

Bulletin

September 25, 2006

Minnesota Department of Human Services □ P.O. Box 64941 □ St. Paul, MN 55164-0941

OF INTEREST TO

- County Directors
- Tribal Health Services Directors
- Social Services Supervisors and Staff
- Adult MH Initiatives Contacts
- ARMHS Providers
- ACT Providers
- Local MH Advisory Council Chairs
- SOS Regional Administrators

ACTION

Please read for information. ARMHS providers should implement changes in policies and procedures of service standards and reimbursement

EXPIRATION DATE

September 25, 2008

Medical Assistance Adult Rehabilitative Mental Health Services (ARMHS) Updates and Clarifications

TOPIC

Adult Rehabilitative Mental Health Services (ARMHS) updates and clarification of service standards and implementation.

PURPOSE

To inform counties, tribal authorities and ARMHS service providers of changes to and clarifications of services standards and reimbursement.

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SIGNED

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Chemical and Mental Health Services

Background

The 2001 Legislature authorized the expansion of Minnesota's Medicaid state plan to cover a broader array of rehabilitative services including adult rehabilitative mental health services (ARMHS).

The purpose of ARMHS is to provide mental health rehabilitative services to people with serious mental illness using evidence-based and best practices to foster recovery and self sufficiency by helping recipients reduce symptoms of mental illness and functional limitations and barriers related to mental illness, and to learn illness management and recovery skills.

ARMHS is consumer-driven and recovery-based. The services must have the flexibility and intensity to meet the rehabilitative services needs of individual recipients; and vary in frequency and intensity to respond to fluctuation in the course of the mental illness. Providers are required to address the "appropriate level of care" for each of their clients.

ARMHS measures success by the outcomes of recipients in meaningful, measurable domains such as community tenure, housing status, employment, social network strength, life skills and self sufficiency.

Eligibility for ARMHS services was expanded intentionally to include individuals recovering from serious mental illness, not just serious and persistent mental illness (SPMI) in order to increase access and to assist people sooner in the course of their illness. The State was also interested in increasing choice of providers across the state.

ARMHS services are covered under the Medicaid Rehabilitation Option. These services, including eligibility, covered services and definitions, provider standards and qualifications and reimbursement rates were submitted as an amendment to the Medicaid State Plan and approved by the Center for Medicare & Medicaid Services (CMS). This information is provided in both Chapter 16 of the Medicaid Provider Manual and in Minnesota Statutes, section 256B.0623. Providers of this service are expected to be knowledgeable about and adhere to the information contained in these documents.

It was recognized that not all services provided to recipients are considered medically necessary as defined by Medicaid but may nonetheless be critical to an individual's recovery process. To that end, the State retained Rule 78 funding to counties with the expectation that these funds would be used for services not covered under the ARMHS funding source or for individuals who were uninsured.

Legal Reference

Minnesota Statutes, section 256B.0623

Action Requested

ARMHS services providers are required to become familiar with these changes and clarifications; and to implement ARMHS services consistent with the content of this bulletin.

Topics/Questions and Answers

Additional Guidance on Services

1. Type and location of ARMHS services

ARMHS services must always be based on individual treatment plan services that must be medically necessary to address mental health rehabilitation needs of a specific individual. A provider entity should always be able to answer the following questions:

- What treatment is being provided to the individual recipient?
- What skill is being taught to the individual recipient, and how is this skill related to assessed limitations/functional needs that relate to the symptoms of the mental illness?
- Is this service helping the recipient to become more self-sufficient as demonstrated by measurable progress?; and
- How do these goals or skills relate to the given individual participant's treatment plan?

The enabling ARMHS legislation states that these services shall be provided on a one-to-one basis in the recipient's home or another community setting or in groups (except community intervention can not be provided in groups). The legislation further requires that services are to be provided for most recipients in the recipient's home and community. The law was based on research that suggests most individuals learn best individually and by practicing skills in real life situations rather than in settings where the recipient has to transfer the skills to real life settings.

In support of the research findings, the majority of ARMHS services must be provided individually, not in groups, and in the recipient's home and community. For clarity, this means the majority of billed recipient services time not the majority of ARMHS staff time. Provider entities who are not providing services in this way must revise their programs and service delivery focus.

