business has been launched, by:

- Helping the individual to identify potential business opportunities;
- Assisting in the development of a business plan, including
 - Investigating potential business financing
 - Developing a business plan
 - Launching a business
 - Identification of the supports that are necessary for the individual to operate the business

Note: Medicaid funds may not be used to defray the expenses associated with starting up or operating a business.

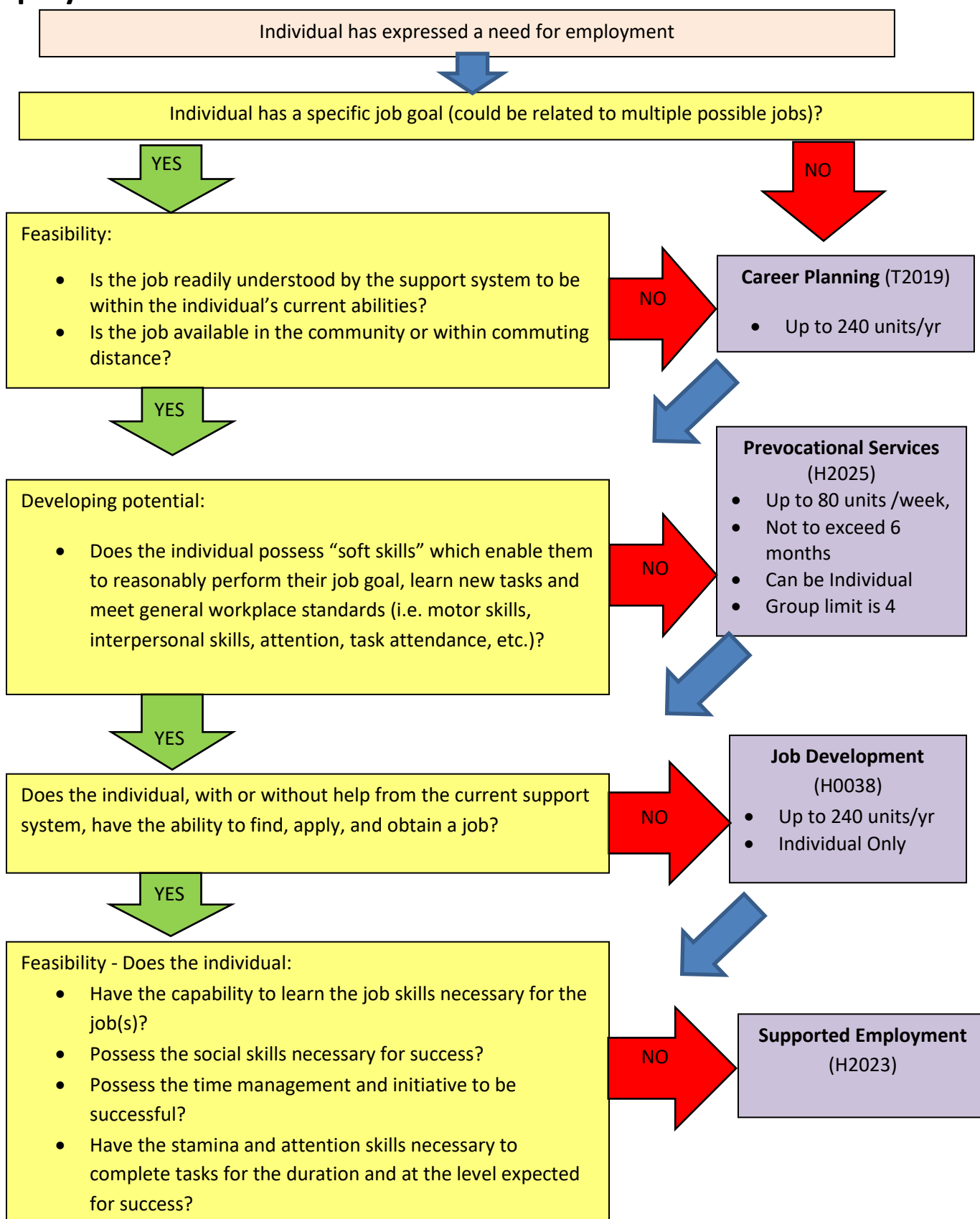
General Notes and Restrictions:

- Cannot supplant other services available outside of waiver funding.
- SE cannot include payment for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business or otherwise covered under the Americans with Disabilities Act
- Can be used in conjunction, but not at the same time as other waiver funded services. Don't double bill.
- Transportation costs are not included in the job development fee, but specialized transportation is available as a separate service if necessary.
- Supported employment services must be provided in a manner that promotes integration into the workplace and interaction between individuals and people without disabilities in those workplaces while maintaining the individual's rights of dignity, privacy and respect.
- Personal Assistance may be a component of an individual's employment retention support plan for assistance with ADL's and IADLS. However, Personal Assistance may not be used in lieu of Supported Employment services as defined above.

Notes on need to document exhaustion of Vocational Rehabilitation services

The Division of Vocational Rehabilitation (DVR) does not provide equivalent prevocational services nor any employment services in a group setting. If the ISP documents as need for these types of services then a referral to DVR to investigate comparable benefits serves no purpose and is unnecessary.

Employment Services Decision Tree



In Home Respite

GENERAL SERVICE DESCRIPTION: In Home Respite Services are designed to give relief to the primary caregiver in their absence or when they need a break from providing the ongoing care to the individual with a Disability. This service is for individuals who are unable to care for themselves thus requiring support. Respite care is available to the person who normally provides care to an individual other than formal, paid caregivers.

Service Description:	Waiver Code:	Non-Waiver Code:	Unit:
In home-daily	S5151	44010F	1 day
In home-hourly-individual	S5150	44010H	15 minutes
In home-hourly-group	S5150 HQ	44010S	15 minutes

Any plan requesting In-Home Respite must address the following questions:	
<input type="checkbox"/>	What specific supports are needed to give the family a break for care?
<input type="checkbox"/>	Are natural supports available to meet this need?
<input type="checkbox"/>	Does the plan document what other alternative services or supports have been considered?
<input type="checkbox"/>	Does the documentation clearly describe the respite as temporary and time limited?
<input type="checkbox"/>	Is Respite being requested in lieu of day services or childcare?

Respite Care: Out-of-Home

GENERAL SERVICE DESCRIPTION: Out-of-Home Respite Care is provided to individuals unable to care for themselves, on a short-term basis, because of the absence or need for relief of those persons normally providing the care.

Service Description:	Waiver Code:	Non-Waiver Code:	Unit:
Out of home-daily	H0045	44020F	1 day
Out of home-hourly-individual	S5150 U8	44010H	15 minutes
Out of home-hourly-group	S5150 HQ U8	44010S	15 minutes

Any plan requesting Out of Home Respite must address the following questions:	
<input type="checkbox"/>	Does the plan document what other alternative services or supports have been considered?
<input type="checkbox"/>	Is the request for Respite temporary and time limited?
<input type="checkbox"/>	Is Respite being requested in lieu of day services or childcare?
<input type="checkbox"/>	Consistent with 60 days per annum waiver limit?

Applied Behavior Analysis “ABA”

There are two* primary types of ABA services:

- “Assessment services” which analyze the situation and lead to recommendations (described in the “Behavior Support Plan”) for how to address the issues, and
- “Adaptive Behavior Treatment services” which are made up of several different methods of treatment, most of which *could* be used alone but which, far more frequently, are used in various combinations.

1) Assessment Services

- a) A “descriptive assessment” comprised of at least these two services:
 - i) **Behavior Identification Assessment**, (0359T) AND
 - ii) **Observational Follow-up Assessment**: (0360T and 0361T)
- b) And possibly this service as well:
 - i) **Exposure Follow-up Assessment** (0362T and 0363T)

2) Adaptive Behavior Treatment

- a) The following could be a stand-alone service if that was the recommendation of the assessment, but likely are used in combination with each other:
 - i) **Exposure Adaptive Behavior Treatment with Protocol Modification** (0373T and 0374T)
 - ii) **Adaptive Behavior Treatment by Protocol Modification** (0368T and 0369T)
 - iii) **Treatment Social Skills Group** (0372T)
- b) The services below would not be a stand-alone service, but might be used in conjunction with the services (a) above:
 - i) **Adaptive Behavior Treatment by Protocol by Technician** (0364T and 0365T)
 - ii) **Family Treatment Guidance** aka “Family Behavior Treatment Guidance” (0370T)

**There are also other support services available through the waiver which are not considered “ABA services”:
Person Centered Strategies Consultation (code) and Crisis Intervention (code)*

Other changes of note

- Qualified Health Care Professional – for ABA services are Licensed Behavior Analysts, Licensed Social Workers, Licensed Psychologists, and Licensed Professional Counselors.
- Licensed assistant behavior analysts must function under the direct supervision of a Licensed Behavior Analyst and cannot be an independent provider (bill directly for services).
- New category of provider is the registered behavior technician for the service -Adaptive Behavior Treatment by Protocol by Technician when direct implementer and intensive implementation of behavior plan is required.
- There will no longer be a 270 day review requirement for behavioral services.

