BILLING POLICY MANUAL

DIVISION OF DEVELOPMENTAL DISABILITIES

Department of Behavioral Healthcare, Developmental Disabilities and Hospitals

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INTRODUCTION

Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) delivers home and community-based services to eligible adults with intellectual and developmental disabilities in accordance with both its statutory requirements and Global Consumer Choice Section 1115 Demonstration Waiver extension. The Medicaid 1115 waiver extension, reauthorized on January 1, 2019, constitutes the legal authority granted to the State by federal government to pursue innovations that improve health care access, quality and outcomes and further the goals of the Medicaid Programs. The terms and conditions of the State's Medicaid 1115 Waiver act as a contract that establishes the scope of the State's flexibility under federal law relative to the Medicaid State Plan. The home and community-based services provided to eligible adults with intellectual and developmental disabilities are financed through legislative appropriations. The State, however, must submit a request to CMS for review and approval of all changes to the Medicaid 1115 Waiver.

http://www.eohhs.ri.gov/ReferenceCenter/MedicaidStatePlanand1115Waiver/WaiverExtension.aspx

BHDDH is guided by its commitment to access, quality and safety and funds a system of services that:

- Supports people living in the community in charge of their lives;
- Allows individuals to spend resources more flexibly;
- Aligns resources to individual needs – people get what they need, no more, no less;
- Uses a standardized reimbursement process that funds equally for the same service as a matter of fairness for providers and for individuals; and
  Is transparent for all our stakeholders, service recipients, providers, the federal government, the legislature and our Governor.

BHDDH authorizes and reimburses the provision of these services by licensed Developmental Disability Organizations (DDOs) through an established fee for service payment model. This payment model was designed to offer the most flexibility and portability to individuals to promote the following:

- Community-based living in the least restrictive settings;
- integrated day and employment support; and
- choice for individuals in how they direct their lives.

SCOPE OF THE MANUAL

This manual intends to provide detailed information and technical guidance on billing practices and requirements for HCBS services for licensed DDOs and other agencies. It provides a summary of DD eligibility, assessment and service definitions and requirements.

ELIGIBILITY CRITERIA

To be eligible for HCBS funded supports through the Division of Developmental Disabilities, individuals must meet two levels of eligibility. The first is the clinical eligibility and is defined in RI state law 40.1-1-8.1. This requires that an applicant be:

- a Rhode Island resident;
- have an Intellectual Disability or meet the definition of developmental disability,

http://www.bhddh.ri.gov/developmentaldisabilities/application_eligibility.php.

Once a decision of DD eligibility has been confirmed, individuals must also be determined Medicaid long-term care eligible by the Department of Human Services. This eligibility is often referred to as the 'DD waiver' but is essentially a decision of financial and clinical eligibility for long term care services through Medicaid. This decision must be confirmed prior to the provision of HCBS services and periodic redeterminations of continued eligibility are required.

With the foundational principles of the 1115 Global Waiver:

- Pay for value, not volume;
- Coordinate physical, behavioral, and long-term healthcare;
- Rebalance the delivery system away from high-cost settings; and
- Promote efficiency, transparency, and flexibility.

BHDDH is committed to a person-centered planning process that considers access to natural supports and other Medicaid services to develop an individualized plan of supports and services that identifies the individual's goals and preferences. Selection of other Medicaid service options may, however, reduce the allocation of certain DD funded services to ensure non-duplication.

The Executive Office of Health and Human Services (EOHHS) provides three other Medicaid options: Rite-at-Home Program, Personal Choice and Independent Provider Model.

- DD individuals who choose the Rite-at-Home Program and are not enrolled in the adult day program through Rite-at-home are eligible for BHDDH's day program, professional services while in day program, transportation, and support coordination services only.

- DD individuals who choose the Personal Choice Program through EOHHS are not eligible for BHDDH services. The EOHHS Personal Choice is a Department of Human Services (DHS) Medicaid Waiver program.

- DD individuals who choose the Independent Provider (IP) Model through EOHHS may be eligible for a reduced BHDHH allocation of DD services. This will be determined by assessing the amount of IP services the individual will receive and decreasing the DD authorization by that amount. There are no DD service exclusions for the remaining DD allocation. It is the responsibility of the plan writer to confirm via the BHDDH social case worker what funding may be available to the individual. Changes in the DD service plan and/or in the IP authorization are relational and will require modifications to remain within DD tier allocation.

ASSESSMENT

Following a determination of eligibility for DD funded services, individuals receive a resource allocation based on their needs assessed through the Supports Intensity Scale (SIS-A) and aligned with the setting where they live (family, independent, SLA, or group home). Individuals use this resource allocation to guide their decision making around the preferred service pathways – agency delivered supports; self-direction; or combination of agency and self-direction.

Using a person-centered planning process, individuals determine the specific services they desire (within the established allocation) including the amount and the provider of the service(s).

If an individual chooses to purchase services from an agency, then the individual selects the agency they wish to receive supports from. After this selection is made, the individual/their family will work with a Support Coordinator from that agency to develop the selection of services they want to purchase that is within their budget.

If an individual chooses to self-direct services, then the individual selects a fiscal intermediary who will work with them to complete background verification of potential employees, assists with new hire paperwork, and ensure payment for services rendered in accordance with federal and state rules. The fiscal intermediary does not write, monitor or modify service plans and additionally does not help with the recruitment or selection of employees. Their role is limited to the administrative requirements of employment.

If an individual prefers to use a hybrid model of agency and self-directed services, the fiscal intermediary will receive the Support Facilitation, and the agency will receive the Support Coordination Combo to ensure coordination of an ISP that represents the selection of both service types.

Regardless of which pathway for services is selected, service planning to develop an Individual Support Plan (ISP) and a Purchase Order (PO)is required *annually* and scheduled in accordance with the individual's anniversary date. The quarter prior to the anniversary date, all consumers will receive a tier letter confirming service allocation levels associated with the most recent SIS-A assessment. All ISPs and P O must be submitted 45 days before the last date of the current ISP for review and processing. ISPs received after the expiration of the current ISP will not be backdated and authorizations will reflect the date the ISP was received.

A P O serves as the basis for the Support Agreement between the individual and the agency. It also serves as the basis for developing Service Allocation Authorizations. The P O request will be completed on a standardized form created by BHDDH. The PO should detail the units of service(s) selected by the individual and multiplied by the current rate on file for that service. If an individual chooses to self-direct services, then the rate sheet shows the maximum rate that BHDDH will pay for a service. *Individuals who self-direct may choose to pay a rate lower than the maximum rate on file.* The lead agency submits the individual's ISP and PO request to BHDDH's ISP email address bhddh.isp@bhddh.ri.gov for processing. BHDDH will review the P O to generate the Service Allocation Authorizations that will be viewable in the provider portal in DXC. The Service Allocation Authorizations are reflected in units, dollars, months, days, and trips. Service Allocation Authorizations are assigned to the providers selected by the individual (via the ISP/P O) on a quarterly basis.

PROVIDER ELIGIBILITY

The Rhode Island Executive Office of Health and Human Services (EOHHS) manages the Medicaid Program. DXC Technology is the fiscal agent for EOHHS and the Medicaid Programs. As the fiscal agent DXC, is responsible for enrollment, claims processing and reconciliation. All licensed DDOs and agencies delivering waiver services need to be enrolled with DXC Technology. Provider enrollment guides are available through DXC Technology.

https://www.riproviderportal.org/HCP/Default.aspx?alias=www.riproviderportal.org/hcp/provider

To participate in the Rhode Island Medicaid Program, providers must meet the following requirements:

- Providers must be located and be performing services in Rhode Island (except for border communities).
- In-state providers must be licensed or certified by the state of Rhode Island; Out-of-state providers must be licensed or certified in their respective states.

Provider enrollment in Rhode Island Medicaid is required for submission and reimbursement of all claims for authorized Medicaid services. Rhode Island Medicaid enrollment requires, at a minimum, a tax ID, National Provider Identifier (NPI) number, and a BHDDH license number.

While Rhode Island Medicaid enrollment is required for billing, Medicaid is always the payer of last resort. All other third-party programs must be utilized prior to any RI Medicaid payment for services. If payment from other third parties is equal to, or exceeds, the RI Medicaid allowable amount, no further payment will be made on the claim. Unless otherwise stipulated, the Medicaid Program reimbursement is considered payment in full. The provider is not permitted to seek further payment from the recipient in excess of the Medicaid Program rate.

When it is stipulated that a recipient must "spend down" or contribute a portion of their personal income towards the cost of care, the amount of the recipient share will be indicated on the DHS notice sent to the recipient. The lead provider must collect this cost of care as all claims will be reduced by the amount of the assessed cost of care obligations. Please refer to Rhode Medicaid Provider Reference Manual pages 7 and 8. http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/MA%20Providers/MA%20Reference%20Guides/General%20Guidelines/General_Guidelines.pdf

SERVICE ALLOCATION AUTHORIZATION PROCESS

Individuals will be given a Tier Allocation determined by the SIS assessment. From this allocation individuals can select the services they want to purchase, the providers from whom they want to purchase the services and the amount of services they prefer in accordance with their allocation.

a. If an individual chooses to self-direct services, then the individual selects a plan writer who will work with them to develop a budget and identify the types and amounts of services they want.
b. If an individual chooses to purchase services from an agency, then the individual selects the agency from which they wish to receive supports. After this selection is made, the individual/their family will work with a Support Coordinator from that agency to develop the selection of services they want to purchase. from their budget.
c. A P O will be created from the process in (a) or (b) which will serve as the basis for the Support Agreement between the individual and the agency. It also serves as the basis for developing Service Allocation Authorizations.

The P O shows the units of service selected by the individual and multiplies each service by the current rate on file for that service.

a. The rate sheet reflects the current approved rates that are paid by BHDDH. If there is a change in rates BHDDH will send out an updated rate sheet to agencies to share with individuals and families during the budgeting process.

