

COMMUNITY, HOPE, OPPORTUNITY, INDEPENDENCE, CAREERS, EMPOWERMENT, SUCCESS (CHOICES) WAIVER

OVERVIEW

Community, Hope, Opportunity, Independence, Careers, Empowerment, Success (CHOICES) is a program that provides services to children and adults with intellectual and developmental disabilities. The Division of Developmental Disabilities (DDD) funds and oversees Case Management Providers and Community Support Providers. Community Support Providers offer residential, supported employment, career exploration, day habilitation, nursing, medical equipment and drugs, and other medically related services, but cannot provide case management services.

ELIGIBLE PROVIDERS

Eligible Providers for CHOICES Waiver services must be enrolled in South Dakota Medicaid and meet any additional requirements mandated by the DDD.

A Community Services Provider (CSP) or a Community Support Provider (SP) providing services under the CHOICES waiver must meet the following criteria:

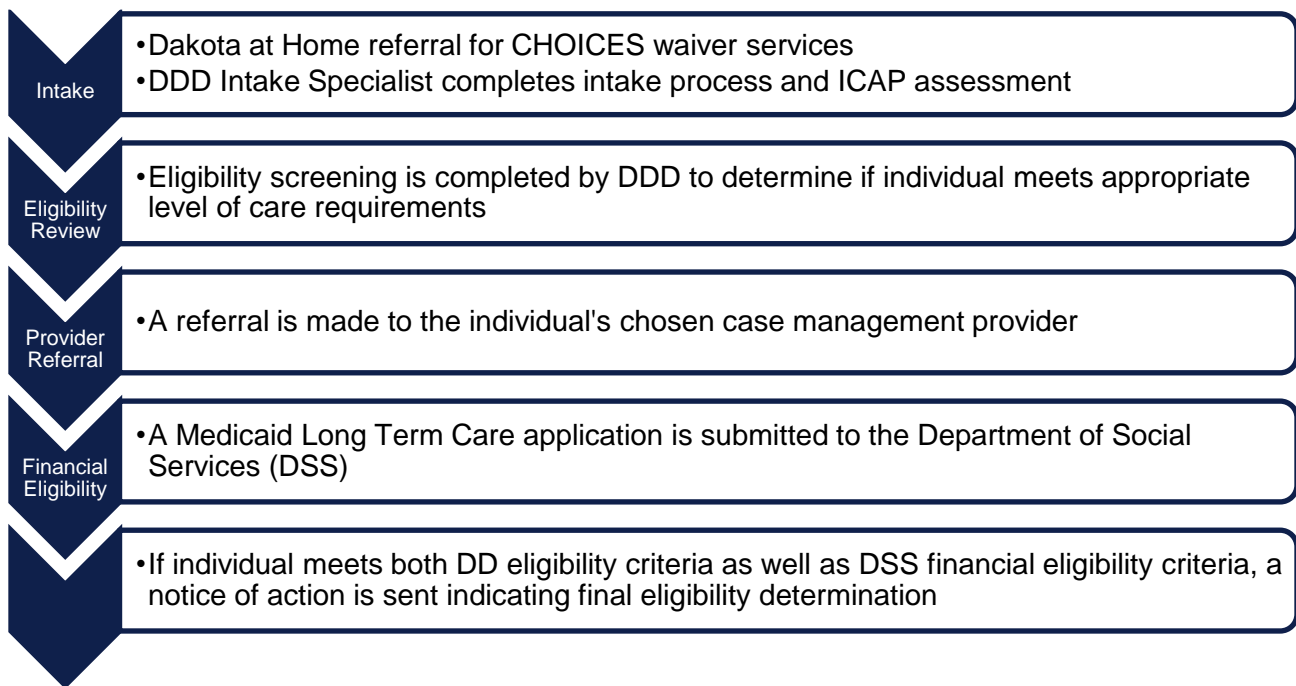
- Be certified as a CSP or SP under the provisions of [ARSD Ch. 46:11](#);
- Have a signed provider agreement with the DDD;
- Have a signed provider agreement with the Department of Social Services; and
- Be accredited by a national quality assurance organization, as designated by the Division.

ELIGIBLE RECIPIENTS

Providers are responsible for checking a recipient's Medicaid ID card and verifying eligibility before providing services. Eligibility can be verified using South Dakota Medicaid's [online portal](#).

In order to be eligible for services provided through the CHOICES waiver, individuals must be recipients of South Dakota Medicaid, and must meet the following criteria as defined in [ARSD 67:54:04:05](#):

Eligibility Determination Process Overview



The following documentation is required to be submitted with the Level of Care:

- A completed Inventory for Client and Agency Planning (ICAP) assessment that indicates a minimum of three substantial functional limitations;
- Psychological examination to determine developmental disability or intellectual disability; and
- HCBS Waiver Rights Form (DHS-DD-717) to inform the applicant that services are available from the Home and Community Based Services Waiver.
 - This form also assures each applicant is provided with a list of HCBS providers, informed of the appeal process for denial of services if the applicant is determined not eligible, and provided with contact information to request a fair hearing; and
- A provisional plan of care that designates the specific waiver services that the individual will receive.

ANNUAL REDETERMINATIONS

Re-evaluation is performed annually. From the Level of Care criteria described above, the state uses a completed ICAP that results in a minimum of three functional limitations assessed by a Qualified Developmental Disability Professional (QDDP) or qualified DHS/DDD staff to reevaluate whether the participant maintains minimum eligibility to receive CHOICES waiver services. The level of care must be reviewed and completed annually for each participant receiving waiver services.

The HCBS provider must update the ICAP data every year, or as changes occur, and submit it to the division through the File Transfer Protocol (FTP) or by sending the ICAP via secure email to the Senior

Secretary for the Division. An ICAP change that is captured due to a change in the participants level of need will only be backdated to the date that the ICAP assessment was completed. ICAPs completed as changes occur must be submitted to DDD within 60 days of the date of the assessment.

The QDDP, as defined in SDCL subdivision [27B-1-17\(14\)](#), must review the ICAP data annually to ensure continued eligibility that indicates at least three substantial functional limitations. The QDDP must forward a copy of the completed Level of Care Determination form to the CSP and the Department of Social Services upon completion of the review.

COVERED SERVICES AND LIMITS

CHOICES waiver services are outlined in the participant's Individualized Support Plan (ISP) and authorized through the Service Change Request (SCR) process. The following are CHOICES services:

- Case Management;
- Residential habilitation;
- Shared living residential habilitation;
- Day services;
- Individual supported employment;
- Group supported employment;
- Small group vocational support;
- Career exploration;
- Assistive technology; and
- Specialized medical equipment and drugs.