For the purposes of this service, community is defined as settings where the recipient demonstrates skills with the over-arching goal of integration in the larger society. It does not mean settings where the recipient must go to receive ARMHS services like provider offices, drop-in centers, clubhouses, and classrooms. Although some providers have the view that for many recipients, the drop-in center, clubhouse or the provider's office is part of the individual recipient's community, this provider interpretation does not apply to ARMHS services. Consistent with sound clinical practice, it is expected that providers will be sensitive to and respectful of individuals' privacy. Discussion of personal history and other sensitive issues should not be discussed in public settings where the discussion can be overheard by others.

ARMHS groups should have specific topics (not general, all-purpose), be time-limited (not open-ended), and have specific session plans and skill training curriculum. These groups should not be confused with groups provided by day treatment. By definition, day treatment is a more intensive, site-based program that emphasizes group psychotherapy and is designed for individuals who require structured programming. Referral to ARMHS groups because the individual “needs to have his/her day structured” is NOT a clinically appropriate reason for the referral.

Whether delivered on a one-to-one basis or in a group setting, ARMHS services must always be based on an individual treatment plan where services are medically necessary to address the mental health rehabilitation needs of a specific individual. ARMHS services must be documented individually; not in group summary notes.

2. ARMHS medication education services

Minnesota Statutes, section 256B.0623 states:

“Adult rehabilitative mental health services instruct, assist, and support the recipient in areas such as: interpersonal communication skills, community resource utilization and integration skills, crisis assistance, relapse prevention skills, health care directives, budgeting and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills, transportation skills, **medication education** (emphasis added) and monitoring, mental illness symptom management skills, household management skills, employment-related skills, and transition to community living services.”

"Medication education services" means services provided individually or in groups that focus on educating the recipient about mental illness and symptoms; the role and effects of medications in treating symptoms of mental illness; and the side effects of medications. Medication education is coordinated with medication management services and does not duplicate it. Medication education services are provided by physicians, pharmacists, physician's assistants, or registered nurses.

To address medication education needs of recipients and to provide this service, a certified ARMHS provider entity must have physicians, pharmacists, physician's assistants, or registered nurses either on staff or under contract. A third new option is for the ARMHS provider entity to have a written, formal interagency agreement with a health service agency to provide a comparable service to medication education.

The contract or agreement shall address billing, reimbursement, records, releases, hours, assure individual and in-home services, and provisions for frequent coordination of services.

Like all ARMHS services, medication education services or health service agency services must have the capacity to be provided individually and in the recipient's home and community

as determined by the needs of recipient and outlined in the Individual Treatment Plan (ITP) or health service agency plan. Medication education services or health service agency services can not be provided only in groups or at provider sites.

Under the leadership of the ARMHS program, the staff providing medication education services for the ARMHS provider entity is responsible for the development of training, policies, procedures, documentation and forms for an education system for medication self-administration by program recipients; procedures for coordination with community psychiatric and medical services, including emergency medical services; and ongoing consultation to program staff as needed.

NOTE: Effective with the issuance of this bulletin:

All applications for ARMHS certification must include the name, license and license number and contact information of the person/s employed to provide medication education services or the signed contract or signed agreement to the DHS Mental Health Division for review and approval.

Since services provided through the third option of an interagency agreement for a similar home health service would not be billed as an ARMHS services, the ARMHS provider entity is required to track which and how many recipients receive services by this alternative method.

3. ARMHS services with employment and housing focus

ARMHS is a medical service, thus, the salient point about its use in employment or housing supports or any other community support venue is that it is used to remediate symptoms, teach illness management and recovery skills, and is tied to the functional limitations of the individual pursuant to a diagnosis of serious mental illness.

Medically necessary services are covered even if the provider is assisting the person with an employment goal. For example, if a person has social deficits due to schizophrenia, a provider might help the consumer plan for an interview, practice interview skills, accompany the person to the interview site to prompt them to interact, and talk with the person afterwards about strategies that worked, didn't work, etc. The services are helping the person use appropriate social skills in the community. It happens that the context was related to jobs. However, vocational services are not covered if the sole purpose of the service is taking the individual to a job interview. The service is neither rehabilitative nor medically necessary, and therefore is not covered.

The following are examples of other situations connected to employment in which ARMHS services are NOT billable:

- Helping a person who can't find a job due to a bad economy, felony history, not having transportation, and/or poor education. The intervention must be related to the symptoms of the mental illness.

