107

107 Waiver Services

Medicaid covers Home and Community-Based Services (HCBS) through the Elderly and Disabled (E&D) Waiver, the State of Alabama Independent Living (SAIL) Waiver (formerly Homebound Waiver), the Technology Assisted (TA) Waiver for Adults, the HIV/AIDS Waiver, and the Alabama Community Transition (ACT) Waiver to categorically needy individuals who would otherwise require institutionalization in a nursing facility.

Medicaid covers the Alabama Home and Community-Based Waiver for Persons with Intellectual Disabilities (ID Waiver), formerly MR Waiver and the Living at Home (LHW) Waiver to Medicaid-eligible individuals who would otherwise require the level of care available in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

The purpose of providing HCBS to individuals at risk of institutional care is to protect the health, safety, and dignity of those individuals while reducing Medicaid expenditures for institutional care. Services that are reimbursable through Medicaid's EPSDT Program shall not be reimbursed as a waiver service. HCBS are provided through a Medicaid waiver for an initial period of three or five years and for five-year periods thereafter upon renewal of waiver by the Centers for Medicare and Medicaid Services (CMS) .

The E&D Waiver is a cooperative effort between the Alabama Medicaid Agency, and the Alabama Department of Senior Services (ADSS). The policy provisions for E&D Waiver providers can be found in the *Alabama Medicaid Agency Administrative Code*, Chapter 36.

The SAIL Waiver is a cooperative effort between the Alabama Medicaid Agency and the Alabama-Department of Rehabilitation Services (ADRS). The policy provisions for SAIL Waiver providers can be found in the *Alabama Medicaid Agency Administrative Code*, Chapter 57.

The ID and LHW Waivers are a cooperative effort between the Alabama Medicaid Agency and the Alabama Department of Mental Health (DMH). The policy provisions for ID and LHW Waiver providers can be found in the *Alabama Medicaid Agency Administrative Code*, Chapters 35 and 52 respectively.

The Alabama Medicaid Agency is the Operating Agency for the TA Waiver for Adults. The policy provisions for providers of the TA Waiver for Adults can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 54.

The HIV/AIDS Waiver is a cooperative effort among the Alabama Medicaid Agency and the Alabama Department of Senior Services. The policy provisions for HIV/AIDS Waiver providers can be found in the Alabama Medicaid Agency Administrative Code, Chapter 58.

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The ACT Waiver is a cooperative effort among the Alabama Medicaid Agency and Alabama Department of Senior Services (ADRS). The policy provisions for the ACT Waiver providers can be found in the Alabama Medicaid Agency Administrative Code, Chapter 44.

NOTE:
Providers rendering private duty nursing services as a result of an EPSDT screening should refer to the Alabama Medicaid Provider Manual, Chapter 31 for policy provisions.

107.1 Enrollment

Applicants who meet the licensure and/or certification requirements of the State of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code* and the *Alabama Medicaid Provider Manual* should apply with the designated waiver Operating Agency for the E&D, SAIL, ID, Living at Home, HIV/AIDS and ACT Waivers. Applicants for the TA Waiver are enrolled directly through DXC. The Operating Agency may contract directly with vendors of non-medical ACT Waiver services.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a waiver provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive direct reimbursement for waiver-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

Providers of waiver services are assigned a provider type of 53 (Waiver Service). Valid specialties for these providers include the following:

Deleted: ~~HIV/AIDS Waiver (620)~~

- Elderly and Disabled Waiver (670)
- SAIL Waiver (660)
- ID Waiver (680)
- Living at Home Waiver (690)
- Technology Assisted (TA) Waiver for Adults (590)
- ACT Waiver (661)

Enrollment Policy for Waiver Service Providers

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

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- Must have a contractual agreement with Medicaid directly or through an Operating Agency.
- Must meet the provider qualifications as outlined in the approved Waiver Document for the appropriate HCBS waiver.
- Electronic visit verification is required for specified services under HCBS Waivers when conducted as part of service delivery for in home services. These services are electronically verified when the following information is electronically captured and submitted to Medicaid through the use of the State contracted EVVM system:

Added: Electronic visit verification…begins and ends.

- (i) the type of service performed;
- (ii) the individual receiving the service;
- (iii) the date of the service;
- (iv) the location of service delivery;
- (v) the individual providing the service; and
- (vi) the time the service begins and ends

Re-enrollment Policy for Waiver Service Providers

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

107.2 Benefits and Limitations

The following table lists the services covered by each type of waiver:

Waiver	***Services Covered***
Elderly and Disabled Waiver	Case Management Services Homemaker Services Personal Care Services Adult Day Health Services Respite Care Services (Skilled and Unskilled) Companion Services Home Delivered Meals (Frozen Shelf-Stable and Breakfast Meals)
SAIL Waiver	Case Management Services Personal Care Services Environmental Accessibility Adaptations Personal Emergency Response System (PERS) Initial Setup Personal Emergency Response System (PERS) Monthly Medical Supplies Minor Assistive Technology Assistive Technology Evaluation for Assisted Technology Assistive Technology Repairs Personal Assistance Services

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Waiver	*Services Covered*
Home and community-based services for ID waiver	Residential Habilitation Training Residential Habilitation-Other Living Arrangement Day Habilitation-(Levels 1-4) Day Habilitation w/transportation-(Levels 1-4) Prevocational Services Supported Employment Small Group Individual Job Coach Individual Job Developer Occupational Therapy Services Speech and Language Therapy Physical Therapy Positive Behavior Support-(Levels 1-3) Companion Services In-Home Respite Care Out-of-Home Respite Care Institutional Respite Personal Care Personal Care on Worksite Personal Care Transportation Environmental Accessibility Adaptations Specialized Medical Equipment Specialized Medical Supplies Skilled Nursing(RN/LPN) Crisis Intervention Community Specialist Individual Directed Goods and Services Benefits and Career Counseling Community Experience Housing Stabilization Service Personal Emergency Response System Supported Employment Emergency Transportation
Home and community-based services for Living at Home Waiver	In-home Residential Habilitation Day Habilitation-(Levels 1-4) Day Habilitation w/transportation-(Levels 1-4) Supported Employment Small Group Supported Employment Emergency Transportation Individual Job Coach Individual Job Developer Prevocational Services In-Home Respite Out-of-Home Respite Personal Care Personal Care on Worksite Personal Care Transportation Physical Therapy Occupational Therapy Speech Therapy Positive Behavior Support-(Levels 1-3) Skilled Nursing Environmental Accessibility Adaptations Specialized Medical Equipment Specialized Medical Supplies Community Specialist Crisis Intervention Individual Directed Goods and Services Assistance in Community Integration Benefits and Career Counseling Community Experience Personal Emergency Response System

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Waiver	Services Covered
Home and community-based services for Technology Assisted (TA) Waiver for Adults	Private Duty Nursing (RN/LPN) Personal Care/Attendant Service Medical Supplies and Appliances Assistive Technology
Home and community-based services for HIV/AIDS Waiver	Case Management Services Homemaker Services Personal Care Services Respite Care Services (Skilled and Unskilled) Skilled Nursing Services Companion Services
Home and community-based services for ACT Waiver	Community Case Management Transitional Assistance Service Personal Care Services Homemaker Services Adult Day Health Home Delivered Meals (Frozen, Shelf-Stable, and Breakfast) Respite Care Services (Skilled and Unskilled) Skilled Nursing (RN/LPN) Adult Companion Services Home Modifications Assistive Technology Assistive Technology Repairs Assistive Technology Evaluation PERS (Installation and Monthly Fee) Medical Equipment, Supplies, and Appliances Personal Assistance Services

107.2.1 Financial Eligibility

Financial eligibility for the E&D waiver is limited to the following individuals:

- Individuals receiving SSI
- SSI related protected groups deemed to be eligible for SSI/Medicaid
- Individuals receiving State Supplementation
- Individuals receiving State or Federal Adoption Subsidy
- Optional categorically needy individuals at a special income level of 300 percent of the Federal Benefit Rate (FBR) who are receiving HCBS waiver services.

Financial eligibility for the ID waiver is limited to the following individuals:

- Individuals receiving SSI
- SSI related protected groups deemed to be eligible for SSI/Medicaid
- Special Home and Community-Based waiver disabled individuals whose income is not greater than 300 percent of the SSI Federal Benefit Rate
- Low Income Families with Children
- Federal or State Adoption Subsidy Individuals

Financial eligibility for the SAIL waiver is limited to the following individuals:

- Individuals receiving SSI

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- SSI related protected groups deemed to be eligible for SSI/Medicaid
- Individuals receiving State Supplementation
- Special Home and Community-Based waiver disabled individuals whose income is not greater than 300% of the SSI Federal Benefit Rate

Financial eligibility for the Living at Home Waiver is limited to the following individuals:

- Individuals receiving SSI
- Medicaid for Low Income Families (MLIF)
- SSI related protected groups deemed to be eligible for SSI/Medicaid
- Individuals receiving State or Federal Adoption Subsidy
- Special Home and Community-Based waiver disabled individuals whose income is not greater than 300 percent of the SSI Federal Benefit Rate

Financial eligibility for Technology Assisted Waiver for Adults and the HIV/AIDS Waiver is limited to the following individuals:

- Individuals receiving SSI
- Special Home and Community-Based waiver disabled individuals whose income is not greater than 300 percent of the SSI Federal Benefit Rate
- State Supplementation
- Individuals eligible for the Pickle Program (continued Medicaid)
- Deemed disabled widow and widowers from age 50 but not yet age 60
- Early widow and widowers age 60-64
- Disabled adult children who lose Supplemental Security Income benefits upon entitlement to or an increase in the child's insurance benefits based on disability
- Individuals who would be eligible for SSI if not for deeming of income of parent(s) or a spouse
- Medicaid for Low Income Families (MLIF)

Financial eligibility for the ACT waiver is limited to the following individuals:

- Individuals receiving SSI
- SSI related protected groups deemed to be eligible for SSI/Medicaid
- Individuals receiving State Supplementation
- Special Home and Community-Based waiver disabled individuals whose income is not greater than 300% of the SSI Federal Benefit Rate

Financial determinations are made by the Alabama Medicaid Agency, or the Social Security Administration (SSA), as appropriate. In addition to the financial and medical eligibility criteria, Medicaid is limited by the number of recipients who can be served by the waiver.

107.2.2 Medical Eligibility

Medical eligibility criteria for the E&D, TA Waiver for Adults, HIV/AIDS, and ACT Waivers are based on current admission criteria for nursing facility care. Admission criteria are described in Chapter 26 of the non-state Provider Manual, Nursing Facility.

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The target groups for SAIL Waiver Services must meet the admission criteria for a nursing facility. The HCBS provider must specifically provide services to individuals with physical disabilities not associated with the process of aging and with onset prior to age 60.

SAIL waiver services are provided, but not limited, to persons with the following diagnoses:

- Quadriplegia
- Traumatic brain injury
- Amyotrophic lateral sclerosis
- Multiple sclerosis
- Muscular dystrophy
- Spinal muscular atrophy
- Severe cerebral palsy
- Stroke
- Other substantial neurological impairments, severely debilitating diseases, or rare genetic diseases (such as Lesch-Nyhan Syndrome)

The target group, for ACT Waiver Services, is individuals currently residing in a nursing facility with a desire to transition to the community.

