Service Definitions:

Wayne County Area Agency on Aging Service Definitions for Aging Waiver Services provided by Wayne County Area Agency on Aging

Service Definitions (Scope):

Enrollment: Enrollment is a process of a set of activities that once successfully completed lead to the enrollment of the individual into the waiver program.

Enrollment activities include:

· Complete the initial in-home visit;

· Educate individuals on their rights and responsibilities in the waiver program, opportunities for self-direction, appeal rights, the Services and Supports Directory (currently list of Providers through SAMS printout), and the right to choose from any qualified provider;

· Provide applicants with a list of qualified Service Coordination agencies and document the individual's choice of Service Coordinator on the OLTL Service provider Choice Form;

· Assist the applicant to obtain a completed physician certification form from the individuals' physician;

· Refer the applicant to the proper party within the AAA for the level of care determination;

· Ensure the individuals CMI is prepopulated from the LOCA;

· Assist the participant to complete the financial eligibility determination paperwork; and

· Facilitate the transfer of the new enrollee to their selected Service Coordination agency, including sending copies of all completed assessments and forms as necessary.

(Taken out of the Side-by-Side Comparison of current and revised language 2/12/2013)

Service Coordination: Service coordination is a service that assists individuals who receive waiver services in gaining access to needed waiver services and other Medicaid State plan services, as well as medical, social, educational and other

services regardless of the funding source. Service Coordination is working with the participant whenever possible to identify, coordinate, and facilitate all necessary services. Service coordination also includes completion of needs assessment, advocacy, arranging for services from local resources, and coordination of services so a participant can realize his/her identified goals for living independently in the community. The Service Coordinator will help the individual and the individual's family determine what services are available and which services are appropriate.

• Activities of a Service Coordinator include:

· performing level of care re-evaluations annually, or more frequently, if needed;

· maintaining current documentation of the participant's eligibility for waiver services, copies of the participant's service plan and service plan addendum, financial data and related information;

· providing information and assistance to participants regarding self-direction;

· informing participants of rights, responsibilities and liabilities when choosing a service model;

· monitoring the health and welfare of the participant and the quality of services provided to the participant through personal visits at a minimum of twice per year, telephone calls at least quarterly or as defined in the service plan – monitoring can be more frequent, but not less frequent than specified in this definition;

· providing notice of amount and frequency of waiver services;

· working with the participant to develop a comprehensive service plan – including risk identification – that meets their needs, preferences and goals;

· reviewing the service plan at least once a year or more frequently, if needed, as applicable to service provision and the participant's assessed need;

· ensuring that services are provided as identified in the participant's approved service plan and delivered appropriately to meet the participant's needs. **Specify applicable (if any) limits on the amount, frequency, or duration of this service:** The frequency and duration of service coordination is based upon the participant's needs as identified and documented in the participant's service plan. Service Coordination is limited to 144 units over a 12-month period. However, in order to meet the varying needs of individuals for service coordination services, this service limitation may be waived when reviewed and approved by OLTL.

Service Definitions:

(Definition taken from Application for a 1915 (c) Home and Community –Based Services waiver Aging waiver application 7/10/2012, with minor revision.)

Service Definitions of other Aging Waiver Services, Services that a Service Coordinator may coordinate for an Aging Waiver consumer (as found in the Aging Waiver application – 3/4/13)

Accessibility, Adaptations, Equipment, Technology and medical supplies-

An item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Items shall be specific to a participant's individual needs. Training to utilize adaptations, modifications and devices is included in the purchase as applicable. This service includes the following components:

• Accessibility adaptations to the participant's home, apartment, or other living arrangement in which the participant resides such as the participant's family's home, or the participant's friend's home, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home and are permanently attached to an individual's fixed environment. This service includes selecting, designing, customizing or replacing accessibility adaptations; evaluating the construction, provision or installation of accessibility adaptations during the adaptation and re-adaptation process; and providing post-installation visual inspections and ensuring that participants accept and can use their accessibility adaptations. Such adaptations include: o The installation of ramps and railings, the installation of specialized electric and plumbing systems that are necessary to ensure the health and welfare of the participant and contribute to the participant's independence in everyday life, environmental and climate control units, automatic door openers and locks, speaker phones and intercom systems, special lighting devices, over-the-bed tables, stair glider, widening doorways and hallways, non-skid mats, stair strips and runners, wall protection strips and wall runners for wheelchairs, light switch adaptations or extensions, door knob extensions, smoke/fire alarm system adaptations; o Handrails and grab bars – such as those required in a bathroom, or in other areas of the home, modification of bathroom facilities, bath bench and bath lifts, stall adaptations – including roll-in showers and fixtures, fixture adaptations for sinks, showers or stoves, kitchen counter and cabinet modifications for participants who use wheelchairs; Rearrangement and new installation of plumbing, drains, electricity, and floor plans to permit least-cost, beneficial home modifications and assistive technology.

