Medicaid, as authorized by Title XIX of the Social Security Act, is a federal and state program of medical assistance to qualified individuals. Each state designates a state agency as the single state agency for the administration of Medicaid. State law has designated the Division of Medicaid (DOM), Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

Section 1915(c) of the Social Security Act authorized the Secretary of Health and Human Services to waive certain Medicaid statutory requirements that enable a state to cover an array of Home and Community-Based Services (HCBS) as an alternative to institutionalization. Prior to 1981, the Medicaid program provided little coverage for long-term care services in a non-institutional setting but offered full or partial coverage for such care in an institution. In an effort to address these concerns, the Omnibus Budget Reconciliation Act (OBRA) was enacted, adding section 1915(c) to the Social Security Act. HCBS waivers offer broad discretion not generally afforded under the State Plan so that the needs of individuals under the State Medicaid Plan may be addressed.

Home and Community-Based Services is an optional benefit under the state's Medicaid program. If individuals are not Medicaid eligible at the time of the HCBS application, Medicaid coverage for HCBS services may be possible for individuals if they meet the medical and eligibility criteria for the specific waiver program, along with the financial criteria for Medicaid coverage.

Waiver Provider participation in the Mississippi Medicaid program is entirely voluntary. However, if a provider does choose to participate in Medicaid, the provider must accept the Medicaid payment as payment in full for those services covered by Medicaid. The provider cannot charge the beneficiary the difference between the usual and customary charge and Medicaid's payment. The provider cannot accept payment from the beneficiary, bill Medicaid, and then refund Medicaid's payment to the beneficiary. DOM does not cover telephone contacts/consultations or missed/cancelled appointments, and providers may **not** bill beneficiaries for these services.

Through an interagency agreement, the Division of Medicaid (DOM) and the Mississippi Department of Mental Health, Bureau of Mental Retardation (MDMH/BMR), maintain joint responsibility for the program. DOM maintains responsibility for the administration and supervision of the waiver. DOM formulates all DOM policies, rules, and regulations related to the waiver. Under the direction of DOM, the fiscal agent is responsible for processing claims, issuing payments to providers, and for notifications regarding billing. MDMH/BMR is responsible for operational functions. MDMH/BMR is responsible for incorporating DOM policies, rules and regulations, provisions of the HCBS MR/DD waiver document approved by the Centers for Medicare and Medicaid Services (CMS), and the *Mississippi Department of Mental Health Minimum Standards for Community Mental Health/Retardation Services* into the provision of covered services.

The Mentally Retarded/Developmentally Disabled (MR/DD) Waiver provides services to individuals who, but for the provision of such services, would require the level of care found in an intermediate care facility for the mentally retarded (ICF/MR). This waiver is jointly administered by the Division of Medicaid and the Mississippi Department of Mental Health, Bureau of Mental Retardation (MDMH/BMR), through an interagency agreement.

Eligibility requirements for the MR/DD Waiver include the following:

1. Beneficiary must be mentally retarded and developmentally disabled, **AND**

2. Beneficiary must require a level of care found in an ICF/MR, **AND**

3. Beneficiary must currently qualify for full Medicaid benefits in one of the following categories:

   - SSI
   - Low Income Families and Children Program
   - Poverty Level Families and Children Program
   - Disabled Child Living at Home Program

   OR an aged, blind, or disabled individual can qualify if income is under 300% of the SSI limit for an individual. Resources must be less than $4,000.00

MR/DD waiver services are available statewide. The waiver carries no age restrictions.

All providers (see exception noted below) interested in becoming providers of Mentally Retarded/Developmentally Disabled Waiver services must **first** complete an application and be certified by the Mississippi Department of Mental Health, Bureau of Mental Retardation (MDMH/BMR). Certification is dependent upon compliance with the *Mississippi Department of Mental Health Minimum Standards for Community Mental Health/Retardation Services.* A web copy of the minimum standards may be found at http://www.dmh.state.ms.us. Click on the link for online documents.