Eligibility criteria for HCBS for ID and LHW recipients are the same as eligibility criteria for an ICF/IID facility. ID and LHW persons who meet categorical medical and/or social requirements for Title XIX coverage will be eligible for HCBS under the waiver. Applicants found eligible are not required to apply income above the personal needs allowance reserved to institutional recipients toward payment of care. In addition to the financial and medical eligibility criteria, Medicaid is limited by the number of recipients who can be served by the waiver.

107.2.3 Limitations

Medicaid does not provide waiver services to recipients in a hospital or nursing facility. However, case management activities are available to assist recipients interested in transitioning from an institution into a community setting under the waivers. Case management activities are limited to a maximum of 180 days prior to discharge into the community.

Medicaid or its operating agencies may deny home and community-based services if it determines that an individual's health and safety is at risk in the community; if the individual does not cooperate with a provider in the provision of services; or if an individual does not meet the goals and objectives of being on the waiver program.

NOTE:

SAIL waiver recipients must be age 18 years or older. LHW & ID waiver recipients must be age 3 years or older. TA waiver recipients must be age 21 or with complex medical conditions who are ventilator dependent or who have tracheostomies. HIV/AIDS Waiver recipients must be age 21 or older.

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107.2.4 Explanation of Covered Services

This section describes the covered services available through the HCBS Waiver Program. Please note that descriptions for services may differ from program to program.

Adult Day Health Services (S5102/Modifier UA - E&D) (S5102/Modifier TF UB-ACT)

Adult Day Health Service provides social and health care for a minimum of 4 hours per day in a community facility approved to provide such care. Adult Day Health Service includes health education, self-care training, therapeutic activities, and health screening.

Adult Day Health is provided by facilities that meet the minimum standards for Adult Day Health Centers as described in the HCBS Waiver for the Elderly and Disabled and the ACT Waiver. The state agencies contracting for Adult Day Health Services must determine that each facility providing Adult Day Health meets the prescribed standards.

A unit is defined as a per diem rate.

Homemaker Services (S5130/Modifier UA - E&D) (S5130/Modifier U6 – HIV/AIDS) (S5130/Modifier TF UB-ACT)

Homemaker services are general household activities that include meal preparation, food shopping, bill paying, routine cleaning and personal services. Provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or is unable to manage the home and care for himself.

A person providing homemaker services must meet the qualifications of a Homemaker Attendant as specified in the approved waiver document.

A unit is defined as 15 minutes.

Case Management Services (T1016/Modifier UA - E&D) (T1016/Modifier UB - SAIL) (T1016/Modifier U6-HIV/AIDS) (T1016/Modifier TF UB-ACT)

Case management is a system under which a designated person or organization is responsible for locating, coordinating, and monitoring a group of services. A case manager is responsible for outreach, intake and referral, diagnosis and evaluation, assessment, care plan development, and implementing and tracking services to an individual. The case manager is also responsible for authorization of waiver and non-waiver services included in the recipient’s care plan, terminations, and transfers and maintenance of recipient records.

Case management is provided by a case manager employed by or under contract with the state agencies as specified in the approved waiver document. The case manager must meet the qualifications as specified in the approved waiver document.

Case management activities may also be used to assist individuals residing in institutional settings, such as hospital and nursing facilities, to transition into community settings. Transitional case management services may be provided up to 180 days prior to discharge from an institution.

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Transitional case management should not be billed until the first day a client is active on the waiver. If the individual fails to transition to the waiver, reimbursement will be at the administrative rate.

A unit is defined as 15 minutes.

Personal Care Services (T1019/Modifier UA - E&D) (T1019/Modifier U6 – HIV/AIDS)

Personal care services are those services prescribed by a physician in accordance with a plan of treatment to assist a patient with basic hygiene and health support activities. These services include assistance with bathing, dressing, ambulation, eating, supervision of the self-administering of medications, and securing health care from appropriate sources.

A person providing personal care services must be employed by a certified Home Health Agency or other agency approved by the Alabama Medicaid Agency and is supervised by a registered nurse, and meets the qualifications of a Personal Care Attendant as specified in the approved waiver document. This service cannot be provided by a family member.

A unit is defined as 15 minutes.

Personal Care Services (T1019/Modifier UB - SAIL) (T1019/Modifier TF UB- ACT) Personal Options (T1019/Modifier UB HX– SAIL) (T1019/Modifier TF HX ACT) (T1019/Modifier UA HX)

Personal care services are those services prescribed by a physician in accordance with a plan of treatment to assist a patient with basic hygiene and health support activities. These services include assistance with bathing, dressing, ambulation, eating, supervision of the self-administering of medications, and securing health care from appropriate sources.

Personal care services may be provided by a relative or a friend when documentation shows that a relative or friend is qualified and there is proof of a lack of other qualified providers in a remote area.

For the SAIL Waiver, the number of units and services provided to each client is dependent upon individual need as set forth in the client's Plan of Care established by the case manager. Personal care services may be provided for a period not to exceed 100 units (25 hours) per week and not to exceed a total of 5,200 units (1300 hours) per waiver year (April 1 – March 31) in accordance with the provider contracting period. Services may be reduced based on need.

There is no unit limit for Personal Care for the ACT Waiver. Services are authorized based upon the specific medical needs of the ACT Waiver participant.

The Personal Options program develops a new service delivery system for participants receiving personal care services on the State of Alabama Independent Living (SAIL) and ACT waivers that will allow for more participant involvement in the direction and choice of the person employed as a personal care worker.

Medicaid will not reimburse for activities performed which are not within the Scope of Services.

A unit is defined as 15 minutes.

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Respite Care (T1005/Modifier UA - E&D)
(T1005/Modifier U6 - HIV/AIDS) (T1005/Modifier TF UB-ACT)
Respite Care Unskilled (S5150/Modifier UA - E&D)
(S5150/Modifier U6 - HIV/AIDS) (S5150/Modifier TF UB-ACT)

Respite care is given to individuals unable to care for themselves on a short-term basis due to the absence or the need for relief of those persons normally providing the care. Respite care is provided in the individual's home and includes supervision, companionship and personal care of the individual.

Respite care may be provided for up to a maximum of 720 hours per waiver year. Respite care may be provided by a companion/sitter, personal care attendant, home health aide, homemaker, LPN or RN, depending upon the care needs of the individual; this service cannot be provided by a family member.

There is no unit limit on Respite Care for the ACT Waiver. Services are authorized based upon the specific medical needs of the ACT Waiver participant.

A unit is defined as 15 minutes. The maximum number of units that can be billed is 2,880 per waiver year for the E&D Waiver and the HIV/AIDS Waiver.

Companion Services (S5135/Modifier UA - E&D)
S5135/Modifier U6 – HIV/AIDS) (S5135/Modifier TF UB- ACT)

Companion services provide support and supervision that is focused on safety and non-medical care such as the following:

- Reminding recipient to bathe, to take care of personal grooming and hygiene, and to take medication
- Observing or supervision of snack and meal planning
- Accompanying recipient to necessary medical appointments and grocery shopping
- Assisting with laundry and light housekeeping duties that are essential to the care of the recipient.

Under no circumstances should any type of skilled medical service be performed. Companion services are provided in accordance with a therapeutic goal and are not purely recreational in nature. A person providing companion services must meet the qualifications of a companion worker as specified in the approved waiver document.

A unit is defined as 15 minutes.

NOTE:

Companion services are only available to recipients who live alone, and may not exceed four hours daily.

Day Habilitation

(T2021/ Modifier UC/HW— ID-Level 1)

(T2021/Modifier UC/TF-ID-Level 2)

(T2021/Modifier UC/TG-ID-Level 3)

(T2021/Modifier UC/HK-ID-Level 4)

(T2021/Modifier UC/HW/SE-ID-Level 1-w/transportation)

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(T2021/Modifier UC/TF/SE-ID-Level 2-w/transportation)

(T2021/Modifier UC/TG/SE-ID-Level 3-w/transportation)

(T2021/Modifier UC/HK/SE-ID-Level 4-w/transportation)

(T2021/Modifier UD/HW - LHW - Level 1)

(T2021/Modifier UD/TF - LHW - Level 2)

(T2021/Modifier UD/TG - LHW - Level 3)

(T2021/Modifier UD/HK – LHW – Level 4)

(T2021/Modifier UD/HW/SE – LHW – Level 1-w/transportation)

(T2021/Modifier UD/TF/SE – LHW – Level 2-w/transportation)

(T2021/Modifier UD/TG/SE- LHW – Level 3-w/transportation)

(T2021/Modifier UD/HK/SE – LHW – Level 4-w/transportation)

Day Habilitation is assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that takes place in a non-residential setting, separate from the home or facility in which the recipient resides.

Services are normally furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, unless provided as an adjunct to other day activities included in the recipient's plan of care. Day Habilitation services shall focus on enabling the individual to attain his or her maximum functional level, and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. If a recipient attends Day Habilitation for less than four (4) hours as a result of a physician visit, and the transportation and escort is provided by the Day Habilitation Program staff, reimbursement will be permitted.

Day Habilitation Training services are provided by a Habilitation Aide and supervised by a Qualified Intellectual Disabilities Professional (QIDP) in coordination with the individual’s plan of care. The Habilitation Aide will be required to complete the training requirements as outlined in the waiver document.

*The level utilized for Day habilitation services in the LHW is determined by the individual’s ICAP score.

The provider for Day Habilitation services can be reimbursed based on eight levels of services.

A unit is defined as 15 minutes.

Residential Habilitation Training (T2016/Modifier UC–ID)

Residential Habilitation Training provides intensive habilitation training including training in personal, social, community living, and basic life skills.

Staff may provide assistance and training in daily living activities such as shopping for food, meal planning and preparation, housekeeping, personal grooming, and cleanliness.

This service includes social and adaptive skill building activities such as the following:

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- Expressive therapy, the prescribed use of art, music, drama, and movement to modify ineffective learning patterns, or influence changes in behavior
- Recreation/leisure instruction, teaching the skills necessary for independent pursuit of leisure time/recreation activities

The rate paid to providers for this service includes the cost to transport individuals to activities such as day programs, social events, or community activities when public transportation or transportation services covered under the State Plan are not available, accessible, or desirable due to the functional limitations of the recipient.

Residential Habilitation Training services may be delivered or supervised by a Qualified Intellectual Disabilities Professional in accordance with the individual's plan of care. Residential Habilitation Training services can also be delivered by a Habilitation Aide. The aide will work under supervision and direction of a QIDP.

A Habilitation Aide is required to be certified by the provider agency as having completed a course of instruction provided or approved by the DMH. Retraining will be conducted as needed, at least annually.

A unit is defined as a per diem rate.

Respite Care - In Home (S5150/Modifier UC - ID)
(S5150/Modifier UD - LHW)

Respite Care - Out-of-Home (T1005/Modifier UC –ID)
(T1005/Modifier UD LHW)

Respite Care – Institutional (T2044/Modifier UC-ID)

Respite care is given to individuals unable to care for themselves on a short term basis due to the absence or the need for relief of persons normally providing the care. Respite care may be provided in the recipient's home, place of residence, or a facility approved by the State which is not a private residence.

Respite care out of the home may be provided in a certified group home or ICF/IID. In addition, if the recipient is less than 21 years of age, respite care out of the home may be provided in a JCAHO Accredited Hospital or Residential Treatment Facility (RTF). While a recipient is receiving out of home respite, no additional Medicaid reimbursement will be made for other services in the institution.

This service cannot be provided by a family member.

A unit is defined as 15 minutes. For institutional respite, a unit is defined as a per diem rate.

