



Florida Medicaid

DEVELOPMENTAL DISABILITIES WAIVER SERVICES COVERAGE AND LIMITATIONS HANDBOOK

Agency for Health Care Administration

November 2010



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

May11, 2012

Dear Medicaid Development Disabilities Waiver Services Provider:

The Development Disabilities Waiver Services Coverage and Limitations Handbook, November 2010, Section 59G-13.083, is amended to implement changes to the handbook that include:

- Changes in fiscal agent references.
- Reductions in paperwork for providers.
- Revisions to a limited number of substantive areas that are in need of clarification and correction.

Please contact your local Medicaid area office if you have any questions. The Medicaid area office phone numbers and addresses are listed on AHCA's website at www.ahca.myflorida.com. All of the Medicaid handbooks are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select *Public Information for Providers*, then *Provider Support*, and then *Provider Handbooks*.

We appreciate the services you provide to Florida's Medicaid recipients.

Sincerely,

Beth Kidder
Assistant Deputy Secretary for
Medicaid Operations





RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

May 11, 2012

Dear Medicaid Providers:

The purpose of this letter is to announce the final adoption of the Developmental Disabilities (DD) Waiver Services Coverage and Limitations Handbook (Rule 59G-13.083, F.A.C.), with an effective date of November, 2010, and to clarify documentation requirements as described below. This handbook replaces the May, 2010 handbook.

In order to help reduce provider reporting requirements for DD Medicaid Waiver funded services, the Agency for Persons with Disabilities (APD) and the Agency for Health Care Administration (AHCA) agreed several years ago to reduce reporting requirements for residential habitation, adult day training, in-home supports, supported employment, and supported living services from monthly reporting documentation to quarterly documentation. Reviews by the Delmarva Foundation, contracted as the certified Quality Improvement Organization (QIO), have indicated that some providers have elected to continue to report monthly rather than quarterly.

AHCA would like to clarify that if a provider elects to maintain monthly documentation, rather than quarterly documentation, they will not be penalized through recoupment for this practice. This practice will be considered acceptable for those services listed above for the May, 2010 and November, 2010 DD Handbooks. Delmarva will correct any reviews which were found to be out of compliance because a provider reported monthly during the period covered by the May, 2010 DD Handbook. In addition, we have clarified this practice in the Medicaid Waiver Individual Budget (iBudget) Draft Handbook to reflect that monthly or quarterly documentation is acceptable; however, both APD and AHCA encourage providers to utilize the quarterly report format to comply with paperwork reduction efforts. Also, please note that the quarterly time period begins from the date of the signature on the support plan and the third quarterly summary will serve as the annual report.

Should you have any questions or need additional information, please consult your local Agency for Persons with Disabilities (APD) Area office.

Sincerely,

Beth Kidder
Assistant Deputy Secretary for
Medicaid Operations

BK/spd



UPDATE LOG

Developmental Disabilities Waiver Services Coverage and Limitations Handbook

How to Use the Update Log

Introduction

The current Medicaid provider handbooks are posted on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select *Public Information for Providers*, then *Provider Support*, and then *Provider Handbooks*. Changes to a handbook are issued as handbook updates. An update can be a change, addition, or correction to policy. An update will be issued as a completely revised handbook.

It is very important that the provider read the updated material in the handbook. It is the provider's responsibility to follow correct policy to obtain Medicaid reimbursement.

Explanation of the Update Log

Providers can use the update log to determine if they have received all the updates to the handbook. Update describes the change that was made. Effective Date is the date that the update is effective.

Instructions

When a handbook is updated, the provider will be notified by a notice. The notification instructs the provider to obtain the updated handbook from the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select *Public Information for Providers*, then *Provider Support*, and then *Provider Handbooks*. Providers who are unable to obtain an updated handbook from the Web site may request a paper copy from the Medicaid fiscal agent's Provider Support Contact Center at 1-800-289-7799.

UPDATE	EFFECTIVE DATE
New Handbook	July 2002
Promulgated Handbook	October 2002
Revised Handbook	June 2005
Revised Handbook	July 2007
Revised Handbook	May 2010
Revised Handbook	November 2010

DEVELOPMENTAL DISABILITIES WAIVER SERVICES COVERAGE AND LIMITATIONS HANDBOOK

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INTRODUCTION TO THE HANDBOOK

Overview

Introduction

This chapter introduces the format used for the Florida Medicaid handbooks and tells the reader how to use the handbooks.

Background

There are three types of Florida Medicaid handbooks:

- *Provider General Handbook* describes the Florida Medicaid Program.
- *Coverage and Limitations Handbooks* explain covered services, their limits, who is eligible to receive them, and the fee schedules.
- *Reimbursement Handbooks* describe how to complete and file claims for reimbursement from Medicaid.

All Florida Medicaid Handbooks may be accessed via the internet at: www.mymedicaid-florida.com/. Select *Public Information for Providers*, then *Provider Support* and then *Handbooks*.

Legal Authority

The following federal and state laws govern Florida Medicaid:

- Title XIX of the Social Security Act;
 - Title 42 of the Code of Federal Regulations;
 - Chapter 409, Florida Statutes;
 - Chapter 59G, Florida Administrative Code.
-

In This Chapter

This chapter contains:

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Handbook Use and Format

Purpose

The purpose of the Medicaid handbooks is to provide the Medicaid provider with the policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients.

The handbooks provide descriptions and instructions on how and when to complete forms, letters or other documentation.

Provider

The term “provider” is used to describe any entity, facility, person or group who is enrolled in the Medicaid program and provides services to Medicaid recipients and bills Medicaid for services.

Recipient

The term “recipient” is used to describe an individual who is eligible for Medicaid.

General Handbook

General information for providers regarding the Florida Medicaid Program, recipient eligibility, provider enrollment, fraud and abuse policy, and important resources are included in the Florida Medicaid Provider General Handbook. This general handbook is distributed to all enrolled Medicaid providers and is updated as needed.

Coverage and Limitations Handbook

Each coverage and limitations handbook is named for the service it describes. A provider who provides more than one type of service will have more than one coverage and limitations handbook.

Reimbursement Handbook

Each reimbursement handbook is named for the claim form that it describes.

Chapter Numbers

The chapter number appears as the first digit before the page number at the bottom of each page.

Page Numbers

Pages are numbered consecutively throughout the handbook. Page numbers follow the chapter number at the bottom of each page.

White Space

The "white space" found throughout a handbook enhances readability and allows space for writing notes.

Characteristics of the Handbook

Format

The format styles used in the handbooks represent a short and regular way of displaying difficult, technical material.

Information Block

Information blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of the subject. Blocks are separated by horizontal lines.

Each block is identified or named with a label.

Label

Labels or names are located in the left margin of each information block. They identify the content of the block in order to help scanning and locating information quickly.

Note

Note is used most frequently to refer the user to important material located elsewhere in the handbook.

Note also refers the user to other documents or policies contained in other handbooks.

Topic Roster

Each chapter contains a list of topics on the first page, which serves as a table of contents for the chapter, listing the subjects and the page number where the subject can be found.

Handbook Updates

Update Log

The first page of each handbook will contain the update log.

Every update will contain a new updated log page with the most recent update information added to the log. The provider can use the update log to determine if all updates to the current handbook have been received.

Each update will be designated by an "Update" and the "Effective Date."

Handbook Updates, continued

How Changes Are Updated

The Medicaid handbooks will be updated as needed. Changes may be:

1. Replacement handbook – Major changes will result in the entire handbook being replaced with a new effective date throughout and it will be a clean copy.
 2. Revised handbook – Changes will be highlighted in yellow and will be incorporated within the appropriate chapter. These revisions will have an effective date that corresponds to the effective date of the revised handbook.
-

Effective Date of New Material

The month and year that the new material is effective will appear at the bottom of each page. The provider can check this date to ensure that the material being used is the most current and up to date.

Identifying New Information

New material will be identified by yellow highlighting. The following information blocks give examples of how new labels, new information blocks, and new or changed material within an information block will be indicated.

New Label and New Information Block

A new label and a new information block will be identified with yellow highlight to the entire section.

New Material in an Existing Information Block or Paragraph

New or changed material within an existing information block or paragraph will be identified by **yellow highlighting to the sentence and/or paragraph affected by the change.**

CHAPTER 1

DEVELOPMENTAL DISABILITIES WAIVER SERVICES PURPOSE, DEFINITIONS, AND PROVIDER QUALIFICATIONS

Overview

Introduction

This chapter describes the Medicaid Developmental Disabilities (DD) Waiver Program, specifies the authority regulating DD waiver services, the purpose of the program, provider qualifications and responsibilities. DD Waiver refers to all four DD Waivers (Tiers One, Two, Three, and Four).

Legal Authority

Medicaid home and community-based services (HCBS) waiver programs are authorized under section 1915(c) of the Social Security Act and governed by Title 42, Code of Federal Regulations (C.F.R.), Parts 440 and 441.

Section 409.906, Florida Statutes (F.S.) and Chapter 59G, Florida Administrative Code (F.A.C.), authorize the Florida Medicaid DD waiver.

Specific statutory authority for the promulgation of the Florida Medicaid Developmental Disabilities Waiver Services Handbook into rule is found in the following provisions of law: sections 408.302 and 409.919, F.S.

The Agency for Health Care Administration (AHCA) has final authority on all policies, procedures, rules, regulations, manuals, and handbooks pertaining to the waiver. The Agency for Persons with Disabilities (APD) is authorized by AHCA to operate and oversee the waiver in accordance with the Interagency Agreement for Medicaid between AHCA and APD regarding the Developmental Disabilities Home and Community-Based Services (DD) Waiver.

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General Definitions

AHCA

The Agency for Health Care Administration (AHCA).

Agency or Group Provider

A business or organization enrolled to provide a waiver service(s) that has one or more staff employed to carry out the enrolled service(s). An agency or group provider for rate purposes is a provider that hires staff to perform the waiver services. The agency rate is used for all services that are directly provided by employees of the provider. All employees of an agency or group provider must meet the qualifications and requirements specified in the provider's agreement and those specified for enrolled service(s). The provider shall maintain personnel file documenting qualifications of all employees and their background screening results.

APD

The Agency for Persons with Disabilities (APD).

Area Office

APD's local office responsible for managing one of APD's 14 service areas.

Note: See Appendix B for APD contact information.

Core Assurances

The document that specifies administrative and programmatic requirements for DD waiver providers. The Core Assurances and the specific service requirements published in this handbook are incorporated into the Medicaid Waiver Services Agreement by reference, and provide the terms and conditions by which the provider of DD waiver services to recipients with developmental disabilities served by APD agrees to be bound.

Note: See Appendix A for additional information on Core Assurances.

Direct Provider Billing

This is a standard billing process for Developmental Disabilities Medicaid Waiver service providers.

All claims for DD waiver services must be submitted either on the CMS-1500 Claim Form or electronically directly to the Medicaid fiscal agent.

Instructions for completing the CMS-1500 claim form are in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500.

Note: The handbooks are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select the Public Information for Providers, then Provider Support, and then Provider Handbooks. The CMS-1500 claim form and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, are incorporated by reference in 59G-4.001, F.A.C.

Direct Service Provider

As defined in section 393.063, F.S., a "direct service provider" means a person 18 years of age or older who has direct face-to-face contact with a recipient or has access to a recipient's living areas or to a recipient's funds or personal property.

FMMIS The Florida Medicaid Management Information System managed by AHCA.

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) makes health insurance more "portable" so that workers may take their health insurance with them when they moved from one job to another, without losing health coverage. This federal legislation also requires the health care industry to adopt uniform codes and forms, streamlining the processing and use of health data and claims which will serve to better protect the privacy of people's health care information and give them greater access to that information.

Independent Vendor

A service provider who meets specified qualifications or holds local occupational licenses.

Job Development

Means the process of developing employer relations and linking recipients with private and public sector labor needs. This process involves exploring job skills and job preferences with the recipient with a disability, as well as networking with the recipient with a disability, the job developer or job coach, other people who know the recipient seeking employment, and local employers.

Licensed Residential Facility

Facilities providing room and board, and other services in accordance with the licensing requirements for the facility type. Community-based recipients with developmental disabilities may receive DD waiver services while residing in:

- Group homes and foster care homes licensed in accordance with Chapter 393, F.S. and Chapter 409, F.S.

- Comprehensive Transitional Education Programs (CTEPs) licensed in accordance with Chapter 393, F.S.
- Assisted Living Facilities, and Transitional Living Facilities, licensed in accordance with Chapters 400 and 429, F.S.
- Residential Habilitation Centers, licensed in accordance with Chapter 393, F.S., and any other type of licensed facility not mentioned above, having a capacity of 16 or more persons, if the recipient has continuously resided at the facility since August 8, 2001 or prior to this date.

Meaningful Day Activities

Choices made by recipients of how to use their time in order to provide direction, purpose and quality to the individual recipient's daily life. The recipient's choice of meaningful day activities must be based on his interests, skills and talents. Meaningful day activities may involve choices that are not paid for by the waiver, including paid employment, volunteer work and school. Meaningful day activities that are paid for under the waiver are limited to 30 hours per week, and include supported employment, adult day training, and companion. A recipient may choose a mix of meaningful day activities, but under no circumstances will the waiver pay for more than 30 hours a week of meaningful day activities for each recipient. Chosen activities must directly address identified goals in the recipient's support plan.

Medicaid State Plan Services

The Medicaid State Plan is Florida Medicaid's contract with the Centers for Medicare and Medicaid that specifies the eligibility categories of low income people and the medical services that Florida Medicaid provides. Medicaid is different in every state. In Florida, the Agency for Health Care Administration (AHCA) develops and carries out policies related to the Medicaid program.

Florida's state plan services are authorized by s.409.905 and 409.906, F.S. General information about Florida Medicaid is available on AHCA's Web site at www.ahca.myflorida.com. Select Medicaid. Detailed descriptions of the services are available in the Florida Medicaid Coverage and Limitations Handbooks.

Note: The Medicaid Coverage and Limitations Handbooks are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. The Coverage and Limitations Handbooks are incorporated by reference in rule 59G-4, F.A.C.

Medicaid Waiver Services Agreement

The Medicaid Waiver Services Agreement means the contract between the Agency for Persons with Disabilities and providers of waiver services. All providers must complete this agreement prior to providing services to recipients enrolled in the DD Waiver Program and comply with the terms and conditions of the agreement. Modifications or additions may be made by APD to the sample agreement provided on a case-by-case basis as necessary to address specific facts or other concerns relevant to an individual provider. An example of the Medicaid Waiver Services Agreement is included as Appendix D.

Medical Case Management Team

The health and safety oversight team designated by the APD Area Office as the service area Medical Case Management Team (MCMT). At a minimum, the MCMT will have one full time or full time equivalency registered nurse who will be the Medical Case Manager. Tasks of the MCMT include:

- Review of recipient needs;
- Review of health related supports and services that a recipient is receiving and the recipient's response to them;
- Follow-up concerning an illness, injury, or accident; and
- Consultation, technical assistance and training with support coordinators, service providers, and medical specialists regarding a recipient's care.

Medical Necessity or Medically Necessary

A set of conditions established by the Agency for Health Care Administration, for determining the need for and appropriateness of Medicaid -funded services for an enrolled recipient.

As defined in rule 59G-1.010(166), F.A.C., as it relates to medical necessity or medically necessary, the medical or allied care, goods, or services furnished or ordered as defined as meeting the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
- Be consistent with generally accepted professional medical standards as defined by the Medicaid program and not be experimental or investigational;
- Be reflective of the level of service that can be safely furnished, for which no equally effective and more conservative or less costly treatment is available, statewide; and

- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

Provider Service Agreement

Prior to providing any services the provider must in order to be compensated for waiver services execute a Medicaid Provider Agreement with the Agency for Health Care Administration, and be issued a Medicaid provider number by the Medicaid fiscal agent. The provider must, at all times, maintain a current and valid Medicaid Provider Agreement with AHCA and must comply with the terms and conditions of the Medicaid Provider Agreement as fully set forth within the agreement.

Residence

The place in which a recipient resides for an extended or a permanent period of time and is considered his home.

Service Authorization

An APD document that the waiver support coordinator sends to a waiver provider authorizing the provision of specific services or supports to a recipient. Without service authorization, the provider is not authorized to provide the service and cannot submit a claim nor be reimbursed for the service. For the purposes of direct provider billing, the service authorization must contain the waiver support coordinator's 9-digit treating provider number. Services provided without authorization are subject to recoupment of funds from the service provider. Support coordinators must ensure service authorizations are provided in writing.

Authorizing a service at a rate or frequency that is higher than that approved by APD will result in the waiver support coordinator being subject to recoupment of funds for support coordination services and recoupment of service dollars billed without proper authorization. This authorization is contingent upon the enrolled recipient remaining eligible for Medicaid during the month of service. Upon a recipient's loss of Medicaid eligibility, the service authorization is null and void. In this instance, the provider must contact the waiver support coordinator or APD to ascertain if alternative funding is available for the services.

Solo Provider

A solo or independent provider who personally renders waiver services directly to recipients and does not employ others to render waiver services for which the rate is being paid. For example: If the provider is a solo provider and incorporates, the provider is still considered a solo or independent provider for rate purposes unless he hires another person to perform the specific waiver service for which the rate is being established. If the provider is a solo provider and incorporates and hires him to perform the service, he

is still considered an independent provider for rate purposes for those services that he directly performs or personally delivers.

Support Plan

An individualized plan of supports and services designed to meet the needs of a recipient enrolled in the waiver. The plan is based on the preferences, interests, talents, attributes and needs of a recipient. The recipient or parent, legal guardian or guardian advocate shall be consulted in the development of the plan and shall receive a copy of the plan and any revisions made to the plan.

Each plan shall include the least restrictive and most cost-beneficial environment for accomplishment of the objectives for individual progress and a specification of all services authorized. This also includes identification of natural and community supports as well as paid services. The plan shall include provisions for the most appropriate level of care for the recipient. The ultimate goal of each plan shall be to enable the recipient to live a dignified life in the least restrictive setting, appropriate to the recipient's needs.

Trip Log

Transportation provided through the DD waiver is billed by the trip, month and mile. All trip logs associated with this service will contain the recipient's name(s), date of service, destination and actual mileage for each vehicle trip. If more than one recipient is being transported, the mileage charge will be shared among the number of recipients transported. When compiling trip and mileage information, to facilitate billing by the month, include the dates of service for each recipient in the trip log.

Waiver Support Coordinator

A waiver support coordinator is an enrolled waiver provider of support coordination services who is selected by the recipient enrolled in the waiver (or his guardian or guardian advocate) to assist the recipient who receives waiver services in gaining access to needed waiver and Medicaid state plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained. In the absence of a selection by the recipient, guardian, or guardian advocate, waiver support coordinators may be assigned by the APD Area Office, subject to the recipient, guardian, or guardian advocate making a different selection at a later date.

The waiver support coordinators are responsible for ongoing monitoring of supports and services to ensure they are provided to meet the recipients' needs. They also initiate and oversee the process of assessment and reassessment of the recipients' level of care and the review of support plans at such intervals as described in the support coordination section of this handbook. Each support coordinator must enroll as a provider,

whether a solo or individual provider, or whether employed by an agency or group provider.

Description and Purpose

Developmental Disabilities Waiver Description

The Developmental Disabilities (DD) Waivers Tiers One, Two, Three, and Four are Medicaid programs that provide home and community-based supports and services to eligible persons with developmental disabilities living at home or in a home-like setting. The DD waivers are funded by the federal Centers for Medicare and Medicaid Services (CMS) and matching state dollars. The waiver is operated by the Agency for Persons with Disabilities, under the authorization of the Agency for Health Care Administration, Division of Medicaid. DD Waiver will refer to all four DD Waivers (Tiers One, Two, Three, and Four).

Purpose of the DD Waiver

The purpose of the DD waiver is to promote, maintain and restore the health of eligible recipients with developmental disabilities; to minimize the effects of illness and disabilities through the provision of needed supports and services in order to delay or prevent institutionalization; and to foster the principles of self-determination as a foundation for services and supports. The intent of the waiver is to provide a viable choice of services that allow eligible recipients to live as independently as possible in their own home or in the community and to achieve productive lives as close to normal as possible as opposed to residing in an Intermediate Care Facility for the Developmentally Disabled (ICF/DD) or other institutional settings. The goal of such waiver programs shall be to allow recipients to live as independently as possible in their own home, and to achieve productive lives as close to normal as possible, in accordance with section 393.066, F.S.

The DD waiver embraces the principles of self-determination, which include for the recipient, the freedom to exercise the same rights as all citizens, authority to exercise control over authorized funds needed for one's own support, including the re-prioritization of these funds when necessary, responsibility for the wise use of public funds, self-advocacy to speak and advocate for oneself and others who cannot do so in order to gain independence and ensure that all individuals with a developmental disability are treated equally.

Recipients enrolled in the DD waiver receive services that enable them to:

- Have a safe place to live.
- Have a meaningful day activity.

- Receive medically-necessary medical and dental services.
- Receive medically-necessary supplies and equipment.
- Receive transportation required to access necessary services.

See the definitions section of this chapter for explanation of a meaningful day activity. The selected activity or activities will usually occupy four to six hours of the person's day. Activities may occur during the day or evening.

Waiver services are not used to cover any copayments, with the exception of patient responsibility for Medicare-funded wheelchairs.

Purpose of This Handbook

This handbook is intended for use by eligible providers who furnish DD waiver services to recipients enrolled in the waiver. DD Waiver refers to all four DD Waivers (Tiers One, Two, Three, and Four). It must be used in conjunction with the Florida Medicaid Provider General Handbook, which contains information about the Medicaid program in general, and the Florida Medicaid Provider Reimbursement Handbook.

Instructions for completing the CMS-1500 claim form are in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500.

Note: The handbooks are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select the Public Information for Providers, then Provider Support, and then Handbooks. The Florida Medicaid Provider General Handbook is incorporated by reference in 59G-5.020, F.A.C. The Florida Medicaid Provider Reimbursement Handbook, CMS-1500, is incorporated by reference in 59G-4.001, F.A.C.

Provider Qualifications and Responsibilities

DD Waiver Provider Applicant Enrollment

DD waiver provider applicants must meet specific qualifications and requirements before becoming eligible to provide DD waiver services. In addition, provider applicants must have no adverse history with the Agency for Persons with Disabilities (APD), the Department of Children and Families (DCF), the Agency for Health Care Administration (AHCA), or any other regulatory agency that causes AHCA or APD to question whether the health, safety and welfare of a waiver participant would be jeopardized during the delivery of an approved waiver service.

Medicaid DD waiver providers must:

- Be determined eligible by the APD Area Office to enroll as a DD waiver provider;
- Not be currently suspended from Medicare or Medicaid in any state;
- Meet provider qualification and responsibility requirements described in Chapter 1 of this handbook;
- Be enrolled with the Medicaid fiscal agent as a DD waiver provider;
- Have a current, signed Medicaid Waiver Services Agreement with APD; and
- Be at least 18 years of age.

DD Waiver Provider Background Screening Requirements

Direct service provider applicants must comply with the requirements of a level 2 screening in accordance with section 435.04, F.S. Compliance with this requirement may be accomplished through one of two ways:

- Background screenings pursuant to s. 393.0655, F.S. or
Applicants must submit a fingerprinting card, an affidavit of good moral character, a caretaker information sheet, and a check made payable to the Florida Department of Law Enforcement (FDLE) to DCF for processing. If the applicant had a screening within 12 months of the time of application and can provide a copy of the report, then the applicant does not need to repeat the screening. The results of this screening will be submitted with the Medicaid enrollment application.
- Background screenings pursuant to section 409.907, F.S.
Applicants must submit a fingerprint card with the Medicaid Enrollment Application and a check made payable to the Medicaid fiscal agent for processing; or, if available, the applicant may submit the screening through an approved live scan location.

Screening is performed at the time of enrollment and every five years thereafter. It is the responsibility of the applicant or provider to ensure this request for screening or re-screening is submitted for processing in a timely manner.

Note: The Medicaid Enrollment Application is available from the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Enrollment. The application is incorporated by reference in 59G-5.010, F.A.C.

Determination of Eligibility for Enrollment

The APD Area Office will provide new provider applicants with a Medicaid Enrollment Application and a DD Waiver Provider Application, as defined below. The provider applicant submits the applications for enrollment to the APD Area Office. The APD Area Office determines if the provider applicant meets the qualifications and requirements for enrollment as a waiver provider. This determination includes a review of previous employment history and other relevant information. The Area Office shall notify the provider in writing if they are denied enrollment as a provider of waiver services. This handbook provides detailed information on each service available through the waiver, including provider qualifications, limitations, and required documentation. If you are considering becoming a provider, please carefully review each service you wish to provide before completing a waiver provider application.

The DD Waiver Provider Application consists of a Medicaid Waiver Services Agreement (contract) and the Core Assurances, which are in Appendix A of this handbook. All DD waiver provider applicants must agree to comply with requirements found in the Medicaid Waiver Services Agreement, the Core Assurances, and the service-specific requirements specified in this handbook, as a condition of enrollment.

The Medicaid forms in the application packet and payment for the background screening if required (i.e., if not completed under Chapter 393, F.S., requirements) from the provider applicant along with a certificate of eligibility are then forwarded to APD's Central Office for further processing. The Medicaid fiscal agent completes final processing and enrollment.

The APD Area Office receives verification from APD's Central Office when the provider applicant is enrolled in Medicaid as a waiver provider. Eligibility for agency and solo providers to provide services will be established when the Medicaid enrollment is completed. When an applicant for enrollment in the waiver has been determined eligible, passed necessary background screening requirements, and is enrolled in Medicaid, the APD Area Office will notify the provider of his eligibility. This notification will list the waiver services the applicant is eligible to provide and the effective date of Medicaid enrollment with the assigned Medicaid provider number. Once the notification of eligibility is received, the provider may render waiver services and receive reimbursement for those services from Medicaid. No waiver-reimbursed service may be rendered until the provider receives notification of his enrollment in Medicaid.

Providers who want to expand their status from a solo provider to an agency provider, or a provider desiring to obtain enrollment eligibility in additional waiver services, must be approved by the APD Area Office in order to expand. A provider must have attained a satisfactory overall score and have no alerts or documentation cites indicating re-

couplement on their last quality assurance monitoring conducted by AHCA, APD or an authorized agent of AHCA or APD in order to be considered for expansion.

For information regarding how to become a waiver service provider, contact the APD Area Office in your area.

All providers are required to participate in the direct deposit program for Medicaid payments and must have an active savings or checking account.

Note: Refer to Chapter 2 in the Florida Medicaid Provider General Handbook, for information concerning general Medicaid provider qualifications.

Agencies Wishing to Provide Multiple Services

Agency providers that specialize in services to recipients who have a developmental disability may apply and be approved eligible to provide additional services if they employ staff who meet the qualifications for that service. For example, an agency that serves recipients with a developmental disability that is enrolled to provide supported living coaching services may also provide companion services.

Special Requirements for Support Coordination Providers

All waiver support coordinators, including solo providers or support coordinators employed by agency providers, shall be determined eligible by the APD Area Office and individually enrolled in the Medicaid program as individual treating providers, prior to providing waiver services and billing Medicaid.

Support coordinators will have their eligibility date established on the date the APD Area Office receives a completed application and the background screening from the Florida Department of Law Enforcement (FDLE) is returned with no record or no disqualifying offense.

When the individual waiver support coordinator completes and submits an application with fingerprint card to the APD Area Office and a statewide background screening has been completed by FDLE and returned with no record or disqualifying offense, the Area Office will determine the applicant eligible to conduct an unsupervised face-to-face visit or to have unsupervised contact with a recipient, pending the results of a level 2 background screening. If the local background screening is returned and indicates a record or disqualifying offense, the applicant may not provide services until the level 2 background screening is completed, returned and eligibility is approved.

However, if the applicant's eligibility for enrollment is denied for any reason, the applicant cannot perform any waiver services with or without the supervision of an enrolled waiver support coordinator.

For applicants who are employed at the time of application and intend to remain in the current employment, the application must include a statement addressing a plan for dual employment. The plan should address the type of employment held at the time of the application, the total number of hours involved in that employment on a weekly basis, a plan for the manner in which the applicant may be contacted by recipients receiving services during the hours employed in the other job, and how conflicting priorities, emergencies and meetings will be handled. The plan shall also address any long-range plan for reducing or terminating the other employment, should he assume a full waiver caseload.

The APD Area Office shall approve the applicant's dual employment plan as part of the waiver enrollment process. If it is determined that the applicant cannot be available to meet the needs of recipients on their caseload, the application may be denied. In no instance may dual employment include the provision of services to recipients with developmental disabilities, other than within a case management or support coordination function.

Specific support coordination responsibilities are specified in the Core Assurances and must be signed by the provider prior to receiving eligibility for enrollment from the APD Area Office.

Family Members Enrolled as DD Waiver Providers or Acting as Service Providers

Parents of minors, spouses, guardians and guardian advocates of waiver participants are specifically excluded from payment for any services provided to their child, spouse or recipient served.

Under no circumstances may a relative provide support coordination to their family member. However, relatives not legally responsible for the care of the recipient may provide respite care, personal care, or transportation. In those limited situations, the relative must meet the same qualifications as other providers of the same waiver service.

Reasons for using a relative not legally responsible for the care of the recipient must be documented and include the lack of available providers or the ability to meet specific scheduling needs of a recipient that other providers cannot meet. Convenience to the recipient, caregiver or family alone is not adequate justification.

Statewide Enrollment

All DD waiver providers are enrolled on a statewide basis unless they indicate a geographic preference on the DD waiver application or the APD Area Office restricts enrollment to specified geographic areas. DD waiver providers may be restricted to the provision of services within specific geographic areas based on concerns regarding the provider's quality of care or other issues that may negatively impact recipients, as determined by the APD Area Office.

Note: Refer to Appendix B for APD contact information.

Freedom of Choice

The waiver is designed around recipient choice. Accordingly, recipients served through the waiver may select among enrolled, qualified service providers and may change providers at any time. Once a recipient has an approved cost plan, the funds allocated to that support plan follow the recipient. Within the funds allocated in the support plan, the recipient is free to change enrolled, qualified providers as desired to meet the goals and objectives set out in the support plan. Freedom of choice includes recipient responsibility for selection of the most cost beneficial residential environment and combination of services and supports to accomplish the recipient's goals.

Provider Responsibility Regarding HIPAA Requirements

Florida Medicaid has implemented all of the requirements contained in the federal legislation known as the Health Insurance Portability and Accountability Act (HIPAA). As trading partners with Florida Medicaid, all Medicaid providers, including their staff, contracted staff and volunteers, must comply with HIPAA privacy requirements. Providers who meet the definition of a covered entity according to HIPAA must comply with HIPAA Electronic Data Interchange (EDI) requirements. The Florida Medicaid Provider Reimbursement Handbooks contain the claims processing requirements for Florida Medicaid, including the changes necessary to comply with HIPAA.

Note: For more information regarding HIPAA privacy in Florida Medicaid, see Chapter 2 in the Florida Medicaid Provider General Handbook.

Note: For more information regarding claims processing changes in Florida Medicaid because of HIPAA requirements, see Chapter 1 in the Florida Medicaid Provider Reimbursement handbook, refer to Chapter 1 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500.

Note: For information regarding changes in EDI requirements for Florida Medicaid because of HIPAA requirements, contact the Medicaid fiscal agent EDI help desk at 866-586-0961 or 800-289-7799 and select Option 3.

Adult Day Training Provider Requirements

Provider Qualifications

Providers of adult day training services shall be designated by the APD Area Office as adult day training centers. Unless waived in writing by the Area Office, the provider shall meet the following minimum qualifications for staff and staffing ratio:

- The manager or director will not have full-time responsibility for providing direct services.
- The program director will possess at a minimum a bachelor's degree from an accredited college or university and two years related experience.
- Instructors (supervisors) will possess at least an associate's degree and two years experience in a related field.
- Related experience will substitute on a year-for-year basis for the required college education.
- Direct service staff will work under appropriate supervision.
- The staffing ratio will not exceed 10 recipients per direct service staff for adult day training facility-based programs. Administrative staff and those not providing direct service to the recipient are not considered direct service staff.
- Direct service staff must be at least 18 years of age and possess at least a high school diploma or equivalent. When determining the equivalency of high school degrees, providers may accept official transcripts, affidavits from educational institutions, and other formal or legal documents that can be reasonably used to determine educational background. Employees who have been hired using the best judgment of the hiring agency, prior to this amendment, will not be affected by this change.

Training Requirements

Proof of training in the areas of Cardiopulmonary Resuscitation (CPR), HIV/AIDS and infection control is required for all staff within 90 days of initially providing adult day training services. Proof of annual or required updated training shall be maintained on file for review. At all times when recipients are present, a minimum of a least one staff member or 50 percent of all staff at the facility (whichever is greater), must be trained in CPR, infection control techniques, zero tolerance (of sexual abuse), core competencies, and the use of approved restraints and seclusion approved by the Agencies.

The provider is responsible for all training requirements outlined in the Core Assurances. Staff is required to attend eight hours of annual in-service training related to implementation of individually tailored services.

Note: Refer to the Core Assurances in Appendix A for the provider training requirements.

Adult Dental Services Provider Requirements

Provider Qualifications

Providers of adult dental services shall be dentists licensed in accordance with Chapter 466, F.S.

Unlicensed dental interns and dental students of university based dental programs may provide services under the general supervision of a licensed dentist but cannot act as a treating provider or bill Medicaid for covered services. The licensed supervising dentist of the facility acts as the treating provider of a covered service. A dentist who has a teaching permit issued by the Florida Board of Dentistry as outlined in section 466.002, F.S. may also act as the treating provider of a covered service. The facility may bill Medicaid for covered services.

Behavior Analysis Provider Requirements

Provider Qualifications

Providers of behavior analysis must have licensure or certification on active status at the time services are provided. Providers of this service must have one or more of the following credentials:

Level 1 Board Certified Behavior Analyst; Florida Certified Behavior Analyst with expanded privileges; or a person licensed under Chapter 490 or 491, F.S., (Psychologist, School Psychologist, Clinical Social Worker, Marriage and Family Therapist or Mental Health Counselor), with more than three years of experience in behavior analysis post certification or licensure.

Level 2 Board Certified Behavior Analyst; Florida Certified Behavior Analyst with expanded privileges; or a person licensed under Chapter 490 or 491, F.S., (Psychologist, School Psychologist, Clinical Social Worker, Marriage and Family Therapist or Mental Health Counselor), with less than three years of experience in behavior analysis post certification or licensure; or a Florida Certified Behavior Analyst with a Masters or Doctorate, regardless of experience.

Level 3 Board or Florida Certified Assistant Behavior Analyst or a Florida Certified Behavior Analyst with bachelors or high school diploma, regardless of experience.

Training Requirements

The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to the Core Assurances in Appendix A for the provider training requirements.

Behavior Assistant Services Provider Requirements

Provider Qualifications

Providers of this service must have at least:

1. A high school diploma and be at least 18 years of age;
2. Two years of experience providing direct services to recipients with developmental disabilities or at least 120 hours of direct services to recipients with complex behavior problems, as defined in rule 65G-4.010(2), F.A.C., or 90 classroom hours of instruction in applied behavior analysis from non-university non-college classes or university or college courses; and
3. 20 contact hours of instruction in a curriculum meeting the requirements specified by the APD and approved by the APD-designated behavior analyst. Instruction must be provided by a person meeting the qualifications of any category of behavior analysis provider as described above.
 - a. Either a certificate of completion or a college or university transcript and a course content description, verifying the applicant completed the required instruction, will be accepted as proof of instruction.
 - b. The 90 classroom hours of instruction specified under number 2 above shall also count as meeting the requirements of the 20 contact hours specified in this section.

Training Requirements

Proof of training in the areas of Cardiopulmonary Resuscitation (CPR), HIV/AIDS and infection control is required within 30 days of initially providing behavior assistant services. Proof of annual or required updated training shall be maintained on file for review. The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to the Core Assurances in Appendix A for the provider training requirements.

Companion Provider Requirements

Provider Qualifications

Providers of companion services may be home health or hospice agencies licensed in accordance with Chapter 400, parts III and IV, F.S. If providing this service as an agency or group provider, using more than one employee to provide companion services and billing for their services, the provider must be registered as a sitter or companion provider in accordance with section 400.509, F.S. if not licensed as a home health agency or a hospice.

Independent vendors are not required to be licensed, certified, or registered if they bill for and are reimbursed only for services personally rendered.

Minimum qualifications for a companion include: be at least 18 years of age and have one year of experience working in a medical, psychiatric, nursing or child care setting, or in working with recipients having developmental disabilities. College, vocational or technical training from an accredited institution can substitute at the rate of 30 semester, 45 quarter or 720 classroom hours for the required experience.

Training Requirements

Proof of training in the areas of Cardiopulmonary Resuscitation (CPR), HIV/AIDS and infection control is required within 30 days of initially providing companion services. Proof of annual or required updated training shall be maintained on file for review. The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to the Core Assurances in Appendix A for the provider training requirements.