Rented property modifications must meet the following:

Service Definitions:

• There is a reasonable expectation that the participant will continue to live in the home;

• Permission is secured from the property owner for the modification;

• Documentation of whether the owner will or will not require the home to be returned to its original state; and

• The landlord will not increase the rent because of repairs or other modifications approved by OLTL as a part of an individual's service plan. All items shall meet applicable standards of manufacture, design and installation. Services will be provided in accordance with applicable federal, state and local building codes.

Specialized medical equipment, technology and supplies include:

· devices, controls, or appliances, specified in the service plan, that enable participants to increase, maintain, or improve their ability to perform activities of daily living;

· devices, controls, or appliances that enable, increase, maintain, or improve the ability of the participant to perceive, control, or communicate with the environment in which they live;

· items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items;

· Such other durable and non-durable medical equipment not available under the Medicaid State Plan that is necessary to address participant functional capabilities; and

Necessary medical supplies not available under the Medicaid State Plan.

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

Assistive technology service-

Means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device.

Assistive technology service includes:

· The evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;

Service Definitions:

· Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants;

· services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;

· Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.

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

Limits**:** Participants must access durable medical equipment and supplies and medical supplies through the Medicaid State Plan before seeking services through the Aging Waiver. The accessibility adaptations, equipment, technology and medical supplies reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the Medicaid State Plan and exclude those items that are not of direct medical or remedial benefit to the participant. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this service except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). Any home accessibility adaptation that exceeds $6,000 requires prior authorization by OLTL. Any specialized medical equipment, technology or supplies that exceed $500 requires a review by the State Medicaid Agency program office. This service does not include TeleCare Services. The frequency and duration of this service are based upon the participant's needs as identified and documented in the participant's service plan. Accessibility Adaptations cannot be provided in residential settings which are owned and operated by a provider.

Adult Daily Living Services-

Adult Daily Living services are comprehensive services provided to meet the personal care, social, nutritional, therapeutic and educational needs of individuals in a licensed

center. The centers offer and are able to provide personal care services, day respite services, nursing services. Meals including special diets, individual health education sessions according to participant's care needs are included in this service. Meals as provided as part of the services shall not constitute a "full nutritional regimen" (3 meals per day). The center staff who provide the hands-on care to the individual, meet the minimum requirements of the service provider qualifications as if the services were stand-alone waiver services. The plan of care drives the services an individual receives while at the center. Adult daily living services can be provided as a full day or a half day Transportation for waiver individuals is included in the rate for providers that provide transportation.

The individualized service plan will account for the services provided in the adult daily living facility and in the community/individual's residence to ensure there is no duplication or excess of needed like-services. Adult Daily Living Services with transportation cannot be provided at the same time as Transportation.

Community Transition Services-

Community Transition Services are one-time expenses for individuals that make the transition from an institution to their own home, apartment or family/friend living arrangement. The funds may be used to pay the necessary expenses for an individual to establish his or her basic living arrangement and to move into that arrangement. The following are categories of expenses that may be incurred:

• Equipment, essential furnishings and initial supplies. Examples—household products, dishes, chairs, tables;

• Moving expenses;

• Security deposits or other such one-time payments that are required to obtain or retain a lease on an apartment, home or community living arrangement;

• Set-up fees or deposits for utility or service access, Examples – telephone, electricity, heating;

• Personal and environmental health and welfare assurances. Example – personal health maintenance supplies, personal items for inclement weather, pest eradication, allergen control, one-time cleaning prior to occupancy.

Limits: Community Transition Services are limited to an aggregate of $4,000 per participant, per lifetime, as pre-authorized by OLTL. Expenditures may not include ongoing payment for rent.