- Specific job skills teaching. If an ARMHS provider wants to meet a person at the work site, it is advisable to step away from the person's work, and document that the person was not completing work tasks while the provider was talking/meeting.
- Job development without the person present.

In the area of housing, ARMHS services cannot be used to pay rent, security deposits, emergency shelter expenses, food, transportation or other commodities. ARMHS can be used if the individual is functionally impaired in an area that requires re-learning a skill - such as food preparation to order to live independently in the community.

4. Incorporating Illness Management and Recovery (IMR) to ARMHS Practice

It is the DHS/Mental Health Division's (MHD) goal to fully implement the evidence-based practice of Illness Management and Recovery into the practice patterns and skill sets of all ARMHS providers by 2009. The MHD understands that full implementation will require a partnership between ARMHS providers, counties and DHS to make this evidence-based practice available to recipients.

The MHD is currently piloting IMR in eight agencies across the state. The information learned from their efforts will determine the exact method DHS will use to add Illness Management and Recovery and its fidelity standards to the requirements for ARMHS. This new practice will add significantly to the requirements for basic knowledge, skills, abilities, and clinical supervision expected of providers of ARMHS. It is crucial that providers use the SAMHSA web site located at <http://www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/about.asp> to evaluate and plan for the changes and training that will be necessary to implement IMR consistent with fidelity standards. The MHD is also committed to providing training and technical assistance as providers incorporate this practice to their ARMHS service.

The MHD is also working on a set of clear definitions and descriptions of core competencies for all of the evidence-based practices. These are expected to be available in the fall of 2006. The definitions for these core competencies will assist the Mental Health Division and providers in making decisions about future training and the scope and content of clinical supervision.

Beginning in 2007, the monthly Adult Mental Health Core Training provided by the MHD will focus on topics relevant to the core competencies. Some of these training sessions should be seen as among the first steps in providing staff training. It is also each agency's and clinical supervisor's responsibility to ensure that their staff are adequately trained, are able to demonstrate appropriate skills, and are adequately supervised in order to meet Illness Management and Recovery fidelity standards.

5. Initial Engagement Period

The symptoms of serious mental illness and past negative experiences with the mental health system may contribute to some recipients' reluctance to "engage" in planning and accepting services. Sometimes, this necessitates multiple initial contacts to build trust and productive rapport between the recipient and provider.

The ARMHS provider should have referral information that describes goals, strengths and functional limitations of the recipient and how ARMHS services can be beneficial. If there are issues of trust and engagement, the provider might focus on one or two of these, and document small incremental steps that give evidence of progress, even if small, that are being achieved in the first contacts. The provider should document in detail if the "engagement" is going slowly because of what the provider believes may be symptoms (example – paranoia) of the mental illness of the recipient.

If the individual is refusing service, unwilling to engage in conversation or it is clear that they have no interest in the ARMHS services, the provider can not bill Medicaid for the service. The provider should consider discussions with the county of financial responsibility about access to other services.

6. Medical necessity criteria

Billable ARMHS services must be medically necessary. Some things such as providing transportation assistance and leisure/recreational activities are not medical services and are never covered.

Additional Guidance on Transportation

7. Medicaid "provider travel"

Medicaid covers provider travel time if a recipient's individual treatment plan requires the provision of mental health services outside of the provider's normal place of business (the majority of ARMHS services are expected to be provided outside the provider's office). This does not include any travel time which is included in other billable services and is only covered when the mental health service being provided to a recipient is covered under Medicaid.

Consider the following:

- ARMHS providers can bill for "provider travel" for traveling to and from seeing a recipient in the recipient's home or community (non-office/center service).
- Provider travel is billed by the individual minute; provider travel should not be "rounded up" or "rounded" into 5 or 10 minute units.
- The provider must provide a Medicaid eligible face-to-face covered service, included in the Individual Treatment Plan, to bill for provider travel.

- Travel time to and from a “no show” appointment with a recipient is not billable.
- Provider travel is NOT an ARMHS service; it is a distinct MA reimbursable activity (see Minnesota Health Care Provider Manual).
- Provider travel is NOT for transporting recipients.
- Provider travel to an individual recipient’s home/community and the provided ARMHS service should be billed on same claim. If the provider did not provide a billable ARMHS service, provider travel time can NOT be billed.