The PO should represent the individuals integrated services by tier, residence type, provider selected, and date range. The PO date range is based on quarterly authorizations (7/1/19 to 9/30/19; 10/1/19 to 12/31/19; 1/1/20 to 3/30/20; and 4/1/20 to 6/30/20). If an individual start on a date that is different from the beginning of a quarter, the provider will need to have more than one PO with prorated units.

- Example: Individual starting on 8/1/19. The first PO will be dated 8/1/19-9/30/19 (end of quarter) with all integrated service units prorated for 2 months. The second PO will be dated for the full quarter (10/1/19 to 12/31/19). All integrated services to reflect the tier units.

a. An individual submits their 90-day Intermittent Individual Service Plan (IISP) or the Individual Service Plan (ISP) along with the (PO request to BHDDH's ISP email address **bhddh.isp@bhddh.ri.gov** for processing. If an individual chooses to self-direct services, then the individual submits their PO through the fiscal intermediary that they have selected.
b. If an individual chooses to purchase services through an agency, then the individual submits their P O through the Support Coordinator. If an individual chooses to receive services from multiple agencies, he/she will still only have one Support Coordinator.
c. If an individual chooses agency services for 90 days, their P O will reflect the start date to the end of the quarter date within the 90 days (see above on dating the P O). If the individual continues with the agency, an ISP will need to be submitted along with new P O that reflect the new date range. The individual should submit their P O through the Support Coordinator for both the IISP and ISP.
d. If an individual chooses to purchase services through self-direction and an agency, the fiscal intermediary will receive the Support Facilitation, and the agency will receive the Support Coordination Combo.
e. BHDDH will review the P O and generate the Service Allocation Authorizations in units, dollars, months, days, and trips.
f. Service Allocation Authorizations will continue to be assigned to the providers that the individual selects on a quarterly basis.
g. For individuals who self-direct services, the Service Allocation Authorizations will continue to be made to the fiscal intermediary.
h. If BHDDH is mandated to increase or decrease expenditures from the Legislature, then the rates paid for services will be adjusted accordingly but the units in the Service Allocation Authorizations will remain constant.
i. Authorizations are not effective prior to the date of IISP/ISP submission. Backdating of POs is not allowed without prior written consent of the department administrators and limited to emergency authorizations to address situations of imminent health and safety.
j. When an individual has been assessed a new tier through the situational Supports Intensity Scale-A (SIS-A) process or a regular SIS-A evaluation, the provider is required to submit the new SIS letter, new ISP and P O reflecting the start date of the new tier and the funding package level that has been awarded.
k. When an individual has a change in residence, the provider must submit a new ISP and P O that reflects the new residence type within the individuals tier funding package.

BILLING CRITERIA AND SERVICE DEFINITIONS

Service Name: Support Coordination				
Definition:	**Responsibilities:**	**Reimbursement Includes:**	**Billing Codes:**	**Service Allocation:**
Services that assist individuals in gaining access to needed waiver and State plan services, as well as necessary medical, social, educational and other services.	Assisting an individual in developing and maintaining their Individualized Service Plan (ISP) with the, support of their family, and other team members (which are designated by the individual). The Support Coordinator is responsible for the ongoing monitoring of the provision of services included in the ISP and for supporting modifications to the ISP as needed or requested.	Wages and fringe benefits of the support coordinator; other provider staff that participate in support coordination activities; Transportation costs incurred by the support coordinator to fulfill job duties; and Provider administrative costs.	Tier A = T2022 Modifier U5 Tier B = T2022 Modifier U5 Tier C = T2022 Modifier U5 Tier D = T2022 Modifier UA Tier E = T2022 Modifier TG Shared Support Coordination (FI/agency) = T2022 L6 Supplemental Funding T2022 L9	Monthly rate assigned using a hierarchal approach in this order Residential; SLA; Community based supports; Day program. The rate will vary based on individual(s) supplemental funding.

<u>Supplemental Service Criteria: Support Coordination</u>

If an individual transfers from one DDO to another agency, the DDO who supports the individual on the 1st of the month will receive the support coordination. The transfer DDO will receive the remaining month(s) within the quarter. As this is a monthly billing unit, there is no partial billing.

BHDDH will not authorize more than one agency for support coordination per month (except in the case of an L6). An L6 is support coordination limited to individuals who choose both self-direction and DDO day services. It provides reimbursement for the secondary DDO to coordinate the ISP for the day program services.

Service Name: Residential Habilitation				
Definition:	**Responsibilities:**	**Reimbursement Includes:**	**Billing Codes:**	**Service Allocation:**
Individually tailored supports provided in a group home setting, that is subject to licensure, to assist with the acquisition, retention, or improvement in skills related to living in the community.	Adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist an individual to reside in the most integrated setting appropriate to his/her needs. Residential habilitation also includes personal care and protective oversight and supervision.	Wages and fringe benefits of the DSP, Supervisory staff, Professional Service/, Behavioral Support/ Medical Support staff. Wages and fringe benefits of all DSPs that provide support in the community setting for the time worked when not face-to-face with individuals, such as training and attendance at Support Coordination meetings; and Vehicle costs and/or mileage reimbursement to staff who transport individuals other than for Day Activity Transportation.	Tier A = T2033 Modifier U5 or T2016 Modifier U5 Non-Congregant; Tier B = T2033 Modifier U6 or T2016 Modifier U6 Non-Congregant; Tier C= T2033 Modifier U7 or T2016 Modifier U7 Non-Congregant; Tier D = T2033 Modifier UA or T2016 Modifier UA Non-Congregant; Tier E = T2033 Modifier TG or T2016 Modifier TG Non-Congregant. Supplemental Funding T2033 L9 or T2016 L9	Per diem; 90, 91, or 92 days per quarter The rate will vary based on individual(s) supplemental funding.

Supplemental Service Criteria: Residential Habilitation

Individuals funded for residential support receive supports and services at a level of, and not to exceed, eighteen (18) hours per day, Monday through Friday and twenty-four (24) hours per day Saturday and Sunday. Individuals should be involved in meaningful day activities or employment programs during hours they do not receive residential supports. The meaningful day activities are to be reimbursed under a separate service.

Residential services are authorized in accordance with the level of care requirements in the approved 1115 Demonstration Waiver. This level of care reserves residential services for those individuals assessed as Tier C, D, and E or for those individuals tier A and B who meet the established exceptions criteria which enable access to service options that do not correspond to their level of need tier.

Residential support services do not include payments for room and board but do include provider program costs and provider administrative costs.

Supplemental funding is approved through the S106 or S109 process (page 35). The DDO billing process for the supplemental funds is as follows:

1. The Tier service is billed using either T2033 Modifier UA or T2016 Modifier UA Non-Congregant.
2. The supplemental funding service is billed using T2033 Modifier L9 or T2016 Modifier L9 Non-Congregant.

Service Name: Shared Living Arrangement				
Definition:	**Responsibilities:**	**Reimbursement Includes:**	**Billing Codes:**	**Service Allocation:**
Individually tailored support option for an individual to reside with and receive supports from someone who has contracted with a shared living placement agency.	Recruitment of qualified contractors; Matching of individuals to qualified contractors; Training, monitoring and ongoing oversight of the SLA placement and adherence to the goals of the ISP; Provision of respite services.	Wages and fringe benefits of the DSPs that receive training related to this service, that provide training to families, and that monitor and conduct visits to SLA Contractor; Payment for respite services for SLA Contractors; Transportation costs incurred by the provider staff to fulfill job duties; and Provider administrative costs include, but are not limited to, recruitment, selection, oversight, and costs to perform criminal background and other checks to ensure the integrity of the SLA Contractor and the safety of the individual in the SLA.	Tier A = T2033 Modifiers U5 and U1 Tier B = T2033 Modifier U6 and U1 Tier C= T2033 Modifier U7 and U1 Tier D = T2033 Modifier UA and U1 Tier E = T2033 Modifier TG and U1 Supplemental Funding = T2033 L9 and U1	Per diem; 90, 91, or 92 days per quarte The rate will vary based on individual(s) supplemental funding.

Supplemental Service Criteria: Shared Living Arrangement

Shared living services are authorized in accordance with the level of care requirements in the approved 1115 Demonstration Waiver. This level of care reserves shared living services for those individuals assessed as Tier B, C, D, and E or for those individuals in tier A who meet the established exceptions criteria which enable access to service options that do not correspond to their level of need Tier.
SLA support services do not include payments for room and board but do include provider program costs and provider administrative costs.

Supplemental funding is approved through the S106 or S109 process (page 35). The DDO billing process for the supplemental funds is as follows:

1. The Tier service is billed using either T2033 Modifier 1 and Modifier 2 (example: T2033 U5 and U1).
2. The supplemental funding service is billed using T2033 Modifier L9 and Modifier U1.

Each SLA resource tier represents the expected number of annual visits or monitoring calls that provider staff will make to an SLA Contractor as well as the average number of respite hours available for the individual:

Tier A: 21 visits/monitoring calls per year, 200 hours of respite per year

Tier B: 28 visits/monitoring calls per year, 200 hours of respite per year

Tier C: 32 visits/monitoring calls per year, 300hours of respite per year

Tiers D/E: 40 visits/monitoring calls per year, 300 hours of respite per year

While SLA host family are contractors of the DDO, BHDDH establishes the minimum amounts to be reimbursed, per tier, to shared living contractors. Providers of the S L services shall retain documentation to support the minimum amounts paid to SLA contractors and the number of annual visits and monitoring calls. Individuals can only be authorized to receive either Community Residence Support, Non-Congregant Residential Support, or Shared Living Arrangement at one time.