Consumable Medical Supplies Provider Requirements

Provider Qualifications

Providers of consumable medical supplies include home health or hospice agencies, pharmacies, medical supply companies, durable medical equipment suppliers and vendors such as discount stores and department stores. Independent vendors may also provide these services.

Home health agencies and durable medical equipment companies must provide a bond, letter of credit or other collateral at the time of application, unless the agency has been a Medicaid enrolled provider for at least one year prior to the date it applies to become

a waiver provider and has had no sanctions imposed by Medicaid or any regulatory body.

Home health and hospices shall be licensed in accordance with Chapter 400, parts III and IV F.S.

Pharmacies shall hold a permit to operate, issued in accordance with Chapter 465, F.S.

Medical supply companies and durable medical equipment suppliers shall hold local occupational licenses or permits, in accordance with Chapter 205, F.S., and shall be currently licensed in accordance with Chapter 400, part VII, F.S.

Assistive technology suppliers and practitioners shall be certified through the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA). Retail stores shall hold local occupational licenses or permits, in accordance with Chapter 205, F.S.

Dietitian Provider Requirements

Provider Qualifications

Providers of dietitian services shall be dietitians or nutritionists licensed in accordance with Chapter 468, part X, F.S.

Training Requirements

The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to the Core Assurances in Appendix A for the provider training requirements.

Durable Medical Equipment Provider Requirements

Provider Qualifications

Providers of durable medical equipment (DME) include home health or hospice agencies, pharmacies, medical supply companies, durable medical equipment suppliers and vendors such as discount stores and department stores. In accordance with 59G-4.070, F.A.C., to enroll as a Medicaid provider, a DME and medical supply entity must comply with all the enrollment requirements outlined in the Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook.

In accordance with 42 C.F.R. 440.70, part providers must be in compliance with all applicable laws relating to qualifications or licensure.

In accordance with section 409.907, F.S., home health agencies and durable medical equipment companies must provide a bond, letter of credit or other collateral at the time of application, unless the agency has been a Medicaid-enrolled provider for at least one year prior to the date it applies to become a waiver provider and has had no sanctions imposed by Medicaid, or any other regulatory body.

Home health and hospice agencies shall be licensed in accordance with Chapter 400, parts III or IV, F.S.

Pharmacies shall hold a permit to operate issued in accordance with Chapter 465, F.S. Medical supply companies and durable medical equipment suppliers shall hold local occupational licenses or permits, in accordance with Chapter 400, part VII, F.S.

Environmental Accessibility Adaptation Provider Requirements

Provider Qualifications

Providers of environmental accessibility adaptation (EAA) services include licensed general or independent licensed contractors, electricians, plumbers, carpenters, architects and engineers.

Any enrolled EAA provider who provides construction work must present a qualified business number, as required in section 489.119, F.S. In accordance with section 489.113, F.S., subcontractors of a qualified business shall hold the required state certificate or registration in that trade category.

Engineers shall be licensed in accordance with Chapter 471, F.S., and must have one year of experience in environmental adaptation assessment and remodeling or be Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) certified.

Architects shall be licensed in accordance with Chapter 481, F.S., and must have one year of experience in environmental adaptation assessment and remodeling or be Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) certified.

Contractors and electricians shall be licensed in accordance with Chapter 489, F.S.

Plumbers shall be licensed in accordance with Chapter 489, F.S.

Carpenters and other vendors shall hold local occupational licenses or permits, in accordance with Chapter 205, F.S. Other professionals who may provide environmental accessibility adaptations assessments include providers with experience in the field of environmental accessibility adaptation assessment, with Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) certification, and an occupational license.

In-Home Support Services Provider Requirements

Provider Qualifications

Providers of in-home support services are independent vendors, who are either individuals or employees of agencies, must be at least 18 years of age and have at least a high school diploma or equivalent and one year of experience working in a medical, psychiatric, nursing or childcare setting or working with recipients who have a developmental disability. College, vocational or technical training equal to 30 semester hours, 45 quarter hours or 720 classroom hours may substitute for the required experience. Licensure, certification, or registration is not required.

Training Requirements

Proof of training in the areas of Cardiopulmonary Resuscitation (CPR), HIV/AIDS and infection control is required within 30 days of initially providing in-home supports. Proof of annual or required updated training shall be maintained on file for review.

The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to the Core Assurances in Appendix A for the provider training requirements.

Occupational Therapy Provider Requirements

Provider Qualifications

Providers of occupational therapy and assessment services shall be licensed as occupational therapists, occupational therapy aides, or occupational therapy assistants, in accordance with Chapter 468, part III, F.S. They may also provide and bill for the services of a licensed occupational therapy assistant. The licensed occupational therapy assistant is not qualified to perform occupational therapy assessments. Assessments can only be performed by a licensed physical therapist.

Occupational therapists, aides and assistants may provide services as independent vendors or an employee of an agency.

Occupational therapy aides and assistants must be supervised by an occupational therapist in accordance with the requirements of their professional licenses.

Training Requirements

The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to the Core Assurances in Appendix A for the provider training requirements.

Personal Care Assistance Provider Requirements

Provider Qualifications

Providers of personal care assistance may be home health or hospice agencies, licensed in accordance with Chapter 400, parts III or IV, F.S. Providers may also be independent vendors. Independent vendors are not required to be licensed, certified, or registered.

Independent vendors and employees of agencies shall be at least 18 years of age and have at least one year of experience working in a medical, psychiatric, nursing or child-care setting or working with recipients who have a developmental disability. College, vocational or technical training equal to 30 semester hours, 45 quarter hours or 720 classroom hours may substitute for the required experience.

Training Requirements

Proof of training in the areas of Cardiopulmonary Resuscitation (CPR), HIV/AIDS and infection control is required within 30 days of initially providing personal care assistance. Proof of annual or required updated training shall be maintained on file for review.

The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to the Core Assurances in Appendix A for the provider training requirements.

Personal Emergency Response (PERS) Provider Requirements

Provider Qualifications

Providers shall be licensed electrical contractors, alarm system contractors, contract agencies for Community Care for the Elderly (CCE), Community Care for Disabled Adults (CCDA) Programs, or hospitals. Freestanding equipment may also be purchased from independent vendors, such as discount or home improvement stores, but these vendors may not provide monitoring.

Electrical or alarm system contractors shall be licensed in accordance with Chapter 489, part II, F.S.

Hospitals shall be licensed in accordance with Chapter 395, F.S.

Independent vendors shall hold local occupational licenses or permits, in accordance with Chapter 205, F.S.

Physical Therapy Provider Requirements

Provider Qualifications

Providers of physical therapy and assessment services shall be licensed as physical therapists and physical therapist assistants in accordance with Chapter 486, F.S. Physical therapists may provide this service as independent vendors or as an employee of an agency. They may also employ and bill for the services of a licensed physical therapy assistant. The licensed physical therapy assistant is not qualified to perform physical therapy assessments. Assessments can only be performed by a licensed physical therapist.

Physical therapy assistants must be supervised by a physical therapist in accordance with the requirements of their professional licenses.

Training Requirements

The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to the Core Assurances in Appendix A for the provider training requirements.

Private Duty Nursing Provider Qualifications

Provider Qualifications

Providers of private duty nursing services shall be nurses registered or licensed in accordance with Chapter 464, F.S.

Nurses may provide this service as employees of licensed home health, hospice agencies or nurse registries licensed in accordance with Chapter 400, parts III or IV, F.S. They may also be enrolled as independent vendors providing services under their own name and license.

Training Requirements

Proof of training in the areas of Cardiopulmonary Resuscitation (CPR), HIV/AIDS and infection control is required within 30 days of initially providing private duty nursing services. Proof of annual or required updated training shall be maintained on file for review. The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to the Core Assurances in Appendix A for the provider training requirements.

Residential Habilitation Provider Requirements

Provider Qualifications

Providers of residential habilitation services shall be transitional living facilities, licensed under Chapter 400, part V, F.S. and Chapter 429 F.S., or residential facilities licensed under Chapter 393, F.S. These services may be provided by a qualified independent vendor for which licensure, certification, or registration is not required.

Standard Residential Habilitation

Direct care staff providing residential habilitation services must be at least 18 years of age and have a high school diploma or equivalent and one year of experience working in a medical, psychiatric, nursing or child care setting or in working with persons who have a developmental disability. College, vocational or technical training equal to 30 semester hours, 45 quarter hours, or 720 classroom hours can substitute for the required experience.

Behavioral Focus Residential Habilitation

Providers of behavioral focus residential habilitation services shall meet the provider and staff qualifications identified above and in addition shall ensure that the following:

A Board Certified Behavior Analyst or Associate Analyst, or Florida Certified Behavior Analyst with a bachelor's degree, or a person licensed under Chapter 490 or Chapter 491, F.S., provides on-site oversight for residential services.

- No fewer than 75 percent of the provider's direct service staff working with the recipient(s) for whom the behavioral focus residential habilitation rate applies have completed the following training: at least 20 contact hours of face-to-face instruction in the following content areas to include:
 - Introduction to applied behavior analysis – basic principles and functions of behavior;
 - Providing positive consequences, planned ignoring, and stop-redirect-reinforce techniques; and
 - Data collection and charting.

The 20 hours of training may be obtained by completing an in-service training program offered privately or through a college or university. Proof of training must be maintained on file for review and verification.

Other staff training can and should be provided in addition to the minimum hours and content areas described in the above training as appropriate for the setting or services provided.

There is a staff monitoring system that verifies that direct service staff continues to be competent in the use of the techniques listed in the training requirement above. Monitoring for competence must occur at least once per month for 50 percent of direct service staff that have completed the training. Staff must be re-certified in the training requirements yearly.

The provider has a system that demonstrates and measures continuing staff competencies on the use of procedures that are included in each person's behavior analysis services plan.

Intensive Behavioral Residential Habilitation

Providers of intensive behavioral residential habilitation services shall meet the behavioral focus provider and staff qualifications identified above, and in addition shall ensure:

- All adjunct services (behavioral, psychiatric, counseling, nursing) are included in the service, or billed to independent insurance policies or sources of reimbursement other than the Medicaid waiver program or APD;

- All direct care service needs are met without an addition to the approved rate;
- The Program or Clinical Services Director meets the qualifications of a Doctorate Level Board Certified Behavior Analyst or Masters Level Board Certified Behavior Analyst, or Florida Certified Behavior Analyst, under Chapter 393, F.S., with expanded privileges, or licensed under Chapter 490 and 491, F.S. The Program or Clinical Services Director must be in place at the time of designation of the organization as an intensive behavioral residential habilitation program;
- Staff responsible for developing behavior analysis services will meet at a minimum the requirements for a Florida Certified Behavior Analyst or Board Certified Associate Behavior Analyst under Chapter 393, F.S. or licensed under Chapter 490 and 491, F.S.;
- The ratio of behavior analysts to recipients is no more than one full-time analyst to 20 recipients; and
- All direct service staff will complete at least 20 contact hours of face-to-face competency-based instruction with performance-based validation, and comply with staff monitoring and the re-certification system as described for behavioral residential habilitation above.

Training Requirements

Proof of training in the areas of Cardiopulmonary Resuscitation (CPR), HIV/AIDS and infection control is required within 90 days of initially providing residential habilitation services. Proof of annual or required updated training shall be maintained on file for review. At all times when recipients are present, a minimum of a least one staff member or 50 percent of all staff at the facility (whichever is greater), must be trained in CPR, infection control techniques, zero tolerance (of sexual abuse), core competencies, and the use of approved restraints and seclusion approved by the Agencies.

The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to the Core Assurances in Appendix A for the provider training requirements.

Residential Nursing Services Provider Requirements

Provider Qualifications

Providers of residential nursing services shall be nurses registered or licensed in accordance with Chapter 464, F.S. Nurses may provide these services as independent vendors or as employees of licensed residential facilities.

Training Requirements

Proof of training in the areas of Cardiopulmonary Resuscitation (CPR), HIV/AIDS and infection control is required within 30 days of initially providing residential nursing services. Proof of annual or required updated training shall be maintained on file for review.

The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to the Core Assurances in Appendix A for the provider training requirements.

Respiratory Therapy Provider Requirements

Provider Qualifications

Providers of respiratory therapy and assessment services shall be respiratory therapists licensed in accordance with Chapter 468, Part V, F.S. Respiratory therapists may be either independent vendors or an employee of an agency.

Training Requirements

The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to the Core Assurances in Appendix A for the provider training requirements.

Respite Care Services Provider Requirements

Provider Qualifications

Providers of respite care services may be licensed residential facilities, licensed home health or hospice agencies, licensed nurse registries, or agencies that specialize in services for recipients with developmental disabilities.

Independent vendors may also provide this service. Independent vendors and employees of agencies may be registered or licensed practical nurses or persons at least 18 years of age with one year of experience working in a medical, psychiatric, nursing or child care setting or working with recipients with developmental disabilities. College, vocational or technical training equal to 30 semester hours, 45 quarter hours or 720 classroom hours may substitute for the required experience.

Independent vendors, who are not nurses, are not required to be licensed, certified, or registered if they bill for and are reimbursed only for services personally rendered. Nurses who render respite care services as independent vendors shall be licensed in accordance with Chapter 464, F.S.

Training Requirements

Proof of training in the areas of Cardiopulmonary Resuscitation (CPR), HIV/AIDS and infection control is required within 30 days of initially providing respite care services. Proof of annual or required updated training shall be maintained on file for review.

The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to Appendix A for provider training requirements.

Skilled Nursing Services Provider Requirements

Provider Qualifications

Providers of skilled nursing services shall be nurses registered or licensed in accordance with Chapter 464, F.S.

Nurses may provide this service as independent vendors or as employees of home health, hospice agencies or nurse registries licensed in accordance with Chapter 400, parts III or IV, F.S.

Home health agencies must also be enrolled in the Medicaid home health program and meet Federal Conditions of Participation in accordance with 42 CFR Part 484.

Training Requirements

Proof of training in the areas of Cardiopulmonary Resuscitation (CPR), HIV/AIDS and infection control is required within 30 days of initially providing skilled nursing services. Proof of annual or required updated training shall be maintained on file for review.

The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to the Core Assurances in Appendix A for the provider training requirements.

Special Medical Home Care Provider Requirements

Provider Qualifications

Providers of special medical home care shall be group homes that employ registered nurses, licensed practical nurses and certified nurse assistant licensed or certified in accordance with Chapter 464, F.S. Certified nurse assistant must work under the supervision of a registered or licensed practical nurse.

Group homes shall be licensed in accordance with Chapter 393, F.S. Nurses and certified nurse assistants must perform services within the scope of their license or certification.

Training Requirements

Proof of training in the areas of Cardiopulmonary Resuscitation (CPR), HIV/AIDS and infection control is required within 30 days of initially providing special medical home care. Proof of annual or required updated training shall be maintained on file for review.

The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to Appendix A for provider training requirements.

Specialized Mental Health Services Provider Requirements

Provider Qualifications

Providers of specialized mental health services shall be:

- Psychiatrists licensed in accordance with Chapter 458 or 459, F.S.;
- Psychologists licensed in accordance with Chapter 490, F.S.; or
- Clinical social workers, marriage and family therapists or mental health counselors licensed in accordance with Chapter 491, F.S.

Providers of specialized mental health services shall have two years experience working with recipients dually diagnosed with mental illness and developmental disabilities.

Training Requirements

The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to the Core Assurances in Appendix A for the provider training requirements.

Speech Therapy Provider Requirements

Provider Qualifications

Providers of speech therapy and assessment services shall be speech-language pathologists and speech-language pathology assistants licensed by the Department of Health, in accordance with Chapter 468, Part I, F.S., and may perform services within the scope of their licenses.

Speech-language pathologists and assistants may provide this service as an independent vendor or as an employee of an agency. Speech therapists may also provide and bill for the services of a licensed or certified speech therapy assistant. Only licensed speech therapists can perform assessments.

Speech-language pathologists with a master's degree in speech language pathology who are in their final clinical year of training may also provide this service. Speech-language assistants must be supervised by a speech-language pathologist in accordance with the requirements of their professional licenses, per Chapter 468, Part I, F.S.

Training Requirements

The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to the Core Assurances in Appendix A for the provider training requirements.

Support Coordination Provider Requirements

Provider Qualifications

Providers of support coordination services may be either solo providers or agency providers.

Training and Experience

- Solo providers and waiver support coordination supervisors employed by agencies shall meet the following minimum qualifications: a bachelor's degree from an accredited college or university and three years of professional experience in developmental disabilities, special education, mental health, counseling, guidance, social work or health and rehabilitative services. A master's degree can substitute for one year of the required experience.
- Support coordinators employed by agencies shall meet the following minimum qualifications: a bachelor's degree from an accredited college or university and

two years of professional experience in developmental disabilities, special education, mental health, counseling, guidance, social work or health and rehabilitative services. A master's degree can substitute for one year of the required experience.

For applicants who have other employment at the time of application to become a waiver provider and intend to remain in the current employment, the application must include a statement addressing a plan for dual employment. The plan should address the type of employment held at the time of the application, the total number of hours involved in that employment on a weekly basis, a plan for the manner in which the applicant may be contacted by recipients receiving services during the hours employed in the other job, and how conflicting priorities, emergencies and meetings will be handled. The plan shall also address any long-range plan for reducing or terminating the other employment should a full waiver caseload be assumed. The APD Area Office shall approve the dual employment plan as a part of the waiver enrollment process. If it is determined that the applicant cannot be available to meet the needs of recipients on the applicant's caseload, the application may be denied. In no instance may the dual employment include providing services to recipients with developmental disabilities, unless services are provided within the role of case manager or support coordination.

Pre-Service Training Requirements

A minimum of 60 hours of pre-service training is required for solo providers and for the director or managers and the waiver support coordinator supervisor of provider agencies. This pre-service training shall consist of 34 hours of statewide pre-service training that is conducted by APD or by a trainer certified by APD and 26 hours of Area training. The Area training shall include orientation to the Area staff and responsibilities, Area resources, ABC training regarding entry and maintenance of recipient's demographic information, and general Area operational procedures. The Area training content must be approved by the APD Central Office to ensure statewide uniformity and must be provided by the Area within 90 days of the completion of the statewide pre-service training.

Support coordinators employed by agencies are required to receive the same number of training hours and are to be trained on the same topics covered in the statewide and area training. This training may be conducted by the support coordination agency once approved by APD. Agency trainers must attend a train-the-trainer session conducted by APD and mandatory refresher courses, as required by APD.

Agency trainers and the agency training plan must be prior approved by the APD's Central and Area Office. Support coordinators trained by their agency in the use of the APD-approved assessment must undergo certification by the Area.

Waiver support coordinators currently enrolled as DD waiver support coordination providers must become certified in the use of an APD assessment within 90 days of the effective date of the implementation of this rule. Failure to become certified in the use of the APD-approved assessment will result in termination as a DD waiver support coordination provider.

Proof of annual or required updated training shall be maintained on file for review.

The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to the Core Assurances in Appendix A for the provider training requirements.

Continuing Training Requirements

All waiver support coordinators and agency supervisors, directors or managers shall attend 24 hours of job-related in-service training annually. Internal management meetings, held by agency providers, shall not apply toward the 24 hours requirement unless approved by the Area. For support coordination supervisors and employees of agency providers, 12 hours of the 24 hours in-service requirement must be provided by trainers outside of the agency.

All waiver support coordinators shall attend training in individually determined goals conducted by the APD or an APD certified trainer within 90 days of receiving a certificate of enrollment from the Area. This training shall satisfy the annually required 24 hours of job related training for that year. Support coordinators who have not completed this training must have a trained waiver support coordinator in attendance when conducting interviews, as part of the annual support planning process.

Documentation of all training will be maintained on file by the solo provider or the agency provider and be available for monitoring and review.

Supported Employment Services Provider Requirements

Provider Qualifications

Providers of supported employment services may be either independent vendors, solo providers or agency vendors.

Independent vendors, solo providers and employees of agencies who render this service shall have a bachelor's degree from an accredited college or university with a major in business; nursing; education; or a social, behavioral or rehabilitative science. In lieu of a

bachelor's degree, a person rendering this service shall have an associate's degree from an accredited college or university with a major in business; nursing; education; or a social, behavioral or rehabilitative science and two years of experience. Experience in one of the previously mentioned fields shall substitute on a year-for-year basis for the required college education.

Licensure and registration is not required

Training Requirements

Agency providers are required to attend 12 hours of pre-service training and eight hours of annual in-service training related to supported employment.

Agency employees and independent vendors and solo providers enrolled after March 01, 2004 are required to attend 18 hours of pre-service training prior to assuming job responsibilities and eight hours of annual in-service training. Training will include the approved curriculum entitled, "Supported Employment and Natural Supports, A Florida Training Curriculum, 2001 Edition", or an equivalent training curriculum, as approved by APD.

Individual vendors must attend at least one supported employment related conference or workshop prior to certification and eight hours of annual in-service training related to supported employment. Proof of annual or required updated training shall be maintained on file for review.

The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to the Core Assurances in Appendix A for the provider training requirements.

Supported Living Coaching Services Provider Requirements

Provider Qualifications

Providers of supported living coaching services may be independent vendors, solo providers or employees of agencies.

Independent vendors, employees of agencies and solo providers who render these services shall have a bachelor's degree from an accredited college or university with a major in nursing; education; or a social, behavioral or rehabilitative science. In lieu of a bachelor's degree, a person rendering these services shall have an associate's degree from an accredited college or university with a major in nursing; education; or a social,

behavioral or rehabilitative science and two years of experience. Experience in one of the previously mentioned fields shall substitute on a year-for-year basis for the required college education.

Training Requirements

Agency employees, independent providers and solo providers are required to attend 12 hours of pre-service training prior to assuming job responsibilities, and eight hours of annual in-service training. Agency employees and independent providers enrolled after October 2003 are required to attend eighteen hours of pre-service training prior to assuming job responsibilities, and eight hours of annual in-service training. Training will consist of a curriculum provided by APD, an overview of affordable housing options and home modifications, and Chapter 65G-5, F.A.C. The pre-service training content must be approved by APD's Central Office to ensure statewide uniformity.

Providers of supported living coaching services must, at a minimum, also complete training covering CPR, infection control, HIV/AIDS, maintaining current certification.

Proof of annual or required updated training shall be maintained on file for review. The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to the Core Assurances in Appendix A for the provider training requirements.

Transportation Services Provider Requirements

Provider Qualifications

In order to provide and be reimbursed for transportation under the Medicaid DD Waiver, transportation providers may be Community Transportation Coordinators (CTC) for the Transportation Disadvantaged; limited transportation providers; Public Transit Authorities that run the community's fixed-route, fixed-schedule public bus system; group homes and other residential facilities in which the recipients being transported live; adult day training programs to which the recipients are being transported; and other public, private for-profit and private not-for-profit transportation entities. The manner in which each of these types of providers may be used is specified in Chapter 427, F.S., and described below.

Pursuant to Chapter 427, part I, F.S., transportation services shall be purchased from Community Transportation Coordinators utilizing the public, private for-profit, or private not-for-profit transportation operators within each county's coordinated transportation system.

Limited transportation providers are relatives, friends and neighbors. They are not “for hire” entities. They are reimbursed at the state mileage rate. The Area is not required to contact or obtain authorization from the CTC in order to use the services of a limited transportation provider. The CTC has no responsibility for overseeing service delivery of such providers. The Area is responsible for this oversight.

When transportation providers are also relatives, controls must be in place to ensure that the payment is made to the relative only in return for specific services rendered, and that there is adequate justification as to why the relative is being paid for the service, rather than being a natural support.

Public Transit Authorities that operate the community’s fixed-route, fixed-schedule public bus system may enroll in the DD Waiver to facilitate the purchase of monthly or other frequency bus passes. If natural supports are unavailable, this transportation option is to be used for recipients who can use the fixed-route, fixed-schedule public bus system to go to some or all of their waiver services. Bus passes are to be purchased for recipients who can utilize the bus system to go to their waiver service sites whenever the cost of the trips to be taken during the month, if taken by Para transit, would exceed the cost of the monthly bus pass. Public Transit Authorities are required to adhere to minimum safety standards set forth in Chapter 14-90, F.A.C. The Area is not required to contact or obtain authorization from the CTC in order to use the services of the fixed-route fixed-schedule bus system. Drivers of fixed-route, fixed-schedule buses are not considered direct service providers within the context of Chapter 393, F.S. Therefore, they are not required to be level 2 background screened. The CTC has no responsibility for overseeing service delivery of such providers.

Group homes or other residential facilities in which recipients live may enroll as transportation providers to transport the recipients to and from their waiver services. Adult day training agencies that recipients regularly attend may enroll as transportation providers to transport the recipients to and from the agencies’ programs. In order to use group homes, residential facilities, or adult day training (ADT) agencies as transportation providers, the Area must obtain written authorization from the CTC. The authorization will result in a written agreement that sets forth the roles and responsibilities of the CTC, the group home, residential facility or ADT agency and the Area for complying with vehicle and passenger safety standards, adhering to, monitoring and overseeing service delivery and any necessary reporting to ensure compliance with Chapter 427, F.S. This arrangement will benefit the providers by enabling them to purchase new or replacement vehicles on state contract through the Department of Transportation.

Transportation providers that are not part of the coordinated transportation system may transport waiver recipients; however, the reason the Area needs to use them as a

provider determines what APD must go through in order to use the provider and the roles and responsibilities of APD and the CTC, as follows.

If the CTC determines it is unable to provide or arrange the required transportation for a recipient, transportation providers who operate outside the coordinated transportation system (e.g., taxi companies, private for-profit or not-for-profit transportation companies) may be used to transport the recipient to and from their waiver services.

The CTC has no responsibility for monitoring adherence to driver, vehicle and passenger safety standards or overseeing service delivery of such providers. The Area is responsible for such oversight. The provider and Area are responsible for complying with reporting requirements of Chapter 427, F.S., through the APD Director's designee on the Commission for the Transportation Disadvantaged.

If the Area Office wishes to utilize a transportation provider that is not a part of the coordinated transportation system, the Area must contact the CTC in the recipient's county of residence and follow their procedures for use of alternative providers, as required by the Florida Commission for the Transportation Disadvantaged. This authorization will be issued to the Area. These providers must meet the driver, vehicle and passenger safety standards of overseeing service delivery of such providers. The provider and Area are responsible for complying with reporting requirements of Chapter 427, F.S., through the APD Director's designee on the Commission for the Transportation Disadvantaged.

CHAPTER 2

DEVELOPMENTAL DISABILITIES WAIVER SERVICES COVERED SERVICES, LIMITATIONS AND EXCLUSIONS

Overview

Introduction

This chapter describes the services covered under the Medicaid Developmental Disabilities (DD) Waiver Program. It also describes the requirements for service provision, service limitations and exclusions. DD Waiver will refer to all four DD Waivers (Tiers One, Two, Three, and Four).

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Requirements to Receive Services

Who Can Receive Services

Participants in the waiver must meet the eligibility requirements of the Developmental Disabilities Program, in accordance with Chapter 393, F.S.; must meet the level of care criteria for placement in an Intermediate Care Facility for the Developmentally Disabled (ICF/DD); and must be eligible for Medicaid under one of a variety of categories described in Chapter 3 of the Florida Medicaid Provider General Handbook. Recipients of DD waiver services must need and receive support coordination services.

Note: The Florida Medicaid Provider General Handbook is available on the Medicaid's fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. It is incorporated by reference in rule 59G-5.020, F.A.C.

Medicaid Eligibility

Recipients who are not already eligible for Medicaid benefits through Supplemental Security Income (SSI), MEDS-AD, or TANF at the time they apply for DD waiver services must apply or have a designated representative apply for Medicaid through the Department of Children and Families. Eligibility can be applied for online at: myflorida.com/accessflorida/.

Note: Refer to Chapter 3 in the Florida Medicaid Provider General Handbook for information on verifying recipient eligibility.

Level of Care Requirements

Recipients who are eligible for Medicaid benefits must also meet all of the following conditions to be eligible for enrollment in the waiver:

The recipient must meet one of the following Developmental Disabilities Program eligibility requirements, in accordance with Chapter 393, F.S.

- The recipient's intelligence quotient (IQ) is 59 or less; OR

- The recipient's IQ is 60-69 inclusive and the recipient has a secondary handicapping condition that includes cerebral palsy, spina bifida, Prader-Willi syndrome, epilepsy, autism; OR ambulation, sensory, chronic health, and behavioral problems; OR the recipient's IQ is 60-69 inclusive and the recipient has severe functional limitations in at least three major life activities including self-care, learning, mobility, self-direction, understanding and use of language, and capacity for independent living; OR
- The recipient is eligible under a primary disability of autism, cerebral palsy, **Down syndrome**, spina bifida, or Prader-Willi syndrome. In addition, the condition must result in substantial functional limitations in three or more major life activities, including self-care, learning, mobility, self-direction, understanding and use of language, and capacity for independent living.

APD determines that DD waiver services are medically necessary as described on the next page. The recipient, the recipient's guardian, or guardian advocate must choose to receive home and community-based supports and services.

DD waiver services shall not be reimbursed when the date of service is prior to the recipient's enrollment into the DD Waiver.

Recipient Enrollment Into the DD Waiver

Once Medicaid and the waiver eligibility requirements are met, the APD Area Office reviews the recipient's request for home and community-based supports and services. That office will determine if: 1) a waiver vacancy is available; 2) sufficient funding is available to meet the recipient's needs; and 3) the recipient can be safely maintained in the community. The determination will be made in accordance with legislatively-appropriated funding and established annual priorities.

The Central Office maintains the statewide wait list of applicants waiting for waiver services.

A recipient's enrollment in the waiver continues indefinitely unless one of the following conditions exist:

- The recipient or guardian chooses to terminate participation in the program;
- The recipient moves out of state or country;
- The recipient becomes ineligible for the waiver because of a loss of eligibility for Medicaid benefits and this loss is expected to extend for a lengthy period;
- The recipient no longer needs waiver services;
- The recipient does not meet level of care for admission to an Intermediate Care Facility for the Developmentally Disabled (ICF/DD); or

- The recipient dies.

Note: Refer to Appendix C for the Wait List Policy.

Medical Necessity

Waiver services shall only be provided when the service or item is medically necessary.

Rule 59G-1.010(166), F.A.C. defines medical necessity as:

(a) “Medically necessary” or “medical necessity” means that medical or allied care, goods or services furnished or ordered must meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
- Be consistent with generally accepted professional medical standards as defined by the Medicaid program and not be experimental or investigational;
- Be reflective of the level of service that can safely be furnished, for which no equally effective and more conservative or less costly treatment is available statewide; and,
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider.

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods or services does not, in itself, make such care, goods or services medically necessary, or a medical necessity, or a covered service.

Medical Necessity Determinations

An appropriate, qualified professional shall make the determination that the standards for medical necessity are met and that the requested item meets the service definition, as contained in the approved DD waiver. When a requested service or item is determined to be medically necessary and the service or item is covered by the waiver, it shall be approved within limits specified, in accordance with this handbook.

If sufficient information is not available to determine that the service or item is medically necessary, a written request for more information will be sent to the waiver support coordinator, recipient, family or guardian. If it is determined that the service is not medically necessary, a written denial of the service and notice of due process will be sent to the recipient, family or guardian and copied to the waiver support coordinator. A Medicaid recipient may appeal decisions made by APD by requesting an Administra-

tive Hearing, in accordance with federal and state laws and regulations. A request for hearing shall be made to the agency, in writing, within 30 days of the recipient's receipt of the notice.

A prescription for a service or item, which has general utility or that is generally available to the public does not change the character of the item for coverage purposes under the waiver. It is the general use and not the specific use that governs coverage.

Service Authorization Requirements

The services described in this handbook represent all approved services that may be purchased for a recipient participating in the DD waiver who needs the service to reach an outcome described on the support plan. In order for a recipient to receive a service it must be identified on a recipient's support plan and cost plan, also known as the plan of care, and be approved by the APD Area Office before the service may be provided. Providers of DD Waiver services are limited to the amount, duration and scope of the services described on the recipient's support plan and current approved cost plan.

Availability of Other Coverage Sources

Supports and services are developed and delivered in natural community settings. Additionally, the supports and services authorized under the waiver should be used to supplement the supports already provided by family, friends, neighbors, and the community. Replacement of such natural and free supports with government-funded services, including educational and vocational services, is contrary to the intent of the waiver program. State and federal funds are the means of last resort and only utilized when a family or community support is unavailable or while a support is being developed. Only by involving the recipient in community inclusive supports and experiences, can full integration into community life be accomplished.

Services and the Hierarchy of Reimbursement

Support coordinators must coordinate access to services through all available funding sources prior to accessing waiver services. Services cannot be authorized under the waiver if they are available from another funding source. It is the responsibility of the waiver services provider to determine whether the same type of service offered through the waiver is also available through other funding sources, including Medicaid state plan, and bill accordingly. Items and services inappropriately billed and paid through the waiver prior to accessing Medicaid state plan or other payor services will be considered as overpayments and subject to recoupment from the service provider.

Other funding sources must be accessed in this order:

1. Third Party Payer

2. Medicare
3. Other Medicaid programs
4. Waiver

No service may be authorized under the waiver if it is already covered by another Medicaid program unless the nature or the amount of service necessary would not be covered under the other Medicaid program.

If a recipient is dually-eligible under Medicare and Medicaid, the support coordinator must authorize services from those providers that are enrolled as Medicare and Medicaid providers so that any services that are covered by Medicare can be billed to Medicare first before billing to Medicaid. For example, Medicaid cannot reimburse a non-Medicare home health agency for Medicare reimbursable services provided to a dual-eligible beneficiary.

Other Medicaid program services must be accessed before using waiver services. For example, the Medicaid Durable Medical Equipment and Medical Supplies Program services must be accessed before using waiver consumable medical supplies or specialized medical equipment.

To obtain specific information about Medicaid state plan coverage, refer to the Medicaid Coverage and Limitations Handbook for the particular service. Handbooks can be downloaded from the Medicaid fiscal agent Web site www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. The Medicaid Coverage and Limitations handbooks for the particular services are incorporated by reference in the service-specific rules in 59G-4, F.A.C.

Service Delivery Timelines

Recipients currently enrolled in the waiver will be provided with those services that have been determined to be medically necessary. APD will make reasonable efforts to provide those waiver services for which a determination of medical necessity has been made within 90 days of the date of the recipient's enrollment in the waiver or request, to the extent that sufficient provider capacity exists.

Documentation Requirements

Introduction

DD waiver services are based on recipient needs that are documented in an approved plan of care. The plan of care includes the support plan and approved cost plan. A per-

son cannot receive Medicaid waiver services until he is determined eligible and is enrolled in the appropriate waiver program.

Medicaid will only reimburse for waiver services that are specifically identified in the approved plan of care by service type, frequency and duration and for which there is sufficient documentation supporting the provision of a service to the recipient. Services are reimbursed at the rates on the Developmental Disabilities Home and Community-Based Services Waiver Provider Rate Table.

Note: The Provider Rate Table is available from the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Fee Schedules. The Provider Rate Table is incorporated by reference in 59G-13.081.

General Service Documentation Requirements

Documentation is a written record that supports the fact that a service has been rendered. When a service is rendered, the provider must document the service and file the documentation appropriately before requesting reimbursement. Appropriate documentation is required in order to receive payment. All documentation must be dated and signed by the individual rendering the service. Progress notes that are co-signed by support coordinator supervisors are acceptable for waiver support coordinators whose application has been submitted to the APD Area Office and approved for enrollment while they are waiting for enrollment notification from APD. An updated support plan and cost plan are submitted, at a minimum, annually to APD.

A list of the documentation that is required for each service is included in each service description. Please refer to the Documentation Requirements section of each service for a detailed listing of documentation that must be submitted for reimbursement, and documentation that must be kept on file by the provider for monitoring and review purposes.

Please refer to the Documentation Definitions contained in this section of this handbook for a description of each type of documentation. For the purpose of efficiency, the required elements of the following documentation may be combined on one form:

- Bi-Weekly Contact Log
- Daily Attendance Log
- Daily Progress Note
- Invoice
- Monthly Summary
- Service Log
- Supported Living Log

It is the responsibility of each service provider to understand and comply with all documentation requirements. Questions regarding further clarification about these requirements should be directed to the APD Area Office.

Definitions

Annual Report

A written report documenting the recipient's progress toward his support plan goal(s) for the year, as required in section 393.0651, F.S. This report must be submitted to the waiver support coordinator no later than 30 days prior to the support plan year-end date.

Behavior Analysis Services Plan

A written plan that includes a description of the specific behaviors to be changed, intervention procedures to be used, data to be collected, training for caregivers, and a monitoring schedule to be followed by the behavior analysis services provider. This plan should be clearly written in language that is easily understood by other service providers.