Service Definitions:

Home Delivered Meals-

The Home Delivered Meals service provides meals that meet at least 1/3 of the Dietary Reference Intakes (DRI) to people in their homes. This service is dependent on the nutritional needs and circumstances of the participant. Individuals may receive more than one meal per day but they cannot receive meals that constitute a “full nutritional regimen” (three meals per day). Meals may consist of hot, cold, frozen, dried, canned, fresh, or supplemental foods. Participants can receive either a hot, cold, frozen or shelf stable meal. Meals may be delivered as single meals or may be delivered in multiples, as long as the number of planned daily meals does not exceed two meals per day. Nutrition education is provided for home delivered meal participants at least quarterly. Nutrition screening must be completed for all new participants. All menus must be approved and signed by an approved dietitian. Participants are given a choice between all qualified providers in their service area. The transportation cost of delivery is included in this service.

Limits: Area Agencies on Aging and service providers may not solicit donations for Home Delivered Meals from waiver participants. The frequency and duration of this service are based upon the participant’s needs as identified and documented in the participant’s service plan.

FMS-

Financial Management Services (FMS) provides financial, payroll, bill-payer services, orientation, and skills training and related functions for participants under the participant-directed models of service. These services assure that Medicaid funds used to provide services and supports outlined in the participant’s Individual Support Plan are managed and paid appropriately as authorized and facilitate the employment of support workers by participants. The FMS provider must operate as either/or a Vendor Fiscal/Employer Agent, in accordance with Section 3504 of the IRS code and Revenue Procedure 70-6 and Proposed Notice 2003-70, or as a Government Fiscal/Employer Agent, in accordance with Section 3504 of the IRS code and Revenue Procedure 80-4 and Proposed Notice 2003-70. Under the Fiscal/Employer Agent model, the participant is the common law employer of the support providers he/she hires directly. The F/EA will obtain an Employer Identification Number (EIN) from the IRS to operate on behalf of the participant to withhold, report and pay state and federal income and unemployment taxes, broker workers compensation for participants’ employees and ensure that all federal and state tax laws and labor law requirements are met.

Service Definitions:

When the F/EA is a direct service provider and/or Care Manager, F/EA activities must be separate and distinct from the service delivery functions of the organization. OLTL recognizes that there may be a potential conflict of interest when the F/EA that provided FMS is also providing other waiver services to the participant. OLTL provides a toll-free complaint line for participants to report concerns about their provider. Additional safeguards will be developed by OLTL as part of the Quality Improvement component of the work plan to ensure participants have the right and ability to select the provider of their choice.

Specifically, the FMS entity will complete the following:

• Enroll participants in FMS and apply for and receive approval from the IRS to act as an agent on behalf of the participant.

• Provide orientation and training to participants on required documentation for all directly hired support workers, including the completion of federal and state forms; the completion of timesheets; good hiring and firing practices; effective management of workplace injuries; and workers compensation; effective management and supervision practices

• Establish, maintain and process records for all participants and support workers with confidentiality, accuracy and appropriate safeguards

• Conduct criminal background checks and when applicable, child abuse clearances, on potential employees

• Assist participants in verifying support workers citizenship or alien status

• Distribute, collect and process support worker timesheets as verified and approved by the participant

• Prepare and issue support workers' payroll checks, as approved in the participant's Individual Support Plan

• Withhold, file and deposit federal, state and local income taxes in accordance with federal IRS and state Department of Revenue rules and regulations

• Broker workers' compensation for all support workers through the Pennsylvania State Insurance Fund (SWIF);

• Process all judgments, garnishments, tax levies, or any related holds on workers' pay as may be required by federal, state or local laws

Service Definitions:

• Prepare and disburse IRS Forms W-2's and/or 1099's, wage and tax statements and related documentation annually

. • Assist in implementing the state's quality management strategy related to FMS

• Establish an accessible customer service system for the participant and the Care Manager Limits of FMS**:** OLTL has secured one entity to provide Financial Management services in all OLTL waivers across the Commonwealth effective January 1, 2013. Waiver participants enrolled in the Aging Waiver who are self-directing some or all of their services will be transitioned to the selected vendor by January 1, 2013. Participants are assessed for services, frequency and duration based upon needs identified and documented in their service plan.

Financial Management Services is reimbursed on a per member per month basis with a one-time start-up fee for all new participants that enroll for Financial Management Services. The one-time start-up fee applies to new participants and will only be paid once in a lifetime per participant. The initial start-up fee covers the lengthy process of enrolling participants as a common law employee. The one-time start-up fee and the ongoing per member per month service fee may not be billed simultaneously.