Tier	**HCPCS**	**Billing Unit**	**BHDDH Adopted Rate (as of July 1, 2017)** ***SLA Host Family Reimbursement***
Tier A	T2033 U5 U1	Per Day	Current Rate $48.00
Tier B	T2033 U6 U1	Per Day	Current Rate $58.00
Tier C	T2033 U7 U1	Per Day	Current Rate $75.00
Tier D & E	T2033 UA U1 and T2033 TG U1	Per Day	Current Rate $90.00

Service Name: Respite				
Definition:	**Responsibilities:**	**Reimbursement Includes:**	**Billing Codes:**	**Service Allocation:**
Direct support to individuals furnished on a short-term basis due to the absence of a caregiver or the need for relief of those persons who normally provide care for th individual. Respite can be delivered in an individual's home, a private place of residence or at the location of a respite care provider or in the community.	The provider must ensure that the individual's routine is maintained to attend school, work, or other community activities/outings. Community outings shall be included in the supports provided and the Respite Care provider is responsible for providing transportation for community outings.	Wages and fringe benefits of the p DSPs; Wages and fringe benefits of all DSPs that provide support for the time worked when not face-to-face with individual's, such as travel time to and from appointments and training time; Wages and fringe benefits of Supervisory staff that provide support to the DSPs; Mileage reimbursement to staff to travel to the individual's location or who transport the individual in the community; and Provider administrative costs.	Tier A – E = T1005 Emergency Respite = S9125 Supplemental funding = T1005 L9	Tier A & B = 200 units per quarter; 15-minute units Tier C, D, & E = 300 units per quarter; 15-minute units Emergency respite = per diem The rate will vary based on individual(s) supplemental funding.

Supplemental Service Criteria: Respite

Respite Care can be billed up to a 24-hour service period. However, when the consecutive number of hours of service is nine (9) or greater in a 24-hour period, the provider shall bill the Respite Care Daily rate on file. Respite Care cannot be provided or billed for at the same hours on the same day as Community-Based Supports or Day Program Services.

Respite reallocation is for emergency coverage or coverage for planned vacations within the individuals plan year. The balance for respite services cannot be rolled over to subsequent years. The reallocation form can be located on the BHDDH website.

Individuals can be authorized to combine/share the Respite units with Community-Based Supports. The shared units must remain within the individuals Tier Package Funding.

Service Name: Access to Overnight Shared Supports				
Definition:	**Responsibilities:**	**Reimbursement Includes:**	**Billing Codes:**	**Service Allocation:**
The availability of direct support and assistance on an on-call basis for individuals who live independently in the community and in a setting where direct support can be easily shared among a group of individuals, such as an apartment building.	Provision of direct support to be shared among individuals to assist them to achieve and/or maintain the outcomes of increased independence, productivity, and inclusion in the community.	Wages and fringe benefits of the DSPs that provide the supports; Wages and fringe benefits of Supervisory staff when Access to Overnight Shared Supports are delivered by DSPs; Wages and fringe benefits of all staff that provide support for the time worked when staff are not face-to-face with individuals, such as training time and attendance at Support Coordination meetings; and Provider administrative costs.	T2016 U8	Per diem

Supplemental Service Criteria: Access to Overnight Shared Supports

Access to Overnight Shared Supports is not intended to supplant nonpaid natural supports. This service is only available to individuals who live independently and not in a BHDDH licensed or unlicensed group home setting. All staff shall be awake for the duration of the service.

Service Name: Community-Based Supports				
Definition:	**Responsibilities:**	**Reimbursement Includes:**	**Billing Codes:**	**Service Allocation:**
The availability of direct support and assistance for individuals, or for the relief of the caregiver, in or out of the individual's residence.	This support is to achieve and/or maintain the outcomes of increased independence, productivity, enhanced family functioning, and inclusion in the community, as outlined in his/her individualized service plan (ISP). Community-based support services are intended to assist or make available the opportunity for a individual to live in	Wages and fringe benefits of the DSP that provide the support; Wages and fringe benefits of Supervisory staff when the Community-Based Supports are delivered by DSPs; Wages and fringe benefits of all DSPs that provide support for the time worked when not face-to-face with individuals, such as travel time to and from appointments, missed appointments, training time and attendance at Support Coordination meetings;	T2017 standard (no modifier) Ratio 1:1 T2017 UN Ratio 1:2 T2017 UP Ratio 1:3 T2017 UQ Ratio 1:4 T2017 UR Ratio 1:5 T2017 US Ratio 1:6 T2017 L9 (supplemental funding)	15 Minutes The rate will vary based on individual(s) supplemental funding.

	their home or in their family home.	Mileage reimbursement to DSPs who travel to the individual's location where the service will be delivered; Provider program costs; and Provider administrative costs.		

Supplemental Service Criteria: Community-Based Supports

Community-based support services are not intended to supplant non-paid natural support., Community-based supports may be delivered one-on-one to an individual or may be shared with other individuals.

Examples of the services that may be provided under Community-Based Supports include:

a. Assistance and prompting with personal hygiene, dressing, bathing, grooming, eating, toileting, ambulation or transfers, other personal care and behavioral support needs, and any medical task which can be delegated.
b. Assistance and/or training in the performance of tasks related to maintaining a safe, healthy and stable home, such as housekeeping, bed making, dusting, vacuuming, laundry, cooking, evacuating the home in emergency situations, shopping, and money management. Not included are the cost of the supplies necessary or the cost of the meals themselves.
c. Personal support and assistance for participating in the community, health, and leisure activities. This may include accompanying the individual to these activities. This does not include the cost of the activity for the individual and/or DSP.
d. Support and assistance in developing relationships with neighbors and others in the community and in strengthening existing informal social networks and natural supports. This may include encouraging and fostering the development of meaningful relationships in the community reflecting the individual's choices and values, such as, doing preliminary work toward membership in civic, neighborhood, church, leisure, etc. groups.
e. Enabling and promoting individualized community supports targeted toward inclusion into meaningful integrated experiences, such as volunteer work, community awareness activities and/or teaching.
f. Providing orientation and information to acute hospital nursing staff concerning the individual's specific Activities of Daily Living (ADLs), communication, positioning, and behavioral needs. The provider can perform support functions, such as facilitating communication needs and assistance with behavioral supports.

Note: This service shall be face to face, and available to respond to the individual's immediate needs. Community-Based Support can be provided outside the individual's home; however, this does not include the staff member's residence, regardless of relationship. Individuals cannot receive Community-Based Supports simultaneously with Community Residence Support or Non-Congregant Residential Support.

Supplemental funding is approved through the S106 or S109 process (page 35). The DDO billing process for the supplemental funds is as follows:

1. The Tier service is billed using either T2017 1:1 has no modifier or T2017 UN Modifier.
2. The supplemental funding service is billed using T2017 Modifier L9.

Service Name: Natural Supports Training				
Definition:	**Responsibilities:**	**Reimbursement Includes:**	**Billing Codes:**	**Service Allocation:**
Training and counseling services provided to an individual's family. Natural Supports Training Service by Professional Staff is limited to a degreed psychologist, a licensed psychiatrist, a licensed physical therapist, a licensed occupational therapist, a licensed speech language pathologist, a licensed social worker, or a registered nurse.	To increase capabilities to care for, support and maintain the individual in their home.	Wages and fringe benefits of the DSPs or professional services staff that provide the support; Wages and fringe benefits of all DSPs that provide support for the time worked when not face-to-face with individuals, such as travel time to and from appointments, missed appointments, training time and attendance at Support Coordination meetings; Mileage reimbursement to DSPs to travel to the individual's location where the service will be delivered; Provider program costs; and Provider administrative costs.	Natural Supports Training (Standard) = T2013 1:1 Natural Supports Training (Professional Staff) = T2013 UD	Per hour

<u>Supplemental Billing Criteria: Natural Supports Training</u>

An individual's authorization for Natural Supports Training cannot exceed eight (8) hours per day. When applicable, a Natural Supports Trainer must meet all BHDDH licensing requirements and must complete training, certification or licensing requirements as defined by the state to provide the specific service.

Service Name: Assistive Technology				
Definition:	**Responsibilities:**	**Reimbursement Includes:**	**Billing Codes:**	**Billing Unit/Service Allocation:**
Assistive technology means an item, piece of equipment, service animal or product system, whether	The evaluation of the assistive technology needs of an individual, including a functional evaluation of the	Costs for the technology and for the service costs as defined in the definition.	T5999	Per service – requires prior approval

acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of beneficiaries, optimize their health and, promote independence and self-care. Assistive technology service means a service that directly assists an individual in the selection, acquisition, or use of an assistive technology device.	impact of the provision of appropriate assistive technology; Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for individuals; Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices; Coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan; Training or technical assistance for the individual, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the individual;			

Supplemental Service Criteria: Assistive Technology

Assistive technology is also inclusive of such other durable and nondurable medical equipment not available under the state plan that is necessary to address or improve individual functional limitations. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the state plan and exclude those items that are not of direct medical or remedial benefit to the individual.

All items shall meet applicable standards of manufacture, design and installation and are subject to prior approval on an individual basis by BHDDH. The provider must maintain receipts for the assistive technology purchased to substantiate the purchase and may only bill and be reimbursed for the actual amount paid for the assistive technology.

Service Name: Day Program				
Definition:	**Responsibilities:**	**Reimbursement Includes:**	**Billing Codes:**	**Service Allocation:**
Day program service is a service offered at a center-based day program or a community-based day program by a licensed developmental disability organization. This service includes the provision of education, training and opportunity to acquire the skills and experience needed to participate in the community.	This may include activities to support individuals with building problem solving skills, social skills, adaptive skills, daily living skills, and leisure skills.	Wages and fringe benefits of the DSPs who provide support; Wages and fringe benefits of Supervisory staff that provide support; Wages and fringe benefits of staff who provide Professional Service, Behavioral Support and Medical Support; Wages and fringe benefits of all DSPs who provide support when not face-to-face with individuals, such as set up and shut down time, training and attendance at Support Coordination meetings; Vehicle costs and/or mileage reimbursement to staff who transport individuals other than for Day Activity Transportation; Provider capital costs; Provider program costs; and Provider administrative cost.	Tier A = T2021 U5 Ratio 1:10 (center-based 40%) T2021 U5 U1 Ratio 1:10 (community-based 60%) Tier B = T2021 U6 Ratio 1:8 (center-based 40%) T2021 U6 U1 Ratio 1:5 (community-based 60%) Tier C = T2021 U7 Ratio 1:5 (center-based 40%) T2021 U7 U1 Ratio 1:2 (community-based 60%) Tier D = T2021 UA Ratio 1:3 (center-based 40%) T2021 UA U1 Ratio 1:2 (community-based 60%) Tier E = T2021 TG Ratio 1:1 (center-based 40%) T2021 TG U1 Ratio 1:1 (community-based 60%) Supplemental Funding T2021 L9	15 Minutes 1536 Units per quarter – 40% Center-based day 60% Community-based day The rate will vary based on individual(s) supplemental funding.

