MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

February 25, 2020

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CODY L. PHINNEY, DEPUTY ADMINISTRATOR

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1800 – ADULT DAY HEALTH CARE

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 1800 – Adult Day Health Care (ADHC) are being proposed to encompass all 1915(i) services in one MSM. Changing the name of MSM 1800 – Adult Day Health Care to 1915(i) – Home and Community Based State Plan Option Adult Day Health Care and Habilitation Services. Addition of federal regulations to become in compliance and necessary changes to be aligned with concurrent state plan amendment changes. Throughout, language specific to Adult Day Health Care were replaced with general 1915(i) requirements and the ADHC service was moved further in the chapter with the addition of two other 1915(i) services combined from MSM 2400.

Throughout the chapter, grammar, punctuation and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and rearranging of sections was necessary.

Entities Financially Affected: None.

Financial Impact on Local Government: None.

These changes are effective March 1, 2020.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
OL 01/22/20 CHAPTER 1800 – ADULT DAY HEALTH CARE	MTL 15/12, 18/13 CHAPTER 1800 – ADULT DAY HEALTH CARE

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1800	**INTRODUCTION**	Deleted language related to Adult Day Health Care. Language added regarding "Section 1915(i) of the Social Security Act (SSA) and

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		eligibility differences between 1915(c) waivers. Language was updated and/or reworded for improved readability and clarity.
1801	**AUTHORITY**	Moved language related to ADHC from this section. Added language regarding Section 1915(i) of the Social Security Act "(1)(a) through (j)." Added new language for Code of Federal Regulations (CFR) "42 CFR 441.710; 441.715, 441.720, 441.725 and 441.730."
1803.1	**ADULT DAY HEALTH CARE (ADHC) SERVICES**	Renamed to "NEEDS-BASED ELIGIBLITY CRITERIA." Added language regarding criteria for needs-based eligibility and whom conducts the eligibility determinations.
1803.1(A)(1)	**COVERAGE AND LIMITATIONS**	Replaced "Eligible Recipients" with "Program Eligibility." Removed reference to "Physician's Evaluation." Removed language for "Eligible Providers" and moved language for "Transportation."
1803.1(A)(2)	**COVERED SERVICES**	Added new section for "Covered Services" and defined services as "Adult Day Health Care, Day Habilitation and Residential Habilitation."
1803.1(A)(3)	**NON-COVERED SERVICES**	Added new section for "Non-Covered Services" and language was updated and/or reworded for improved for readability and clarity.
1803.1(B)	**PROVIDER RESPONSIBILITIES**	Replaced subsection title "Medicaid Contract Requirements" with "Provider Qualifications." Added subsections and language related to "Medicaid Eligibility," "Direct Marketing" and "Serious Occurrence Reports." Language moved to this section regarding "HIPAA, Privacy and Confidentiality," "Service Plan" and "Training Requirements." Removed language related to "Criminal Background Checks," "Tuberculosis Testing," language was updated and/or reworded for improved readability and clarity.
1803.4	**RECIPIENT RESPONSIBILITIES**	Added language regarding individuals receiving 1915(i) services are "entitled to privacy, to be treated with respect and free

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		from coercion and restraint." Additional language included that recipients or a designated representative must adhere to certain requirements.
1803.5	**ADHC SERVICES**	Moved language from previous Section 1803.1 to this section.
1803.5(A)	**COVERAGE AND LIMITATIONS**	Added new section title "COVERAGE AND LIMITATIONS" and included language moved from Section 1803.1.
1803.5(B)	**PROVIDER RESPONSIBILITIES**	Added new section "Provider Responsibilities" including subsection for "Provider Qualifications" for ADHC services. Added language regarding experience working with "individuals with a history of aggressive behavior" under Staffing Requirements. Deleted language for "Physician Evaluation" and "Universal Needs Assessment." Moved Service Plan to Section 1803.1B. Deleted language regarding "Plan of Care." Clarified language under "Attendance Record and Nursing Notes." Deleted language for "Employee Record Requirements," "Recipient Record Requirements," "Confidentiality and Release of Recipient Records" and "Provider Liability." Moved language for "NOTIFICATION OF SUSPECTED ABUSE AND NEGLECT" and "HIPAA, PRIVACY AND CONFIDENTIALITY." Deleted language for "RECIPIENT RESPONSIBILITIES."
1803.6	**DAY HABILITATION**	Added new section for "Day Habilitation" services explaining the services included.
1803.6(A)	**COVERAGE AND LIMITATIONS**	New section with language that Day Habilitation Services are targeted to individuals with a Traumatic Brain Injury (TBI) or Acquired Brain Injury (ABI).
1803.6(B)	**PROVIDER RESPONSIBILITIES**	Added new section "Provider Responsibilities" including subsection for "Provider Qualifications" and "Attendance Records and Daily Logs" for Day Habilitation services.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1803.7	**RESIDENTIAL HABILITATION**	Added new section for "Residential Habilitation" services explaining the services included.
1803.7(A)	**COVERAGE AND LIMITATIONS**	New section with language for Residential Habilitation Services are targeted to individuals with a Traumatic Brain Injury (TBI) or Acquired Brain Injury (ABI).
1803.7(B)	**PROVIDER RESPONSIBILITIES**	Added new section "Provider Responsibilities" including subsection for "Provider Qualifications" for Residential Habilitation services.
1803.8	**INTAKE AND ONGOING PROCOEDURES**	Added new section and language for Intake and Ongoing Procedures. New subsections for "Referral" including process for applying for 1915(i) services, subsection "Person-Centered Plan of Care" detailing the process for developing a Person-Centered Plan of Care and subsection "Ongoing Procedures" detailing process for retaining services.
1803.1E	**PRIOR AUTHORIZATION AND BILLING**	Deleted language regarding "Prior Authorization Procedure" and "Provider Billing."
1803.09	**TERMINATION OF 1915(i) SERVICES**	New section added with language regarding the "Termination of 1915(i) Services" including details on the basis for denials to terminate from 1915(i) services.
1804	**RATES AND REIMBURSMENT**	Added new section for "Rates and Reimbursement" and reference to billing guide and reimbursement code.
1805	**QUALITY ASSURANCE**	Renumbered to 1805 from 1804 and clarified language. Removed language referring to ADHC and provider reviews. Updated language to referral to "Quality Improvement Strategy outlined in the 1915(i) HCBS State Plan." Language was updated and /or reworded for improved readability and clarify.
1806	**TRANSPORTATION**	Renumbered and moved section from

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		1803.1A(3) to this new section. Language was updated and /or reworded for improved readability and clarify.
1807	**HEARINGS**	Renumbered and language was updated and/or reworded for improved readability and clarity.

1800 INTRODUCTION

~~ADULT DAY HEALTH CARE (ADHC)~~Under Section 1915(i) of the Social Security Act (SSA) states can provide Home and Community-Based Services (HCBS) to individuals who require less than institutional level of care and therefore would otherwise not be eligible for such services through an 1915(c) HCBS Waiver.