When the provider has met all standards for certification, MDMH/BMR will send written notification to the Division of Medicaid, HCBS Division of the Bureau of Long Term Care (HCBS/LTC). HCBS staff will mail a Mississippi Medicaid Provider Application to the provider. Upon completion, the application must be **mailed** back to the Division of Medicaid, HCBS Division of the Bureau of Long Term Care. **The enrollment application for waiver services cannot be submitted electronically.**

DOM HCBS staff will review the application. If approved, the application will be forwarded to the DOM Bureau of Provider/Beneficiary Relations for approval. When all approvals have been obtained, the application will be forwarded to the fiscal agent. Upon notification that a provider number has been issued, DOM HCBS staff will notify MDMH/BMR.

Exception: Independent providers of occupational therapy (OT), speech-language therapy (ST), physical therapy (PT), and durable medical equipment (DME) are not required to apply through MDMH/BMR. Providers must, however, comply with all other policies and standards related to the applicable waiver services, and they must have or apply for a current Mississippi Medicaid provider number. Independent provider is defined as a DME, OT, PT, or ST provider who is not employed/ contracted with an agency certified by MDMH.

Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services. Section 1902(a) (23) of the Social Security Act provides that "any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person qualified to perform the service or services required."

MR/DD waiver services will not restrict a beneficiary's freedom to choose providers. The beneficiary has the right to request modification and/or cancellation of services at any time. The beneficiary must notify the support coordinator when a change in providers, services, etc. is requested.

When the service amounts, frequencies, duration, and/or scope are reduced, denied, or terminated, the beneficiary will be provided written notice of recourse/appeal procedures within ten (10) calendar days of the effective reduction, termination, or denial of services.

Prior approval must be obtained from the Division of Medicaid before a beneficiary can receive services through the Home and Community-Based Waiver Program. To obtain **initial approval**, the following forms must be submitted to the HCBS Division of the Bureau of Long Term Care:

- Evaluation Summary and Interdisciplinary Recommendations Report
- DOM 260-MR/DD Physician Certification
- BMR-301 Plan of Care
- HCBS 105 Home and Community-Based Services Recipients Admitted and Discharged Form

Evaluation Summary and Interdisciplinary Recommendations Report

A Pre-Admission Screening (PAS) system is used to perform the initial level of care evaluation for both MR/DD Waiver applicants and ICF/MR applicants. Educational/professional qualifications for evaluators are the same for MR/DD Waiver applicants and applicants for ICF/MR facilities. Evaluations are conducted at one of the Mississippi Department of Mental Health's five comprehensive regional centers (Ellisville State School, Boswell Regional Center, Hudspeth Regional Center, North Mississippi Regional Center, or South Mississippi Regional Center), depending on where the applicant lives. When the evaluation is complete, the Diagnostic Services Department prepares the Evaluation Summary and Interdisciplinary Recommendations Report. This report is the tool used to determine whether the applicant requires ICF/MR level of care. The applicant must require ICF/MR level of care to be eligible for waiver services.

DOM-260 MR/DD Physician Certification

The DOM 260-HCBS Physician Certification form is completed by a physician, certifying that the applicant meets the medical criteria for ICF/MR level of care. The physician's signature must be dated within ninety (90) days of the submission of the form. The beneficiary must be recertified by the physician on an annual basis. Certification is valid 364 days from the date of the physician's signature.

BMR 301 Plan of Care

The BMR 301 Plan of Care in conjunction with the Diagnostic and Evaluation Report contains objectives, the types of services to be furnished, and frequency of services. This form is completed by the Support Coordinator.

HCBS 105 Home and Community-Based Services Recipients Admitted and Discharged Form

The HCBS 105 form is used to admit and discharge beneficiaries into and from the Home and Community-Based Services waiver program. It must be completed at the time of the initial certification into the program, at each recertification, and any time there is a change in the beneficiary's status. This

form is completed by the Support Coordinator.