APD-Approved Assessment

The APD-approved assessment is designed to provide a rational basis for the allocation of waiver funds to an individual with developmental disabilities. The assessment is completed at least every three years or as determined necessary by the recipient and the waiver support coordinator, due to the changing needs and condition of the recipient. Training on how to complete the assessment is provided by APD.

Central Record of a Recipient

A file, or a series of continuation files, kept by the waiver support coordinator in which the following documentation must be recorded, stored and made available for review:

- Recipient demographic data including emergency contact information; parental or guardian contact data; permission forms; and results of assessments, evaluations, and medical and medication information;
- Legal data such as guardianship papers, court orders and release forms; and
- Service delivery information including the current support plan, cost plan or written authorization of services, and implementation plans, as required.

The central record is the property of APD and follows the recipient if the recipient's waiver support coordinator changes.

Claim Form

The CMS-1500 claim form is the standard claim form to be used when submitting claims for reimbursement for DD Waiver Services. Claim forms must be complete and legible when submitted to the Medicaid fiscal agent for reimbursement for services rendered. The provider may submit claims to the Medicaid fiscal agent either on paper claims forms or electronically by using the free software supplied by the Medicaid fiscal agent.

Note: See Chapter 3 for additional billing and reimbursement information.

Community Integrated Settings

Local settings that are not limited to, or segregated settings for, recipients with developmental disabilities, and that possess the following characteristics: generic local community resources utilized by other people without disabilities and settings which promote direct personal interaction with others with or without developmental disabilities.

Cost Plan

The cost plan is the document used by the waiver support coordinator that lists all waiver services requested by the recipient on the support plan and the anticipated cost of each waiver service. The cost plan for each recipient is updated annually based on the results of the support planning process to reflect current needs and situations. APD must approve the cost plan prior to service provision. A cost plan may be amended at a time other than the annual update only if there is a documented significant change in the recipient's condition or circumstance that affects the recipient's health or welfare; when a change in the plan is required to avoid institutionalization; or when a service array will result in a more cost effective and less restrictive plan. Each time a recipient has a significant change in condition or circumstance that indicates the need for an increase in the approved plan or added services, the cost plan must be amended and approved in order for the service to be initiated.

A change in a recipient's condition or circumstances that affects the recipient's health or welfare is significant if it is a change of considerable magnitude or considerable effect. Examples of a significant change are:

- 1) A deterioration in medical condition that requires that the recipient receive services at a greater intensity or in a different setting to ensure that recipient's health or safety;
- 2) Onset of a health, environmental, behavioral, or medical condition that requires that the recipient receive services at a greater intensity or in a different setting to ensure the recipient's health or safety; or
- 3) A change in age or service setting resulting in a loss of services funded or otherwise provided from sources other than the waiver. This may include a

change in living setting which requires a different service array or a change in presence or health status of a primary caregiver that prevents the caregiver from continuing to provide support.

Daily Attendance Log

The daily attendance log is a listing of the recipients and the days of the month. For each day the recipient participated in the service, the date is checked (✓) or marked with an "X".

Daily Progress Note

Daily, on the days that service was rendered, notes of the recipient's progress towards achieving his support plan goals for the period being billed or the summary describing the treatment or training provided to the recipient or task accomplished. For example: August 11, 2007, John prepared macaroni and cheese in the microwave successfully for his housemates. This activity supports a goal on his support plan to learn how to cook.

Data Displays

Graphed data of target and replacement behaviors, including planned environmental interventions, medication changes, unplanned environmental changes or events, for the time period displayed.

Dietary Management Plan

A nutritional plan based on an assessment that includes current weight, height, usual weight, body measurements, results of laboratory tests useful in establishing current nutritional status, possible symptoms of or contributors to malnutrition, appetite, dysphasia (difficulty swallowing), odynophagia (pain on swallowing), correlation between drug therapy and appetite, chronic digestive conditions, current dietary practices, vitamins, herbal supplements, food preferences, and hydration status. The plan should address problems based on the assessment and establish targets for weight, nutritional intake, food texture and consistency, fluid and caloric intake.

Family Home

The primary residence occupied by the recipient and member(s) of his immediate family, which include spouse, children, parents, siblings, stepchildren, stepparents, stepsiblings and in-laws. (For supported living coaching, the service limitation of a family home do not apply when the parents or spouse in the home are determined to be eligible service consumers of the Agency for Persons with Disabilities.)

Home

With respect to the home of a recipient receiving supported living services, means a house or apartment, or comparable living dwelling space meeting community housing standards and rule 65G-5.004, F.A.C., requirements, which is neither a community care facility, health facility, nor a family home; in which no parent, guardian, or guardian advocate of the recipient resides; and which a recipient chooses, owns or rents, controls and occupies as a principle place of residence.

Home Accessibility Assessment

An assessment conducted by a Rehabilitation Engineer or other certified professional that determines the medically-necessary physical adaptations to a recipient's home to permit accessibility when adaptations are in excess of \$3,500. This assessment must also be used to determine appropriateness of ceiling tracking systems and may be used for determination of appropriate van modifications.

Implementation Plan

A plan developed with direction from the recipient, which includes information from the recipient's current support plan and other pertinent sources. The specific areas of training and strategies to meet support plan goal(s) for each recipient will be addressed in the recipient's implementation plan. Training objectives appropriate to the recipient's programs and services may also be included in the implementation plan. At a minimum, the implementation plan will include:

- The name, address, and contact information of the recipient served.
- The goal(s) from the support plan that the service will address.
- The strategies employed to assist the recipient in meeting the support plan goal(s).
- The system to be used for data collection and assessing the recipient's progress in achieving the support plan goal(s). The information from this assessment will be used to update and modify the plan, as needed, to ensure that progress toward goal achievement is attained.

The implementation plan will be developed, at a minimum, within 30 days of the initiation of the new service, or within 30 calendar days of the support plan effective date for continuation of services and annually thereafter. A copy of the implementation plan, approved by the recipient, shall be furnished to the recipient, guardian and to the waiver support coordinator at the end of this 30-day period. The progress toward achieving the goal(s) identified on the implementation plan shall be documented in daily progress notes or quarterly summaries, as specified in each service description. Data supporting the recipient's progress or lack thereof, summarized in the quarterly summary shall be available for review.

Monthly Nutritional Status Report

A report that reflects the recipient's progress toward meeting targets in his Dietary Management Plan. Weight gains or losses should be reported as well as any recommended dietary adjustments.

Prescription

Instructions written by a physician. A copy of the prescription is needed prior to requesting funding for medical services or certain medical equipment or supplies and is kept in the recipient's central file. The original prescription for an individual medical service is maintained in the medical service provider's file with a copy maintained in the recipient's central file.

Provider File

Documentation maintained by the provider is in both electronic and hard copy format, which includes the authorization for services, lease forms and service delivery documentation as specified in this handbook. This documentation is related to the service and support activities identified in the implementation plan.

The provider file maintained by the support coordinator is designated as the recipient's central record, but remains the property of APD.

Quarterly Summary

A written summary of the quarter's activities indicating the recipient's progress toward achieving support plan goals for the services billed in that quarter.

For residential nursing services, the quarterly summary must include details such as health risk indicators, information about medication, treatments, doctor's appointments and anything else of significance regarding the recipient's health.

Recipient Nursing Assessment

A recipient nursing assessment is a detailed assessment that includes height, weight, blood pressure, allergies, medications, a comprehensive evaluation of mental status, physical status, neurological, respiratory, cardiovascular, gastro-intestinal, reproductive and musculoskeletal systems, nursing diagnosis, and recommendations for nursing interventions. A nursing assessment is performed to determine the need for the service or to evaluate the recipient for care plan development. Reimbursement for a nursing assessment is considered two hours of service at the registered nurse rate. Only registered nurses may perform an assessment. Nursing assessments should be updated annually or if there is a significant change in the recipient's health status.

Service Log

A form used to document service delivery. The service log shall include the recipient's name and Medicaid ID number. The log shall include the date, time, duration of the service, and summary of services provided.

Supported Living Log

Written documentation of the dates, times and summary of the supports provided during contact with the recipient, as described in rule 65G-5.012, F.A.C.

Treatment Plan

A written plan developed by a provider of specialized mental health services. The initial treatment plan must be provided to the waiver support coordinator with an updated plan submitted every six months thereafter.

Adult Day Training

Description

Day training programs for adults are training services intended to support the participation of recipients in daily, meaningful, valued routines of the community, which for adults may include work-like settings that do not meet the definition of supported employment.

Adult day training (ADT) services stress training in the activities of daily living, self-advocacy, adaptive and social skills and are age and culturally appropriate. The service expectation is to achieve the outcomes (goals) defined by each recipient; and to attain and support participation in less restrictive settings. The training, activities and routine established by the adult day training program shall be meaningful to the recipient and provide an appropriate level of variation and interest. This training is provided in accordance with a formal implementation plan, developed under the direction of the recipient, reflecting goal(s) from the current support plan.

Services are typically facility-based and are usually furnished at a **maximum** of six hours per day on a regularly scheduled basis, for one or more days per week. Four of the six hours must be spent in training and program activities. Services may also be provided in the community if the activity is reflected in the individual's support plan and included in the implementation plan. Adult day training services may be provided as an adjunct to other services included on a recipient's support and cost plan. For example: a recipient may receive supported employment or other services for part of a day or week and adult day training services at a different time of the day or week. Adult day training ser-

vices will only be billable for the prorated share of the day or week that the recipient actually attended that service.

Mobile crews, enclaves and entrepreneurial models that do not meet the standards for supported employment and that are provided in groups of four or more recipients are included as ADT off site services.

Any recipient receiving adult day training or ADT-off site services who is performing productive work that benefits the organization or that would have to be performed by someone else if not performed by the recipient must be paid. Recipients who are working must be paid commensurate with members of the general work force doing similar work per wage and hour regulations of the U.S. Department of Labor.

At least annually, providers will conduct an orientation informing recipients of supported employment and other competitive employment opportunities in the community.

ADT-off site models include the following services that teach specific job skills and other services directed at meeting specific employment objectives:

1. Enclave - A group approach to training where recipients with disabilities work either as a group or are dispersed individually throughout an integrated work setting with supervision by the provider.
2. Mobile Crew - A group approach to training where a crew (lawn maintenance, janitorial) of recipients with disabilities are in a variety of community businesses or other community settings with supervision by the provider.
3. Entrepreneurial - A group approach to training where recipients with disabilities work in a small business created specifically by or for the recipient's.

Limitations

Adult day training services are usually provided five days a week, for up to six structured hours per day of operation, and up to 240 days a year. The stepped rate published for ADT and ADT off-site services is based on seven hours of staff time to accommodate the variance in recipient schedules for attendance. The provider shall render services at a time mutually agreed to by the recipient and the provider. This will allow a recipient the flexibility to determine when to attend the ADT program for limited hours or only on certain days. Billing will be by the quarter hour for the number of quarter hours attended each day the recipient is present.

Recipients attending full time, six hours, will be billed at the quarter hour rate for each full day the recipient is present. This service generally begins at the age of 22 when a recipient is out of the public school system or when they have graduated from the public school system, receiving a standard diploma. However, a recipient can begin at the

age of 16 without a standard diploma if the public school system is willing to provide funding for this service throughout the recipient's legal age of eligibility. Recipients over the age of 22 who have not graduated shall also be eligible.

Adult day training services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan. The staffing ratio shall not exceed ten recipients per direct care staff. This service cannot be provided concurrently with personal care assistance or companion services.

A recipient may not receive a combination of ADT, companion, or supported employment services that exceeds 30 hours per week. A recipient may not receive more than a total of 30 hours a week of a paid support or a combination of paid supports designed to be used as a meaningful day activity.

Documentation Requirements

Reimbursement* and monitoring documentation to be maintained by the provider:

1. *Copy of claim(s) submitted for payment;
2. *Recipient's implementation plan and supporting data; and
3. Staffing documentation such as staffing schedules, payroll records indicating identified support staff and hours worked, and any other supplemental support staffing schedules that document required staffing ratios.

In addition to the minimum required components of the individual implementation plan described in the definitions section of this handbook, the individual implementation plan for adult day training service must contain the following: a description of methods that the provider will use to ensure the recipient makes an informed choice concerning types of work and meaningful day activities (type of activities). This information is to be discussed with recipients and documented at least annually.

Quarterly summaries are completed as follows:

1. A quarterly summary for each quarter of the support plan year;
2. A quarterly summary for the third quarter of the support plan year also serves as the annual report and must include:
 - a summary of the fourth quarter of the previous support plan year, and
 - a summary of the first three quarters of the current support plan year.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of service log, monthly;
2. Copy of the recipient's implementation plan developed at a minimum within 30 days of the initiation of a new service, or within 30 days of the support plan ef-

fective date for continuation of services and annually thereafter. A copy of the implementation plan, approved by the individual/guardian shall be furnished to the individual/guardian and to the waiver support coordinator; and

3. Quarterly summaries as follows:
 - A quarterly summary for each quarter of the support plan year;
 - A quarterly summary for the third quarter of the support plan year also serves as the annual report and must include:
 - a summary of the fourth quarter of the previous support plan year, and
 - a summary of the first three quarters of the current support plan year.

*Indicates reimbursement documentation.

Note: Refer to the definitions section for additional information regarding specific documents required.

Place of Service

Adult day training services must be provided in a designated adult day training center or other training sites in the community as agreed to by the recipient and provider.

Special Considerations

Adult day training providers are paid separately for transportation services only when they are enrolled as a transportation provider and transportation is provided between a recipient's place of residence and the training site. Transportation between day training sites, if the activities provided are a part of day training services, will be included as a component part of the adult day training services and included in the rate paid to the provider of the adult day training service.

ADT staff is responsible for assisting recipients into and out of facilities when they have been transported in vehicles not owned or operated by the ADT. Drivers of such vehicles are responsible for ensuring the recipient's safe entry of and exit from the vehicle.

When the supervisor of a mobile crew or enclave does not meet the qualifications for a supported employment coach, even when the recipient meets the criteria for supported employment, the support must be billed as adult day training-off site.

Adult day training services and ADT off-site services will be billed based on the stepped rate for the services that are listed on the Provider Rate Table, at the 1 staff to 10 recipient ratio rate level. Exceptions to this rate level shall be made only when it has been determined through use of the APD-approved assessment and the support planning process that a recipient requires a different support staffing ratio. The rate and staffing ratio shall be identified in the recipient's support plan and cost plan and on the authori-

zation for service submitted to the provider by the recipient's support coordinator. The rate ratio is determined by what is the usual and customary service delivery pattern and does not fluctuate with incidental absences of one or more recipients included in the rate ratio.

Adult day training services shall be billed at the standard rate level for the service based on the Provider Rate Table. The standard rate is paid when a recipient requires minimal assistance, through instructional prompts, cues, and supervision to properly complete the basic personal care areas of eating, bathing, toileting, grooming and personal hygiene. A rate other than the standard rate level for this service shall only be authorized when it has been determined through use of the APD-approved assessment and the support planning process that a recipient requires an enhanced level of supports.

Indicators of a one staff to five recipient staffing rate ratio level include:

- Recipients who have a moderate level of support for personal care services on the APD-approved assessment may receive the rate level identified as moderate for the service. The moderate rate is paid when a recipient routinely requires prompts, supervision and physical assistance to complete the basic personal care areas of eating, bathing, toileting, grooming, and personal hygiene; or
- A recipient who is on a behavioral services plan that is implemented by the adult day training provider, and who requires visual supervision during all waking hours and occasional intervention as determined by a Certified Behavioral Analyst. The recipient does not have to live in a licensed residential facility.

Indicators of a one staff to three recipient staffing rate ratio level include:

- An intense level of personal care support services as indicated on an APD approved assessment;
- Recipients who have an intense level of support identified in the current abilities section of the APD-approved assessment may receive the rate level identified as intense for the service. The intensive rate is paid when a recipient requires total physical assistance, to include lifting and transferring, in at least three of the basic personal care areas of eating, bathing, toileting, grooming, and personal hygiene, due to physical, cognitive or behavioral limitations; and
- A recipient who is on a behavioral services plan that is implemented by the adult day training provider and who exhibits the characteristics required for behavioral residential habilitation services as determined by a Certified Behavioral Analyst. The recipient does not have to live in a licensed residential facility. The behavioral services plan and its effects on the behavior must be reviewed by the Local Review Committee (LRC) on a regular schedule as determined appropriate by the LRC.

Indicators of a one staff to one recipient staffing rate ratio level include:

- A recipient who is on a behavioral services plan that is implemented by the adult day training provider, and that exhibits the characteristics required for behavioral residential habilitation or intensive behavioral residential habilitation services as determined by a Certified Behavior Analyst. The need for this level of supervision must be verified in writing by the APD Area Office Review Committee Chair. The recipient does not have to live in a licensed residential facility. The behavioral services plan and its effects on the behavior must be reviewed by the Local Review Committee (LRC) on a regular schedule as determined appropriate by the LRC.
- The ADT provider must maintain documentation of the LRC review schedule, the LRC review dates and recommendations made, and the changes made related to these recommendations.

If the support is provided to groups larger than eight recipients, regardless of the wage, the service will be billed as adult day training-off site. If the support is provided in groups of eight or less and the recipients are paid less than minimum wage, the service shall be billed as adult day training-off site.

Payment shall not be made for any time period the recipient is absent from the service.

Providers shall combine each day's service in a month and bill at the end of the month, using the last day of the month as the date of service. If services terminate before the end of the month, providers shall combine each day's service for the service period and bill at the end of the service period, using the last day of the service period as the date of service.

Adult Dental Services

Description

Adult dental services cover dental treatments and procedures that are not otherwise covered by the Medicaid Dental Services Program state plan services.

Adult dental services include diagnostic, preventive and restorative treatment; extractions; endodontics, periodontal and surgical procedures. The services strive to prevent or remedy dental problems that if left untreated could compromise a recipient's health, by increasing the risk of infection or disease, or reducing food options, resulting in restrictive nutritional intake.

Emergency dental procedures to alleviate pain and or infection and full and partial dentures are covered by Medicaid state plan dental services.

This service is not available to individuals enrolled on the DD Waiver – Tier Four.

Limitations

Adult dental services are limited to recipients 21 years of age or older. Adult dental services will not duplicate dental services provided to adults by the Medicaid Dental Services Program. The Medicaid Dental Program state plan services provide dental services for recipients under the age of 21.

Adult cleanings are limited to two per year.

There is no limit in the number of emergency episodes per year or the number of teeth that may be extracted per emergency episode. Refer to the Florida Medicaid Dental Services Coverage and Limitations Handbook for additional information regarding Medicaid state plan coverage.

A recipient shall receive no more than ten units of this service per day.

Note: The Florida Medicaid Dental Services Coverage and Limitations Handbook is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. The handbook is incorporated by reference in 59G-4.060.

Documentation Requirements

Reimbursement* and monitoring documentation to be maintained by the provider:

1. *Copy of claim(s) submitted for payment.
2. All treatment records.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of claims submitted at time of claim submission; and
2. Copy of treatment plan.

* Indicates reimbursement documentation.

Place of Service

Adult dental services shall be provided in the provider's office or other setting, determined appropriate by the provider.

Special Considerations

Adult dental services are to be authorized only to prevent or remedy problems that could lead to a deterioration of the recipient's health, thus placing the recipient at risk of an institutional placement. Second opinions are covered when extensive dental work is planned or there is a question about medical necessity of all the work planned.

Providers of adult dental services are paid for each date of service and shall prepare their bills accordingly. The provider will submit an invoice listing each procedure and negotiated cost. All procedures or treatments rendered on one day shall be totaled into one bill for payment.

Behavior Analysis Services

Description

Behavior analysis services are provided to assist a person or persons to learn new behavior that are directly related to existing challenging behaviors or functionally equivalent replacement behaviors for identified challenging behaviors. Services may also be provided to increase existing behavior, to reduce existing behavior, and to emit behavior under precise environmental conditions. The term "behavior analysis services" includes the terms "behavior programming" and "behavioral programs." Behavior analysis includes the design, implementation and evaluation of systematic environmental modifications for the purposes of producing socially significant improvements in and understanding of human behavior based on the principles of behavior identified through the experimental analysis of behavior. It includes the identification of functional relationships between behavior and environment. It uses direct observation and measurement of behavior and environment. Contextual factors, establishing operations, antecedent stimuli, positive reinforcement and other consequences are used based on identified functional relationships between behavior and environment, in order to produce practical behavior change.

Behavioral services must include procedures to insure generalization and maintenance of behaviors. The services are designed to engineer environmental modifications including ongoing styles of interactions, and contingencies maintained by significant others in the recipient's life. Training for parents, caregivers and staff is also part of the services when these persons are integral to the implementation or monitoring of a behavior analysis services plan. Services should be provided for a limited time and discontinued as the significant others gain skills and abilities to assist the recipient to function in more independent and less challenging ways.

Delivery of behavioral services is a complex process that includes provision of services directly to the recipient, at times, or others supporting the recipient in his or her presence, as well as services required to assess, plan and train others without the recipient present. Examples of services provided to the recipient to caregivers, staff or other providers while the recipient is present include: analog functional analysis, observation of the recipient for descriptive functional assessment, observations of and feedback regarding interactions of caregivers, staff or other providers with the recipient, modeling procedures with the recipient for caregiver, staff, or other providers, probing new procedures with the recipient, and direct training to the recipient (typically with caregivers, staff, or other providers present). In addition, services required to support behavior analysis services, may include: behavior plan development, graphing and analysis of data, behavior plan revision, training staff, caregivers or other providers (recipient not present), consultation to other professionals, Local Review Committee presentation, and treatment team meeting (with or without recipient present). The latter support services may not be reimbursed in excess of 25 percent of the total units for the cost plan year.

Behavior analysis does not rely on cognitive therapies and expressly excludes psychological testing, neuropsychology, psychotherapy, sex therapy, psychoanalysis, hypnotherapy and long-term counseling as treatment modalities. Provision of behavioral services must comply with rule 65G-4.009, F.A.C. Services provided by behavior analysts with limited experience in the problem area or by behavior analysts who are not Board Certified Behavior Analysts with three years of experience or licensure under Chapter 490 or 491, F.S., should receive oversight and approval of services with a more experienced behavior analyst or with the above described highest level of certification.

Limitations

A recipient shall receive no more than 16 units of this service per day. A unit is defined as a 15-minute time period or portion thereof. This service may be provided concurrently (at the same time and date) with another service.

Documentation Requirements

Documentation of services must comply with rule 65G-4.009, F.A.C. Reimbursement* and monitoring documentation to be maintained by the provider includes:

1. *Copy of claim(s) submitted for payment;
2. *Copy of service log;
3. *Copy of assessment report, when an assessment has been requested;
*Quarterly summary of monitoring including the who, what, when and where of the monitoring events;
 - A quarterly summary for each quarter of the support plan year;
 - A quarterly summary for the third quarter of the support plan year also serves as the annual report and must include:

- a summary of the fourth quarter of the previous support plan year, and a summary of the first three quarters of the current support plan year.
4. *Behavior analysis service plan and services provided including graphic display of acquisition and reduction behaviors related to implementation of the service plan; and
 5. *Dated evidence of LRC reviews and recommendations specific to target behaviors and the behavior plan, when the procedures and behaviors meet criteria for review and approval in accordance with rule 65G-4.010, F.A.C.

Documentation to be submitted to the waiver support coordinator by the provider:

1. *Copy of service log, monthly;
2. *Copy of assessment report within 30 days of initially providing services, when an assessment has been requested;
3. *A copy of the provider's behavior analysis service plan within 90 days of initially providing services;
4. *Updates of the intervention plan as it is modified;
5. *Graphic displays of acquisition and reduction behaviors related to implementation of the service updated monthly, with baseline data to allow evaluation of progress; and
6. Annual report prior to the annual support plan update.

*Indicates reimbursement documentation.

Note: Refer to the definitions section for additional information.

Place of Service

These services may be provided in the provider's office, the recipient's place of residence or anywhere in the community. However, in all cases, behavior analysis services must also be provided in the setting(s) relevant to the behavior problems being addressed.

Special Considerations

Behavior analysis and assessment services are described more fully in Chapter 65G, F.A.C., which is available through the APD Area Office. As stated in rule 65G-4.010, F.A.C., approval for behavior analysis services for behaviors meeting the characteristics described in the rule must be obtained from certified behavior analysts meeting educational and experience requirements or persons licensed pursuant to Chapter 490 or 491, F.S., prior to implementation of the services.

Note: The F.A.C. is available online at flrules.org.

Behavior Assistant Services

Description

Behavior assistant services are one-on-one activities related to the delivery of behavior analysis services, as defined under Behavior Analysis Services and Assessment, and are designated in and required by a behavior analysis service plan. Activities include monitoring of behavior analysis services, the implementation of behavioral procedures for acquisition of replacement skills and reduction of problematic behaviors, data collection and display (e.g., graphics) as authorized by a recipient's behavior analysis service plan and assist the person certified as a behavior analyst or licensed under Chapter 490 or 491, F.S., in training of caregivers. The behavior analysis service plan must be designed, implemented, monitored, and approved in accordance with rule 65G-4.009, F.A.C.

Behavior assistant services are designed for recipients for whom traditional residential habilitation services have been documented unsuccessful or are considered to be inappropriate for health or safety reasons and for children who require behavioral services, but for whom providing services in the family home will likely be more effective and least restrictive. Services should be provided for a limited time and discontinued as the support persons gain skills and abilities to assist the recipient to function in more independent and less challenging ways. Behavioral assistant services for children should supplement and support, transfer stimulus control and generalize behavior change, the acquisition and reduction plans designed and implemented by the primary source of services for children, the education system.

Documentation Requirements

Reimbursement* and monitoring documentation to be maintained by the provider:

1. *Copy of claim(s) submitted for payment;
2. *Copy of service log;
3. *Quarterly summary of monitoring of program implementation including the who, what, when, and where of the monitoring events;
 - A quarterly summary for each quarter of the support plan year;
 - A quarterly summary for the third quarter of the support plan year also serves as the annual report and must include:
 - a summary of the fourth quarter of the previous support plan year, and

- a summary of the first three quarters of the current support plan year.
4. *Copy of the behavior analysis service plan must be in the recipient's file prior to claim submission.
 5. *Monthly data displays;
 6. *A record of the LRC review of the behavior services plan and data displays must be provided if the targeted reduction behaviors meet the requirements identified in 65G-4.009, F.A.C.; and
 7. A record of the LRC review of the behavior services plan and data displays must be provided if more than 65 quarter hours of behavior assistant services are approved daily.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of monthly service log;
2. Quarterly summaries as follows:
 - A quarterly summary for each quarter of the support plan year;
 - A quarterly summary for the third quarter of the support plan year also serves as the annual report and must include:
 - a summary of the fourth quarter of the previous support plan year, and
 - a summary of the first three quarters of the current support plan year.
3. Copy of the behavior analysis services plan within 90 days of providing the services; and
4. Data displays if an increase in the level of services is being requested.
5. Data displays at the third quarterly summary submission.

*Indicates reimbursement documentation.

Place of Service

These services may be provided in the provider's office, the recipient's place of residence or anywhere in the community. However, in all cases, behavior assistant services must also be provided in the setting(s) relevant to the behavior problems being addressed.

Special Considerations

The services of a Behavior Assistant must be approved by the responsible Behavior Analysis Services Local Review Committee Chairperson, as defined in rule 65G-4.008, F.A.C., and monitored by a person who is certified in behavior analysis or licensed under Chapters 490 or 491, F.S., in accordance with rule 65G-4.009, F.A.C.

Companion Services

Description

Companion services consist of non-medical care, supervision and socialization activities provided to an adult on a one-on-one basis or in groups not to exceed three recipients. This service must be provided in direct relation to the achievement of the recipient's goals per his support plan. A companion provider may also assist the recipient with such tasks as self-care needs, meal preparation, laundry and shopping; however, these activities shall not be performed as discrete services. This service does not entail hands-on medical care. Providers may also perform light housekeeping tasks, incidental to the care and supervision of the recipient. The service provides access to community-based activities that cannot be provided by natural or other unpaid supports, and should be defined as activities most likely to result in increased ability to access community resources without paid support. Companion services may be scheduled on a regular, long-term basis.

Companion services are not merely diversional in nature, but are related to a specific outcome or goal(s) of the recipient. Examples of acceptable companion activities are volunteer activities performed by the recipient as a pre-work activity; going to the library, getting a library card, learning how to use the library and checking out books or videos for personal use; shopping for groceries; or going to an animal shelter to learn about animals, and volunteering or assisting at the animal shelter.

This service is not available to individuals enrolled on the DD Waiver – Tier Four.

Limitations

Providers of companion services are limited to the amount, duration, and scope of the services described on the recipient's support plan and current approved cost plan. A recipient shall receive no more than six hours or 24-quarter hour units of these services per day. A unit is defined as a 15-minute time period or a portion thereof.

A recipient is limited to no more than 30 hours a week of companion services. The unit value is 15 minutes. Companion services are used to provide a meaningful day activity for a recipient. A recipient may not receive a combination of ADT, companion or supported employment services that exceeds 30 hours per week. A recipient may not receive more than a total of 30 hours a week of a paid support, or combination of paid supports designed to be used as a meaningful day activity. The companion rate shall be based on one to three recipients receiving the service during the same time interval. The rate ratio is determined by what is the usual and customary service delivery pattern and does not fluctuate with incidental absences of one or more recipients included in the rate ratio.

Companion services are limited to adults only (21 or older). Recipients may not receive this service in the provider's home. This service cannot be provided concurrently (at the same time) with adult day training, personal care assistance, in-home support services (quarter hour), supported employment and residential habilitation services.

Documentation Requirements

Reimbursement* and monitoring documentation to be maintained by the provider:

1. *Copy of claim(s) submitted for payment;
2. *Copy of service log.

The provider must submit a copy of service log, monthly, to the waiver support coordinator.

If the provider plans to transport the recipient in his private vehicle, at the time of enrollment, the provider must be able to show proof of valid: 1) driver's license, 2) car registration, and 3) insurance. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date.

*Indicates reimbursement documentation.

Place of Service

Companion services may be provided in the recipient's own home or family home, or while a recipient who lives in his own home, family home or licensed facility is engaged in a community activity. Companion services provided to a recipient living in a licensed group or foster home must be performed in the community, not the licensed living environment. No service may be provided or received in the provider's home.

Special Considerations

Companion services are provided in accordance with an outcome on the recipient's support plan and are not merely a diversion.

If the provider plans to transport the recipient in his private vehicle, at the time of enrollment, the provider must be able to show proof of valid: 1) driver's license, 2) car registration, and 3) insurance. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date.

Companion services providers are not reimbursed separately for transportation and travel costs. These costs are integral components of companion services and are included in the basic rate.

Consumable Medical Supplies

Description

Consumable medical supplies are those non-durable supplies and items that enable recipients to increase their ability to perform activities of daily living. Consumable medical supplies are of limited usage and must be replaced on a frequent basis. Supplies covered under the Developmental Disabilities waiver must meet all of the following conditions: a) be related to a recipient's specific medical condition; b) not be provided by any other program; c) be the most cost-beneficial means of meeting the recipient's need; and d) not primarily for the convenience of the recipient, caregiver, or family. Consumable medical supplies covered by the DD waiver are listed under Limitations.

Limitations

Consumable medical supplies cannot duplicate supplies provided by the Medicaid Durable Medical Equipment (DME) and Medical Supplies Program state plan services. Refer to the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook for additional information on Medicaid state plan coverage. Supplies not available under the Medicaid State Plan or that are available in insufficient quantity to meet the needs of the recipient may be purchased by the waiver. All supplies shall have direct medical or remedial benefit to the recipient and must be related to the recipient's developmental disability.

If multiple vendors are enrolled to provide this service, the recipient shall be encouraged to select from among the eligible vendors based on an item's availability, quality and best price. No more than ten items per day may be purchased.

Consumable medical supplies covered by the DD waiver are listed below. Some items have specific requirements or limitations.

1. Diapers, including pull-ups, adult diapers or adult disposable briefs.
2. Wipes.
3. Disposable gloves, when a recipient requires personal care that exposes the caregiver to body fluids. Latex-free gloves will be authorized when the recipient's or the caregiver's physician certifies that the recipient or caregiver has a latex allergy or that there is a probable expectation that the recipient or caregiver may have a latex allergy (i.e., recipients with spina-bifida). Disposable gloves are only available for purchase through the waiver when Medicaid DME and Medical Supplies Program state plan services allowable units are exhausted and additional gloves are determined to be medically necessary.
4. Surgical masks, when prescribed by a physician and are:

- a. Worn by a recipient with a compromised immune system as a protection from infectious disease; or
 - b. Worn by a caregiver who must provide a treatment that requires strict, sterile procedure in which they are trained to provide care to a recipient who has a compromised immune system and who must be protected at all cost from exposure to any airborne organisms or substances.
 - c. The physician must renew the prescription quarterly.
5. Disposable or washable bed or chair pads and adult sized bibs.
 6. Ensure or other food supplements, not covered by the Medicaid DME and Medical Supplies Program state plan services, when determined necessary by a licensed dietitian. Recipients that require nutritional supplements must have a dietitian's assessment documenting such need. The assessment shall include documentation of weight fluctuation.
 7. Feeding tubes and supplies, not covered by Medicaid State Plan and prescribed by a physician. Excludes supplies for a recipient who qualifies for food supplements under the Florida Medicaid Durable Medical Equipment and Medical Supplies Program or the Medicare Program.
 8. Dressings not covered by the Medicaid DME and Medical Supplies Program state plan services that are required for a caregiver to change wet to dry dressing over surgical wounds or pressure ulcers, and prescribed by a physician.
 9. Hearing aid batteries, cords and routine maintenance and cleaning prescribed by an audiologist.
 10. Bowel management supplies purchased under the waiver are limited to \$150.00 every 3 months. These supplies include laxatives, suppositories and enemas determined necessary for bowel management by the recipient's physician.

Items not contained on this list that meet the definition of consumable medical supplies may be approved through exception by APD. To request an exception, a physician must prescribe the item. The statement from the physician must delineate how the item is medically necessary, how it is directly related to the recipient's developmental disability, and without which the recipient cannot continue to reside in the community or in his current placement. Items specifically excluded in this handbook will not be approved through exception.

The request will be reviewed by the APD physician or nurse to determine compliance with the standards for medical necessity and to determine whether the requested item fairly meets the service definition. Consumable medical supplies must be directly and specifically related to the recipient's disability. Items of general use such as: toothbrushes, toothpaste, toothpicks, floss, deodorant, feminine hygiene supplies, bath soap, lotions, razors, shaving cream, mouthwash, shampoo, cream rinse, tissues, aspirin, Tylenol, Benadryl, nasal spray, creams, ointments, vapor rub, powder, over-the-counter

antihistamines, decongestants and cough syrups, clothing, etc., are not covered. Supplies for investigational or experimental use are not covered.

A prescription submitted for supplies, diets, over-the-counter medications, vitamins, herbs, etc., which has general utility or is generally available to the general population without a prescription, does not change the character of the item for purposes of coverage in this category. For example, a physical therapist, occupational therapist or physician recommending or prescribing items like Tylenol, Ginkgo Biloba, vitamins, gluten-free foods, cotton balls or Q-tips, does not convert that item from general utility items to consumable medical supplies covered under the DD waiver. Items covered in this category generally include only those items that are specifically designed for a medical purpose, and are not used by the general public or other general utility uses. It is the general character and not specific use of the item that governs for purposes of coverage under this category.

Consumable medical supplies are approved for a year at a time. Supplies may be ordered for 3 months at a time. The waiver does not allow for payment or reimbursement of copayments for consumable medical supplies covered by third party insurance.

Note: The Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Provider Handbooks. The handbook is incorporated by reference in 59G-4.070. F.A.C.

Documentation Requirements

Reimbursement* and monitoring documentation to be maintained by the provider:

1. *Copy of claim(s) submitted for payment;
2. *Copy of service log, listing supplies purchased; and
3. Original prescription for the supply (if prescribed).

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of service log listing supplies purchased prior to or at the time of claim submission; and
2. Copy of original prescription for the supply (if prescribed).

*Indicates reimbursement documentation.

Special Considerations

Educational supplies are not consumable medical supplies and are not covered by the waiver. These supplies are expected to be furnished by the local school system. Recipients or their family members shall not be reimbursed for consumable medical supplies they purchase.

Dietitian Services

Description

Dietitian services are those services prescribed by a physician that are necessary to maintain or improve the overall physical health of a recipient. The services include assessing the nutritional status and needs of a recipient; recommending an appropriate dietary regimen, nutrition support and nutrient intake; and providing counseling and education to the recipient, family, direct service staff and food service staff. The services may also include the development and oversight of nutritional care systems that promote a recipient's optimal health.

This service is not available to individuals enrolled on the DD Waiver – Tier Four.

Limitations

A recipient shall receive no more than 12 units of these services per day. A unit is defined as a 15-minute time period or portion thereof.