Specifically, Section 1915(i) of the Act allows the Nevada Division of Health Care Financing and Policy (DHCFP) to provide State Plan HCBS similar to that of a 1915(c) HCBS Waiver using a needs-based eligibility criterion rather than an institutional level of care criteria. Additionally, a 1915(i) HCBS State Plan Option has no cost neutrality requirement as required under a 1915(c) HCBS Waiver. This significant distinction affords the Nevada DHCFP the opportunity to offer HCBS to recipients whose needs are substantial, but are not severe enough to qualify them for institutional or waiver services.

~~Nevada Medicaid reimburses for ADHC services that include health and social services recommended by a physician to ensure the optimal functioning of the recipient.~~

~~The goals of ADHC services are:~~

~~a. to safeguard the recipient's safety and well being and maintain and/or enhance his/her quality of life; and~~

~~b. to improve and maintain the recipient's level of functioning or to lessen any decline in functioning due to disease and/or the aging process.~~

~~All providers participating in the Nevada Medicaid program must offer services in accordance with the rules and regulations of the Medicaid program.~~

1801 AUTHORITY

~~Adult Day Health Care (ADHC) Services is an optional Medicaid State Plan Service and is authorized under State Plan authority titled "Nevada 1915(i) State Plan Home and Community-Based Services (HCBS)". The State Plan was amended in 2008 in response to the~~ Section 6086 of the Deficit Reduction Act, added Section 1915(i) to the SSA, ~~Section 6086. Congress amended the Social Security Act with Section 1915(i)~~ allowing states the option to offer home and community-based services previously only available through a ~~to provide~~ traditional 1915(c) ~~services~~ Waiver.~~as covered State Plan benefits. ADHC was covered under Nevada's State Plan.~~

Statutes and Regulations:

- Social Security Act: 1915(i) (1)(a) through (j)
- Code of Federal Regulations (CFR)
  - 42 CFR 441.710 State Plan Home and Community-Based Services under Section 1915(i)(1) of the Act
  - 42 CFR 441.715 Needs-Based Criteria and Evaluation
  - 42 CFR 441. 720 Independent Assessment
  - 42 CFR 441.725 Person-Centered Service Plan
  - 42 CFR 441.730 Provider Qualifications
- Nevada Revised Statutes (NRS) Chapter 449
- Nevada Administrative Code (NAC) Chapter 449

1802 RESERVED

1803 POLICY

1803.1 ~~ADULT DAY HEALTH CARE (ADHC) SERVICES~~ NEEDS-BASED ELIGIBILTIY CRITERIA

The DHCFP 1915(i) Home and Community-Based Services (HCBS) State Plan Option utilizes a needs-based criteria to evaluate and reevaluate whether an individual is eligible for services. The criteria considers the individual's support needs and risk factors.

In order to be eligible, a recipient must need assistance or prompting in at least two Activities of Daily Living (ADL) which includes bathing, dressing, grooming, toileting, transfer, mobility, eating and must also have one of the following risk factors:

1. At risk of social isolation due to lack of family or social supports;

2. At risk of a chronic medical condition being exacerbated if not supervised by a registered nurse; or

3. A history of aggressive behavior if not supervised or if medication is not administered by a registered nurse.

The DHCFP Health Care Coordinator (HCC) conducts the needs-based eligibility determinations.

~~ADHC Facilities provide medical services on a regularly scheduled basis as specified in the Service Plan. Services include health and social services needed to ensure the optimal functioning of the participant. Services are generally furnished in four or more hours per day on a regularly scheduled basis. The schedule may be modified as specified in the service plan. Services must take place in a community-based setting and not an institutional setting. Services provided by the appropriate professional staff include the following:~~

~~nursing services to include assessment, care planning, treatment and medication administration, evaluation and supervision of direct care staff;~~

~~restorative therapy and care;~~

~~nutritional assessment and planning;~~

~~care coordination to assist the recipient and family to access services needed by the recipient to maintain or improve their level of functioning or to minimize a decline in the level of functioning due to the progression of a disease or other condition that may not be remedied;~~

~~recipient training in Activities of Daily Living (ADLs);~~

~~medical supervision and assistance to assure the recipient's well-being and that care is appropriate to meet the recipient's needs;~~

~~social and recreational activities to enhance the recipient's functioning and/or to maintain or improve the recipient's quality of life; and~~

~~meals provided as a part of these services shall not constitute a "full regimen" which is three meals per day.~~

1803.1A COVERAGE AND LIMITATIONS

1. PROGRAM ELIGIBILITY ~~RECIPIENTS~~

a. ~~The~~ An individual must meet and maintain~~be~~ Medicaid eligibility~~e~~.

b. ~~The~~ An individual must be 18 years of age or older.

c. ~~The~~ An individual must meet the needs-based eligibility requirements. ~~of the "1915(i) Home and Community-Based Services (HCBS) Universal Needs Assessment Tool" or must qualify for a 1915(c) waiver.~~

~~d. The individual must obtain a Physician's Evaluation identifying the services needed during the time they are present in the facility.~~

~~e.~~d. The individual must reside in the community.

~~An individual is not eligible if they receive Adult Day Care as a waiver service under the Home and Community-Based Waiver (HCBW) for the Frail Elderly.~~

2. COVERED SERVICES

a. Adult Day Health Care.

b. Day habilitation-targeted to individuals with Traumatic Brian Injury (TBI) or Acquired Brain Injury (ABI).

c. Residential Habilitation-targeted to individuals with Traumatic Brian Injury (TBI) or Acquired Brain Injury (ABI).

3. NON-COVERED SERVICES

The following services are not covered benefits under the 1915(i) HCBS State Plan Option and are therefore not reimbursable:

a. Services provided to an individual who is not eligible for Nevada Medicaid.

b. Services rendered to a recipient who no longer meets the needs-based eligibility criteria.

c. Services rendered to a recipient who is no longer in the community setting but is institutionalized (hospital, nursing facility, correction, or Intermediate Care Facility (ICF) for intellectual or developmental disabilities).

d. For Adult Day Health Care (ADHC), a recipient who resides in a residential setting such as group home, assisted living or other type of residential facility where a per diem rate is paid for 24-hour care is not eligible for ADHC services.

~~a.~~e. For Day Habilitation or Residential Habilitation, services provided to an individual who does not have a TBI or ABI diagnosis.