The Support Coordinator must forward all four (4) documents to MDMH/BMR for review. MDMH/BMR will in turn forward the documents to DOM, HCBS Division of the Bureau of Long Term Care, for approval. If approved, an enrollment date is established, appropriate forms are forwarded to the fiscal agent, and the beneficiary is locked into the waiver program. DOM HCBS staff will indicate program approval/denial on the forms, retain a copy, and forward originals to MDMH/BMR. The Support Coordinator will retain all original forms as part of the case record.

A beneficiary may be enrolled in only one DOM HCBS waiver program at a time.

The MR/DD Waiver provides the following services:

- Support Coordination
- Respite Care
- Residential Habilitation (Supported Residential Habilitation, Supervised Residential Habilitation)
- Day Habilitation
- Prevocational Services
- Supported Employment
- Attendant Care
- Behavioral Support/Interventions
- Therapy Services (Physical Therapy, Occupational Therapy, Speech-Language Therapy)
- Specialized Medical Supplies

Support Coordination

Support Coordination is defined as services designed to assist beneficiaries in accessing needed waiver and other State Plan services, as well as needed medical, social, educational, or other services, regardless of the funding source for the services. The service is provided by MDMH/BMR Support Coordinators located in each of the state's five comprehensive regional centers.

Support Coordinators are responsible for making arrangements for the initial eligibility assessment and annual reassessments by the Diagnostic Services Department. In addition, they are responsible for developing a written plan of care for each beneficiary, review/revision of the plan of care at least quarterly, assisting the beneficiary in locating and gaining access to all services on the plan of care, and monitoring the beneficiary's condition and all services included in the beneficiary's plan of care.

There are two levels of MR/DD Waiver Support Coordination: Normal and High.

> **Normal** is defined as those cases requiring a minimum of two phone contacts with the beneficiary/legal representative during a month and review of documentation and claim forms submitted monthly by providers. This also includes a required quarterly face-to-face contact.
>
> **High** is defined as those cases requiring more than two phone contacts with the beneficiary/legal representative and at least two collateral contacts on behalf of the beneficiary in addition to the

required monthly review of documentation and claim forms submitted by providers during the month **OR** when more than two phone contacts, a home visit in addition to the quarterly visit, a trip to the doctor to pick up forms, etc. during a month are necessary in addition to the required monthly review of documentation and claims forms submitted by providers.

Respite Care

Respite Care is defined as services that provide assistance to beneficiaries who are unable to care for themselves. Care is furnished on a **short-term** basis because of the absence of, or the need to provide relief to, the primary caregiver(s). Four types of respite services are provided through the waiver: In-Home Nursing Respite, In-Home Companion Respite, Community Respite, and ICF/MR Respite.

- **In-Home Nursing Respite**

  In-Home Nursing Respite services are provided in the beneficiary's home by a Licensed Practical Nurse (LPN) or Registered Nurse (RN). The need for nursing respite is dependent upon whether or not the beneficiary requires nursing care (as defined in the Nurse Practice Act) in the absence of the primary caregiver. Providers may be individual nurses currently licensed according to state law and certified by MDMH or those employed by an agency certified by MDMH.

- **In-Home Companion Respite**

  In-Home Companion Respite services are provided in the beneficiary's home by a Certified Nurses' Aide (CNA). In-Home Companion Respite differs from attendant care services in that the primary emphasis is relief of the caregiver versus support to the beneficiary. Only agencies certified by MDMH may provide these services. CNAs must be supervised by an RN or a Qualified Mental Retardation Professional (QMRP).

- **Community Respite**

  Community Respite services are provided in a community setting. Community respite is designed to provide primary caregivers a break from constant caregiving as well as provide the beneficiary with a safe place to go that will provide scheduled activities to address beneficiary preferences/requirements. **Community Respite cannot be provided overnight and cannot be provided in a private residence.** Community Respite cannot be used in place of regularly scheduled day activities such as Supported Employment, Day Habilitation, or Prevocational Services. Only facilities certified by MDMH may provide these services.

- **ICF/MR Respite**

  ICF/MR Respite services are provided in a state-licensed ICF/MR facility. ICF/MR respite services may be provided up to thirty (30) days per fiscal year. Services may only be provided to beneficiaries when authorized by the Support Coordinator as part of the approved plan of care. Only facilities certified by MDMH may provide these services.