Documentation Requirements

Reimbursement* and monitoring documentation to be maintained by the provider:

1. *Copy of claim(s) submitted for payment;
2. *Copy of service log;
3. *Monthly nutritional status report;
4. *An assessment;
5. Individual Dietary Management Plan;
6. Daily progress notes (on days service was rendered);
7. Annual report; and
8. Original prescription for the service.

Documentation to be submitted to the waiver support coordinator by the provider:

9. Copy of service log, monthly;
10. Copy of assessment at time of initial claim submission and at time of reassessments;

11. Copy of individual dietary management plan at time initial claim submission and at least annually thereafter at the time of the support plan update;
12. Copy of annual report prior to the annual support plan update; and
13. Copy of original prescription for service.

*Indicates reimbursement documentation.

Place of Service

This service may be provided in the provider's office, in the home, or anywhere in the community.

Special Considerations

Dietitian services require an annual physician's order and shall be limited only to recipients who require specialized oversight of their nutritional status in order to prevent deterioration of general health that could result in an institutional placement. Recipients requiring nutritional supplements must have a dietitian's assessment documenting such need. Nutritional supplements are available through the Medicaid DME and Medical Supplies Program state plan services, under specific circumstances. For additional information on Medicaid state plan coverage requirements, refer to the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook.

Note: The Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. The handbook is incorporated by reference in 59G-4.070. F.A.C.

Durable Medical Equipment and Supplies

Description

Durable medical equipment includes specified, prescriptive equipment required by the recipient. Durable medical equipment generally meets all of the following requirements: a) can withstand repeated use; b) is primarily and customarily used to serve a medical purpose; c) is generally not useful to a recipient in the absence of a disability; and d) is appropriate for use in the home. Examples of durable medical equipment covered by the DD waiver are listed in the Limitations segment of this section.

Limitations

Durable medical equipment and supplies cannot duplicate DME and supplies provided through the Medicaid Durable Medical Equipment (DME) and Medical Supplies Program state plan services. Refer to the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook for additional information on Medicaid state plan coverage. Supplies not available under the Medicaid DME and Medical Supplies Program state plan services or that are available in insufficient quantity to meet the needs of the recipient may be purchased by the waiver. All supplies shall have direct medical or remedial benefit to the recipient and are related to the recipient's disability. The following is a list of equipment that the DD waiver will cover under the category of durable medical equipment. Some items have specific requirements or limitations.

1. Van adaptations, including lifts, tie downs, raised roof or doors in a family-owned or individually owned full-size van. The conversion of mini-vans is limited to the same modifications, but exclude the cost to modify the frame (e.g., lower the floor) to accommodate a lift. Van modifications must be necessary to ensure accessibility of the recipient with mobility impairments and when the vehicle is the recipient's primary mode of transportation. Only one set of modifications per vehicle is allowed, and only one modification will be approved in a five-year period. No adaptations will be approved for an additional vehicle if the Department has paid for adaptations to another vehicle during the preceding five-year period.

The vehicle modified must also have a life expectancy of at least five years. This is to be documented with an inspection by an Automotive Service Excellence (ASE) certified mechanic. The lift approved cannot then exceed 2 ½ times the NADA (blue book) value for the make, model and mileage on the van. Purchase of a vehicle and any repairs or routine maintenance to the vehicle are the responsibility of the recipient or family. Payments for repair to adaptations after the warranty expires may be approved by APD. Many automobile manufacturers offer a rebate of up to \$1,000 to recipients purchasing a new vehicle requiring modifications for accessibility. To obtain the rebate the recipient or family is required to submit documented expenditures of modifications to the manufacturer. If the rebate is available it must be applied to the cost of the modifications. If a recipient or a family purchases a used vehicle with adaptive equipment already installed, the waiver may not be used to fund the vehicle purchase or any portion of the purchase related to the adaptive equipment already installed.

A rehabilitation engineer or other certified professional may be reimbursed under home accessibility assessment to assess the appropriateness of any van conversion including identification of an appropriate lift system.

2. Wheelchair carrier for the back of the car is limited to one carrier for a five-year period.
3. Wheelchairs, to the extent that they are medically necessary and not covered by the Medicaid DME and Medical Supplies Program state plan services. A physician must prescribe the specific item. Coverage in this category will typically only be provided when the following criteria are met:
 - a. The recipient has a customized power wheelchair funded through Medicare or Medicaid, which is used as his primary mode of ambulation; or the recipient is ambulatory, but has a documented medical condition that prevents walking for sufficient lengths of time to go about his daily activities, for example cardiac insufficiency or emphysema. This condition must be documented by a physician and include a statement addressing how the recipient is limited in normal daily activities by the condition;
 - b. The recipient needs a manual wheelchair to facilitate movement within his own home, and to enable the recipient to be safely transported in an automobile. It must be documented that the vehicle does not have a lift or that the recipient's primary chair, if applicable, cannot be collapsed to fit into a trunk or on a wheelchair carrier;
 - c. The requested wheelchair is the most cost-beneficial device that meets the needs of the recipient;
 - d. The wheelchair covered by this service is a standard (manual) wheelchair and not intended for a recipient who cannot use a standard chair for any length of time without adaptation.

If the recipient usually uses a customized wheelchair but needs a standard wheelchair to transfer to an automobile that does not have a lift or for around the home to avoid the need for accessibility adaptations, an additional second (standard) wheelchair should be considered. Any adaptive wheelchair, including a customized power wheelchair, is covered through the Medicaid DME and Medical Supplies Program state plan services.

Payments for repair to wheelchairs after the warranty expires may be approved by APD (if not covered by Medicare or Medicaid). Only one manual wheelchair may be purchased in a five-year period. The waiver will not fund the purchase of both a manual wheelchair and a stroller in a five-year period. Excluded from coverage are wheelchairs requested to facilitate recreational activities such as beach wheelchairs, sports wheelchairs, or wheelchairs that are not the most cost-beneficial way to meet the needs of the recipient. Waiver services are not used to cover any copayments, with the exception of patient responsibility for Medicare-funded wheelchairs.

4. Strollers, subject to the same criteria and limitations for wheelchairs, as stated above, except reimbursement for a stroller will be limited to \$1,200. Only one

stroller or manual wheelchair can be purchased in any five-year period. As a cost-effective alternative the base unit for an adaptive car seat could be covered in lieu of a stand-alone stroller unit. Payments for repair to strollers after the warranty expires may be approved by APD, if not covered by Medicare or Medicaid DME and Medical Supplies Program state plan services. APD will respond to requests for repairs to strollers within 10 working days of receipt of such requests.

5. Portable ramps when the recipient requires access to more than one non-accessible structure.
6. Patient lift, hydraulic or electric with seat or sling, when the recipient requires the assistance of more than one person to transfer between a bed, a chair, wheelchair or commode are limited to adults and limited to one lift every eight years. Cost not to exceed \$2,000. Payments for repair to lifts after the warranty expires may be approved by APD, if not covered by Medicare or Medicaid DME and Medical Supplies Program state plan services.
7. Patient lifts are available through DME and Medical Supplies Program state plan services. The DD waiver will fund ceiling lifts only when the lift systems available through the Medicaid DME and Medical Supplies Program will not meet the recipient's need. A ceiling lift requires a home accessibility assessment by a rehabilitation engineer or appropriate professional to insure the structural integrity of the home to support the ceiling lift and track system. When this system is requested, it must be documented that it is the most cost-effective means of meeting the recipient's need and that the specific item selected does not exceed the medically necessary needs of the recipient. Medical necessity is usually limited to necessary access to an individual bedroom and bath. Only one system will be allowed for any recipient. If after at least five years the recipient moves, it will be determined if the most cost-efficient means to meet the recipient's need is by moving the current system or purchasing a new system if still required by the recipient. A new assessment and determination must be made. The cost may not exceed \$10,000. Payments for repair to ceiling lifts after the warranty expires may be approved by APD, if not covered by Medicare or Medicaid DME and Medical Supplies Program state plan services.
8. Adaptive car seat, for recipients being transported in the family vehicle and who cannot use the standard restraint system or can no longer fit into a standard child's car seat. The seat must be prescribed by a physical therapist that will determine that the recipient cannot use standard restraint devices or car seats. The physical therapist will identify appropriate equipment for the recipient. Adaptive car seats are limited to one per recipient every three years and cost no more than \$1,000.
9. Bidet, limited to recipients who are able to transfer onto commodes independently, but whose physical disability limits or prevents thorough cleaning. This item requires a prescription by a physician and assessment by a physical or

- occupational therapist to determine that the recipient can use the item independently. The bidet and installation must cost no more than \$1,000.
10. Single room air conditioner, when there is a documented medical reason for the recipient's need to maintain a constant external temperature. Conditions for which a single room air conditioner may be appropriate include congestive heart failure, severe cardiac disease, COPD (emphysema), or damage or disease of the hypothalamus. Only one single room air conditioner with a maximum of 250 square feet capacity will be approved per recipient for a five-year period. The air conditioning unit must cost no more than \$300.
 11. Single room air purifier, when there is a documented medical reason for the equipment. The documentation necessary for this equipment would be a prescription from a pulmonologist along with a medical statement explaining the medical diagnosis, the reason why the equipment is necessary and the expected outcome of the treatment. Conditions for which a single room air purifier may be appropriate include severe asthma with documented sensitivity to indoor airborne particles, chronic obstructive pulmonary disease, emphysema or pulmonary dysplasia. The air purifier unit must cost no more than \$250. Only one air purifier unit will be approved per recipient for a five-year period.
 12. Adaptive switches and buttons to operate equipment, communication devices, environmental controls, such as heat, air conditioning, and lights, for a recipient living alone or who is alone without a caregiver for a major portion of the day. Excluded are adaptive switches or buttons to control devices intended for entertainment, employment, or education.
 13. Adaptive door openers and locks for recipients living alone or who are alone substantial portions of the day or night and have a need to be able to open, close or lock the door and cannot do so without special adaptation.
 14. Environmental safety devices limited to door alarms, anti-scald device, and grab bars for the bathroom.
 15. Bath or shower chair when medically indicated and not covered through Medicaid DME and Medical Supplies Program state plan services. Coverage is limited to the most cost-beneficial item necessary to meet the recipient's need for bathing. Items that exceed the basic needs of the recipient are not covered.
 16. Adaptive eating devices, including adaptive plates, bowls, cups, drinking glasses, and eating utensils, that are prescribed by a physical therapist, occupational therapist or Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) certified provider. Adaptive bathing aids, to facilitate independence, as prescribed by a physical, occupational therapist, or RESNA certified provider.
 17. Picture communication boards and pocket charts, selected and prescribed by a speech therapist.
 18. Gait belts for safety during transfers and ambulation, and transfer boards.

19. Egg crate padding for a bed, when medically indicated and prescribed by a physician.
20. Hypoallergenic covers for mattress and pillows, ordered by a physician, who documents necessity based upon severe allergic reaction to airborne irritants.
21. Generators, may be covered for a recipient when:
 - a. The recipient is ventilator-dependent;
 - b. The recipient requires daily use of oxygen via a concentrator;
 - c. The recipient requires continuous, 24-hour total parenteral nutrition via an electric pump;
 - d. The recipient requires continuous, 24-hour infusion of total nutritional formula through a jejunostomy or gastrostomy tube via an electric pump;
 - e. The recipient requires continuous, 24-hour infusion of medication via an electric pump; or
 - f. The recipient meets the medical need for a single room air-conditioner.

The size of the generator is limited to the wattage necessary to provide power to the essential life-sustaining equipment. When a generator is requested, it must be documented that the specific model identified is the most cost-beneficial that meets but does not exceed the recipient's need. One generator per recipient may be purchased per 10-year period. Payments for repair to generators after the warranty expires may be approved by APD, if no other funding is available.

22. Bolsters, pillows, or wedges, necessary for positioning that are prescribed by a physical or occupational therapist.
23. Therapy mat prescribed by a physical therapist when a recipient is involved in a home-therapy program designed by a therapist and carried out by the family or caregiver in the recipient's own or family home.
24. Pulse oximeters may be purchased for recipients with respiratory or cardiac disease, who use supplemental oxygen on a continuous or intermitted basis. This equipment must be prescribed by the recipient's pulmonologist, cardiologist or primary care physician.

Items not contained on this list that meet the definition of durable medical equipment may be approved through exception by APD. To request an exception, a physician must prescribe the item. The statement from the physician must delineate how the item is medically necessary, how it is directly related to the recipient's developmental disability, without which the recipient can not continue to reside in the community or in his current placement. The request will be reviewed by an appropriate, qualified professional to determine whether the standards for medical necessity are met, and to determine whether the requested item fairly meets the service definition.

Items specifically excluded in this handbook will not be approved through exception.

If multiple vendors are enrolled to provide this service, the recipient shall select from among all eligible vendors based on the item's availability, quality and best price. No more than five items per day may be purchased.

A prescription submitted for a piece of equipment, which has general utility or is generally used for physical fitness or personal recreational choice, does not change the character of the equipment for purposes of coverage in this category. For example, a physical therapist, occupational therapist or physician recommending or prescribing a stationary bicycle or hot tub, does not convert that item from personal fitness or recreational choice equipment to durable medical equipment covered under the DD Waiver.

Items covered in this category generally include those specifically designed for a medical purpose, and are not used by the general public for physical fitness purposes, recreational purposes, or other general utility uses. It is the general character and not the specific use of the equipment that determines its purpose, for coverage under this category.

Items usually found or used in a physician's office, therapist's office, hospitals, rehabilitation centers, clinics or treatment centers, or items designed for use by a physician or trained medical personnel are not covered. This includes items such as prone or supine standers, gait trainers, activity streamers, vestibular equipment, paraffin machines or baths, therapy balls, etc.

Also excluded are experimental equipment, weighted vests and other weighted items used for the treatment of autism, facilitated communication, hearing and vision systems, institutional type equipment, investigational equipment, items used for cosmetic purposes, personal comfort, convenience or general sanitation items, or routine and first aid items.

Excluded Services

Items for diversional or entertainment purposes are not covered. Items that would normally be available to any child or adult, and would ordinarily be provided by families are also excluded. Examples of excluded items are toys, such as crayons, coloring books, other books, and games; electronic devices, such as videotapes, CD players, radios, cassette players, tape recorders, television, VCRs, cameras, film, computers and software; exercise equipment, such as treadmills and exercise bikes; indoor and outdoor play equipment, such as swing sets, slides, bicycles, tricycles (including adaptive types), trampolines, play houses, and merry-go-rounds; and furniture or appliances. Items that are considered family recreational choices are also not covered (i.e., air conditioning for campers, swimming pools, decks, spas, patios, hot tubs, etc.).

Documentation Requirements

Prior to the provider submitting the claim for payment, the recipient's waiver support coordinator must document that the equipment was received and it works according to the manufacturer's description, either by conducting a site visit or obtaining verbal verification from the recipient or family.

Reimbursement* and monitoring documentation to be maintained by the provider:

1. *Copy of the pre-approved claim(s) form submitted for payment.
2. Original prescription for the medical equipment, if prescribed by a physician.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Service log listing equipment provided and documenting waiver support coordinator verification that equipment was received and works, per manufacturer's description, prior to submission of claim for payment; and
2. Copy of original prescription, if prescribed by physician.

*Indicates reimbursement documentation.

Special Considerations

Recipients and their family members shall not be reimbursed for equipment they purchase. Any durable medical equipment must be determined to be cost-beneficial. Once the most reasonable alternative has been identified and specifications developed, three competitive bids must be obtained for all items \$1,000 and over to determine the most economical option. If three bids cannot be obtained, it must be documented to show what efforts were made to secure the three bids and explain why less were obtained. For items under \$1,000, one bid is required as long as it can be demonstrated that the bid is consistent with local market value.

The DD waiver shall not provide durable medical equipment that is available for purchase through Medicaid DME and Medical Supplies Program state plan services. Medicaid often covers like equipment, but not the specific brand requested. When this occurs, the recipient is limited to the Medicaid covered device. The lack of coverage for a specific brand name is not a medically necessary justification for waiver purchase. Only the equipment that is not covered through Medicaid DME and Medical Supplies Program state plan services or not in a sufficient quantity to meet the needs of the recipient may be purchased through the DD waiver, and then only consistent with what is described above.

All equipment shall have direct medical or remedial benefit to the recipient, shall be related to the recipient's developmental disability and shall be necessary to prevent institutionalization. Assessment and recommendation of appropriateness by a licensed physician, physical therapist or occupational therapist is required.

In accordance with rule 65G-8.001 F.A.C., totally enclosed cribs and barred enclosures are considered restraints and are not covered under the waiver. Strollers and wheelchairs, when used for restraint are also not covered.

Environmental Accessibility Adaptations

Description

Environmental accessibility adaptations (EAA) are those physical adaptations to the home that are required by the recipient's support plan and are "medically necessary" to avoid institutional placement of the recipient and enable him to function with greater independence in the home. A Home Accessibility Assessment is an independent assessment by a professional rehabilitation engineer or other specially trained and certified professional to determine the most cost-beneficial and appropriate accessibility adaptations for a recipient's home.

Home accessibility assessments may also include pre-inspection of up to three houses a recipient or family is considering for purchase, review of ceiling lift and track systems, van conversions, and oversight and final inspection of any approved EAA.

If the construction is not completed by the independent assessor, the assessor can still provide construction oversight and a final inspection. The assessment may also include pre-purchase inspection of up to three homes identified by a recipient or family to determine the best design to meet the recipient's needs and any potential adaptations that may be required to make the home accessible.

Limitations

Environmental accessibility adaptation services are limited to the amount, duration and scope of the adaptation project described on the recipient's support plan and current approved cost plan. If multiple vendors are enrolled to provide this service, the recipient shall be encouraged to select from among the eligible vendors based on availability, quality of workmanship, and best price.

Environmental accessibility adaptations covered under this waiver includes the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities or installation of specialized electric and plumbing systems required to accommodate

the medical equipment and supplies, which are necessary for the welfare of the recipient.

Excluded are those adaptations or improvements to the home, which are of general utility and are not of direct medical or remedial benefit to the recipient, such as carpeting, roof repair, central air conditioning, etc.

Environmental accessibility adaptations (EAA) are approved when they are medically necessary. APD must approve exceptions. To submit an exception request, the appropriate professional must complete an assessment documenting how the specific EAA is medically necessary, how it is directly related to the recipient's developmental disability, how it is directly related to accessibility issues within the home; and how without the selected EAA, the recipient cannot continue to reside in his current residence. The request will be reviewed by an appropriate, qualified professional to determine whether the standards for medical necessity are met and to determine whether the requested item fairly meets the service definition.

Adaptations specifically excluded in this handbook will not be approved through exception.

Environmental accessibility adaptations include only adaptations to an existing structure, and must be provided in accordance with applicable state or local building codes. Adaptations that add to the total square footage of the home are excluded from this benefit.

Documentation Requirements

Prior to the provider submitting the claim for payment, the recipient's waiver support coordinator must document that the services were completed in accordance with the contract or agreement, either by conducting a site visit or by obtaining verbal verification from the recipient or family.

Reimbursement* and monitoring documentation to be maintained by the provider:

1. *Copy of claims submitted for payment;
2. *Copy of service log; and
3. Original prescription for medical equipment.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Service log monthly, including documentation of waiver support coordinator's verification that services were completed in accordance with the contract or agreement, prior to submission of claim for payment; and

2. Copy of original prescription for medical equipment.

*Indicates reimbursement documentation.

Place of Service

Environmental accessibility adaptations shall be made only to a recipient's family home or recipient's own home, including rented houses or apartments. Recipients living in foster homes, group homes, assisted living facilities, or homes for special services (any licensed residential facility) are not eligible to receive this service. The responsibility for EAA rests with the facility owner or operator.

Special Considerations

Environmental accessibility adaptations shall be determined "medically necessary" before approved. This determination includes the following considerations:

- There are no less costly or conservative means to meet the recipient's need for accessibility within the home;
- The environmental accessibility adaptation is individualized, specific and consistent with the recipient's needs and not in excess of his needs; and,
- The environmental accessibility adaptation enables the recipient to function with greater independence in the home and without which, the recipient would require institutionalization.

Environmental accessibility adaptations that are required to support proper functioning of medical equipment, such as electrical upgrades, are limited to the requirements for the safe operation of the specified equipment and not intended to correct existing code violations in the recipient's home.

Environmental accessibility adaptations shall be approved for a recipient's own home or family home whether owned or leased, as needed, to make the home accessible to the recipient. No more than five units shall be billed per day. Once adaptations are made to a recipient's residence, adaptation to another residence cannot be made until five years after the last adaptation to the first residence except for extenuating circumstances, such as total loss of residence. The waiver program does not cover routine repairs to the existing EAA or general repairs to the home or residence. The waiver program cannot be used to fund corrections to any existing code violation(s) to the home.

If a recipient or family builds a home while the recipient is receiving waiver services, major or structural changes will not be covered. Environmental accessibility adaptations covered under these circumstances are the difference in the cost, if any, between a handicapped-accessible bathroom and a standard bathroom. However, the cost differ-

ence for each item and adaptation must be documented, with total cost not exceeding \$3,500.

Rental property is limited to minor adaptations as defined below. Prior to any adaptation to a rental property, a determination should be made as to what, if anything, the landlord will cover. The landlord, prior to service, shall approve all proposed environmental accessibility adaptations in writing. The written agreement between the recipient or family and the landlord must specify any requirements for restoration of the property to its original condition if the occupants move and must indicate that the Department of Children and Families and waiver funding are not obligated for any restoration costs. Waiver funds cannot be placed in escrow to undo any accessibility adaptations when the recipient moves out. Recipients or families requesting EAA are expected to apply for all other assistance that may be available to assist in meeting the recipient's needs. This includes local housing authorities, county, and local and community funding, etc.

Environmental accessibility adaptations shall be separated into two categories. Minor adaptations shall be defined as those EAA costing under \$3,500 for all adaptations in the home. Major adaptations shall include those adaptations to a home when the total cost is \$3,500 and over. Total EAA cannot exceed \$20,000 during a five-year period. Major environmental accessibility adaptations require the assessment of a rehabilitation engineer or other professional qualified to make a home accessibility assessment. This home accessibility assessment shall include evaluation of the current home and describe the most cost-beneficial manner to permit accessibility of the home for the recipient on the waiver.

The report must demonstrate that the environmental accessibility adaptation recommended is a "prudent purchase." Prudent purchase is a combination of quality and cost, where quality is measured by the ability to meet the recipient's accessibility need and cost is measured by being the most reasonable and economical approach necessary to meet that need. Each environmental accessibility adaptation must be the most reasonable alternative based on the results of the review of all options, including a change in the use of rooms within the home or alternative housing.

Environmental accessibility adaptations must be cost-beneficial. Once the most reasonable alternative has been identified and specifications been developed, three competitive bids must be obtained for all EAA to a home costing \$3,500 and over to determine the most economical option.

If three bids cannot be obtained, it must be documented to show what efforts were made to secure the three bids and explain why less was obtained. For EAA to a home costing between \$1,000 and \$3,499 at least two competitive bids must be obtained. If

two bids cannot be obtained, it must be documented to show what efforts were made to secure the two bids and explain why only two were obtained. For EAA to a home costing under \$1,000 only one bid is required, as long as it can be demonstrated that the bid is consistent with local market value. Environmental accessibility adaptations do not include those adaptations or improvements to the home that are of general utility, are considered to be standard housing obligations of the owner or tenant, are considered to be experimental, or are not of direct medical or remedial benefit to the recipient on the waiver. Routine maintenance of the adaptations and general repair and maintenance to the home is the responsibility of the owner or landlord and not a covered waiver service.

Examples of items not covered include replacement of carpeting and other floor coverings; roof repair; driveways; decks; patios; fences; swimming pools; spas or hot tubs; sheds; sidewalks; central heating and air conditioning; raised garage doors; storage (i.e., cabinets, shelving, closets); standard home fixtures (i.e., sinks, commodes, tub, stove, refrigerator, microwave, dishwasher, clothes washer and dryer, wall, window and door coverings, etc.); furnishings (i.e., furniture, appliances, bedding); and other non-custom items which may routinely be found in a home. Also, specifically excluded are any adaptations that will add square footage to the home.

In-Home Support Services

Description

In-home supports are services that provide recipients who live in their own homes with up to 24 hours-a-day assistance from a support worker or support workers. The support worker may live in the recipient's home or apartment and share living expenses (rent, utilities, phone, etc.) with the recipient. The support worker provides companionship and personal care and may assist with or perform activities of daily living and other duties necessary to maintain the recipient in supported living. The support worker may perform grocery shopping, housekeeping, and cooking responsibilities or may conduct training programs designed by the supported living coach to teach these and other daily living skills. The in-home support services are separate and not a replacement for the services performed by a supported living coach. Some recipients in supported living may need only the services of an in-home support worker or only the services of a supported living coach. Other recipients may need both services. When both services are used, the providers must coordinate their activities to avoid duplication.

The support worker, to the extent properly qualified and licensed, may maintain the recipient's home and property as a clean, sanitary and safe environment. The support worker's services may include heavy household chores to make the home safer, such as

washing floors, windows and walls; tacking down loose rugs and tiles; replacing a broken window; or moving heavy items or furniture.

This service offers individualized training and is provided for the express purpose of providing access to the community-based activities that cannot be provided by natural or other unpaid supports, and are defined as activities most likely to result in increasing ability to access community resources without paid support.

This service is available to recipients enrolled on the DD Waiver – Tier 4 in the family home, including foster homes, and for individuals in Tiers 1, 2 and 3 living in their own home.

Limitations

In-home support services are available only to recipients residing in their own homes, excluding family home or sharing of a home with family members. The APD Area Office may also approve the use of in-home, live-in, and hourly live-in services at the appropriate live-in and hourly rate for the service, for recipients who are in need of support and who reside in a licensed foster or group home, limited to no more than three recipients living in the home. A recipient receiving in-home support services is not eligible to receive personal care, or residential habilitation services. In-home support services may be billed up to 365 days a year when the recipient is present.

Documentation Requirements

Reimbursement* and monitoring documentation to be maintained by the provider:

1. *Copy of claims submitted for payment;
2. *Copy of service log;
3. Quarterly summaries as follows:
 - A quarterly summary for each quarter of the support plan year;
 - A quarterly summary for the third quarter of the support plan year also serves as the annual report and must include:
 - a summary of the fourth quarter of the previous support plan year, and
 - a summary of the first three quarters of the current support plan year.
4. Staffing documentation such as in-home staffing schedules, payroll records indicating identified in-home support staff and hours worked, and other supplemental in-home support staffing schedules which document required staffing ratios.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of service log, monthly; and

2. Monthly summary notes at the time of claims submission.

If the provider plans to transport the recipient in his private vehicle, at the time of enrollment, the provider must be able to show proof of valid: 1) driver's license, 2) car registration, and 3) insurance. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date.

Note: *Indicates reimbursement documentation.

Place of Service

In-home support services are provided in the recipient's own home or if authorized by the APD Area Office in a licensed foster or group home where three or less recipients reside in the home. The in-home support services worker may also accompany the recipient to activities in the community.

Special Considerations

The in-home support provider or the provider's immediate family shall not be the recipient's landlord or have any interest in the ownership of the housing unit, as required by rule 65G-5.004, F.A.C. If renting, the name of the recipient receiving In-home support services must appear on the lease either singularly or with a roommate or a guarantor. Provider is defined as an individual or corporation including all board members and any paid employees and staff of the provider agency, its subsidiaries or subcontractors.

In-home supports provided by a provider or an employee of a provider who is living in a recipient's home must be billed at the live-in stepped rate for the service listed on the DD Provider Rate Table, which is incorporated by reference in 59G-13.081, F.A.C. The live-in rate shall be determined based on from one to three recipients in the home receiving the service. The live-in rate includes a relief factor for primary staff performing the support. Additional in-home supports above the live-in rate may be approved by the APD Area Office with concurrence from the APD Central Office based on the support needs of the recipient.

Up to 6 hours or 24 quarter hours above the live-in rate may be approved to provide additional supports that shall be billed by the quarter hour. In-home supports billed by the quarter hour above the live-in rate may be approved under the following circumstances:

- A. Recipient requires additional supervision due to intense behavioral challenges that make the recipient a danger to themselves or others. In this situation, the recipient must have a behavioral services plan that is implemented by the in-home support services provider, and the recipient requires visual supervision

during all waking hours and intervention as determined by a certified behavioral analyst. The behavioral services plan and its effects on the behavior must be reviewed by the Local Review Committee (LRC) on a regular schedule as determined appropriate by the LRC.

- B. Recipient requires temporary additional supervision and assistance to recover from a medical condition, procedure or surgery. The additional supports may only be approved on a time limited basis during the recipient's recovery. This must be documented by medical information signed by the recipient's physician.

A provider or employees of a provider do not have to "live-in" a recipient's home for the live-in rate to be applied for the service.

When the in-home support worker lives in the recipient's home, and the home is considered the support worker's primary residence, the support worker or provider will pay an equal share of the room and board for the home. The equal share determination shall be made prior to any stipend calculation for the recipient(s).

The recipient has the option to negotiate with the support worker for a share of the household expenses during the time that the support worker shares the living arrangement when it is not the primary residence.

In-home support services that are provided on an hourly basis instead of live-in shall be billed by the quarter hour in accordance with the stepped rate for in-home supports awake staff for up to eight hours a day. If in-home hourly supports are required in excess of eight hours a day, or 32 quarter hour units, the service must be billed at the in-home live in daily rate. The live-in daily rate provides from 8 to 24 hours of supports. When periodic additional staff assistance is required for in-home live in services, an in-home hourly support service may be billed for up to six hours a day in addition to the live in support if approved by the APD Area Office with concurrence from the APD Central Office. The rate for the service will be determined based on from one to three recipients in the home receiving the service. The rate ratio is determined by what is the usual and customary service delivery pattern and does not fluctuate with incidental absences of one or more recipients included in the rate ratio.

The in-home support services worker is prohibited from paying rent or the cost of other living expenses directly to the recipient, since such financial transactions could jeopardize the recipient's eligibility status as a Medicaid recipient. The support worker should instead pay his portion of the rent directly to the landlord and his portion of other living expenses (utilities, phone, etc.) directly to the service companies. If the recipient owns the home, the waiver support coordinator or APD Area Office staff must assist the recip-

ient in negotiating the provider's fee, and then negotiate offsetting the fee by the amount the provider owes the recipient for rent and other living expenses.

When a recipient receives supported living coaching and in-home support services, the providers must work together and with the waiver support coordinator to avoid duplication of services.

In-home support providers are not reimbursed separately for transportation and travel costs. These costs are integral components of in-home support services and are included in the basic rate.

Occupational Therapy

Description

Occupational therapy services are services prescribed by a physician that are necessary to produce specific functional outcomes in self-help, adaptive, and sensory motor skill areas, and assist the recipient to control and maneuver within the environment. The services also include an occupational therapy assessment, which does not require a physician's prescription. In addition, this service includes training direct care staff and caregivers and monitoring those individuals to ensure they are carrying out therapy goals correctly.

This service is not available to individuals enrolled on the DD Waiver – Tier Four.

Limitations

Occupational therapy and assessment services are available through the Medicaid Therapy Services Program state plan services to recipients under the age of 21. Services for these recipients may not be purchased under the waiver.

Refer to the Florida Medicaid Therapy Services Coverage and Limitations Handbook for additional information on Medicaid state plan coverage.

Children who receive this service through a school health program may still be eligible for additional Medicaid state plan occupational therapy services.

A recipient shall receive no more than eight units of these services per day. A unit is defined as a 15 minute time period or portion thereof. The occupational therapy assessment is limited to one per year.

Note: The Florida Medicaid Therapy Services Coverage and Limitations Handbook are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. The handbook is incorporated by reference in 59G-4.320, F.A.C.

Documentation Requirements

Reimbursement* and monitoring documentation to be maintained by the provider:

1. *Copy of claim(s) submitted for payment;
2. *Copy of service log;
3. *Monthly summary note;
4. *Assessment report (if requesting reimbursement for assessment);
5. Annual report; and
6. The original prescription for the service.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of the assessment report;
2. Copy of annual report prior to the annual support plan update;
3. Copy of original prescription for the service; and
4. Copy of service log, monthly.

*Indicates reimbursement documentation.

Place of Service

These services may be provided in the therapist's office, in the recipient's residence, or anywhere in the community.

Personal Care Assistance

Description

Personal care assistance is a service that assists a recipient with eating and meal preparation, bathing, dressing, personal hygiene, and other self care activities of daily living. The service also includes activities such as assistance with meal preparation, bed making and vacuuming when these activities are essential to the health, safety and welfare of the recipient and when no one else is available to perform them. This service is provided on a one-on-one basis. Personal care assistance may not be used solely for supervision. Personal care assistance may not be used as a substitute for a meaningful day activity.

This service is not available to individuals enrolled on the DD Waiver – Tier Four.

Limitations

Personal care assistance is limited to the amount, duration and scope of the services described in the recipient's support plan and current approved cost plan. A recipient shall receive no more than 180 hours a month, or 720 quarter hour units of this service per month. A recipient having intensive physical, medical, or adaptive needs meeting the requirements for the intense level of personal care assistance, who needs additional hours over 180 to maintain their health and medical status, may request additional hours of personal care assistance services. The requested additional units must be prior authorized by APD.

Personal care assistance services shall be billed at the standard rate level for the service based on the published rate system. The standard rate is paid when a recipient requires minimal support through instructional prompts, cues, and supervision to properly complete the basic personal support areas of eating, bathing, toileting, grooming, and personal hygiene. Standard and moderate level needs for the service cannot exceed 180 hours or 720 quarter hour units of the service per month. A rate other than the standard rate level for this service shall only be authorized when it has been determined through use of the APD-approved assessment and the support planning process that a recipient requires an enhanced level of supports.

The need for an enhanced rate and the approved rate level shall be identified in the recipient's support and cost plan and on the authorization for service submitted to the provider by the recipient's support coordinator. Recipients with the following needs may require enhanced services:

- Recipients who have a moderate level of support identified in the current abilities section of the APD-approved assessment may receive the rate level identified as moderate for the service. The moderate rate is paid when a recipient routinely requires prompts, supervision and physical assistance, to include lifting and transferring, to complete the basic personal care areas of eating, bathing, toileting, grooming, and personal hygiene. Moderate needs for the service cannot exceed 180 hours or 720 quarter hour units of the service per month.
- Recipients who have an intense level of support identified in the current abilities section of the APD-approved assessment may receive the rate level identified as intense for the service. The intensive rate is paid when a recipient requires total physical assistance, to include lifting and transferring, in at least three of the basic personal care areas identified above due to physical, medical or adaptive limitations. Additional hours a month over the 180 hour limit may be requested for intensive physical, medical or adaptive needs when the hours are essential to maintain the recipient's health and medical status. Any recipient who re-

quires PCA services between 10:00 p.m. and 6:00 a.m. shall provide documentation from a physician stating that PCA services are medically necessary during this time. The support plan shall also explain the duties that a PCA provider will perform between the hours of 10:00 p.m. and 6:00 a.m.

This service cannot be provided concurrently (at the same time) with companion services or ADT services. Recipients who receive in-home support services are not eligible to receive personal care assistance.

Note: Refer to the Florida Medicaid Home Health Services Coverage and Limitations Handbook for additional information on Medicaid State Plan coverage. The handbook is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Provider Handbooks. The handbook is incorporated by reference in 59G-4.130, F.A.C.

Documentation Requirements

Reimbursement* and monitoring documentation to be maintained by the provider:

1. *Copy of claim(s) submitted for payment; and
2. *Copy of service log.

The provider must submit a copy of service log, monthly, to the waiver support coordinator.

If the provider plans to transport the recipient in his private vehicle, at the time of enrollment, the provider must be able to show proof of valid: 1) driver's license, 2) car registration, and 3) insurance. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date.

*Indicates reimbursement documentation.

Place of Service

Personal care assistance shall be provided in the recipient's own home or family home or while the recipient who lives in one of those arrangements is engaged in a community activity. No service may be provided or received in the provider's home, a hospital, an ICF/DD or other institutional environment.

Special Considerations

Personal care assistance for persons under the age of 21 may be provided through Medicaid Home Health State Plan Program services. Recipients who live in their own home

or adults that live in a family home may require personal care assistance to assist them with meeting their own personal care needs.

For recipients living in their own home, consider the physical limitations or abilities to meet daily personal care assistance needs.

Recipients living in foster or group homes are not eligible to receive this service, except:

- During an overnight visit with family or friends away from the foster or group home to facilitate the visit; or
- When a group home resident recovering from surgery does not require the care of a nurse, and the group home operator is unable to provide the personal attention required to insure the recipient's personal care needs are being met. Under these circumstances, it would be considered reasonable to provide this service to a group home resident only on a time-limited basis. Once the recipient has recovered, the service must be discontinued.