~~An individual who is a resident of a State licensed facility, i.e., Group Care, Assisted Living, or other type of residential facility where a daily all inclusive rate is paid to the facility during the course of a covered Medicaid stay may not receive Medicaid reimbursement for ADHC services. This facility daily all inclusive rate includes services such as, but not limited to: nursing services, dietary services, activity programs, medically related social services, active treatment program and day training programs which are services similar to ADHC.~~

~~State plan ADHC must not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local and private entities. For ADHC services, the State includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.~~

~~2. ELIGIBLE PROVIDERS~~

~~ADHC facilities may receive reimbursement from Medicaid for the care and treatment of eligible persons as described if they are licensed and maintain licensure as an ADHC Facility by the Bureau of Health Care Quality and Compliance (HCQC). Providers must~~

~~maintain compliance with the criteria set forth in this Chapter, Chapter 100 of the Medicaid Services Manual (MSM) and maintain a current Medicaid Provider Agreement.~~

~~3. TRANSPORTATION~~

~~Refer to MSM Chapter 1900, Transportation Services, for requirements of the Division of Health Care Financing and Policy (DHCFP) medical transportation program. Medicaid may reimburse for necessary and essential medical transportation to and from medical providers~~.

1803.1B PROVIDER RESPONSIBILITIES

1. ~~MEDICAID CONTRACT REQUIREMENTS~~PROVIDER QUALIFICATIONS

In addition to this chapter, providers must also comply with rules and regulations for providers as set forth in the MSM Chapter 100. Each 1915(i) service outlines specific provider qualifications which must be adhered to in order to render that 1915(i) service.

2. MEDICAID ELIGIBLITY

All providers must verify each month continued Medicaid eligibility for each recipient. This can be accomplished by utilizing the electronic verification system (EVS) or contacting the eligibility staff at the welfare office hot line. Verification of Medicaid eligibility is the sole responsibility of the provider.

3. DIRECT MARKETING

Providers shall not engage in any unsolicited direct marketing practices with any current or potential Medicaid 1915(i) recipient. Providers may not, directly or indirectly, engage in door-to-door, telephone, direct mail, email or other type of cold-call marketing activities. All marketing activities must be limited to the general education about the benefits of 1915(i) services.

Marketing material must be accurate and not mislead, confuse, defraud current or potential recipients. Statements considered inaccurate, false or misleading include, but are not limited to, any assertion or statement that:

a. The recipient must enroll with a specific provider in order to obtain benefits or in order to not lose benefits; or

b. The provider is endorsed, certified or licensed by the DHCFP.

Additionally, compensation or incentive of any kind which encourage a recipient to transfer from one provider to another is strictly prohibited.

4.~~13~~. HIPAA, PRIVACY AND CONFIDENTIALITY

Refer to MSM Chapter 100 for information on HIPAA, privacy and confidentiality of recipient records and other Protected Health Information (PHI).

5. NOTIFICATION OF SUSPECTED ABUSE OR NEGLECT

State law requires that persons employed in certain capacities must make a report to the appropriate agency immediately, but in no event later than 24 hours after there is reason to suspect abuse or neglect. The DHCFP expects that all providers be in compliance with the intent of all applicable laws.

~~For adults aged 60 and over, t~~The Aging and Disability Services Division (ADSD) accepts reports of suspected abuse, neglect or self-neglect, exploitation or isolation. Refer to NRS 200.5091 to 200.50995 regarding elder abuse or neglect.

~~For all other individuals or vulnerable persons (NRS 200.5091 to 200.50995) contact law enforcement agencies. Individuals or vulnerable persons are defined as a person 18 years of age or older who:~~

~~suffers from a condition of physical or mental incapacitation because of a developmental disability, organic brain damage or mental illness; or~~

~~a. has one or more physical or mental limitations that restrict the ability of the person to perform the normal ADLs contact local law enforcement agencies.~~

6. SERIOUS OCCURRENCE REPORTS (SORS)

Providers must report any recipient incidents, or issues regarding the provider/employee's ability to deliver services. The 1915(i) Health Care Coordinator must be notified of serious occurrences within 24 hours of discovery. Providers must complete the web-based Nevada DHCFP SOR Form; this form is available at www.medicaid.nv.gov under Provider Forms. A completed SOR must be made by a provider within five business days and maintained in the provider's recipient record.

Serious occurrences involving either the provider, employee or recipient may include, but are not limited to the following:

a. Suspected physical or verbal abuse;

b. Unplanned hospitalization;

c. Neglect, exploitation or isolation of the recipient;

d. Theft;

e. Sexual harassment or sexual abuse;

f. Injuries requiring medical intervention;

g. An unsafe working environment;

h. Any event which is reported to Adult Protective Services or law enforcement agencies;

i. Death of the recipient during the rendering of 1915(i) services;

j. Loss of contact with the recipient for three consecutive scheduled days; or

k. Medication errors resulting in injury, hospitalization, medical treatment or death.

7. SERVICE PLAN

A service plan must be completed within 30 days of the recipient beginning services. ~~and submitted as part of the prior authorization process. The service plan requires pre-approval by the QIO-like vendor prior to authorizing services and must include the description of services, amount of time (hourly, daily, weekly) and the title of the staff that will be providing the specific services within the ADHC facility.~~

The service plan is developed by the ADHC provider using the ~~completed~~ 1915(i) HCBS Plan of Care (POC) and includes the identified needs from the POC. ~~Universal Needs Assessment Tool and the Physician Evaluation Form, in conjunction with the recipient and/or recipient's legal representative.~~The service plan must include the description of services and amount of time (hourly, daily, weekly).

The provider must also ensure the recipient, or the recipient's ~~legal~~ designated representative, is fully involved in the treatment planning process which is ~~and choice of providers. Recipient, family (when appropriate) and/or legal representative participation in service planning must be~~ documented on the ~~s~~Service ~~p~~Plan.

~~The service plan must include a written statement that the recipient was offered a choice of ADHC providers and must be kept in a file maintained for the recipient. Additionally, the DHCFP must review a representative sample of participant service plans each year.~~

~~The service plan must include the identified needs from the Universal Needs Assessment and the Physician Evaluation.~~

The recipient must provide a signature on the ~~s~~Service ~~p~~Plan. If the recipient is unable to provide a signature due to cognitive and/or physical limitation, this must be clearly documented in the recipient file. A ~~legal~~ designated representative may sign for the recipient.

The ~~facility~~provider may create a signature page which can encompass a recipient signature for the ~~s~~Service ~~p~~Plan~~,~~ ~~the POC~~ and any other signature requirements. If the ~~facility~~provider uses a signature page, it must be included in the ~~packet~~recipient file. ~~to the QIO-like vendor for prior authorization.~~

8. TRAINING~~raining~~ REQUIREMENTS~~equirements~~

All employees must participate in a program of general orientation and must receive training on a regular basis, but not less than 12 hours per year.

General orientation training includes, but is not limited to:

a. policies, procedures and expectations of ~~the agency relevant to the~~ the provider, including recipient~~'s~~ and provider~~'s~~ rights and responsibilities;

b. record keeping and reporting including daily records and attendance records;

c. interpersonal and communication skills and appropriate attitudes for working effectively with recipients including:

   i. understanding care goals;

   ii. respecting recipient rights and needs;

d. respect for age, cultural and ethnic differences;

e. recognizing family relationships;

f. confidentiality;

g. respecting personal property;

h. ethics in dealing with the recipient, family and other providers;

i. handling conflict and complaints; and

j. other topics as relevant.