Residential Habilitation - Other Living Arrangement (OLA)
(T2017/Modifier UC –ID)
(T2017/Modifier UD - LHW)

Residential Habilitation Training in other living arrangements is a service under which recipients reside in integrated living arrangements such as their own apartments or homes. The basic concept of this service is that for some individuals, learning to be independent is best accomplished by living independently.

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These services are delivered in the context of routine day-to-day living rather than in isolated "training programs" that require the individual to transfer what is learned to more relevant applications. Habilitation may range from a situation where a staff member resides on the premises to those situations where the staff monitors recipients at periodic intervals.

The staff may provide assistance/training in daily living activities such as shopping for food, meal planning and preparation, housekeeping, personal grooming, and cleanliness.

This service includes social and adaptive skill building activities such as the following:

- Expressive therapy, the prescribed use of art, music, drama, and movement to modify ineffective learning patterns, or influence changes in behavior
- Recreation/leisure instruction, teaching the skills necessary for independent pursuit of leisure time/recreation activities

Residential habilitation training services for individuals in other living arrangements may be delivered or supervised by a QIDP in accordance with the individual's plan of care. Residential habilitation training can also be delivered by a Habilitation Aide. The aide will work under supervision and direction of a QIDP.

A Habilitation Aide will be required to be certified by the provider agency as having completed a course of instruction provided or approved by the DMH/ID. Retraining will be conducted as needed, at least annually.

The rate paid to providers for this service includes the cost to transport individuals to activities such as day programs, social events, or community activities when public transportation or transportation services covered under the State Plan are not available, accessible, or desirable due to the functional limitations of the recipient.

Supported Employment (T2019/Modifier UC – ID) (T2019/Modifier UC/HN – ID) (T2019/Modifier UD/HN – LHW) (T2019/Modifier UC/HO – ID) (T2019/Modifier UD/HO – LHW) (T2019/Modifier UD – LHW) (S0215/Modifier UC – ID) (S0215/Modifier UD – LHW) (T2003/Modifier UC – ID) (T2003/Modifier UD – LHW)

Supported employment services consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting.

Supported employment also includes activities needed to sustain paid employment by waiver recipients, including supervision and training.

Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed.

When supported employment services are provided at a work site in which persons with disabilities are employed, payment will be made only for the adaptations, supervision, and training required by waiver recipients as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business settings.

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Supported employment may be provided under the Individual Job Coach and Job Development services to provide on-going supports to participants who, because of their disabilities, need intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Supported employment may be provided in small groups. Supported Employment Small Group services are services and training activities provided in regular business, industry, and community settings for groups of two (2) to eight (8) workers with disabilities.

Supported employment (both group and individual) services do not include facility based, or other similar types of vocational services furnished in specialized facilities that are not part of the general workplace.

Supported employment services are not available to recipients eligible for benefits under a program funded by either Section 110 of the Rehabilitation Act of 1973, or Section 602 (16) and (17) of the Education of the Handicapped Act.

Routine transportation, as by van within a 15-mile radius, is included in the fee for these services. This does not preclude other arrangements such as transportation by family or public conveyance.

Supported Employment Emergency Transportation service can be authorized, under special circumstances, intended to be limited in scope, duration, and not to exceed the annual cap.

A unit is defined as 15 minutes.

Prevocational Services (T2015/Modifier UC–ID)
(T2015/Modifier UD – LHW)

Prevocational services are not available to recipients who are eligible for benefits under a program funded under Section 110 of the Rehabilitation Act of 1973 or Section 602 (16) and (17) of the Education of the Handicapped Act.

Prevocational services prepare an individual for paid or unpaid employment, but are not job task oriented. Prevocational services include teaching such concepts as compliance, task completion, attention, problem solving, and safety.

Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs).

Waiver recipients are compensated at a rate of less than 50 percent of the minimum wage.

A unit is defined as 1 hour.

Physical Therapy (97110/Modifier UC-ID) (97110/Modifier UC/HW – ID) (97110/Modifier UD-LHW) (97110/Modifier UD/HW-LHW)

Physical therapy includes services that assist in determining an individual's level of functioning by applying diagnostic and prognostic tasks and providing treatment training programs.

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Such services preserve and improve abilities for independent function, such as range of motion, strength, tolerance, coordination, and activities of daily living.

This service also helps with progressive disabilities through means such as the use of orthotic prosthetic appliances, assistive and adaptive devices, positioning, behavior adaptations, and sensory stimulation.

Physical Therapists may also provide consultation and training to staff or caregivers (such as recipient's family or foster family). The Physical Therapist must meet all state licensure requirements and be designated as a regulated Physical Therapist by the national accreditation body.

Physical Therapy can be directed by individual participants or family but must adhere to all the traditional service rules.

A unit is defined as 15 minutes.

Occupational Therapy Services (97535/Modifier UC –ID) (97535/Modifier UC/HW – ID) (97535/Modifier UD – LHW) (97535/Modifier UD/HW – LHW)

Occupational therapy services include the evaluation of an individual to determine level of functioning by applying diagnostic and prognostic tasks and guiding and treating individuals in the prescribed therapy to secure or obtain necessary function.

Therapists may also provide consultation and training to staff or caregivers (such as recipient's family or foster family). The Occupational Therapist must meet all state licensure requirements and be designated as a regulated Occupational Therapist by the national accreditation body.

Occupational Therapy can be directed by individual participants or family but must adhere to all the traditional service rules.

A unit is defined as 15 minutes.

Speech and Language Therapy (92507/Modifier UC –ID) (92507/Modifier UC/HW – ID) (92507/Modifier UD – LHW) (92507/Modifier UD/HW – LHW)

Speech and language therapy are diagnostic, screening, preventive, corrective services provided on an individual basis, when referred by a physician (M.D., D.O.). These services may include:

- Screening and evaluation of person’s speech and hearing functions and comprehensive speech and language evaluations when so indicated;
- Participation in the continuing interdisciplinary evaluation of individuals for purposes of implementing, monitoring and following up on the person’s habilitation programs;
- Treatment services as an extension of the evaluation process that include:
    1. Consulting with others working with the individual for speech education and improvement
    2. Designing specialized programs for developing an individual’s communication skills comprehension and expression.

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Therapists may also provide training to staff and caregivers (such as a recipient's family and/or foster family). Services to direct caregivers will be allowed when the service to caregivers is for the direct benefit of the recipient and is necessary to enable the recipient to be cared for outside of an institution. The Speech/Language Therapist must meet all state licensure requirements.

Speech and Language Therapy can be directed by individual participants or family but must adhere to all the traditional service rules.

A unit is defined as an encounter.

Personal Emergency Response System (PERS) (S5160/Modifier UB - Installation - SAIL) (S5160/Modifier TF UB – Installation-ACT) (S5161/Modifier UB – Monthly - SAIL) (S5161/Modifier TF UB – Monthly- ACT)

PERS is an electronic device that enables certain high-risk patients to secure help in the event of an emergency. The recipient may also wear a portable "help" button to allow for mobility. The system is connected to a patient's phone and programmed to signal a response center once a "help" button is activated. PERS must be provided by trained professionals. Only one installation per recipient can be approved. Initial setup and installation of PERS must be on the individual's plan of care, prior authorized and approved by the Alabama Medicaid Agency or its designee.

A unit is defined as a monthly rate.

Personal Care (T1019/Modifier UC –ID) (T1019/Modifier UC/HW – ID) (T1019/Modifier UC/ HN) (T1019/Modifier UD – LHW) (T1019/Modifier UD/HW-LHW) (T1019/Modifier UD/HN – LHW)

Personal care services are services provided to assist residents with activities of daily living such as eating, bathing, dressing, personal hygiene, and activities of daily living. Services may include assistance with preparation of meals, but not the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bed-making, dusting, and vacuuming, which are essential to the health and welfare of the recipient.

While in general personal care will not be approved for a person living in a group home or other residential setting, under the ID Waiver and LHW, personal care may be approved by the Division of Development Disabilities for specific purposes that are not duplicative.

Personal care can also include supporting a person at an integrated worksite where the individual is paid a competitive wage. There will be a separate procedure code for this service, provided at the worksite, to distinguish it from other personal care activities.

The personal care attendant will work under the supervision of a QIDP and will be observed every 90 days. The personal care attendant is also required to complete the training requirements prior to providing services.

Personal care may be self-directed to allow participants and their families to recruit, hire, train, supervise, and if necessary to discharge, their own personal care workers.

A unit is defined as 15 minutes.

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Personal Care Transportation (T2001/Modifier UD – LHW) (T2001/Modifier UC – ID)

Personal care attendants may transport consumers in their own (the attendant's) vehicles as an incidental component of the personal care service. In order for this component to be reimbursed, the personal care attendant must be needed to support the consumer in accessing the community, and not merely to provide transportation. The Personal Care Transportation service will provide transportation into the community to shop, attend recreational and civic events, go to work and participate in *People First* and other community building activities. Additional payment will be made for mileage and the provider's cost of an insurance waiver to cover any harm that might befall the consumer as a result of being transported.

The attendant must have a valid Alabama driver's license and his/her own insurance coverage as required by State law. The provider agency shall assure the attendant has a good driving record and is in-serviced on safety procedures when transporting a consumer.

Personal Care Transportation shall not replace transportation that is already reimbursable under day or residential habilitation nor the Medicaid non-emergency medical transportation program. The planning team must also assure the most cost-effective means of transportation, which would include public transport where available. Transportation by a personal care attendant is not intended to replace generic transportation nor to be used merely for convenience.

A unit is defined as a mileage rate.

Companion Services (S5135/Modifier UC –ID) (S5135/Modifier UC/HW – ID)

Companion services are non-medical supervision and socialization provided to a functionally impaired adult. Companions may assist the individual with such tasks as meal preparation and shopping, but may not perform these activities as discrete services.

The provision of companion services does not entail hands-on medical care.

Companions may perform light housekeeping tasks that are incidental to the care and supervision of the recipient.

This service is provided in accordance with a therapeutic goal in the plan of care and is not merely recreational in nature. This service must be necessary to prevent institutionalization of the recipient.

The person providing companion service must meet the qualifications of a companion worker as specified in the waiver document. They also must have completed all training requirements.

Companion Services can be directed by individual participants or family but must adhere to all the traditional service rules.

A unit is defined as 15 minutes.

Positive Behavior Support

(H2019/Modifier UC/HP - ID - Level 1)

(H2019/Modifier UC/HN – ID- Level 2)

(H2019/Modifier UC/HM – ID-Level 3)

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(H2019/Modifier UC/HP/SE – ID-Level 1)

(H2019/Modifier UC/HN/HM – ID – Level 2)

H2019/Modifier UC/HM/SE – ID – Level 3)

(H2019/Modifier UD/HP – LHW – Level 1)

(H2019/Modifier UD/HN – LHW – Level 2)

(H2019/Modifier UD/HM – LHW – Level 3)

(H2019/Modifier UD/HP/SE – LHW – Level 1)

(H2019/Modifier UD/HN/SE – LHW – Level 2)

(H2019/Modifier UD/HM/SE – LHW – Level 3)

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

Positive Behavior Support (PBS) waiver service is comprised of two general categories of service tasks. These are (1) development of a BSP and (2) implementation of a BSP. In addition, this waiver service has three service levels: two professional and one technical, each with its own procedure code and rate of payment. The service levels are distinguished by the qualifications of the service provider and by supervision requirements. Both professional and technical level service providers may perform tasks within both service categories, adhering to the supervision requirements that are described under provider qualifications.