Home Health Care-

Home Health Care services must be provided by a home health aide who is supervised by a Registered Nurse (RN). The RN supervisor must reassess the participant situation bi-weekly. Home health care activities include: performing simple measurements and tests to monitor a participant's medical condition, assisting with ambulation, assisting with other medical equipment, assisting with exercises taught by an RN, Licensed Practical Nurse (LPN), or licensed physical therapist. Home Health Care services must be prescribed by a physician. Nursing – services must be performed by an RN or LPN. 49 PA Code Chapter 21 (State Board of Nursing) provides the following service definition for the practice of professional nursing, "Diagnosing and treating human responses to actual or potential health problems through such service as case finding, health teaching, health counseling, provision of care supportive to or restorative of life and well-being, and executing medical regimens as prescribed by a licensed physician or dentist. The term does not include acts of medical diagnosis or prescription of medical, therapeutic or corrective measures, except as may be authorized by rules and regulations jointly promulgated by the State Board of Medicine and the Board, which rules and regulations will be implemented by the Board." Services must be ordered by a physician and within the scope of the State's Nurse Practice Act and provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse licensed to practice in the state. The physician's

order must be obtained every sixty (60) days for continuation of service. Skilled nursing is individual and can be continuous, intermittent, or part time based on individual's assessed need. Physical Therapy – services must be provided by a licensed physical therapist or physical therapist assistant as prescribed by a physician, and documented in the service plan. The physician's order must be obtained every sixty (60) days for continuation of service. Per the Physical Therapy Practice Act (63 P.S. §1301 et seq.), physical therapy means, "the evaluation and treatment of any person by the utilization of the effective properties of physical measures such as mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage, mobilization, and the use of therapeutic exercises and rehabilitative procedures including training in functional activities, with or without assistive devices, for the purpose of limiting or preventing disability and alleviating or correcting any physical or mental conditions, and the performance of tests and measurements as an aid in diagnosis or evaluation of function." Occupational Therapy – services must be provided by an occupational therapist or occupational therapy aide and are direct services provided to assist individuals in the restoration of a skill that the individual previously had but lost. Services are provided as prescribed by a physician and outlined in a service plan. The physician's order must be obtained every sixty (60) days for continuation of service. The Occupational Therapy Practice Act (63 P.S. §1501 et seq.) defines occupational therapy as follows, "The evaluation of learning and performance skills and the analysis, selection and adaptation of activities for an individual whose abilities to cope with the activities of daily living, to perform tasks normally performed at a given stage of development and to perform essential vocational tasks which are threatened or impaired by that person's developmental deficiencies, aging process, environmental deprivation or physical, psychological, injury or illness, through specific techniques which include: (1) Planning and implementing activity programs to improve sensory and motor functioning at the level of performance for the individual's stage of development. (2) Teaching skills, behaviors and attitudes crucial to the individual's independent, productive and satisfying social functioning. (3) The design, fabrication and application of splints, not to include prosthetic or orthotic devices, and the adaptation of equipment necessary to assist patients in adjusting to a potential or actual impairment and instructing in the use of such devices and equipment. (4) Analyzing, selecting and adapting activities to maintain the individual's optimal performance of tasks to prevent disability." Speech and Language Therapy – services must be provided by a speech and language therapist and are direct services provided to assist individuals in the restoration of a skill that the individual previously had, but lost. Services are provided as prescribed by a physician and outlined in a service plan. The physician's order must be obtained every sixty (60) days for continuation of service. Speech and Language Therapy services include the evaluation, counseling, habilitation and rehabilitation of individuals whose communicative disorders involve the functioning of speech, voice or language, including the prevention, identification,

examination, diagnosis and treatment of conditions of the human speech language system. Speech and Language Therapy services also include the examination for, and adapting and use of augmentative and alternative communication strategies. Home Health services may only be funded through the waiver when the services are not covered by the Medicaid State Plan or private insurance, due to service limitations or coverage exclusions.

Home Health Care Aide services cannot be provided simultaneously with Personal Assistance Services, Adult Daily Living Services, or Respite. The frequency and duration of this service is based upon the participant's needs as identified and documented in the participant's service plan.

Non-Medical Transportation-

Non-Medical Transportation services are offered in order to enable waiver participants to gain access to waiver services and other community activities and resources as specified by the individualized service plan. This service is offered in addition to medical transportation services required under 42 CFR §440.170(a) (if applicable), and shall not replace them. Non-Medical Transportation services include personnel costs for drivers and others to transport a participant and/or the purchase of tickets or tokens to secure transportation for a participant.