Behavior Services Myths

- There are no prerequisite services prior to consideration of behavioral services.
- BRT staff are not providing a behavioral service, they are better described as Universal Strategies/Tiered Supports Specialists.
- The Behavior Support Plan is not valid without ongoing behavioral services- support plan. It must be managed, monitored and under the control of a QHCP

ABA Services Decision Tree: Begins with the Planning Team recognition of problem behaviors

SC/Planning team seeks consultation with a DMH-contracted behavior service provider (NOT BRT!) (This is a no-cost recommendation based on a brief conversation; no UR approval is necessary)

- Provider makes recommendation for type and amount of Functional Behavioral Assessment (FBA) needed

The Functional Behavioral Assessment (AKA "FBA", "ABA Assessment," or "Functional Assessment")

- Will always consist of:
 - "Behavior Identification Assessment" (0359T) AND
 - "Observational Follow Up Assessment" (0360T & 0361T)
- And might or might not include:
 - Exposure Follow-Up Assessment (0362T & 0363T)

- Annual or amended plan is developed based on the recommendation, including documentation of need and provider choice
- Support Coordinator submits request for services
- Standard UR and approval process completed

FBA is completed by behavior service provider and the report is forwarded to the individual/family and SC

FBA Recommendation is to address the issues with Applied Behavioral Analysis (ABA) services

FBA Recommendation is to address the issues with non-ABA services

Development of the initial Behavior Support Plan

ABA Treatment always consists of one or a combination of these three services:

- **Exposure Adaptive Behavior Treatment with Protocol Modification**, (0373T & 0374T) *And/Or*
- **Adaptive Behavior Treatment by Protocol Modification** (0368T & 0369T), *And/Or*
- **Treatment Social Skills Group** (0372T)

And perhaps one or both of these two (which are not stand-alone services, meaning they can only be authorized in conjunction with one or more of the services above)

- **Adaptive Behavior Treatment by Protocol by Technician** (0364T and 0365T)
- **Family Treatment Guidance** (0370T)

Non-ABA Services

- "Person-Centered Strategies Consultation" (H0004)
- Crisis Intervention" (S9484)
- Referral for Community Mental Health Services
- Referral for Medical services

- SC/Planning Team develops request for services/ISP addendum
- Standard UR and approval process completed

Service Title	Description	How it might be used
Behavior Identification Assessment: 0359T	Involves the qualified healthcare provider completing a record review, interview of individual and/or folks who know the person to identify the target behaviors and situations of concern, and skill assets and deficits	Necessary part of all Functional Behavioral Assessments (FBA)
Observational Behavioral Follow-Up Assessment*: 0360T – the 1st 30 minute for a date of service and 0361T-subsequent 30 minute units on a date of service	QHCP directed or completed observations, baseline data collection if behaviors and situations to determine hypothesis of functions of problem behaviors, includes interpretation of data and report	Part of FBA, might involve QHCP or LaBA or RBT completing observations and data collection under direction of behavior analyst. Might involve several observations with data collected on antecedents, behavior and consequences in situations for which the behavior of concern is common and for which the behavior rarely occurs.
Exposure Behavioral Follow-Up Assessment: 0362T and 0363T 0362T – the 1st 30 minute for a date of service and 0363T-subsequent 30 minute units on a date of service	Can only be authorized through review by Chief Behavior Analyst QHCP designs and implements brief controlled situations to determine if the person reacts to potential variables that might be controlling the problem behavior	Part of some FBAs. Will be done to isolate variables function of the problem behaviors when reasonable hypotheses cannot be developed for complex behavioral situations. This is anticipated to be an infrequently authorized service.
Adaptive Behavior Treatment with Protocol Modification*: 0368T and 0369T 0368T – the 1st 30 minute for a date of service and 0369T-subsequent 30 minute units on a date of service	Provided by the QHCP or LaBA and is the process of managing, monitoring, training and demonstrating the behavioral strategies in the behavior support plan (BSP) and the data collection for the BSP. addresses the individual's specific target problems and treatment goals	Goals of adaptive behavior treatment may include reduction of repetitive and aberrant behavior, and improved communication and social functioning. Adaptive behavior treatment may take place in multiple sites and social settings, it is not a counseling service. For a mild problem situation it might be the sole ABA service and involve 2-4 one hour visits from the provider per month for several months. An intensive problem situation might involve one or more additional ABA services, with this service occurring for several hours per visit and multiple visits per week for extensive time.
Exposure Adaptive Behavior Treatment with Protocol Modification: 0373T and 0374T 0373T – the 1st 30 minute for a date of service and 0374T-subsequent 30 minute units on a date of service	Can only be authorized through review by Chief Behavior Analyst QHCP designs and implements brief controlled situations to teach the person to avoid or respond appropriately to variables that might be controlling the problem behavior	Would be part of a BSP for situations in which the person was restricted from participation or access to certain situations due to danger to self or others. The probes or teaching/testing sessions would be necessary to ensure the skills and

Service Title	Description	How it might be used
		reduction in problem behavior achieved in controlled settings generalized to the problem situations.
Adaptive Behavior Treatment by Protocol by Technician*: 0364T and 0365T 0364T – the 1st 30 minute for a date of service and 0365T-subsequent 30 minute units on a date of service	A RBT that provides the primary implementation, modeling and training of a complicated BSP that requires more expertise, time, and intensity than most strategies in a BSP. The service should be working towards care provider implementation of strategies as these are able to be less complex and intensive.	ABA services for a 22 year old son with severe functional limitations who is not consistently toileting independently, has not learned to communicate, and has been engaging in significant property destruction and aggression on a daily basis. The BSP requires interaction at a rate of several times per minute, intensive toilet training with a behavioral protocol, continuous functional communication training and use of prompts, physical guidance and physical crisis intervention.
Family Behavior Treatment Guidance*: 0370T	Provided by the QHCP or LaBA to discuss BSP, progress, changes or provide training in use of strategies without the individual present.	Most of the training to implement, monitoring of plan and discussion with care providers (family and/or staff) can occur as part of the Adaptive treatment with protocol modification, however, there may be some situations in which this would be difficult or not beneficial for the individual. Might occur monthly for a mild level of service or weekly for an intensive service.
Behavior Treatment Social Skills Group*: 0372T	Provided by QHCP or LaBA to persons in a group for purposes of teaching and practicing social skills.	A group of individuals (not more than 8) with similar needs and goals for social skills development meet repeatedly to learn and practice conversation skills.

Community Specialist

GENERAL SERVICE DESCRIPTION: Community Specialist services are used when specialized supports are needed to assist the individual in achieving outcomes in the ISP. Community Specialist supports includes:

- Professional Observation and assessment
- Individualized program design and implementation
- Consultation with team members
- Advocacy
- Assistance with locating and accessing services
- Design and implementation of specialized programs to enhance self-direction, independent living skills, community integration, social, leisure and recreational services.

Service Description:	Waiver Code:	Non-Waiver Code:	Unit:
Community Specialist	T1016	52000H	15 minutes

Any plan requesting Community Specialist must address the following questions:	
<input type="checkbox"/>	What are the specific specialized supports that are needed?
<input type="checkbox"/>	Why are these supports needed?
<input type="checkbox"/>	When are the supports needed?
<input type="checkbox"/>	Where will the supports be provided?
<input type="checkbox"/>	How will the supports be delivered?
<input type="checkbox"/>	Are natural supports available to meet this need?
<input type="checkbox"/>	Does the plan document what other alternative services or supports have been considered?
<input type="checkbox"/>	Does the plan document teaching strategies and outcomes that would enable the individual to become more independent and support fading as appropriate?

Community Transition

Transition services are one-time, set-up expenses for individuals who transition from an institution (ICF/ID or Title XIX Nursing Home or other congregate living setting) to a less restrictive community living arrangement such as; a home, apartment, or other community-based living arrangement.