Service Name: Home-Based Day Program				
Definition:	**Responsibilities:**	**Reimbursement Includes:**	**Billing Codes:**	**Service Allocation:**
Home-Based Day program service is a service offered by a licensed developmental	This may include activities to support individuals with building problem solving skills, social	Wages and fringe benefits of the DSPs who provide support;	Tier A = T2020 U5 Ratio 1:10 Tier B = T2020 U6 Ratio 1:8	Home-based day service = per diem (64 days per quarter)

disability organization. This service includes the provision of education, training and opportunity to acquire the skills and experience needed to participate in the community.	skills, adaptive skills, daily living skills, and leisure skills.	Wages and fringe benefits of Supervisory staff that provide support; Wages and fringe benefits of DSPs who provide Professional Service, Behavioral Support and Medical Support; Wages and fringe benefits of all staff who provide support when not face-to-face with individuals, such as set up and shut down time, training and attendance at Support Coordination meetings; Vehicle costs and/or mileage reimbursement to DSPs who transport individuals other than for Day Activity Transportation; Provider capital costs; Provider program costs; and Provider administrative costs.	Tier C = T2020 U7 Ratio 1:5 Tier D = T2020 UA Ratio 1:2 Tier E = T2020 TG Ratio 1:1 Supplemental Funding T2020 L9	The rate will vary based on individual(s) supplemental funding.

<u>Supplemental Service Criteria: Day Program Service (Center-Based Day Program Service, Community-Based Day Program Service, and Home-Based Day Program Service)</u>

The expected resources for each individual are based on the Day Program Resource Levels. Individuals are authorized for Center-Based Day Program and Community-Based Day Program Services not to exceed eight hours per day. Day Program Services must not be provided nor billed at the same hours on the same day as any other waiver service. The unit to bill for Home-Based Day Program Service is per day and it assumes services provided up to eight hours per day.

Individuals can combine the Day Program Center-Based, Community-Based Support units with Respite, Home Health Agency, Transportation, and Employment. **Note:** The shared units must remain within the Individuals Tier Package Funding.

If an individual chooses multiple service providers for day program services (Center-Based Day Program services, Community-Based Day Program Services, Home-Based Day Program Services, Job Development or Assessment, Prevocational Training, or Supported Employment), a Service Allocation is required for each agency providing a service to the individual.

Supplemental funding is approved through the S106 or S109 process (page 35). The DDO billing process for the supplemental funds is as follows:

1. The Tier service is billed using either T2021 Modifier for tier or T2020 Modifier for tier.
2. The supplemental funding service is billed using T2021 Modifier L9 or T2020 L9.
3. When billing for a full Tier difference awarded through the S107/S110 process, follow number 1 instruction and simultaneously bill the L9 the difference.

Service Name: Professional Services				
Definition:	**Responsibilities:**	**Reimbursement Includes:**	**Billing Codes:**	**Service Allocation:**
Professional Services include, but are not limited to: psychologist, psychiatrist, physical therapist, occupational therapist, speech therapist, registered nurses, interpreters, licensed social workers, licensed mental health counselors ("LMHCs"), and licensed marriage and family therapists ("LMFTs").	Professional Services while in Day Program Community-based Support Professional Staff		T2021 U8 1:1 T2017 UD U8 1:1	15 Minutes 15 Minutes

Service Name: Transportation				
Definition:	**Responsibilities:**	**Reimbursement Includes:**	**Billing Codes:**	**Service Allocation:**
Transportation is defined as a program providing transportation for an individual from his/her residence, or the immediate vicinity thereof, to and from the individual's program in order to participate in employment/day activities.	In providing these services, the DDO is requested to utilize the most clinically appropriate, least restrictive method of transporting the individual. DDOs shall make every effort to support individuals with accessing the Paratransit Program RIDE or any other statewide initiative that is available to transport individuals.	Wages and fringe benefits of the DSPs that provide the service, including their time not face-to-face with the individual; Vehicle costs and/or mileage reimbursement to DSPs to transport Individuals; and Provider administrative costs.	Tier A, B, and C = T2003 Tier D = T2003 UA Tier E = T2003 TG Supplement Funding = T2003 L9	Per trip = 128 per quarter. The rate will vary based on individual(s) supplemental funding.

Supplemental Service Criteria: Transportation

The allowable maximum daily units are 6 trips per day allowing flexibility for day and employment needs. The individual's billable trips are required to adhere to the allocations within the individuals Tier packages.

Transportation Billing Alternative

This method provides an alternative transportation option to employment where the current DDO transportation rates are insufficient for extended travel needs and alternative modes are necessary. Individuals will have the ability to flex their tier package funding for transportation by going through a Fiscal Intermediary to bill transportation such as Ride/taxi/black car/Uber/Lyft. The F I will be the fiduciary agent for transportation while the individual will still access all other services through their lead DDO agency.

Current allocations allow for 128 units of transportation per quarter with a rate based on Tier Level billed to code T2003. Units are defined as individual one-way trips.

Duties outlined by each entity are as follows:

Lead DDO Agency:

1. The Lead DDO Agency will assist the individual(s) with securing a (FI to self-direct their transportation.
2. The Lead DDO Agency will coordinate with an F I to provide all the individual(s) information, anniversary date, P O amendment date, and the amount of agreed transportation funding being assigned to the FI.
3. Upon receipt of the revised PO from the FI, the Lead Agency will email the revised P O with the Self-Direct Tier Funding Reallocation for Transportation Request form to BHDDH.ISP@bhddh.ri.gov.
4. Transportation funds transferred to the I must also include a portion of the funding for Support Facilitation billed to code T2022 U5 U2. The remaining Support Coordination funding will continue to be allocated to the Lead DDO Agency.

Fiscal Intermediary:

1. The F I will complete a self-direct PO for the individual in need of the ability to allocate funding for transportation.
2. The F I will forward the self-direct P O to the Lead DDO Agency. The F I will receive a portion of the Support Facilitation billed to code T2022 U5 U2.
3. The F I will make payments based upon the individual's FI agency's policies. Support documentation must be provided, as an example, a monthly tracking log denoting appropriate and approved destination/return locations with corresponding vendor receipts.
4. The F I will maintain all records and receipts regarding transportation for fiduciary auditing purposes.

If the individual is not authorized for any residential services, the Day Activity Transportation is assigned to their Day Program Service, Prevocational Training or Supported Employment provider. If the individual chooses to self-direct services, then no separate Day Activity Transportation authorization is necessary. The amount that would have been authorized for Day Activity Transportation is subsumed into the individual's total authorization.

A service allocation to the agency providing residential services to the individual will also be given a service allocation for transportation.

1. If one agency serves the individual residentially but another agency serves the individual during the day, and the day program is the agency that provides the transportation, the residential provider may either:

    a. Set up an agreement with the day program agency to pay the day program provider as a subcontractor and bill BHDDH for the transportation delivered by the day program agency, or
    b. Make a request to BHDDH to reassign the transportation Service Allocation directly to the day program provider. This reassignment can be either a revised P O or a Transportation Reallocation Form. (Reallocation form can be located on the BHDDH website Forms- Rhode Island -Dept of Behavioral Healthcare, Developmental Disabilities and Hospitals).

2. In the case of an individual that is only authorized for Day Program services, then the Transportation Service Allocation will be assigned to the Day Program agency.

Service Name: Home Modifications			
Definition:	**Responsibilities:**	**Billing Codes:**	**Service Allocation:**
Home modifications are inclusive of: wheelchair ramps, grab bars in bathrooms and hallways, widening doorways, stair lifts, walk-in tubs, removing safety hazards, or other necessary modifications.	Home modifications must have prior approval from BHDDH in order to be delivered or reimbursed. The provider must maintain receipts for the home modifications purchased to substantiate the purchase and may only be reimbursed for the actual amount paid for the modification.	S5165	Per Service

Home Health Agencies (HHA)

HHA's provide attendant care services and home maker services.

Rates for home care services are established by the RI Executive Office of Health & Human Services (EOHHS) Medicaid office, and approved by the Centers of Medicare and Medicaid Services (CMS)." Individuals can be authorized for services through an HHA and a DDO, providing shared services remain within the individual's Tier funding.

Home Health Agency Rate Increases

HHA rates (codes S5125, S5125 U1, S5130, and S5130 TE) increased as of July 1, 2018. Tier packages for individuals will remain the same. Individuals who utilize all or part of their service packages on HHA services will have the opportunity to exceed their tier packages but only by the amount necessary to compensate for these rate increases.

Existing POs can remain the same. BHDDH fiscal staff will be review all new and renewal PO submissions and will not authorize any services above the Tier package that is not due to the rate increase. As is current practice, if additional services are needed, individuals and agencies must submit an S-109 request for supplemental funding.

If HHAs plan to utilize modifiers, these should be noted as accurately as possible on the submitted PO. Furthermore, when completing a PO, HHAs should use the rate that will be billed. BHDDH staff review utilization quarterly; if there is significant variance from the PO, a revised PO may be required for subsequent quarterly authorizations.

For those individuals who use HHA services through an FI, additional steps may be required. Please contact the FI for further instructions.

Attendant Care Services

Services provided by HHAs who deliver direct support in the home or community to assist individuals in performing tasks based on their individualized service plan for which they are functionally unable to complete independently due to their disability.

Attendant care services include: assistance with activities of daily living, such as grooming, personal hygiene, toileting, bathing, and dressing; assistance with monitoring making, dusting, vacuuming, laundry, grocery shopping, cleaning); assistance with transferring and ambulation; assistance with arranging for or directly providing transportation; and assistance with the use of special mobility devices.