Residential Habilitation

Residential Habilitation is defined as services designed to assist the beneficiary with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the beneficiaries to reside in a non-institutional setting.

Residential Habilitation services that will **not** be reimbursed by DOM include, but are not limited to, the following:

- Administrative costs for a facility or group home
- Costs associated with facility maintenance, upkeep, and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents or to meet the requirements of the applicable life safety code
- Payments made, directly or indirectly, to members of the recipient's immediate family
- Routine care and supervision that should be provided by a family or group home provider
- Activities or supervision for which payment is made by a source other than the Division of Medicaid.

Two types of Residential Habilitation are available: supervised and supported.

- **Supervised Residential Habilitation**

  Staff must be available on site, twenty-four (24) hours per day. Staff must be able to respond to requests for assistance within five (5) minutes.

  No more than three (3) beneficiaries may live together in an apartment or house, regardless of whether all three (3) are eligible for waiver services. The staff to recipient ratio is normally 1:6, but may vary depending on the needs of each beneficiary.

- **Supported Residential Habilitation**

  Staff must be available as needed to support the beneficiary living independently in the community. Staff must be on call twenty-four (24) hours per day, but they do not need to be on-site twenty-four (24) hours per day. The staff to recipient ratio is 1:10.

  The maximum number of hours of Supported Residential Habilitation allowed is seven (7) hours per week, depending on the needs of the beneficiary. The Support Coordinator has the authority to authorize additional hours to meet unforeseen circumstances or needs.

Transportation may be provided to a beneficiary who is receiving either type of Residential Habilitation. The cost of transportation, if provided, is included in the rate paid to the provider. Only agencies certified by MDMH may provide these services.

Day Habilitation

Day Habilitation is defined as services designed to assist the beneficiary with acquisition, retention, or improvement in self-help, socialization, and adaptive skills. Services focus on enabling the beneficiary to attain or maintain his/her maximum functional level and are coordinated with physical, occupational, and/or speech-language therapies listed in the plan of care.

Day Habilitation services take place in a nonresidential setting, separate from the home or facility in which the beneficiary resides. Services are furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week, unless provided as an adjunct to other day activities included in the beneficiary's plan of care.

In cases where the beneficiary receives services in more than one place, transportation may be provided between the beneficiary's place of residence and the site of the services as a component part of the services. The cost of transportation, if provided, is included in the rate paid to the provider.

Only agencies certified by MDMH may provide these services.

Prevocational Services

Prevocational Services is defined as a facility-based service system that provides training not available from a program funded under Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of the Individuals with Disabilities Education Act (IDEA). Services are directed toward specific habilitation goals leading to vocational skill development but are not job oriented. Services include teaching concepts such as compliance, attendance, task completion, problem solving, and safety. Activities are directed toward underlying habilitative goals, such as attention span and motor skills, rather than specific job skills. Services are reflected in the beneficiary's plan of care as habilitative, rather than employment objectives.

Prevocational Services may be provided to beneficiaries 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). If the beneficiary engages in any form of compensable work as a necessary but subordinate part of habilitation services, the program must be a certified work activity center in accordance with Section 14(c) of the Fair Labor Standards Act.

In cases where the beneficiary receives services in more than one place, transportation may be provided between the beneficiary's place of residence and the site of the services as a component part of the services. The cost of transportation, if provided, is included in the rate paid to the provider.

Only agencies certified by MDMH may provide this service.

Supported Employment

Supported Employment is defined as paid employment for beneficiaries 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 is conducted in a variety of settings, particularly work sites in which persons without disabilities are also employed. Supported Employment includes activities needed to sustain paid work, including supervision and training. When Supported Employment services are provided at a work site where persons without disabilities are also employed, payment will be made only for the adaptations, supervision, and training required by beneficiaries receiving waiver services, and will not include payment for the supervisory activities rendered as a normal part of the business setting. Only facilities certified by MDMH may provide these services.