Congregate living settings shall include any provider-owned residential setting where MO HealthNet reimbursement is available, including the following:

- Intermediate Care Facilities for Individuals with Intellectual Disabilities
- Nursing Facilities
- Residential Care Facilities
- Assisted Living Facilities
- DD Waiver Group Homes

Examples of expenses that may be covered include:

- Expenses to transport furnishings and personal possessions to the new living arrangement;
- Essential furnishing expenses required to occupy and use a community domicile;
- Security deposits that are required to obtain a lease on an apartment or home that does not constitute paying for housing rent;
- Utility set-up fees or deposits for utility or service access (e.g. telephone, water, electricity, heating, trash removal);
- Health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy.

Essential furnishings include items for an individual to establish his or her basic living arrangement, such as a bed, a table, chairs, window blinds, eating utensils, and food preparation items. Community transition services shall not include monthly rental or mortgage expenses, food, regular utility charges, and/or household appliances or items that are intended for purely diversional or recreational purposes such as televisions, cable TV access or VCRs or DVD players.

This service is limited to persons who transition from a congregate living to the waiver. The services must be necessary for the person to move from an institution and the need must be identified in the person's plan. Total transition services are limited to \$3,000 per participant over their lifetime in the process of moving from a congregate living setting to the community. A unit of service is one item or expense.

Community Transition Services may not be used to pay for furnishing living arrangements that are owned or leased by a waiver provider where the provision of these items and services are inherent to the service they are already providing.

Crisis Intervention

Crisis Intervention provides immediate therapeutic intervention, available to an individual on a 24-hour basis, to address personal, social, and/or behavioral problems which otherwise are likely to threaten the health and safety of the individual or of others and/or to result in the individual's removal from his current living arrangement.

Crisis intervention may be provided in any setting and includes consultation with family members, providers and other caretakers to design and implement individualized crisis treatment plans and provide additional direct services as needed to stabilize the situation.

Individuals with developmental disabilities are occasionally at risk of being moved from their residences to institutional settings because the person, or his or family members or other caretakers, are unable to cope with short term, intense crisis situations. Crisis intervention can respond intensively to resolve the crisis and prevent the dislocation of the person at risk. The consultation which is provided to caregivers also helps to avoid or lessen future crises. This service is a cost effective alternative to placement in an ICF-ID.

Specific crisis intervention service components may include the following:

- Analyzing the psychological, social and ecological components of extreme dysfunctional behavior or other factors contributing to the crisis;
- Assessing which components are the most effective targets of intervention for the short term amelioration of the crisis;
- Developing and writing an intervention plan;
- Consulting and, in some cases, negotiating with those connected to the crisis in order to implement planned interventions, and following-up to ensure positive outcomes from interventions or to make adjustments to interventions;
- Providing intensive direct supervision when a consumer is physically aggressive or there is concern that the consumer may take actions that threaten the health and safety of self and others;
- Assisting the consumer with self-care when the primary caregiver is unable to do so because of the nature of the consumer's crisis situation; and
- Directly counseling or developing alternative positive experiences for consumers who experience severe anxiety and grief when changes occur with job, living arrangement, primary care giver, death of loved one, etc.

Providers of crisis intervention shall consist of a team under the direction and supervision of a psychologist, counselor or social worker licensed by the State of Missouri (RSMo. 1994, Chapter 337).

Alternately, the supervisor may be employed by the State of Missouri as a psychologist, clinical social worker or in an equivalent position (such positions are exempt from licensure) and meet the requirements of a QDDP* (as defined at 42 CFR 483.430). All team members shall have at least one year of work experience in serving persons with developmental disabilities, and shall, either within their previous work experience or separately, have a minimum of 40 hours training in crisis intervention techniques prior to providing services.

Crisis teams may be agency based (certified or accredited ISL lead agencies, day habilitation providers, and group homes, or Division of DD regional offices and habilitation centers), or they may stand alone.

The scope of the waiver crisis intervention service is significantly above and beyond the scope of the state plan service and is meant to be provided by a team, not a single individual. It would be extremely rare for a crisis situation involving a DD waiver participant to be resolved within 60 minutes, and by a person without specialized training working with people with developmental disabilities. Many crisis situations in the DD system may be due to an environmental situation where the individual does not have the language skills to communicate their discomfort or distress, and the average provider of traditional “talk therapy” may not have the experience, skills and educational background to appropriately address this need.

Crisis Intervention services are expected to be of brief duration (4 to 8 weeks, maximum). When services of a greater duration are required, the individual should be transitioned to a more appropriate services program such as counseling or respite.

Crisis intervention needs for the eligible person that can be met through state plan, including EPSDT crisis services, as applicable, shall first be accessed and utilized, in accordance with the requirement that state plan services must be exhausted before waiver services can be provided. Waiver crisis intervention shall be provided above and beyond any state plan, including EPSDT crisis service that can meet the individual's need.

Billing codes:

Crisis Intervention, Professional: S9484, Unit of Service: Hour, Maximum Units: 24/day

Crisis Intervention, Technical: S9484 HM, Unit of Service: Hour, Maximum Unit: 24/day

Group Home

GENERAL SERVICE DESCRIPTION: Group Home services provide care, supervision and skills training in activities of daily living and community integration. This service is provided to groups of individuals who live in a home together. Services include:

- Staff support in the areas of self-care, sensory/motor development, interpersonal skills, communication, behavior shaping, community living skills, mobility, health care, socialization, money management, and household responsibilities.
- Transportation (as available)

Service Description:	Waiver Code:	Non-Waiver Code:	Unit:
Group Home	T2016 HQ	None	1 day
Group Home-Intensive rate	T2016 HQ		1 day
Group Home-Transition rate	T2016 HQ		1 day

Any plan requesting Group Home Services must address the following questions:	
<input type="checkbox"/>	Does the plan document that alternative housing options consistent with available financial resources were discussed with the individual?
<input type="checkbox"/>	If the plan describes restrictions in the group home related to freedom of movement, access to communication, access to food, etc., have those restrictions been reviewed and approved by the Due Process Committee?
<input type="checkbox"/>	Does the plan document that the individual expressed a desire to reside in this setting?
<input type="checkbox"/>	Does the plan affirm the individual's choice of provider and roommate, if sharing a bedroom?
<input type="checkbox"/>	Does the plan document teaching strategies and outcomes that promote independence in the home and in the community?

Individualized Supported Living

Service Description:	Waiver Code:	Non-Waiver Code:	Unit:
Supported Living	T2016	None	1 day

GENERAL SERVICE DESCRIPTION: Individualized Supported Living services enable an individual to be fully integrated into their community. Services include individualized supports, delivered in a personalized manner to individuals who live in homes of their choice. ISL's are characterized by creativity, flexibility, responsiveness and diversity. Principles of Supported Living Services include:

- People live and receive needed supports in the household of their choice
- Personal preferences and desires are respected
- Personal autonomy and independence is promoted
- Existing resources and natural supports are maximized from the community at large
- Training focuses on acquiring functional useful skills within the community.
- Services are outcome focused and based on an individual's needs

Any plan requesting Individualized Supported Living Services must address the following questions:	
<input type="checkbox"/>	What specific supports are needed to achieve personal outcomes that enhance an individual's ability to live in and participate in their community?
<input type="checkbox"/>	Does the plan document that alternative housing options consistent with available financial resources were discussed with the individual?
<input type="checkbox"/>	If the plan describes restrictions in the group home related to freedom of movement, access to communication, access to food, etc., have those restrictions been reviewed and approved by the Due Process Committee?
<input type="checkbox"/>	Does the plan document that the individual expressed a desire to reside in this setting?
<input type="checkbox"/>	Does the plan affirm the individual's choice of provider and roommate, if sharing a bedroom?
<input type="checkbox"/>	Does the plan document outcomes and teaching strategies that promote independence?

Shared Living

GENERAL SERVICE DESCRIPTION: Shared Living is an arrangement in which an individual chooses to live with a couple, another individual, or a family in the community to share their life experiences together. Shared Living can be provided in the home of the care giver (Host Home Services) or in the individual's home (Companion Services).

A Host home or Companion Home is a private home, licensed or certified by the Division of Developmental Disabilities, where a family or individual accepts the responsibility for caring for up to three individuals with developmental disabilities.

Shared Living offers a safe and nurturing home by giving guidance, support and personal attention. The provider plays an active role in the individual's team and the collaborative development of a service plan. The support plan is based on the team's knowledge of the individual's personal challenges, strengths, skills, preferences and desired outcomes. The support plan provides guidelines and specific strategies that address the person's needs in the social, behavioral and skill areas and is designed to lead to positive lifestyle changes. Living in a home environment presents daily opportunities to acquire and use new skills.