BHDDH HHA Service Title	HCPCS	Modifier	Description of Modifier
Attendant Care	S5125		
Attendant Care-LPN	S5125	TE	LPN – Licensed Practical nurse
Attendant Care –Weekends	S5125	TV	Weekends – Saturday and Sunday
Attendant Care- Medicaid	S5125	U1	Level 1 Care
Attendant Care – Medicaid	S5125	U9	Level 9 Care
Attendant Care – Evenings	S5125	UH	3:00 pm – 11:00 pm
Attendant Care – Nights	S5125	UJ	11:00 pm – 7:00 am
Supplemental Funding	S5125	L9	S110 approval over tier

Homemaker Service is defined as performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker. This service is delivered when an individual is unable to perform these services for themselves or in the temporary absence of the primary caregiver.

BHDDH HHA Service Title	HCPCS	Modifier	Description of Modifier
Homemaker	S5130		
Homemaker - LPN	S5130	TE	LPN – Licensed Practical nurse
Homemaker –Weekends	S5130	TV	Weekends - Saturday and Sunday
Homemaker - Medicaid	S5130	U1	Level 1 Care

Homemaker – Medicaid	S5130	U9	Level 9 Care
Homemaker – Evenings	S5130	UH	3:00 pm – 11:00 pm
Homemaker – Nights	S5130	UJ	11:00 pm – 7:00 am

BHDDH has developed a separate PO for completion by a HHA upon requesting services for BHDDH individuals. (see links and resources for PO).

Service Name: Job Assessment and Development				
Definition:	**Responsibilities:**	**Reimbursement Includes:**	**Billing Codes:**	**Service Allocation:**
Job Assessment and Development Services are services which assist individuals in engaging in the discovery process, implementation of career development plans, participation in trial work experience, and completion of vocational assessments.	Actions to develop, locate and secure employment for individuals in integrated community-based employment settings.	Wages and fringe benefits of the DSPs that provide the support; Transportation costs incurred by the Job Developer to fulfill job duties; and Provider administrative costs.	T2025 UD 1:1 Supplemental Funding = T2025 L9	Per Hour The rate will vary based on individual(s) supplemental funding

<u>Supplemental Service Criteria: Job Assessment and Development</u>

The Job Assessment and Development rate assumes an average of 4.6 hours per day for face-to-face time with individuals and 3.4 hours per day for non-face-to-face time performing other job functions such as outreach to employers, development, education, research, and travel time in the community.

Examples of the services that may be provided under Job Assessment and Development include:

- Discussion with the individual to consider personal interests and motivations
- Consideration of the individual's education, work history, skill level, and strengths
- Consideration of potential barriers to the meeting their employment goal (e.g., absence of transportation)
- Consideration of what the individual must do to improve the probability for success (e.g., receive needed training), or what significant others, such as family members, might do to promote success
- Developing an individualized vocational plan to establish sequenced activities for the individual to assist in achieving their vocational goal(s)
- Establishing and maintaining a job resource bank
- Initiating and maintaining ongoing personal contacts with a variety of business and industry representatives and job placement/training agencies to promote programs for integrated employment
- Explanation of the benefits and employment support services provided by programs to employers, including addressing employer's special needs
- Providing program information to various businesses, schools, chambers of commerce and committees and setting up business orientations

- Researching newspapers, agencies, and other resources for job leads
- Locating jobs for individuals who have successfully completed training programs;
- Matching job skills with applicant qualifications
- Referring qualified applicants to employers
- Participating in outreach and recruitment activities by coordinating and attending job fairs
- Coordinating with high schools to help develop and implement effective transition from school to work for students
- Assisting an individual in business planning

Service Name: Job Coaching				
Definition:	**Responsibilities:**	**Reimbursement Includes:**	**Billing Codes:**	**Service Allocation:**
Job Coaching Services consists of training individuals by a Job Coach, who uses structured intervention techniques to help the individual learn to perform job tasks to the employer's specifications and to learn the interpersonal skills necessary to be successful as an employee at the job site and in related community contacts. In addition to job site training.	Job coaching includes: related assessment, counseling, advocacy, travel training, and other services needed to maintain the employment of the individual.	Wages and fringe benefits of the DSPs that provide support; Wages and fringe benefits of Supervisory staff that provide support; Wages and fringe benefits of all DSPs that provide support when not face-to-face with individuals, such as travel time to and from appointments, missed appointments, training and attendance at Support Coordination meetings; Mileage reimbursement to DSPs while performing job duties; and Provider program costs provider administrative cost.	T2019 1:1 T2019 UN Ratio 1:2 T2019 UP Ratio 1:3 T2019 UQ Ratio 1:4 T2019 UR Ratio 1:5 T2019 US Ratio 1:6 Supplemental Funding = T2019 L9	15 Minutes The rate will vary based on individual(s) supplemental funding

Supplemental Service Criteria: Job Coaching

An individual's authorization for Job Coaching cannot exceed eight (8) hours per day. To bill for this service, the individual and the Job Coach must be present.

When Job Coaching services are provided at a work site in which persons without disabilities are employees, payment will be made only for the adaptations, supervision, and training required by individuals receiving waiver services because of their disabilities and will not include payment for the supervisory activities rendered as a normal part of the business. Job Coaching cannot be provided or reimbursed for the same hours on the same day as any other waiver service.

Service Name: Job Retention				
Definition:	**Responsibilities:**	**Reimbursement Includes:**	**Billing Codes:**	**Service Allocation:**
Job Retention is defined as an employment outcome and support service necessary for a person to maintain or advance in employment consistent with the person's strengths, abilities, capabilities, and interests.	Short-term or intermittent job coaching, communication with the individual and his/her supervisor to ensure job satisfaction and/or promoting employment enhancement.	Wages and fringe benefits of the Job Coaches that provide support at the individual's job site; Wages and fringe benefits of the DSPs that provide job retention support; Wages and fringe benefits of all DSPs that provide supports where they are not face-to-face with individuals, such as travel time to and from appointments, missed appointments, training and attendance at Support Coordination meetings; Mileage reimbursement to DSPs while performing job duties; and Provider program costs and provider administrative costs.	Tier A = T2023 U5 Tier B = T2023 U6 Tier C = T2023 U7 Tier D = T2023 UA Tier E = T2023 TG	Per Month

Supplemental Service Criteria: Job Retention

If an individual request a job change or support to seek an additional job, providers should cease billing job retention and shift to billing job development and/or job coaching.

If the individual should secure additional job responsibilities or require increased job coaching support, the provider should cease billing job retention and bill job coaching.

As guidance, an approximate amount of support hours associated with each tier is listed below to support the expected monthly billing rate for job retention. **If job coaching exceeds these hours the provider may cease billing job retention and bill job coaching.**

Tier A	7 hours
Tier B	9 hours
Tier C	12 hours
Tier D	17 hours
Tier E	21 hours

Note: This service is not to be billed in conjunction with any other employment service**. Job Retention should be billed at the end of each month to ensure no other employment services have been provided.**

Service Name: Prevocational Training				
Definition:	**Responsibilities:**	**Reimbursement Includes:**	**Billing Codes:**	**Service Allocation:**
Prevocational Training Service is assisting individuals in the development of employment related skills. These may include instruction on how to operate work-related equipment, develop work-related skills, and specialized work-related training and education.	Prevocational training is intended to be a service that individuals receive on a time-limited basis in preparation for securing paid employment by an employer other than the provider.	Wages and fringe benefits of the DSPs that provide support; Wages and fringe benefits of Supervisory staff that provide support; Wages and fringe benefits of all DSPs that provide support when not face-to-face with individuals, such as set up and shut down time, training and attendance at Support Coordination meetings; Vehicle costs and/or mileage reimbursement to DSPs to transport individuals other than for Day Activity Transportation; Provider capital costs, program costs; and administrative costs.	T2015 1:1 T2015 UN Ratio 1:2 T2015 UP Ratio 1:3 T2015 UQ Ratio 1:4 T2015 UR Ratio 1:5 T20215 US Ratio 1:6 Supplemental Funding = T2015 L9	Per Hour The rate will vary based on individual(s) supplemental funding

<u>Supplemental Service Criteria: Prevocational Training</u>

An individual's authorization for Prevocational Training cannot exceed eight (8) hours per day. To bill for this service, the individual and the DSP must be present. Prevocational Training cannot be provided or reimbursed for the same hours on the same day as any other waiver service.

A Service Allocation Authorization to the agency that will provide employment services combined with (either Center-Based Day Program Services, Community-Based Day Program Services, Home-Based Day Program Services) is required.

SELF-DIRECT BILLING CRITERIA AND SERVICE DEFINITIONS

<u>Individual Directed Goods or Services</u>

The unit to bill for Individual Directed Goods or Services is per hour (for services) or per item (for goods).

Individuals providing Individual Directed Services shall meet all training and certification as defined by the state to provide the service and must work with the I designated by the self-directed individual.

For Individual Directed Goods, the FI shall maintain receipts for all goods purchased as backup to substantiate the purchase. The FI may only bill for the actual amount paid for the goods.

1. Individual Directed Goods or Services shall mean and include the provision of assistance and resources to individuals with developmental disabilities and their families to improve and maintain opportunities and experiences in living, working, socializing, recreating, and personal growth, safety and health.

2. Individual directed goods or services are services, equipment supplies, not otherwise provided in these regulations or through the Medicaid State Plan that address an identified need and are in the approved individualized service plan and meet the following requirements:

    a. The item or service would decrease the need for other Medicaid services; and/or promote inclusion in the community; and/or
    b. The item or service would increase the individual's ability to perform activities of daily living; and/or
    c. Increase the individual's safety in the home environment; and/or
    d. Alternative funding sources are not available.

Under Medicaid rules, individuals who self-directed their services can use their funding allocation not only to hire DSPs, but also to purchase other goods and services designed to meet disability-related needs.

