

ASSISTIVE DAILY LIVING SERVICES (ADLS) WAIVER

OVERVIEW

The ADLS waiver supports individuals to live independently in a home and community-based setting in conjunction with South Dakota Medicaid services and other natural supports. Services provided under the ADLS waiver program are considered extended services that are not available under the traditional benefits of South Dakota Medicaid.

The goal of the ADLS program is to support eligible individuals with quadriplegia to live independently in their homes and in the communities of their choice as an alternative to living in an institution.

The objectives of the ADLS Waiver are to:

- Promote independence for participants through the provision of services while ensuring health and safety;
- Offer an alternative to costly institutional care through an array of services and supports that promote independence; and
- Support participants to exercise their rights and responsibilities for their program regardless of the method of service delivery.

ELIGIBLE PROVIDERS

In order to receive payment, all eligible provider's National Provider Identifiers (NPI) must be enrolled with South Dakota Medicaid. ADLS providers are enrolled as an agency. The agency must have a current contract with the Department of Human Services, Division of Rehabilitation Services and meet following requirements:

- Experience in delivering services to individuals with severe disabilities;
- Maintain a process for gathering participant input;
- Provide available services including:
 - Personal attendant services;
 - Case management services;
 - Consumer preparation services; and
 - Ancillary services;
- Assure participants a choice of providers by either employing individuals who are qualified to provide the assistive daily living services contained in a participant's case service plan or maintaining directories of qualified service providers; and
- Maintain a grievance procedure under which a participant may appeal to the provider agency any decision or action by the service provider or the provider agency that adversely affects the participant. The procedure must be in writing and the provider agency must provide the participant with a copy of the grievance procedure at the time services begin and must assist the participant in submitting a grievance, if requested. If a written document of the procedure is not an appropriate format for the participant involved, the provider agency must also provide the information to the participant in a format that is appropriate for the participant. A provider agency

may limit its assistance to referral of the participant to another agency, organization, or individual that can advocate for or represent the participant during the grievance process.

ELIGIBLE PARTICIPANTS

An individual must meet the following requirements to be eligible to receive ADLS services:

- At least 18 years old;
- Have quadriplegia due to or resulting from ataxia, cerebral palsy, rheumatoid arthritis, muscular dystrophy, multiple sclerosis, traumatic brain injury, a congenital condition, an accident or injury to the spinal cord, or another neuromuscular or cerebral condition or disease other than traumatic brain injury; or the individual has four limbs absent due to disease, trauma, or congenital conditions;
- Require a nursing facility level of care;
- Have a service plan prepared under the provisions of [ARSD 67:54:06:05](#) that requires one or more of the services provided under this chapter;
- Be a participant of SSI or must qualify for Medicaid as determined by the Department of Social Services under [article 67:46](#) except for residing in a long-term care facility;
- If receiving personal attendant services, able to independently direct and manage the needed personal attendant services or have the ability to select an authorized representative;
- Medically stable and free from life-threatening conditions as determined by the individual's personal physician; and
- Receive personal attendant, , consumer preparation, or ancillary services for continued eligibility.

Providers are responsible for verifying a participant's eligibility for the ADLS waiver by reviewing the participant's eligibility through the South Dakota Medicaid [online portal](#).

COVERED SERVICES AND LIMITS

Consumer Preparation Services

Services can only be provided by trained administrative agency staff or designee. Consumer Preparation Services support the participants to exercise Employer Authority as co-employers of Personal Care and Respite Care Personal Attendants. The services include instructing and supporting participants in:

- The methods of identifying personal needs and effectively communicating those needs to the personal care attendant;
- Personal health maintenance tasks;
- Managing a personal attendant, including interviewing, selecting, training, supervising, and scheduling the attendant; and
- The appropriate personal and professional relationships to be maintained by the participant and the participant's personal care attendant.

The purpose of all Consumer Preparation Services is to provide the instruction and tools that the participant can use to self-direct their services in future instances.