Case Management

Case Management services require the facilitation and development of a comprehensive person-centered ISP written by the case manager and reviewed by the state. Case managers provide ongoing monitoring of the participant's provision of services, health, welfare, and monitor the implementation of the participant's ISP at least quarterly. The plan is reviewed by the entire ISP team at least annually or more frequently as requested by the participant or as circumstances dictate. Case managers initiate a comprehensive assessment and periodic reassessment of individual needs to develop, revise and update the participant's ISP as well as advocate for the participant to exercise individual choice and independence. Case management services require the development of a 24-hour individual back-up plan with paid and natural supports. Case managers provide transition case management services to assist participants to transition from institutional settings to community settings by identifying needed waiver services, state plan services, as well as medical, social, housing, educational, non-paid natural supports, and other needed services, regardless of funding source. The costs of such services are considered to be incurred and billable when the person leaves the institutional setting and enters the waiver. The individual must be reasonably expected to be eligible for and to enroll in the waiver. If for any unseen reason, the individual does not enroll in the waiver (e.g., due to death or a significant change in condition), transitional services may be billed to Medicaid as an administrative cost.

Case Management services cannot be delivered by the same provider of other waiver services. Transition case management services are limited to 60 days prior to the participant's transition to the CHOICES waiver from an institutional setting, unless otherwise agreed upon within the provisional plan of care approved by the DHS.

Residential Habilitation

Residential Habilitation services are provided to participants living in their own home, which may include a group home or supervised apartment. Residential Habilitation services shall provide the participant with the opportunity to live as independently as possible, with the supports needed to maintain their safety.

Services may include, but are not limited to, assistance in acquiring, retaining, and improving skills related to activities of daily living, such as oral and personal hygiene, bathing, toileting, dressing, personal grooming and cleanliness, bed making, dusting, vacuuming, cleaning, laundry and housekeeping chores, simple home maintenance tasks, eating, cooking and the preparation of food, shopping, money management, budgeting, safety and self-help, recreation and socialization, and adaptive skills necessary for the person's health and welfare.

The service definition and limits outlined below do not include all details and requirements. For the service standards, limitations, provider types and qualifications, and reimbursement information, refer to the CHOICES Waiver.

Residential Habilitation includes:

1. Services provided in one of the following settings:
 - a. Group homes (level one) are residential settings where services are offered by a provider that has round-the-clock responsibility for the health and welfare of residents. Group home participants receive services and supports from a setting staffed 24 hours daily due to the demonstrated need of the participants residing there. Group homes are considered provider owned/controlled settings.
 - b. Supervised living services (level two) that support a person in his or her home or apartment when the provider does not have round-the-clock responsibility for the person's health and welfare. These services can be provided in other community settings but are primarily furnished in a person's home or apartment. Supervised Living model assumes that residential staff are not needed during nighttime hours as well as daytime hours when residents are employed outside the home or participating in day services. Supervised living residences are considered provider owned/controlled settings.
 - c. Supported living services (level three) that support a person in his or her home, shared family home, or apartment, when the provider furnishes services intermittently to the individual. These services can be provided in other community settings but are primarily furnished in a participant's home or apartment. This service may include supervision, socialization, and assistance for a participant to maintain safety in the home and

community, and to enhance independence. Supported living services cannot be provided in a provider owned/controlled setting.

2. All residential habilitation service levels are eligible for delivery via a technology modality.
 - a. Technology may be utilized by participants of community residential services as approved in their person-centered service plan. Technology may be utilized to ensure health, safety, and other support needs when the method of support is appropriate, chosen and preferred by the person.
 - b. The desired outcome of supports provided via technologies is that more participants live in their own homes, with fewer roommates and less dependence on a physical staff presence. Natural support networks may be bolstered and further reduce dependence on paid supports at home and in the community. The use of technologies can benefit participants who possess the skills to live independently but experience challenges that necessitate varying levels of staff supports.
 - c. The use of technology supports must receive prior authorization by DHS/DDD.
3. Group home and supervised living service levels are reimbursed at a daily rate.
 - a. To be eligible to bill for group home, the provider must be in the residence with the participant a minimum ten hours or more out of a 24-hour period 12:00am-11:59pm.
 - b. Part or all of the ten hours of the day may be the time the participant is asleep, as long as this is appropriate per the participant's ISP and all needs are being met. DDD expects that overnight staff remain awake and available during sleeping hours.
 - c. To be eligible to bill for supervised living, the provider must be in the residence with the participant a minimum of 6 hours or more out of a 24-hour period 12:00am-11:59pm.
 - d. Family visits and trips are encouraged.
4. Group home and supervised living service rates are determined using the participant's ICAP service score and the size of the home where services are to be delivered. Please refer to the [CHOICES Fee Schedule](#) for detailed rates. The support level is subject to DDD review and approval.
5. Supported living services are reimbursed at a 15-minute unit rate. Please refer to the [CHOICES Fee Schedule](#) for detailed rates.
 - a. Support living includes activities of daily living, such as but not limited to:
 - i. Personal hygiene
 - ii. Laundry and household chores
 - iii. Meal preparation
 - iv. Activities in the community (such as grocery shopping)
 - v. Social and leisure skills
 - b. Supported living services cannot be provided when the participant is sleeping.
 - c. A portion of this service can be delivered virtually, which includes but is not limited to:
 - i. The use of telephonic/virtual supports through FaceTime, Zoom, Echo or other means of telecommunication to provide verbal prompting for a participant and/or

- their support person to provide personal care supports to perform activities of daily living.
- ii. The use of telephonic/virtual supports through FaceTime, Zoom, or Echo other means of telecommunication to continue to support participants with medication management.
 - iii. Check-in phone calls are considered a case management function and would not be considered telephonic/virtual habilitative supports.
6. A lease, residency agreement, or other form of written agreement must be in place to protect the participant from eviction according to landlord and tenant laws.
 7. Residential Habilitation cannot overlap with, replace, or duplicate other similar services provided through Medicaid.
 8. Payments for Residential Habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of participants, or to meet the requirements of the applicable life safety code.
 9. Payments will not be made for the routine care and supervision which would be expected to be provided by a family (i.e., activities that would be performed ordinarily for an individual without a disability and/or chronic illness of the same age) or for activities or supervision for which a payment is made by a source other than Medicaid.
 10. All group home and supervised living settings must receive prior approval from DDD before any services are delivered to ensure compliance with the HCBS Settings Rule. Please refer to the new settings process for further information on this process.
 11. Transportation between the participant's place of residence and other service sites or places in the community is provided as a component of Residential Habilitation services and the cost of this transportation is included in the rate.
 - a. Participants may choose not to use the transportation provided by the group home. In that event, however, the participant's choice to use public transportation must be documented in the participant's care plan. Charges associated with the alternative transportation method are the responsibility of the participant. Travel throughout a typical day is included within residential services.
 - b. If there is a situation where a provider is unable to provide transportation to a participant, alternative transportation should be arranged at the expense of the provider, as those costs are considered in the rate.
 - c. Transportation to/from Day Services, Employment-related Services is included in the rate for those services.

Residential Habilitation support activities:

1. Nursing supports are factored into the residential habilitation reimbursement. Nursing supports include the following:
 - a. Screenings and assessments;
 - b. Nursing diagnosis treatment;
 - c. Staff training;
 - d. Monitoring of medical care and related services;
 - e. Policy and procedure development;
 - f. Review and response to medical emergencies, tuberculin tests, and phlebotomy for hepatitis screening; and
 - g. Medication administration.
2. Staff time spent on medical appointment activities for CHOICES waiver participants is considered a support activity.
3. Community Support Providers must meet the administrative requirements outlined in [ARSD 46:11:07](#).