NOTE: At least one employee trained to administer first aid and cardiopulmonary resuscitation (CPR) must be on the premises at all times.

1803.4 RECIPIENT RESPONSIBILITIES

Individuals receiving 1915(i) services are entitled to their privacy, to be treated with respect and be free from coercion and restraint.

The recipient or the recipient's designated representative will:

a. Notify the provider(s) and Health Care Coordinator of a change in Medicaid eligibility.

b. Notify the provider(s) and Health Care Coordinator of changes in medical status, service needs or changes of status of designated representative.

c. Initial and/or sign the provider service documentation logs as applicable, verifying services were rendered unless otherwise unable to perform this task due to cognitive and/or physical limitations.

d. Notify the Health Care Coordinator if services are no longer requested or required.

e. Notify the provider(s) and the Health Care Coordinator of unusual occurrences, complaints regarding delivery of services or specific staff.

f. Not request a provider(s) to perform services not authorized in the plan of care.

g. Contact the Health Care Coordinator to request a change of provider.

1803.5 ADULT DAY HEALTH CARE (ADHC) SERVICES

Adult Day Health Care ~~Facilities~~services provide assistance with the Activities of Daily Living (ADL), medical ~~services~~equipment and medication administration. ~~on a regularly scheduled basis as specified in the Service Plan~~. Services include health and social services needed to ensure the optimal functioning of the participant. Services are generally furnished in four or more hours per day on a regularly scheduled basis, for one or more days per week. The schedule may be modified as specified in the ~~service~~ plan of care.

1803.5A COVERAGE AND LIMITATIONS

~~Services must take place in a community-based setting and not an institutional setting.~~ Services provided by the appropriate professional staff include the following:

1. nursing services to include assessment, care planning, treatment and medication administration, evaluation and supervision of direct care staff;
~~restorative therapy and care;~~

2. nutritional assessment and planning;

3. care coordination to assist the recipient and family to access services needed by the recipient to maintain or improve their level of functioning or to minimize a decline in the level of functioning due to the progression of a disease or other condition that may not be remedied;

4. recipient training in ~~Activities of Daily Living~~ADLs~~;~~

5. medical supervision and assistance to assure the recipient's well-being and that care is appropriate to meet the recipient's needs;

6. social and recreational activities to enhance the recipient's functioning and/or to maintain or improve the recipient's quality of life; and

7. meals provided as a part of these services shall not constitute a "full regimen" which is three meals per day.

NOTE: A recipient who resides in a residential setting such as group home, assisted living or other type of residential facility where a per diem rate is paid for 24-hour care is not eligible for ADHC services.

1803.5B PROVIDER RESPONSIBILITIES

In addition to the Provider Responsibilities listed in Section 1803.1B, providers must adhere to the following requirements specific to rendering ADHC services:

1. PROVIDER QUALIFICATIONS

Each provider of ADHC services must obtain and maintain licensure as required in the 1915(i) State Plan and NAC Chapter 449. Furthermore, providers must adhere to all requirements of NAC 449 as applicable to licensure.

~~In order to qualify as a Medicaid provider, in addition to meeting and maintaining compliance with all state licensure regulations, the ADHC facility must enroll as a Provider Type 39 and enter into the agreement with the Division of Health Care Financing and Policy (DHCFP), through the Quality Improvement Organization (QIO) like vendor and must submit required licenses, registrations, certificates, etc., as stated in MSM Chapter 100.~~

~~If the facility fails to meet the Medicaid requirements at review, the facility will be notified and given 30 days to comply. Otherwise, a Medicaid provider contract will not be issued or if already issued will be subject to termination.~~

~~a. Criminal Background Checks~~

~~All agency personnel, including owners, officers, administrators, managers, employees and consultants must undergo State and Federal Bureau of Investigation (FBI) background checks upon enrollment as a Medicaid provider and then at a minimum of every five years thereafter to ensure no convictions of applicable offenses have been incurred. In addition, provider agencies are required to conduct routine screenings on all applicants who will perform services for recipients to ensure the health and welfare of recipients and to make every effort possible to prevent recipient abuse. These requirements are available on the HCQC website: http://healthdev.webtest.nv.gov/HCQC_CriminalHistory.htm.~~

~~The DHCFP QIO-like vendor will not enroll any provider agency whose operator has been convicted of a felony under State or Federal law for any offense which the DHCFP determines is inconsistent with the best interest of recipients.~~

~~The DHCFP QIO-like vender will also not enroll, as a provider, any applicant convicted of any felony or misdemeanor involving fraud or abuse in any government programs or has been found guilty of fraud or abuse in any civil proceeding, or entered into a settlement in lieu of convictions for fraud or abuse, within the previous seven years.~~

~~Providers are required to initiate diligent and effective follow up for results of background checks within 90 days of submission of prints and continue until results are received. This is particularly important when an "undecided" result is received. Documentation must be maintained in the employee's personnel file and submitted to the DHCFP upon request.~~

~~Documentation of the request, and applicable results, must be maintained in each employee personnel record and made available to the DHCFP upon request. Employees must have the criminal background check through the Nevada Department of Public Safety (DPS) initiated by the employee prior to providing any Medicaid reimbursable services to a recipient.~~

~~If an employee believes that the information provided as a result of the criminal background check is incorrect, the individual must immediately inform the employing agency in writing. Information regarding challenging a disqualification is found on the HCQC website at: http://health.nv.gov/HCQC_CriminalHistory.htm.~~

~~b. Tuberculosis (TB) Testing~~

~~Before initial employment, an employee must have a:~~

~~1. physical examination or certification from a licensed physician that the person is in a state of good health, is free from active TB and any other communicable disease in a contagious stage; and~~

~~2. TB screening test within the preceding 12 months, including persons with a history of Bacillus Calmette-Guerin (BCG) vaccination.~~

~~a. According to Nevada Administrative Code (NAC) 441A.192 "Tuberculosis screening test" is any TB screening test that has been:~~

~~1. Approved by the Food and Drug Administration (FDA); and~~

~~2. Endorsed by the Centers for Disease Control and Prevention (CDC).~~

~~Further information about TB testing can be found on the HCQC website at: http://health.nv.gov/CD_HIV_TBManual.htm~~

~~If the employee has only completed the first step of a 2-step Mantoux tuberculin skin test within the preceding 12 months, then the second step of the 2-step Mantoux tuberculin skin test or other single-step TB screening test must be administered. A single annual TB screening test must be administered thereafter.~~

~~An employee with a documented history of a positive TB screening test is exempt from screening with skin tests or a chest x-ray unless he/she develops symptoms suggestive of TB.~~