Provider Travel Vignette: During his work shift, ARMHS staff person Joe has five appointments with ARMHS recipients at their homes – 8:30 with recipient Mary; 10:00 with recipient Lou; 12:45 with recipient Glen; and 2:30 with recipient Josephine; and planned a short appointment at 4 pm with Fran. Joe leaves the ARMHS office at 8:12 to drive to Mary’s and it takes him 16 minutes (note: travel time is not the same as the “appointment time”). After the appointment with Mary, Joe drives to his next appointment with Lou which takes 12 minutes. Joe stops for a brief lunch in route to his third appointment with Glen – Joe bills for the time it takes to travel directly from Lou’s to Glen’s – 27 minutes – Joe does not bill for any of the travel time for going off the direct route to stop at the restaurant for lunch. After seeing Glen, Joe travels to Josephine’s which takes 14 minutes. However, Josephine is not at home – a “no show”. Joe can not bill for travel time to Josephine’s (billing travel time for “no shows” is prohibited). Joe calls Fran to see if he could stop by early since Joe’s time is freed up because of the no show. Joe travels to Fran’s which takes about 15 minutes. However, Joe bills for travel time for what would have been for the direct route and time from Glen’s to Fran’s – which would be 20 minutes. After completing the appointment with Fran, Joe drives back to the office. He bills travel time to Fran’s account for the travel time back to the office – 18 minutes.

(Please see Attachment A for diagram)

To review, Joe bills 93 minutes of provider travel time for this day:

- 16 minutes from office to Mary’s – bill to Mary’s claim as “provider travel” – not ARMHS
- 12 minutes from Mary’s to Lou’s – Lou’s claim
- 27 minutes from Lou’s to Glen’s (partial estimate of direct travel time because of exclusion of detour time to have lunch at a restaurant) – Glen’s claim
- No provider travel time or ARMHS time is billed to Josephine’s claim because Josephine was a “no show”
- 20 minutes for Joe’s best estimate of the direct travel time from Glen’s to Fran’s (as if Joe had not experienced the no show with Josephine, and had traveled directly from Glen’s to Fran’s) – Fran’s claim
- 18 minutes back to the office from Fran’s – to Fran’s claim, too. It would also be an acceptable billing method to equally split the “time driving back to the office” across all recipients seen that day (excluding “no shows”).

8. Can ARMHS services be billed while transporting a recipient?

ARMHS providers can NOT bill for transporting a recipient somewhere. ARMHS is not a transportation service. However, if the ARMHS provider is providing a planned ARMHS service that is medically necessary, written in the ITP, and the planned service happens to be in the provider's car with the recipient, the portion of time where legitimate rehabilitation services are provided is billable (because an ARMHS service is being provided). Idle or non-goal specific time is considered transporting the recipient, and is not billable. The goal/objective, planned services provided, recipient progress/reaction to services should be documented in the recipient's case file in the same way that other ARMHS services are documented. The planned services must be time-limited and focus on teaching the recipient self-sufficiency. Plans to accompany recipients to medical appointments, community outings, grocery shopping, etc. are not billable services.

If transporting a recipient to a health service, the transportation MAY in some situations be reimbursed by the county. It is the provider's responsibility to contact the county. In those instances where an ARMHS recipient needs non-medically necessary transportation assistance, the ARMHS provider may contact the recipient's county of financial responsibility to determine if the county provides transportation services or might reimburse the ARMHS provider for transporting a recipient.

Medicaid can only be billed for transporting recipients if the provider is an enrolled medical transport provider and the recipient is receiving a Medicaid covered service. This is billed as a separate service and uses a distinct code. In the metro area, these services are generally provided through the Minnesota Non-Emergency Medical Transportation (MNET) program (651-645-3982).

If you are interested in learning more about how to become a medical transportation provider, please contact John Kowalczyk at 651-431-2485.

Transportation skills are one of the areas that ARMHS providers can focus on when teaching individual recipients to be more self-sufficient. Teaching the recipient transportation skills, such as learning to ride public transportation, must be medically necessary and based on the functional limitations of the recipient due to the symptoms of the serious mental illness. (MN Statutes, section 256B.0623 Subd. 13. (1).