Limits: Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge should be utilized. Medicaid State Plan transportation services will be used to access Medicaid State Plan services. The individual's service plan must document the need for waiver transportation services. Non-Medical Transportation does not pay for vehicle purchases, rentals or repairs. Transportation cannot be provided at the same time as Adult Daily Living Services with transportation.

Personal Assistance Services-

Personal Assistance Services are aimed at assisting the individual to complete tasks of daily living that would be performed independently if the individual had no disability.

These services include:

• Non-medical personal care (eating, bathing, dressing, personal hygiene), general household activities/chores (light housekeeping tasks, preparing meals, grocery shopping, laundry), cueing to prompt the participant to perform a task, and companion services to assist a functionally impaired individual who cannot be safely left alone;

Service Definitions:

• Health maintenance activities provided for the participant, such as bowel and bladder routines, ostomy care, catheter, wound care and range of motion as indicated in the individual's service plan;

• Routine wellness services enabling adequate nutrition, exercise, keeping of medical appointments and all other health regimens related to healthy living activities;

• Chore services needed to maintain the home in a clean, sanitary and safe environment, such as washing floors, windows and walls, and tacking down loose rugs and tiles;

• Overnight Personal Assistance Services provide intermittent or ongoing, awake, overnight assistance to a participant in their home for up to eight hours. Overnight Personal Assistance Services require awake-staff.

Limits**:** Personal Assistance Services may be provided to escort participants to community activities or access other services in the community and be billed as Personal Assistance Services. Costs incurred by the personal assistance workers are not reimbursable under the waiver as Personal Assistance Services. The scope of Personal Assistance Services may include performing incidental homemaker and chore services tasks. However, such activities may not comprise the entirety of the service. Chore services are provided only when neither the participant nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision. Personal Assistance Services cannot be provided simultaneously with Home Health Care Aide Services, Adult Daily Living Services, Non-Medical Transportation, Participant-Directed Community Supports, Participant-Directed Goods and Services, or Respite. The frequency and duration of this service are based upon the participant's needs as identified and documented in the individualized service plan.

Personal Emergency Response Services (PERS)-

PERS is an electronic device which enables waiver participants to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified. The PERS vendor must provide 24 hour staffing, by trained operators of the emergency response center, 365 days a year. Installation and maintenance are included in this service. All other medical equipment and supplies that

Service Definitions:

will be of value to the participant to maintain safety in the home can be purchased using “Accessibility Adaptations, Equipment, Technology and Medical Supplies”.

Limits: PERS services are limited to those individuals (1) who live alone, or who are alone for significant parts of the day and (2) have no regular caregiver for extended periods of time, or live with an individual that may be limited in their ability to access a telephone quickly when a participant has an emergency, and (3) who would otherwise require extensive routine monitoring and assistance. Smoke detectors cannot be billed under PERS. Smoke detectors must be billed under “Accessibility Adaptations, Equipment, Technology and Medical Supplies”. PERS covers the actual cost of the service and does not include any additional administrative costs. The frequency and duration of this service are based upon the participant’s needs as identified and documented in the participant’s service plan.

Respite Services-

Respite services are provided to support individuals on a short-term basis due to the absence or need for relief of those persons normally providing care. Federal and state financial participation through the waivers is limited to: 1) Services provided for individuals in their own home, or the home of relative, friend, or other family, or 2) Services provided in a Medicaid certified Nursing Facility. Room and board costs associated with respite care services that are provided in a facility approved (licensed or accredited) by the state that is not a private residence are reimbursable. Respite services furnished in a participant’s home are provided in quarter hour units. Respite services may also be provided in a long-term care facility on a per diem basis. Respite services may be provided by a relative or family member as long as the relative or family member is not a legal guardian, power of attorney, or reside in the home.

Limits: Room and board costs are excluded from respite services when the service is provided in a setting that is not facility-based and approved by the state. Individuals are authorized for up to 14 consecutive days in an institutional facility. However, this may be increased up to 29 consecutive days, based on need and with the prior approval of the State Medicaid Agency program office. In-home Respite services cannot be provided simultaneously with Home Health Aide Services, Personal Assistance Services Participant-Directed Community Supports or Participant-Directed Goods and Services. The frequency and duration of this service are based upon the participant’s needs as identified and documented in the participant’s service plan.

Telecare-

Service Definitions:

TeleCare is a model of service that integrates social and healthcare services supported by innovative technologies to sustain and promote independence, quality of life and reduce the need for nursing home placement. By utilizing in-home technology, more options are available to assist and support individuals so that they can remain in their own homes and reduce the need for re-hospitalization.