Shared Living Residential Habilitation

Shared Living is an arrangement of services provided to a participant in private home of a community member or friend. Shared living services are meant to provide a more person-centered approach to supports and are built on the foundation of life sharing, developing natural supports, and being an active member of the community.

The Shared Living Provider (SLP) as defined in [ARSD 46:04:01](#) shall provide services, including assistance, support, and guidance in life domain areas such as daily living, safety and security, community living, healthy lifestyle, social interactions, spirituality, citizenship, and advocacy. The SLP shall provide age-appropriate services to the participant as specified in the participant's Individualized Service Plan (ISP). Family members are allowed to provide Shared Living Residential Habilitation services as an SLP.

The service definition and limits outlined below do not include all details and requirements. For the service standards, limitations, provider types and qualifications, and reimbursement information, refer to the CHOICES Waiver.

Shared Living includes:

1. A host home provider that shall provide services including assistance, support, and guidance in life domain areas such as daily living, safety and security, community living, healthy lifestyle, social interactions, spirituality, citizenship, and advocacy.
2. A shared home setting in which the participant has access to individualized person-centered supports. The participant will have stability, consistency, and positive control over which services they receive.
3. Shared Living services are reimbursed at a daily rate:
 - a. To be eligible to bill for shared living, the provider must be in the residence with the participant a minimum ten hours or more out of a 24-hour period 12:00am-11:59pm.

- b. Family visits and trips are encouraged.
- 4. Shared Living rates are determined using the participant’s ICAP service score and the Please refer to the [CHOICES Fee Schedule](#) for detailed rates.
- 5. Shared living homes are limited to a maximum capacity of 2 participants.
- 6. Shared Living Providers are reimbursed by the CSP through a standardized per diem as set by DDD. The same stipend is provided to Shared Living providers for each participant.

ICAP Score	ICAP Tier	Daily Stipend
85-100	1	\$120
70-84	2	\$135
55-69	3	\$150
40-54	4	\$165
25-39	5	\$180
1-24	6	\$195

- 7. Shared Living services may be provided by a family member, relative, or legal guardian.
 - a. The Shared Living Provider cannot serve as the representative payee for the participant.
- 8. Shared living settings in which the Shared Living Provider is an unrelated caregiver are subject to meet all requirements outlined in the HCBS Settings Rule.
- 9. Relief care staff chosen by the participant may be used in place of the Shared Living Provider.
 - a. Relief care staff must deliver the same habilitative services to the participant in the participant’s home, follow the participant’s usual schedule, and meet the provider qualification requirements outlined in [ARSD 46:04](#).
 - b. The Shared Living Providers cannot use relief care staff for more than 30 calendar days per participant’s ISP year.
- 10. Shared Living Providers must comply with all safety, training, and other applicable requirements published via [South Dakota Administrative Rules 46:04:01 – 46:04:01:27](#), and the South Dakota Shared Living Guide.

Day Services

Day Services shall be intended to assist the person to gain opportunities for meaningful life experiences in coordination with the person’s personal goals and supports and agreed upon by the ISP team. Individuals in this service may not be paid a wage for activities in which they participate. Activities and environments are designed to:

- Build positive social relationships, interpersonal competence, greater independence and personal choice;
- Foster the acquisition of skills;
- Assist in maintaining skills and functioning and preventing or slowing regression for those with degenerative conditions;
- Empower the person to attain or maintain their highest level of self-determination;
- Occur in coordination with any physical, occupational, or speech therapies listed in the person-centered ISP; and

- Include personal care/assistance, but these supports may not comprise the entirety of the service.

Day Services may be provided in integrated, community-based settings to promote volunteer activities that include acquiring, retaining, and improving self-help, socialization, and adaptive skills. Day Services settings may also be provided in fixed site facilities or in certain circumstances, virtually. Day Services does not include compensation or the production of goods or services. Meals provided as part of Day Services shall not constitute a full nutritional regimen.

The service definition and limits outlined below do not include all details and requirements. For the service standards, limitations, provider types and qualifications, and reimbursement information, refer to the CHOICES Waiver.

1. Facility-Based Day Services:

- a. Facility-based day services are provided in provider owned/controlled settings in which the provider supports several participants throughout the day.
- b. Delivery of Facility-Based Day Services is largely based on individual participant to staff ratios and are generally based on each participant's Inventory for Client and Agency Planning (ICAP) Assessment score. Each participant's staffing level will fall into one of three levels:
 - i. Basic (1:8)
 - ii. Intermediate (1:5)
 - iii. Enhanced (1:3)
- c. The ISP team is responsible to determine the most appropriate service level for the participant based on the needs of the participant as documented through the ICAP assessment. Staffing ratios are based off average assumptions. Providers are responsible to maintain documentation that justifies billing at the appropriate ratio. The support level is subject to DDD review and approval.

2. Community-Based Day Services:

- a. Community- based day services encourage integrating participants into activities in a community-based setting (not provider owned/controlled).
- b. The increased staffing support level (1:4 or 1:2) allows for appropriate supervision of participants while in the community depending on the needs of the participant. The level of support required will be identified through the ISP process.
- c. Community-based day service is a habilitation service. Training on objectives, which shall be focused on community access as outlined in the participant's ISP, is expected as part of the provision of services, and progress shall be documented.
- d. Examples of community-based day services include:
 - i. Group exercise at a local gym, book club, group classes
 - ii. Going out to eat shopping, or other community activities
- e. All community-based services activities must be related to a participant's goal outlined on the ISP and should not be confused with community outings associated with residential services.

- f. Community-based day services can begin at the participant's home but cannot be provided in the home. The majority of the time billed must occur in the community.
 - g. Delivery of Community-Based Day services is largely based on individual participant to staff ratios and are generally based on each participant's Inventory for Client and Agency Planning (ICAP) Assessment score. Each participant's staffing level will fall into one of two levels:
 - i. Community (1:4)
 - ii. Community (1:2)
3. Remote Day Services:
- a. Remote Day Services are reserved for outstanding circumstances that restrict a participant's access to Facility and/or Community Support Day Services. The following examples are types of virtual day services:
 - i. The use of telephonic/virtual supports through Facetime, Zoom, Echo, or means of telecommunication to promote socialization that aligns with ISP goals. CSPs can use technology to promote and support social interaction through "virtual hangouts" for participants to engage with their friends and other natural supports.
 - ii. Utilizing technology to support individuals to access community events that they previously engaged in. Examples of this may include supporting participants to access online church services, remote book clubs, etc.
 - b. Remote day services are not intended for regular, daily use. The total combined hours for virtual supports may not exceed a weekly amount of 10 hours.
 - c. Providers will only bill for the direct service hours provided to the participant.
 - d. A minimum of 31 minutes of service must be provided to constitute an hour of billing.
4. Behavioral Support:
- a. Behavioral Support Day Services are reserved for participants who have a demonstrated behavioral need or diagnosis, identified through the ICAP and/or Functional Needs Assessment, and cannot safely participate in Day Services without this additional support.
 - b. The participant must also have a Behavior Support plan in place prior to receiving Behavioral Support Day Services.
 - c. Behavioral Support Day Services must be provided by a direct service worker with two (2) years of experience in direct support of individuals with an intellectual and/or developmental disability and challenging behavior or two (2) years of experience in Behavioral Health. A bachelor's degree in a related field can replace the requirement of two years of experience. In addition, the direct service worker must also complete training, approved by DHS/DDD, in:
 - i. Conducting and using a Functional Behavioral Assessment.
 - ii. Positive behavioral support.
 - d. Frequent staff interaction and personal attention for significant behavioral needs shall be provided. Support and supervision needs are moderately intense but can still generally be provided in a shared staffing environment. Frequent personal attention shall be given