The two professional service provider levels are distinguished by the qualifications of the person providing the service. Both require advanced degrees and specialization, but the top level also requires board certification in behavior analysis. The third service provider level is technical and requires that the person providing the service be under supervision to perform PBS

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tasks. There is a different code and rate for each of the three service provider levels.

The maximum units of service per year of both professional and technician level units combined cannot exceed 1200 and the maximum units of service of professional level one (1) or two (2) cannot exceed 800. Maximum units of Technician level service are the balance between billed professional level one (1) and two (2) units and the combined maximum per year. Providers who bill more than the 800 units of professional level will receive a denial notice. Once the denial notice is received, the provider should submit another claim for 800 units at the professional level and the remaining units at the technical level in order to receive payment for services rendered. Providers of service must document which tasks are provided by date performed in addition to their clinical notes. There will be no accommodation for exceeding the overall cap of 1200 units for all three levels.

Providers of service must maintain a service log that documents specific days on which services are delivered. The following do not qualify for billing under this waiver service: 1) individual or group therapy, 2) group counseling, 3) behavioral procedures not listed in a formal BSP or that do not comply with the current Behavioral Services Procedural Guidelines and Community Certification Standards, 4) non-traditional therapies, such as music therapy, massage therapy, etc., 5) supervision.

Providers at Level 1 must have either a Ph.D. or M.A. and be certified as a Behavior Analyst by the Behavior Analysis Certification Board.

Providers at level 2 must have either a Ph.D. or M.A. in the area of Behavior Analysis, Psychology, Special Education or a related field and three years of experience working with persons with developmental disabilities. Level 2 providers with a doctorate do not require supervision and may provide all of the service functions. Master's degree individuals require supervision equaling two hours per week by a level 1 provider or level two Ph.D. provider may provide all of the service functions. Level 3 providers must be either a (QIDP) (per the standard at 43 CFR 483.430) or be a Board Certified Associate Behavior Analyst and work only in the technical service area. With two years of experience and authorization by the Administering Agency, the Board Certified Behavior Analyst Associate may qualify as a level 2 provider and work in both the service component areas (professional and technical) with supervision. This supervision requires an average at a minimum of one hour per week by either a Level 1 provider or a Level 2 Doctoral provider.

All level 1 and 2 providers certified or not, must complete an orientation training provided by DMH.

Positive Behavior Support can be directed by individual participants or family but must adhere to all the traditional service rules.

A unit is defined as 15 minutes.

Environmental Accessibility Adaptations (S5165/Modifier U – SAIL) (S5165/Modifier UC –ID) (S5165/Modifier UC/HW – ID) (S5165/Modifier TF U –ACT) (S5165/Modifier UD – LHW) (S5165/Modifier UD/HW – LHW)

Environmental modifications are those physical adaptations to the home, required by the individual's plan of care, that are necessary to ensure the health, welfare and safety of the individual or enable the individual to function

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with greater independence in the home. This service must be necessary to prevent institutionalization of the individual.

Such adaptations may include the installation of ramps and grab-bars and/or the widening of doorways in order to accommodate the medical equipment and supplies necessary for the welfare of the individual.

Environmental Modifications exclude adaptations or improvements to the home which are not of direct medical or remedial benefit to the waiver recipient, such as floor covering, roof repair, central air conditioning, etc. Adaptations that add to the square footage of the home, any type of construction affecting the structural integrity of the home, changes to the existing electrical components of the home, or permanent adaptations to rental property are traditionally excluded from this Medicaid-reimbursed benefit. All services provided must comply with applicable state or local building codes. Environmental accessibility adaptations must be prior authorized and approved by the Alabama Medicaid Agency or its designee and must be listed on the client's plan of care.

Total costs of environmental accessibility adaptations under the ID and LHW shall not exceed $5,000 per year, per individual.

Environmental Accessibility Adaptations for ID and LHW recipients can be directed by individual participants or family but must adhere to all the traditional service rules.

Under the SAIL and ACT Waivers the maximum amount for this service is $5,000 per recipient for the entire stay on the waiver. Any expenditure in excess of $5000 must be approved by the State Coordinator and the Medicaid designated personnel. This service may also be provided under the SAIL and ACT Waivers to assist an individual to transition from an institutional level of care to the SAIL or ACT Waivers. The modifications should not be billed until the first day the client is transitioned and has begun to receive waiver services in order to qualify as billable waiver expenditures. If the individual fails to transition to the SAIL or ACT Waivers, reimbursement will be at the administrative rate.

A unit is defined as an item.

A unit is defined as an item for the ID and LHW.

Specialized Medical Equipment
(T2029/Modifier UD - LHW) (T2029/Modifier UD/HW – LHW)
(T2029/Modifier UC-ID) (T2029/Modifier UC/HW –ID)

Specialized medical equipment includes devices, controls, or appliances specified in the plan of care, which enable recipients to increase their ability to perform activities of daily living or to perceive, control or communicate with the environment in which they live. Included items are those necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefits to the recipient. Providers of this service must maintain documentation of items purchased for each individual. All items shall meet applicable standards of manufacture, design and installation. Costs are limited to $5,000 per year, per individual.

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Specialized Medical Equipment can be directed by individual participants or family but must adhere to all the traditional service rules.

A unit is defined as an item.

Specialized Medical Supplies
(T2028/Modifier UC-ID) (2028/Modifier UC/HW – ID) (T2028/Modifier UD-LHW) (T2028/Modifier UD/HW – LHW)

Specialized medical supplies are those which are specified in the plan of care and are necessary to maintain the recipient's health, safety and welfare, prevent further deterioration of a condition, or increase a recipient's ability to perform activities of daily living. Supplies reimbursed under this service shall not include common over-the-counter personal care items, supplies otherwise furnished under the Medicaid State plan, and items which are not of direct medical or remedial benefit to the recipient. All items shall meet applicable standards of manufacture and design.

Providers of this service must maintain documentation of items purchased for each individual. Costs for medical supplies are limited to $1800 per year, per individual.

Specialized Medical Supplies can be directed by individual participants or family but must adhere to all the traditional service rules.

A unit is defined as an item.

Assistive Technology (T2029/Modifier UB – SAIL)
(T2029/Modifier U5 - TA Waiver for Adults) (T2029/Modifier TF UB –ACT)

Assistive technology includes devices, pieces of equipment, or products that are modified or customized and are used to increase, maintain or improve functional capabilities of individuals with disabilities.

Assistive technology services also include any service that directly assists a disabled individual in the selection, acquisition, or use of an assistive technology device, including evaluation of need, acquisition, selection, design, fitting, customization, adaptation, and application. Items reimbursed with waiver funds are in addition to any medical equipment furnished under the State Plan and exclude those items which are not of direct medical or remedial benefit to the recipient. This service must be necessary to prevent institutionalization or to assist an individual to transition from an institutional level of care to the SAIL or ACT Waivers. All items shall meet applicable standards of manufacture, design and installation and must be listed on the client's plan of care. This service along with transitional assistive technology requires prior authorization and approval by the Alabama Medicaid Agency or its designee. Upon completion of the service, the client must sign and date a form acknowledging receipt of the service.

The amount for this service under the SAIL Waiver is $15,000.00 per waiver recipient for the entire stay on the waiver. Any expenditure in excess of $15,000.00 must be approved by the state coordinator and the designated Medicaid personnel. Vehicle modifications can only be authorized if it can be demonstrated that all Non-Emergency Transportation (NET) Services have been exhausted.

For the ACT Waiver, the combined amount for Assistive Technology, Assistive Technology Repair, and Evaluation for Assistive Technology, cannot exceed $15,000.

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A unit is defined as a per diem rate.

Skilled Nursing (S9123/Modifier UC–RN; S9124/Modifier UC–LPN – ID) (S9123/Modifier UD – RN; S9124/Modifier UD–LPN – LHW) (S9123/Modifier UC/HW – ID); (S9124/Modifier UC/HW – ID) (S9123/Modifier UD/HW – LHW); (S9124/Modifier UD/HW – LHW) (S9123/Modifier U6 – HIV/AIDS) (S9123/Modifier TF UB-RN-ACT; S9124/Modifier TF UB-LPN-ACT)

Skilled nursing services are services listed in the plan of care that are within the scope of the Alabama Nurse Practice Act and are 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. This service must be necessary to prevent institutionalization of the recipient.

This service may also be self-directed when provided to a participant or family which is self-directing personal care services. Service includes training and supervision related to medical care and/or assistance with ordinarily self-administered medications to be provided by the personal care worker.

ID/LHW - A unit is defined as 1 hour.

HIV/AIDS - A unit is defined as 1 hour.

ACT Waiver- A unit is defined as 1 hour.

Medical Supplies (T2028/Modifier UB – SAIL) (T2028/Modifier TF UB-ACT)

Medical supplies are necessary to maintain the recipient's health, safety, and welfare and to prevent further deterioration of a condition such as decubitus ulcers. These supplies do not include common over-the-counter personal care items such as toothpaste, mouthwash, soap, shampoo, Q-tips, deodorant, etc.

These medical supplies will only be provided when authorized by the recipient's physician and shall meet applicable standards of manufacture, design and installation. Providers of this service will be those who have a signed provider agreement with Medicaid and the Department of Rehabilitation Services. Medical supplies are limited to $1800.00 per recipient per year. The OA must maintain documentation of items purchased for the recipient.

A unit is defined as a per diem rate.

Evaluation for Assistive Technology (T2025/Modifier UB - SAIL) (T2025/Modifier TF UB –ACT)

This service will provide for an evaluation and determination of the client's need for assistive technology. The evaluation must be physician-prescribed and be provided by a physical therapist licensed to do business in the state of Alabama who is enrolled as a provider with the Alabama Department of Rehabilitation Services (ADRS).

When applicable, a written copy of the physical therapist's evaluation must accompany the prior authorization request, and a copy must be kept in the recipient's file. This service must be listed on the recipient's plan of care before being provided. Reimbursement for this service will be the standard cost per evaluation, as determined by Alabama Medicaid or its designee. This service must be necessary to prevent institutionalization of the recipient.

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This service may also be provided to assist an individual to transition from an institutional level of care to the home and community based waiver. The service should not be billed until the first day the client is transitioned and has begun to receive waiver services in order to qualify as billable waiver funds. If the individual fails to transition to the SAIL Waiver, reimbursement will be at the administrative rate.

For the ACT Waiver, the combined total of Assistive Technology, Assistive Technology Repair, and Assistive Technology Evaluation cannot exceed $15,000.

A unit is defined as a per diem rate.

Assistive Technology Repairs (T2035/Modifier UB - SAIL) (T2035/Modifier TF UB –ACT)

This service will provide for the repair of devices, equipment or products that were previously purchased for the recipient. The repair may include fixing the equipment or devices, or replacement of parts or batteries to allow the equipment to operate. This service is necessary to ensure health and safety and prevent institutionalization. All items must meet applicable standards of manufacture, design and installation. Repairs must be arranged by the case manager and documented in the plan of care and case narrative. Prior authorization is not required for this service. Reimbursement for repairs shall be limited to $2,000 annually per recipient. Repair total must not exceed the amount originally paid for the equipment or device.

For the ACT Waiver, the combined total of Assistive Technology, Assistive Technology Repair, and Assistive Technology Evaluation cannot exceed $15,000.

A unit is defined as a per diem rate.

Minor Assistive Technology (T2028 UB SC- SAIL)

Minor Assistive Technology (MAT) includes supplies, devices, controls, or appliances, specified in the Plan of Care, which enable individuals to increase their ability to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. All MAT supplies must be prescribed by a physician, be medically necessary and be specified in the Plan of Care. MAT is necessary to maintain the recipient's health, safety, and welfare and to prevent further deterioration of a condition and does not include common over the counter personal care items.