The following list provides information on allowable and not allowable requests for goods and services:

- Requests for goods and services must:
    - be submitted with and documented in the annual ISP
    - have a clear connection to the individual's identified and established goals
    - be drawn from an individual's allocated resource package
- Requests can be made outside of the annual plan in the event of an emergency or exceptional need for a plan modification.
- Goods and Services can only be authorized through self-directed plans if not available through other funding sources such as health coverage.
- Substitutions to the goods and services approved in an annual budget may be made within the budget category with a similar or related alternative that is within the original budgeted amount for that item.
    - For example, if a specific lifelong learning class is budgeted, but the individual elects to attend a different class, this is allowable without submitting a formal budget modification. If the alternate class costs more, this would require a modification.

Examples of Allowable Self-Directed Goods and Services:

- Transportation for covered service-related activities
- Health coverage for employees
    - Should not exceed $3,000 annually or $250 per month
- Therapeutic services funded discretely or in conjunction with a health club membership or other allowable services. Allowable therapies or therapeutic services include, but are not limited to, physical

therapy, occupational therapy, speech therapy, personal training, hippotherapy, or other therapy that meets all the following conditions:
  - Helps an individual physically, socially, or emotionally
  - Is recognized and provided by a Certified or Licensed practitioner
  - Is tied to specific goals in the individual's ISP
  - Is recommended and documented by a physician as a current need

- Health club memberships and enrollment fees
  - Should not exceed $1200 per year
  - Do not require a physician's note

- Memberships to organizations when there is a clear connection to an outcome measure listed in the individual's ISP
- Specialized equipment and/or assistive technology that will enable or support an individual's independence, functionality, and/or increased access to the community
- Lifelong learning that is not associated with college credits
  - **Note:** Documentation of the requirement of materials necessary for participation in the class must be provided to use allocated funds to purchase the materials.
- Employee Wages and Taxes directly related to support services
- Support Brokerage & Administrative Fees (Workers Compensation, Plan Development)
- Trainings that are related to the individual's overall health, safety or community participation

Examples of Non-Allowable Self-Directed Goods and Services:

- Food
- Housing costs, including utilities or maintenance related expenses
- Prescriptions or co-payments for covered medical services, including eyeglass frames or contact lenses
- Experimental or prohibited treatments

BHDDH Service Title	**HCPCS**	**Modifier**	**Billing Unit**	**BHDDH Adopted Rate (as of July 1, 2017)**
All Tier's	T2025	UD	Varies	Appendix for current rate model

Service Name: Support Facilitation				
Definition:	**Responsibilities:**	**Reimbursement Includes:**	**Billing Codes:**	**Service Allocation:**
Support Facilitation Service empowers individuals to define and direct their own personal assistance	The Support Facilitator guides and supports, rather than directs, and manages the	Wages and fringe benefits of the Support Facilitator Wages and fringe benefits of other DSPs	Vendor transportation only or 2 or less vendors and annual contract <	Per Month

needs and services. The Support Facilitation Service is managed by a Supports Facilitator.	individual through the service planning and delivery process. The Supports Facilitator counsels, facilitates and assists in the development of the Individualized Service Plan and in facilitating the individual in securing and employing their staff. The Support Facilitation Service also includes the services provided by fiscal intermediary.	that participate in Support Facilitation activities or that provide Fiscal Intermediary services; Transportation costs incurred by the Support Facilitator to fulfill job duties; and Provider administrative costs.	$14,999.00 T2022 U5 U2 Vendor Payroll, workers comp and/or vendor payments (over 3 vendors or annual contract < $14,999.00 T2022 U7 U2 Vendor Payroll, workers comp and/or vendor payments (annual contract > $15,000.00) T2022 UA U2 or T2022 TG U2	

Supplemental Service Criteria: Support Facilitation

The expected Support Facilitation resources per individual are defined in each Tier. The authorization for Support Facilitation is assigned to the F I that the individual selects to assist them in self-direction.

If an individual chooses to self-direct services, then the following Service Allocations may be created:

1. A Service Allocation to the FI is selected by the individual for Support Facilitation.
2. A Service Allocation to the FI is selected by the individual for waiver services which will be self-directed. The FI merely serves as the conduit from the individual to DXC, BHDDH's fiscal agent for services purchased under this Service Allocation.
3. An individual may also have other Service Allocations to an agency or agencies if he/she selects an agency to deliver some services within his/her resource allocation (e.g. day program services). In this case, the Service Allocation created will be given to the FI for the units of services selected by the individual.
4. A Support Coordination Service is given to the secondary agency when individuals have a combination of F I and agency Service Allocations. For example: a individual with Tier C Shared Living Arrangement SLA allocates Day Program supports to their FI. In this situation the FI will receive the support facilitation T2022 UA/U1, and the SLA agency will receive the Support Coordination T2022 L6. There can be other combinations with FI and agency combo's such as sharing day and community-based standard supports. The secondary agency will receive the Support Coordination T2022 L6.

Supports Brokerage

Supports Brokerage Service is a support that empowers individuals to define and direct their own personal needs and services. Individuals choosing a individual-directed service model will hire in the supports brokerage service to serve as a guide to the individual through the service planning and delivery process.

Supports Brokerage Service cannot exceed eight (8) hours per day. The person providing the Supports Brokerage service must meet all training and certification as defined by the state to provide the service and must work with the FI designated by the individual self-directing their services and supports. The Supports Broker counsels, facilitates and assists in development of an ISP which includes both paid and unpaid services and supports designed to allow the individual to live in the home and participate in the community. A back-up plan is also developed to assure that the needed assistance will be provided in the event of change in regular services identified in the ISP.

Support Brokerage may be members of the individual's family, provided they do not live in the family member's residence. Payment shall not be made for services furnished by a legally responsible relative defined as: parent of a minor child, foster parent, tutor, curator, legal guardian; or the individual's spouse.

BHDDH Service Title	HCPCS	Modifier	Billing Unit	BHDDH Adopted Rate (as of July 1, 2017)
Support Brokerage, Self-Directed Program	T2041	U2	15 Minutes	See current rate model
First Plan fee	T2041	U2	40 units	One-time payment $500.00
Renewal Fee	T2041	U2	28 units	One-time payment $350.00

Self-Direct Reallocation of Funding

The reallocation process can only occur within a plan year. Funding cannot be transferred from one plan year to another. The process of reallocation is on the Request Reallocation of Funds form which is connected to the self-direct Reallocation Purchase Order. If an individual experiences unexpected overage in expenses in one quarter, and under spending in another, these funds can be reallocated to the quarter needed within the plan year. This is done at the closing of an individual's plan year.

sample of reallocation 2.pdf

sample of reallocation.pdf

Self-Direct HCPC's and Modifiers

When the following services are self-directed, the rate shown is the **maximum** that the individual can pay for the service under self-direction. The individual can pay less than the maximum. Self-directed rate of payment is a blended rate which cannot be higher than the **maximum** rate shown below. (Example: Staffing T2017 U2 rate $20.00 per hour divided by 4 (15-minute increments) is $5.00 blended rate per hour).

BHDDH Service Title	HCPCS	Modifier 1	Modifier 2	Modifier 3	Billing Unit	BHDDH Adopted Rate (as of October 2019)
Self-Directed Goods or Services	T2025	U2			Per Service or Per Hour	$50.00
Day Program Services (community-based)	T2021	U5	U1		15 Minutes	$1.53
Day Program Services (community-based)	T2021	U6	U1		15 Minutes	$1.53
Day Program Services (community-based)	T2021	U7	U1		15 Minutes	$3.47
Day Program Services (community-based)	T2021	UA	U1		15 Minutes	$7.07
Day Program Services (community-based)	T2021	TG	U1		15 Minutes	$7.07
Day Program Supports Prof. Staff while in day program	T2021	U8	U1		15 Minutes	$13.13
Day Program Services (community-based) Supplemental funding	T2021	L9			15 Minutes	Negotiated
Transportation	T2003	U2			Per Trip	$27.70
Transportation	T2003	L9			Per Trip	Negotiated
Community-Based Supports (standard)	T2017	U2			15 Minutes	$7.10
Community-Based Supports (standard)	T2017	L9			15 Minutes	Negotiated

Supplemental funding						
Community-Based Supports (standard)	T2017	UN	U2		15 Minutes	$4.08
Community-Based Supports by Prof. Staff	T2017	UD	U2		15 Minutes	$13.13
Community-Based Supports by Prof. Staff	T2017	UN	UD	U2	15 Minutes	$7.55
Natural Supports Training (standard)	T2013	U2			Per Hour	$32.66
Natural Supports Training (standard	T2013	UN	U2		Per Hour	$18.78
Natural Supports Training by Prof. Staff	T2013	UD	U2		Per Hour	$47.72
Natural Supports Training by Prof. Staff	T2013	UN	UD	U2	Per Hour	$27.44
Respite Care	T1005	U2			15 Minutes	$5.73
Respite Care Supplemental funding	T1005	L9			15 Minutes	Negotiated
Respite Care (overnight)	T1005	UJ	U2		15 Minutes	$4.12
Job Development or Assessment *	T2025	UD	U2		Per Hour	$60.18
Prevocational Training	T2015	U2			Per Hour	$27.76
Job Coaching	T2019	U2			15 Minutes	$7.36

* **Providers can bill code T2025 up to 3 hours for completing necessary paperwork such as Integrated Community Employment – Reporting Form (ICE-RF), employment related goals in the ISP and Variance documentation, when needed.**

BILLING CLAIM REQUIREMENTS

Provider Agencies will only be reimbursed for services delivered.

Note: Absences (vacancy rate) have already been factored into residential and day program rates. Missed appointments/cancellations have already been factored into community-based service rates as well. Please refer to DXC Billing Guidelines for additional information:

http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/MA%20Providers/MA%20Reference%20Guides/General%20Guidelines/General_Guidelines.pdf

The agency must maintain enough documentation to support the services billed and the number of units billed. Please see detailed documentation requirements for each service category. For example, when services are defined by tiers which presume specific staffing levels, weekly schedules and/or payroll timesheets are examples of documentation to retain to support claims submitted for reimbursement. Attendance sheets showing time in/out for individuals is another source of documentation. BHDDH reserves the right to review any documentation for services that are maintained by the provider in order to support billing for the services rendered to an individual. This may include either an on-site or desk review conducted by BHDDH personnel or its assigned designee. Failure to provide adequate supporting documentation for services rendered to individuals may result in the remittance of payments back to BHDDH these payments will be recovered by means of a withhold against future payments.