- throughout the day for reinforcement, positive behavior support, personal care, or social activities.
- e. Behavioral support services can be provided in facility or community-based settings. Behavioral support services are considered a day habilitation services. Day habilitation services cannot be provided in the participants home.
 - f. Behavioral support services is considered a day service and cannot be billed simultaneously with community, facility, or virtual day services.
5. Billing parameters:
- a. Day services are reimbursed at an hourly unit rate. A billable unit consists of a minimum of 31 minutes. Please refer to the [CHOICES Fee Schedule](#) for detailed rates. The support level is subject to DDD review and approval.
 - b. A participant may receive Day Services in combination with other non-residential services, but the total combined hours cannot exceed 35 hours per week. Examples of other non-residential services include: Career exploration
 - i. Small Group Vocational Support
 - ii. Group supported employment
 - iii. Individual Supported employment
 - c. Facility, Community, and Behavioral Support Day services cannot be provided in a residential setting.
 - d. Participants may not engage in paid work in Day Services. Participants may also not do unpaid work for which others are typically paid while receiving day services.
 - e. Transportation between the participant's place of residence and the Day Services site is provided as a component of Day Services and the cost of this transportation is included in this rate.
 - i. Participants may choose not to use the transportation provided by the day services provider. In that event, however, the participant's choice to use public transportation must be documented in the participant's care plan. Charges associated with the alternative transportation method are the responsibility of the participant.
 - ii. If there is a situation where a provider is unable to provide transportation to a participant, alternative transportation should be arranged at the expense of the provider, as those costs are considered in the rate.
 - iii. Providers should not bill for the minutes spent transporting participants, as those costs are factored into the rate.
6. Day Services support activities:
- a. Nursing supports are factored into the residential habilitation reimbursement. Nursing supports include the following:
 - i. Screenings and assessments;
 - ii. Nursing diagnosis treatment;
 - iii. Staff training
 - iv. Monitoring of medical care and related services;
 - v. Policy and procedure development; and

- vi. Review and response to medical emergencies, tuberculin tests, and phlebotomy for hepatitis screening.
- b. Staff time spent on medical appointment activities for CHOICES waiver participants is considered a support activity.
- c. Community Support Providers must meet the administrative requirements outlined in [ARSD 46:11:07](#)

Career Exploration

Career Exploration services are based on the belief that all individuals with developmental disabilities can work in integrated, competitive employment and that individuals of working age should be provided the supports necessary not only to gain and maintain employment but to advance in their chosen fields and explore new employment options as their skills, interests, and needs change. The outcome of the service is to obtain paid employment at or above minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

The service definition and limits outlined below do not include all details and requirements. For the service standards, limitations, provider types and qualifications, and reimbursement information, refer to the CHOICES Waiver.

1. Career Exploration:
 - a. Participants receiving career exploration services must have an outcome to sustain competitive, integrated, paid employment at or above minimum wage in an integrated setting in the general workforce in a job that meets personal and career goals included in their person-centered ISP. The service must be reviewed at least annually or more frequently as needed to assess the need for the service and progress on the employment outcome.
 - b. Career Exploration services are designed to assist participants in identifying and developing skills to prepare them for integrated competitive jobs and compensation at or above minimum wage, but not less than customary wage and level of benefits paid by the employer for similar work performed by employees without disabilities. This includes:
 - i. Developing general work-related skills that are not job-specific
 - ii. Following multiple step directions and instructions
 - iii. Staying on task for extended periods of time
 - iv. General health maintenance, including performing activities of daily living as it relates to maintaining employment
 - c. Career Exploration includes occupational training to teach participants skills for the competitive labor market, and personal training designed to develop appropriate worker traits. Occupational training through this service will include teaching concepts such as following directions, attendance, task completion, problem solving, and workplace safety.
 - d. Primarily focusing on the development of competitive worker traits through a trial-work training model, Career Exploration services can be furnished in a variety of community settings and is not limited to fixed-site facilities.

- e. Participant training will include learning the expectations of a competitive work environment, problem solving skills and strategies, and general workplace safety and mobility training.
 - f. Further Career Exploration components will include training participants on benefits management, the financial information needed by participants when they enter employment in the general workforce, and the use of work-related evaluations which involve the use of planned activities, systematic observation, job shadowing, internships, and work trials to accomplish a formal assessment of the participant skills and interests, including identification of service needs and identification of employment objectives.
 - g. Career Exploration services are limited to an 18-month delivery window, with a maximum of two three-month extensions. Upon culmination of Career Exploration, a participant has identified and is prepared to pursue additional career goals through other Employment-related Services.
 - h. The DHS/DDD will preauthorize participant access to Career Exploration as well as requests for extension. Access and requests for extension must include ISP team determination of the person's interest in employment, existing work readiness skills and the length of time likely needed to transition successfully to competitive, integrated employment.
2. Billing Parameters:
- a. Career Exploration services are reimbursed at an hourly unit rate. A billable unit consists of a minimum of 31 minutes. Please refer to the [CHOICES Fee Schedule](#) for detailed rates.
 - b. A participant may receive Career Exploration in combination with other non-residential services, but the total combined hours cannot exceed 35 hours per week. Examples of other non-residential services include:
 - i. Day services
 - ii. Small Group Vocational Support
 - iii. Group supported employment
 - iv. Individual Supported employment
 - c. Transportation between the participant's place of residence and the Day Services site is provided as a component of Day Services and the cost of this transportation is included in this rate.
 - i. Participants may choose not to use the transportation provided by the day services provider. In that event, however, the participant's choice to use public transportation must be documented in the participant's care plan. Charges associated with the alternative transportation method are the responsibility of the participant.
 - ii. If there is a situation where a provider is unable to provide transportation to a participant, alternative transportation should be arranged at the expense of the provider, as those costs are considered in the rate.
 - iii. Providers should not bill for the minutes spent transporting participants, as those costs are factored into the rate.
 - d. Waiver funds cannot be used to pay or add to a participant's wages.

- e. If the participant receives a wage less than the minimum wage, the Community Support Provider must have a Certificate pursuant to Section 14 (C) of the Fair Labor Standards Act from the Federal Department of Labor permitting payment of a sub-minimum wage.
- f. Services must not duplicate services provided by the Division of Vocational Rehabilitation.