~~A person who demonstrates a positive TB screening test shall submit to a chest x-ray and medical evaluation for active TB.~~

~~Annual screening for signs and symptoms of an active disease must be completed prior to the one year anniversary of the last screening. Documentation of the annual screening and the results must be maintained in the employee's file.~~

~~The annual screening for signs and symptoms must address each of the following areas of concern and must be administered by a qualified health care provider:~~

~~1. Has had a cough for more than three weeks;~~

~~2. Has a cough which is productive;~~

~~3. Has blood in his sputum;~~

~~4. Has a fever which is not associated with a cold, flu or other apparent illness;~~

~~5. Is experiencing night sweats;~~

~~6. Is experiencing unexplained weight loss; or~~

~~7. Has been in close contact with a person who has active TB.~~

~~Documentation of TB testing must be issued by a medical facility or licensed medical professional qualified to administer the test, signed by the physician or his/her designee, stating the date of the test, the date the test was read, and the results. Any lapse in the required timelines above will result in a finding of non-compliance with this section.~~

~~c. Training Requirements~~

~~All employees must participate in a program of general orientation and must receive training on a regular basis, but not less than 12 hours per year.~~

~~General orientation training includes, but is not limited to:~~

~~b.a. policies, procedures and expectations of the agency relevant to the provider, including recipient's and provider's rights and responsibilities;~~

~~c.a. record keeping and reporting including daily records and attendance records;~~

~~d.a. interpersonal and communication skills and appropriate attitudes for working effectively with recipients including:~~

~~a.d. understanding care goals;~~

~~b.d. respecting recipient rights and needs;~~

~~c.d. respect for age, cultural and ethnic differences;~~

~~d. recognizing family relationships;~~

~~e.d. confidentiality;~~

~~f.d. respecting personal property;~~
~~g.d. ethics in dealing with the recipient, family and other providers;~~

~~h.d. handling conflict and complaints; and~~

~~i.d. other topics as relevant.~~

~~NOTE: At least one employee trained to administer first aid and cardiopulmonary resuscitation (CPR) must be on the premises at all times.~~

2. STAFFING REQUIREMENTS

~~A~~In addition to the requirements of NAC 449, each ADHC ~~facility~~ center must employ persons with the necessary education, skills and training to provide the Medicaid required services. Medical services must be provided by Nevada licensed/certified personnel and staff files maintained as required by the licensing entity. ~~Copies of current licensure, certificates, education, finger prints, FBI checks and TB tests must be maintained in staff files.~~

a. REGISTERED NURSE (RN)

The ~~facility~~ center must employ a full time RN to oversee and provide medical services, particularly for physician ordered services~~by a physician~~. The RN must have at least one year of experience with the senior population, ~~and~~ individuals with disabilities or individuals with a history of aggressive behavior. Within the first 30 days of admission, ~~T~~the RN ~~is responsible for conducting a recipient's health assessment within the first 30 days of admission and is responsible for~~must ~~developing~~ develop ~~the~~ a ~~Plan of Care (POC)~~Service Plan ~~and~~ to indicate the management of each recipient's care and treatment. An RN or Licensed Practical Nurse (LPN) under the supervision of an RN, will administer medications provided to the recipient while in the ~~facility's~~ center's care. An RN, or LPN under the supervision of an RN, must be physically on ~~duty~~ the premises during the hours in which a Medicaid ~~Eligible~~ recipient is in attendance at the ~~facility~~center.

b. PROGRAM DIRECTOR

The ~~facility~~ center must employ a full time Program Director who has a minimum of two or more years of education and/or experience with the senior population, ~~and~~ individuals with disabilities or individuals with a history of aggressive behavior.

The duties of the Program Director will include at a minimum the development of plans and policies for the ~~facility's~~ center's operation, recruitment, employment and training of qualified staff, supervision and appropriate disciplinary action of staff, maintenance of employee and recipient information and records, maintenance of the ~~facility's~~ center's physical plant, housekeeping and nutritional services and the development and implementation of an evaluation plan of recipient services and outcomes.

c. DIRECT CARE STAFF

The ~~facility~~ center must have direct care staff who observes the recipient's functioning and provide assistance to the recipient in the skills of daily living. Direct care staff must have education, experience and necessary qualifications to work with the senior population, ~~and~~ individuals with disabilities or individuals with a history of aggressive behavior.

The ~~facility~~ center must also provide for janitorial, housekeeping and activity staff or other staff as necessary to provide the required services and ensure each recipient's needs are met.

~~3. PHYSICIAN EVALUATION~~

~~A recipient must have undergone an evaluation using the Physician Evaluation Form prior to admission to an ADHC Facility by a physician licensed to practice in Nevada. This evaluation must be face-to-face.~~

~~The evaluation must include:~~

~~a. primary and other significant diagnosis.~~

~~b. description of mental and physical disabilities.~~

~~c. nutritional status and needs.~~
~~d. medications prescribed including route, frequency and dosage.~~

~~e. medical history.~~

~~f. TB testing and results.~~

~~g. allergies.~~

~~h. infectious diseases.~~

~~i. physician's order.~~

~~A physician within the scope of their professional practice as defined and limited by Federal and State law with experience in conducting assessments will be responsible for conducting the face-to-face independent assessments and reassessments of an individual's support needs and capabilities.~~

~~The individual performing the assessment must be an independent third party and must not be:~~

~~j. related by blood or marriage to the individual;~~

~~k. any paid caregiver of the individual;~~

~~l. financially responsible for the individual;~~

~~m. empowered to make financial or health related decisions on behalf of the individual;~~

~~n. service providers or individuals or corporations with financial relationships with any providers.~~

~~The physician must re-evaluate the recipient annually within the same month, or when a significant change occurs.~~

~~4. UNIVERSAL NEEDS ASSESSMENT~~

~~The "1915(i) HCBS Universal Needs Assessment Tool" must be used to evaluate and re-evaluate whether an individual is eligible for the Nevada 1915(i) HCBS state plan services. In order to qualify for services, the individual meets at least two of the following:~~

~~a. The inability to perform two or more ADLs;~~
~~1. Bathing/Dressing/Grooming.~~

~~2. Mobility.~~

~~3. Toileting.~~

~~4. Eating.~~

~~5. Transferring.~~

~~b. Cognitive and/or behavioral impairments;~~

~~c. Medical needs;~~

~~d. Supervision needs;~~

~~e. Substance abuse; and~~

~~f. Multiple social service system involvements.~~

~~This evaluation must be face-to-face.~~

~~A physician within the scope of their professional practice as defined and limited by Federal and State law with experience in conducting assessments will be responsible for conducting the face-to-face independent assessments and reassessments of an individual's support needs and capabilities.~~

~~The individual performing the assessment must be an independent third party and must not be:~~