A relative is defined as someone other than a legally responsible family member, who is required to provide care for the recipient such as a parent of a minor child or a family member who is also a plenary guardian of an adult. With regard to relatives providing this service, controls must be in place to make sure that the payment is made to the relative as a provider only in return for specific services rendered; and there is adequate justification as to why the relative is the provider of care. An example of a viable reason may be lack of providers in a rural area.

Personal care assistance is monitored through the statewide quality assurance program for waiver services and the recipient's or family's contact with the waiver support coordinator. The recipient or family member should contact the waiver support coordinator when concerns arise or if needs change. The waiver support coordinator must request changes to the care plan to increase or decrease services based on a significant change in the recipient's condition or circumstance and must submit the changes to the APD Area Office for approval.

Reimbursement for nursing oversight of services provided by home health agencies and nurse registries is not a separate reimbursable service. The cost must be included in the personal care service.

Personal care assistance providers are not reimbursed separately for transportation and travel cost. These costs are included in the rate.

Personal Emergency Response Systems

Description

A personal emergency response system is an electronic communication system that enables a recipient to secure help in the event of an emergency. The recipient may also wear a portable "help" button that allows for mobility while at home or in the community. The system is connected to the person's phone and programmed to signal a response center. When the "help" button is activated, qualified personnel are dispatched to the recipient's location.

Limitations

A personal emergency response system is limited to those recipients who live alone or who are alone for significant parts of the day have no regular caregiver for extended periods of time, and otherwise require extensive routine supervision. Recipients living in licensed residential facilities are not eligible to receive this service. A cell phone does not meet the definition of a personal emergency response system. This service does not include the cost for the telephone or telephone line.

Documentation Requirements

Reimbursement* documentation to be maintained by the provider:

1. *Copy of claim(s) submitted for payment; and
2. *Service log, detailing services provided.

For monitoring review purposes, the equipment installation provider and the emergency monitoring provider must have a copy of the invoices for the period being reviewed. The equipment itself is generally free of charge. The cost of this service involves installation, testing and monitoring.

The provider must submit a copy of service log, monthly, including the waiver support coordinator's verification of the receipt of equipment prior to submission of claim for payment to the waiver support coordinator.

*Indicates reimbursement documentation.

Place of Service

A personal emergency response system shall be provided in the recipients own home or apartment or the family's home or apartment. A mobile "help button" is also available for the recipient to wear while engaged in a community activity.

Special Considerations

A personal emergency response system is available only for at-risk recipient's who require a limited degree of supervision, but live alone or are alone for periods of time without a caregiver.

Physical Therapy

Description

Physical therapy is a service prescribed by a physician that is necessary to produce specific functional outcomes in ambulation, muscle control, and postural development and to prevent or reduce further physical disability.

The service may also include a physical therapy assessment, which does not require a physician's prescription. In addition, this service may include training and monitoring direct care staff and caregivers to ensure they are carrying out therapy goals correctly.

This service is not available to individuals enrolled on the DD Waiver – Tier Four.

Limitations

Physical therapy and assessment services are available through the Medicaid Therapy Services Program state plan services to recipients under the age of 21. Services for these recipients may not be purchased under the waiver.

Children who receive this service through a school health program are still eligible for medically-necessary services funded by the Medicaid Therapy Services Program state plan coverage. When additional therapy is necessary, families must seek Medicaid Therapy Program state plan services. Refer to the Florida Medicaid Therapy Services Coverage and Limitations Handbook for additional information on Medicaid state plan coverage.

Adults may receive up to \$1,500 annually in outpatient services under the Medicaid Hospital Program state plan services, including physical therapy. If the recipient is able to use a hospital outpatient facility for physical therapy and the setting is appropriate to meet the recipient's needs, it may be possible to receive limited services funded by the Medicaid Hospital Program state plan services.

The waiver should only be used to fund physical therapy services for adults either when the outpatient dollar limits are reached or when physical therapy must be provided in a location other than a hospital outpatient facility.

A recipient shall receive no more than eight units of therapy service per day. A unit is defined as a 15-minute time period or portion thereof. The physical therapy assessment is limited to one per year.

Note: The Florida Medicaid Therapy Services Coverage and Limitations Handbook and the Florida Medicaid Hospital Services Handbook are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Provider Handbooks. The therapy handbook is incorporated by reference in 59G-4.320, F.A.C. and the hospital handbook in 59G-4.160, F.A.C.

Documentation Requirements

Reimbursement* and monitoring documentation to be maintained by the provider:

1. *Copy of claim(s) submitted for payment;
2. *Copy of service log;
3. *Monthly summary note;
4. *Assessment report (if requesting reimbursement for assessment).
5. Annual report; and
6. Original prescription for the service.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of service log, monthly;
2. Copy of assessment report;
3. Copy of annual report prior to the annual support plan update; and
4. Copy of original prescription for the service.

*Indicates reimbursement documentation.

Place of Service

This service may be provided in the therapist's office, recipient's residence, or anywhere in the community.

Private Duty Nursing

Description

Private duty nursing services are prescribed by a physician and consist of individual, continuous nursing care provided by registered or licensed practical nurses. Nurses must provide private duty nursing services, in accordance with Chapter 464, F.S.

This service is not available to individuals enrolled on the DD Waiver – Tier Four.

Limitations

Private duty nursing services are available through the Medicaid Home Health Program state plan services to children under the age of 21 with complex medical needs. Licensed nursing is available to children and adults when determined medically necessary by the Medicaid Home Health State Plan Program and related to the care of a medical condition.

To be eligible for this service, a recipient must require active nursing interventions on an ongoing basis. This service is provided on a one-to-one basis to eligible recipients. If the service is provided with two or more recipients present, the amount of time billed must be prorated between the numbers of recipients receiving the service. This service may be provided concurrently (at the same date and time) with another service. A nursing assessment may be performed to determine the need for the service or to evaluate the recipient for care plan development. Reimbursement for a nursing assessment is considered two hours of service at the registered nurse rate. Only registered nurses may perform an assessment. Nursing assessments should be updated annually or if there is a significant change in the recipient's health status.

The DD waiver may pay only for those medically-necessary services not covered by the Medicaid State Plan Home Health Program. A recipient shall receive no more than 96 units of this service per day. A unit is defined as a 15-minute time period or portion thereof.

Note: Refer to the Florida Medicaid Home Health Services Coverage and Limitations Handbook for additional information on Medicaid state plan coverage. The handbook is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Provider Handbooks. It is incorporated by reference in 59G-4.130, F.A.C.

Documentation Requirements

Reimbursement* and monitoring documentation to be maintained by the provider:

1. *Copy of claim(s) submitted for payment;
2. *Copy of nursing care plan;
3. *Copy of service log;
4. *Individual nursing assessment (must be completed at the time of the first claim submission and annually thereafter);
5. Daily progress notes;
6. Original prescription for the service; and
7. List of duties to be performed by the nurse.

Nurses delivering this service as independent providers must provide proof of meeting the educational requirements specified in Chapter 464.008(1), F.S., for licensure as a registered professional nurse or a licensed practical nurse, whichever is applicable. Nurses will also demonstrate either verbally or in writing their knowledge, skills and ability to provide the specific care required by the recipient, as well as a plan for the care that they provide. This documentation must be provided to the waiver support coordinator before rendering services.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of service log, monthly;
2. Copy of nursing care plan at time of first claim submission and annually thereafter;
3. Individual nursing assessment, at time of first claim submission and annually thereafter; and
4. Copy of original prescription for the service.

*Indicates reimbursement documentation.

Place of Service

Private duty nursing services shall be provided in the recipient's own home or family home.

Special Considerations

Private duty nursing services shall not be used for ongoing medical services and oversight in a licensed residential facility.

Residential Habilitation Services

Description

Residential habilitation provides supervision and specific training activities that assist the recipient to acquire, maintain or improve skills related to activities of daily living. The service focuses on personal hygiene skills such as bathing and oral hygiene; home-making skills such as food preparation, vacuuming and laundry; and on social and adaptive skills that enable the recipient to reside in the community. This training is provided in accordance with a formal implementation plan, developed with direction from the recipient, and reflects the recipient's goal(s) from their current support plan.

Recipients with challenging behavioral disorders may require more intense levels of residential habilitation services described as behavior focus residential habilitation or intensive behavioral residential habilitation. The necessity for these services is determined by specific recipient behavioral characteristics that impact the immediate safety, health, progress and quality of life for the recipient, and the determination that less intensive services have not been sufficient to alter these behaviors. The need for more intense levels of residential habilitation, behavior focus residential or intensive behavioral residential habilitation must be verified by APD.

This service is not available to individuals enrolled on the DD Waiver – Tier Four.

Note: Refer to special considerations under behavioral analysis and behavioral assistant services for additional requirements.

Limitations

Residential habilitation services (quarter hour) are provided to children living in their family home or adults 18 years of age or older living in their own home. Residential habilitation services (daily, monthly, or live-in) are provided to children and adults living in a licensed facility.

A child or an adult may receive residential habilitation services as follows:

1. Residential habilitation services (quarter hour) may be provided in the family home for children ages 16-18 with a focus on developing independent living skills.
2. Residential habilitation services (daily, monthly, or live-in) may be provided for children or adults with an emphasis on acquisition, generalization and skill maintenance. Children or adults with severe behavioral issues may also receive services in a licensed facility.

3. Children living in their family home, or adults living in their own home, whose primary problem is behavioral in nature should receive services through behavior assistant services. When behavior assistant services are not available, residential habilitation services (quarter hour) may be provided to children or adults with severe behavioral issues under the supervision of a certified behavior analyst. Residential habilitation quarter hour services cannot be approved with behavior assistant services. The child or adult must have a written behavior analysis services plan that is written and monitored by a certified behavior analyst. The focus of the service for children is to assist the parents in training and implementing the behavior analysis services plan. The focus of the service for adults is to assist the recipient to develop new skills and to reduce socially inappropriate behaviors.

Recipients may not receive residential habilitation services and supported living coaching services at the same time, except when the recipient lives in a licensed residential facility and has a personal goal or outcome for supported living on their support plan. In this case, the recipient may receive both services for a maximum of ninety days prior to their move to the supported living setting.

Recipients may not receive any combination of residential habilitation services and in-home support services.

A recipient who receives residential habilitation services that are billed by the quarter hour is limited to no more than four hours, or 16-quarter hour units, of the service in a calendar day.

When this service is provided in a recipient's own home or family home, the service must be directly related to a training goal(s) on the recipient's support plan and cannot be used for the supervision of the recipient. If a recipient is receiving residential habilitation services and has a goal on the support plan to move to their own home, supported living coaching services may also be provided for up to 90 days prior to moving to his own home.

The APD Area Office may approve the use of residential habilitation, live-in services at the appropriate live-in rate for the service for recipients who are in need of support and who reside in a licensed foster or group home, limited to no more than three recipients living in the home. Residential habilitation live-in services may be billed up to 365 days a year when the recipient is present. A provider or employees of a provider do not have to "live-in" the licensed home for the live-in rate to be applied for the service. The live-in daily rate provides from 8 to 24 hours of supports.

Documentation Requirements

Reimbursement* and monitoring documentation to be maintained by the provider:

1. *Copy of claim(s) submitted for payment;
2. *Daily attendance log;
3. *Copy of the individual implementation plan to be developed, at a minimum, within 30 days of the initiation of a new service or within 30 days of the support plan effective date for continuation of services and annually thereafter;
4. *Quarterly summary: the third quarterly summary shall include a summary of the first three quarters of the support plan year and will be considered the annual report;
5. LRC review an approval dates and recommendations made specific to the plan and review schedules for the plan as indicated in rules 65G-4.009 and 65G-4.010, F.A.C. for individuals residing in licensed behavior focus or intensive behavior homes; and
6. Staffing documentation such as direct care staffing schedules, payroll records indicating identified direct care support staff and hours worked, and any other supplemental support staffing schedules which document staffing ratios and direct contact hours worked.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of daily attendance log, monthly;
2. Copy of individual implementation plan;
3. Quarterly summary: the third quarterly summary shall include a summary of the first three quarters of the support plan year and will be the considered the annual report;
4. LRC review dates and recommendations made specific to the plan and review schedules for the plan as indicated in rules 65G-4.009 and 65G-4.010, F.A.C., for individuals residing in licensed behavior focus and intensive behavior homes; and
5. If the provider plans to transport recipients in his private vehicle, at the time of enrollment, the provider must be able to show proof of valid: 1) driver's license; 2) car registration, and 3) insurance. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date.

*Indicates reimbursement documentation.

Place of Service

This service shall be provided primarily at the recipient's place of residence, which must be the recipient's own home, family home, a licensed foster home or a licensed residential facility. However, some activities associated with daily living that generally take place in the community, such as grocery shopping, banking or working on social and adaptive skills are included in the scope of this service.

Special Considerations

Residential habilitation providers are paid separately for transportation services if they are currently enrolled as a DD waiver transportation provider, only when transportation is provided between a recipient's place of residence and another waiver service training site. Incidental transportation or transportation provided as a component of residential habilitation services is included in the rate paid to the provider.

Residential habilitation training services shall not take the place of a job or another meaningful day service, but must be scheduled around such events. For example, if a recipient works a Monday through Friday, 9 a.m. - 4 p.m. schedule, residential habilitation training services must be scheduled in the evening hours and on weekends.

Employees of licensed residential facilities that provide residential habilitation are usually direct care staff; however, in certain situations it may be appropriate to include other staff as residential habilitation direct care providers.

Providers of residential habilitation services provided in a recipient's own home or family home must bill for services by the quarter-hour based on the rate for the service listed on the Provider Rate Table. Up to three recipients may receive this service during the same time period, if approved by the APD Area Office. If more than one recipient receives the service during the same time period, the service will be billed at the stepped rate ratio for the service.

When residential habilitation is provided in a recipient's own home, the provider shall not be the recipient's landlord or have any interest in the ownership of the housing unit, as provided in rule 65G-5.004, F.A.C. If renting, the name of the recipient receiving residential habilitation services must appear on the lease either singularly, with a roommate or a guarantor. Provider is defined as an independent provider or a corporation including all board members and any paid employees and staff of the provider agency, its subsidiaries or subcontractors.

Providers of residential habilitation and behavior focus residential habilitation in a licensed facility shall bill for services only when the recipient is present, up to 350 days a

year, using the monthly or daily rate authorized based on the published rate for the service.

Minimum Staffing Requirements for Standard and Behavior Focus Residential Habilitation Services Provided in a Licensed Facility

Providers of standard and behavior focus residential habilitation services shall provide a minimum level of staffing consistent with the minimum Direct Care Staff Hours per Person per 24 Hour Day identified in the table below. Staffing ratios shall be established by the provider using the available total minimum Direct Care Staff Hours per Person per 24 Hour Day consistent with the support and training needs of recipients receiving residential habilitation services for functional, behavioral or physical needs. The provider will meet the minimum staffing levels on a per day basis for each home, or shall provide the required staffing over a seven day period for each home to accommodate for absences from the home and to establish optimal coverage on weekends. Providers of residential habilitation services and their employees shall provide sufficient staffing and staff ratios while delivering these services to meet individual needs and provide appropriate levels of training and supervision for recipients of the service.

Direct Care Staff Hours per Person per 24 Hour Day:

<u>Level of Disability</u>	<u>Level of Staffing</u>	
	<u>Hours per Day</u>	<u>Hours per Week</u>
Basic Level	2	14
Minimal Level	4	28
Moderate Level	6	42
Extensive 1 Level	8	56
Extensive 2 Level	11	77

Hours counted must be provided by direct care staff or by other staff, who are providing direct care or direct time spent on client training, intervention or supervision. Provider compliance with direct care staffing levels for residential habilitation services substantiates Medicaid billing requirements only; other provisions of this Handbook remain fully applicable to all providers.

Calculating Available Minimum Direct Care Staff Hours per Person per 24 Hour Day for the provision of Standard and Behavior Focus Residential Habilitation Services:

To determine minimum required staffing for each level of support for residential habilitation services, the minimum direct care staff hours per person per 24 hour day authorized for recipients receiving residential habilitation services are multiplied by the number of recipients receiving the service at that level in the home setting. All available staff hours per level are totaled to obtain a daily minimum total number of staff hours. The resulting total is then divided by 8 hours of staff work time to produce an FTE level per day. The number of all available staff hours is multiplied by seven to establish a

weekly minimum total. For example: The calculation below is for six recipients receiving the service and living in the same home, all authorized at the Moderate Level of Supports. The minimum number of direct care staff hours per person per 24 hour day for the moderate level is 6 hours. The calculation is as follows:

6 recipients X 6 direct care staff hours per person per 24 hour day = 36 available direct care staff hours per day, or 252 available direct care staff hours per week. 36 direct care staff hours per day divided by an 8 hour staff working day = 4.5 Full Time Equivalents (FTEs) per day for minimum residential habilitation direct care staffing purposes.

Minimum Staffing Requirements for Standard and Behavior Focus Residential Habilitation Services Provided in a Licensed Facility, continued Minimum staffing requirements for Intensive Behavioral Residential Habilitation services shall be determined at the time the rate for the service is established. Minimum staffing for Live-In Residential Habilitation services is determined by the rate ratio authorized for the home.

Example of the application of 4.5 staff FTEs at the Moderate Level as calculated above:

The 4.5 FTEs generated using the calculation above may be used to establish a staffing pattern for standard or behavior focus residential habilitation providers and their employees of 1.5 staff per 8 hour shift over a 24 hour period. If recipients are engaged in the receipt of other services during a period of time during the day, the residential habilitation provider may modify the staffing pattern to maximize staff during the time that recipients are in the home and receiving the service, and to optimize coverage on the weekends and holidays.

Residential Habilitation with a Behavioral Focus

Service characteristics for residential habilitation with a behavioral focus include:

- A Board Certified Behavior Analyst or Associate Analyst; or Florida Certified Behavior Analyst with a bachelor's degree; or a person licensed under Chapter 490 or 491, F.S. provides on-site oversight for residential services.
- Integration of behavioral services throughout residential and community programs,
- No fewer than 75 percent of the provider's direct service staff who work with the recipient(s) for whom the residential habilitation with a behavioral focus rate applies have completed at least 20 contact hours of face-to-face competency-based instruction with performance-based validation in the following content areas;
 - Introduction to applied behavior analysis – basic principles and functions of behavior.
 - Providing positive consequences, planned ignoring, and stop-redirect-reinforce techniques.
 - Data collection and charting.

- The service provides for comprehensive monitoring of staff skills and their implementation of required procedures. Monitoring for competence must occur at least once per month for 50 percent of direct service staff that have completed the training described above. Staff must be recertified in the training requirements yearly. The provider has a system that demonstrates and measures continuing staff competencies on the use of procedures that are included in each recipient's behavior analysis services plan.

Provides for the eventual transitioning of behavioral improvement of the recipient, to a less intense service alternative, through formalized procedures incorporated into implementation plans.

In order for the provider to receive a residential habilitation with a behavioral focus rate for a recipient based on the Provider Rate Table, the provider must meet the specified staff qualifications for the service, and the recipient must exhibit the characteristics listed below. This rate level shall be approved only when it has been determined through use of the APD-approved assessment by a certified behavior analyst and the support planning process that a recipient requires residential habilitation services with a behavioral focus. The need for residential habilitation with a behavioral focus and the rate for the service shall be identified on the recipient's support and cost plan and on the authorization for service submitted to the provider by the recipient's support coordinator. Service authorization shall be based on established need and re-evaluated at least annually while the recipient is receiving the services. The provider must document evidence of continued need as well as evidence that the services are assisting the service provider in meeting the needs of the recipient so that transition to less restrictive services may be possible.

Recipients exhibiting one of the following characteristics may need residential habilitation with a behavioral focus services. Recipients receiving the service have behavioral challenges that fit one or both of the following two categories of behavioral problems:

1. The person does not engage in an adaptive behavior that if not performed by the person or taught by a caregiver would result in a real and present threat of substantial harm to the person's health or safety. This includes not engaging in adaptive behaviors such as following safety rules, responding in acceptable ways to conflict, performing daily living activities safely and maintaining basic health.
2. The person has exhibited a problem with behavior during the past year or currently exhibits a problem with behavior that meets one of the criteria below:
 - Requires visual supervision during all waking hours and intervention as determined by a certified behavior analyst or licensed behavior analysis professional.

- Is being addressed through the use of behavior analysis services and reviewed by the Local Review Committee (LRC).
- Has lead to the use of restraint or emergency medications within the past year.
- Has resulted in one or more of the following:
 1. Self-inflicted, detectable, external or internal damage requiring medical attention or the behavior is expected to increase in frequency, duration, or intensity resulting in self-inflicted, external or internal damage requiring medical attention. These types of behaviors include head banging, hand biting, and regurgitation.
 2. External or internal damage to other persons that requires medical attention or the behavior is expected to increase in frequency, duration or intensity resulting in external or internal damage to other persons that requires medical attention. These types of behavior include hitting others, biting others and throwing dangerous objects at others.
 3. Arrest and confinement by law enforcement personnel.
 4. Major property damage or destruction in excess of \$500 for any one intentional incident.
 5. A life-threatening situation. Examples of these types of behaviors are excessive eating or drinking, vomiting, ruminating, eating non-nutritive substances, refusing to eat, swallowing excessive amounts of air, or severe insomnia.

Intensive Behavioral Residential Habilitation

Intensive behavioral residential habilitation rates for a recipient must be approved and authorized through the prior service authorization process performed by the APD or an agent of the APD. Authorization shall require review by at least one board certified behavior analyst or a Florida certified behavior analyst with expanded privileges who holds a master's degree with a primary emphasis in applied behavior analysis. The review process shall include evaluation of the proposed rates for the service being sought. Authorized rates for this service may vary across providers and recipients based on the specific service needs of the recipient. Service authorization shall occur prior to service delivery, for new services, within 30-days of the adoption of this rule for existing services and at least annually while the recipient is receiving the service. The provider must meet provider qualifications for this level of service. Further, the following recipient characteristics and service characteristics must be met in order to receive an intense behavioral residential habilitation rate. Service authorization shall be based on established need and re-evaluated at least annually while the recipient is receiving the services. The provider must document evidence of continued need as well as evidence that the service is assisting in meeting the needs so that transition to less restrictive services may be possible.

Intensive Behavioral Residential Habilitation Recipient Characteristics

Intensive behavioral residential habilitation is for recipients who present problems with behavior that are exceptional in intensity, duration, or frequency and that meet one or more of the following conditions.

Within the past 6-months the recipient:

1. Engaged in behavior that caused injury requiring emergency room or other inpatient care from a physician or other health care professional to self or others.
2. Engaged in a behavior that creates a life-threatening situation. Examples of these types of behavior are excessive eating or drinking, vomiting, ruminating, eating non-nutritive substances, refusing to eat, swallowing excessive amounts of air, and severe insomnia.
3. Set a fire in or about a residence or other facility in an unauthorized receptacle or other inappropriate location.
4. Attempted suicide.
5. Intentionally caused damage to property in excess of \$1,000 in value for one incident.
6. Engaged in behavior that was unable to be controlled via less restrictive means and necessitated the use of restraints, mechanically, manually or by commitment to a crisis stabilization unit, three or more times in a month or six times across the applicable six-month period.
7. Engaged in behavior that resulted in arrest and confinement.
8. Requires visual supervision during all waking hours and intervention as determined by a certified behavior analyst or licensed behavior analysis professional to prevent behaviors previously described above that were likely, given past behavior in similar situations, without such supervision.
9. Engaged in sexual behavior with any person who did not consent or is considered unable to consent to such behavior, or engaged in public displays of sexual behavior (e.g. masturbation, exposure, peeping Tom, etc.).
10. If the supervision and environment is such that the person lacks opportunity for engaging in the serious behaviors the behavior analyst providing oversight must determine that the behavior would be likely to occur at least every six months if the person is without the supervision or environment provided and document in the recipient's records.

Intensive Behavioral Residential Habilitation Service Characteristics

Intensive behavioral residential habilitation shall provide aggressive, consistent implementation of a program of specialized and generic training, treatment, health services

and related services that is directed toward: (1) the acquisition of the behaviors necessary for the recipient to function with as much self determination and independence as possible; and (2) the reduction or replacement of high risk, problems with behavior. Treatment may also include intensive medical oversight when warranted by the recipient's specific concerns.

Individual goals must relate to the assessment, management, and replacement of problems with behavior. Goals also include, especially as treatment progresses and is effective, generalization and maintenance of new behavior and behavior reductions in settings that are increasingly similar to less intensive treatment settings, but within which continued treatment and maintenance services are included.

The problems with behavior and any related medical conditions are the central focus of treatment for these individuals. This means that all behavior change targets included in the treatment plan are linked to the initial problem statement. For example, if a problem with behavior were described as self-injury that occurs when the person is in the presence of aversive stimuli of a specific nature, then the targets for change would include alternatives to self-injury that would be controlled by the same stimuli. In addition, the recipient's assessment might identify socially-skilled behavior deficits that make more likely the self-injury. These deficits might include communication and social skills necessary to independently function in other settings or basic self care skills.

Recipients in intensive residential habilitation programs are not able to function independently without continuous training, supervision, and support by the staff. Only near the end of treatment will a noticeable reduction in intensity occur. However, even at this stage, because the goal is to ensure that gains made are maintained in settings other than the treatment setting, services remain comprehensive and continuous.

Intensive Behavioral Residential Habilitation Special Considerations

Treatment must also include the arrangement of contingencies designed to improve or maintain performance of activities of daily living. This would occur when a recipient, for example, does not bathe regularly and this is resulting in the person being socially isolated. The objective in this case would typically be to establish acceptable bathing routines in the absence of highly engineered contingencies. In these cases, incidental training is provided. For example, a person is provided instruction while getting dressed in order to assist the person in learning to select appropriate clothing for a specific job site. In this way, training on basic skills is provided as one component of active treatment.

Individual service plans for recipients receiving intensive behavioral residential habilitation will include a written plan to decrease services through improved behavior and when applicable, medical condition. Environmental changes or adjustments that are

made as the person's behavior and medical condition improves are tracked, measured and graphed.

The transition criteria for intensive residential habilitation define the conditions under which the treatment team must recommend a less structured, more open environment, including levels of involvement from direct care staff, staff supervisors and professional care providers. The goal of an intensive residential habilitation service is to prepare the person for full or partial reintegration into the community, with established behavioral repertoires, such as developing a healthy lifestyle, filled with engaging and productive activities.

Evaluation criteria for the recipient include:

1. Living in a communal setting without harmful or dangerous behavior or significant conflict.
2. Interacting safely in a wide range of social settings.
3. Exhibiting stable work behavior.
4. Participating appropriately in a high level of social activities.
5. Identifying the set of services and supports, including minimal supervision, necessary to maintain performance and health.

Conditions for transition include:

1. The behavioral excesses that made treatment necessary no longer occur in the presence of the environmental conditions that previously evoked those behaviors.
2. The behaviors do not occur as a function of new environmental conditions.
3. The behaviors intended to replace the problem behavior now reliably occur in the presence of the environmental conditions that previously evoked those behaviors that previously controlled the behavioral excesses.
4. Caregivers reliably carry out the medical and behavioral strategies necessary to maintain or continue improvements in health and behavior without direct supervision from a nurse, behavior analyst or other professional care provider. The direct care providers and recipient no longer require the levels of oversight established within the exceptional services program for professional care providers including physicians, nurses, and behavior analysts.
5. Direct care providers no longer require the levels established within the exceptional services program for direct supervision. Supervision is the same as that which is typically provided in the residential setting to which the person is most likely to move.

6. The provider has determined the recommended transition levels of staff across all categories and the physical environment requirements needed for the recipient to maintain or to continue improvements.

When the conditions identified above are met, the recipient would no longer require intensive residential habilitation treatment. However, treatment would continue with the focus shifting to ensuring that the gains made maintain or continue to improve in settings that have more variability in the prevailing contingencies and afford greater access to unplanned, everyday encounters with untrained people.

Residential Nursing Services

Description

Residential nursing services are services prescribed by a physician and consist of continuous nursing care provided by registered or licensed practical nurses, in accordance with Chapter 464, F.S., and within the scope of Florida's Nurse Practice Act, for recipients who require ongoing nursing intervention in a licensed residential facility, group or foster home.

A nursing assessment may be performed to determine the need for the service or to evaluate the recipient for care plan development. Reimbursement for a nursing assessment is considered two hours of service at the registered nurse rate. Only registered nurses may perform an assessment. Nursing assessments should be updated annually or if there is a significant change in the recipient's health status.

This service is not available to individuals enrolled on the DD Waiver – Tier Four.

Limitations

This service supplements nursing services available through the Medicaid State Plan Home Health Program. Private duty nursing services are available to children under the age of 21 with complex medical needs. Licensed nursing is available to children and adults when determined medically necessary by the Medicaid State Plan Program and related to the care of a medical condition. Nursing services not available to recipients under the Medicaid State Plan Home Health Program may be paid for by the DD waiver, if determined medically necessary by the APD.

A recipient may receive up to 96 units (24 hours) of nursing services a day. A unit is defined as a 15-minute time period or a portion thereof. This service may be provided concurrently (at the same date and time) with another service being furnished by another provider.

Note: Refer to the Florida Medicaid Home Health Services Coverage and Limitations Handbook for additional information on Medicaid state plan coverage. The handbook is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Provider Handbooks. It is incorporated by reference in 59G-4.130, F.A.C.

Documentation Requirements

Reimbursement* and monitoring documentation to be maintained by the provider:

1. *Copy of claim(s) submitted for payment;
2. *Service log;
3. *Monthly summary (must include details, such as health risk indicators, information about medication, treatments, medical appointments, and other relevant information);
4. *Nursing assessment, must be completed at the time of initial claim submission and annually thereafter or as needed, should the recipient's condition change;
5. *Nursing care plan;
6. *Prescription for the service; and
7. List of duties to be performed by the nurse.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of nursing assessment at time of initial claim submission and annually thereafter;
2. Copy of monthly summary at time of claim submission;
3. Copy of service log, monthly; and
4. Nursing care plan.

*Indicates reimbursement documentation.

Place of Service

Residential nursing services must be provided at a licensed group or foster home considered to be the recipient's place of residence.

Respiratory Therapy

Description

Respiratory therapy is a service prescribed by a physician and relates to impairment of respiratory function and other deficiencies of the cardiopulmonary system. Treatment

activities include ventilator support, therapeutic and diagnostic use of medical gases, respiratory rehabilitation, management of life support systems, bronchopulmonary drainage, breathing exercises and chest physiotherapy. The provider determines and monitors the appropriate respiratory regimen and maintains sufficient supplies to implement the regimen. The provider may also provide training to direct care staff to ensure adequate and consistent care is provided. Respiratory therapy services may also include a respiratory assessment.

This service is not available to individuals enrolled on the DD Waiver – Tier Four.

Limitations

Respiratory therapy and assessment services are available through the Medicaid Therapy Services Program state plan services for recipients under the age of 21. Services for these recipients may not be purchased under the waiver. Children receiving this service through a school health program are still eligible for medically-necessary services funded by the Medicaid State Plan. When additional therapy is necessary, families must seek the Medicaid State Plan services for funding. The Medicaid Durable Medical Equipment (DME) and Medical Supplies Program state plan services covers respiratory equipment and supplies for adults and children. The waiver cannot reimburse for respiratory supplies and equipment. A recipient shall receive no more than eight units of this service per day. A unit is defined as a 15-minute time period or portion thereof. Two assessments per year are allowed.

Note: Refer to the Florida Medicaid Therapy Services Coverage and Limitations Handbook and the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook for additional information on Medicaid state plan coverage. The handbooks are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. The Florida Medicaid Therapy Services Coverage and Limitations Handbook is incorporated by reference in rule 59G-4.320, F.A.C.; and the Florida Medicaid Durable Medical Equipment and Medical Supply Services is incorporated by reference in rule 59G-4.070, F.A.C.

Documentation Requirements

Reimbursement* and monitoring documentation to be maintained by the provider:

1. *Copy of claim(s) submitted for payment;
2. *Service log;
3. *Monthly summary note;
4. Assessment report, if a claim is submitted for an assessment; and
5. Original prescription for service.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of service log prior to or at time of claim submission;
2. Copy of monthly summary note;
3. Copy of assessment prior to or at time of claim submission; and
4. Copy of original prescription for service.

*Indicates reimbursement documentation.

Place of Service

This service is usually provided in the recipient's place of residence.

Special Considerations

Respiratory therapy services shall be medically necessary and provided under a physician's prescription.

Respite Care

Description

Respite care is a service that provides supportive care and supervision to a recipient when the primary caregiver is unable to perform these duties due to a planned brief absence, an emergency absence or when the caregiver is available, but temporarily physically unable to care for or supervise the recipient for a brief period.

Limitations

Respite care service providers are not reimbursed separately for transportation and travel cost. These costs are integral components of respite care services and are included in the basic fee.

Respite care services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan. The amount of respite services are determined individually and limited to no more than thirty days per year, (720 hours) per recipient.

Documentation Requirements

Reimbursement* and monitoring documentation to be maintained by the provider:

1. *Copy of claim(s) submitted for payment; and
2. *Service log.

The provider must submit a copy of service log, monthly, to the waiver support coordinator.

If the provider plans to transport the recipient in his private vehicle, at the time of enrollment the provider must be able to show proof of: 1) a valid driver's license; 2) car registration, and 3) insurance. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date.

*Indicates reimbursement documentation.

Place of Service

This service may be provided in the recipient's own home, family home or foster home. The recipient may also go to a licensed group, foster home, or assisted living facility to receive the service. Overnight respite care can be provided only in the recipient's own home, family home, licensed foster home, group home or ALF. This service cannot be provided in the provider's home.

Special Considerations

Recipients living in licensed group homes are not eligible to receive respite care services.

Relatives who live outside the recipient's home and are enrolled as Medicaid waiver providers may provide respite care services and be reimbursed for the services. The relative must meet the same qualifications as other providers of the same service. With regard to relatives providing this service, safeguards must be taken to ensure that the payment is made to the relative as a provider, only in return for specific services rendered, and there is adequate justification as to why the relative is the provider of care. An example of a valid reason may be a general lack of enrolled providers due to the rural setting.

Most recipients who require respite care services do not need the services of a registered or licensed practical nurse. Nurses should only be employed to perform this service when the recipient has a complex medical condition. If a nurse provides this service, a prescription will be necessary.

Providers of respite services must use the published stepped quarter hour rate for the service or the daily rate if respite services are provided for ten or more hours a day. The provider must bill for only those hours of direct contact with the recipient(s). The respite rate shall be determined based on from one to three recipients in the home receiving the service. Respite services provided in a licensed residential facility will be billed at the ratio of 1:1 in the stepped rate for the service.

Skilled Nursing

Description

Skilled nursing is a service prescribed by a physician and consists of part-time or intermittent nursing care provided by registered or licensed practical nurses, in accordance with Chapter 464, F.S.

A nursing assessment may be performed to determine the need for the service, or to evaluate the recipient for care plan development. Reimbursement for a nursing assessment is considered two hours of service at the registered nurse rate. Only registered nurses may perform an assessment. Nursing assessments should be updated annually, or if there is a significant change in the recipient's health status.

This service is not available to individuals enrolled on the DD Waiver – Tier Four.

Limitations

This service supplements nursing services available through the Medicaid State Plan Home Health Program. Skilled nursing services are available under Medicaid State Plan to children under the age of 21 with complex medical needs. Licensed nursing is available to children and adults when determined medically-necessary by the Medicaid State Plan Program and related to the care of a medical condition.

Nursing services not available to recipients under the Medicaid State Plan may be paid for by the DD waiver, if the appropriate, qualified professional determines on behalf of the APD, that the standards for medical necessity are met. The DD waiver may pay only for those medically necessary services not covered by the Medicaid State Plan Home Health Program.

The recipient shall receive no more than 32 units of this service per day. A unit is defined as a 15-minute time period or portion thereof. This service may be provided concurrently (at the same time and date) with another service being furnished by another provider. Skilled nursing services do not include time spent completing the OASIS assessment.

Note: Refer to the Florida Medicaid Home Health Services Coverage and Limitations Handbook for additional information on Medicaid State Plan coverage. The handbooks are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. The handbook is incorporated by reference in rule 59G-4.130, F.A.C.

Documentation Requirements

Reimbursement* and monitoring documentation to be maintained by the provider:

1. *Copy of claim(s) submitted for payment;
2. *Nursing care plans and revisions;
3. *Service log;
4. *Nursing assessment (must be completed at time of first claim submission and annually thereafter);
5. Daily progress notes;
6. *Prescription for service; and
7. List of duties to be performed by the nurse.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of service logs, monthly;
2. Nursing care plan at time of initial claim submission and annually thereafter;
3. Nursing assessment, prior to or at time of claim submission; and
4. Copy of original prescription for service.

*Indicates reimbursement documentation.

Place of Service

Skilled nursing services shall be provided at the recipient's place of residence and other waiver service sites, such as an adult day training program.

Special Considerations

Skilled nursing services shall not be used for the ongoing medical oversight and monitoring of direct care staff or caregivers in a licensed residential facility or in the recipient's own or family home.