Small Group Vocational Support

Small Group Vocational Support services are based on the belief that all individuals with developmental disabilities can work in integrated, competitive employment and that individuals of working age should be provided the supports necessary not only to gain and maintain employment but to advance in their chosen fields and explore new employment options as their skills, interests, and needs change. Unlike Individual and Group Supported Employment, which seeks to provide participants with the supports and training necessary to maintain a job in an integrated competitive employment environment, Small Group Vocational Support services are designed to create a pathway towards integrated community-based employment for those who are not yet ready to receive Group or Individual Supported Employment services.

The service definition and limits outlined below do not include all details and requirements. For the service standards, limitations, provider types and qualifications, and reimbursement information, refer to the CHOICES Waiver.

1. Small Group Vocational Support:
 - a. Small Group Vocational Support services provide opportunities for a participant to be paid while gaining work experience in a community business setting:
 - i. A participant receiving these services is not employed by the community business.
 - ii. The Community Support Provider holds a contract with the business for a job and the business pays the CSP for the contract.
 - iii. The CSP pays the participant or group of participants who complete the job.
 - b. Participants receiving Small Group Vocational Support services must have an outcome to sustain competitive, integrated, paid employment at or above minimum wage in an integrated setting in the general workforce in a job that meets personal and career goals included in their person-centered ISP. This service is not considered to be competitive integrated employment.
 - c. The service must be reviewed at least annually or more frequently as needed to assess the need for the service and progress on the employment outcome.
 - d. Small Group Vocational Support services include services provided at the work site of a competitive employer where a worker with a disability or a group of workers with disabilities are working and supervised by staff from the Community Support Provider.
 - e. Services include work crews where a small crew of participants works as a distinct unit. This typically includes janitorial or grounds keeping work.
 - f. Participants receiving Small Group Vocational Support services should have opportunities for interaction between participants and employees or customers.

- g. Small Group Vocational Support services also include assistance with personal care, health maintenance, and supervision.
 - h. Small Group Vocational Support can be provided to a group of (2) to (8) individuals.
 - i. Examples of Small Group Vocational Support services include but are not limited to an individual or work crew doing work such as:
 - i. Landscaping or groundskeeping
 - ii. Mowing/snow removal
 - iii. Cleaning or janitorial work
 - iv. Sorting or folding documents
 - v. Newspaper routes
 - vi. Laundry
 - vii. Clearing tables, dishwashing, or rolling silverware
2. Billing parameters:
- a. Small Group Vocational Support services are reimbursed at an hourly unit rate. A billable unit consists of a minimum of 31 minutes. Please refer to the [CHOICES Fee Schedule](#) for detailed rates.
 - b. A participant may receive Small Group Vocational Support services in combination with other non-residential services, but the total combined hours cannot exceed 35 hours per week. Examples of other non-residential services include:
 - i. Day services
 - ii. Career Exploration
 - iii. Group supported employment
 - iv. Individual Supported employment
 - c. Transportation between the participant's place of residence and the Small Group Vocational Support services site is provided as a component of Small Group Vocational Support services and the cost of this transportation is included in this rate.
 - i. Participants may choose not to use the transportation provided by the day services provider. In that event, however, the participant's choice to use public transportation must be documented in the participant's care plan. Charges associated with the alternative transportation method are the responsibility of the participant.
 - ii. If there is a situation where a provider is unable to provide transportation to a participant, alternative transportation should be arranged at the expense of the provider, as those costs are considered in the rate.
 - iii. Providers should not bill for the minutes spent transporting participants, as those costs are factored into the rate.
 - d. Small Group Vocational Support services cannot be provided in a provider owned or controlled setting.
 - e. Waiver funds cannot be used to pay or add to a participant's wages.
 - f. Services must not duplicate services provided by the Division of Vocational Rehabilitation.

Group Supported Employment

The outcome of Group Supported Employment is sustained paid employment at or above minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals. Participants receiving group supported employment services must have an outcome to sustain competitive, integrated, paid employment at or above minimum wage in an integrated setting in the general workforce in a job that meets personal and career goals included in their person-centered ISP. The service must be reviewed at least annually or more frequently as needed to assess the need for the service and progress on the employment outcome.

Group Supported Employment services are supports to a group of participants to obtain and maintain a job in integrated competitive employment, customized employment, or self-employment. Services include job coaching, job support, retention, and follow along. Participants may access Supported Employment regardless of whether Pre-Employment services have been previously accessed.

The service definition and limits outlined below do not include all details and requirements. For the service standards, limitations, provider types and qualifications, and reimbursement information, refer to the CHOICES Waiver.

1. Group Supported Employment:
 - a. Group supported employment services are integrated work setting in the general workforce.
 - b. Participants receiving group supported employment services receive compensation at or above the minimum wage.
 - c. Group Supported Employment can be provided to a group of (2) to (4) individuals.
 - d. Group supported employment services must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in those workplaces.
 - e. Goals and/or supports related to employment are outlined within the person-centered ISP.
 - f. Group supported employment services are provided to participants that are employed by the community business and are on their payroll.
 - g. Group supported employment services aim to connect participants with coworkers at the work site and include a plan to decrease the need for a job coach through the development of job-related skills.
 - h. Examples of group supported employment include:
 - i. Learning a work schedule
 - ii. Working alongside coworkers
 - iii. Talking with the boss about work needs
 - iv. Learning work expectations
2. Billing parameters:
 - a. Group Supported Employment services are reimbursed at an hourly unit rate. A billable unit consists of a minimum of 31 minutes. Please refer to the [CHOICES Fee Schedule](#) for detailed rates.

- b. A participant may receive Group Supported Employment in combination with other non-residential services, but the total combined hours cannot exceed 35 hours per week. Examples of other non-residential services include:
 - i. Day services
 - ii. Career Exploration
 - iii. Small Group Vocational Support
 - iv. Individual Supported employment
- c. Transportation between the participant's place of residence and the Group Supported Employment services site is provided as a component of Group Supported Employment services and the cost of this transportation is included in this rate.
 - i. Participants may choose not to use the transportation provided by the day services provider. In that event, however, the participant's choice to use public transportation must be documented in the participant's care plan. Charges associated with the alternative transportation method are the responsibility of the participant.
 - ii. If there is a situation where a provider is unable to provide transportation to a participant, alternative transportation should be arranged at the expense of the provider, as those costs are considered in the rate.
 - iii. Providers should not bill for the minutes spent transporting participants, as those costs are factored into the rate.
- d. Group Supported Employment services cannot be provided in a provider owned or controlled setting.
- e. Waiver funds cannot be used to pay or add to a participant's wages.
- f. Providers will bill the same rate for each participant in the group based on the number of hours of support provided.
- g. Services must not duplicate services provided by the Division of Vocational Rehabilitation.

Individual Supported Employment

Individual Supported Employment services are supports to a participant to obtain and maintain a job in integrated competitive employment, customized employment, or self-employment. Services include job coaching, job support, retention, and follow along. Participants may access Supported Employment regardless of whether Pre-Employment services have been previously accessed.