Emails can be used in limited circumstances, but the email must be included in the record, it must include the instruction and/or support provided to the participant and should not be the main method of communication with the member. Email communication is limited to 1 total unit per day. Voice messages cannot be billed.

A claim for billable Consumer Preparation Services must have corresponding documentation to support the time being billed and be descriptive about the instruction or supports that were offered to the participant to justify the units being billed and if any follow up is needed.

Examples of billable Consumer Prep time:

- New participant admitted to Waiver-The Consumer Prep Specialist orientated participant to Policies and Procedures specific to the ADLS waiver using the Consumer Prep Training manual.
- Participant starts new staff- Consumer Prep Specialist and participant together completed New Hire Orientation with personal care attendant.
- Participant requires a change in services. The consumer prep specialist provides instruction to the participant to identify the change and relay the change to the Service Coordinator. The Consumer Prep Specialist also provides guidance to the participant on how to relay the changes in the care plan to personal care attendants.
- The Consumer Prep Specialist provides sample interview questions and coaching on how to complete interviews for personal care attendants.
- The Consumer Prep Specialist provides guidance to the participant on how to complete performance evaluations for personal care attendants.

Consumer Preparation Services do not include:

- Administrative costs of facilitating employment of staff by performing as the participant's agent such employer responsibilities as processing payroll, withholding federal, state, and local tax and making tax payments to appropriate tax authorities.
- Administrative preparation of time sheets and/or EVV Records for billing.
- Agency of Choice Responsibilities such as background check, new hire packets (if not providing support to participant to complete), assuring compliance with labor laws and regulations
- Services provided on behalf of the participant instead of instruction or supporting the participant to complete the task.

Environmental Accessibility Adaptations

Physical adaptations to the private residence of the participant, or the participant's family home, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function at a greater independence within the home are covered. Such adaptations may include installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric or plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. The scope of modifications may include the performance of necessary assessments to determine the types of modifications that are necessary.

Adaptations or improvements to the home which are of general utility and are not a direct medical or remedial benefit to the individual, such as carpeting, roof repair, air conditioning and others are not covered. Adaptations which add to the total square footage of the home are also not covered. Adaptations to an area that is already accessible are not covered. All services must be in accordance

with applicable state or local building codes. This service is limited to \$4,000 per service plan year. If the service exceeds this limit, the service coordinator may request an exception to exceed the limit. The exception must be approved prior to service commencement.

When a participant is identified as needing environmental accessibility adaptations through the ADLS waiver as part of the assessment process, the ADLS Service Coordinator will:

- Refer the participant to a Center for Independent Living (CIL) to open an Independent Living case (IL). A list of CILs is available on the [DHS website](#). The participant must identify that they are on the ADLS waiver and need assistance coordinating home modification quotes from vendors the CIL utilizes for that service.
- The IL Specialist will work with the participant to obtain two quotes for the home modification and provide them to the ADLS Service Coordinator.
- Once the quotes are approved, the ADLS Service Coordinator will send an authorization to the CIL, along with a vendor letter.
 - If the quotes are not approved, the participant will receive a letter with appeal rights.
- The vendor will complete the home modification and the CIL will pay the vendor for the service, then bill Medicaid using the appropriate procedure code found on the authorization.

In-Home Nursing

In-home nursing is individual and continuous care provided by a nurse who holds a current license under the provisions of [SDCL chapter 36-9](#). This waiver service is only provided to individuals age 21 and over. All medically necessary in-home nursing services for individuals under age 21 are covered in the state plan pursuant to the EPSDT benefit. A physician order indicating the diagnosis, frequency and duration of services is required for in-home nursing.

Personal Attendant Services

Personal attendant services include a range of assistance to enable participants to accomplish tasks that the participant would normally do for themselves if the participant did not have a disability. Participants will not be able to access both state plan services and waiver services for personal care at the same time. Homemaker services are only available for participants living independently.