Special Medical Home Care

Description

Special medical home care services are for a period of up to 24-hours-a-day nursing services and medical supervision provided to residents of a licensed foster or group home that serves recipients with complex medical conditions. The group home must maintain sufficient staffing in the home as authorized to meet the needs of recipients requiring this level of nursing care.

This service is not available to individuals enrolled on the DD Waiver – Tier Four.

Limitations

Only those recipients with complex medical conditions, requiring an intense level of nursing care, and who reside in licensed foster or group homes are eligible for this service. The APD may establish a level of nursing staff based on individual recipient support needs at the time of the prior service authorization review required to authorize the service and rate.

Documentation Requirements

Reimbursement* and monitoring documentation to be maintained by the provider:

1. *Copy of claim(s) submitted for payment;
2. *Nursing care plans and revisions;
3. *Service log;
4. *Nursing assessment (must be completed at the time of the first claim submission and annually thereafter);
5. Daily progress notes on days service was rendered, for the period being reviewed: these notes should be directly related to the recipient's plan of care and treatment;
6. *Prescription for service; and
7. List of duties to be performed by the nurse.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of service logs, monthly;
2. Nursing care plan at time of initial claim submission and annually thereafter;
3. Nursing assessment, prior to or at time of claim submission; and
4. Copy of original prescription for service.

*Indicates reimbursement documentation.

Place of Service

Special medical home care services shall be provided at the recipient's licensed group home.

Special Considerations

Special medical home care services and the rate for the service require approval through a prior authorization by the APD or a representative of the APD.

Most licensed group homes do not provide this level of nursing care, nor do most recipients require such close medical supervision. APD shall determine when a group home

qualifies to be a provider of this service and which recipients require this level of nursing support.

When special medical home care is provided, the provider may not receive reimbursement for residential habilitation or residential nursing services.

Special medical home care services can only be billed for days the recipient was present and received services up to 365 days a year. The provider may not bill for days the recipient is hospitalized or is participating in a home visit.

Specialized Mental Health Services

Description

Specialized mental health services for persons with developmental disabilities are services provided to maximize the reduction of a recipient's mental illness and restoration to the best possible functional level. Specialized mental health services focus on the unique treatment of psychiatric disorders and rehabilitation for impairments for persons with developmental disabilities and mental illness. These services include specialized individual, group and family therapy provided to recipients using techniques appropriate to this population.

Specialized mental health services include information gathering and assessment, diagnosis, development of a plan of care (treatment plan) in coordination with the recipient's support plan, mental health interventions designed to help the recipient meet the goals identified on the support plan, medication management and discharge planning. This specialized treatment will integrate the mental health interventions with the overall service and supports to enhance emotional and behavioral functions.

This service is not available to individuals enrolled on the DD Waiver – Tier Four.

Limitations

This service supplements mental health services available under the Medicaid Community Behavioral Health Program state plan services. Mental health services are available to recipients with diagnosed mental illnesses who can benefit from and participate in therapeutic services provided under the Medicaid Community Behavioral Health Program. Refer to the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook for additional information on Medicaid State Plan coverage.

This service excludes hippo therapy, equine therapy, horseback riding therapy, music therapy, recreation therapy, etc.

This service is provided one to two times weekly for one hour.

Note: The Florida Medicaid Community Behavioral Health Coverage and Limitations Handbook is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support and then on Provider Handbooks. The handbook is incorporated by reference in rule 59G-4.050, F.A.C.

Documentation Requirements

Reimbursement* and monitoring documentation to be maintained by the provider:

1. *Copy of claim(s) submitted for payment;
2. *Monthly summary note;
3. *Assessment and treatment plan, even if preliminary, or plan for further action, must be completed at time of first claim submission and a final treatment plan at the subsequent claim submission; and
4. *Service log.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of service log, monthly;
2. Copy of assessment and treatment plan prior to or at time of claim submission;
3. Monthly progress notes including training, instructions or assistance provided to caretakers to provide consistent carryover in the home setting; and
4. Treatment plan updates, every 6 months.

If the provider plans to transport the recipient in his private vehicle, at the time of enrollment, the provider must be able to show proof of valid: 1) driver's license, 2) car registration, and 3) insurance. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date.

*indicates reimbursement documentation.

Place of Service

These services may be provided in the provider's office, the recipient's place of residence, or anywhere in the community.

Special Considerations

For purposes of this service, "family" is defined as the persons who live with or provide care to a recipient served on the waiver, and may include a parent, spouse, children,

relative, foster family, or in-laws. “Family” does not include individuals who are employed to care for the recipient.

Community mental health centers are not eligible to enroll to provide this service. If they are able to meet the needs of a recipient, their services are billed to the Medicaid Community Behavioral Health Program.

Speech Therapy

Description

Speech therapy is a service prescribed by a physician and is necessary to produce specific functional outcomes in the communication skills of a recipient with a speech, hearing or language disability. The service may also include a speech therapy assessment, which does not require a physician’s prescription. In addition, this service may include training and monitoring of direct care staff and caregivers, to ensure they are carrying out therapy goals correctly.

This service is not available to individuals enrolled on the DD Waiver – Tier Four.

Limitations

Speech therapy and assessment services are available through the Medicaid Therapy Services Program state plan services for recipients under the age of 21. Services for these recipients may not be purchased under the waiver. Children receiving this service through a school health program are still eligible for medically necessary services funded by Medicaid state plan coverage. When additional therapy is necessary, families must seek Medicaid state plan services coverage.

Assessments for augmentative communication devices and assessments for training are covered by the Medicaid Therapy Services Program state plan services for all Medicaid recipients.

A recipient shall receive no more than eight units of this service per day. A unit is defined as a 15-minute time period or portion thereof. The speech therapy assessment is limited to one per year.

Documentation Requirements

Reimbursement* and monitoring documentation to be maintained by the provider:

1. *Copy of claim(s) submitted for payment;
2. *Copy of service log;
3. *Monthly summary note;
4. *Assessment report, if requesting reimbursement for assessment;
5. Original prescription for the service; and
6. Annual report.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of service log, monthly;
2. Copy of assessment report prior to or at time of initial claim submission;
3. Copy of annual report prior to the annual support plan update; and
4. Copy of original prescription for the service.

*Indicates reimbursement documentation.

Note: The Florida Medicaid Therapy Services Coverage and Limitations Handbook is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Provider Handbooks. The therapy handbook is incorporated by reference in rule 59G-4.320, F.A.C.

Place of Service

This service may be provided in the therapist's office, in the recipient's place of residence, or anywhere in the community.

Support Coordination

Description

Support coordination is the service of advocating, identifying, developing, coordinating and accessing supports and services on behalf of a recipient, or assisting the recipient or family to access supports and services on their own. These services may be provided through waiver and Medicaid State Plan services, as well as needed medical, social, educational, other appropriate services, and community resources regardless of the funding source through which access is gained. The waiver support coordinator is responsible for assessing a recipient's needs, preferences and future goals (outcomes). From that information, the waiver support coordinator assists the recipient in developing a support plan and cost plan.

Once a recipient's support plan is developed and the cost plan is approved by the APD, the waiver support coordinator assists the recipient to meet his support plan outcomes or personal goals by linking the recipient with natural and generic supports and services available through family, friends and community resources. When natural or generic supports are unavailable or are in the process of development, the waiver support coordinator assists the recipient in locating services available through local, state or federal sources, including Medicaid, the DD waiver and APD, as authorized.

Waiver support coordinators promote the dignity and respect for each recipient with regard to the recipient's personal privacy, sharing personal information and making decisions.

Support coordinators promote the health, safety and well-being of the recipient; assist the recipient to identify and access formal and informal support systems; assist the recipient to increase or maintain the capacity to direct formal and informal resources; promote advocacy or informed choice for the recipient; provide information regarding the Medicaid fair hearing process; increase the recipient's involvement in the community; and assist the recipient to achieve personal goals.

Transitional Support Coordination

Transitional support coordination consists of activities that assist the recipient in transitioning from a nursing facility (NF), Developmental Disabilities Institution (DDI), or an intermediate care facility for the developmentally disabled (ICF/DD). These activities include working with the recipient to arrange for the provision of community-based services and supports upon discharge, including those available under this waiver and other services and supports, regardless of funding source, necessary to ensure the health and welfare of the recipient.

Waiver support coordinators are responsible for working with the institutional provider and staff and coordinating their activities with the facility's discharge planning process. The waiver support coordinator will develop an initial support plan based on current assessments including the facility's summary of the recipient's developmental, behavioral, social, health and nutritional status and discharge plan designed to assist the recipient in adjusting to their new living environment. The support plan will identify the community supports and services required to meet these identified needs. Waiver support coordinators can bill for up to 90 days (three months) for services rendered prior to the recipient's discharge. These services can be billed only after the recipient is discharged.

The waiver support coordinator will maintain, at a minimum, weekly contact with the recipient for the first 30 days following discharge to ensure that community supports and services are meeting the recipient's needs. The waiver support coordinator will update the support plan at the end of the 30-day period, identifying progress made with

the transition to community-based living and changes in supports and services. At the end of each month following discharge, if the waiver support coordinator has provided all necessary services, including the weekly face-to-face visits for the first 30 days following discharge, they may bill for up to 90 days at the enhanced waiver support coordination rate.

Limited Support Coordination

Limited support coordination services are less intensive case management services available upon request by an adult receiving services or the adult's guardian. Adults receiving limited support coordination may request to change to full support coordination due to an increased need for assistance, but must remain in full support coordination for the remainder of the cost plan year.

Children under the age of 18 who live in the family home shall use only limited support coordination. Limited support coordination for children living in their family home may be approved at the full support coordination level by the APD Area Office for a time limit not to exceed 60 days per cost plan year should a family emergency warrant increased support from this service. The Area Office will maintain documentation of the approval and the nature of the emergency on file. The emergency approval and explanation of the need should be clearly documented in the case notes for the recipient by the waiver support coordinator.

Limited support coordination services are billed at a reduced rate and have reduced contact requirements. The limited support coordinator must conduct two (2) face-to-face visits per year (including at least one home visit) and one (1) other billable activity a month as outlined in the Documentation Requirements section of the handbook for this service.

The face-to-face contacts conducted in the support plan development period may count as one face-to-face contact. The second face-to-face contact shall occur toward the middle of the support plan year. The support coordinator shall:

1. Perform required assessments and develop the annual support and cost plan. The cost plan shall be submitted for prior service authorization.
2. Document in case notes and other records all activities completed on behalf of the recipient.
3. Arrange initial providers and complete service authorizations as needed.
4. Continue to ensure that Medicaid eligibility is maintained by providing all assistance necessary to maintain Medicaid benefits.
5. Enter into an agreement specifying the activities the recipient expects the support coordinator to conduct as part of the limited support coordination on his or her behalf and those that the recipients and family will assume.

Limited Support Coordinators will not:

1. Be responsible for ongoing monthly face-to-face contact and other required monthly contacts, except as identified above.
2. Oversee the delivery of supports and services.

Limitations

The provider must accept all recipients who select the provider for waiver support coordination services and not reject any recipient referred to them or who selects them from within the geographic boundaries previously approved by the APD Area. The APD may grant exceptions to this requirement in writing.

The caseload for waiver support coordination is established by the Legislature. Effective January 1, 2008 the caseload for this service is 43 full time recipients. Each waiver support coordinator shall maintain a caseload of no more than 43 full time recipients, or as specified in statute, even when that total includes recipients who are not participants in the waiver or are not recipients of the Developmental Disabilities Program. Support coordination services are rendered in a ratio that does not exceed one certified full-time equivalent (FTE) waiver support coordinator position to every 43 full time recipients. "Full Time Equivalent" means a person who is providing support coordination services for 43 full time recipients. A recipient who receives limited support coordination is considered a half-time recipient on a caseload. Waiver support coordinators who provide limited support coordination may have a caseload of more than 43 individuals, not to exceed 43 full time recipients. Supervisors of waiver support coordinators within group providers shall limit their caseloads to less than 43 full time recipients and must ensure that adequate supervision is also provided for support coordination employees. When a provider is planning to expand services, providers may temporarily exceed the above ratios for a period not to exceed 60 consecutive days.

The support coordination provider must notify the APD Area Office in writing of any vacancies or leave of absences granted with a list of recipients affected by this vacancy, within five days of each occurrence. Vacancies due to the termination or resignation of a waiver support coordinator that result in caseloads temporarily exceeding the maximum of 43 full time recipients may be for a period of no more than 60 consecutive days, per vacancy. The 60 consecutive days begin with the date the vacancy actually occurs. Failure of the provider to notify the APD Area Office of the vacancy within the required timeframe will result in recoupment of funds received by the provider.

Vacancies due to a waiver support coordinator submitting a written request to the APD Area Office for leave based on the intent of the Family and Medical Leave Act that result

in caseloads temporarily exceeding the maximum of 43 full time recipients are allowed for a period of no more than 60 working days, per vacancy.

If the support coordination provider cannot fill a reported vacant position within the time allotted, the APD Area Office must be notified prior to the 60th consecutive or 60th working day, whichever is applicable to the situation. Upon receipt of this notification, the APD Area Office will provide 14 calendar days notice to the affected recipients and agency of the need to select a different waiver support coordination provider. This notification will enable the APD Area Office to inform the affected recipients of the impending change in their support coordination provider. This notification will allow sufficient time for the recipient to choose an available provider from within or outside the current agency and the provider to complete needed paperwork and take any other necessary actions. It will also allow the recipient time to adjust to the anticipated changes. Vacancies resulting in caseloads exceeding the maximum of 43 full time recipients for more than the above stated number of days may subject the provider to recoupment of funds and the recipients served to transition to another enrolled support coordination provider, chosen by the recipient. All caseload transfers will be accomplished by the APD Area Office working with the provider to identify those recipients affected by the vacancy and who will cause the temporary support coordinator to exceed the maximum caseload of 43 full time recipients.

Expansion of services includes increasing the number of recipients served by a solo practitioner or an agency, as well as a solo practitioner changing or expanding their status from solo practitioner to an agency. A provider must have no alerts or documentation cites indicating recoupment and have attained a satisfactory overall score on the last quality assurance monitoring conducted by the APD, AHCA or their authorized representative, and be approved by the APD Area Office in order to expand services.

The provider and all its employees who supervise staff, train staff or conduct support coordination activities shall remain free from influences that interfere with the recipient's choice of supports and services. This includes, but is not limited to, the following:

- The provider and its employees do not currently, and shall not while certified to render support coordination services, provide direct services within the state of Florida, other than support coordination or related administrative activities to recipients who receive services from APD;
- The provider, its board members and its employees shall be legally and financially independent from and free-standing of persons or organizations providing direct services within the state of Florida, other than support coordination and related administrative activities to recipients who receive services from APD;
- The provider and its employees shall not be a subsidiary of, or function under the direct or indirect control of, persons or organizations providing direct ser-

vices within the state of Florida, other than support coordination and related administrative activities to recipients who receive services from APD;

- The provider shall not, nor shall employees of the provider, be the guardian, apply to be the guardian, or be affiliated with an organization or person who is the guardian of a recipient served by the provider;
- The provider shall not, nor shall employees of the provider, render support coordination services to a recipient who is a family member of the provider or any employee of the provider, unless the recipient receives services in an APD service area where the family member is not certified to provide support coordination;
- The provider shall not, nor shall employees of the provider, secure paid services on behalf of a recipient from a service vendor who is a family member of the provider or any employee of the provider. Exceptions to this prohibition may be made in writing by APD; and
- The provider and its employees shall not assume control of recipient's finances or assume possession of a recipient's checkbook or cash, nor shall they become representative payee for recipient benefits.

Support and Service Planning Requirements

The provider must be available to meet the recipient's needs and to perform the responsibilities for support coordination. The provider shall have an on-call system in place that allows recipients to access support coordination services 24-hours per day, 7 days per week. The APD Area Office must approve this on-call system.

Any time a back-up support coordinator is used during the provider's absence, the back-up support coordinator shall be a certified and an enrolled waiver support coordinator. The name and contact information for the back-up waiver support coordinator shall be clearly communicated to the recipient and to the APD Area Office. Access to the provider or back-up provider shall be available, without toll charges to the recipient.

Waiver support coordinators should assist ADT recipients with information or referral to rehabilitation, vocational habilitation, and other employment services and employment opportunities available in their community. On an annual basis, waiver support coordinators shall provide service counseling for recipients currently in sheltered workshops or segregated work environments to apprise them of the options available to them for meaningful work activities and training. The support coordinator shall provide information to recipients on residential options available to them including owning or renting their own home with supports. This shall occur at a minimum of once a year during support planning but should also occur when anticipating a change in the residential situation.

The waiver support coordinator will complete activities that assist the recipient in determining their own future. At least once annually the provider will assist the recipient, primary caregiver, or legal guardian to:

- Complete or update tools, necessary to assist in identifying personal goals, needs and services prior to the development of the support plan; make decisions and informed choices;
- Complete the support plan, including required signature(s) of recipient or legal guardian;
- Complete the cost plan; and
- Complete the waiver eligibility work sheet.

When a recipient is newly enrolled to receive waiver services the support coordinator must complete the support plan and cost plan within 60 days of the recipient's selection of the support coordinator.

In accordance with section 393.0651, F.S., the provider shall complete an annual report of progress.

The waiver support coordinator shall provide a copy of the notice of privacy practices required by HIPAA regulations to the recipient or legal guardian upon initial contact with the recipient, and at any time there is a significant change that necessitates the protection of a recipient's personal health information.

The waiver support coordinator will submit to the APD Area Office, no later than twenty calendar days prior to the support plan effective date, a new annual support plan and cost plan with supporting documentation. The APD Area Office will in turn respond no later than ten working days of its receipt of the cost plan, with a statement of approval or denial. Copies of the support plan and complete approved cost plan will be provided to the recipient or his guardian at any time they are requested, but at a minimum, within ten calendar days of the effective date of the support and cost plan. If changes to the support plan's effective date must be made by the support coordinator for purposes of case load management, the support coordinator shall notify providers 60 days in advance of the change.

For emergency support and cost plan requests, the waiver support coordinator will notify the APD Area Office of the crisis situation and provide the updated support plan, cost plan and supporting documentation, within three working days of becoming aware of the crisis.

The cost plan (plan of care) is updated annually by the support coordinator. An amendment to the plan to change services or to increase service intensity or frequency

may only be submitted during the year if there is a documented significant change in the recipient's condition or circumstance that impacts on health, safety, or welfare, or when a change in the plan is required to avoid institutionalization. A comprehensive description of these changes, including updated assessment information and sufficient information concerning the change in service needs should be thoroughly documented in an update to the support plan and the waiver support coordinator's progress notes. Updates to the cost plan shall be initiated when the waiver support coordinator becomes aware of the need for change. The updated support and cost plans are submitted to the APD, for review and approval within five working days of the date the waiver support coordinator becomes aware of the need for change. The APD may request copies of the waiver support coordinator's progress notes, which support and describe the need for an updated cost plan. The APD Area Office will in turn respond within ten days of their receipt of the updated cost plan, with a statement of approval or denial. Within five working days of receiving the APD Area Office response, the waiver support coordinator will notify the service provider through submission of a new service authorization of the updated changes to the cost plan and the change in the needs of the recipient.

The provider shall assist the recipient in using family, neighborhood and community supports and services funded by private, city and county sources prior to seeking services funded by federal and state sources. The provider shall assist the recipient in using Medicaid State Plan services prior to seeking services funded by the DD waiver. When services must be purchased by a source other than the DD waiver, the provider must work cooperatively with the APD Area Office in locating service vendors who meet the needs of the recipient in the most cost-beneficial manner possible.

A copy of support plan information, pertinent to the provider, and an approved service authorization will also be provided to other providers of services to authorize and initiate service delivery by the effective date of the approved support and cost plans. Through conversations with the recipient, those who know the recipient well, and through review of the service vendor's documentation, the waiver support coordinator monitors the recipient's involvement in purchased services to determine if the activities meet the recipient's expectations. The waiver support coordinator will determine that these services are age and culturally appropriate; address the need for which they are intended; and provide appropriate challenges, motivation and experiences to meet the recipient's identified goals.

When services must be purchased by the DD waiver, the provider shall locate potential service vendors who are qualified to meet the needs of the recipient in the most cost-beneficial manner possible. The provider may recruit qualified vendors who are acceptable to the recipient and assist them with waiver enrollment procedures. The waiver support coordinator must assure that purchased supports and services do not exceed the annual limits of the current approved cost plan(s) for recipients served. The waiver

support coordinator shall use the ABC system to regularly monitor service utilization and expenditures. If the support coordinator becomes aware that supports and services are in excess of the annual limits of the approved cost plan, he will notify the APD Area Office and provider as soon as the excess is known to them.

If paid services are used, the provider shall review with service vendors the goals to be achieved for the recipient and note these discussions in the recipient's progress notes. The agreed upon goal(s) shall be reflected on the service authorization form for that provider.

The provider shall maintain each recipient's central record in accordance with APD procedures. The central records remain the property of the APD. The APD retains the right to review, retrieve, or take possession of a recipient's central record at any time.

The provider shall assist the recipient in maintaining their Medicaid eligibility. The provider shall also notify other waiver service providers and the APD when it is determined that a recipient receiving services is ineligible for Medicaid. The waiver support coordinator will work with providers and the APD to plan for alternative funding sources.

The provider is responsible for the cost of the electronic access to the APD's intranet site as well as entering, updating and assuring the accuracy of demographic information pertinent to the recipient in the ABC system. Failure of the waiver support coordinator to enter, update and assure the accuracy of this information could result in recoupment of funds paid to the waiver support coordinator.

The provider shall comply with all written procedures established by the APD regarding the transition of recipients from developmental disabilities support coordinators or other waiver support coordinators to the provider.

The recipient receives follow-up reviews by the psychiatrist, neurologist or ARNP at a frequency established by these practitioners. If the frequency of review established by the psychiatrist, neurologist or ARNP is less frequent than every ninety days, documentation for their rationale will be provided. This documentation will be maintained in the recipient's central record.

If while serving a recipient, the recipient chooses another support coordination provider, the current provider shall render quality services for the recipient until the end of the month, when the transfer to the new support coordination provider takes place, unless otherwise instructed by the APD. Additionally, the current provider shall assist the recipient in making a smooth transition to the new support coordination provider.

When a new support coordination provider is selected by the recipient; the support coordination services agency is downsized; or the support coordination services are terminated, either voluntarily or involuntarily, the waiver support coordinator shall assure that all appropriate central record information is transferred to the new provider or to the APD Area Office, as directed, within two weeks of the effective date of the action.

Documentation Requirements

For reimbursement* purposes, the provider must meet certain basic billing requirements. These include support coordination notes, which adequately document the support coordination services rendered and which are individualized. Exceptions granted by the APD to any requirements set forth in the assurances or policy must also be documented. All documentation must be filed in the recipient's central record prior to billing. For full support coordination, the provider must have, at a minimum, two contacts with or activities on behalf of recipients each month in order to bill to Medicaid. For limited support coordination, the provider must have a minimum of one contact with or activity on behalf of recipient each month in order to bill Medicaid. Prior to submitting a claim for payment of support coordination services for a recipient, the provider shall complete the following:

1. *Have on file in the recipient's central record, the recipient's current support planning information to include the individually determined goal information, the APD-approved assessment, a current waiver eligibility worksheet, a current support plan and current approved cost plan; and
2. Full support coordination: *Have at least one face-to-face contact monthly with recipients living in a licensed residential facility or supported living situation. Have at least one face-to-face contact every three months for recipients living in their family home, and two of those contacts per year will be held in the recipient's residence at six-month intervals.
3. Limited support coordination: Have at least two face-to-face contacts per year, with a minimum of one of the contacts being in the recipient's home. One face-to-face contact should occur at the time of support planning and the second face-to-face contact should occur at approximately a six month interval.
4. Face-to-face contacts shall relate to or accomplish one or more of the following:
 - (a) Assist the recipient to reach outcomes on the support plan, including gathering information to identify outcomes;
 - (b) Monitor the health and well-being of the recipient;
 - (c) Obtain, develop and maintain resources needed or requested by the recipient to include natural supports, generic community supports and other types of resources;
 - (d) Increase the recipient's involvement in the community;
 - (e) Promote advocacy or informed choice for the recipient; or

(f) Follow-up on unresolved concerns of conflicts.

*For recipients in supported living, residing in their own home or residing in licensed facilities, a face-to-face visit with the recipient in the recipient's place of residence is required every three months. If the recipient lives with his family, the face-to-face contact with the recipient in the residence is required every six months for full support coordination, and once a year for limited support coordination. The recipient or family may not waive the required visit(s) in the home. The need for more frequent face-to-face visits may be determined by the recipient, family or primary caregiver. The waiver support coordinator shall document this preference in the support plan. The purpose of the face to face visit is to discuss progress/changes to the individual's goals, status of any unresolved issues, and satisfaction with current supports received.

*For recipients receiving supported living coaching services, it is the waiver support coordinator's responsibility to schedule a quarterly meeting with the recipient and the supported living coach. The purpose of this meeting is to:

- Revise the individual's progress toward achieving goals and determine if services are being provided in a satisfactory manner, consistent with the individual's needs.
- Review the health and safety checklist, housing survey, financial profile and financial records to determine if there is a need for follow up with unresolved issues or changed needs. The waiver support coordinator shall document the results of each meeting in the progress notes.

This quarterly meeting with the recipient and the supported living coach, unless the supported living coach is excluded at the request of the recipient, may satisfy the quarterly face-to-face meeting requirement above, provided the meeting takes place in the recipient's home.

*Conduct at least one other contact or activity per month. These contacts or activities are not merely incidental, but are planned and shall relate to or accomplish those items, previously identified in 4 (a-f). These contacts or activities may be either with the recipient or with other persons, such as family members, service vendors, community members and others, and may be conducted face-to-face or via telephone, letter writing or through e-mail transmission. Administrative activities such as typing, filing, mailing, or leaving messages shall not qualify as contacts or activities, nor do calls to schedule meetings, setting up face to face visits or scheduling meetings with the individual's employer, family, providers, etc.

Upon receipt of a determination that terminates or reduces the level of services, the support coordinator will, within ten business days of receipt of the determination, inform the recipient of the decision and submit a revised service authorization to the service provider. If the determination affects the provider immediately, the support coordinator

dinator must contact the provider by phone call, fax or other method to inform him of the need to immediately revise the services being provided with notification that the service authorization will be sent to the provider to document the change. If the support coordinator does not follow these procedures and this results in the provider not being notified of the service change, the support coordinator may be subject to recoupment of the services that were provided when the service provider was unaware of the need to change the level of service provision. Upon receipt of a determination of approval of a new service, the support coordinator must issue a service authorization within ten business days of receipt of the determination.

For monitoring review purposes the provider must have on file, for the period being reviewed:

1. A copy of all of the recipients' support plans and approved cost plans in their central records;
2. Documentation in the central records that the basic billing requirements were met for the months in which the provider was reimbursed for services;
3. Documentation in the support coordination notes and the support plan of activities and contacts that assisted the support coordinator in meeting individually determined goals;
4. Documentation that the support coordinator facilitated opportunities for community involvement as determined by the support plan goals. The notes clearly and adequately reflect services provided in sufficient detail;
5. Documentation in the central records that a face-to-face visit with the recipient was conducted in their place of residence, including those recipients in supported living, quarterly meetings with the recipient and their supported living coach;
6. Documentation that service authorizations were provided to all service providers within **ten (10) business** days of the support coordinator receiving approval of the service; and
7. Current and correct demographic information for each recipient, including current health and medical information and emergency contacts.

In addition, the provider is expected to document in all recipient central records all other support coordination services, activities or contacts that assisted him in meeting support plan outcomes or personal goals, become more integrated into communities and address each recipient's or family's concerns. Support coordination notes should adequately and clearly document all support coordination services provided to a recipient.

If the provider plans to transport the recipient in his private vehicle, at the time of enrollment, the provider must be able to show proof of valid: 1) driver's license, 2) car reg-

istration, and 3) insurance. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date.

*Indicates reimbursement documentation.

Place of Service

This service may be provided in the recipient's residence or anywhere in the community.

Special Considerations

Support coordination services may be rendered in any community location conducive to the contact or activity being provided, including the waiver support coordinator's office, the recipient's residence, a library, a park, or any other community location. In order to get to know each recipient well, waiver support coordinators are encouraged to interact with and observe each recipient in a variety of settings during different times of the day and on different days of the week.

Support coordination may be provided while a recipient is a temporary patient in a hospital or nursing facility. The waiver support coordinator may not duplicate the services of the hospital or nursing facility case manager or discharge planner and may not bill until after the recipient is discharged.

Providers of support coordination services must participate in monitoring reviews conducted by the APD, AHCA or an authorized representative of the state. Support coordinators are expected to meet the needs of the recipients receiving services; regardless of the number of contacts it takes to meet those needs. Waiver support coordinators should not assume that meeting the basic billing requirements will necessarily result in a successful monitoring review and approval to continue services.

The provider will be responsible for the cost to access any APD or AHCA required management, claim submission information or data collection systems.

Supported Employment

Description

Supported employment services provide training and assistance in a variety of activities to support recipients in sustaining paid employment at or above minimum wage unless the recipient is operating a small business. The supported employment provider assists with the acquisition, retention or improvement of skills related to accessing and maintaining such employment or developing and operating a small business. With the assistance of the supported employment provider, the recipient is assisted in securing em-

ployment according to their desired outcomes, including the type of work environment, activities, hours of work, level of pay and supports needed. Supported employment is conducted in a variety of settings, to include work sites in which individuals, without disabilities, are employed.

Supported employment includes activities needed to sustain paid work at or above minimum wage for recipients receiving waiver services, including supervision and training. This training can focus on both the recipient's needs, as well as providing consultation to the employer to enhance supports natural to the workplace rather than imposing paid supports. Supported employment providers will immediately notify the recipient's waiver support coordinator of any changes affecting the recipient's income. The service provider shall work with both the recipient and the respective support coordinator to maintain eligibility under the DD waiver, as well as health and income benefits through the Social Security Administration and other resources.

Models of supported employment services include:

Individual Model - One person at a time approach to obtaining competitive employment through the support of a job coach, employment specialist, or consultant for job development, intensive training (Phase I) and systematic follow-along supports (Phase 2). The individual model can apply to either employment in the general work force or in development and operation of establishing a business to be operated by the recipient.

Phase I is defined as time-limited supports needed to obtain a job and reach stabilization. These billable support activities include:

- (a) A situational assessment to determine a person's employment goals, preferences and skills;
- (b) Job development for a specific recipient, matching the person with a job that fits personal expectations; and
- (c) Intensive, systematic on-the-job training and consultation focused on building skills needed to meet employer productivity requirements, learning behaviors and acceptance in the social environment of the job setting, building job related supports with the employer from those naturally occurring at that work site and other job related supports.

The number of hours of intervention is intended to diminish over the first few weeks of employment as the supported employee becomes more productive and less dependent on paid supports. Phase I ends after demonstration that the supported employee has established job stability. The stabilization period begins when the person has achieved satisfactory job performance as judged by the employer, provider, Vocational Rehabilitation counselor (if applicable) and the supported employee or when the need for paid supports diminishes to fewer than 20 percent of weekly hours of employment. The sta-

bilization period is a minimum of 90 days following the onset of stabilization. If the supported employee continues to perform the job satisfactorily the service moves into extended, ongoing support services (Phase 2).

Staff is expected to provide varying intensities of services to each supported employee, beginning with high intensity and fading to achieve stabilization. Given the nature of this wide variation in level of support intensity and duration needed per person, usual and typical staff to service recipient ratios demonstrate that one staff person can support up to two to three supported employees who are in Phase I at any given point in time. Phase I services typically average 6-8 hours a day per recipient during the first week of services. Average hours of service should fade to 1-2 hours a week in preparation for transition to Phase 2. The average time period for Phase I is 24 to 25 weeks, but is different for each recipient depending upon need.

Phase 2 is defined as long-term, ongoing supports needed to maintain employment indefinitely. These billable support activities include:

- (a) Ongoing, systematic contacts with supported employees to determine the need, intensity and frequency of supports needed to maintain productivity, social inclusion and maintain employment;
- (b) Remedial on-the-job training to meet productivity expectations, consultation and refinement of natural supports or other elements important to maintaining employment; and
- (c) Related work supports such as accessing transportation and other supports necessary for the recipient to maintain a job, or consultation to family members or other members of a recipient's support network including employers and co-workers.

Phase 2 supports assume periodic life changes and personal tensions that will cause job instability. Supports and services are designed to be dynamic and to change in intensity and duration consistent with the needs of each supported employee during periods of job instability and possibly during job loss and re-employment activities. When supports needed to maintain employment for a given person become too great in intensity or duration, it may be necessary to move back to Phase I services to access a better job match or seek employment alternatives. Moving to Phase I supports must include a referral to Vocational Rehabilitation or the local school system (as applicable) to seek required funding. Medicaid waiver funding shall be used only if these alternative resources are not available.

During Phase 2 the service levels needed per supported employee vary according to individual needs but typically average 1-2 hours a week per recipient. Usual and typical

demonstration of Phase 2 services assert an expectation of a staff to service recipient ratio of one staff person supporting up to twenty supported employees.

Group Models – Including:

1. Enclave - A group approach to employment where up to eight recipients with disabilities work either as a group or dispersed individually throughout an integrated work setting with supervision by the provider.
2. Mobile Crew - A group approach to employment where a crew, such as lawn maintenance or janitorial, of up to eight recipients with disabilities are in the community in businesses or other community settings with supervision by the provider.
3. Entrepreneurial - A group approach to employment where up to eight recipients with disabilities work in a small business created specifically by or for the recipients.

Providers of supported employment services shall comply with requirements found in the Medicaid Waiver Services Agreement, Core Assurances, and those specified in this handbook.

Limitations

Supported employment services are limited to the amount, duration and scope of the services described in the recipient's support plan and current approved cost plan. The provider shall render services at a time mutually agreed to by the recipient and the provider. Off-hours support may occur as an alternative or supplement to the on-the-job contacts.

Decisions to change the duration or intensity of the service to less than twice monthly contacts, in the individual model of service delivery, or to terminate supported employment services, shall only be made through consensus among the recipient receiving services and his guardian; the Vocational Rehabilitation counselor, if applicable; the APD Area Office or waiver support coordinator; and the provider. If for any reason a recipient has terminated services and requests reinstatement due to the need for ongoing supports, he will be given priority for restoration of services.

Recipients working an average of less than 20 hours per week must have at least a quarterly review. Documented attempts to increase work hours or secure an appropriate job must be summarized quarterly. Recipients should not remain in job development status for more than a two month period. For recipients who remain in job development status for more than two months, the supported employment coach will justify monthly the reason(s) why employment has not been obtained and the strategies planned for securing employment.

Phase I supported employment services are limited to eight hours, or 32-quarter hour units per recipient a day. Phase 2 supported employment services are limited to eight hours, or 32-quarter hour units per recipient per week. Group model services are limited to eight hours, or 32-quarter hour units per recipient a day.

Transportation of recipients to and from their job is not a component of supported employment services but may be funded under transportation services when no other community, natural, or generic support is available.

Separate payment for transportation services furnished by the supported employment provider will not be made when rendered as a component of this service.

Note: Refer to the transportation section description in this handbook for additional information.

Documentation Requirements

Reimbursement* and monitoring documentation to be maintained by the provider:

1. *Copy of claim(s) submitted for payment;
2. *Service log
3. *Quarterly summary, the third quarterly summary which includes a summary of the activities of the current and previous quarters of the support plan and shall be considered the annual report.
4. Documentation, in the form of a letter from Vocational Rehabilitation (VR) Services or a case note detailing contact with a named VR representative, the date, summary of conversation, etc., indicating a lack of available VR funding for supported employment.
5. *Individual employment plan must be completed within 30 days of the initiation of a new service or within 30 days of the support plan effective date for continuation services and at any time updates and changes are made before they are implemented and annually thereafter.

In addition to the minimum required components of the individual plan for employment described in the definitions section of this handbook, the plan must also contain the following:

- Documented review by the provider to furnish information and supports for the recipient to make an informed choice in the type of work preferred, job changes or career advancement opportunities.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of service log, monthly;
2. Individual plan for employment; and
3. Third quarterly summary which summarizes the current and previous quarters of the activities of the support plan and will count as the annual report.

If the provider plans to transport recipients in his private vehicle, at the time of enrollment, the provider must be able to show proof of: 1) a valid driver's license, 2) car registration, and, 3) insurance. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date.

*Indicates reimbursement documentation.

Place of Service

Supported employment services are provided in the recipient's place of employment in the community or in a setting mutually agreed to by the supported employee, the employment coach or consultant and the employer.

Should the employment location of a recipient change, the provider shall notify the recipient's waiver support coordinator within five working days.