Supported Employment services under the waiver **do not** include services available under programs funded by the Rehabilitation Act of 1973 or P.L. 94-142, also known as Individuals with Disabilities Education Act (IDEA).

In cases where the beneficiary receives services in more than one place, transportation may be provided between the beneficiary's place of residence and the site of the services as a component part of the services. The cost of transportation, if provided, is included in the rate paid to the provider.

Attendant Care

Attendant Care is defined as those services designed to meet daily living needs and to ensure adequate support for optimal functioning at home or in the community, but only in non-institutional settings. Attendant Care services are non-medical and do not involve nursing skills. Services are provided in accordance with a therapeutic goal in the plan of care and are not purely diversional in nature. Attendant Care services must be supervised by a state-licensed Registered Nurse or a Qualified Mental Retardation Professional (QMRP). Only agencies certified by MDMH may provide these services.

Attendant Care services may include, but are not limited to, the following:

- Support for activities of daily living such as bathing (sponge bath), personal grooming, dressing, hygiene, toileting, transferring, and assistance with ambulation

- Assistance with housekeeping that is directly related to the beneficiary's disability and which is necessary for the health and well-being of the beneficiary (e.g. changing bed linens, straightening area used by beneficiary, doing the personal laundry of the beneficiary, preparation of meals for the beneficiary, cleaning the beneficiary's equipment such as wheelchairs, walker, etc.)

- Food shopping, meal preparation, and assistance with eating, but not the cost of the meals themselves

- Support for community participation by accompanying and assisting the beneficiary with access to community resources and support for participating in community activities, including appointments, shopping, community recreation/leisure resources, socialization opportunities, etc.

Attendant Care providers may be members of the beneficiary's family. Family members who provide Attendant Care services must meet the same standards as providers who are unrelated to the beneficiary. DOM will not reimburse for services provided to a minor by a parent (or step parent), or to a beneficiary by that beneficiary's spouse, or by anyone who normally resides in the same house or who is normally expected to provide care to the beneficiary.

Beneficiaries who receive Attendant Care services may not concurrently receive Supervised Residential Habilitation services. Beneficiaries may receive Supported Residential Habilitation services and Attendant Care as long as the service objectives are distinctly different in nature and scope.

Transportation, if provided, is included in the rate paid to the provider.

Behavioral Support/Interventions

Behavioral Support/Interventions is defined as services provided for beneficiaries who exhibit behavior problems that prevent them from benefiting from other services being provided or cause them to be so disruptive in their environment(s) that there is imminent danger of removal or dismissal. The provider works directly with the beneficiary and trains staff and family members to assist in the implementation of specific behavior support/intervention programs.

Services may be provided in the home, in a habilitation setting, or the provider's office. **Services cannot be provided in a public school setting.** The provider may observe the beneficiary in the school setting to gather information.

Behavioral Support/Intervention services may include the following:

- Assessing the beneficiary's environment and identifying antecedents of particular behaviors, consequences of those behaviors, maintenance factors for the behaviors, and in turn how these particular behaviors impact the beneficiary's environment and life

- Developing a behavior support plan, implementing the plan, collecting the data, measuring outcomes to assess the effectiveness of the plan, and training staff and/or family members to maintain and/or continue implementing the plan

- Providing therapy services to the beneficiary to assist him/her in becoming more effective in controlling his/her own behavior either through counseling or by implementing the behavior support plan

Behavior Support/Intervention services may be provided by a state-licensed doctoral level psychologist, a state-licensed clinical social worker, or an individual who is certified by the Mississippi Department of Mental Health and who has at least four (4) years documented experience developing and implementing behavior support plans for persons with mental retardation/developmental disabilities.

Additionally, individuals who have less than four (4) years of documented experience and individuals who have a Bachelor's degree in an appropriate field (either with or without four (4) years experience) may be approved by MDMH to provide Behavior Support/Intervention services under the supervision of one of the above mentioned professionals.