Minor Assistive Technology is limited to $500.00 per recipient per year. The OA must maintain documentation of items purchased for the recipient.

Providers of this service will be those who have a signed provider agreement with the Alabama Medicaid Agency and the Department of Rehabilitation Services.

Vendors providing MAT devices should be capable of supplying and training in the use of the minor assistive technology/device.

A unit is defined as a daily rate.

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Waiver Frozen Meals (S5170/Modifier UA - E & D) (S5170/Modifier TF UB-ACT)
Waiver Shelf-Stable Meals (S5170/Modifier SC - E & D) (S5170/Modifier TF SC- ACT)
Breakfast Meals (S5170 - E & D) (S5170/Modifier TF UA- ACT)

Home Delivered meals are provided to an individual who is unable to meet his/her nutritional needs. It must be determined that the nutritional needs of the individual can be addressed by the provision of home delivered meals. (The individual must be age 21 or older to receive this service on the E&D waiver.)

This service will provide at least one (1) nutritionally sound meal per day to adults unable to care for their nutritional needs because of a functional disability dependency, who require nutritional assistance to remain in the community and do not have a caregiver available to prepare a meal for them. Meals provided by this service will not constitute a full daily nutritional regimen.

This service will be provided as specified in the plan of care, which may include: seven (7) or fourteen (14) frozen meals per week. In addition to frozen meals, the service may include the provisions of two (2) or more shelf-stable meals (not to exceed six meals per six-month period) to meet emergency nutritional needs when authorized in the recipient's care plan.

In the event of an expected storm or disaster, the Meals Coordinator will authorize an approved Disaster Meal Service Plan.

A unit is defined as:

Seven-(7) pack of frozen meals equal to 1 unit.

Two (2) shelf-stable meals equal to 1 unit.

Seven-(7) pack of breakfast meals equal to 1 unit.

Personal Assistance Services (S5125/Modifier UB – SAIL)
(S5125/Modifier TF UB- ACT)

Personal Assistant Services (PAS) are a range of services provided by one or more persons designed to assist an individual with a disability to perform daily activities on and off the job. These activities would be performed by the individual, if that individual did not have a disability. Such services shall be designed to increase the individual's independence and ability to perform every day activities on and off the job.

This service will support that population with physical disabilities who are seeking competitive employment either in their home or in an integrated work setting. An integrated work setting is defined as a setting typically found in the community, which employs an individual with disabilities and there is interaction with non-disabled individuals who are in the same employment setting.

This service must be sufficient in amount, duration, and scope such that an individual with a moderate to severe level of disability would be able to obtain the support needed to both live and get to and from work.

A unit is defined as 15 minutes.

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Personal Care/Attendant Service (T1019/Modifier U5 – TA Waiver for Adults)

Personal Care/Attendant Service (PC/AS) provides in-home and out-of-home (job site) assistance with eating, bathing, dressing, caring for personal hygiene, toileting, transferring from bed to chair and vice versa, ambulation, maintaining continence, medication management and other activities of daily living (ADLs). It may include assistance with independent activities of daily living (ADLs) such as meal preparation, using the telephone, and household chores such as laundry, bed-making, dusting and vacuuming, which are incidental to the assistance provided with ADLs or essential to the health and welfare of the client rather than the client's family.

PC/AS is designed to increase an individual's independence and ability to perform daily activities and to support individuals with physical disabilities in need of these services as well as those seeking or maintaining competitive employment either in the home or an integrated work setting.

A unit is defined as 15 minutes.

Medical Supplies and Appliances (T2028/Modifier U5 – TA Waiver for Adults)

This service includes medical equipment and supplies that are not covered in the Medicaid State Plan. The medical equipment or supplies must be included in the recipient's plan of care, and they must be necessary to maintain the recipient's ability to remain in the home. This service must be necessary to avoid institutionalization of the recipient. Invoices for medical equipment and supplies must be maintained in the case record

A unit is defined as a per diem rate.

Private Duty Nursing (S9123/Modifier U5 – RN; S9124/Modifier U5 – LPN - TA Waiver for Adults)

The Private Duty Nursing Service is a service which provides skilled medical observation and nursing services performed by a Registered Nurse or Licensed Practical Nurse who will perform their duties in compliance with the Nurse Practice Act and Alabama State Board of Nursing. Private Duty Nursing under the waiver will not duplicate Skilled Nursing under the mandatory home health benefit in the State Plan. If a waiver client meets the criteria to receive the home health benefits, home health should be utilized first and exhausted before Private Duty Nursing under the waiver is utilized. The objective of the Private Duty Nursing Service is to provide skilled medical monitoring, direct care, and intervention for individuals 21 and over to maintain him/her through home support. This service is necessary to avoid institutionalization and the individual must meet criteria outlined in the approved waiver document prior to receipt of services.

A unit is defined as 1 hour.

Community Specialist (H2015-UD – LHW) (H2015-UC – ID) (H2015/Modifier UC/HW – ID); (H2015/Modifier UD/HW – LHW)

Community Specialist Services include professional observation and assessment, individualized program design and implementation, training of consumers and family members, consultation with caregivers and other agencies, and monitoring and evaluation of planning and service outcomes. The functions outlined for this service differs from case management in that

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these functions will incorporate person-centered planning, whereas case management does not. The service may also, at the choice of the consumer or family, include advocating for the consumer and assisting him or her in locating and accessing services and supports.

Targeted case managers will continue to perform traditional duties of intake, completion of paperwork regarding eligibility, serving in the capacity of referral and resource locating, monitoring and assessment.

The planning team shall first ensure that provision of this service does not duplicate the provision of any other services, including Targeted Case Management provided outside the scope of the waiver. The community specialist will frequently be involved for only a short time (30 to 60 days); in such an instance, the functions will not overlap with case management.

This service may be self-directed for participants who self-direct Personal Care. The community specialist will inform and consult, intervene, and trouble shoot any problems the participant may have with self-directing their services.

A unit of service is defined as 15 minutes.

Crisis Intervention (H2011–UD - LHW)

(H2011-UC - ID)

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

When need for this service arises, the service will be added to the plan of care for the person. A separate crisis intervention plan will be developed to define in detail the activities and supports that will be provided. All crisis intervention services shall be approved by the regional community service office of the DMH prior to the service being initiated.

Crisis intervention services will not count against the $25,000 per person per year cap in the waivers, since the need for the service cannot accurately be predicted and planned for ahead of time.

A unit of service is defined as 15 minutes.

Transitional Assistance Service (T2038/Modifier TF UB- ACT)

Transitional Assistance Services consists of the following items, when appropriate and necessary for the participant's discharge from a nursing facility and safe transition to the community:

1. Security deposits that are required to obtain a lease on an apartment or home;
2. Essential household furnishings and moving expense required to occupy and use a community domicile, including: furniture, window coverings, food preparation items, and bed/bath linens;
3. Set-up fees or deposits for utility or services access, including telephone, electricity, heating and water;
4. Household services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy.

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Transitional Assistance Service cannot exceed $3,500.

Individual Directed Goods and Services (T1999/Modifier UD – LHW) (T1999/Modifier UC – ID)

Individual directed Goods and Services are services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address an identified need in the service plan (including improving and maintaining the participant's opportunities for full membership in the community and meet the following requirements: the item or service would decrease the need for other Medicaid services; and/or promote inclusion in the community; and/or increase the participant's safety in the home environment; the item or service is not illegal or otherwise prohibited by Federal and State statutes and regulations, and the participant does not have the funds to purchase the item or service or the item or service is not available through another source.

The limit on the amount is determined individually based on the balance of the individual's saving account at the time of the request which is maintained by the Financial Management Service Agency, but not to exceed $1000 annually.

A unit of service is an item.

Benefits and Career Counseling (H2014/Modifier UD – LHW) (H2014/Modifier UC – ID)

The Benefits and Career Counseling service is designed to assist people and family member(s) with respect to waiver services and employment. The Benefits and Career Counselor provides intensive work incentive counseling services to beneficiaries of SSDI/recipients of SSI.

The Counselor must be a certified Work Incentives Counselor (CWIC) through the Social Security Administration. The Counselor will receive beneficiary referrals from the primary Information and Referral Triage (CWIC) based on the beneficiary county of residence. Based on the identified needs, an array of benefits counseling and work incentive services will be developed, provided, and documented. These services may include but are not limited to: Intensive benefits counseling, Benefits Summary and Analysis, Work Incentive Plan, Ongoing Benefits Planning and documentation of those services.

A unit of service is defined as 15 minutes.

Community Experience (H2021/Modifier UD – LHW) (H2021/Modifier UC – ID) (H2021/ Modifier UD/SE – LHW) (H2021/Modifier UC/SE – ID) (H2021/Modifier UD/ HW – LHW) (H2021/Modifier UC/HW – ID)

S5160 Community Experience has three distinct categories: Individual, Group, and Self-Directed. Community Experience services are non-work related activities that are customized to the individual(s) desires to access and experience community participation. Community Experience is provided outside of the person's residence and can be provided during the day, evening, or weekends. The intent of this service is to engage in activities that will allow the person to either acquire new adaptive skills or support the

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person in utilizing adaptive skills in order to become actively involved in their community.

Community Experience Individual services are provided to an individual participant, with a one-to-one staff to participant ratio which is determined necessary through functional and health risk assessments prior to approval. Additionally, a behavioral assessment will need to support this specialized staffing if related to behavioral challenges prior to approval. Community Experience Group services are provided to groups of participants, with a staff to participant ratio of one to two or more, but no greater than four (4) participants.

Community Experience Self-Directed service is for individuals who choose (and are approved) to self-direct services and would otherwise need day supports and services (i.e. day habilitation) to obtain identified goals.

A unit of service is defined as 15 minutes.

Housing Stabilization (T2025/Modifier UC – ID)

The Housing Stabilization Service enables waiver participants to maintain their own housing as set forth in the participant's approved plan of care (POC). Services must be provided in the home or a community setting. The service includes the following components:

1. Conducting a Housing Coordination and Stabilization Assessment identifying the participant's preferences related to housing and needs for support to maintain housing, budgeting for housing/living expenses, obtaining/accessing sources of income necessary for rent, home management, establishing credit and understanding and meeting obligations of tenancy as defined in lease terms.
2. Assisting participant with finding and securing housing as needed. This may include arranging or providing transportation.
3. Assisting participant in securing supporting documents/records, completing/submitting applications, securing deposits, and locating furnishings.
4. Developing an individual housing stabilization plan based upon the Housing Coordination and Stabilization Assessment as part of the overall Person Centered Plan.
5. Participating in Person-Centered plan meetings at redetermination and/or revision plan meetings as needed.
6. Providing supports and interventions per the Person-Centered Plan (individualized housing stabilization portion).
7. Communication with the landlord and/or property manager regarding the participant's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager.
8. If at any time the participant's housing is placed at risk (i.e., eviction, loss of roommate or loss of income), Housing Stabilization Services will provide supports to retain housing or locate and secure new housing or sources of income to continue community based supports which includes locating new housing, sources of income. etc.

A unit of service is defined as 15 minutes.