~~g. related by blood or marriage to the individual;~~

~~h. any paid caregiver of the individual;~~

~~i. financially responsible for the individual;~~

~~j. empowered to make financial or health-related decisions on behalf of the individual;~~

~~k. service providers or individuals or corporations with financial relationships with any providers.~~

~~The physician must re-evaluate the recipient's eligibility annually within the same month, or when a significant change occurs.~~

~~5. SERVICE PLAN~~

~~A service plan must be completed and submitted as part of the prior authorization process. The service plan requires pre-approval by the QIO-like vendor prior to authorizing services and must include the description of services, amount of time (hourly, daily, weekly) and the title of the staff that will be providing the specific services within the ADHC facility.~~

~~The service plan is developed by the ADHC provider using the completed 1915(i) HCBS Universal Needs Assessment Tool and the Physician Evaluation Form, in conjunction with the recipient and/or recipient's legal representative.~~

~~The provider must ensure the recipient, or the recipient's legal representative, is fully involved in the treatment planning process and choice of providers. Recipient, family (when appropriate) and/or legal representative participation in service planning must be documented on the service plan.~~

~~The service plan must include a written statement that the recipient was offered a choice of ADHC providers and must be kept in a file maintained for the recipient. Additionally, the DHCFP must review a representative sample of participant service plans each year.~~

~~The service plan must include the identified needs from the Universal Needs Assessment and the Physician Evaluation.~~

~~The recipient must provide a signature on the service plan. If the recipient is unable to provide a signature due to cognitive and/or physical limitation, this must be clearly documented in the recipient file. A legal representative may sign for the recipient.~~

~~The facility may create a signature page which can encompass a recipient signature for the service plan, the POC and any other signature requirements. If the facility uses a signature page, it must be included in the packet to the QIO-like vendor for prior authorization.~~

~~6. PLAN OF CARE (POC)~~

~~A POC must be developed within 30 days of the first day of attendance for a new applicant to the ADHC and within 30 days of new prior authorizations. Based on the service plan, the 1915(i) HCBS Universal Needs Assessment Tool, and the Physician Evaluation Form, the individualized POC must be developed and meet the requirement of NAC 449. 4088.~~

~~The POC specifically outlines the services and activities of a recipient and must be available to all staff members in the ADHC Facility.~~

~~The POC:~~

~~a. is developed by the RN using a person-centered process involving the individual, the individual's treating physician, health care or supporting professionals and where appropriate, the individual's family, caregiver, or representative, and the DHCFP care coordinator.~~

~~b. identifies the necessary services to be furnished to the individual,~~

~~c. includes objectives and directives for all medication administration and management, social and recreational activities, case management and nutritional needs,~~

~~d. takes into account the extent of, and need for, any family or other supports for the individual,~~

~~e. prevents the provision of unnecessary or inappropriate care,~~

~~f. is guided by best practices and research on effective strategies for improved health and quality of life outcomes,~~

~~g. is reviewed and updated by the RN annually within the same month, when a new prior authorization has been approved, or as needed when there is significant change in the individual's circumstances.~~

~~The POC must be kept in a file maintained for the recipient and must include a signature of the recipient. If the recipient is unable to provide a signature due to cognitive and/or physical limitation, this must be clearly documented in the recipient file. A legal representative may sign for the recipient.~~

~~The facility may create a signature page which can encompass a recipient signature for the service plan, the POC and any other signature requirements. If the facility uses a signature page, it must be included in the packet to the QIO-like vendor for prior authorization~~.

~~7.~~d. ATTENDANCE RECORD AND ~~PROGRESS/~~NURSING NOTES

The ~~facility~~ center must have documentation of daily attendance and notes that ~~document~~ indicate the health component of this service, which is maintained in the recipient's file. This documentation is verification of service provision and may be used to review claims paid.

The delivery of specific services ~~including those~~ required by ~~Medicaid~~the POC and outlined in the Service Plan must be documented in the daily records. The RN on duty or an LPN under the supervision of an RN, during the provision of services is responsible for documenting the recipient's care.

The recipient and a ~~facility~~ center staff member must sign each record. If the recipient is unable to provide a signature due to cognitive and/or physical limitation, this must be clearly documented in the recipient file. A~~n~~ ~~authorized~~ designated representative may sign on behalf of the recipient.

The ~~facility~~ center may create a signature page which can encompass a recipient signature for the ~~s~~Service ~~p~~Plan~~,~~ ~~the POC~~ and any other signature requirements.

~~8. EMPLOYEE RECORD REQUIREMENTS~~

~~In compliance with NAC 449.40835, the facility must maintain records on each employee.~~

~~Employee records must include:~~

~~a. finger prints and background results;~~

~~b. annual TB tests; and~~

~~c. training, required licenses, registrations and certificates.~~

~~9. RECIPIENT RECORD REQUIREMENTS~~

~~In compliance with NAC 449.40835, the facility must maintain records on recipients including daily records and attendance records. All entries made in the recipient's file must be signed and dated by the employee making the entry. The delivery of specific services including those required by Medicaid must be documented in the daily records. The RN on duty or an LPN under the supervision of an RN, during the provision of services is responsible for documenting the recipient's care.~~

~~Recipient records must include:~~

~~a. Medicaid eligibility: The facility must maintain proof of each recipient's Medicaid eligibility. Verification of eligibility is the provider's responsibility. Eligibility should be verified monthly. Refer to MSM, Chapter 100 for additional information regarding verification of eligibility.~~

~~b. Physician Evaluation.~~

~~c. Universal Needs Assessment.~~

~~d. Service Plan.~~

~~e. Statement indicating recipient made an informed choice in providers.~~

~~f. POC.~~

~~g. Attendance Records.~~

~~h. Progress or Nursing notes.~~

~~i. Annual TB tests.~~

~~The facility must maintain an accurate record of the recipient's attendance by using an attendance record. The record must also reflect any absence from the facility by the recipient for purposes of obtaining other services. This record is to include date, duration of absence and destination or purpose for absence.~~

~~10. CONFIDENTIALITY AND RELEASE OF RECIPIENT RECORDS~~

~~The facility is required to comply with applicable state and federal laws, rules and regulations regarding privacy and protection of an individual's health information.~~

~~11. PROVIDER LIABILITY~~

~~Provider liability responsibilities are included in the Medicaid and Nevada Check Up (NCU) Provider Contract and are incorporated in this chapter by reference.~~

~~12. NOTIFICATION OF SUSPECTED ABUSE OR NEGLECT~~

~~State law requires that persons employed in certain capacities must make a report to the appropriate agency immediately, but in no event later than 24 hours after there is reason to suspect abuse or neglect. The DHCFP expects that all providers be in compliance with the intent of all applicable laws.~~

~~For adults aged 60 and over, the Aging and Disability Services Division (ADSD) accepts reports of suspected abuse, neglect or self-neglect, exploitation or isolation. Refer to NRS 200.5091 to 200.50995 regarding elder abuse or neglect.~~