Therapy Services (Physical Therapy, Occupational Therapy, Speech-Language Therapy)

Physical Therapy (PT), Occupational Therapy (OT), and Speech-Language Therapy (ST) services are those therapy services available under the waiver to beneficiaries who are not covered for such services under regular State Plan benefits. Therapy policy for regular State Plan services may be found in Section 47.0, Physical Therapy; Section 48.0 Occupational Therapy; and Section 49.0, Speech Therapy in this manual.

When therapy services are not available or have been exhausted under the regular State Plan services, they may be covered through this waiver if included in the approved Plan of Care (POC).

Therapy providers (individual and/or facility) must meet state and federal licensing/certification requirements, and they must have an active Mississippi Medicaid provider number.

Specialized Medical Supplies

Specialized Medical Supplies are those supplies available under the waiver to beneficiaries who are not covered for such supplies under regular State Plan benefits. Durable Medical Equipment policies for regular State Plan benefits may be found in Section 10.0 in this manual.

When specialized medical supplies are not available or have been exhausted under the regular State Plan services, they may be covered through this waiver if included in the approved Plan of Care (POC). Supplies covered under the waiver include only specified types of catheters, diapers, and under pads. Supplies must be included in the plan of care.

DME providers must meet state and federal licensing/certification requirements, and they must have an active Mississippi Medicaid provider number.

All waiver services must be included in the beneficiary's Plan of Care. The initial Plan of Care must be prior approved by the Support Coordinator and DOM, HCBS Division of the Bureau of Long Term Care. All requests to add or increase services require prior approval from the MDMH/BMR.

Waiver providers must meet and maintain compliance with quality assurance standards in the HCBS MR/DD waiver document approved by the Centers for Medicare and Medicaid Services (CMS) and in the *Mississippi Department of Mental Health Minimum Standards for Community Mental Health/Retardation Services.*

A web copy of the *Mississippi Department of Mental Health Minimum Standards for Community Mental Health/Retardation Services* may be found at http://www.dmh.state.ms.us. Click on the link for online documents.

A copy of the HCBS MR/DD waiver document approved by the Centers for Medicare and Medicaid Services (CMS) is available, upon written request, through the Division of Medicaid, HCBS Division of the Bureau of Long Term Care.

Compliance with quality assurance standards must be maintained for the entire period of time that the provider chooses to provide waiver services.

Only DOM can initiate, in writing, any interpretation or exception to Medicaid rules, regulations, or policies.

All providers participating in the Medicaid program are required to maintain legible, accurate, and complete records that disclose and justify the services rendered and billed under the program, and upon request, make these records available to representatives of DOM in substantiation of any and all claims. These records must be maintained a minimum of five (5) years to comply with all state and federal regulations and laws. Statistical and financial data supporting a cost report must be maintained for at least five (5) years from the date the cost report (or amended cost report or appeal) is submitted to DOM.

Documentation/record maintenance for reimbursement purposes must, at a minimum, reflect applicable quality assurance standards found in the HCBS MR/DD waiver document approved by the Centers for Medicare and Medicaid Services (CMS) and the MDMH/BMR record guide. Waiver providers certified by MDMH/BMR are required to submit copies of all service logs/documentation of visits along with a copy of their billing for each waiver beneficiary served to the beneficiary's Support Coordinator no later than the 15th of the month following the month in which the service was rendered. Additional documentation requirements may be found in Section 7.03 of this manual.

If the provider's records do not substantiate services paid for under the Mississippi Medicaid program, as previously noted, the provider will be asked to refund to DOM any money received from the Medicaid program for any such non-substantiated services. If a refund is not received within thirty (30) days, a sum equal to the amount paid for such services will be deducted from any future payments that are deemed to be due the provider.

A provider who knowingly or willfully makes, or causes to be made, a false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under federal and state criminal laws. A false attestation can result in civil monetary penalties, as well as fines, and may automatically disqualify the provider as a provider of Medicaid services.

Section 1902(a) (14) of the Social Security Act permits states to require certain beneficiaries to share some of the costs of receiving Medicaid services. **Co-payment may be required of waiver beneficiaries for those services covered under the State Plan.**

Beneficiaries enrolled in waiver programs are exempt from co-payment for the **additional** services offered as part of the waiver. **Additional** services are those specifically listed as covered services under the waiver.