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Assistance in Community Integration (T2025/Modifier UC – LHW)

The Assistance in Community Integration service enables waiver participants to maintain their own housing as set forth in the participant's approved plan of care (POC). Services must be provided in the home or a community setting. The service includes the following components:

1. Conducting a community integration assessment identifying the participant's preferences related to housing and needs for support to maintain community integration.
2. Assisting participant with finding and securing housing as needed. This may include arranging for or providing transportation.
3. Assisting participant in securing supporting documents/records, completing/submitting applicants, securing deposits, and locating furnishings.
4. Developing an individualized community integration plan based upon the assessment as part of the overall Person Centered Plan. Identify and establish short and long-term measurable goal(s), and establish how goals will be achieved and how concerns will be addressed.
5. Participating in Person-Centered plan meetings at re-determination and/or revision plan meetings as needed.
6. Providing supports and interventions per the Person-Centered Plan (individualized community integration portion). Identify any additional supports or services needed outside the scope of Community Integration services and address among the team.
7. Supports to assist the individual in communicating with the landlord and/or property manager regarding the participant's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager.
8. Assistance in Community Integration will provide supports to preserve the most independent living arrangement and/or assist the individual in locating the most integrated option appropriate to the individual.

A unit of service is defined as 15 minutes.

Personal Emergency Response System (PERS) (S5160Modifier UD – LAH) (S5160Modifier UC – ID) (S5160Modifier UD/HW – LAH) (S5160Modifier UC/HW – ID) (S5161Modifier UD – LAH) (S5161Modifier UC – ID) (S5161Modifier UD/HW – LAH) (S5161Modifier UC/HW – ID)

Personal emergency response system (PERS) is a service that provides a direct telephonic or other electronic communications link between someone living in the community and health professionals to secure immediate assistance in the event of a physical, emotional or environmental emergency. PERS may also include cellular telephone service used when a conventional PERS is less cost-effective or is not feasible. This service may include installation, monthly fee (if applicable), upkeep and maintenance of devices or systems as appropriate.

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The use of these technologies requires assurance that safeguards are in place to protect privacy, provide informed consent, and that documented needs are addressed in the least restrictive manner. The person centered plan should identify options available to meet the need of the individual in terms of preference while also ensuring health, safety, and welfare.

Personal Emergency Response System (PERS) can be directed by individual participants or family but must adhere to all the traditional service rules.

Emergency Response System installation and testing is approximated to cost $500.00; Emergency Response Monthly Service Fee (excludes installation and testing) is approximated to cost no more than $83.00/month; Emergency Response system purchase is approximated to cost $1,500.00. The maximum cost for all PERS per year is $3,000.00.

Supported Employment Emergency Transportation (S0215Modifier UD – LAH) (S0215Modifier UC – ID) (T2003Modifier UD – LAH) (T2003Modifier UC – ID)

Supported Employment Emergency Transportation is the provision of service to permit waiver participants access to and from their place of employment in the event that the support team is unable to facilitate transportation arrangements quickly or there is a risk of the participant missing a day of scheduled work. The provision of this service must be necessary to support the person in work related travel and cannot be reimbursed for merely transportation.

Transportation must be provided by public carriers (i.e. charter bus or metro transit bus) or private carriers (i.e. Taxicab). The recipient may use a commercial transportation agency.

A maximum amount of $1,000 per fiscal year is allowable.

107.2.5 Characteristics of Persons Requiring ICF-IID Level of Care Through the ID Waiver (formerly MR Waiver) and Living at Home Waiver

Services provided in an intermediate care facility for individuals with intellectual disabilities in Alabama are those services that provide a setting appropriate for a functionally individual with intellectual disabilities in the least restrictive productive environment currently available.

Generally, persons eligible for the ICF-IID level of care provided through the ID and LH Waiver need such a level of care because the severe, chronic nature of their mental impairment results in substantial functional limitations in three (3) or more of the following areas of life activity:

- Self Care
- Receptive and expressive language
- Learning
- Self-direction
- Capacity for independent living
- Mobility

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ICF-IID care requires the skills of a QIDP to provide directly or supervise others in the provision of services. ICF-IID services address the functional deficiencies of the beneficiary to allow the beneficiary to experience personal hygiene, participate in daily living activities appropriate to his functioning level, take medication under appropriate supervision (if needed), receive therapy, receive training toward more independent functioning, and experience stabilization as a result of being in the least restrictive, productive environment that promotes the individual's developmental process.

Determining Eligibility for ID and LH Waiver

Determination regarding eligibility for care under the ID & LH Waiver is made by a Qualified Intellectual Disabilities Professional (QIDP). An interdisciplinary team (described below) recommends continued stay. The recommendation is certified by a (QIDP) and a physician.

Qualifications of Interdisciplinary Review Team

An interdisciplinary team consisting of a nurse, social worker, and a member of appropriate related discipline, usually a psychologist, recommends continued stay.

The nurse will be a graduate of a licensed school of nursing with a current state certification as a Licensed Practical Nurse (LPN) or Registered Nurse (RN). This person will have knowledge and training in the area of intellectual disabilities with a minimum of two years' experience.

The social worker will be a graduate of a four-year college with an emphasis in social work. This person will have knowledge and training in the area of intellectual disabilities with a minimum of two years' experience.

The psychologist will possess a Ph.D. in Psychology. This person will be a licensed psychologist with general knowledge of test instruments used with intellectual disabilities with a minimum of two years' experience.

Other professional disciplines may be represented on the assessment team as necessary depending on the age, functional level, and physical disability of the recipients:

- Special Education
- Speech Pathologist
- Audiologist
- Physical Therapist
- Optometrist
- Occupational Therapist
- Vocational Therapist
- Recreational Specialist
- Pharmacist
- Doctor of Medicine
- Psychiatrist
- Other skilled health professionals

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Individual Assessments

Medicaid requires an individual plan of care for each ID & LH waiver service recipient. The Individual Habilitation Plan (IHP) is subject to review by Medicaid and CMS.

The DMH (or its contract service providers) uses assessment procedures to screen recipients for eligibility for the Waiver services as an alternative to institutionalization. Assessment procedures are based on eligibility criteria for ICF-IID-developed jointly by DMH and Medicaid.

Review for "medical assistance" eligibility may be performed by a qualified practitioner in the DMH, by its contract service providers, or by qualified (Diagnostic and Evaluation Team) personnel of the individual or agency arranging the service.

Recipients are re-evaluated on an annual basis. Written documentation of all assessments is maintained in the recipient's case file and is subject to review by Medicaid and CMS.

A written assessment is a method for determining a recipient's current long-term care needs. This comprehensive instrument is used to access each individual recipient's functional, medical, social, environmental, and behavioral status. Information obtained should be adequate enough to make a level of care decision and for case managers to develop an initial plan of care.

Re-evaluations are done on an annual basis or when needed. Written documentation of all assessments is maintained in the recipient's case file and is subject to review by Medicaid and CMS.

107.2.6 Informing Beneficiaries of Choice

Medicaid is responsible for ensuring that beneficiaries of the waiver service program are advised of feasible service alternatives and receive a choice regarding which type of service they wish to receive (institutional or home-and/or community-based services).

Medicaid advises applicants for NF, ICF, ICF-IID services, or their designated responsible party, of feasible alternatives to institutionalization at the time of their entry into the waiver system. All applicants found eligible will be offered the alternative unless there is reasonable expectation that the services required would cost more than institutional care.

When residents of long-term care facilities become eligible for home and community-based services under this waiver, the resident will be advised of the available services and given a choice of service providers.

107.2.7 Cost for Services

The costs for services to individuals who qualify for home and community-based care under the waiver program will not exceed, on an average per capita basis, the total expenditures that would be incurred for such individuals if home and community-based services were not available.

The cost for services to individuals who qualify for home and community-based care under the LAH waiver program will not exceed a cap of $25,000 per client per year with the exception that crisis intervention services are not included in the cap.

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107.2.8 *Records Used for Medicaid Audits*

Providers must maintain financial accountability for funds expended on HCBS and provide a clearly defined audit trail.

Providers must retain records that fully disclose the extent and cost of services provided to eligible recipients for a three-year period. These records must be accessible to the Alabama Medicaid Agency and appropriate state and federal officials. If these records are not available within the state of Alabama, the provider will pay the travel cost of the auditors.

The state agencies as specified in the approved waiver document as operating agencies of home and community-based services will have their records audited at least annually at the discretion of the Alabama Medicaid Agency. Payments for services are adjusted to actual cost at the end of each waiver year.

The Alabama Medicaid Agency will review at least annually the recipient's care plans and services rendered by a sampling procedure. The review will include appropriateness of care and proper billing procedures.

The state agencies as specified in the approved waiver document provide documentation of actual costs of services and administration. The quarterly cost report includes all actual costs incurred by the operating agency for the previous quarter and includes costs incurred for the current year-to-date. The state agencies submit this document to Medicaid before the first day of the third month of the next quarter.

Failure to submit the actual cost documentation can result in the Alabama Medicaid Agency deferring payment until this documentation has been received and reviewed.

The providers of the HCBS waivers will have their records audited at least annually at the discretion of Medicaid. Medicaid will recover payments that exceed actual allowable cost.

Medicaid reviews recipients' habilitation and care plans and services rendered by a sampling procedure. The review includes appropriateness of care and proper billing procedures.

Providers of the E&D and SAIL HCBS waivers are required to file a complete uniform cost report of actual statistics and costs incurred during the entire preceding year. The cost reports for E&D must be received by Medicaid on or before December 31. Cost reports for the SAIL Waiver must be received on or before June 1. Extension may be granted only upon written request. Failure to submit the actual cost documentation may result in the AMA deferring payment until this documentation has been received and reviewed.

Providers of the LHW, TA Waiver for Adults, ID, HIV/AIDS, and ACT Waivers are not required to submit uniform cost reports. The method of payment is on a fee-for-service basis.

Quarters for E&D are defined as follows:

Quarter	***Reporting Period***	***Due Date***
1st	October – December	Due before March 1
2nd	January – March	Due before June 1
3rd	April – June	Due before September 1
4th	July – September	Due before December 1

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Quarters for SAIL are defined as follows:

Quarter	*Reporting Period*	*Due Date*
1st	April - June	Due before September 1
2nd	July - September	Due before December 1
3rd	October - December	Due before March 1
4th	January- March	Due before June 1

107.2.9 HCBS Payment Procedures

Each covered HCB waiver service is identified on a claim by a procedure code. Respite care will have one code for skilled and another for unskilled.

The basis for the fees are usually based on audited past performance with consideration given to the health care index and renegotiated contracts. The interim fees may also be changed if a provider can show that an unavoidable event(s) has caused a substantial increase or decrease in the provider's cost.

For each recipient, the claim will allow span billing for a period up to one month. There may be multiple claims in a month; however, no single claim can cover services performed in different months. For example, 10/15/02 to 11/15/02 would not be allowed. If the submitted claim covers dates of service part or all of which were covered in a previously paid claim, the claim will be rejected.

Payment will be based on the number of units of service reported on the claim for each procedure code.

Accounting for actual cost and units of services provided during a waiver year must be captured on CMS Form 372. The following accounting definitions will be used to capture reporting data, and the audited figures used in establishing new interim fees:

- A waiver year consists of twelve consecutive months starting with the approval date specified in the approved waiver document.
- An expenditure occurs when cash or its equivalent is paid in a quarter by a state agency for waiver benefits. For a public/governmental provider, the expenditure is made whenever it is paid or recorded, whichever is earlier. Non-case payments, such as depreciation, occur when transactions are recorded by the state agency.
- The services provided by an operating agency is reported and paid by dates of service. Thus, all services provided during the twelve months of the waiver year will be attributed to that year.