Personal attendant services provided through the ADLS Waiver differ from State Plan personal care services in scope, nature, supervision arrangements and provider type. The waiver services are based upon participant direction. Participants utilizing personal attendant services recruit, screen, train, and direct their personal care attendants. The waiver encourages the employment of spouses, parents or adult children to provide these services. Personal attendant services covered under the ADLS waiver include

- Practicing infection control methods;
- Handling and disposing of body fluids;
- Bathing techniques including bed, tub, and shower;
- Caring for hair, including shaving;
- Maintaining oral hygiene, including brushing teeth and cleaning dentures;

- Dressing and undressing a consumer;
- Assisting with toileting;
- Caring for a participant who is incontinent;
- Performing routine eye care;
- Taking a participant's temperature;
- Caring of nails and feet;
- Applying an ace wrap and anti-embolic stockings;
- Assisting the participant apply or remove a prosthesis or orthotic;
- Assisting a participant with self-administration of medications;
- Changing dressings on non-infected sores;
- Caring for skin including giving back rubs;
- Turning and positioning the participant in bed;
- Transferring the participant;
- Performing range of motion exercises designed for the specific participant;
- Performing routine ostomy care;
- Assisting with a bladder and bowel program;
- Assisting the participant into and out of a vehicle;
- Providing ventilator management if the personal attendant is a family member;
- Performing tracheostomy care if the personal attendant is a family member;
- Providing chest physiotherapy;
- Providing nebulizer therapy;
- Applying topical medications;
- Caring for service animal;
- Feeding or assisting a participant with eating, unless there is another person in the home who is able to perform the task;
- Planning and preparing meals including shopping for and purchasing food, unless there is another person in the home who is able to perform the task;
- Maintaining the participant's home in a clean and safe condition, unless there is another person in the home who is able to perform the task;
- Laundering and mending clothes, unless there is another person in the home who is able to perform the task;
- Assisting the participant with paying bills, balancing a checkbook, and managing a home budget, unless there is another person in the home who is able to perform the task; and
- Transportation limited to transporting the consumer to the grocery store or pharmacy for food,

personal care items, and medications. Transportation is not covered if there is another person in the consumer's home capable of transporting the individual.

Personal Emergency Response System

A personal emergency response system is an electronic device that enables participants to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once the "help" button is activated. The response center is staffed by trained professionals. Monitoring of the participant's device is covered under this service.

Respite Care Services

Respite care services are provided to assist participants unable to care for themselves, furnished on an intermittent, occasional or emergency basis due to the absence or need for relief of those persons normally providing the care. The cost of room and board is not covered except when provided as part of respite care furnished in a facility approved by the State that is not a private residence. Respite care may be provided in the following locations:

- Participant's home or place of residence;
- Adult foster home;
- Medicaid certified hospital;
- Medicaid certified ICF/IDD;
- Group home;
- A home approved in the plan of care, which may be a private residence; or
- Other community care residential facility approved by the State that is not a private residence, such as a licensed day care.

Respite care may be provided in a hospital, ICF/IDD, group home, or other community care residential facility. Respite may not be utilized if there is more than one family member in the home and all are not requesting relief at the same time. The respite care worker may not live with or be considered the participant's primary caregiver.

Specialized Medical Equipment and Supplies

Specialized medical equipment and supplies include devices, controls or appliance that enable participants to increase their ability to perform activities of daily living; enable the participant to perceive, control, or communicate with the environment in which they live; or are necessary for life support or to address physical conditions, along with ancillary supplies and equipment necessary to the proper function of such items, are necessary to address participant's functional limitations, or are necessary medical supplies. Equipment or supplies for recreation or exercise are not covered. This service includes a wide variety of adaptive positioning devices, mobility aids, adaptive equipment, as well as augmentative communication devices and services. All items shall meet applicable standards of manufacture, design and installation.