~~For all other individuals or vulnerable persons (NRS 200.5091 to 200.50995) contact law enforcement agencies. Individuals or vulnerable persons are defined as a person 18 years of age or older who:~~

~~b.a. suffers from a condition of physical or mental incapacitation because of a developmental disability, organic brain damage or mental illness; or~~

~~c.a. has one or more physical or mental limitations that restrict the ability of the person to perform the normal ADLs contact local law enforcement agencies.~~

~~13. HIPAA, PRIVACY AND CONFIDENTIALITY~~

~~Refer to MSM Chapter 100 for information on HIPAA, privacy and confidentiality of recipient records and other Protected Health Information (PHI).~~

~~1803.1C~~1803.6 ~~RECIPIENT RESPONSIBILITIES~~DAY HABILITATION

Day Habilitation services are regularly scheduled activities in a non-residential setting, separate from the recipient's private residence or other residential living arrangement. Services include assistance with the acquisition, retention or improvement in self-help, socialization and adaptive skills that enhance social development and develop skills in performing activities of daily living and community living.

Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independent and personal choice. Services are identified in the recipient's POC according to recipient's need and individual choices. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day).

Day habilitation services focus on enabling the participant to attain or maintain his or hermaximum potential and shall be coordinated with any needed therapies in the recipient's POC such as physical, occupational or speech therapy.

1803.6A COVERAGE AND LIMITATIONS

Day habilitation services are targeted to individuals who have a TBI or Acquired Brian Injury or ABI.

1803.6B PROVIDER RESPONSIBILITIES

In addition to the Provider Responsibilities listed in Section 1803.1B, providers must adhere to the following requirements specific to rendering Day Habilitation services.

1. PROVIDER QUALIFICATIONS

Each provider of Day Habilitation services must obtain and maintain certification as required in the 1915(i) State Plan.

2. ATTENDANCE RECORDS AND DAILY LOGS

The provider must have documentation of daily attendance and notes that indicate the health component of this service which is maintained in the recipient's file. This documentation is verification of service provision and may be used to review claims paid. The delivery of specific services required by the POC and outlined in the Service Plan must be documented in the daily records. The recipient and a center staff member must sign each record. If the recipient is unable to provide a signature due to cognitive and/or physical limitation, this must be clearly documented in the recipient file. A designated representative may sign on behalf of the recipient. The center may create a signature page which can encompass a recipient signature for the Service Plan and any other signature requirements.

1803.7 RESIDENTIAL HABILITATION

Residential habilitation means individually tailored supports that assist with the acquisition, retention or improvement in skills related to living in the community. These services include adaptive skill development, assistance with activities of daily living, community inclusion, adult educational supports, social and leisure skill development that assist the recipient to reside in the most integrated setting appropriate to his/her needs. Residential habilitation also includes personal care, protective oversight and supervision.

1803.7A COVERAGE AND LIMITATIONS

Residential habilitation services are targeted to individuals who have a TBI or ABI.

Additionally, payment for room and board is prohibited.

1803.7B PROVIDER RESPONSIBILITIES

In addition to the Provider Responsibilities listed in Section 1803.1B, providers must adhere to the following requirements specific to rendering residential habilitation services.

1. PROVIDER QUALIFICATIONS

Each provider of residential habilitation services must obtain and maintain certification as required in the 1915(i) State Plan

2. ATTENDANCE RECORDS AND DAILY LOGS

The provider must have documentation of daily attendance and notes that indicate the health component of this service which is maintained in the recipient's file. This documentation is verification of service provision and may be used to review claims paid. The delivery of specific services required by the POC and outlined in the Service Plan must be documented in the daily records. The recipient and a center staff member must sign each record. If the recipient is unable to provide a signature due to cognitive and/or physical limitation, this must be clearly documented in the recipient file. A designated representative may sign on behalf of the recipient. The center may create a signature page which can encompass a recipient signature for the Service Plan and any other signature requirements.

1803.8 INTAKE AND ONGOING PROCEDURES

The following procedures describe how a person can obtain 1915(i) services and the process required to maintain services.

1. INTAKE PROCEDURES

a. A referral or inquiry for 1915(i) services may be initiated by phone, mail, fax, in person or by another party on behalf of the potential applicant.

b. If an applicant appears to meet program criteria, a face-to-face visit will be scheduled to assess needs-based eligibility using the Comprehensive Social Health Assessment (CSHA) tool. The DHCFP Health Care Coordinator will contact the applicant/representative within seven working days of the referral date to schedule a time to conduct an assessment.

i. If an applicant or representative fails to respond to the contact, a notification letter will be sent to the address on the referral form requesting contact within 10 business days, otherwise the referral will be closed.

c. If during the face-to-face assessment, the Health Care Coordinator determines the applicant does not appear to meet the needs-based criteria, a Notice of Decision will be mailed to the address on file and the applicant will be referred to other agencies for needed services or assistance not included under the 1915(i) program.

The following reasons will serve as a basis for denial:

i. The applicant is under the age of 18 years.

ii. The applicant does not meet the needs-based criteria.

iii. The applicant has withdrawn his or her request for 1915(i) services.

iv. The applicant's support system is not adequate to provide a safe environment during the time when services are not being provided.

v. The DHCFP Health Care Coordinator has lost contact with the applicant.

vi. The applicant has moved out of state.

vii. Another agency or program will provide the services.

viii. The applicant is in an institution (hospital, nursing facility, correctional or ICF) and discharge within 30 days is not anticipated.

ix. The applicant has chosen a provider that is not an enrolled or qualified Medicaid provider.

x. There are no enrolled Medicaid providers in the applicant's area.

2. PERSON-CENTERED PLAN OF CARE

For applicants determined eligible for 1915(i) services, a person-centered POC will be developed that includes, at a minimum, the individual's needs, goals to meet those needs, identified risks and services to be provided. The recipient, family, support systems and/or designated representatives are encouraged to participate in the development of the POC and to direct the process to the maximum extent possible.

POC DEVELOPMENT PROCESS:

a. The initial POC is developed based on information obtained during the initial assessment.

~~a.~~b. The POC is person centered, based on personalized goals, needs, preferences and developed with participation from the recipient, the family, the designated representative and anyone else the recipient chooses. The Health Care Coordinator documents this information in the CSHA narrative.

~~b.~~c. The POC reflects the recipient's service needs and includes both 1915(i) and non-1915(i) services in place at the time of POC completion, along with informal supports that are necessary to address those needs. The Health Care Coordinator is responsible for identifying services needed.

~~c.~~d. The POC development process considers risk factors, equipment needs, behavioral status, current support system and unmet service needs (this list is not all inclusive). The personalized goals are identified by the recipient and documented in the initial POC and each time the POC is updated with information obtained during the contacts with the recipient.