Providers should refer to Section 2.0, Benefits, for information on Medicaid benefits. Providers should refer to Section 3.08, Beneficiary Information, for information on beneficiary cost sharing.

Reimbursement for waiver services can be requested no earlier than the first day of the month following the month in which services are rendered. (Example: services provided in June cannot be billed before July 1.)

In-Home Respite Services

When more than one family member is a waiver beneficiary receiving In-Home Respite services provided by the same provider staff person, the provider must bill the full currently approved reimbursement rate for the service for one of the beneficiaries and **half** of the currently approved reimbursement rate for the other (to total time and a half). The provider must document all services provided to each beneficiary. The total time billed cannot exceed the total time the provider is in the home. For example, if the provider is in the home from 2pm-6pm and there are two (2) beneficiaries receiving services at the same time, the provider must bill sixteen (16) units (the equivalent of 4 hours) of in-home respite (either nursing or companion) at the currently approved reimbursement rate for one of the beneficiaries and sixteen (16) units (the equivalent of 4 hours) at **half** the current reimbursement rate for the other beneficiary. The Service Authorization from the MR/DD Waiver Support Coordinator will clearly indicate if a provider is to bill the multi-beneficiary rate or the single-beneficiary rate.

If services are provided to more than one beneficiary, both beneficiaries must be immediately related (example: siblings, parent/sibling). The provider must bill separately for each beneficiary.

Supervised Residential Habilitation

Supervised Residential Habilitation is provided to a beneficiary only in his/her home. Billing must reflect only days that the beneficiary was physically present in his/her home. The provider may bill even if the beneficiary was there for only a portion of the day. The provider may not bill for days that the beneficiary is not physically present in his/her home. (Example: if the beneficiary's family picks the beneficiary up at 9:00 on a Friday morning and brings the beneficiary back at 6:00 Sunday evening, the provider may bill the daily rate for Friday and Sunday, but not for Saturday.)

Attendant Care Services

Payment will not be made for Attendant Care Services provided during the same hours that the beneficiary is receiving Respite, Day Habilitation, Supervised Residential Habilitation, Prevocational, or Support Employment services.

When more than one family member is a waiver beneficiary receiving In-Home Respite services provided by the same provider staff person, the provider must bill the full currently approved reimbursement rate for the service for one of the beneficiaries and **half** of the currently approved reimbursement rate for the other (to total time and a half). The provider must document all services provided to each beneficiary. The total time billed cannot exceed the total time the provider is in the home. For example, if the provider is in the home from 2pm-6pm and there are two (2) beneficiaries receiving services at the same time, the provider must bill sixteen (16) units (the equivalent of 4 hours) of in-home respite (either nursing or companion) at the currently approved reimbursement rate for one of the beneficiaries and sixteen (16) units (the equivalent of 4 hours) at **half** the current reimbursement rate for the other beneficiary. The

Service Authorization from the MR/DD Waiver Support Coordinator will clearly indicate if a provider is to bill the multi-beneficiary rate or the single-beneficiary rate.
If services are provided to more than one beneficiary, both beneficiaries must be immediately related (example: siblings, parent/sibling). The provider must bill separately for each beneficiary.

Specialized Medical Supplies

The only supplies available under the MR/DD waiver include disposable under pads, disposable diapers, and urinary catheters. All supplies must be purchased from an approved Durable Medical Equipment (DME) provider.

Transportation

Transportation, if provided, is included in the rate paid to the provider.

Codes/Modifiers

Providers will be reimbursed according to the methodology derived for each service. **Providers must use the appropriate procedure codes with the U3 modifier** as outlined in the table on the following page.