Participants receiving Individual Supported Employment services must have an outcome to sustain competitive, integrated, paid employment at or above minimum wage in an integrated setting in the general workforce in a job that meets personal and career goals included in their person-centered ISP. The service must be reviewed at least annually or more frequently as needed to assess the need for the service and progress on the employment outcome.

The service definition and limits outlined below do not include all details and requirements. For the service standards, limitations, provider types and qualifications, and reimbursement information, refer to the CHOICES Waiver.

1. Individual Supported Employment is defined as:
 - a. Individual Supported Employment services are integrated work setting in the general workforce.
 - b. Participants receiving group supported employment services receive compensation at or above the minimum wage.
 - c. Individual Supported Employment services must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in those workplaces.
 - d. Individual Supported Employment services may include service and supports that assist the participant in achieving self-employment through the operation of a business. However, waiver funds may not be used to defray the expenses associated with starting up or operating a business. Assistance for self-employment may include:
 - i. aiding the participant to identify potential business opportunities
 - ii. assistance in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business
 - iii. identification of the supports that are necessary in order for the participant to operate the business
 - iv. ongoing assistance, counseling and guidance once the business has been launched
 - e. Individual Supported Employment services are provided on a 1:1 ratio and the individual in on the payroll of the community business.
 - f. Examples of Individual Supported Employment include:
 - i. Learning a work schedule
 - ii. Working alongside coworkers
 - iii. Talking with the boss about work needs
 - iv. Learning work expectations
2. Individual Supported Employment Phases:
 - a. Discovery: Development of an employment profile as the desired outcome.
 - b. Job Development: Coordination between the job seeker and employer to identify and negotiate job responsibilities.
 - c. Stabilization: Provision of necessary supports that result in the person learning job responsibilities, building relationships with supervisor(s) and coworkers, and achieving professional growth as identified by the person.
 - d. Long-Term Support: Provision of on-going supports as identified by the team or person to sustain long-term employment, which may include re-engagement of additional supports if needed. The delivery of Supported Employment services may include personal care type services as long as those supports do not encompass the entirety of the service (more than 20%).
3. Billing Parameters:
 - a. Individual Supported Employment are reimbursed at a 15-minute unit rate. A billable unit consists of a minimum of 8 minutes. Please refer to the [CHOICES Fee Schedule](#) for detailed rates.

- b. A participant may receive Individual Supported Employment in combination with other non-residential services, but the total combined hours cannot exceed 35 hours per week. Examples of other non-residential services include:
 - i. Day services
 - ii. Career Exploration
 - iii. Small Group Vocational Support
 - iv. Group Supported employment
- c. Individual Supported Employment services cannot be billed unless the staff providing the service meet the training requirements outlined by DDD.
- d. Transportation between the participant's place of residence and the Individual Supported Employment services site is provided as a component of Supported Employment services and the cost of this transportation is included in this rate.
 - i. Participants may choose not to use the transportation provided by the day services provider. In that event, however, the participant's choice to use public transportation must be documented in the participant's care plan. Charges associated with the alternative transportation method are the responsibility of the participant. [Ticket to Work: Work Incentives Series—Impairment-Related Work Expenses \(ssa.gov\)](#)
 - ii. If there is a situation where a provider is unable to provide transportation to a participant, alternative transportation should be arranged at the expense of the provider, as those costs are considered in the rate.
 - iii. Providers should not bill for the minutes spent transporting participants, as those costs are factored into the rate.
- e. Individual Supported Employment should not be billed for transportation purposes only, including for pick up and/or drop off assistance when a participant cannot secure transportation to an employment or service site. Transportation between the participant's place of residence and the employment or service site is allowable only when the provider remains onsite to provide Supported Employment services.
- f. Individual Supported Employment services cannot be provided in a provider owned or controlled setting unless the participant is competitively employed by the community support provider. All the following criteria must be met for the team to determine the participant qualifies for Individual Supported Employment while working for the community support provider:
 - i. the person is working in an integrated environment
 - ii. the person is earning at least minimum wage
 - iii. the person is supervised as others in the same area
 - iv. the person's supervisor cannot deliver a waiver service – can't be paid to be a supervisor AND a job coach
 - v. if the person requires supports on the job, a designated job coach or employment staff is available.
- g. Individual Supported Employment hours may only be billed for the time that the job coach is providing support.
- h. Waiver funds cannot be used to pay or add to a participant's wages or to purchase supplies for a participant's self-employment related activities.

- i. Income from a customized home business does not have to meet the minimum wage requirement.
- j. Individual Supported Employment services cannot be provided at the same time a participant is receiving day services.
- k. Self-employment supports does not include:
 - i. paying expenses with starting up or operating a business (consider accessing [Small Business Administration \(sba.gov\)](http://Small Business Administration (sba.gov)) ;
 - ii. supporting the participant to engage in self-employment that is not likely to result in earning at least minimum wage for hours worked within the first year of creating the business;
 - iii. supporting an activity if the activity is a hobby and not a business; and
 - iv. providing supervision, bookkeeping or related administrative duties required to operate the participant's business;
- l. Services must not duplicate services provided by the Division of Vocational Rehabilitation.

Specialized Medical Equipment and Drugs

Specialized Medical Equipment and Drugs is a service available to those participants whose Individualized Service Plan (ISP) specifies a need for the assessment of adaptive functioning needs and/or specifies the use of particular equipment and supplies as necessary to carry out the participant's ISP. Participants can utilize this service to obtain an assessment of their functional limitations and needs, or to purchase, rent, repair, or maintain medical equipment and drugs in accordance with their Individualized Service Plan.

The service definition and limits outlined below do not include all details and requirements. For the service standards, limitations, provider types and qualifications, and reimbursement information, refer to the CHOICES Waiver.

1. Specialized Medical Equipment and Drugs includes:
 - a. Devices, controls or appliances specified in the participant's ISP which enable the participant to increase or maintain their ability to perform activities of daily living;
 - b. Devices, controls or appliances specified in the participant's ISP which enable the participant to increase or maintain their ability to perceive, control, or communicate with the environment in which they live;
 - c. Items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items;
 - d. Items must be functionally necessary and relate specifically to the participant's medical need or disability that qualifies the individual for the CHOICES waiver. There should be a reasonable expectation that the item will likely improve the participant's functional abilities or the ability of a caregiver or service provider to maintain the participant in a community setting and delay or prevent institutional placement.
 - e. Medically necessary drugs and nutritional supplements that are not covered by the State Plan or EPSDT, and that are prescribed or recommended by a licensed practitioner to address caloric or nutritional needs as specified in the participant's ISP (excludes any