Specialized Medical Equipment and Supplies must not be available to the participant under the [South Dakota Medicaid Durable Medical Equipment and Supplies](#) benefit. If an item is not covered due to the recipients exceeding limits or not meeting medical necessity criteria for coverage under the South Dakota Medicaid Durable Medical Equipment and Supplies benefit, a copy of the denial from the DME

provider, a physician's prescription, and a certificate of medical necessity is necessary to bill the service under the ADLS waiver.

When the service coordinator identifies that a participant may benefit from specialized medical equipment or supplies the following steps must be taken:

- Obtain two quotes for needed items from a Medicaid approved DME providers. The quote must include the model and manufacturer of the equipment. The waiver will pay the lesser of MSRP (Manufacturer Suggested Retail Price) or the providers usual and customary charge for the equipment.
- Send quotes (scanned) to Waiver Manager to review and consider for approval.
- Authorize in VRFACES for the equipment and supplies that is necessary and most cost effective (canned statement to select is "Other Provider Billing").
- Send vendor letter and authorization to the DME.
- Add to Service Plan in VRFACES.
- DME must provide item to the ADLS participant prior to billing for the equipment.

Note: If an item is listed on the Medicaid Departments of Social Services DME fee schedule, a copy of the denial from the DME provider with the appropriate denial codes, a physician's prescription, and a Certificate of Medical Necessity is necessary to cover the service under the ADLS waiver. The Service Coordinator may issue the ***Intent to Pay*** letter to the DME if requested.

Specialty Independent Living Items under \$500

- Obtain a quote for needed item(s) from a Medicaid approved DME provider or Center for Independent Living. The quote must include a description of the item, the intended usage for independent living skill to modify or enhance, the model and manufacturer of the equipment, and the MSRP. The waiver will pay the lesser of MSRP or the providers usual and customary charge for the equipment.
- Send quote (scanned) to Waiver Manager to review and consider for approval.
- Authorize in VRFACES for the equipment and supplies that is necessary and increases the independent living skill.
- Send vendor letter and authorization to the DME;
- Add to Service Plan in VRFACES;
- The DME provider Must provide item to the ADLS participant prior to billing for the equipment.

Vehicle Modifications

Vehicle modifications and adaptive devices consist of alterations to a vehicle that is the waiver participant's primary means of transportation and are needed to accommodate the transportation needs of the participant. Vehicle modifications and adaptive devices are specified in the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant.

Modifications to vehicles may include lifts, ramps or transfer systems, vehicle body modifications, wheelchair securement systems or adaptive driving controls. The vehicle that is modified may be owned by the individual, a family member with whom the individual lives or has consistent and on-going contact, or a non-relative who provides primary long-term support to the individual and is not a paid provider of such services. ADLS Waiver assistance is limited to - \$30,000 every 10 years. The financial limit can be increased with approval from Waiver Manager.

The following are specifically excluded:

- Adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the participant;
- Purchase or lease of a vehicle, and;
- Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of approved modifications or adaptive devices.

When an ADLS participant is identified as needing vehicle modifications or adaptive devices through the ADLS waiver as part of the assessment process, the Service Coordinator will:

- The Service Coordinator will complete the ADLS Vehicle Modifications and Adaptive Devices Checklist with the participant. This will obtain the information needed to meet the participant's transportation needs.
- The Service Coordinator will email the checklist to the Waiver Manager for review.
- If the participant will be driving a driver assessment is required and they must have the appropriate restriction "C" on their driver's license. The owner of vehicle must obtain insurance to cover the cost of the vehicle and modifications and adaptive devices and provide proof of the insurance to Service Coordinator once the modification is complete.
- Refer the participant to an independent living center to open an IL case. The participant needs to identify that they are on the ADLS waiver, and need assistance coordinating vehicle modification and adaptive devices quotes.
- The Service Coordinator will share the checklist with the IL Specialist to ensure they have all the information they need to assist in obtaining accurate quotes for needed modifications and adaptive devices.
- The IL Specialist will work with the participant and use the ADLS Vehicle Modifications and Adaptive Devices Vendor and Services table and vendor list to obtain a price quote for the modifications or adaptive devices and provide the quote to the Service Coordinator.
- The Service Coordinator will send the quote and Checklist to the Waiver Manager for approval. The Waiver Manager will recommend any changes needed and upon approval will contact the Service Coordinator to add the service to FOCoS. Once approved, the Service Coordinator will send an authorization to the Independent Living Center, along with a copy of the quote.
 - If the quote is above the limit of \$30,000 the quote will be reviewed by the ADLS Waiver Manager and DRS Assistant Director or designee.
- The IL Specialist will arrange for the completion of the vehicle modification or installation of the adaptive devices.
- The vendor will send a bill to the Independent Living Center, who will pay the vendor for the service, then bill Medicaid using the appropriate procedure code (T2039).

If the CIL has problems getting paid on their claim, please refer them to DRS ADLS Program Specialist at 605-773-3195.

NON-COVERED SERVICES

Only services on the participant's approved service plan and authorized by an ADLS service coordinator are covered. The following are non-covered personal attendant services:

- Washing outside windows;
- Moving large furniture;
- Shoveling snow;
- Performing garden or yard work;

- Cleaning up before or after company or visitors;
- Washing walls;
- Caring for pets or livestock;
- Painting;
- Visiting, except while performing approved services;
- Shampooing carpets; or
- Other tasks not necessary to maintain a client in the client's home.

DOCUMENTATION REQUIREMENTS

General Requirements

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least 6 years after the last date a claim was paid or denied. Please refer to the [Documentation and Record Keeping](#) manual for additional requirements.

ADLS Documentation

Each service provided by an ADLS provider must be documented. Services that are not documented are considered to have not occurred and are subject to recoupment of payment in the event of an audit.

The Provider must comply with federal Electronic Visit Verification (EVV) requirements. The State has purchased an EVV system for providers to utilize at no cost to the provider. If the Provider determines utilization of the State purchased EVV system is not feasible, the Provider may complete the "Provider Request for Approval for Alternative IT System for Electronic Visit Verification (EVV)" form. If an alternative IT system is approved, the Provider must ensure the minimum EVV requirements are met. EVV requirements include the type of service performed, the individual receiving the service, the date of the service, the location of service delivery, the individual providing the service, and the time the service begins and ends.

- The provider must use EVV (Electronic Visit Verification) to substantiate all claims billed for personal attendant (PA) services. The EVV must designate date of service, time in and time out, and the type of service performed, the participant receiving the service and the location the service is performed at. All EVV visits must be signed by the personal attendant;
- In the event the EVV is unavailable the provider agrees to have a back up documentation system in place. This system should verify the service(s) performed, participant receiving the service, date of the service, exact time the service begins and ends, the individual providing the service, the location of the service and the reason the EVV was unavailable.

All consumer preparation services billed must have corresponding documentation to justify time billed. This documentation must note date of service, units of service provided, a description of services being provided, and who completed the note.

If your agency is providing in-home nursing services to a participant, the Nursing services to be performed will be specified in the Therap Service Auth and accompanying documents. Time billed for nursing must designate date of service, time in and time out, and the type of service performed.

REIMBURSEMENT AND CLAIM INSTRUCTIONS

Timely Filing

South Dakota Medicaid must receive a provider's completed claim form within 6 months following the month the service was provided. Requests for reconsiderations will only be considered if they are received within the timely filing period or within 3 months of the date a claim was denied. The time limit may be waived or extended by South Dakota Medicaid in certain circumstances. Providers should refer to the [General Claim Guidance manual](#) for additional information.