The provider's costs shall be divided between benefit and administrative cost. The benefit portion is included in the fee for service. The administrative portion will be divided in twelve equal amounts and will be invoiced by the provider directly to the Alabama Medicaid Agency. Since Administration is relatively fixed, it will not be a rate per claim, but a set monthly payment. As each waiver is audited, this cost, like the benefit cost, will be determined and lump sum settlement will be made to adjust that year's payments to actual cost.

The Alabama Medicaid Agency's Provider Audit/Reimbursement Division maintains the year-end cost reports submitted by the Alabama Department of Senior Services (ADSS).

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Providers must retain records that fully disclose the extent and cost of services provided to the eligible recipients for a five (5) year period. These records must be accessible to the Alabama Medicaid Agency and appropriate state and federal officials.

There must be a clear differentiation between waiver services and non-waiver services. There must be a clear audit trail from the point a service is provided through billing and reimbursement. The OA, Alabama Medicaid Agency and Centers for Medicare and Medicaid Services (CMS) must be able to review the Plan of Care to verify the exact service and number of units provided, the date the service was rendered, and the direct service provider for each recipient. There must be a detailed explanation of how waiver services are segregated from ineligible waiver costs.

NOTE:

The rates for each service for each operating agency may differ. For the E&D waiver, operating agencies have 120 days from the end of a waiver year to file their claims. The operating agency for the SAIL waiver has 180 days from the end of a waiver year to file. Since the actual cost incurred by the operating agency sets a ceiling on the amount it can receive, no claims for the dates of service within that year will be processed after the adjustment is made. For the LHW, ID, HIV/AIDS, and ACT Waivers, the operating agency must file all claims for services within 12 months from the date of service. For the TA Waiver for Adults, the providers must file all claims for services rendered within 12 months from the date of service provision.

107.2.10 Records for Quality Assurance Audits

The operating agencies for the E&D, ID, LHW, ACT, and HIV/AIDS waivers are required to maintain all records pertaining to the waiver recipients. They should also maintain the following information for audit purposes:

- Daily activity logs
- Narratives
- Evaluations and reevaluations
- Complaints and grievances
- Billing and payment records
- Plan of Care
- Delivery of services
- Any other important tools used to determine the success of the waiver services

This information is used to ensure that the state is in accordance with the approved waiver document and services are appropriate for the individual being served.

This information shall be made available to Medicaid and any other party in the contractual agreement at no cost.

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NOTE:
Records for Quality Assurance audits for the TA Waiver for Adults conducted by the in-house Medicaid reviewer will be maintained at the Alabama Medicaid Agency.

107.2.11 Appeal Procedure (Fiscal Audit)

Medicaid conducts fiscal audits of all services. At the completion of a field audit there will be an exit conference with the provider to explain the audit findings. The provider will have the opportunity agree or disagree with the findings.

Medicaid reviews the field audit and provider comments and prepares a letter to make the appropriate findings official. If the provider feels that some of the findings are not justified, the provider may request an informal conference with Medicaid. To request the informal conference, the provider must submit a letter within 30 days of the date of the official audit letter. This letter must specify the findings that are contested and the basis for the contention. This letter should be addressed to Provider Audit Division, Alabama Medicaid Agency, 501 Dexter Avenue, P. O. Box 5624, Montgomery, AL 36103-5624.

Medicaid forwards decisions made as a result of the informal conference to the provider by letter. If the provider believes that the results of the informal conference are still adverse, the provider will have 15 days from the date of the letter to request a fair hearing.

Quality Assurance (QA) reviews are performed on an annual basis by Medicaid. At the end of this review there will be an exit conference with the providers to explain the findings. The provider will have an opportunity to agree or disagree.

Medicaid reviews the findings and prepares an official letter. If the provider feels that some of the findings are not justified, the provider may request an informal conference with Medicaid. To request the informal conference, the provider must submit a letter within 30 days of the date of the official review letter. This letter must specify the findings that are contested and the basis for the contention. This letter should be addressed to Quality Assurance Division, Alabama Medicaid Agency, 501 Dexter Avenue, P.O. Box 5624, Montgomery, AL 36103-5624.

If the provider is not satisfied with the findings of the informal conference, the provider may request a fair hearing.

107.3 Prior Authorization and Referral Requirements

Certain procedure codes for waivers require prior authorization. Refer to Section 4, Obtaining Prior Authorization, for general guidelines.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39, Patient 1st Billing Manual to determine whether your services require a referral from the Primary Medical Provider (PMP).

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Application Process

The case manager receives referrals from hospitals, nursing homes, physicians, the community, and others for persons who may be eligible for HCBS.

The plan of care, which is developed by the case manager and applicant's physician, is part of this assessment. The plan of care includes the following:

- Objectives
- Services
- Provider of services
- Frequency of services

The Alabama Medicaid Agency requires providers to submit an application in order to document dates of service provision to long term care recipients maintained by the long term care file. Application approvals will be done automatically through systematic programming. Quality Improvement and Standards Division will perform random audits on a percentage of records to ensure that documentation exists to support the medical level of care criteria, physician certification, as well as other state and federal requirements.

Case managers and/or designated staff of the HCBS waiver Operating Agency (ies) will assess the client to determine the risk for institutionalization and determine if the medical level of care is met according to Medicaid criteria.

Assessment data will be entered and submitted electronically through the use of the Alabama Medicaid Agency Interactive website. If problems are encountered such as mismatched Social Security Numbers and/or Medicaid numbers, date conflicts, invalid NPIs, or financial ineligibility, the auto-application will be denied and returned. Information will be provided to the user of the appropriate action(s) to take to correct the problem and will be allowed to resubmit the application.

The application, upon completion of processing, will systematically assign approval dates in one-year increments. For initial assessments, once the application is submitted with an indication of an initial assessment, the system will apply the begin date as the date of submission plus one year, which is extended to the last day of the month. For re-determinations, the application is submitted with an indication of a re-determination and the system will pick up the end date already on the file and extend for one year.

No charges for services rendered under the waiver program prior to the approval payment dates will be paid.

Application Process for TA Waiver for Adults

The Alabama Department of Senior Services (ADSS) targeted case manager will receive referrals from hospitals, nursing homes, physicians, the community and others for persons who may be eligible for home and community based services.

An assessment document will be completed by the targeted case manager, in conjunction with the applicant's physician. This document will reflect detailed information regarding social background, living conditions, and medical problems of the applicant. A copy of this document will be submitted to the Alabama Medicaid Agency for approval.

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The targeted case manager, in conjunction with the applicant's physician will develop a plan of care. The plan of care will include objectives, services, provider of services, and frequency of service. The plan of care must be submitted to the Alabama Medicaid Agency for approval. Changes to the original plan of care are to be made as needed to adequately care for an individual. Reasons for changes must be documented on the client's care plan, which is subject to the review of the Alabama Medicaid Agency. The plan of care must be reviewed by the targeted case manager as often as necessary and administered in coordination with the recipient's physician.

The targeted case manager will coordinate completion of the medical need admissions form with the applicant's physician and the financial application form for submission to the Alabama Medicaid Agency's Long Term Care Division.

The LTC Division will submit the medical application to the Associate Medical Director for review to determine if the individual meets the criteria for nursing facility care, in accordance with Rule No 560-X-10-.10 of the Alabama Medicaid Administrative Code. The LTC Division will submit the "Waiver/Slot Confirmation Form" to the District Office for processing financial determination.

If approved, the applicant and the targeted case manager will be notified in writing.

If denied, the applicant and the targeted case manager will be notified and the reconsideration process will be explained in writing as described in Rule No. 560-X-10-.14 of the *Alabama Medicaid Administrative Code*.

When an application is approved by the Alabama Medicaid Agency, a payment date is also given for the level of care for which a recipient has been approved. No charges for services rendered under the Waiver Program prior to this approved payment date will be paid.

A current assessment document, along with a new plan of care, and medical need admission form must be submitted by the targeted case manager to the Alabama Medicaid Agency at each re-determination of eligibility which shall be at least every twelve (12) months.

HCBS Waiver Appeal Process

An individual receiving a Notice of Action (denial, termination, suspension, reduction in services) from the operating agency (OA), may request an appeal if he/she disagrees with the decision. The Notice of Action explains the reason for the denial, termination, suspension, or reduction in waiver services and the appeal rights made available to them.

Appeal requests for ACT, SAIL, E&D, HIV/AIDS, & TA Waivers

If an individual chooses to appeal an adverse decision, a written request must be submitted to the contact person designated by the OA **within 30 days from the date of the notice of action.** However, services may continue until the final outcome of the hearing process, if the written request is received **within 10 days after the effective date of the action unless:**

(1) It is determined at the hearing that the sole issue is one of Federal or State law or policy; and

(2) The agency promptly informs the beneficiary in writing that services are to be terminated or reduced pending the hearing decision.

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The individual will have an Informal Conference. After the Informal Conference, the Medicaid Waiver Program Administrator will send a certified letter notifying the individual of the decision. If the individual/guardian is dissatisfied with the decision, a Fair Hearing may be requested. A written request for a hearing must be received **no later than 30 days from the date of the notice of action.**

Requests made for ID and LHW Waivers

If an individual chooses to appeal an adverse decision, a written request must be submitted to the Associate Commissioner for Intellectual Disabilities (ID) **no later than 15 calendar days after the effective date printed on the notice of action.** However, services may continue until the final outcome of the hearing, if the written request is received **within 10 days after the effective date of the action unless:**

(1) It is determined at the hearing that the sole issue is one of Federal or State law or policy; and

(2) The agency promptly informs the beneficiary in writing that services are to be terminated or reduced pending the hearing decision.

Upon receipt of an appeal request by the Associate Commissioner for ID, contact is made with the Regional Community Services Offices to request the information packet that they reviewed to base the denial decision. The Associate Commissioner will contact the individual/guardian and inform them that the division is in the process of reviewing their information. A written decision from the Associate Commissioner is mailed (certified) to the individual/guardian within 21 days after the review of all information. If the individual/guardian disagrees with the Associate Commissioner's decision, he/she can request a Fair hearing to the AMA. A written hearing request must be received by the AMA **no later than 15 calendar days from the date of the Associate Commissioner's letter.**

107.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by Waiver service providers.

107.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Waiver service providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claims processing turnaround
- Ability to immediately correct claim errors
- Online adjustments capability
- Enhanced access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

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NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted. TA Waiver for Adults providers must file claims on a UB-04 claim form when filing hard copy. Medicare-related claims must be filed using the Institutional/Medicare-related claim form for TA Waiver recipients.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

107.5.1 Time Limit for Filing Claims

The operating agencies for the E&D waiver have 120 days at the end of the waiver year to process claims. The operating agency for the SAIL waiver has 180 days at the end of the waiver year to process claims. Living at Home Waiver, Technology Assisted Waiver for Adults, ID, HIV/AIDS Waiver, and ACT Waiver claims are to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

107.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-9 or ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

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107.5.3 Procedure Codes

The following procedure codes apply when filing claims for Elderly and Disabled Waiver services:

Code	Description	PA Required?
T1016-UA	Case Management	No
T1019-UA	Personal Care	No
S5102-UA	Adult Day Health	No
T1005-UA	Respite Care – Skilled– Billed per hour	No
S5150-UA	Respite Care – Unskilled	No
S5130-UA	Homemaker	No
S5135-UA	Companion	No
S5170-UA	Waiver Frozen Meals	No
S5170-SC	Waiver Shelf-Stable Meals	No
S5170	Waiver Breakfast Meals	No

The following procedure codes apply when filing claims for SAIL Waiver services. These services are limited to recipients age 18 and over.