TeleCare includes:

1) Health Status Measuring and Monitoring TeleCare Service,

- uses wireless technology or a phone line, including electronic communication between the participant and healthcare provider focused on collecting health related data, i.e., vital signs information such as pulse/ox and blood pressure that assists the healthcare provider in assessing the participant's condition, and providing education and consultation;

- must be ordered by a primary physician, physician assistant, or nurse practitioner;

- includes installation, daily rental, daily monitoring and training of the participant, their representative and/or employees who have direct participant contact;

- monitoring service activities must be provided by trained and qualified home health staff; and

- have a system in place for notification of emergency events to designated individuals.

2) Activity and Sensor Monitoring TeleCare Service,

- employs sensor-based technology on a 24 hour/7 day basis by remotely monitoring and passively tracking participants' daily routines and may report on the following: wake up times, overnight bathroom usage, bathroom falls, medication usage, meal preparation and room temperature;

- includes installation, monthly rental, monthly monitoring, and training of employees who have direct participant contact; and

- ensures there is a system in place for notification of emergency events to designated individuals.

3) Medication Dispensing and Monitoring TeleCare Services.

- assists participants by dispensing and monitoring medication compliance; and

Service Definitions:

· utilizes a remote monitoring system personally pre-programmed for each participant to dispense, monitor compliance and provide notification to the provider or family caregiver of missed doses or non-compliance with medication therapy.

All other medical equipment and supplies of value to the participant to maintain safety in the home can be purchased using “Accessibility Adaptations, Equipment, Technology and Medical Supplies”.

Limits: Participants can only receive TeleCare services when they meet eligibility criteria specified in the state’s published TeleCare Services policy guidance, and the services are not covered under Medicare or other third party resources. The Care Manager is responsible for verifying that third party limitations have been exhausted prior to funding services through the waiver. Documentation that the services are not available under another source of funding must be maintained in the individual’s file and updated annually. If a participant only requires a medication dispenser unit and no monitoring services, the Medication Dispensing and Monitoring TeleCare Service will not be authorized under TeleCare. Medication dispensers without monitoring should be billed under “Accessibility Adaptations, Equipment, Technology and Medical Supplies”. Medication dispensing services cannot be provided at the same time as Personal Assistance Services, Home Health Care Aide Services or in-home Respite Services. The frequency and duration of this service are based upon the participant’s needs as identified and documented in the individualized service plan.

Therapeutic and Counseling Services-

Therapeutic and counseling services are services that assist individuals to improve functioning and independence, are not covered by the State Medicaid Plan, and are necessary to improve the individual’s inclusion in their community. Therapeutic and Counseling Services are provided by professionals and/or paraprofessionals in counseling and nutritional counseling. The service may include assessing the individual, developing a home treatment/support plan, training family members/staff and providing technical assistance to carry out the plan, and monitoring of the individual in the implementation of the plan. This service may be delivered in the individual’s home or in the community as described in the service plan.

• Counseling services are provided to participants in order to resolve individual or social conflicts and family issues. While counseling services may include family members, the therapy must be on behalf of the participant and documented in his/her service plan. Services include initial consultation and ongoing counseling performed by a licensed psychologist, licensed social worker, or licensed professional counselor.

Service Definitions:

• Nutritional Counseling services provided by a registered dietitian that are essential to the health and welfare of the participant. Services include initial consultation and ongoing counseling performed by a licensed and registered dietitian. Nutritional Counseling services are limited to 90-minutes (6 units) of nutritional consultations per month.

Limits: Therapeutic and Counseling Services may only be funded through the waiver when the service is not covered by the Medicaid State Plan or private insurance unless the required expertise and experience specific to the disability is not available through the Medicaid State Plan or private insurance providers. This may be because the Medicaid State Plan or insurance limitations have been reached, or the service is not covered under the Medicaid State Plan or private insurance, or the provider does not have the expertise or experience specific to the disability. The Care Manager is responsible for verifying and documenting in the participant's file that the Medicaid State Plan and private insurance limitations have been exhausted or that the Medicaid State Plan or private insurance provider does not have the expertise or experience specific to the disability prior to funding services through the waiver. Documentation must be maintained in the individual's file by the Care Manager. This documentation must be updated annually. The frequency and duration of this service are based upon the participant's needs as identified and documented in the participant's service plan.