Guidance on Coordination of ARMHS Services

9. Coordination when more than one ARMHS provider is involved or when county is providing services

In some instances, recipients of ARMHS services can receive ARMHS services from more than one provider. This is in keeping with the federal mandate and DHS' philosophy to assure free choice of provider for consumers, and to foster greater self-direction for people

seeking services. However, coordination of care is also a critically important clinical standard and the use of multiple providers at the same time can threaten the delivery of clear, unified services.

Examples of appropriate use of two providers include:

- An individual transitioning from one level of care to another or one provider to another in order to provide continuity; and
- A recipient may choose to work with different agencies at the same time for different goals, or different skill sets.

The hallmark of appropriateness of more than one provider is effective coordination and planfulness about why such an arrangement serves the recipient's goals and is medically necessary.

ARMHS providers are responsible for identifying health care, social services, and other significant services providers of each recipient; and seeking releases of information authorizing coordination of services and coordinating actively with other providers.

Consistent with sound clinical practice, if a recipient currently receiving ARMHS services is seeking services from a second ARMHS provider, the second ARMHS provider needs to explain to the recipient that coordination is important to provide effective services and to avoid service redundancy. Prior to initiating services, the second ARMHS provider must seek releases of information and coordinate services with the current ARMHS provider.

Multiple providers working on common goals create redundancy of efforts. This is not reimbursable under Medicaid. To assure that duplication of services is not occurring the DHS Mental Health Division will be scrutinizing billings by multiple providers to a single ARMHS recipient and intervening as needed. Counties also have the option of withdrawing local certification or not locally recertifying an ARMHS provider if there is a lack of demonstrated service coordination.

Counties have the authority under the local certification process to require an ARMHS provider (or multiple ARMHS providers with a common recipient client) serving a consumer who is also receiving mental health services from the county to develop a single integrated ITP/case management plan.

10. Provision of ARMHS services by board and lodge, or adult foster care providers.

Any services provided by a hospital, board and lodge, or residential facility to an individual who is a patient in or resident of that facility are not covered under ARMHS. This language was added to the legislation to separate the role of the residential facility provider from the role of the provider of ARMHS services.

ARMHS services can be provided to eligible residents in a board and lodge (B&L) or adult foster care (AFC) settings. However, if the B&L or AFC provider/operator wishes to provide ARMHS, current law requires that the ARMHS program is a separate provider program from the B&L/AFC residential facility operator.

It is understood that some organizations run multiple service programs and operate residential facilities. If the same organization that runs a B&L/AFC is also an ARMHS provider, the following is required:

- The ARMHS program must be a distinct program within the organization; this should be reflected in the organizational chart that the ARMHS program is distinct. This does not mean that the ARMHS program must be separately legally incorporated from the larger organization (or have a separate EID number);
- ARMHS staff can not be assigned to work shifts or coverage at the B&L/AFC – they are not residential facility staff and the ARMHS staff are not there to supervise residents;
- ARMHS services are medically necessary services to enable recipients to achieve and maintain independence and self-sufficiency and community integration. The majority of ARMHS services should be individual and in the community;
- ARMHS services do not replace the responsibilities of B&L and AFC providers;
- Coordination between B&L/AFC staff and ARMHS staff must be authorized by the recipient and releases of information in place;
- Recipients have the right to choose their ARMHS provider – the organization can not require recipient residents to choose the organization's own ARMHS services; nor can the ARMHS provider require recipients to live at a specific B&L/AFC; and
- ARMHS eligible recipients have the right to refuse ARMHS services.

Additional Guidance on Documentation of ARMHS Services

11. Documentation of services

Providers of ARMHS services should refer to the documentation standards in the MHCP Manual, MHCP provider updates, DHS Bulletins, Rule 47, ARMHS legislation and Center for Medicare and Medicaid Services federal standards as sources for documentation requirements and standards. At the most basic level, there should be a clear relationship between the mental illness symptoms, functional limitations due to symptoms and illness, medical necessity of services, the Individual Treatment Plan, goals and progress notes. Documentation should clearly state the treatment services provided and recipient progress toward accomplishing mutually determined goals of the recipient and provider. ARMHS services must be delivered and documented according to these standards.

ARMHS provider entities must meet the standard that ensures that mental health professionals, mental health practitioners, and mental health rehabilitation workers are skilled in the delivery of the specific adult rehabilitative mental health services provided to the individual eligible

recipient. ARMHS provider entities have provided signed assurances that the provider entity agrees to maintain all necessary records required by federal and state laws, rules and policies; and provide services consistent with all applicable federal and state laws and regulations.