The host family or companion helps the individual participate in family and community activities and facilitate a relationship with the person and his/her natural family and the general community. They help the person learn and use community resources and services as well as participate in activities that are valued and appropriate for the person's age, gender and culture. The provider ensures that the person's identified health and medical needs are met and comply with licensure or certification regulations of the Division of Developmental Disabilities.

A single family host or companion home may be licensed by and directly contract with the DMH, or the host family or companion may be directly employed by or under contract with an agency licensed by and under contract with DMH to provide host home and/or companion services.

Host Home and Companion services include the following:

- (a) Basic personal care and grooming, including bathing, care of the hair and assistance with clothing;
- (b) Assistance with bladder and/or bowel requirements or problems, including helping the individual to and from the bathroom or assisting the individual with bedpan routines;
- (c) Assisting the individual with self-medication or provision of medication administration for prescribed medications, and assisting the individual with, or performing health care activities;
- (d) Performing household services essential to the individual's health and comfort in the home (e.g., necessary changing of bed linens or rearranging of furniture to enable the individual to move about more easily in his/her home);
- (e) Assessing, monitoring, and supervising the individual to ensure the individual's safety, health, and welfare;
- (f) Light cleaning tasks in areas of the home used by the individual;
- (g) Preparation of a shopping list appropriate to the individual's dietary needs and financial circumstances, performance of grocery shopping activities as necessary, and preparation of meals;

- (h) Personal laundry;
- (i) Incidental neighborhood errands as necessary, including accompanying the individual to medical and other appropriate appointments and accompanying the individual for short walks outside the home; and
- (j) Skill development to prevent the loss of skills and enhancing skills that are already present that will lead to greater independence and community integration.

Payment to the host or companion home is a flat monthly rate to meet the individual's support needs, and is exempt from income taxes. The host or companion home will be paid on the basis of intensity and difficulty of care.

No more than three individuals receiving host home services may share a residence. Individuals receiving host home services and sharing a home with housemates shall each have a private bedroom, unless they choose otherwise.

Parents of minor children, legal guardians, and spouses cannot be providers for their child, ward, or spouse.

People who live in a host or companion home may also receive any other waiver service except for group home, individualized supported living, and personal assistant.

Payments for Host or Companion Home services do not include room and board, items of comfort or convenience, or the costs of home maintenance, upkeep, and improvement.

Persons who receive Host or Companion Home services shall not also receive state plan personal care or Adult Day Care.

Shared Living billing code: S5136, Unit of Service: Day, Maximum Units of Service: 1/Day

Environmental Accessibility Adaptations

Service Description:	Waiver Code:	Non-Waiver Code:	Unit:
Environmental Accessibility Adaptations	S5165	39271W	1 job

GENERAL SERVICE DESCRIPTION: Any physical adaptation that is identified in the ISP and is needed to ensure the health, welfare and safety of the individual or that are needed to allow greater independence in the community. Adaptations must be directly related to the individual's disability and without these adaptations the individual would require a more restrictive environment. Examples of EAA include Ramps Modifications to vehicles Grab-bars Widening of doorways Modification of bathroom facilities Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies needed for the welfare of the individual

Costs are limited to \$7,500 per year, per individual for the Comprehensive, Support, Autism, MOCDD and PfH Waivers. The annual limit corresponds to the waiver year, which begins July 1 and ends June 30 for the Comprehensive, Support, and Autism Waivers. The annual limit corresponds to the waiver year which begins October 1 and ends September 30 each year for MOCDD and PfH Waivers

Any plan requesting Environmental Accessibility Adaptation must address the following questions:	
<input type="checkbox"/>	What specific adaptations are needed?
<input type="checkbox"/>	Were the supports/modifications described within a report from a licensed/registered Occupational or Physical Therapist?
<input type="checkbox"/>	Are the modifications clearly of primary benefit to the individual?
<input type="checkbox"/>	Are there at least two bids from providers contracted with the Division to perform home modifications/vehicle modifications? If not, is the clear and convincing documentation as to the efforts made to obtain another bid?
<input type="checkbox"/>	Are the bids itemized sufficiently to allow comparisons with each other?
<input type="checkbox"/>	Are natural supports in place to meet this need?
<input type="checkbox"/>	Does the plan document what other alternative services or supports have been considered?
<input type="checkbox"/>	Is the request within the Medicaid Waiver cap for this service? If not, is there an exception in place?

<input type="checkbox"/>	Does the plan clearly document that the individual/guardian owns or leases (controls) the residence?
<input type="checkbox"/>	If a leased residence, has the owner's permission for the modification been documented, including documentation that the owner understands that the modifications cannot be reversed through waiver funding?

EAA Flow Chart: Discussion with individual and family or guardian leads to the decision to modify a home.

- ☐ Can the modifications be provided by a non-waiver source?

YES

- ☐ If so, use that funding source describe in ISP.

NO

- ☐ Obtain a formal home mod need evaluation from an OT or PT

- ☐ Is there a relevant OT or PT evaluation describing the needs of the individual and need for home modifications?

NO

- ☐ Can an OT/PT eval be funded through non waiver sources?

NO

YES

- ☐ Assist the individual or guardian to arrange for the evaluation.
- ☐ Provide information to the Therapist regarding the information and format needed

YES

- ☐ Develop or amend ISP to request funding for the OT/PT Eval and submit to UR Committee and Regional Office for approval.
- ☐ Document why the Eval cannot be obtained using funding other than

- ☐ Collaborate with OT/PT to improve documentation

NO

SC reviews Home Mod Eval Report completed by OT/PT, determines:

- ☐ Does eval clearly provide detailed

YES

- ☐ Contact potential bidders
- ☐ Provide potential bidders with copy of OT/PT eval
- ☐ Inform potential bidders of recommended bid form and provide them with a copy.

- ☐ Bids Received

Complete the ISP in preparation for review

- ☐ OT/PT Eval attached
- ☐ If only one bidder, documentation of efforts and response for additional bids
- ☐ Review of bids
- ☐ Bids Attached (Is all the information included? Does the bid represent ONLY the modifications identified by the OT/PT Evaluation? If not, contact bidder and obtain more information.)
- ☐ Service Codes and budget attached

- ☐ Submit ISP to the UR Committee

- ☐ If approved, contact contractor and monitor service through contact with the family and, when possible, site visit to assure all work is completed and done so as described in the bid.

EAA/Home Modification

Frequently Asked Questions

(written from the perspective of the individual/family)

1. ***Who pays for the evaluation and report from a credentialed (licensed or certified) Occupational Therapist or Physical Therapist?*** Waiver funds can be used to pay for the PT or OT evaluation. There is no rule saying that only waiver funds can be used for this, and sometimes families already have access to a report from an OT or PT recommending environmental modifications. Depending on the level of detail in that report, it is possible that no further report will be needed for this part of the information.
2. ***How do I find an OT or PT who will perform these evaluations?*** Your SC should be able to help you with this.
3. ***What if the PT or OT's report does not recommend the home modification?*** If there is no recommendation from an OT or PT for this modification, it will not be approved for Waiver funding.
4. ***How do I present the report to the UR Committee?*** The Support Coordinator will submit this OT/PT evaluation request through the URC for approval/consideration. The Support Coordinator will include the OT/PT evaluation to the ISP.
5. ***Do we need a doctor's order for these modifications?*** NO While PT's and OT's often need a physician's orders to provide services, they do not need one to assess the individual's need for EAA.
6. ***What do the qualifications of the providers have to be?*** The companies providing the estimate must have a contract with Division that allows them to bill for those services.
7. ***What if we can only find one qualified company to provide a bid? Who decides which company we will use?*** If there is only one provider that serves the area, then only one bid would be needed. This would need to be documented that the planning team contacted at least one other EAA provider and determined that that provider and the reason the provider indicated not meeting the request (e.g., is not interested in serving that area of the State).
8. ***What if we prefer the company who gives the higher bid? Do we always have to use the lowest bid?*** URC will review all bids and approve the lowest and/or best price if the price is reasonable based on the purchase experience of the regional office of similar jobs, and if the

cost for the equipment or supplies does not exceed the annual maximum allowed for the service. The waiver allows the individual or family to appeal a denial of a service but not the provider being used.