EOHHS has time limits for filing claims. All Medicaid claims must be received within 365 days of the first services to be accepted for processing and payment. If the individual has other insurance and the **claim is past the 365-day limit**, then an exception will be allowed to process the claim if the other insurance EOB is within the past 90 days. Claims filed past the 90 days will require BHDDH approved paper claim to be filed to DXC. All paper claims and documentation should be mailed to: DXC Technology, PO Box 2010, Warwick, RI 02887-2010. Attached is the waiver claim form link that DD provider use.

Form: http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/waiver_form.pdf

Instructions: http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/waiver_form_inst.pdf

Units for residential services (Community Residence Supports and Non-congregant Residential Supports) will be authorized at the Agency/HCPCS/Modifier level. Agencies cannot bill different modifier rates for these services.

Units for day program services will be authorized at the agency level. Agencies may bill different services or at different modifier rates for these services so long as the individual has selected to use their resource allocation to purchase services in this manner. There are 15-minute increments of service and 250 days of day program.

Integrated Day Services must be individually selected and designed by the service recipient through person-centered planning and include the services and supports necessary to allow individuals to participate in an array of group and non-group, structured and unstructured, activities and to facilitate meaningful choice by individuals between group and non-group activities and structured and unstructured activities.

BHDDH recognizes that individuals in integrated day programs can choose how to plan their day activities. Below is a sample of how an individual can breakout the day activities and how the provider can bill for these day activities.

1. Community-based day programs solely out in the community
2. Center-based day programs that also include outings in the community outside the center
3. Both center-based and community-based day programs, depending on the day
   * For tracking purposes, use the HCPCS/modifier combinations to bill (1), (2)

   - Example: An individual goes to the center for a 6-hour day. For one hour in the day, the individual goes to get ice cream with others in the community. In this example, the agency should bill 5 hours (20 units at 15 min each) to the center-based day program

HCPCS/modifier (T2021 U5) and 1 hour (4 units) to the community-based day program HCPCS/modifier.

- Example: An individual goes to the center for a 6-hour day. Upon arrival, she and others go from the center to a picnic at the park for the day. In this example, the agency should bill all 6 hours (24 units at 15 min each) to the community-based day program HCPCS/modifier. (T2021 U5, U1).

- Example: An individual resides in a group home and receives 1:3 ratio for day supports at the group home. M-W-F she does not leave the group home. Tue-Thu she volunteers 3 hours at a local animal shelter and then returns home to her residence for the remaining 3 hours of day program. In this example, the agency bills home based day program (per diem rate) M-W-F, agency bills T-Thu for the 3hours Community-based day and 3 hours Center-based Day.
  * Example above is based on a 6-hour day (24 units at 15-minute each), 8-hour day maximum is (32 units at 15-minute each).

When billing for a specific service, be mindful of the sequence of the placement of modifiers as shown in the Appendix Section. The exact order of the modifiers is critical, otherwise your claim will be denied for 'non-valid HCPCS/modifier combination'.

If you are billing some units for a specific service using one modifier sequence and other units using another modifier sequence, then divide the units among these two modifier sequences on two different lines on the claim (exception is L9 modifier services- see a below).

- If you are billing for L9 services, bill the number of units delivered on the first line with the tier funding primary modifier. Then bill the difference on the line below it with the same number of units using the L9 modifier.

Recoupment of Claims

Recoupments may be requested by BHDDH for several different circumstances.

a. Individuals have been evaluated to have a higher Support Intensity Scale (SIS) Tier at which time the agency will need to recoup the billing in the date range effective by the increase in Tier;
b. Individual transfers to another agency and services were over billed by the original agency;
c. Individuals late notification of closure of services and the agency's billing date range does not align with the closure date;
d. Audit finding by BHDDH;
e. Error in original billing identified by the agency;
f. Occasions when it is necessary for the agency to recoup the full amount paid by EOHHS.
g. The Claim Recoupment Request Form can be used to recoup an overpayment by EOHHS. Recoupments are deducted from the next Medicaid payment.

Rhode Island Medicaid Provider Reference Manual – General Guidelines on how to process electronic Replacement/Void Claims for recoupments:
http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Billing101_Part3_slides.pdf

Once the recoupment is processed by EOHHS DXC Technologies an Electronic Replacement, Remittance Advice (RA) is sent to the agency. The RA is the official documentation needed for verification of recoupment. The agency will email the RA to the BHDDH Fiscal Department for review and to make the necessary adjustments to the authorized services.

SUPPLEMENTAL FUNDING

The S106 and S109 is a process for individuals and families to apply for supplemental funding for the exceptional needs of an individual. The DD Committee will review requests on a weekly basis. The decision for the S106 is an S107 and the decision for the S109 is an S110. The approved funding is billed under L9 modifier (see Appendix).

Should an individual submit an S106 or an S109:

S106 is defined as:

- An EMERGENCY/crisis in the individual's living situation
- Risk of losing living situation
- Risk of life-threatening incidents
- Repeated incidents relating to the individual’s health and safety
- A new diagnosis of mid-stage organic brain syndromes
- A new diagnosis of serious mental health condition
- Development of new co-morbid conditions
- Development of significant health or medical condition

S109 is defined as:

- Non-Emergency request for supplemental needs but directly related to the imminent health and safety needs as well as employment needs of an individual that cannot be met within tier allocation
-

Requests need to be submitted at least 60 days prior to the requested start date of these services.

When an S109 request for a tier difference (example: difference between tier C and tier E) is submitted and approved anS110 will be sent out to the individua and/or their guardian. A new PO will need to be completed which reflects the additional approved L9 funding. See the L9 Conversion Worksheet that coincides with the correct quarterly tier funding difference on the BHDDH Website. (see links and resources).

The S106 and S109 fillable forms can be found on the BHDDH Website (see links and resources). **All completed forms are to be emailed to bhddh.s109@bhhd.ri.gov.**

FAQ's

Q1. What is a DDO?

> **ANSWER:** "Developmental disability organizations" or "DDOs" means an organization licensed by BHDDH to provide services to adults with disabilities, as provided herein. As used herein, DDOs shall have the same meaning as "providers" or "Organizations." TITLE 212 – DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES, AND HOSPITALS CHAPTER 10 – LICENSING AND GENERAL ADMINISTRATION (section 1:3 24)

Q2. When to submit an Individualized Service Plan (ISP)?

> **ANSWER:** The ISP needs to be completed and submitted to BHDDH.ISP@bhddh.ri.gov email 45 days in advance of the Individuals anniversary quarter. Example: Individuals anniversary is May. The ISP needs to be submitted to BHDDH.ISP@bhddh.ri.gov email in March.

Q3. Does the Interim Individualized Service Plan (IISP) cover Residential and Day?

> **ANSWER:** YES- it should cover all services. The IISP is Interim coverage for 90 days of service. Agencies need to submit an ISP to continue services prior to the end of 90-day IISP.

Q4. Do we need to submit an ISP and Purchase Order (PO) when there is a change in the services, residential status or agency?

> **ANSWER:** YES – Any time there is a change in an individual's residential status or Tier. If an individual chooses to move to a self-directed program or They remove or add another agency, a revised ISP and PO needs to be submitted to the BHDDH.ISP@bhddh.ri.gov email for processing.

Q5. Does the PO need to be signed?

> **ANSWER:** YES – all agencies need to sign the PO, individual and/or Guardian.

Q6. Do we need to do a PO for each quarter?

> **ANSWER:** NO – with exception – If an individual leaves the State for the winter months, you will need to complete the PO's applicable to the quarters the individual is receiving services, or when the disbursement of units/dollars is different each quarter.

Q7. Is the Day Program based on 250 days?

> **ANSWER:** YES

Q8. Is there a 6-hour cap for Day Program services each day?

> **ANSWER:** No – the cap is on the total dollars for day activities. An individual may select to utilize 8- hour on day and none another day. The authorization allocations, however, were built on the assumption

that the individual would use 6 hours of service every weekday in the calendar quarter. Utilizing 8-hour day services every weekday will reduce the dollars faster with a quarterly authorization allocation.

Q9. If day program services are based on 6-hour day; can you bill 5-hours one day and 7-hours on another day so long as the max number of units is not exceeded?

ANSWER: YES.

Q10. Can agencies move unused units or dollars from one quarter to the next?

ANSWER: NO – If the services were not provided within the authorized quarterly allocation, the units or dollars stay within the authorized quarter. If the individual sends in more than one PO to allocate the needed units or dollars to be disbursed within a quarter that might need more than another quarter. All funding needs to stay within the Individuals Tier.

Q11. When does a Individuals anniversary date change?

ANSWER: The only time the anniversary date changes is when the individual chooses to move services from an agency to a Fiscal Intermediary (self-direct) services.

Q12. When does the renewal services take effect?

ANSWER: The quarter after the individual's anniversary quarter.

Example: If an individual's anniversary is in May, a regular SIS notice goes to the lead agency 3 months prior to the anniversary quarter expiring. If there is a Tier change the regular SIS Tier change will take effect within the next quarter of the anniversary, which is the 1st quarter (July to September).

Q13. Where are the forms located?

ANSWER: http://www.bhddh.ri.gov/developmentaldisabilities/forms_provider.php

Q14. Where do I submit my completed S-106/ S109 forms and required documents?

ANSWER: **BHDDH.S109@bhddh.ri.gov**

Q15. Can I backdate request for additional funding?

ANSWER: No, the division will not accept any requested backdates for authorizations except in emergency situations (and/or major life changes) and those with prior written approval from Administration.

Q16. If an individual starts services on the 15th of the month, do we need to have two PO's or just one PO?