ARMHS provider entities are responsible to train staff (employed directly or subcontracted) to assure knowledge and skills in provision and documentation of services. The ARMHS clinical supervisor is responsible for the clinical supervision of ARMHS services planned and provided, determination that services are medically necessary, that services are effective and reviewed and documented, and that staff are competent to provide and document services. ARMHS providers are strongly encouraged to have internal compliance monitoring systems that include documentation review within their agencies.

12. Update of Individual Treatment Plans (ITP)

It should be noted that the six month requirement to update Individual Treatment Plans (ITP) is the **minimum** standard. It is expected that ITP's will be updated whenever there is a significant change in the recipient's situation or functioning, change in services or employed service methods and/or at the request of the recipient or his/her legal guardian. This is consistent with a consumer-driven and recovery-based approach to service delivery.

Additional Guidance on Eligibility for Medicaid Rehabilitation Services

13. ARMHS Eligibility

The following criteria must be used when determining if an individual is eligible to receive ARMHS:

1. The individual is age 18 or older; is diagnosed with a medical condition such as mental illness, for which adult rehabilitative mental health services are needed; has substantial disability and functional impairment in three or more areas so that self sufficiency is markedly reduced and has had a recent diagnostic assessment by a qualified professional that indicates ARMHS services are medically necessary.
2. The focus of the services is in regaining or restoring lost capabilities as a result of the onset of a mental disorder.
3. The individual has the cognitive capacity to benefit from rehabilitative services techniques and methods.

It is the responsibility of the service provider to determine eligibility based on the three criteria above - hence, the importance of comprehensive diagnostic and functional assessments to determine eligibility, medical necessity and appropriateness of rehabilitation services. If this distinction can not be documented, do not bill for ARMHS.

Additional Guidance on ARMHS Reimbursement

14. Reminder of changes to ARMHS thresholds for hours of services

As of 4/1/06, the 260-hour per “rolling” 6-month period authorization threshold for basic social and living skills is eliminated. The calendar year threshold of 300 hours is unchanged. This was communicated previously in a RA message to Minnesota health care providers.

15. Billing for multiple brief contacts on the same day

The unit of ARMHS services for billing is 15 minutes. If on the same day, face-to-face contact occurs in very brief intervals (e.g., 5-8 minutes or less) due to the nature of the treatment, the provider may bill for one unit of basic living skills when the total face-to face-time is at least 11 minutes. This assumes the provider needs at least four minutes to document the contact time without the recipient.

Example: Ima, rehab worker, is working with a client on a skill that requires brief periodic face-to-face contacts, each followed by documenting progress and other client-related activity. Ima spends 15 minutes discussing with her client the work and anticipated outcome required for skill development. Ima returns to the client an hour later and spends five minutes exploring the client’s progress and documents appropriately. Ima returns an hour later to repeat the process, spending another four minutes face- to- face and repeats this activity once more spending three minutes face- to- face with the client followed by appropriate documentation. Ima then spends a half hour face-to-face at the end of the day to review with the recipient the skills being practiced, and progress made on the goal over the course of the day, and recipient homework for the next appointment.

- Total billable basic/social skills time for the day in example = 4 units (1 hour)
 - 1 unit for initial 15 minute face-to-face time;
 - 1 unit for face/face intervals: 5minutes + 4 minutes + 3 minutes = 12 minutes face-to-face and 4 minutes for client-related activities documenting; and
 - 2 units for half hour spent at end of day for face-to-face.
- = 4 units for the day.

16. Billing of two or more services at the same time are prohibited

Medicaid prohibits (with very limited exceptions) the billing of two services at the same time. This is based on the concept that a recipient can not benefit fully from simultaneous services. For example, an ARMHS provider is asked by the recipient or the recipient’s psychiatrist to

attend the recipient’s psychiatric appointment to add information and suggestions. The ARMHS provider can **not** bill for the time committed to the appointment because the time is being billed as a psychiatric appointment.