9. ***After we pick one company, can the other companies appeal our decision?*** No
10. ***Is there a limit to how much money can be spent on environmental modifications?*** The annual maximum allowed for this service through the waiver is \$7500 per plan year. If an individual's need cannot be met with the limit, an exception may be approved by the Regional Director to exceed the limit if this will result in a decreased need of one of more other services. The limit for the exception is \$10,000 per plan year.
11. ***Can we get reimbursed for a home modification we have already made?*** No waiver funded service is to be provided without prior approval. This means that the waiver cannot be used to reimburse anyone for an environmental modification that already been planned and purchased before the approval of the Division of DD.
12. ***Can environmental adaptations or modifications be made before the individual has moved into the home?*** Yes, as long as there is a certainty that the individual will move into the home at a certain date in the near future. If the individual does not end up moving to the modified home then the provider will not be paid for the modification.
13. ***Can providers use waiver funds to make their facilities more accessible for individuals with disabilities?*** No. These funds are limited to use in the individual's residence.
14. ***Can we use waiver funds to build an addition to our home?*** No, these funds cannot be used to increase the footprint of the home unless absolutely necessary to complete an adaptation.
15. ***Can we use waiver funds to make changes to property we are renting or do we have to own our own home?*** EAA can be approved for any residential setting where the individual lives, regardless of whether it is owned or leased. The waiver cannot be used to fund modifications to service-provider owned or leased settings such as an Independent Supported Living setting or Group Home.
16. ***Is there a rule of thumb to help us understand the difference between home modifications and specialized medical equipment?*** If the item is attached to the home, then it would be considered a home modification (or EAA) and not specialized medical equipment (SME). For example, a grab bar is attached to the home structure, and so would be EAA. A portable shower chair, though, is not attached to the home and would be considered SME.

17. ***Can we use these funds to make repairs to the home, such as fixing a leaky roof or repairing a heating system or worn carpet?*** No. The definition for this service specifically excludes those types of general changes to a home. There are other specific exclusions to the types of modification that can be funded through the waiver. Your SC should be able to help you make sure your plan is appropriate.
18. ***Can Waiver funds be used to remove EAA when the individual leaves that home?*** No, that is specifically excluded.
19. ***Can we choose the style and appearance of the modification to match our home?*** Generally, no. The waiver pays only for “construction grade” materials. You might be able to have choices within the category of “construction grade materials” depending on the situation. You can discuss the choices, if any are available, with the provider. Any cost above the construction grade may be met by the person or family, including any additional cost necessary to meet a home owner association or historic district. Think of it this way: the waiver is available to improve the function of the home, not the appearance of the home.
20. ***Can a higher cost modification be split over two plan years?*** No. The cost of a single modification project cannot be split over two plan years.

Alternative Funding Options:

Depending on where you live and the local supports present in your community, there are often other ways to get funding for your need. Church groups, school groups and other community organizations sometimes will provide all or part of the materials and labor for simple projects. The ease of access to those sources and the speed and quality of the work vary, but it might be worthwhile to look at these options.

The Missouri Department of Health and Human Services, through its Division of Senior and Disability Services has an Independent Living Waiver. That waiver can also be used to fund EAA services. A person can only participate in one Medicaid waiver at a time, though, so that person would have to choose between the DD waiver and the Independent Living waiver.

There are 22 Centers for Independent Living (CIL's) in Missouri who can also fund some home modification services. Details can be found at www.mosilic.org

There is also a program called the Home Repair Opportunity Program (HeRO). This program is targeted to families with low incomes, but can fund home repair, accessibility modifications, and maintenance. More information can be found at www.mhdc.com/homes/hero/index.htm

The primary advantage to using these alternative sources is that they often are easier to access, without as many “strings” for qualification, compared to using Medicaid Waiver funding through the Division. Your SC should be able to help you locate these programs, but it might also be good to ask friends and family members if they can recommend options.

Assistive Technology

GENERAL SERVICE DESCRIPTION: This service includes Personal Emergency Response Systems (PERS), Medication Reminder Systems (MRS) and other electronic technology that protects the health and welfare of an individual. This service may also include electronic support systems using video, web-cameras, or other technology. However, use of such systems may be subject to due process review. Assistive technology shall not include household appliances or items that are intended for purely diversional or recreational purposes.

Assistive technology should be evidenced based, and shall not be experimental.

Electronic support systems using video, web-cameras, or other technology is only available on an individual, case-by-case basis when an individual requests the service and the planning team agrees it is appropriate and meets the health and safety needs of the individual. Remote support technology may only be used with full consent of the individual and his/her guardian and with written approval by the due process committee when applicable to verify that due process was followed for the remote support request.

Remote support will enable a person to be more independent and less reliant on staff to be physically present with them at all times, in particular for night time supports.

The type of equipment and where placed will depend upon the needs and wishes of the individual and their guardian (if applicable), and will also depend upon the particular company selected by the individual or guardian to provide the equipment. The installation of video equipment in the home will be done at the direction of the individual. If the home is shared with others the equipment will be installed in such a manner that it does not invade others' privacy. The remote device is controlled by the waiver individual and can be turned on or off as needed.

The provider must have safeguards and/or backup system such as battery and generator for the electronic devices in place at the base and the individual's residential living site(s) in the event of electrical outages. The provider must have backup procedures for system failure (e.g., prolonged power outage), fire or weather emergency, individual medical issue or personal emergency in place and detailed in writing for each site utilizing the system as well as in each individual's ISP. The ISP must specify the individuals to be contacted by base staff who will be responsible for responding to these situations and traveling to the individual's living site(s). In situations requiring a person to respond to the individual's residence, the response time should not exceed 20 minutes.

In emergency situations staff should call 911.

Waiver individuals interested in electronic support technology must be assessed for risk following the division's risk assessment guidelines posted at <http://dmh.mo.gov/docs/dd/riskguide.pdf> and must be provided information to ensure an informed choice about the use of equipment versus in-home support staff.

Personal Emergency Response System (PERS) is an electronic device that enables an individual at high risk of institutionalization to secure help in an emergency that is connected to a device and programmed

to signal a response center once the help button is activated. The response center is staffed with trained professionals. The service is limited to those who live alone, live with others who are unable to summon help, or who are alone for significant portions of the day, have no regular caregiver for extended periods of time and would otherwise require extensive routine supervision.

A medication reminder system (MRS) is an electronic device programmed to provide a reminder to an individual when Medications are to be taken. The reminder may be a phone ring, automated recording or other alarm. This device is for individuals who have been evaluated as able to self-administer medications with a reminder. The electronic device may dispense controlled dosages of medication and may include a message back to the center if a medication has not been removed from the dispenser. Medications must be set-up by an RN or professional qualified to set-up medications in the State of Missouri.

All electronic device vendors must provide equipment approved by the Federal Communications Commission and the equipment must meet the Underwriters Laboratories, Inc., (UL) standard for home health care signaling equipment. The UL listing mark on the equipment will be accepted as evidence of the equipment's compliance with such standard.

The emergency response activator must be able to be activated by breath, by touch, or some other means and must be usable by persons who are visually or hearing impaired or physically disabled.

Any assistive technology device must not interfere with normal telephone use.

The PERS and MRS must be capable of operating without external power during a power failure at the recipient's home in accordance with UL requirements for home health care signaling equipment with stand-by capability and must be portable.

An initial installation fee is covered as well as ongoing monthly rental charges and upkeep and maintenance of the devices.

Any assistive technology devices authorized under this service shall not duplicate services otherwise available through state plan.

MRS and PERS are just two of many different types of assistive technology. More examples of assistive technology that can enable people to be less dependent upon direct human assistance include but are not limited to electronic motion sensor devices, door alarms, web-cams, telephones with modifications such as large buttons, telephones with flashing lights, phones equipped with picture buttons programmed with that person's phone number, devices that may be affixed to a wheelchair or walker to send an alert when someone falls (these may be slightly different than a PERS) text-to-speech software, devices that enhance images for people with low vision, intercom systems.

Costs are limited to \$9,000 per year, per individual. The annual limit corresponds to the waiver year, which begins July 1 and ends June 30 each year.

Billing code: A9999, Unit of Service: 1 job or item, Maximum Units of Service: 1/month

Specialized Medical Equipment and Supplies

GENERAL SERVICE DESCRIPTION: Specialized medical equipment and supplies includes devices, controls, or appliances, specified in the support plan, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

Includes:

- Items necessary for life support,
- Ancillary supplies and equipment necessary to the proper functioning of such items,
- Durable and non-durable medical equipment and supplies, and
- Equipment repairs

When the equipment, supplies and repairs are not covered under the Medicaid State DME plan.

Includes incontinence supplies.

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. All items shall meet applicable standards of manufacture, design and installation.

Costs are limited to \$7,500 per year, per individual. The annual limit corresponds to the waiver year, which begins July 1 and ends June 30 each year.

Other specialized equipment, supplies and equipment repair needs for the eligible person that can be met through state plan, including EPSDT, as applicable, shall first be accessed and utilized, in accordance with the requirement that state plan services must be exhausted before waiver services can be provided. DD waiver other specialized equipment, supplies and repairs shall be provided above and beyond any state plan, including EPSDT, equipment, supplies, and repair service that can meet the individual's needs. Further, this waiver service may also be authorized for items/repairs not covered under state plan and falls within the waiver service definition described above.