- vitamins, supplements, or alternative forms of nutrition not prescribed by a licensed practitioner).
- i. Medically necessary drugs and nutritional supplements may include, but are not limited to, nutritional supplements to address caloric intake, vitamin and mineral supplements, herbal preparations, and over-the-counter (OTC) medications directly related to the participant's primary medical condition. Utilization rationale for drugs and supplements, including support for their medical necessity, must be recorded in the participant's ISP.
 - f. Other allowable costs include identification of the type of equipment and supplies needed; costs necessary for selecting, designing, fitting, adapting, repairing, and maintaining equipment; the cost of training or technical assistance necessary for the participant or caregivers to operate and maintain the medical equipment; and payment of devices used when safety concerns exist (e.g., Lifeline services, Comfort One bracelets). All equipment, supplies, or other items provided to a participant through this service shall meet all applicable standards for manufacture, design, and installation.
 - g. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State Plan.
 - h. To the extent that any listed services are covered under the state plan, including EPSDT, the utilization of this waiver service (Specialized Medical Equipment & Supplies) would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.
 - i. all items, whether durable or non-durable medical equipment and supplies, purchased for a participant via this service are the property of the participant or the participant's family.
 - j. Examples of Specialized Medical Equipment and Drugs includes:
 - i. Wheelchair parts and repairs
 - ii. Adaptive clothing and specialized shoes
 - iii. Bathing lifts/chairs
 - iv. Adaptive beds
 - v. Adaptive eating and cooking utensils
 - vi. Medication minders
 - vii. Thickening agents
2. Billing Parameters:
- a. Specialized Medical Equipment and Drugs are reimbursed per item.
 - b. Costs for the repair of durable medical equipment shall be limited to scenarios where product warranty or State Plan benefit coverage does not exist. An uninsured item that is damaged, stolen, or lost may be replaced once every two years.
 - c. Non-allowable costs include assisting participants with taking their medications; Part D covered and Medicare excluded medications for dual-eligible participants; and Medicaid State Plan services.
 - d. Specialized Medical Equipment and Drug can be offered by a vendor. A vendor is a company or agency enrolled as a Medicaid provider, but not a certified DDD provider.
 - e. A vendor cannot charge more than they would to the general public. They must use a usual and customary rate for a service. A vendor who offers a discount to a certain

- group of people, such as students or senior citizens, must offer the same discount to a participant in that group.
- f. Specialized Medical Equipment and Drugs must be purchased within a participant's annual budget maximum of \$5,000. A participant may request funding over the annual budget cap due to a critical health or safety need. DDD approval is determined based on available funding.
 - g. The following items are considered non-covered services include but are not limited to:
 - i. Items used for leisure, recreation, education, and vocational purposes and not determined to be necessary for the participant to remain in their home or community
 - ii. Non-adaptive items of clothing
 - iii. Basic household furniture
 - iv. Non-medical supplies (e.g. cleaning productions, routine personal care items)
 - v. Home appliances
 - vi. Televisions, stereos, radios, DVDs, mp3 players
 - vii. Toys
 - viii. Eyeglass, frames, and lenses
 - ix. Recreational or exercise equipment
 - x. Incontinence supplies
 - xi. Items which are not of direct medical or remedial benefit to the participant

Assistive Technology

Assistive Technology means a device, item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of the participant.

Assistive Technology service is available to those participants whose Individualized Service Plan (ISP) specifies a need for the assessment of adaptive functioning needs and/or specifies the use of particular assistive technology is necessary to ensure the participant's health, welfare, and safety.

1. Assistive Technology service includes:
 - a. The evaluation of the Assistive Technology needs of the participant, including a functional evaluation of the impact of the provision of appropriate Assistive Technology and appropriate services to the participant in the customary environment of the participant.
 - b. Services consisting of purchasing, leasing, or otherwise providing for the acquisition of Assistive Technology devices for the participant.
 - c. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing Assistive Technology devices.
 - d. Coordination and use of necessary therapies, interventions, or services with Assistive Technology devices, such as therapies, interventions, or services associated with other services in the participant's ISP.

- e. Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant in the operation and/or maintenance of the AT device.
 - f. Training or technical assistance for professionals or other persons who provide services to, employ, or are otherwise substantially involved in the major life functions of participants in the operation and/or maintenance of the AT device.
2. Examples of Assistive Technology include:
- a. Communication devices (ex. iPad with Proloque2go)
 - b. Home automation devices (such as smart home controls)
 - c. Text to speech software
 - d. Apps that can help participants access the community or perform activities of daily living
 - e. Apps that promote independence and/or replace the need for staff assistance
3. Assessments:
- a. Independent assessments for the AT service shall be conducted by independent professional consultants. Independent, professional consultants include, for example, speech-language therapists, physical therapists, occupational therapists, physicians, behavioral therapists, certified rehabilitation specialists, or rehabilitation engineers.
 - b. Providers that supply the AT service for the waiver individual may not perform assessments or consultation or write specifications for that individual. The provider shall receive a copy of the professional evaluation to purchase the items recommended by the professional. If a change is necessary, then the provider shall notify the assessor to ensure the changed items meet the individual's needs.
4. Billing parameters:
- a. The assistive technology service shall be covered in the least expensive, most cost-effective manner and shall be limited to \$5,000 per plan year. There shall be no carryover of unspent funds from year to year.
 - b. The AT service shall not be approved primarily for the purpose of convenience of the caregiver, restraint of the individual, or recreation or leisure activities.
 - c. Assistive technology funds cannot be used to cover the costs of internet subscriptions.
 - d. Assistive Technology has the following limitations:
 - i. All assistive technology must be provided in accordance with applicable state or local building codes or standards of manufacturing, design, and installation.
 - ii. An item over \$500 must include insurance or an extended warranty.
 - iii. An uninsured item that is damaged, stolen, or lost may be replaced once every two years.
 - iv. Assistive Technology is reimbursed per item.
 - v. DDD may require an on-site assessment of the environmental concern by an appropriate Medicaid-enrolled professional provider.
 - vi. The cost of transportation is not included in the rate for Assistive Technology.
 - vii. Assistive Technology cannot overlap with, replace, or duplicate other similar services provided through Medicaid. A participant should find out if Medicaid would pay for assistive technology before requesting this service.

NON-COVERED SERVICES

General Non-Covered Services

Providers should refer to [ARSD 67:16:01:08](#) or the [General Coverage Principles](#) manual for a general list of services that are not covered by South Dakota Medicaid.

Home and Community Based Services consist only of those services which are not currently available under the Medicaid State Plan. Services do not include room and board.

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.

As described in [ARSD 46:11:04:04](#) a provider must maintain records for six years or supervise the maintenance of records including:

- Any applications for a person that was accepted and is receiving services including any supporting documents;
- Any documents that determine eligibility;
- Any documents pertaining to the provision of services;
- Any documents on administrative costs; and
- Any fiscal documentation or other records, and information necessary for reporting and accountability as required by the division.

Each provider must have a written procedure for destruction of records.

In accordance with South Dakota Medicaid 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. Medical and financial records must be retained for at least six years after the last claim is paid or denied. Records may not be destroyed when an audit or investigation is pending. Medical and financial records must be retained in their original form or in a legally reproduced form, which may be electronic. Providers must have a medical record system that ensures that the record may be accessed and retrieved promptly.

Documentation must be kept for each participant. Documentation must meet the minimum requirements which include the type of service performed, the participant 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. Additionally, the provider must retain documentation of all tasks completed during each visit with a participant. All information must be captured within the IRIS system.