ANSWER: You will need to complete two PO. Example: First P O will reflect the start date from September 15th to September 30th and prorated services for one month. The second PO will reflect the next full quarter dates and services. Example: dates from October 1st to December 31st with full quarterly services.

Q17. Can self-directed funds be utilized to pay for an applicant's (employee's) drug test?

ANSWER: NO. The test should be paid by the applicant's (employee's) health insurance, or out-of-pocket.

Q18. Can a step-parent, who lives in the same home, work with the Sole Proprietor and be paid?

ANSWER: YES, if the step-parent is not the legal guardian, re-payee or managing the plan.

Q19. Can we give bonuses to self-direct staff if the individuals funding has not been exhausted?

ANSWER: NO, but you can increase the staffing hourly rate (blended rate) as long as the increase rate to blended rate does not exceed the BHDDH posted rate.

Q20. Can you bill less than 15 minutes?

ANSWER: NO. You need to bill the allowable billable unit, which is indicated on the BHDDH Rate Model. (Example: if the service shows Billing Unit of 1 hour, you cannot bill ½ hour, if the Billing Unit is Per Day, you cannot bill ½ day, if the service Billing Unit is 15 Minutes, you cannot bill 1-14 Minutes).

LINKS TO RESOURCES

DXC TECHNOLOGY –Provider Enrollment User Guide.
https://www.riproviderportal.org/hcp/provider/Home/tabid/135/Default.aspx?p17=wutigon2pnns2rrqmwvqcumu&p6=7cbpT2KS6l%2bhiJNYQbTdw1Spnno%3d

BHDDH – Provider links:

http://www.bhddh.ri.gov/developmentaldisabilities/forms_provider.php

Rules and Regulations for Developmental Disability Organizations - Rhode Island Department of State

Rules and Regulations for the Licensing of Organizations and Facilities Licensed by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals - Rhode Island Department of State

Rules and Regulations for Behavioral Healthcare Organizations - Rhode Island Department of State

Executive Office of Health and Human Services (EOHHS):

Executive Office of Health & Human Services > Home

APPENDIX

RATE MODEL:

http://www.bhddh.ri.gov/developmentaldisabilities/pdf/October%201,%202019%20Rate%20Increase%20-%20Rate%20Table.pdf.

HCPCS – Modifier Requirements:

BHDDH Service Title	HCPCS	Modifier Required? (Always, Sometimes, Never)	Notes
Community Residence Supports	T2033	Always	Refer to 'Legend of Modifiers' and 'Rate Table' for crosswalk of modifiers to rates.
Non-congregant Residential Supports	T2016	Always	Refer to 'Legend of Modifiers' and 'Rate Table' for crosswalk of modifiers to rates.
Shared Living Arrangements	T2033	Always	Refer to 'Legend of Modifiers' and 'Rate Table' for crosswalk of modifiers to rates.
Community-Based Supports (standard)	T2017	Sometimes	Do not put a modifier on when service delivered 1:1. Put a modifier on when billed 1: >1, refer to Rate Sheet for crosswalk of modifiers to rates.
Community-Based Supports (standard)	T2017	Always	Always put the U2 modifier when self-directed.
Community-Based Supports by Prof. Staff	T2017	Always	Always put the UD modifier. If billed 1: >1 or self-directed, another modifier is required as well.
Community-Based Supports by Prof. Staff	T2017	Always	Always put the UD U2 modifier when self-direct.
Natural Supports Training (standard)	T2013	Sometimes	Do not put a modifier on when service delivered 1:1. Put a modifier on when billed 1: >1 or when self-directed.
Natural Supports Training by Prof. Staff	T2013	Always	Always put the UD modifier. If billed 1: >1 or self-directed, another modifier is required as well.
Respite Care	T1005	Sometimes	When delivered overnight, put the UJ modifier on the claim. Otherwise, no modifier required.

Job Development or Assessment	T2025	Always	The UD modifier is always required when billing for this service.
Prevocational Training	T2015	Sometimes	Do not put a modifier on when service delivered 1:1. Put a modifier on when billed 1: >1 or when self-directed.
Supported Employment	T2019	Sometimes	Do not put a modifier on when service delivered 1:1. Put a modifier on when billed 1: >1 or when self-directed.
Day Program Services (center-based)	T2021	Always	Refer to 'Legend of Modifiers' and 'Rate Table' for crosswalk of modifiers to rates.
Day Program Services (community-based)	T2021	Always	Refer to 'Legend of Modifiers' and 'Rate Table' for crosswalk of modifiers to rates.
Day Program Services (home-based)	T2020	Always	Refer to 'Legend of Modifiers' and 'Rate Table' for crosswalk of modifiers to rates.
Professional Services while in Day Program	T2021	Always	Always put the U8 modifier. If billed self-directed, another modifier is required as well.
Support Coordination	T2022	Always	Refer to 'Legend of Modifiers' and 'Rate Table' for crosswalk of modifiers to rates.
Day Activity Transportation	T2003	Sometimes	If billing standard rate, no modifier required. If billing enhanced rate, TG modifier is required.
Support Facilitation	T2022	Always	Refer to 'Legend of Modifiers' and 'Rate Table' for crosswalk of modifiers to rates.
Supports Brokerage, Self- Directed Program	T2041	Always	The U2 modifier is always required when billing for this service.
Self-Directed Goods or Services	T2025	Always	The U2 modifier is always required when billing for this service.
Pers Emergency Response System, install/testing	S5160	Never	
Pers Emergency Response System, service	S5161	Never	
Pers Emergency Response System, purchase	S5162	Never	
Home Modifications	S5165	Never	
Assistive Technology	T5999	Never	

MODIFIER LEGEND

The following are used only with Residential Services, Day Program Services, Support Coordination and Support Facilitation:

Modifier or Modifier Combination	Modifier Description/Usage in State Fiscal Year 2019	Notes
U5	Tier A	
U6	Tier B	
U7	Tier C	
UA	Tier D	
TG	Tier E	
U8	Professional Services	
L9	Supplemental Funding needs above Tier	
	The following are used only with community-based services other than residential and day program services	
U5 U1	Shared Living Arrangement Tier A	Options available when billed with SLA Service HCPCS T2033
U6 U1	Shared Living Arrangement Tier B	
U7 U1	Shared Living Arrangement Tier C	
UA U1	Shared Living Arrangement Tier D	
TG U1	Shared Living Arrangement Tier E	
U5 U1	Tier A when delivered in the community	Options available when billed with Day Program Service HCPCS T2021
U6 U1	Tier B when delivered in the community	
U7 U1	Tier C when delivered in the community	
UA U1	Tier D when delivered in the community	
TG U1	Tier E when delivered in the community	
L9 U1	Supplemental Funding needs above Tier	
UN	Service provided to 2 clients simultaneously by 1 Direct Service Professional	

UP	Service provided to 3 clients simultaneously by 1 Direct Service Professional	Options available when billed with Day Program Service HCPCS T2017
UQ	Service provided to 4 clients simultaneously by 1 Direct Service Professional	
UR	Service provided to 5 clients simultaneously by 1 Direct Service Professional	
US	Service provided to 6 or more clients simultaneously by 1 Direct Service Professional	
UN UD	Service provided to 2 clients simultaneously by 1 Licensed Professional*	Options available when billed with Day Program Service HCPCS T2017
UP UD	Service provided to 3 clients simultaneously by 1 Licensed Professional*	
UQ UD	Service provided to 4 clients simultaneously by 1 Licensed Professional*	
UR UD	Service provided to 5 clients simultaneously by 1 Licensed Professional*	
US UD	Service provided to 6 or more clients simultaneously by 1 Licensed Professional*	
UJ	Services provided at night	Only used with Respite code. Providers do not need to differentiate other services provided at night (i.e., it's the same rate for day or night service for services other than Respite).
U2	Self-Directed services	Whenever a service is delivered and paid through a fiscal intermediary, the U2 modifier must be included on the claim detail line.

*Licensed Professional means a licensed psychologist, a degreed psychologist, a licensed physical therapist, a licensed occupational therapist, a licensed speech language therapist, a licensed social worker, or a registered nurse.

DOCUMENTATION REQUIREMENTS FOR CLAIMS BILLING

The Department reserves the right to review any documentation of the amount, duration and scope maintained by the provider to support billing for the services rendered to a Individual. This may include either an on-site or desk review conducted by Department personnel or its designee. Failure to provide adequate supporting documentation for services rendered to Individuals may result in remittance of payments back to the Department recovered by means of a withhold against a future payment.

The Following Guidelines are Required for Proper Billing Documentation: Assistive **Technology:** Provider must maintain original receipts along with BHDDH approval.

Attendant Care: Employee timesheet, progress report, attendance sheet with individual's signature.

Community Residence Supports/SLA: Employee timesheet and attendance sheet with individual's signature.

Community Based Supports: Employee timesheet, progress report, attendance sheet with individual's signature.

Day Activity Transportation: Attendance sheet with individual's signature, transportation log.

Day Program (Center and Community Based): Employee timesheet, progress report, attendance sheet with individual's signature.

Day Program (Home Based): Employee timesheet, progress report, attendance sheet with individual's signature.

Home Maker Services: Employee timesheet, progress report, attendance sheet with individual's signature.

Job Coaching: Employee timesheet, progress report, attendance sheet with individual's signature.

Job Development: Employee timesheet, progress report

Job Retention: Employee timesheet, progress report, attendance sheet with individual's signature.

Natural Supports Training: Employee timesheet, attendance sheet.

Non-Congregant Residence Supports: Employee timesheet, attendance sheet with individual's signature.

Prevocational Training: Employee timesheet, attendance sheet with individual's signature.

Respite Care: Employee timesheet, progress report, attendance sheet with individual's signature.

Support Coordination: Employee timesheet, progress report, attendance sheet with individual's signature.

Supports Brokerage/Self Directed: Progress report, attendance sheet with individual's signature.

REVISIONS TO THE MANUAL

All revisions to this manual will be posted to the BHDDH Website along with necessary technical bulletins and notifications as they become available.

CONTACT INFORMATION

For all inquiries please email BHDDH.AskDD@bhddh.ri.gov