Specialized Medical Equipment (SME) FAQ

Is it necessary to document that state plan services cannot fund the equipment?

Yes, as will all waiver services, state plan services must be exhausted before waiver funds may be used. *See addendum for a chart from MO HealthNet of what State Plan will authorize. For those items that can be authorized through the Medicaid exceptions process, the expectation is that the exceptions process be used.*

Are bids necessary for SME?

Yes. At least two bids must be documented. *Authority for this is on page 153 of the Comprehensive waiver, and identical language is used in the other waivers. See addendum.*

When there are multiple items being ordered, and one bidder has a lower overall cost but has a higher item cost for some of the items, what happens then?

Provider A			
Item	Quantity	\$/Per Item	\$Total
Gloves	100	\$0.03/10	\$3.00
Wipes	400	\$2.28/100	\$9.12
Adult Diapers	100	\$2.25 ea	\$225.00
TOTAL			237.12

Provider B			
Item	Quantity	\$/Per Item	\$Total
Gloves	100	\$0.03/10	\$3.00
Wipes	400	\$2.12/100	\$8.48
Adult Diapers	100	\$2.45 ea	\$245.00
TOTAL			256.48

Example: Provider A has the lowest overall costs, but the cost for wipes is actually higher than Provider B. Provider A should get the approval, and there is no expectation that any material be ordered from Provider B even though Provider B gave a lower bid for an individual item (wipes). Approval goes to the provider with the lowest overall bid for the total of the items to be ordered.

Where does provider choice come in? What if the individual or family wants to use the provider with the higher bid?

Provider choice is afforded when choosing the providers from whom bids will be solicited. The individual or family is essentially saying that both providers are agreeable, and that they will accept services from whichever one presents the lowest bid.

Would it ever be acceptable to use the provider with the higher bid?

Theoretically, yes, but it would be very unlikely to be necessary in a practical sense. If there was some overriding reason why a particular provider wouldn't be acceptable (because of a reputation for unreliability, for example) a best practice for case management would be to simply find another acceptable provider from which you could get a bid. In these days with easy access to companies providing medical supplies by mail this should be a fairly painless process. That being said, a strong argument in the individual support plan (ISP) could justify the choice of a more expensive bid.

Can SME be used to fund nutritional supplements?

No. The purchase of such supplements, if medically necessary, would fall under the obligation of the standard state Medicaid plan.

Does SME require a physician's order?

The plan must compellingly document the need for the SME, and a physician's order would be good evidence of need. There is no language in the approved waiver applications or provider manual that requires a doctor's order for SME,

Authoritative Sources and Language (with added emphasis)

From page 126 of the Comprehensive Waiver approved application (identical to the definition in other waivers):

Service Definition (Scope):

Specialized medical equipment and supplies includes devices, controls, or appliances, specified in the support plan, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, durable and non-durable medical equipment and supplies, and equipment repairs when the equipment, supplies and repairs are not covered under the Medicaid State DME plan. Includes incontinence supplies.

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. All items shall meet applicable standards of manufacture, design and installation.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Costs are limited to \$7,500 per year, per individual. The annual limit corresponds to the waiver year, which begins July 1 and ends June 30 each year. Other specialized equipment, supplies and equipment repair needs for the eligible person that can be met through state plan, including EPSDT, as applicable, shall first be accessed and utilized, in accordance with the requirement that **state plan services must be exhausted before waiver services can be provided**. DD waiver other specialized equipment, supplies and repairs shall be provided above and beyond any state plan, including EPSDT, equipment, supplies, and repair service that can meet the individual's needs. Further, this waiver service may also be authorized for items/repairs not covered under state plan and falls within the waiver service definition described above.

From page 153 of the Comprehensive Waiver approved application (identical to the definition in other waivers):

Effective July 1, 2017, the Targeted Case Management (TCM) entity may provide waiver services, but NOT to an individual for whom the agency provides support coordination, unless that service is transportation or specialized medical equipment.

From page 153 of the Comprehensive Waiver approved application (identical to the definition in other waivers):

Special Equipment, Supplies and Services: For environmental accessibility adaptations, specialized medical equipment and supplies and Assistive Technology a flat rate is not used. **Bids** or estimates of cost for a job, equipment or supplies are obtained from two or more providers the individual chooses. A dollar amount is authorized for the provider with the lowest and best price if the price is reasonable based on the purchase experience of the regional office of similar jobs, equipment or supplies and does not exceed the annual maximum allowed for the service.

Click the link below to access the Specialized Medical Equipment section of the **Service Coordinator's Manual**:

<https://dmh.mo.gov/docs/dd/scmanual/specialized-medical-equipment-supplies.pdf>

Note:

“Through waiver” means that a waiver could be used to fund that product without having to go through the exception process.

DD Waivers should not be used for

- *any product that could be provided for the individual through State Plan, or*
- *any product which could be submitted to the State Plan exceptions process.*

If the product could be approved through the State Plan exceptions process and that process rejects a request, DD waivers could be an appropriate funding source if the need is compellingly included in the ISP.

Person Centered Strategies Consultation

This service involves consultation to the individual's support team to improve the quality of life for the individual through the development of and implementation of positive, proactive and preventative, Person Centered Strategies and a modified environment and/or lifestyle for the individual.

Person Centered Strategies consultation involves evaluating a person's setting, schedule, typical daily activities, relationships with others that make up the supports for an individual including paid staff/paid family and unpaid natural supports.

The evaluation leads to changes in strategies including such things as:

- Re-arranging the home to reduce noise and stimulation,
- Adding a personal quiet area to allow the individual to get away from annoying events,
- Teaching skills to promote more positive interactions between the individual and supporting staff or family.

Evaluation may involve identifying skills that would help the individual to have a better quality of life and assist the support staff/family to teach these meaningful skills to the individual and identify ways to proactively prevent problem situations and assisting the individual and support staff/family to use these new strategies and problem solving techniques for the individual. Such strategies developed could include: clarifying the expectations for the individual and all members of the support team, and establishing positive expectations or rules for the individual with the support team learning to change their system to support in these more positive ways, improving recognition of desirable actions and reduction of problematic interactions that might evoke undesirable responses from the individual. A large part of the consultation will involve assisting the support system to develop a sustainable implementation plan and to insure a high fidelity of implementation and consistency of use of the strategies to assist and support the individual. This is not a direct therapy type service, for example the consultant's interaction with the individual should be pleasant and positive, but it is not this interaction that improves the quality of the person's life, rather the changes made to the person's support system, especially those focusing on implementation of identified strategies make the difference for the individual.

Person Centered Strategy consultation might work towards improved quality of life for the individual through training of support persons and developing a way for the support system to monitor and evaluate the interactions and systems to establish increased opportunities for teaching and practice of necessary skills by the individual, increasing recognition of desirable actions by the individual and the support team, increased frequency and types of positive interactions by support persons with and by the individual and the support team, increased frequency and types of positive interactions by support persons with and by the individual, and assisting the individual and support team to arrange practice opportunities such as social skills training groups or arranging a system of coaching and prompting for desirable actions in situations that commonly are associated with problems. The consultant might establish and lead such practice opportunities while coaching support person to continue the practice when the service is discontinued.

The unit of service is one-fourth hour. This is a short term service that is not meant to be on going, the typical duration of service is to be twelve months or less.

This service is not to be provided for development or implementation of behavior support plans or functional assessment as these services require licensure as a behavior analyst, psychologist, counselor or social worker with specialized training in behavior analysis. However, this service might work in conjunction with a behavior analysis service provider to develop and establish a support system that can implement strategies towards a good quality of life for the individual.

Person Centered Strategies Consultation differs from the Behavior Analysis Service in that PCSC the focus and whole scope of the service is on identifying barriers to a good quality of life and improving proactive, preventative and teaching based strategies to increase desirable, healthy skills and thus reduce problem situations. In addition, the PCSC will require providers with a less involved level of training and experience than BAS. Psychology/Counseling services under EPSDT do not include Person Centered Strategies services.

Physical Therapy

Physical Therapy treats physical motor dysfunction through various modalities as prescribed by a physician and following a physical motor evaluation. It is provided to individuals who demonstrate developmental, habilitative or rehabilitative needs in acquiring skills for adaptive functioning at the highest possible level of independence.