Two potential exceptions include:

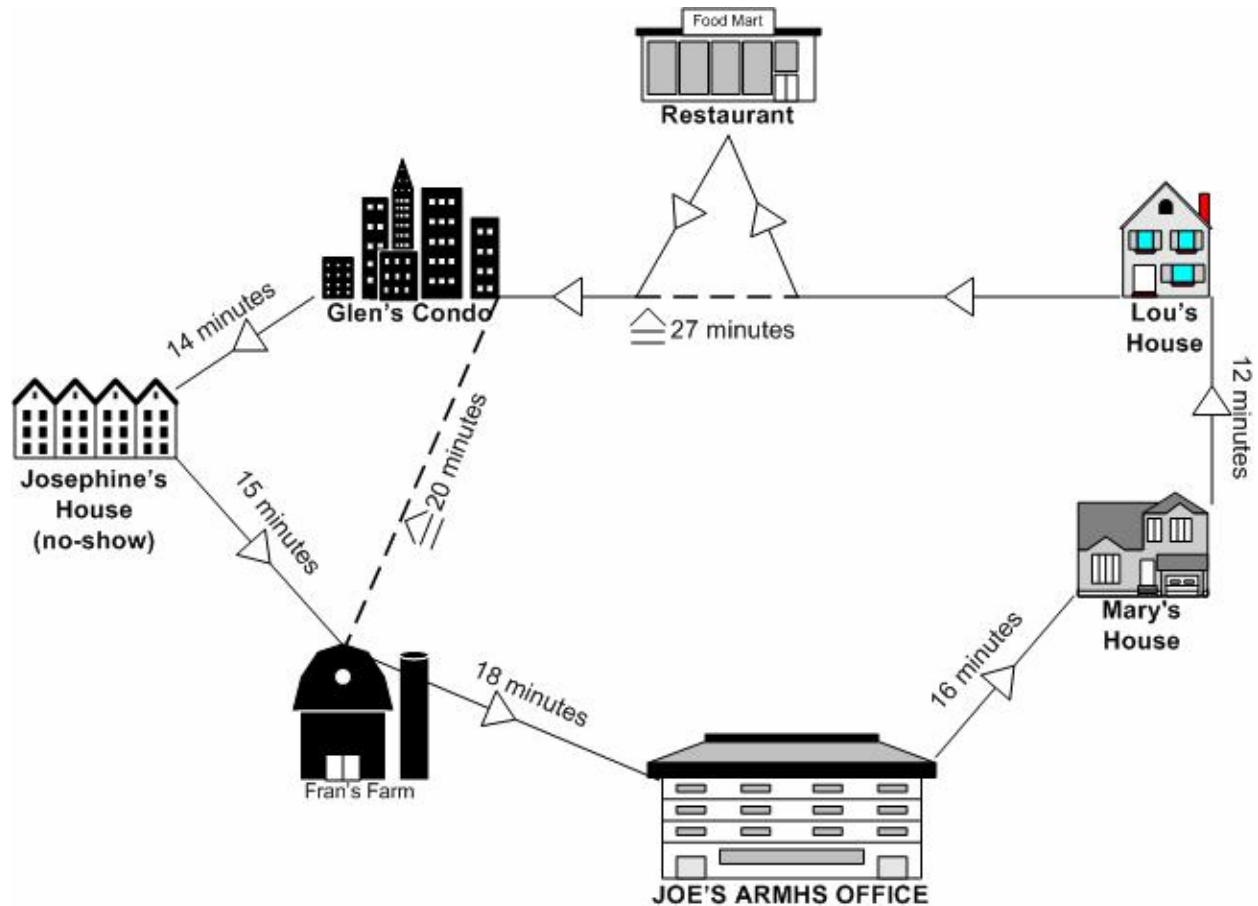
- Extraordinary skills training services when it is absolutely essential to have two staff participate with the individual recipient. This must be brief in terms of planned frequency and documented in detail as to why two staff participating is essential to obtaining the recipient's skill objective; and
- Unusual situations where there may be considerations of the personal safety of the staff going into the recipient's home. Again, this should be infrequent (generally during the assessment and building rapport phase) and documented in detail as to the necessity.

Special Needs

This information is available in other forms to people with disabilities by contacting us at 651-431-2225 (voice), or through the Minnesota Relay Service at 1-800-627-3529 (TDD), 7-1-1 or 1-877-627-3848 (speech to speech relay service).

ATTACHMENT

Additional Guidance on Transportation: Topic #7. Medicaid
“provider travel” vignette diagram



Legend



Joe's driving
direction & real time
travel



Estimate of travel
time