Service	Code	Modifier	Billing Unit
Support Coordination-normal	T2022	U3	Monthly
Support Coordination-high	T2022	U3 TF	Monthly
In-Home Nursing Respite	T1055	U3	15 minutes equal 1 unit
In-Home Companion Respite	S5150	U3 POS 12	15 minutes equal 1 unit
Community Respite	S5150	U3 POS 99	15 minutes equal 1 unit
ICF/MR	H0045	U3	Daily
Supervised Residential Habilitation	S5136	U3	Daily
Supported Residential Habilitation	T2017	U3	15 minutes equal 1 unit
Day Habilitation	S5100	U3	15 minutes equal 1 unit
Prevocational Services	T2015	U3	Hourly
Supported Employment	H2023	U3	15 minutes equal 1 unit
Attendant Care	S5125	U3	15 minutes equal 1 unit
Physical Therapy	G0151	U3	15 minutes equal 1 unit
Occupational Therapy	G0152	U3	15 minutes equal 1 unit
Speech-Language/Hearing Therapy	G0153	U3	15 minutes equal 1 unit
Behavioral Support-Evaluation	H0002	U3	Hourly
Behavioral Direct Intervention Master's Level	H2019	U3 HO	15 minutes equal 1 unit
Behavioral Direct Intervention Bachelor's Level	H2019	U3 HN	15 minutes equal 1 unit
Disposable Under Pad (Blue Pad)	A4554	U3	Per Pad
Disposable Brief/Diaper	T4521 T4522 T4523 T4524	U3	Per Diaper
Urinary Catheter	A4338 A4340 A4344 A4346 A4351 A4352 A4353	U3	Per Catheter

Beneficiary Service Decisions

Decisions made by the Division of Medicaid (DOM) that result in services being denied, terminated, or reduced may be appealed. The beneficiary/legal representative has thirty (30) days from the date of the notice regarding services to appeal the decision. All appeals must be in writing.

The Support Coordinator will notify the beneficiary/legal representative of any action that results in the denial, termination, or reduction of services. The beneficiary/legal representative is entitled to send a written request to appeal the decision to the Deputy Executive Director of the Mississippi Department of Mental Health (MDMH). The beneficiary/legal representative will be notified in writing within ten (10) days of the decision to uphold or deny the appeal. A copy will be retained in the beneficiary file.

If the beneficiary/legal representative disagrees with the decision of the MDMH Deputy Executive Director, a written request to appeal the decision may be made to the Executive Director of the Mississippi Department of Mental Health (MDMH). The beneficiary/legal representative will be notified in writing within ten (10) days of the decision to uphold or deny the appeal. A copy will be retained in the beneficiary file.

If the beneficiary/legal representative disagrees with the decision made by MDMH Deputy Executive Director and Executive Director, a written request to appeal the decision may then be made to the Division of Medicaid, Bureau of Long Term Care. When a DOM hearing is requested, the Support Coordinator will prepare a copy of the case record and forward it to the Division of Medicaid, Bureau of Long Term Care no later than five (5) days after notification of the appeal.

The Division of Medicaid, Bureau of Long Term Care will assign a hearing officer. The beneficiary/legal representative will be given advance notice of the hearing date, time, and place. The hearing may be conducted with all parties involved present, or it may be conducted as a conference call (telephone) hearing. The hearing will be recorded.

The hearing officer will make a recommendation, based on all evidence presented at the hearing, to the Executive Director of the Division of Medicaid. The Executive Director will make the final determination of the case, and the beneficiary/legal representative will receive written notification of the decision. The final administrative action, whether state or local, will be made within ninety (90) days of the date of the initial request for a hearing. MDMH/BMR will be notified by the Division of Medicaid to either initiate/continue or terminate/reduce services.

During the appeals process, contested services that were already in place must remain in place, unless the decision is one of immediate termination due to possible danger or racial or sexual harassment of the service providers. The Support Coordinator is responsible for ensuring that the beneficiary receives all services that were in place prior to the notice of change.

Provider Certification Decisions

Providers who must be certified by the Mississippi Department of Mental Health, Bureau of Mental Retardation (MDMH/BMR) may appeal certification decisions to MDMH. Certification is dependent upon compliance with the *Mississippi Department of Mental Health Minimum Standards for Community Mental*

Health/Retardation Services. The minimum standards also address the appeals process. A web copy may be found at http://www.dmh.state.ms.us. Click on the link for online documents.