Physical Therapy requires a prescription by a physician and evaluation by a certified physical therapist (PT) or certified physical therapeutic assistant (CPTA) under the supervision of a PT. The service includes evaluation, planned development, direct therapy, consultations and training of caretakers and others who work with the individual. This service may include clinical consultation provided to individuals, parents, primary caregivers, other programs or habilitation services providers.

A unit of service is 1/4 hour.

Therapies available to adults under the state plan are for rehabilitation needs only. Therapies in the waiver are above and beyond what the state plan provides. Therapies in the waiver are more habilitative in nature; habilitative therapy is not available under the state plan.

Physical therapy needs for the eligible person through EPSDT, as applicable, shall first be accessed and utilized, in accordance with the requirement that state plan services must be exhausted before waiver services can be provided. Physical therapy through EPSDT for eligible persons under age 21 shall be provided and exhausted first before the waiver physical therapy is provided. Children have access to EPSDT services.

Speech Therapy

Speech Therapy is for individuals who have speech, language or hearing impairments. Services may be provided by a licensed speech language therapist or by a provisionally licensed speech therapist working with supervision from of a licensed speech language therapist. The individual's need for this therapy must be determined in a speech/language evaluation conducted by a certified audiologist or a state certified speech therapist. The need for services must be identified in the support plan and prescribed by a physician. Speech therapy provides treatment for delayed speech, stuttering, spastic speech, aphasic disorders, and hearing disabilities requiring specialized auditory training, lip reading, signing or use of a hearing aid.

Services may include consultation provided to families, other caretakers, and habilitation services providers. A unit of services is 1/4 hour.

Waiver providers must be licensed by the State of Missouri as a Speech Therapist. The Medicaid Waiver enrolled provider may employ a person who holds a provisional license from the State of Missouri to practice speech-language pathology or audiology. Persons in their clinical fellowship may be issued a provisional license. Clinical fellowship is defined as the supervised professional employment period following completion of the academic and practicum requirements of an accredited training program. Provisional licenses are issued for one year. Within 12 months of issuance, the applicant must pass an exam promulgated or approved by the board and must complete the master's or doctoral degree from an institution accredited by the Council on Academic Accreditation of the American Speech-Language-Hearing Association in the area in which licensing is sought. Provisionally licensed speech therapists must receive periodic, routine supervision from their employer, a Medicaid waiver enrolled speech therapy provider.

Therapies available to adults under the state plan are for rehabilitation needs only. Therapies in the waiver are above and beyond what the state plan provides. Therapies in the waiver are more habilitative in nature; habilitative therapy is not available under the state plan.

The individual's need for this therapy must be determined in a speech/language evaluation conducted by a certified audiologist or a state certified speech therapist. Services must be required in the support plan and prescribed by a physician. This service may not be provided by a paraprofessional.

Speech therapy needs for the eligible person through EPSDT, as applicable, shall first be accessed and utilized, in accordance with the requirement that state plan services must be exhausted before waiver services can be provided. Speech therapy through EPSDT.

Occupational Therapy

Occupational therapy requires prescription by a physician and evaluation by a certified occupational therapist (OT) or certified occupational therapeutic assistant (COTA) under the supervision of an OT. The service includes evaluation, plan development, direct therapy, consultation and training of caretakers and others who work with the individual. It may also include therapeutic activities carried out by others under the direction of an OT or COTA. Examples are using adaptive equipment, proper positioning and therapeutic exercises in a variety of settings.

Occupational therapy is covered under the Medicaid state plan for children and youth under the age of 21, so waiver OT is only for people age 21 and over. Occupational therapy services authorized through the waiver shall not duplicate state plan services.

Counseling

Counseling Services include goal oriented counseling to maximize strengths and reduce behavior problems and/or functional deficits, which interfere with an individual's, personal, familial, and vocational or community adjustment. It can be provided to individuals and families when the consumer is present with the family. This service is not available to children who are eligible for psychology/counseling services reimbursed under the Healthy Children and Youth (EPSDT) program nor adults when State plan psychology services are appropriate to meet the individual's need.

Counseling includes psychological testing, initial assessment, periodic outcome evaluation and coordination with family members, caretakers and other professionals in addition to direct counseling.

This service is needed by certain waiver participants whose living arrangement, job placement or day activity is at risk due to maladaptive behavior or lack of adjustment.

The planning team ensures this service does not duplicate, nor is duplicated by, any other services provided to the individual.

Counseling is a cost effective alternative to placement in an ICF-ID.

This service is not available to children who are eligible for psychology/counseling services reimbursed under the Healthy Children and Youth (EPSDT) program nor adults when State plan psychology services are appropriate to meet the individual's need.

This waiver will only be utilized when a prior authorization request has been submitted to and denied by MO HealthNet.

Professional Assessment and Monitoring

Professional Assessment and Monitoring (PAM) is intended to promote and support an optimal level of health and well-being. PAM is a consultative service by a licensed health care professional that may include assessment, examine, evaluate, and/or treat an individual of identified condition(s) or healthcare needs and planning to include instructions and training for caregivers when indicated. PAM services maintain, restore and / or improve an individual's functional status. PAM may include ancillary, management and / or instructional strategies.

PAM providers are to coordinate and communicate with the individual, their caregivers and the support team. This would include but is not limited to reporting all changes in health status to the physician and the support coordinator and providing written reports of the visit to the support coordinator. All services must be documented in the individual record.

Any changes in health status are to be reported to the physician and Support coordinator as needed. Written reports of the visit are required to be sent to the Support coordinator. This service may be provided by a licensed registered professional nurse, or a licensed practical nurse under the supervision of a registered nurse, or a licensed dietitian to the extent allowed by their respective scope of practice in the State of Missouri.

This service must not supplant Medicaid State plan services or Medicare services for which an individual is eligible.

Excluded services include Diabetes Self-Management Training available under the state plan and medical nutrition therapy services prescribed by a physician for Medicare eligibles who have diabetes or renal diseases.

Professional Assessment and Monitoring service providers must have a valid DMH contract and/or provide services through an Organized Health Care Delivery system for the provision of Professional Assessment and Monitoring services.

Service Documentation:

Providers of Professional Assessment and Monitoring must maintain an individualized plan of treatment and detailed record of intervention activities by unit of service. The provider is required to follow procedures set forth under The Code of State Regulations 13 CSR 70-3.030, which defines adequate documentation.

Transportation

Transportation is reimbursable when necessary for an individual to access waiver and other community services, activities and resources specified by the service plan. Transportation under the waiver shall not supplant transportation provided to providers of medical services under the state plan as required by 42 CFR 431.53, nor shall it replace emergency medical transportation as defined at 42 CFR 440.170(a) and provided under the state plan.

Transportation is a cost effective and necessary part of the package of community services, which prevent institutionalization.

A variety of modes of transportation may be provided, depending on the needs of the individual and availability of services.

Alternatives to formal paid support will always be used whenever possible. A unit is one per month.

State plan transportation under this waiver is limited to medical services covered in the state plan. State plan transportation does not cover transporting persons to waiver services, which are not covered under the state plan.

Temporary Residential (PfH only)

GENERAL SERVICE DESCRIPTION: Temporary Residential is care outside of the home in a licensed, accredited or certified facility for a period of no less than 24 hours to provide planned relief to the customary caregiver. This service is not intended to be permanent placement.

Service Description:	Waiver Code:	Non-Waiver Code:	Unit:
Temporary Residential	H0045	41010F	1 day

Any plan requesting Temporary Residential Services must address the following questions:	
<input type="checkbox"/>	What specific supports are needed?
<input type="checkbox"/>	Why are these supports needed?
<input type="checkbox"/>	When are the supports needed?
<input type="checkbox"/>	Where will the supports be provided?
<input type="checkbox"/>	How will the supports be delivered?
<input type="checkbox"/>	Are natural supports available to meet this need?
<input type="checkbox"/>	Does the plan document what other alternative services or supports have been considered?

Dental Service (PfH only)

GENERAL SERVICE DESCRIPTION: Dental services may be provided to an individual who is age 21 years or older when there is a basic dental need and it is not related to trauma. Services can include, but is not limited to the following.

- procedures necessary to control bleeding
- relieve pain
- eliminate acute infection;
- Operative procedures that are required to prevent the imminent loss of teeth
- Examinations, oral prophylaxes, and topical fluoride applications.
- pulp therapy for permanent teeth;
- restoration of carious permanent teeth;
- Limited provision of removable prostheses when masticatory function is impaired, when an existing prosthesis is unserviceable.

Service Description:	Waiver Code:	Non-Waiver Code:	Unit:
Dental Services	T2025	None	1 visit

Any plan requesting Dental Services must address the following questions:	
<input type="checkbox"/>	Does the plan document what other alternative services or supports have been considered?
<input type="checkbox"/>	Is this support available through Medicaid or private insurance?