Code	Description	PA Required?
T1016-UB	Case Management	No
T1019-UB	Personal Care Services	No
S5165-UB	Environmental Accessibility Adaptations	Yes
T2028-UB	Medical Supplies – (exempt from TPL)	No
T2028-UB & SC	Minor Assistive Technology	No
S5160-UB	Personal Emergency Response Systems/Initial (exempt from TPL)	Yes
S5161-UB	Personal Emergency Response Systems/Monthly Service Fee	No
T2029-UB	Assistive Technology	Yes
S5125-UB	Personal Assistance Services	No
T2025-UB	Evaluation for Assistive Technology	No
T2035-UB	Assistive Technology Repairs	No

The following procedure codes apply when filing claims for Intellectual Disabilities services:

Code	Description	PA Required?
T2021-UC & HW	Day Habilitation Services- Level 1	No
T2021-UC & TF	Day Habilitation Services-Level 2	No
T2021-UC & TG	Day Habilitation Services-Level 3	No
T2021-UC & HK	Day Habilitation Services-Level 4	No
T2021-UC & HW & SE	Day Habilitation Services w/ transportation- Level 1	No
T2021-UC & TF & SE	Day Habilitation Services w/transportation-Level 2	No

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Code	***Description***	***PA Required?***
T2021-UC & TG & SE	Day Habilitation Services w/transportation-Level 3	No
T2021-UC & HK & SE	Day Habilitation Services w/transportation-Level 4	No
T2016-UC	Residential Services	No
S5150-UC	In-home Respite Care	No
T1005-UC	Out-of-Home Respite	No
T2044-UC	Institutional Respite	No
T2017-UC	Residential Services - Other Living Arrangements	No
T2019-UC	Supported Employment Services	No
T2019-UC & HN	Individual Job Coach	No
T2019-UC & HO	Individual Job Developer	No
T2015-UC	Prevocational Services	No
97110-UC	Physical Therapy	No
97110-UC & HW	Self-Directed Physical Therapy	No
97535-UC	Occupational Therapy	No
97535-UC & HW	Self-Directed Occupational Therapy	No
92507-UC	Speech and language Therapy	No
92507-UC & HW	Self-Directed Speech and Language Therapy	No
T1019-UC	Personal Care	No
T1019-UC & HN	Self-Directed Personal Care	No
T1019-UC & HW	Personal Care on Worksite	No
T2001-UC	Personal Care Transportation	No
S5135-UC	Companion Services	No
S5135-UC & HW	Self-Directed Companion Services	No
H2019-UC & HP	Positive Behavior Support-Level 1	No
H2019-UC & HP & SE	Self-Directed Positive Behavior Support – Level 1	No
H2019-UC & HN	Positive Behavior Support-Level 2	No
H2019-UC & HN & SE	Self-Directed Positive Behavior Support – Level 2	No
H2019-UC & HM	Positive Behavior Support-Level 3	No
H2019-UC & HM & SE	Self-Directed Positive Behavior Support – Level 3	No
S5165-UC	Environmental Accessibility Adaptations	No
S5165-UC & HW	Self-Directed Environmental Accessibility Adaptations	No
S9123-UC	Skilled Nursing-RN	No
S9123-UC & HW	Self-Directed-RN	No

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Code	Description	PA Required?
S9124-UC	Skilled Nursing-LPN	No
S9124-UC & HW	Self-Directed-LPN	No
T2028-UC	Medical Supplies	No
T2028-UC & HW	Self-Directed Medical Supplies	No
T2029-UC	Specialized Medical Equipment	No
T2029-UC & HW	Self-Directed Medical Equipment	No
H2015-UC	Community Specialist	No
H2015-UC & HW	Self-Directed Community Specialist	No
H2011-UC	Crisis Intervention	No
T1999-UC	Individual Directed Goods and Services	No
H2014-UC	Benefits and Career Counseling	No
H2021-UC	Community Experience 1:1	No
H2021-UC & SE	Community Experience Small Group	No
H2021-UC & HW	Community Experience Self Directed	No
T2025-UC	Housing Stabilization Service	No
S5160-UC	Personal Emergency Response System (initial)	No
S5160-UC & HW	Self-Directed Personal Emergency Response System (initial)	No
S5161-UC	Personal Emergency Response System (Monthly service fee)	No
S5161-UC & HW	Self-Directed Personal Emergency Response System (Monthly service fee)	No

The following procedure codes apply when filing claims for Living at Home Waiver services:

Code	Description (All services exempt from TPL and MC)	PA Required?
T2017-UD	In-Home Residential Habilitation	No
T2021-UD & HW	Day Habilitation (Level 1)	No
T2021-UD & TF	Day Habilitation (Level 2)	No
T2021-UD & TG	Day Habilitation (Level 3)	No
T2021-UD & HK	Day Habilitation (Level 4)	No
T2021-UD & HW & SE	Day Habilitations w/transportation – Level 1	No
T2021-UD & TF & SE	Day Habilitations w/transportation – Level 2	No
T2021-UD & TG & SE	Day Habilitations w/transportation - Level 3	No
T2021-UD & HK & SE	Day Habilitations w/transportation – Level 4	No
T2019-UD	Supported Employment	No
T2019-UD & HN	Individual Job Coach	No

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Code	Description (All services exempt from TPL and MC)	PA Required?
T2019-UD & HO	Individual Job Developer	No
S0215-UD	Supported Employment Emergency Transportation-Mile	No
T2003-UD	Supported Employment Emergency Transportation-Item	No
T2015-UD	Prevocational Services	No
S5150-UD	Respite In-Home	No
T1005-UD	Respite Out-of-Home	No
T1019-UD	Personal Care	No
T1019-UD & HN	Self-Directed Personal Care	No
T1019-UD & HW	Personal Care on Worksite	No
T2001-UD	Personal Care Transportation	No
97110-UD	Physical Therapy	No
97110-UD & HW	Self-Directed Physical Therapy	No
97535-UD	Occupational Therapy	No
97535-UD & HW	Self-Directed Occupational Therapy	No
92507-UD	Speech Therapy	No
92507-UD & HW	Self-Directed Speech Therapy	No
H2019-UD & HP	Positive Behavior Support-Level 1	No
H2019-UD & HP & SE	Self-Directed Positive Behavior Support-Level 1	No
H2019-UD & HN	Positive Behavior Support-Level 2	No
H2019–UD & HN & SE	Self-Directed Positive Behavior Support-Level 2	No
H2019-UD & HM	Positive Behavior Support-Level 3	No
H2019-UD & HM & SE	Self-Directed Positive Behavior Support-Level 3	No
S9123-UD	Skilled Nursing RN	No
S9123-UD & HW	Self-Directed Skilled Nursing –RN	No
S9124-UD	Skilled Nursing - LPN	No
S9124-UD & HW	Self-Directed Skilled Nursing – LPN	No
S5165-UD	Environmental Accessibility Adaptations	No
S5165-UD & HW	Self-Directed Environmental Accessibility Adaptations	No
T2028-UD	Specialized Medical Supplies	No
T2028-UD & HW	Self-Directed Medical Supplies	No
T2029-UD	Specialized Medical Equipment	No

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Code	Description (All services exempt from TPL and MC)	PA Required?
T2029-UD & HW	Self-Directed Medical Equipment	No
H2015-UD	Community Specialist	No
H2015-UD & HW	Self-Directed Community Specialist	No
H2011-UD	Crisis Intervention	No
T1999-UD	Individual Directed Goods and Services	No
H2014-UD	Benefits and Career Counseling	No
T2025-UD	Assistance in Community Integration	No
H2021 UD	Community Experience 1:1	No
H2021-UD & SE	Community Experience Small Group	No
H2021-UD & HW	Community Experience Self-Directed	No
S5160 –UD	Personal Emergency Response System (initial)	No
S5160-UD & HW	Self-Directed Personal Emergency Response System (initial)	No
S5161-UD	Personal Emergency Response System (monthly service fee)	No
S5161-UD & HW	Self-Directed Personal Emergency Response (monthly service fee)	No
H2014-UD	Benefits and Career Counseling	No

The following procedure codes apply when filing claims for TA Waiver for Adults services:

Code	***Description***	***PA Required?***
S9123-U5	Private Duty Nursing - RN	No
S9124-U5	Private Duty Nursing - LPN	No
T1019-U5	Personal Care/Attendant Service	No
T2028-U5	Medical Supplies and Appliances	No
T2029-U5	Assistive Technology	Yes

The following procedure codes apply when filing claims for HIV/AIDS Waiver services:

Code	***Description***	***PA Required?***
T1016-U6	Case Management Services	No
T1019-U6	Personal Care Services	No
T1005-U6	Respite Care Services – Skilled	No
S5150-U6	Respite Care Services - Unskilled	No
S5130-U6	Homemaker Services	No
S9123-U6	Skilled Nursing	No
S5135-U6	Companion Service	No

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The following procedure codes apply when filing claims for ACT Waiver services:

Code	***Description***	***PA Required?***
T1016-TF UB	Case Management	No
T1019-TF UB	Personal Care Services	No
S5165-TF UB	Environmental Accessibility Adaptations	Yes
T2028-TF UB	Medical Supplies – (exempt from TPL)	No
S9123-TF UB	Skilled Nursing (RN)	No
S9124-TF UB	Skilled Nursing (LPN)	No
S5160-TF UB	Personal Emergency Response Systems/Initial (exempt from TPL)	Yes
S5161-TF UB	Personal Emergency Response Systems/Monthly Service Fee	No
T2029-TF UB	Assistive Technology	Yes
S5125-TF UB	Personal Assistance Services	No
T2038-TF UB	Transitional Assistance Service	No
S5130-TF UB	Homemaker Service	No
S5102-TF UB	Adult Day Health	No
T1005-TF UB	Respite Services (Skilled)	No
S5150-TF UB	Respite Services (Unskilled)	No
S5170-TF UB	Home Delivered Meals	No
S5170-TF SC	Home Delivered Meals (Shelf Stable)	No
S5170-TF UA	Home Delivered Meals (Breakfast)	No
S5135-TF UB	Adult Companion Service	No

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107.5.4 Place of Service Codes

The following place of service codes apply when filing claims for Waiver service:

POS Code	Description
12	Home (Residential) —ID Waiver, SAIL Waiver, LHW, TA Waiver for Adults, ACT Waiver, and the HIV/AIDS Waiver
21	Inpatient Hospital-SAIL Waiver, HIV/AIDS Waiver, ACT Waiver
31	Skilled Nursing Facility or Nursing Home-SAIL Waiver, HIV/AIDS Waiver, and ACT Waiver
32	Nursing Facility-SAIL Waiver, HIV/AIDS Waiver, and ACT Waiver
51	Inpatient Psychiatric Facility-SAIL Waiver, HIV/AIDS Waiver, and ACT Waiver
54	Intermediate Care Facility/Individuals with Intellectual Disabilities - SAIL Waiver, HIV/AIDS Waiver, and ACT Waiver
99	Other Unlisted Facility —ID Waiver, Elderly & Disabled Waiver, LHW, TA Waiver for Adults, SAIL, HIV/AIDS, and ACT Waiver

107.5.5Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to Claims with Third Party Denials.

Refer to Section 5.8, Required Attachments, for more information on attachments.

107.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Chapter 5
Patient 1st	Chapter 39
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
UB92 Claim Filing Instructions	Chapter 5

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