Case notes cannot be submitted for a future date. Case notes documented by DSPs working an overnight shift must be split across days. For example:

- An 8pm to 8am overnight shift requires two case notes.
 - 1st case note- 8pm-11:59pm
 - 2nd case note- 12:00am- 8:00am

A billable unit for each service is outlined in the CHOICES Billing Guidance Document. A billable claim for services amounts to the total number of minutes spent delivering the service throughout the entirety of the day, whether the time is consecutive or not. For example:

- For day services, an hour unit is attained when 31 minutes have elapsed. A second hour unit is attained when a total of 91 minutes has elapsed (60 minutes for the first unit + 31 minutes for the second unit).
 - If a participant attends day services from 10:00am to 10:31am, leaves and returns from 12:00pm to 12:31 pm, this constitutes 62 minutes of service delivery for the day totaling 1 billable unit.
 - 30 minutes or less of services provided would not constitute an hourly billable unit.
- For supported living level 3 services, a 15-minute unit is attained when 8 minutes have elapsed. A second 15-minute unit is attained when 23 minutes have elapsed (15 minutes for the first unit + 8 minutes for the second unit).

Place of Service Codes

The following place of service codes are available in IRIS:

- **02** Telehealth Provided Other than in the Patient's Home (used for remote services provided outside of the home)
- **03** School (used for educational services)
- **10** Telehealth Provided in the Patient's Home (used for remote services provided in the home)
- **12** Home (used for Shared Living, Level 2, and Level 3 residential services)
- **14** Group Home (used for Level 1 residential services)
- **18** Place of Employment – Worksite (used for Individual & Group Supported employment, and Small Group Vocational Support)
- **77** Audio-Only Service (used for services provided using voice only technology)
- **99** Other Place of Service (used for facility, community, specialized equipment, and assistive technology)

Examples of an Acceptable Case Notes

- Group Home Residential Services:
 - Provided Sandy support to complete bathing and eating her breakfast. Assisted with the preparation of her grocery list for the week. Walked over to the fast-food restaurant to go to grab lunch and a pop.
- Supported Living Residential Services:

- Assisted John to fill his medication minder for the week. Spent time reviewing his budget and planning for his monthly bills. Supported him to clean up his bathroom.
- Facility-Based Day Services:
 - John participated in the community bingo event at the day services location. He was able to spend some time with his friends. We worked together on identifying the numbers and appropriately calling out when we got BINGO.
- Community-Based Day Services:
 - Supported Sandy to attend an event at the local community center. Helped her make connections with other individuals in attendance. Also went lunch and worked with Sandy on how to read a menu and order her meal.
- Career Exploration Services:
 - Supported John upon arrival at Career Exploration location to store personal belongings in appropriate area. Worked with John to proceed to task area and identify supplies needed to complete first task of the day. Worked with John to stay on task for up to 1 hour and to respond appropriately to redirection from supervisor/job coach.
- Small Group Vocation Support Services:
 - Supported Sandy with the work crew completing janitorial work at the school. Assisted Sandy with operating the mop to help her develop his skills. Worked on teaching Sandy how to keep track of her time worked.
- Individual Supported Employment Services:
 - Staff and John reviewed the app for using public transit. After review of tasks, John and staff went downstairs to wait for transit to arrive. John remembered to tell the driver his name and show his ride card. John also told the driver where he wanted to be taken to. John and staff sat down and waited until John saw his work building. Staff encouraged John to stay seated until the bus stopped. John and staff got off bus and went to John's work. John then went to his work area and began working. Staff stayed for another 15 minutes to make sure that John understood his tasks for the day.
- Specialized Medical Equipment and Drugs
 - Ordered approved weighted vest for participant from Adaptive Equipment provider.
 - Charges are for the actual device purchased and should match the approved authorization in IRIS.
 - Reoccurring charges will be entered as the frequency of billing occurs (i.e., one case note a month for a monthly subscription for a medication minder)
- Assistive Technology
 - Ordered approved iPad with Proloque2go communication app.
 - Charges are for the actual device purchased and should match the approved authorization in IRIS (i.e., one case note a month for a monthly subscription for an app to support independent living).

Examples of Non-Acceptable Case Notes

- Simply restating the service that was provided, such as only stating: "Residential Services" or "Day Services."
- Phone call with John.

- Went to the store.
- Copying and pasting one day's documentation onto the next.
- Missing elements of the required documentation, such as missing start and end time, missing individual providing the service, etc.

REIMBURSEMENT AND CLAIM INSTRUCTIONS

Timely Filing

Provider agrees to submit an initial bill for services within 30 days following the end of the month in which services were provided. If the provider cannot submit a bill within the 30-day timeframe, a written request for an extension of time must be provided to the State.

If a claim has not been received by the State, the State reserves the right to refuse payment.

An exception to this is when a provider is waiting for program/funding eligibility determination and billing cannot be made within 30 days. Valid adjustments and/or voiding of claims can continue to occur past the 30-day timeframe.

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 recipients 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 Consumer Service Authorization. Current service unit rates are available on the [South Dakota Medicaid's fee schedule webpage](#).

Reimbursement will be made for each participant enrolled in the program for whom there is documented training and provision of services according to the Individual Service Plan (ISP) as determined by the interdisciplinary team.

Claim Instructions

Services must be billed for in accordance with [ARSD Ch. 67:54](#). Detailed instructions for CHOICES Waiver Providers on how to complete the CMS 1500 Claim Form can be found on the [Department of Social Services website](#).

DEFINITIONS

1. Advocate,” any individual designated by a participant to support that participant by speaking or acting on the participant's behalf.
2. “Certification,” the department decision following procedures in chapter [46:11:02](#) which entitles an organization to receive government funds and provide services to participants.
3. “Community support provider (CSP),” a nonprofit provider of services as defined in SDCL subdivision [27B-1-17\(4\)](#).
4. “Department,” the Department of Human Services.
5. “Developmental disability,” a disability as defined by SDCL [27B-1-18](#).
6. “Division,” the Division of Developmental Disabilities, a division of the Department of Human Services.
7. “Family,” a person or a group of people who are related to the participant by blood, marriage, or adoption, or as defined by the participant as a family based upon bonds of affection. For the purposes of this subdivision, the phrase, bonds of affection, means enduring ties that do not depend on the existence of an economic relationship and the relationship is expected to endure over time.
8. “Group home,” a congregate residential facility, other than a supervised apartment, for individuals with developmental disabilities.
9. “Guardian,” as defined in SDCL subdivision [29A-5-102\(4\)](#).
10. “Individualized service plan (ISP),” a single plan for the provision of services and supports to the participant that is person centered, directed by the participant, oriented around personal outcomes measures, and is intended to specify all needed assessments, supports, and training.
11. “ISP team,” a team composed of the service coordinator, the participant, the participant's parent if the participant is under 18 years of age, or the participant's guardian, if any, and anyone else the participant desires.
12. “Participant,” a person receiving services or supports under the provisions of the CHOICES waiver.
13. “Community services provider or SP,” a for-profit or a not-for-profit provider of services, as defined in SDCL subdivision [27B-1-17\(4\)](#).
14. “Provider,” a CSP or a SP.

15. "Direct home and community-based services (direct HCB services)," Any waiver service provided by a CSP, SP, or a qualified provider in the community, except for case management.

REFERENCES

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