Third-Party Liability

Medicaid participants may have one or more additional source of coverage for health services. South Dakota Medicaid is generally the payer of last resort, meaning Medicaid only pays for a service if there are no other liable third-party payers. Providers must pursue the availability of third-party payment sources and should use the Medicare Crossover or Third-Party Liability [billing instructions](#) when applicable. Providers should refer to the [General Claim Guidance manual](#) for additional information.

Reimbursement

Services are reimbursable when provided according to the participant's approved service plan and are authorized by an ADLS service coordinator. Current service unit rates are available at on the Department of Social Services [website](#).

Claim Instructions

All personal care services claims must be submitted electronically through FOCOS. For further information please contact FOCOS using one of these methods:

- FOCOS Provider Support: 1-888-448-4776
- FOCOS Fax Line: 1-877-578-5561
- FOCUS Email: support@focosinnovations.com

All non-personal care claims for ADLS Waiver services must be submitted on a CMS 1500 claim form or via an 837P electronic transaction. Detailed claim instructions are available on DSS [website](#).

DEFINITIONS

1. "Ancillary services," services or equipment that supplement the direct care services provided under this chapter;
2. "Assistive daily living services," services of a personal attendant, case management and participant preparation services, and ancillary services performed on behalf of and at the request of an individual with quadriplegia to allow the individual to remain in the individual's own home;
3. "Case management," services designed to monitor and assist a participant gain access to services contained in the case service plan;
4. "Client" or "participant," an individual with quadriplegia who is receiving assistance under the provisions of this chapter;

5. "Consumer preparation," services designed to train the participant in areas such as medical self-care, activities of daily living, time management, and management of a personal attendant;
6. "Emergency response device," a device that links an individual living at home to an individual who will respond in the event of an emergency;
7. "Electronic Visit Verification(EVV)" [Section 12006\(a\) of the 21st Century Cures Act](#) mandates that states implement EVV for all Medicaid personal care services (PCS) and home health services (HHCS) that require an in-home visit by a provider. This applies to PCS provided under sections 1905(a)(24), 1915(c), 1915(i), 1915(j), 1915(k), and Section 1115; and HHCS provided under 1905(a)(7) of the Social Security Act or a waiver.
8. "Independently direct and manage," the ability to recruit, screen, interview, select, schedule, train, supervise, arrange for emergency coverage, determine the attendant's competency to perform the needed services, direct the attendant to do the task, resolve conflict, and, if necessary, terminate the attendant if the conflict cannot be resolved, all with only a minimal amount of assistance or direction from or collaboration with the provider agency;
9. "Personal attendant," an individual who completes tasks on behalf of an individual with quadriplegia or assists an individual with quadriplegia in the completion of a task when the individual with quadriplegia is unable to do the task or to do the task would take an exceptionally long time to complete alone;
10. "In-Home nursing," temporary nursing services prescribed by a physician and provided by a nurse who holds a current license under the provisions of [SDCL chapter 36-9](#);
11. "Service Plan Year" starts the first day of the participants eligibility for the ADLS Waiver program through a full calendar year.
12. "Unit," a 15-minute measurement of time or fraction thereof; and
13. "Utilization review team" or "URT," a team employed by the Department of Human Services that consists of a registered nurse, a physician, and an employee of the Department of Human Services.

REFERENCES

- [Administrative Rule of South Dakota \(ARSD\)](#)
- [South Dakota Medicaid State Plan](#)
- [Code of Federal Regulations](#)

QUICK ANSWERS

- 1. The participant will be leaving the state of South Dakota for an extended period of time. Can personal attendant services be provided while the participant is out of state?**

Yes, however, service hours are limited to activities of daily living as outlined in the approved care plan.

- 2. Is driving time a billable personal care service?**

Yes, transportation limited to transporting the consumer to the grocery store or pharmacy for food, personal care items, and medications as part of the personal care benefit. Transportation is not covered if there is another person in the consumer's home capable of transporting the individual.

Travel to medical appointments may be eligible for [NEMTreimbursement](#).