Special Considerations

Supported employment services furnished under the waiver are not available through programs funded by the Rehabilitation Act of 1973 or Public Law 94-142. Documentation to this effect will be maintained in the file of each recipient receiving this service.

When the supervisor of a mobile crew or enclave does not meet the qualifications for a supported employment coach, although the recipient meets the criteria for supported employment, the support service must be billed as adult day training off-site, rather than supported employment.

Supported employment services are defined as competitive employment, which may be performed on a full-time or part-time basis, in an integrated setting, for which an individual is compensated at or above minimum wage but not less than the customary wage, and at a level of benefits paid by the employer for the same or similar work that is performed by trained, non-disabled individuals.

Providers of supported employment – group model services will bill for each recipient based on the published stepped rate for the service. The group rate shall be determined based on from two to eight recipients receiving the service.

Providers of supported employment – individual model services will bill, based on a one to one ratio, the rate established for the service in the published rate system.

Payment will not be made for incentives, subsidies, or unrelated vocational training. The supported employment vendor will not bill for supports provided by the employer.

Supported Living Coaching

Description

Supported living coaching services provide training and assistance, in a variety of activities, to support recipients who live in their own homes or apartments. These services are provided by qualified supported living coaches to a recipient residing in a living setting meeting the requirements set forth in rule 65G-5.004, F.A.C., and may include assistance with locating appropriate housing; the acquisition, retention or improvement of skills related to activities of daily living such as personal hygiene and grooming; household chores; meal preparation; shopping; personal finances and the social and adaptive skills necessary to enable recipients to reside on their own.

Supported living services mean the provision of supports necessary for an adult who has a developmental disability to establish, live in and maintain a household of his choosing in the community. This includes supported living coaching and other supports.

Functional Community Assessment: The basis for identifying the types of training, assistance and the intensity of support rendered by the provider. It is a document designed to assist the provider in becoming familiar with the recipient and his capabilities and needs. This assessment addresses all areas of daily life including relationships, medical and health concerns, personal care, household and money management, community mobility, recreation and leisure. The supported living provider is responsible for helping the recipient complete a functional community assessment prior to his move to a supported living arrangement. This assessment shall be updated annually.

The Housing Survey: The basis for surveying a prospective home to ensure that it is safe. The supported living coach must forward a copy of the completed survey of the housing that was selected by the recipient, to the recipient's support coordinator within ten working days of the selection. This survey must be updated quarterly and made available for review by the support coordinator at the time of the support coordinator's quarterly home visit. These updates shall include a review of the recipient's overall health, safety and well-being status.

Financial Profile: An analysis of the household costs and revenue sources associated with maintaining a balanced monthly budget for the recipient. The analysis will substantiate the need for a monthly subsidy or initial start-up costs and should be a source of information for determining strategies for assisting the person in money management. The supported living coaching provider is to assist the recipient in completing the financial profile and submitting it to the support coordinator no more than ten days following the selection of housing by the recipient. If the financial profile indicates a need for a one time or recurring subsidy, the profile must be submitted to the waiver support coordinator and approved by the APD Area Office before the recipient signs a lease.

Providers of supported living services shall comply with requirements found in the Medicaid Waiver Services Agreement, Core Assurances, Chapter 65G-5, F.A.C., and those specified in this handbook.

Limitations

Supported living coaching services are limited to the amount, duration and scope of the services described on the recipient's support plan and current approved cost plan, not to exceed six hours or 24 quarter hour units per day. Recipients who also receive in-home support services may receive supported living coaching services for no more than 20 hours or 80 quarter hours per month.

The provider shall render supported living coaching services at the time and place mutually agreed to by the recipient and provider. The provider shall have an on-call system in place that allows recipient's access to services for emergency assistance 24 hours-per-day, 7 days-per-week. If an individual vendor, the provider must specify a backup person to provide supports in the event he is unavailable. The specified backup provider must be a certified, enrolled Medicaid provider and certified as a supported living coaching provider, pursuant to Chapter 65G-5, F.A.C. Telephone access to the provider or the backup provider shall be available, without toll charges to the recipient.

Supported living coaching services are limited to adults (age 18 or over) who rent or own their own homes or apartments in the community. The supported living coaching provider or the provider's immediate family shall not be the recipient's landlord or have any interest in the ownership of the housing unit, as stated in rule 65G-5.004, F.A.C. If renting, the name of the recipient receiving supported living coaching services must appear on the lease either singularly, with a roommate or a guarantor. A provider is defined as an independent provider or a corporation including all board members and any paid employees and staff of the provider agency, its subsidiaries or subcontractors. Supported living coaching encourages maximum physical integration into the community. The homes of recipients receiving supported living coaching services shall meet requirements set forth in rule 65G-5.004, F.A.C. Recipients receiving supported living coaching services shall live where and with whom they choose. However, recipients receiving supported living coaching services shall live with no more than two other people

who have developmental disabilities and shall have control over the household and its daily routines.

Recipients who live in family homes, foster homes or group homes are not eligible for these services unless the recipients have an outcome (goal) to move into their own homes or apartments. Within 90 days from moving, supported living coaching services may be made available to recipients who are in the process of looking for a place of their own, even though they will reside in a family, foster or group home during the search process and may receive residential habilitation services.

Supported living coaching services are provided on a one-on-one basis. The provider will bill for supported living coaching services in accordance with the published rate structure for individual supports for the recipient. If services are provided with two or more recipients present, the amount of time billed must be prorated based on the number of recipients receiving the service.

Documentation Requirements

Reimbursement* and monitoring documentation to be maintained by the provider:

1. *Copy of claim(s) submitted for payment;
2. *Service log, which includes documentation of activities, supports and contacts with the recipient, other providers and agencies with dates and times, and a summary of support provided during the contact, any follow up needed and progress toward achieving support plan goals. This service log and progress notes shall be placed in the recipient's record prior to claim submission; and
3. *Individual implementation plan, or in the case of transition, a transition plan within 30 days of the initiation of a new service or within 30 days of the support plan effective date for continuation services and annually thereafter. A copy of the implementation plan, approved by the individual or their guardian shall be furnished to the individual or their guardian and to the waiver support coordinator at the end of the 30 day period.

In addition to the minimum required components of the individual implementation plan described in the definitions section of this handbook, the individual implementation plan for supported living coaching service must also contain the following:

1. The frequency of the supported living service;
2. How home, health and community safety needs will be addressed and the supports needed to meet these needs to include a personal emergency disaster plan;
3. The method for accessing the provider 24-hours per-day, 7-days per-week for emergency assistance;

4. A description of how natural and generic supports will be used to assist in supporting the recipient; and
5. A financial profile that includes strategies for assisting the person in money management, when requested by the recipient or guardian; and the amount approved for the supported living subsidy. The financial profile is critical in determining whether or not the housing selected by the recipient is within his financial means and will identify the need for monthly subsidy which must be approved by the APD Area Office;
6. A quarterly written report, which summarizes quarterly activities and the recipient's progress toward achieving the goal(s) from the support plan. The annual report shall include objective, fact-based, information reflecting the results of training and supports provided to the recipient over the course of the quarter, as well as recommendations. The third quarterly summary which includes a summary of the activities of the current and previous quarters of the support plan and shall be considered the annual report.
7. The quarterly review which reflects activities completed at the quarterly home visit. This review shall include: a review of the supported living services to ensure services are assisting the individual with identified support plan goals, a review of the person's financial status including a review of the financial profile, financial records and the status of the subsidy if provided, review of the individual's health and safety status including identified need for follow-up, a review of the housing survey. Documentation of the quarterly home visit and subsequent recommendations shall be made in the individual's record.
8. An initial housing survey containing quarterly updates of the recipient's health and safety status. The housing survey will be updated quarterly and made available to the waiver support coordinator at or prior to the quarterly meeting. Documentation of the meeting and subsequent recommendations will be made in the recipient's record;
9. Up-to-date information regarding the demographic, health, medical and emergency information, and a complete copy of the current support plan, if approved by the recipient or guardian, for each recipient served.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of service log or time intervention log, monthly
2. Copy of individual implementation plan or in the case of transition, a transition plan, completed within 30 days of the initiation of a new service or within 30 days of the support plan effective date for continuation services and annually thereafter; and
3. Third quarterly summary which includes a summary of the activities of the current and previous quarters of the support plan and shall be considered the annual report.

If the provider plans to transport the recipient in his private vehicle, at the time of enrollment, the provider must be able to show proof of valid: 1) driver's license, 2) car registration, and 3) insurance. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date.

*Indicates reimbursement documentation.

Place of Service

Supported living coaching services are provided in the recipient's place of residence or in the community.

Special Considerations

Providers of supported living coaching services must participate in monitoring reviews conducted by the APD or its authorized representatives.

When a recipient receives supported living coaching, in-home supports, personal care assistance or companion services, the providers must work together to avoid duplication of activities with coordination by the waiver support coordinator.

Supported living coaching services are not to be provided concurrently with residential habilitation services, except for the 90 days prior to the recipient moving into the supported living setting.

Supported living coaching services may not duplicate services available from programs funded by the Rehabilitation Act of 1973 or Public Law 94-142 or their subsequent updates.

Transportation

Description

Transportation services are the provision of rides to and from the recipient's home and community-based waiver services, enabling the recipient to receive the supports and services identified on both the support plan and approved cost plan, when such services cannot be accessed through natural (i.e., unpaid) supports.

Transportation services funded through the DD waiver shall be used only for recipients who have no other means to get to a service identified on the support plan and approved cost plan. Family members, neighbors or friends who already transport the recipient, or who are capable of transporting the recipient at no cost to the APD, shall be

encouraged to continue their support of the recipient. Recipients who are capable of using the fixed route public transit system to access services on their support plan shall be encouraged to use that method of transportation.

This service is not available for transporting a recipient to school through 12th grade. Transportation to and from school is the responsibility of the public school system. For other transportation needs not identified on the recipient's support plan and approved cost plan, the recipient should be directed to the local Community Transportation Coordinator or, if available, the local area's fixed route fixed schedule public transit (bus system).

Vehicles shall not carry more passengers than the vehicle's registered seating capacity. Driver and driver's assistant(s) are considered passengers.

Fifteen passenger vehicles that are not lift-equipped shall not carry more than ten passengers at any given time and shall reference the National Highway Transportation Safety Board guidelines for loading such vehicles.

Boarding assistance shall be provided as necessary or as requested by the recipient being transported. Such assistance shall include opening the vehicle door, fastening the seat belt, securing a wheelchair, storage of mobility assistance devices, and closing the vehicle door. Recipients shall not be carried. Drivers and drivers' assistants shall not assist passengers in wheelchairs up or down more than one step, unless it can be performed safely as agreed by the recipient, recipient's guardian, or recipient's representative. Drivers and drivers' assistants shall not provide any assistance that is unsafe for the driver, the driver's assistant, or the recipient.

Drivers, drivers' assistants or escorts provided by the provider to accompany the recipient shall be trained in CPR, disease transmission, and use of the on-board first aid kit.

In accordance with section 316.613, F.S., children five years of age or younger must be transported in a federally-approved child restraint device. The provider must have the installation of the child restraint device and the positioning of the child checked at a local authorized child safety seat fitting station or by a certified child seat safety technician. For children from birth through three years of age, such restraint device must be a separate carrier or a vehicle manufacturer's integrated child seat. For children from four through eight years of age, a separate carrier, an integrated child seat, or a booster seat with appropriately positioned safety belt, as appropriate for the child's size and age, may be used. In Florida, every county sheriff's office and city police station serves as a fitting station and every traffic law enforcement officer has been trained to provide assistance.

In vehicles with passenger-side air bags turned on, children under the age of 12 and any adult or child less than 100 pounds must be transported in the back seat. In vehicles that also have side-impact air bags, children and adults less than 100 pounds must be transported as close to the middle of the back as possible.

A first aid kit equivalent to Red Cross Family Pak #4001 and an A-B-C fire extinguisher shall be carried on board the vehicle at all times when transporting recipients.

When the vehicle is in motion, all mobility devices (wheelchairs, scooters, etc.) shall be secured with appropriate tie-downs, regardless of whether or not a person is physically positioned in the mobility device; and cell phone, fire extinguisher, first aid kit, and any other such items that could become airborne in the event of a sudden stop or accident must be secured.

Limitations

Providers of adult day training, companion services, in-home support services, personal care assistance, residential habilitation, respite care, specialized mental health services, support coordination and supported living coaching may not bill separately for transportation that is an integral part of the provision of their primary service.

In order for providers of adult day training, companion services, in-home support services, , personal care assistance, residential habilitation, respite care, specialized mental health services, support coordination and supported living coaching to bill separately for transportation provided between a recipient's place of residence and the site of a distinct waiver service, or between waiver service sites when the service at each site is provided by a different provider, they must qualify for and enroll as a transportation provider.

Transportation between habilitation sites operated by the same provider or transportation that is an integral part of the service being received by the recipient is included in the rate paid to the providers of the appropriate types of waiver services.

Transportation services are available through the Medicaid Non-Emergency Transportation Program state plan services to transport recipients to Medicaid-eligible medical appointments and services. DD waiver funds shall not be used when the recipient's trip is for a Medicaid State Plan service.

When a transportation provider is paid by the Medicaid State Plan to transport a Medicaid recipient to an eligible service, the recipient will be charged a copayment, for which the recipient is responsible. DD waiver funds cannot be used to pay any copayment for Medicaid funded transportation services.

When the recipient uses a DD waiver provider for transportation to a service listed on the support plan and current approved cost plan and the provider is paid with DD waiver funds, the provider shall not charge the recipient a copayment.

Providers may bill for their service by the mile, by the one-way trip, or by the month. Regardless of how services are billed, all providers, except limited service providers, must during the rate-setting process define the charges for their services in terms of cost per vehicle mile. Providers must ensure group trips, ride sharing and multi-loading to the greatest extent possible. If more than one recipient is being transported, the mileage charge will be shared among the number of waiver recipients transported. When a provider is reimbursed by the trip, a recipient shall receive no more than four one-way trips per day, or 80 per month of this service. Only providers that want to bill for actual expenses incurred may bill by the month. Limited transportation providers, i.e., family members, friends or neighbors, will be reimbursed at the state mileage rate.

Documentation Requirements

Reimbursement* and monitoring documentation to be maintained by the provider:

1. *Copy of claim(s) submitted for payment; and
2. *Trip logs.

The provider must submit a copy of trip logs, monthly, to the waiver support coordinator.

The APD Area Offices must maintain a database for each enrolled provider to include:

- The names of the recipients being transported by that provider;
- The beginning and ending date of each recipient's service;
- The destination and distance of each recipient's authorized trip;
- The cost per vehicle mile; and
- The amount authorized to be billed monthly for each recipient.

This information may be obtained from the recipient's service authorizations and verified by trip logs and quarterly operating or service reports submitted by providers.

Transportation providers that are not CTCs, public fixed-route, fixed-scheduled bus systems, or limited transportation providers must, at the time of enrollment, be able to show proof of current Florida driver's licenses for all drivers who will be transporting recipients, vehicle registration for all vehicles to be used in the provision of this service and 100/300 vehicle liability insurance coverage.

Fixed-route, fixed-schedule bus systems must at the time of enrollment provide the APD Area Office with proof of their status as the local Public Transit Authority.

Limited transportation providers shall at the time of enrollment provide the APD Area Office with proof of a current Florida driver's license, vehicle registration, possess a vehicle that is in safe operating condition, and maintain at least minimum vehicle liability insurance coverage as required by Florida law (PIP).

Subsequent to enrollment, all providers are responsible for keeping drivers' licenses, vehicle registrations, and insurance up-to-date. Drivers shall be at least 18 years of age and possess a current, valid commercial or non-commercial driver's license appropriate to the vehicle and for the purpose it is being used, in accordance with Chapter 316, F.S.

*Indicates reimbursement documentation.

Place of Service

This service is provided anywhere in the community.

Special Considerations

When a recipient must have an escort to provide assistance, the transportation provider may be paid for transporting both the recipient and the escort, unless it is the policy of the transportation provider to allow an escort to ride free of charge. Some county coordinated transportation systems do not charge for an escort to ride with a recipient with a disability.

Providers shall not be paid separately for transportation services provided as an integral part of performing the following services: adult day training, companion services, in-home support services, personal care assistance, residential habilitation, respite care, specialized mental health services, support coordination and supported living coaching. Group and foster homes that provide transportation as a component of their long-term residential care services shall not be paid separately for the transportation service.

When paid vendors are also family members, controls must be in place to ensure that the payment is made to the relative only in return for specific services rendered; and there is adequate justification as to why the relative is the paid vendor of the service, rather than a natural support.

CHAPTER 3

DEVELOPMENTAL DISABILITIES WAIVER SERVICES REIMBURSEMENT INFORMATION

Overview

Introduction

This chapter provides and describes reimbursement information regarding the DD Waiver Program.

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Reimbursement Information

Procedure Codes

Medicaid reimburses home and community-based waiver procedure codes based on the Healthcare Common Procedure Coding System (HCPCS) codes, Level I and Level II.

Level 1 procedure codes (CPT) are a systematic listing and coding of procedures and services performed by providers. Each procedure or service is identified by a five digit numeric code. The codes are part of the standard code set described in the Physician's Current Procedure Terminology (CPT) book. Please refer to the CPT book for complete descriptions of the standard codes. CPT codes and descriptions are copyright 2007 by the American Medical Association. All rights reserved.

Level 2 procedure codes are national codes used to describe medical services and supplies. They are distinguished from Level 1 codes by beginning with a single letter (A through V) followed by four numeric digits. The codes are part of the standard code set described in HCPCS Level II Expert code book. Please refer to the HCPCS Level II Expert code book for complete descriptions of the standard codes. The HCPCS Level II Expert code book is copyright 2007 by Ingenix, Inc. All rights reserved.

The procedure codes and maximum units of service that Medicaid reimburses for DD waiver services are listed on the Developmental Disabilities Home and Community-Based Services Waiver Procedure Codes and Maximum Units of Service Table.

Note: The Developmental Disabilities Home and Community-Based Services Waiver Procedure Codes and Maximum Units of Service Table is available on the Medicaid fiscal agent's Web Portal at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Fee Schedules. The procedure code table is incorporated by reference in 59G-13.082, F.A.C.

Billing Procedures

Each provider is required to submit all claims (paper or electronic) for DD waiver services directly to Medicaid's fiscal agent. **Paper claims are submitted on the CMS-1500 claim form.**

Billing for services that use a quarter hour unit must be billed according to the following schedule:

- Services provided from 1 -15 minutes are billed for one quarter hour.
- Services provided from 16 - 30 minutes are billed as two quarter hours.
- Services provided from 31 - 45 minutes are billed as three quarter hours.
- Services provided from 46 - 60 minutes are billed as four quarter hours.

When billing for services by the quarter hour the provider should total at the end of each billing period actual time spent with the recipient and round the total to the nearest quarter hour as described above. Rounding for the specific service provided should occur only once at the time of billing.

Billing instructions will be in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500.

The Medicaid fiscal agent provides billing training for providers of DD Waiver services. The Medicaid fiscal agent may be contacted at 800-829-0218 to request this training.

Note: The Florida Medicaid provider handbooks are available on the Medicaid fiscal agent's Web Portal at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. The Florida Medicaid Provider Reimbursement Handbook, CMS-1500, is incorporated by reference in 59G-4.001, F.A.C.

DD Waiver Service Rates

Effective July 1, 2003, all rates are determined by the operating agency, which is the Agency for Persons with Disabilities, based on the availability of appropriated funding from the Florida Legislature.

Note: The Developmental Disabilities Waiver Provider Rate Table is available on the Medicaid fiscal agent's Web Portal at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Fee Schedules. It is incorporated by reference in 59G-13.081, F.A.C.

Recoupment of Funds

Providers of waiver services must provide these services in a manner that meets the definition and requirements found in this handbook and in the Medicaid Waiver Services Agreement. If the provider fails to meet service standards, to properly document the delivery of services or to receive reimbursement for services not properly authorized or delivered, these payments are considered overpayments and can result in a recoupment of funds by the Agency for Persons with Disabilities (APD) or the Agency for Health Care Administration (AHCA), in accordance with 409.913 and 59G-9.070, F.A.C.

In addition, providers of services that require the development of implementation plans are subject to the recoupment policies specific to the development and implementation of their services for each recipient they serve. These services are: adult day training, non-residential support services, residential habilitation, supported employment and supported living coaching.

1. An amount equal to the daily rate, or a pro-rated daily portion of a monthly rate shall be paid back to APD by the provider for each day that the daily service log or progress note does not document that the service was provided as billed and after the 30-calendar day time frame that a final implementation plan was not available.
2. An amount equal to a monthly rate shall be paid back to APD for each month that a **quarterly** summary was not available describing the recipient's progress for the month toward attaining the support plan goal(s).

Support coordinators are subject to the recoupment policies specific to the performance of identified, essential support coordination activities.

1. An amount equal to the daily rate, or a pro-rated daily portion of each monthly rate shall be paid back to APD by the provider for each day after the effective date of a recipient's support plan, that a plan is not available and after the

effective date of the recipient's cost plan, that a cost plan is not available and sent to the APD Area Office for approval.

2. An amount equal to the monthly rate shall be paid back to APD for each month that services were billed, without supporting documentation. Face-to-face contact for a recipient, quarterly, semi-annual or annual visit to the recipient's place of residence as defined above, and no documentation to support a family's desire to postpone the visit; the monthly payback is applicable to the month when the visit was scheduled to occur.

All other providers are subject to the recoupment policies specific to the service requirements specified in this handbook.

Note: Refer to the Appendix A and Chapters 1 and 2 for additional information and requirements pertaining to waiver support coordination as well as other services.

Limitations

Providers may not bill for service when a recipient is not in attendance, except as noted in the description section of that service.

A provider shall not render a claim or bill for more than one service to the same recipient at the same time and date unless authorized to do so. Services authorized to bill concurrently with another service include behavior analysis, private duty nursing, skilled nursing and residential nursing.

Procedure Code Modifiers

Definition of Modifier

For certain types of services, a two two-digit modifier must be entered on the claim form. Modifiers more fully describe the procedure performed so that accurate payment may be determined.

DD waiver services providers must use the modifiers with the procedure codes listed on the Developmental Disabilities Home and Community-Based Services Waiver Procedure Codes and Maximum Units of Service Table when billing for the specific services in the procedure code descriptions. The modifiers listed on table can only be used with the procedure codes listed. Use of modifiers with any other procedure codes will cause the claim to deny or pay incorrectly.

APPENDIX A

Core Assurances for Providers of Developmental Disabilities Home and Community-Based Waiver Services Program

Chapter 393, Florida Statutes, charges the Agency for Persons with Disabilities (APD) with providing the services, particularly community-based services, to ensure the well being and improve the quality of life of recipients with developmental disabilities. Section 393.066, Florida Statutes, specifically directs the APD to purchase these services through contracts with private businesses, not-for-profit corporations, units of local government and other organizations capable of providing the services in a cost-beneficial manner. APD, as the operating agency and the Agency for Health Care Administration (Agency/AHCA) the single state Medicaid agency, have agreed to jointly purchase necessary services for recipients with developmental disabilities through the Developmental Disabilities Home and Community-Based Services Waiver. This waiver is a federally approved Medicaid waiver services program, authorized by Title XIX of the Social Security Act. The APD and AHCA are required to establish contractual performance standards for all contracted recipient services and service provision quality in the delivery of contracted Medicaid waiver services. The APD expressly requires that the contractual performance standards assure financial integrity.

These Core Assurances and the specific service requirements published in the Developmental Disabilities Waiver Services Coverage and Limitations Handbook, incorporated into this Agreement by reference, provides the terms and conditions by which the provider of waiver services to recipients with developmental disabilities served by APD agree to be bound. Breach of the terms and conditions set forth in these Assurances shall be considered indicative of the provider's failure to comply with the terms and conditions set forth in this document and the Medicaid Waiver Services Agreement.

Programmatic Definition of Terms

Agency or AHCA means the Agency for Health Care Administration.

Agency or Group Provider means a business or organization enrolled to provide a waiver service(s) that has one or more staff employed to carry out the enrolled service(s). All employees of an agency or group provider must meet the qualifications and requirements specified in this Agreement and those specified for enrolled service(s). The provider shall maintain a personnel file, documenting qualifications of all employees and their background screening results.

APD means the Agency for Persons with Disabilities, which includes the Central Office, located in Tallahassee, and the APD Area Offices, located throughout the state.

APD Area means a service area of the Agency for Persons with Disabilities.

Central Record or Provider File of a Recipient means a file (or a series of continuation files) kept by the provider. The provider file maintained by the support coordinator is designated as the recipient's Central Record. These files contain the following documentation that must be recorded, stored and made available for monitoring and review: (1) recipient's demographic data including emergency contact information, parental or guardian contact data, permission forms, results of assessments and evaluations, and medical and medication information; (2) legal data such as guardianship papers, court orders and release forms; (3) service delivery information including the current support plan, cost plan or written authorization of services, and implementation plans; and, (4) service delivery documentation in the form of progress reports or as specified in the Developmental Disabilities Waiver Services Coverage and Limitations

Handbook, that are related to the service and support activities identified in the recipient's implementation plan.

Community Integrated Settings means those local, non-segregated, settings for recipients with developmental disabilities, which possess the following characteristics: (1) generic local community resources, utilized by other people without disabilities; and (2) settings which promote direct personal interaction with others, with or without developmental disabilities.

Core Assurances means the document that specifies administrative and programmatic requirements for the Developmental Disabilities Home and Community-Based Services Waiver and Developmental Disability Program waiver(s) providers.

Cost-Beneficial means economical in terms of the goods or services received and the money spent.

Cost Plan is used by the waiver support coordinator listing all services requested by the recipient on the support plan, regardless of funding source, and the anticipated cost of each waiver service and approval. The APD Area Office must approve the cost plan prior to service provision. Each time a recipient's support plan is amended to increase or add services, the cost plan too must be amended and approved, in order for the service to be initiated. A support plan and cost plan must be updated for each recipient enrolled in the waiver at least annually, during the annual support planning process to reflect current needs and situations.

Cost Plan Year means the 365 or 366 days that correspond to the span of time, covered by the recipient's support plan.

Developmental Disabilities Waiver Services Coverage and Limitations Handbook is incorporated by reference in rule 59G-13.083, F.A.C. promulgated by the Agency for Health Care Administration (AHCA) and is used by waiver providers as a reference guide. The handbook lists all waiver services offered under the Developmental Disabilities Home and Community-Based Services Waiver. Provider qualifications and training requirements, projected service outcomes, service descriptions, service limitations, documentation requirements, place of service and special considerations are included in this document. The handbook also contains the core assurances, contact directories for AHCA area and APD Area Offices, and eligibility determination information. Compliance with handbook requirements will assure the provider is delivering successful waiver services while meeting program guidelines established by state and federal authorities.

Individually Determined Outcome means the major expectation(s) that a recipient has during their life. The recipient's expectations for the services and supports they receive are defined by these outcomes, which may also be referred to as their personal goals.

Individually determined Outcome Process is the process used, with the recipient, to assess how to obtain the outcomes they consider most important in their life. This process includes getting to know the recipient and the significant people in their life, determining the presence or absence of individually determined outcomes, and the supports necessary to achieve the outcomes desired. The process may also involve record review, on-site visits to service providers and additional interviews with the provider's staff. With this information, the waiver support coordinator is responsible for compiling and reporting information and planning for needed supports and services.

Implementation Plan is an individualized document, developed by the provider with direction from the recipient that specifies how the recipient will be assisted by the provider(s) to achieve or maintain specific support plan goal(s). This plan also includes any training objective(s) to be met by the recipient. At a minimum, the plan will include the actions and tasks (strategies) to be employed by the provider to achieve the recipient's identified goal(s) or objectives. The system of data assessment used for measuring the progress of programs and services is the Developmental Disabilities Waiver Services Coverage and Limitations Handbook for implementation plan adding more detailed requirements regarding specific services.

Medicaid Home and Community-Based Services Waiver Programs means federally approved Medicaid programs, authorized by Title XIX of the Social Security Act, for the Developmental Disabilities Home and Community-Based Services Waiver (DD). Chapter 393, F.S., specifies Medicaid funded services for an enrolled recipient.

Medicaid Provider Agreement is the contractual agreement between the provider and the Agency for Health Care Administration, which establishes the provider's eligibility to render services under the Medicaid program.

Medicaid Waiver Services Agreement is the contractual agreement between APD and providers of waiver services that consists of the Medicaid Waiver Services Agreement, the Core Assurances for providers of Medicaid Home and Community-Based Waiver Services Programs, and Provider Rate Tables. Specific service requirements, as defined in the Developmental Disabilities Waiver Services Coverage and Limitations Handbook are incorporated into the Agreement by reference. All providers must complete and submit this agreement to APD for its approval, before providing services to recipients enrolled in the Developmental Disabilities Home and Community-Based Services Waiver.

Medical Necessity or Medically Necessary means a set of conditions established by the Agency for Health Care Administration (AHCA) in section 59G-1.010(166)(a)(c), F.A.C., and Chapter 393, F.S., for determining the need for and appropriateness of Medicaid funded services for an enrolled recipient.

Monitoring is a review by APD, the Agency for Health Care Administration, or an authorized agent of either, of the provider's administrative and programmatic service delivery systems.

Non-Reimbursed Transportation means any transportation that is provided as a component to one or more primary waiver service(s) for recipients on the waiver. This transportation service is not reimbursed separately from the primary waiver service.

Person-Centered is an approach, developed from the recipient's perspective rather than that of the program or resource, used to provide the services and supports necessary to meet the recipient's needs.

Provider means an individual, group or agency vendor that is also an approved Medicaid waiver provider which has entered into a contractual agreement with APD that is eligible to provide one or more of the DD waiver services listed in the Developmental Disabilities Waiver Services Coverage and Limitations Handbook.

Provider Self-Assessment is an evaluation completed by the provider reviewing its organizational capabilities for meeting the recipient's outcomes or goals and the service requirements identified in the Medicaid Waiver Services Agreement and the Developmental Disabilities Waiver Services Coverage and Limitations Handbook. This self-assessment also reviews the provider's policies and procedures by identifying the extent to which they are consistent with their daily practices and the objectives stated in the Medicaid Waiver Service Agreement.

Quality Improvement Plan means a plan of proposed, corrective actions developed by the provider that address the improvements needed for services cited below standard by APD or its authorized agent. Those providers deemed non-compliant with these Assurances and requirements found in the Developmental Disabilities Waiver Services Coverage and Limitations Handbook, will submit written Quality Improvement Plans (QIPs) as required in their written monitoring report. The provider may also develop a Quality Improvement Plan, addressing needed program improvements identified through a self-assessment.

Recipient(s) is any person receiving services through the Developmental Disabilities Home and Community-Based Services Waiver.

Reportable Events are any of the following events, which must be reported to the Area:

- a. **Altercation:** A physical confrontation occurring between a recipient and employee or two or more recipients at the time services are being rendered, or when a recipient is in the physical custody of APD, which results in one or more recipients or employees receiving medical treatment by a licensed health care professional.
- b. **Recipient Death:** A person whose life ends due to or allegedly due to an accident, act of abuse, neglect or other incident occurring while in the presence of an employee, in an APD operated or contracted facility or service center; while in the physical custody of APD; or when a death review is required.
- c. **Recipient Injury or Illness:** A medical condition of a recipient requiring medical treatment by a licensed health care professional sustained or allegedly sustained due to an accident, act of abuse, neglect or a medical condition requiring hospital or emergency room intervention or other incident occurring while in the presence of an employee, in an APD or contracted facility or service center, or who is in the physical custody of APD.
- d. **Elopement:** The unauthorized absence beyond eight hours, or other time frames as defined by a specific program operating procedure or manual, of a child or adult who is in the physical custody of APD.
- e. **Escape:** The unauthorized absence as defined by statute, APD operating procedure or manual, of a recipient committed to, or securely detained in, a mental health or Developmental Disabilities forensic facility authorized by Chapters 393, 394 or 916, F.S.
- f. **Other Incident:** An unusual occurrence or circumstance initiated by something other than natural causes or out of the ordinary such as a tornado, kidnapping, riot or hostage situation, which jeopardizes the health, safety and welfare of recipients who are in the physical custody of APD.
- g. **Sexual Battery:** An allegation of sexual battery by a recipient on a recipient, employee on a recipient, or recipient on an employee as indicated by medical evidence or law enforcement involvement.

h. **Suicide Attempt:** An act which clearly reflects the physical attempt by a recipient to cause his own death while in the physical custody of APD or an APD contracted or certified provider and which results in bodily injury requiring medical treatment by a licensed health care professional.

i. Zero Tolerance

1. **Penalties for Abuse, Neglect, Exploitation, and Sexual Misconduct:** Confirmed cases of abuse, neglect, exploitation, or sexual misconduct by service providers will result in immediate termination of the waiver enrollment status of the individual who committed the abuse, neglect, exploitation, or sexual misconduct as well as the imposition of legal penalties. If it is determined that administrators, owners, or operators of a provider agency are considered to be culpable for such incident(s) through negligence or failure to report the incident(s), their waiver enrollment status will be terminated. Criminal and administrative penalties will be pursued.
2. **Mandatory Reporting Requirements:** Any person who knows, or has reasonable cause to suspect, that a person with a developmental disability is being abused, neglected, or exploited by a relative, caregiver, or household member or, in the case of self-neglect, by themselves, is required to report such knowledge or suspicion to the Florida Abuse Hotline at 1-800-96-ABUSE or 1-800-962-2873. **Failure to report known or suspected cases of abuse, neglect, or exploitation is a criminal offense.** In addition, service providers who fail to report known or suspected cases of abuse, neglect, exploitation, or sexual misconduct will be subject to termination of their waiver enrollment status. Criminal and administrative penalties will also be pursued.
3. **The Sexual Misconduct Law:** Sexual activity between a direct service provider and a person with a developmental disability (to whom he or she is rendering services) is not only unethical but may also be a crime, regardless of whether or not consent was first obtained from the victim. Pursuant to s. 393.135, the term "sexual misconduct" refers to any sexual activity between a covered person (such as a direct service provider) and a recipient to whom that covered person renders services, care, or support on behalf of the agency or its providers, or between a covered person and another client who lives in the same home as the recipient to whom a covered person is rendering the services, care, or support, regardless of the consent of the client. The crime of sexual misconduct is punishable as a second degree felony.
4. **Client-on-Client Sexual Abuse:** Known or suspected sexual abuse between two individuals with developmental disabilities must also be reported immediately to the Central Abuse Hotline at 1-800-96-ABUSE (1-800-962-2873), so that an investigation will occur in order to determine whether or not the sexual abuse was the result of inadequate supervision or neglect on the part of a service provider or caregiver. The incident must also be reported immediately to the APD Area Office to ensure the continued health and safety of the individuals involved.
5. **Reporting Abuse, Neglect, Exploitation, or Sexual Misconduct:** Direct service providers who know or suspect that a person with a developmental disability is being abused, neglected, or exploited by a relative, caregiver, or household member or may be the victim of sexual misconduct, should do all of the following immediately:
 - Call the Florida Abuse Hotline, which is a nationwide, toll-free telephone number, at 1-800-96-ABUSE (1-800-962-2873), or send a faxed statement the Abuse Hotline's statewide toll-free fax number, 24 hours a day, 7 days a week, at (1-800-914-0004), and
 - Call the police, and

- Notify their supervisor, and
- The direct service provider or his/her supervisor should notify the area Agency for Persons with Disabilities (APD) office in accordance with established APD incident reporting procedures.

For situations in which the life of a person with a developmental disability is in immediate danger due to abuse, neglect, or exploitation, direct service providers should call 911 before calling anyone else.

6. **Additional Reporting Requirements:** Direct service providers should report knowledge or suspicion of abuse, neglect, exploitation, or sexual misconduct to their supervisors who will be required to report this information to the local APD office (in accordance with established APD reporting procedures). However, provider agencies may not require their employees to first report such information to them before permitting their employees to call the Florida Abuse Hotline or police. In fact, any person who knowingly and willfully prevents another person from reporting known or suspected abuse is guilty of a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

These reporting procedures do not replace the abuse, neglect and exploitation reporting system. Regardless of their status as an event in recipient risk prevention, allegations of abuse, neglect or exploitation must always be reported immediately to the Florida Abuse Hotline and appropriate Area human rights advocacy committees as required by law. The toll-free telephone number for the Florida Abuse Hotline is 1-800-96-ABUSE (1800-962-2873). For individuals with speech or hearing impairments, TDD access is gained by dialing 1-800-453-5145.

Retail Outlet means any provider that derives fifty percent or more of its revenue from the sale of goods to the general public and not engaged in any business that is specifically targeting recipients receiving waiver services. Retail outlets are certified only for the purpose of delivering commodities.

Solo Provider is an eligible provider who personally renders waiver services directly to recipients and does not employ others to render waiver services.