Support Broker

A Support Broker (SB) provides the individual or their designated representative (DR) with information & assistance in order to self-direct supports and to secure the supports and services identified in the Individual Service Plan (ISP). The Support Broker does not do these tasks for the individual/ designated representative, but provides information and assistance in order for the individuals/DR to fulfill their employer related responsibilities. The goal for everyone in SDS is to move towards 'Independence' and for individuals and families to have the support they need in order to self-direct services.

Service code: T2041

Tasks include:

- Provide Practical Skills Training to Assist the Employer in Manage Services and Supports (recruiting, hiring, managing, terminating workers, managing and approving timesheets, problem solving, conflict resolution, filing grievances and complaints)
- Provide Assistance with Establishing Work Schedules
- Provide Assistance in Managing Budget and Employee Rate Setting
- Provide Assistance in Seeking Supports or Resources
- Provide Assistance to define goals, needs and preferences
- Assist Individual/ Designated Representative with employee training

*SB Service must have at least one identified Personal Outcome

This assessment will assist in determining what supports are needed in order for the individual/ designated representative to be successful in self-directing supports and the role of the SB.

<http://dmh.mo.gov/dd/progs/docs/sbassessment.pdf>

UR Frequently Asked Questions

General Questions

How should we determine what service a person should request?

As always, specific services should be determined through an analysis of need. The support coordinator will be instrumental in helping to determine the appropriate service.

Employment

Give an example of when it would be appropriate to provide Job Development without the individual served being present.

There are times when a job developer may meet individually with a business to develop a relationship, explore the needs of the business, discuss types of employment positions available, and/or conduct a task analysis to assist with customizing employment. This consultative service may be completed without the individual served being present.

Who should be referred to Vocational Rehabilitation (VR)?

Per VR regulations, appropriate referrals are individuals who have a documented diagnosis which results in a substantial impediment to employment and where documentation supports the current ability to be successfully employed. Waiver funded employment services should be accessed if the individual expresses an interest (need) in exploring employment and documentation is not present to demonstrate the current ability to be successfully employed.

Who should not be referred to Vocational Rehabilitation (VR)?

VR does not provide prevocational services for individuals over the age of 24; therefore, individuals needing prevocational services who are 25 years of age and older should not be referred to VR. Also, as VR does not provide Group Supported Employment, individuals should not be referred to VR if this is their assessed employment need.

When can pre-vocational services be used?

Pre-vocational services can be provided for an individual who has a need to further develop habilitative skills which are precluding the pursuit of a competitive and integrated employment goal. The specific skill needing to be developed, as it relates to the identified job goal, should be identified when requesting this service as well as the intervention strategies and necessary skill thresholds to achieve.

Is training available on benefit analysis and planning? If so, how do we contact trainers?

Benefit analysis and planning (evaluation of earned income on benefits) is an activity which is billable as part of career planning. The Regional Employment First Specialist is a resource to assist with further training in the use of tools and resources for conducting benefits planning.

Can you volunteer at a job where others are paid in an effort to gain employment skills?

According to the United States Department of Labor, Fair Labor Standard Act, individuals may not serve as unpaid volunteers at “for-profit” agencies unless specific exemptions are present which are associated with an educational Individualized Education Plan (IEP) or an approved service

through an IPE as part of VR services. Generally speaking, “volunteering” is relegated to “public sector” employers or religious/charitable/non-profit organizations. Information on volunteering and unpaid employment experiences can be found at www.dol.gov.

Applied Behavioral Analysis (ABA) Services

When should behavioral services be used?

A person should strongly consider accessing behavioral services if:

- There are restrictions in the ISP due to safety/behavioral concerns
- There are multiple psychotropic medications prescribed
- There have been placement changes because of behavior problems, he/she is considered difficult to support, or staff won't work with him/her
- Multiple psychiatric or ER hospitalizations due to behavior problems or out of control behavior
- Episodes of aggression, property destruction or self-injury
- Police involvement
- Elopement
- Not making progress in learning/being taught functional skills

What if an individual needs services but there is no provider in the area?

The support team should identify the need in the ISP and include the request for behavioral services in the UR request. This will allow tracking and identifying service provider needs and work on recruiting providers and make estimates for budgetary planning.

When requesting ABA services, can you put both the assessment and treatment request together?

No, these two services must be authorized separately, because the information on the assessment is necessary to make informed decisions about treatment.

Can ABT by Protocol by Tech be used if individuals are on a waitlist for Functional Behavioral Analysis (FBA) but there are no Licensed Behavioral Analysts (LBA) available?

No. This service must be provided by a Registered Behavior Therapist who must be supervised by a Licensed Behavior Analyst. There must be ongoing behavioral services and a behavior support plan in place.

Are there different FBA unit caps for different environments?

No. The services that are part of a functional assessment have the same caps regardless of the environments.

Does the law state that individuals with co-occurring disorders and use psychotropics are required to have FBA's?

There is no law that mandates a FBA in this situation. Using behavioral supports that are positive and focused on problem solving are best practices for individuals with co-occurring disorders and help to evaluate the effectiveness of psychotropic medications.

Are there pre-requisites for requesting behavioral services?

There are no pre-requisites for requesting behavioral services.

Is Person Centered Strategies Consultation considered behavioral services? Can Support Coordinators write, train, or modify behavior support plans?

Person Centered Strategies Consultation is for identification of barriers for good quality of life and help the person be supported in the manner to best ensure good quality of life.

Only licensed professionals, with specialized training in applied behavior analysis, can provide behavioral services and write or modify behavior support plans.

Community Integration (CI)

For CI, it states that one of the goals can be supporting a person participating as a member of a social event/club. Are segregated clubs included - People First, Phelps Co Recreation, Special Olympics?

While the focus of some groups might be on individuals with disabilities, it is not always accurate to assume that the groups themselves are entirely segregated. Special Olympics, for example, is an organization made up of a wide spectrum of individuals with and without disabilities who foster interactions with friends, family and interested parties and often have no identified disability at all. Community Integration services could be used to support participation in groups of individuals with disabilities, if that was consistent with the interest and choice of the person being served.

Individualized Skill Development (ISD)

Can those in a non-24 group home receive ISD services?

Per the waiver application, individuals who receive Group Home may not receive this service because it is encapsulated within these aforementioned services and would cause duplication.

Day Habilitation

Can an individual have units of both Medical Exception Day Habilitation and regular Day Habilitation?

No. An individual who has a documented need for Medical Exception Day Habilitation would receive that exception for the entire time spent receiving Day Habilitation.

Scenario: An individual wants to plan an outing where he can learn how to plan a menu, grocery shop, budget his money and open a checking account. During this outing he also wants to meet his friends to eat and play basketball. The staff takes him to the bank to open the checking account, to the park to eat with friends and play basketball and then to the grocery store to purchase food from the menu. Will the provider be expected to use ISD for the bank task, then PA for the social interaction and then back to ISD for the skill development of grocery shopping?

The answer to this type of question would depend on the needs of the individual and the intent of the service. PA is intended to provide the necessary support to ensure that the individual accomplishes a task, while ISD and CI are intended to improve the individual's ability to meet his or her own needs.

A day service provider is currently providing medical supports through a direct care staff (not a CNA) and the direct care staff is receiving oversight from an RN. Does the provider HAVE to change the service to Day Hab Medical and hire a CNA – or can they choose to continue as regular day hab with the staff they have?

As currently written, a person with exceptional medical support needs must receive services under Day Hab, Medical Exception using a CNA or higher certification/licensure. However, the Division is exploring a waiver amendment which would remove the CNA requirement and align the language to be consistent with residential and PAMS nursing oversight.

Do maximum unit limits for services apply to each service code or to the total number of units for all codes under a service? Example: Community Integration has a limit of 32 units a day/25 hours a day. However, there are two service codes under that heading. On the Medicaid Max rate sheet, each service is represented separately with a maximum number of units.

The unit limit applies to each code, not each service type.

Request for Waiver Nursing Service(s) – Individualized Support Plan Amendment

(revised: 3-28-19)

This document is useful when planning for Waiver Nursing Services.

This document may be found at the following link:

<https://dmh.mo.gov/dd/manuals/docs/urnursingservicestemplate.pdf>

SELF-DIRECTED SUPPORT SDSC Pre-UR Review Tool

This document is useful when planning Self-Directed Support (SDS).services.

This document may be found at the following link:

<https://dmh.mo.gov/dd/progs/docs/selfdirectedsupportsdscpreurreviewtool.pdf>