Support Coordination is the service of advocating, identifying, developing, coordinating and accessing supports and services on behalf of a recipient, or assisting the recipient or family to access supports and services on their own. These services may be provided through waiver and Medicaid State Plan services, as well as other needed medical, social, educational and other appropriate services, regardless of the funding source through which access is gained.

Support Plan is an individualized plan of supports and services designed to meet the needs of an enrolled recipient. This plan is based upon the preferences, interests, talents, attributes and needs of a recipient. The recipient or parent, legal guardian advocate, as appropriate, shall be consulted in the development of the plan and shall receive a copy of the plan and any revisions made to the plan. Each plan shall include the most appropriate, least restrictive and most cost-beneficial environment for accomplishment of the objectives and a specification of all services authorized. The plan shall include provisions for the most appropriate level of care for the recipient. The ultimate goal of each plan, whenever possible, shall be to enable the recipient to live a dignified life in the least restrictive setting, appropriate to the recipient's needs.

Valued Social Roles means those activities that are recognized by the general public, defining the recipient in the context of their relationships with others. Typical valued social roles are co-worker, employee, neighbor, volunteer, student, friend, family member, athlete, theatergoer, church member, taxpayer, citizen, etc.

Waiver Support Coordinator is an enrolled waiver provider of support coordination services that is selected by the recipient enrolled in the waiver (or guardian) to assist recipients who receive waiver services in gaining access to needed waiver and Medicaid State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Each support coordinator must enroll as a provider, whether a solo or individual provider or employed by an agency or group provider.

THE ASSURANCES

The provider assures compliance with the following stipulations:

1.0 COMPLIANCE WITH LAWS AND REGULATIONS

A. *Compliance with State Law and Regulations*

1. The provider will comply with state statutes and rules of the operating agency, which is APD, including Chapters 393 and 409, F.S., Chapters 65G-2 through 65G-5, and 59G-13 F.A.C., and with all procedures pertaining to the implementation of the waiver, including all rates and fee schedules developed under such laws, rules, and regulations.
2. The provider will uphold the rights and privileges of recipients with developmental disabilities, as specified in Chapter 393.13, F.S., "The Bill of Rights of Persons Who Are Developmentally Disabled."

B. *Compliance with Federal Laws and Regulation*

1. The provider will comply with Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. 2000d et seq., prohibiting discrimination on the basis of race, color or national origin in programs and activities that receive or benefit from federal financial assistance.
2. The provider will comply with Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. s.794(a), et. seq., in regard to employees or applicants for employment.
3. The provider will comply with the Age Discrimination Act of 1975, as amended, 42 U.S.C. s.12101 et. seq., which prohibits discrimination on the basis of age, in programs or activities that receive or benefit from federal financial assistance.
4. The provider will comply with the Omnibus Budget Reconciliation Act of 1981, PL 97-35, prohibiting discrimination on the basis of sex or religion in programs and activities that receive or benefit from federal financial assistance.
5. The provider will comply with the Americans with Disabilities Act of 1990, PL 101-336, prohibiting discrimination, based on disability, in employment, public accommodations, transportation, state and local government services and telecommunications.

6. The provider will comply with Title 42, Code of Federal Regulations (CFR) 431.51, which states that each recipient served by the provider will be provided freedom of choice within the scope of available funding levels. Freedom of choice includes:
 - a. Opportunities for the recipient to select non-waiver funded supports available to the general community from among those activities or experiences that meet the recipient's needs and preferences;
 - b. Opportunities for the recipient to select providers of Medicaid State Plan services from among those providers enrolled in the Medicaid waiver program, and that also meet the recipient's needs and expectations;
 - c. Opportunities for the recipient to select providers of waiver services from those eligible to provide waiver services and enrolled in the Medicaid program, meeting the recipient's needs and expectations;
 - d. Opportunities for the recipient to change providers of supports and services;
 - e. Opportunities for the recipient to work with a provider to identify mutually agreeable times and settings for the provision of supports or services; and
 - f. The opportunity for the recipient to end his participation in the waiver.

2.0 PROGRAM REQUIREMENTS

- A. The provider will not disclose or use any information concerning a recipient who is receiving services under the waiver, without the written consent of the recipient or the recipient's legal guardian, in accordance with Chapter 393.13, F.S., and federal regulations.
- B. In accordance with Chapter 415.1034, F.S., the provider or any employee of the provider who knows, or has reasonable cause to suspect, that a recipient receiving services from Developmental Disabilities is being or has been abused, neglected or exploited, will immediately report such knowledge or suspicion to the central abuse registry and tracking system of DCF, using the statewide toll-free telephone number (1-800-96ABUSE). TDD users call 1-800-453-5145.
- C. The provider understands and agrees that APD and Medicaid is responsible for the expenditure of all funds appropriated to APD by the Florida Legislature for recipients receiving services from APD and Developmental Disabilities Home and Community-Based Services Waiver Programs. APD is ultimately responsible for determining the appropriateness or medical necessity of services purchased, in accordance with 59G 1.010 F.A.C., Chapter 393, F.S., and the amount of Developmental Disabilities funds available to purchase services and goods.
- D. The provider agrees, within the mission and scope of the service(s) offered, to safeguard the health, safety and well being of all recipients receiving services from the provider.

- E. The provider agrees, within the mission and scope of the service(s) offered, to assist people in their achievement of personal goals, choice, social inclusion, relationships, rights, dignity and respect, health, environment, security and satisfaction.
- F. The provider agrees to participate in and support the individually determined outcome process for each recipient. The provider will also use the recommendations from the person-centered review process to: (1) implement person-centered supports and services; (2) enhance service delivery in a manner that supports the achievement of individually determined outcomes; and (3) make improvements in the provider's service delivery system.
- G. The provider agrees, with the recipient's permission, to participate in the discussion of the recipient's record, the recipient's progress, the extent to which the recipient's needs are being met or any need for modifications to their support plan, implementation plan, or other documents, as applicable. This discussion could involve APD or its authorized representatives, other service providers, the recipient, the guardian, family and friends.
- H. The provider agrees, with the recipient's permission, to provide information about the recipient to assist in the development of the support plan, and to attend the support planning meeting when invited by the recipient, family member or guardian.
- I. The provider agrees to provide the recipient with opportunities for relevant training, achieve his personal goals, and to expand his life experiences within the community through the provision of person-centered supports and services. These services and supports will be provided within the scope, intensity and duration specified on the recipient's support plan and approved cost plan.
- J. It is the responsibility of the Developmental Disabilities Home and Community-Based Services Waiver providers, and employees of waiver providers who furnish non-reimbursed transportation services to recipients as part of one or more primary waiver service(s) and that are not reimbursed for such transportation, to meet the following requirements. The provider must be able to show, at time of enrollment, proof of a valid driver's license, car registration and insurance. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date.
- K. The provider understands and agrees to provide and bill for those services that have been authorized and approved by the Area Office on the recipient's cost plan. The provider agrees not to bill for services until rendered, as authorized.
- L. The provider shall attend training sessions specific to the type of services provided, monthly support coordination APD Area meetings and quarterly provider meetings as scheduled by the APD Area Office.
- M. All Medicaid waiver providers shall have a computer with internet access which allows for transmission to and from APD on a valid, active e-mail address. Waiver support coordinators shall also have access through internet Explorer, emulation software, and a VPN. The computer must be used exclusively by the provider and stored in a secure manner.

2.1 Required Training

The provider and its employees will ensure they receive the specific training required to successfully serve each recipient including the following topics:

- A. Emphasis on individual choice and rights;
- B. The responsibilities of and procedures for maintaining the health, safety, and well being of recipients served;
- C. Recognition of abuse and neglect and required reporting procedures, to include domestic violence and sexual assault;
- D. Development and implementation of the required documentation for each waiver service;
- E. The Medicaid Waiver Services Agreement and its Attachments. The Developmental Disabilities Waiver Services Coverage and Limitations Handbook and its appendices, and the use of personal goals to establish a person-centered approach to service delivery;
- F. Other training specific and appropriate to the needs of the recipients served by the provider and required for specific services listed in the Developmental Disabilities Waiver Services Coverage and Limitations Handbook, for which the provider is enrolled and eligible to provide;
- G. All direct service providers are required to complete training in the APD's Direct Care Core Competencies Training, or an equivalent curriculum approved by APD within 90 days of employment or enrollment to provide the service. Said training may be completed using APD's web-based instruction, self-paced instruction or classroom-led instruction; and
- H. All direct service providers hired after 90 days from the effective date of this rule are required to complete the Agency for Persons with Disabilities developed Zero Tolerance Training course prior to rendering direct care services (as a pre-service training activity). Said training may only be completed via APD's web-based instruction or classroom-led instruction (using APD's approved classroom curriculum presented either by APD staff or an individual who has been trained and approved by APD to conduct such classroom trainings). In addition, all direct service providers shall be required to complete the APD developed Zero Tolerance training course at least once every three years. The provider shall maintain on file for review, adequate and complete documentation to verify its participation, and the participation of its employees, in the required training sessions.

The documentation for the above listed training shall, at a minimum, include the training topic(s), length of training session, date and location of training, name and signature of trainer, name and signature of person(s) in attendance. Proof of training shall be on file and available for monitoring and review.

2.2 APD Notification

The provider will share responsibility and assist APD and others in the notification and resolution of the following issues and concerns for, or on behalf of, each recipient served by the provider:

- A. Notifying the APD Area Office and other providers of issues concerning:
 1. The recipient's continued eligibility for waiver services. Any provider that becomes aware of a recipient's loss of Medicaid benefits shall immediately contact the recipient's waiver support coordinator.
 2. The possibility of losing Medicaid eligibility. Any provider that becomes aware of a recipient's pending loss of Medicaid benefits shall immediately contact the recipient's waiver support coordinator.
 3. Plans to move out of the Area or state; and
 4. Plans to discontinue receiving services from the provider, waiver or APD.

- B. Immediate notification to the APD Area Office of an emergency or of an unusual occurrence or circumstance. Said notification of an unusual occurrence or circumstance includes:
 1. Hospitalization of the recipient;
 2. Involvement of law enforcement agencies;
 3. Concerns about abuse, neglect, or exploitation and reporting of abuse, and reportable events; and
 4. Death of a recipient.

3.0 ADMINISTRATIVE POLICIES, PROCEDURES, AND PRACTICES

Pursuant to Section 393.062, Florida Statutes, APD is charged with ensuring the most cost-beneficial and effective community-based services for recipients with developmental disabilities. In order to accomplish this objective, APD requires that each provider type and those providing the services listed below develop written policies and procedures for the provision of services to recipients under the Medicaid waiver:

- All agency or group providers;
 - Solo practitioners providing the following services: residential habilitation services, support coordination, supported employment, and supported living coaching.
- A. The provider's practices shall be consistent with its written policies and procedures. Revisions to the provider's policies and procedures shall be made in a timely manner if modifications in provider practices deviate from the policies as written.

 - B. The provider's policies shall address, at a minimum, the following:
 1. Procedures governing how a person-centered approach to services will be provided in order to meet the needs of the recipients served and to achieve the personal goals on the support plan;

2. Policies and procedures that will promote the health and safety of every recipient who receives services from the provider;
 3. Policies and procedures, which detail the safe administration and handling of medication in order to assure the health and safety of recipients served; if it is the policy of the provider that the provider or the provider's staff should not administer or assist in administration of medication, this should be clearly stated;
 4. Policies and procedures to ensure the smooth transition of the recipient between providers and other supports and services;
 5. Policies and procedures that address the provider's staff training plan and that specify how pre-service and in-service activities will be carried out including HIV/AIDS training pursuant to Chapter 381.0035, F.S., CPR, and all other mandated training;
 6. The provider's grievance procedures, as outlined in section 3.9 of this document; and
 7. The provider's procedures for conducting provider self-assessments.
- C. Each agency or group provider will maintain a current table of organization, including board of directors (when applicable), directors, supervisors, support staff, and all other employees.

3.1 Self-Assessment

Each agency or group provider, or solo or individual provider furnishing specific services referenced in 3.0 above shall perform an annual self-assessment to determine the effectiveness of services being offered and the provider's compliance with requirements identified in this agreement and the Developmental Disabilities Waiver Services Coverage and Limitations Handbook. This annual assessment will assist the provider to determine, within the realm and scope of the service(s) that is provided, the extent to which the provider is developing and maintaining person-centered processes that will assist recipients in the achievement of personal goals, choice, social inclusion, relationships, rights, dignity and respect, health, environment, security and satisfaction. At a minimum, the provider's self-assessment survey will include a combination of: a) records review; b) interviews to determine the extent to which provider actions support the achievement of personal goals identified by recipients receiving services; and c) annual recipient satisfaction surveys. The provider, as part of the self-assessment process, develops a Quality Improvement Plan addressing the areas in need of improvement.

3.2 Changes in Provider Status

- A. The provider understands and agrees that APD and recipients served will be notified of any change, sale or transfer of ownership. Recipients receiving services will be given an opportunity to receive services from the new owner, purchaser, or transferee, or to select another provider.

- B. The provider understands and agrees that APD shall be notified, prior to any change in provider status from a solo or individual provider to an agency or group provider. Such change shall be subject to APD review and approval.
- C. The provider understands and agrees that if they voluntarily terminate services, experiencing a break in service of ninety (90) days or more, and desire to return to the waiver in any capacity, that they will be considered a new applicant and shall comply with all the requirements of a new applicant.

3.3 Records Retention

- A. The provider will establish and maintain for review records pertinent to this Agreement that sufficiently and properly reflect all services provided and revenues and expenditures of funds provided by APD and Medicaid under this Agreement. All records pertinent to this Agreement, including information stored in electronic media, shall be retained for a period of at least five years after the completion date of the Agreement. If a state or federal audit has been initiated and audit findings have not been resolved at the end of five years, the records shall be retained until resolution of the audit findings or any litigation, which is based on the terms of this Agreement. Records shall be established and maintained in accordance with generally accepted accounting procedures and practices.
- B. The provider agrees that if all or part of the business is sold or transferred, the provider will maintain and make available to APD and the Agency for Health Care Administration, those Medicaid-related records required to be kept unless the provider enters into an agreement with a third party to do so and furnishes APD with a copy of such agreement. Any such agreement will require the holder or custodian of the records to comply with the terms set forth in this document for retention and access to said records.

3.4 Financial Requirements

- A. The provider agrees to notify APD in writing prior to any filing for bankruptcy protection.
- B. Appropriate to the type and scope of services rendered, the provider agrees to maintain a separate checking account for any personal funds of any and all recipients in the care of, or receiving services from, the provider. If a single trust account is maintained for all recipients' personal funds, a separate accounting must be maintained for each recipient's funds, which reconciles monthly to the account's total as noted on the bank statement and is retained by the provider for review by APD or Agency for Health Care Administration. The provider further understands and agrees that at no time should any recipient's personal funds be co-mingled with any other funds, including those of the provider or any of its employees. The provider shall maintain on file a written consent to manage personal funds, signed by the recipient or his legal guardian. The provider shall maintain on file receipts for individual purchases of \$25.00 or more.
- C. Neither the provider nor its employees, in their official capacity, will receive any financial benefit as a result of being named the beneficiary of a life insurance policy covering a recipient served by the provider.
- D. Neither the provider nor its employees, in their official capacity, will benefit financially by borrowing or otherwise using the personal funds of a recipient served by the provider.

3.5 Marketing Practices

The provider will market its services in a professional and ethical manner.

- A. The provider shall not, nor shall employees of the provider, possess or use for the purpose of solicitation, lists or other information from any source that identifies recipient's receiving services from APD.
- B. The provider shall not, nor shall employees of the provider, solicit recipients directly or through an agent, through the use of fraud, intimidation, undue influence, or any form of overreaching or vexatious conduct, including offering discounts or special offers that include prizes, free services, or other incentives.
- C. The provider shall not, nor shall employees of the provider, unduly influence a recipient to request a support or service, select a support or service vendor or participate in an activity, regardless of whether or not the recipient request, selection or participation results in any benefit to the provider.

3.6 Goods and Services Provided

- A. The provider will conduct or be responsible for the following duties, for or on the behalf of each recipient served by the provider. The provider will:
 - B. Document all service provision clearly and legibly, in accordance with the Developmental Disabilities Waiver Services Coverage and Limitations Handbook, in a manner that will describe the limits of service, units of service, payment of service, location of service, and any other special consideration that will clearly document the rationale for the provision of the service;
 - C. File all required documentation in the recipient's record prior to submitting a claim for services rendered;
 - D. Maintain documentation in accordance with procedures specified in these Agreement documents, including the specific service requirements identified in the Developmental Disabilities Waiver Services Coverage and Limitations Handbook, for each participant being served, as well as for each waiver service being provided. APD, Agency for Health Care Administration, or their authorized representatives retain the right to review a recipient's record(s) at any time.
 - E. Bill for only those services for which an approved service authorization has been received. Services shall be billed only at the approved rate, frequency and duration. Copies of service authorizations shall be kept on file by the provider and shall be made available to APD, Agency for Health Care Administration, or their authorized representatives for monitoring purposes.
- F. The provider understands and agrees that APD and Agency for Health Care Administration has the final authority on all matters pertaining to paid services or goods purchased with funds appropriated to APD for recipients who receive services through the waiver.

3.7 Payment Provisions

- A. The provider understands and agrees that all claims for duly authorized and rendered services will be submitted directly through the Medicaid FMMIS system. Claims submitted for payment and the corresponding support documentation must be correct and legible.

- B. The provider understands and agrees that the Medicaid fiscal agent or the Office of the Comptroller will not pay a different Medicaid waiver payment rate for the same level of service for the same provider-type and will only pay for those services authorized and directly related to the recipient's goals as identified in his current support plan and that are authorized on the recipient's current and approved cost plan.
- C. The provider understands and agrees that payment from the Medicaid fiscal agent is made to a provider that is determined eligible by an Area Office and has executed a Medicaid Waiver Services Agreement. The provider further understands that payment is contingent upon its enrollment in Medicaid as a waiver provider of Developmental Disabilities Home and Community-Based Services Waiver services.
- D. The provider understands that Medicaid payment will be payment in full for the services provided. The provider understands that it may not bill the recipient or family for any service that is authorized for reimbursement by Medicaid.
- E. The provider understands and agrees that payment from the Medicaid fiscal agent will be made only after services are rendered.
- F. Payment shall not be made for services not rendered.
- G. The provider understands and agrees that APD is under no obligation to fund or fill vacancies created, under any circumstance.
- H. The provider understands and agrees that submission of a claim for a service that is not authorized on the service authorization form is grounds for termination of the Medicaid provider agreement.

3.8 Recoupment of Funds

- A. The provider understands and agrees that APD or Agency for Health Care Administration will recoup funds paid to the provider for any reimbursed service for which the provider cannot produce the required documentation that fully supports the service as being rendered.
- B. The provider understands that payment for services that are not authorized, appropriately documented, or not billed appropriately through the Medicaid FMMIS system, or are billed in excess of the maximum units authorized, will result in recoupment of funds by APD or Agency for Health Care Administration.

3.9 Grievance Procedures

The provider understands and agrees to establish and maintain written grievance procedures that will be used to resolve conflicts that may arise between the recipient, family, or guardian and the provider. The-

se procedures do not preclude appropriate requests for a hearing, nor do they preempt the recipient, family, and guardian's right to request a change in services and/or provider.

A. These procedures will specify:

1. That grievance procedures will be reviewed and signed by the recipient, family or guardian within 30 days of beginning services and annually thereafter.
2. Those grievance procedures will be communicated in clear, understandable language to the recipient, his family or guardian. Responses to grievances will be provided verbally and in writing at the recipient's level of comprehension and in the language understood by the recipient.
3. That a log of all grievances filed by recipients, families or guardians will be maintained for review and will include the following information:
 - (a) The name of the person making the complaint and his relationship to the recipient receiving services;
 - (b) The date the complaint is received;
 - (c) A clear description of the complaint. Oral complaints will be documented in writing. All complaints should be retained in the recipient's file and a copy retained with the grievance log; and
 - (d) The date of and the final disposition of each logged complaint.
4. The established procedures should provide for prompt resolution of any conflict.

APPENDIX B AREA OFFICES FOR THE AGENCY FOR PERSONS WITH DISABILITIES

<i>Area and Telephone Number</i>	<i>Counties in the Area</i>
1 (850) 595-8351	<i>Escambia, Okaloosa, Santa Rosa, Walton</i>
2 (850) 487-1992	<i>Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Liberty, Leon, Madison, Taylor, Wakulla, Washington</i>
3 (352) 955-5793	<i>Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee, Union</i>
4 (904) 992-2440	<i>Baker, Clay, Duval, Nassau, St. Johns</i>
7 (407) 245-0440	<i>Brevard, Orange, Osceola, Seminole</i>
8 (239) 338-1572	<i>Charlotte, Collier, Glades, Hendry, Lee</i>
9 (561) 837-5564	<i>Palm Beach</i>
10 (954) 467-4218	<i>Broward</i>
11 (305) 349-1478	<i>Dade, Monroe</i>
12 (386) 947-4026	<i>Flagler, Volusia</i>
13 (352) 330-2749	<i>Citrus, Hernando, Lake, Marion Sumter</i>
14 (863) 413-3360	<i>Hardee, Highlands, Polk</i>
15 (772) 468-4080	<i>Indian River, Martin, Okeechobee, St. Lucie</i>
23 (813) 233-4300	<i>DeSoto, Hillsborough, Manatee, Pasco, Pinellas, Sarasota</i>

Visit the APD Web site for current contact information www.apd.myflorida.com.

Visit the AHCA Web site at www.ahca.myflorida.com for the AHCA Area Offices contact information. The AHCA Area Offices contact information is also in Appendix A of the Florida Medicaid Provider General Handbook.

APPENDIX C WAIVER ELIGIBILITY DETERMINATION

1. Waiver Eligibility Determination

- A. The procedure and criteria for determining waiver eligibility are as follows:
- (1) For applicants who are not APD clients, the determination of waiver eligibility shall be pended until eligibility for APD services has first been determined. The qualifying definitions for developmental disability and the conditions included in that definition are found in section 393.063, F.S.
 - (2) For applicants who are APD clients, eligibility for the waiver is limited to the following qualifying disabilities:
 - (a) The individual's intelligence quotient (IQ) is 59 or less; or the individual's IQ is 60-69 inclusive and the individual has a secondary handicapping condition, that includes cerebral palsy, spina bifida, Prader-Willi syndrome, epilepsy, autism, ambulation, sensory, chronic health, or behavior, or the individual's IQ is 60-69 inclusive and the individual has severe functional limitations in at least three of the major life activities, including self-care, learning, mobility, self-direction, understanding and use of language, and capacity for independent living; or
 - (b) The individual is eligible under a primary disability of autism, cerebral palsy, **Down syndrome**, spina bifida, or Prader-Willi syndrome. In addition, the condition must result in substantial functional limitations in three or more major life activities, including self-care, learning, mobility, self-direction, understanding and use of language, and capacity for independent living.
- B. Upon a preliminary determination that the applicant is eligible or ineligible for a waiver based on disability criteria, the following action shall be taken:
- (1) Eligibility is denied: If an applicant is determined to not meet the disability criteria, the applicant shall be promptly notified of the denial, and such notification shall include notice that the applicant has a right to an administrative hearing to contest APD's decision.
 - (2) Eligibility is approved: If an applicant is determined to meet the disability criteria the APD Area Office shall consult with the APD Central Office to determine whether funding is available.
 - (a) If funding is available, the procedures relating to waiver enrollment outlined in the Section 3 of this Appendix shall be followed.
 - (b) If funding is not available and the applicant's situation does not to require immediate ICF/DD placement, or if ICF/DD placement is not requested, the applicant shall be placed on the wait list, as described in Section 2 of this Appendix.

2. Wait List

The APD Central Office shall maintain the statewide wait list of all applicants requesting and waiting for waiver services.

- A. Only applicants who are eligible for APD services and who have a qualifying disability can be added to the wait list.
- B. If a preliminary determination of eligibility for the waiver is made, but no funding is available, the applicant will receive prompt written notification of his placement on the wait list for the waiver. The effective date for placement on the wait list shall be the date the applicant is preliminarily determined waiver eligible in accordance with Section 1.
- C. Applicants will be listed in date order, with the earliest effective dates at the top of the wait list.
- D. A preliminary determination of waiver eligibility and placement on the wait list for waiver enrollment is not an entitlement to waiver services. The final determination of the applicant's eligibility must also include a determination of Medicaid eligibility and shall be made at the time that funding is available and prior to enrolling the applicant on the waiver.

3. Waiver Enrollment

- A. When the level of funding annually appropriated by the Florida Legislature provides funding for additional enrollment, recipients will be added to the waiver in the following order, unless otherwise specified in the Appropriations Act:
 - (1) Individuals determined, pursuant to Chapter 65G-1, F.A.C., to be in crisis shall have first priority for services.
 - (2) Children on the wait list who are from the child welfare system with an open case in the Department of Children and Family Services' statewide automated child welfare information system.
 - (3) All other individuals shall be considered for enrollment on the waiver in the date order in which they are listed on the statewide wait list, beginning with the earliest dates.
- B. Should sufficient funding be available to serve some but not all of the applicants having the same effective date on the wait list, current information relating to the applicant's intensity of service needs, as determined by the APD approved assessment, will be used to prioritize the applicants. Circumstances for applicants on the wait list may change over time. Accordingly, when the APD Area Office is notified that funding is available to serve applicants through a particular eligibility date, the information necessary to determine priority will be requested for affected applicants.

Incorporated by reference in 59G-13.083, F.A.C., effective _____.

- C. The following enrollment activities shall be taken as part of the enrollment process once funding becomes available to serve additional applicants:
- (1) The APD Area Office where the applicant resides will be notified to complete an initial assessment to finalize waiver eligibility, begin the enrollment process, and determine service.
 - (2) If the applicant is not enrolled in Medicaid, the APD Area Office shall make the appropriate referrals for the determination of Medicaid eligibility.
 - (3) Once Medicaid eligibility has been determined, waiver enrollment can be completed. The APD Area Office will notify the Central Office, that the Central Office will add the person as enrolled to the automated Allocation, Budget & Contract Control (ABC) system. Once the individual is enrolled on ABC, the individual is officially on the waiver.
- D. When a recipient is enrolled on the waiver, the waiver position allocated to the recipient is his until he becomes ineligible or chooses to discontinue waiver services. If the recipient loses his eligibility or chooses to discontinue waiver services, he may return to the same waiver position allocated and resume receiving waiver services provided that he has been disenrolled for less than one year.

If waiver eligibility cannot be re-established, or the individual who has chosen to disenroll has been continuously disenrolled for one year or longer, he is no longer eligible to return to the waiver until a new waiver vacancy and funding is available. In this instance, the individual is added to the wait list of individuals requesting waiver participation. Their new effective date is the date eligibility is re-established or the individual requests re-enrollment for waiver participation.

APPENDIX D MEDICAID WAIVER SERVICES AGREEMENT

This Agreement is entered into between the Florida Agency for Persons with Disabilities, hereinafter referred to as “APD”, and _____, hereinafter referred to as the “Provider”. Pursuant to the terms and conditions of this Agreement, APD authorizes the Provider to furnish _____ Home and Community-Based Services (HCBS) Medicaid waiver services to eligible APD clients, and to receive payment for such services. The services that may be provided in any one APD service area are limited to the services that the APD area office, pursuant to the standards specified in Florida’s HCBS waivers, authorizes the Provider to furnish in that service area.

I. AGREEMENT DOCUMENTS:

A. The Medicaid Waiver Services Agreement consists of the terms and conditions specified in this Agreement, any attachments, and the following documents, which are incorporated by reference:

- 1. *The Developmental Disabilities Waiver Services Coverage and Limitations Handbook***, dated July 2007, and any updates or replacements thereto. The Handbook can be found at the Medicaid fiscal agent’s Web Portal: www.mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Provider Handbooks. The Handbook lists the requirements for specific services as well as the Core Assurances, which provide the terms and conditions by which the provider of Developmental Disabilities HCBS waiver services agrees to be bound.
- 2. *Attachment*** _____, providing individually negotiated unit rates of payment for services not already established and available on APD’s site: www.apd.myflorida.com/providers, as referenced in II.E., and any other service or data requirements, as applicable.

B. Prior to executing this Agreement and furnishing any waiver services, the Provider must have executed a Medicaid Provider Agreement with the Agency for Health Care Administration (AHCA), and be issued a Medicaid provider number by AHCA. The Provider must at all times during the term of this Agreement, maintain a current and valid Medicaid Provider Agreement with AHCA, and comply with the terms and conditions of the Medicaid Provider Agreement.

II. THE PROVIDER AGREES:

To comply with all of the terms and conditions contained within this Agreement, including all documents incorporated by reference and any attachments.

A. Monitoring, Audits, Inspections, and Investigations

Incorporated by reference in 59G-13.083, F.A.C., effective _____.

To permit persons duly authorized by APD, the Agency for Health Care Administration (AHCA), or representatives of either, to monitor, audit, inspect, and investigate any recipient records, payroll and expenditure records (including electronic storage media), papers, documents, facilities, goods and services of the Provider which are relevant to this Agreement, and to interview any recipients receiving services and employees of the Provider to assure APD of the satisfactory performance of the terms and conditions of this Agreement.

1. Following such monitoring, audit, inspection, or investigation, APD or its authorized representative, will furnish to the Provider a written report of its findings and, if deficiencies are found, request for development, by the Provider, a Quality Improvement Plan (QIP) for needed corrections. The Provider hereby agrees to correct all noted deficiencies identified by APD, AHCA, or their authorized representatives within the specified period of time identified within the report documentation. Failure to correct noted deficiencies within stated time frames may result in termination of this Agreement.
2. Upon demand, and at no additional cost to the APD, AHCA, or their authorized representatives, the Provider will facilitate the duplication and transfer of any records or documents (including electronic storage media), during the required retention period of six years after termination of the Agreement, or if an audit has been initiated and audit findings have not been resolved at the end of six years, the records shall be retained until resolution of the audit findings or any litigation which may be based on the terms of this Agreement, at no additional cost to APD.
3. To comply and cooperate immediately with APD requests for information, records, reports, and documents deemed necessary to review the rate setting process to ensure that provider rates are based on accurate information and reflect the existing operational requirements of each service. Any individual who knowingly misrepresents the information required in rate setting commits a felony of the third degree, punishable as provided in sections 775.082 and 775.083, F.S.
4. To comply and cooperate immediately with any inspections, reviews, investigations or audits deemed necessary by APD's Office of the Inspector General pursuant to section 20.055, F.S.
5. To include the aforementioned audit, inspections, investigations and record keeping requirements in all subcontracts and assignments.

B. Confidentiality of Client Information

Not to use or disclose any information concerning a client receiving services under this Agreement for any purpose prohibited by state or federal law or regulation, except with the written consent of a person legally authorized to give that consent or when authorized by law. This includes compliance with: the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. 1320d, and all applicable regulations provided in 45 CFR Parts 160, 162, and 164; and 42 CFR, Part 431, Subpart F, relating to the disclosure of information concerning Medicaid applicants and recipients.

C. Indemnification

Incorporated by reference in 59G-13.083, F.A.C., effective _____.

1. To be liable for and indemnify, defend, and hold APD, AHCA and all of their officers, agents, and employees harmless from all claims, suits, judgments, or damages, including attorneys' fees and costs, arising out of any act, actions, neglect, or omissions by the Provider, its agents, employees, or subcontractors during the performance or operation of this Agreement or any subsequent modifications thereof, whether direct or indirect, and whether to any person or tangible or intangible property. The Provider shall not be liable for that portion of any loss or damages proximately caused by the negligent act or omission of APD or AHCA.
2. That its inability to evaluate its liability or its evaluation of liability shall not excuse the Provider's duty to defend and to indemnify within 7 days after notice by APD or AHCA by certified mail. After the highest appeal taken is exhausted, only an adjudication or judgment specifically finding the Provider not liable shall excuse performance of this provision. The Provider shall pay all costs and fees, including attorneys' fees related to these obligations and their enforcement by APD or AHCA. APD or AHCA's failure to notify the Provider of a claim shall not release the Provider of these duties.

D. Insurance

To obtain and maintain at all times continuous and adequate liability insurance coverage during the term of this Agreement. The Provider accepts full responsibility for identifying and determining the type and extent of liability insurance necessary to provide reasonable financial protection for the Provider and APD clients served by the Provider. All insurance policies shall be through insurers authorized or eligible to write policies in Florida. Such coverage may be provided by a self-insurance program established and operating under Florida law.

E. Payment

To accept payment for goods and services at rates periodically established by AHCA and APD. The most current rates are available on APD web site: www.apd.myflorida.com/providers. The signatories recognize that APD is limited by appropriation and acknowledge that Florida law requires AHCA and APD to make any adjustment necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, including but not limited to adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or limiting enrollment. [See sections 393.0661, 409.906, 409.908, F.S.]

F. Return of Funds

To be responsible for the timely correction of all billing or reimbursement errors resulting in an overpayment, including reimbursement for services not properly authorized or documented. Reimbursement will be made pursuant to the Florida Medicaid Provider Reimbursement Handbook, CMS-1500. Federal regulations, 42 CFR § 433.312, require refund of overpayments within 60 days of discovery. AHCA will be the final authority regarding the timeliness of the reimbursement process.

G. Independent Status

That the Provider acts at all times in the capacity of an independent service provider and not as an officer, employee, or agent of APD, AHCA, or the State of Florida. The Provider shall not

represent to others that it has the authority to bind the APD or AHCA unless specifically authorized in writing to do so. In addition to the Provider, this is also applicable to the Provider's officers, agents, employees, or subcontractors in performance of this Agreement.

III. TERMINATION:

A. This Agreement may be terminated by either party without cause, upon no less than 30 calendar days notice in writing to the other party unless a lesser time is mutually agreed upon in writing by both parties. Said notice shall be delivered by certified mail, return receipt requested, or in person with proof of delivery.

B. This Agreement may be terminated for the Provider's unacceptable performance, non-performance or misconduct upon no less than 24 hours notice in writing to the Provider. Waiver by either party of any breach of any term or condition of this Agreement shall not be construed as a waiver of any subsequent breach of any term or condition of this Agreement. If APD determines that the Provider is not performing in accordance with any term or condition in this Agreement, APD may, at its exclusive option, allow the Provider a period of time to achieve compliance. The provisions herein do not limit APD's right to any other remedies at law or in equity.

IV. GOVERNING LAW:

This Agreement shall be construed, performed, and enforced in all respects in accordance with all the laws and rules of the State of Florida, and any applicable federal laws and regulations.

V. AGREEMENT DURATION:

This Agreement shall be effective _____ or the date on which it has been signed by both parties, whichever is later, and shall terminate on _____ which is no later than three years from the effective date.

VI. OFFICIAL REPRESENTATIVES (Names, Address, Telephone Number, and E-mail Address):

1. The Provider's contact person and street address where financial and administrative records are maintained is:

Name: _____
Telephone Number: _____
Address: _____
E-mail Address: _____

2. The representative of the Provider responsible for administration of the services under this Agreement is:

Name: _____
Telephone Number: _____
Incorporated by reference in 59G-13.083, F.A.C., effective _____.

Address: _____
E-mail Address: _____

3. The Agency for Persons with Disabilities contact person for this Agreement is:

Name: _____
Telephone Number: _____

Address: _____
E-mail Address: _____

4. Upon change of the representative's names, addresses, telephone numbers, and e-mail addresses, by either party, notice shall be provided in writing to the other party and the notification attached to the originals of this Agreement.

VII. INTEGRATED AGREEMENT:

Only this Agreement, any attachments referenced, the Medicaid Provider Agreement, the *Developmental Disabilities Waiver Services Coverage and Limitations Handbook*, and the *Family and Supported Living Waiver Services Directory*, which are incorporated into this Agreement by reference, contain all the terms and conditions agreed upon by the parties.

There are no provisions, terms, conditions, or obligations other than those contained herein, and this Agreement shall supersede all previous communications, representations, or agreements, either verbal or written between the parties. If any term or provision of the Agreement is found to be illegal or unenforceable, the remainder of the Agreement shall remain in full force and effect and such term or provision shall be stricken.

The Provider, by signing below, attests that the Provider has received and read the entire Agreement, inclusive of its attachment's and documents as referenced in Section I, A., including the service-specific requirements and Core Assurances for enrolled providers, contained in the *Developmental Disabilities Waiver Services Coverage and Limitations Handbook* and the *Family and Supported Living Waiver Services Directory*, and understands each section and paragraph.

IN WITNESS THEREOF, the parties hereto have caused this ____ page Agreement to be executed by their undersigned officials as duly authorized.

PROVIDER:

STATE OF FLORIDA,
AGENCY FOR PERSONS WITH DISABILITIES

SIGNED
BY:
NAME:

SIGNED
BY:
NAME:

TITLE:

TITLE:

DATE:

DATE:

Medicaid Provider #:

(DD Waiver)

and/or

(FSL Waiver)

Example
For Review Only

Incorporated by reference in 59G-13.083, F.A.C., effective _____.