~~d.~~e. Facilitation of individual's choice regarding services and supports and who provides the services is given during the initial assessment. The recipient must sign the Statement of Understanding acknowledging they had the right to choose the services and providers.

f. The POC identifies the services required, including type, scope, amount, duration and frequency of services. The service providers are contacted by the Health Care Coordinator to establish availability and are given a copy of the recipient's POC prior to the initiation of services.

g. A recipient will receive a copy of the initial POC which must be signed within 60 calendar days of the date of the Statement of Understanding (SOU). If the recipient signature cannot be obtained due to extenuating circumstances, services can commence with verbal approval from the recipient. The Health Care Coordinator document the recipient's verbal approval in the CSHA narrative and obtain the signature and dateon the finalized POC.

h. The provider must also sign and date a copy of all new, or a reported change, POCs within 60 calendar days. The Health Care Coordinator ensures the provider returns a signed copy of the POC for the case file.

i. The DHCFP Health Care Coordinators are responsible for prior authorizing 1915(i) services.

3. ONGOING PROCEDURES

a. Once a recipient is authorized for 1915(i) program services, that authorization period is for 12-months from the date of authorization.

i. Prior to the 12-month authorization period ending, the Health Care Coordinator will contact the recipient within 30 days to initiate a re-evaluation. The re-evaluation includes a face-to-face assessment to determine whether the recipient continues to meet needs-based criteria.The POC will be updated during the re-evaluation assessment and the recipient/designated representative will receive a copy of the POC which must be signed.

b. If a recipient has a change in condition during the authorization period, the Health Care Coordinator will conduct a visit to update the POC with the recipient/designated representative. A copy of the signed, updated POC will be provided to the recipient and service provider.

c. During the provision of services, if a recipient chooses to transfer to a different service provider, the recipient or representative must contact a DHCFP Health Care Coordinator to initiate the transfer process including the prior authorization for the new provider.

~~1. Presenting any forms or identification necessary to utilize other health insurance coverage.~~

~~2. Making and keeping medical appointments as required in obtaining the Universal Needs Assessment and Physician Evaluation from their primary physician.~~

~~3. Participating in the development of the POC using a person centered process.~~

~~4. Obtaining required TB testing per NAC 441.380.~~

1803.~~1D~~6 ~~RESERVED~~DAY HABILITATION

~~1803.1E PRIOR AUTHORIZATION AND BILLING~~

~~1. PRIOR AUTHORIZATION PROCEDURE:~~

~~ADHC Services must be prior authorized. The ADHC provider must complete the "ADHC Prior Authorization Request Form" and submit the request form with the DHCFP approved Physician Evaluation Form, the DHCFP approved 1915(i) HCBS Universal Needs Assessment Tool and Service Plan (including the statement that the recipient was offered a choice of ADHC providers) to the QIO-like vendor before services are provided. All prior authorization requests must be complete and accurate. If insufficient information is provided to support the completion of a request, the ADHC provider must supply the needed information within 72 hours of notification. When complete information is submitted, the QIO-like vendor must make a decision within five business days. Retro eligibility authorization is not available for this service.~~

~~The QIO-like vendor must review and provide approval for all services plans and provide a written authorization to the ADHC facility which includes a prior authorization number and service authorization. The prior authorization number must be included on all claims.~~

~~g. Types of prior authorization requests include:~~

1. ~~an initial prior authorization request must be submitted before providing services to a Medicaid recipient for the first time.~~
2. ~~a new prior authorization is required if a recipient requires services beyond the end of the current annual prior authorization. The new prior authorization should be submitted no less than 15 days prior to the end of the current authorization period so an interruption in services may be avoided.~~

3. ~~a revised prior authorization must be submitted when a recipient's needs change during the current authorization period, for an increase or decrease in authorized days or hours per day.~~

h. ~~The prior authorization request must identify and include all of the following:~~

1. ~~The recipient meets the eligibility requirements using the 1915(i) HCBS Universal Needs Assessment Tool.~~

2. ~~The recipient requires at least one of the services identified in Section 1803.1.~~

3. ~~Frequency and duration of the requested services; and~~

4. ~~The request must include a copy of the Physician Evaluation and Service Plan.~~

~~Prior authorization may be approved for up to one year through the end of the eligibility month. The prior authorization is dependent upon meeting the eligibility criteria using the 1915(i) HCBS Universal Needs Assessment Tool and medical necessity using the Physician's Evaluation. If services are needed after the current authorization ends, the facility must submit a new prior authorization request to the QIO-like vendor and include the same information that is required with an initial prior authorization request.~~

~~Services provided without prior authorization are not reimbursable.~~

2. ~~PROVIDER BILLING:~~

~~Providers are responsible for requesting the appropriate number of days or units the recipient requires for attendance. This may be at the daily rate or the unit rate but not both in the same day. (15 minutes equals one unit).~~

~~If a recipient is expected to be in attendance full-time, which is six or more hours per day, the daily rate will be utilized. If the recipient is expected to be in attendance less than six hours a day the unit rate should be utilized. Some recipient's care plans may include a~~

~~combination of full and partial days (example: full days Monday/Wednesday/Friday (use the daily rate these days) and half time Tuesday/Thursday (use the unit rate for these days). Occasionally recipients may be present part of the day, but not the full day, due to prescheduled appointments, transportation issues, sudden illness, etc. In these cases, the provider may bill the authorized per diem rate and document the reason for the partial absence in the recipient's attendance log. Providers may not bill for days in which recipients are not present at all.~~

1803.09 TERMINATION OF 1915(i) SERVICES

Once a recipient is eligible for 1915(i) services there may be circumstances which result in a recipient becoming ineligible for services. The following reasons serve as a basis for terminating a recipient from the 1915(i) HCBS State Plan Option:

a. The recipient is no longer eligible for Medicaid.

b. The recipient no longer meets the 1915(i) needs-based criteria.

c. The recipient/ designated representative has requested termination of services.

d. The recipient has failed to cooperate with the DHCFP service providers in establishing and/or implementing the POC, implementing services or verifying eligibility for services. (The recipient/designated representative signature is necessary on all required paperwork).

e. The recipient's support system is not adequate to provide a safe environment during the time when 1915(i) services are not being provided.

f. The recipient fails to show a continued need for the minimum number of authorized hours for 1915(i) services.

g. The recipient has moved out of state.

h. The recipient chooses to transfer to a provider that is not an enrolled or qualified Medicaid provider.

i. The recipient has signed fraudulent documentation on one or more of the providers.

j. Another agency or program will provide the services.

k. The applicant is in an institution (e.g. hospital, nursing facility, correctional, ICF) and discharge within thirty days is not anticipated.

l. The DHCFP has lost contact with the recipient.

~~Should the absences of the recipient become more frequent or the needs of the recipient change, the ADHC provider may request a new prior authorization for the unit rate. A change to the unit rate is required if the recipient attendance has been less than six hours a day for ten days within a two week period. When the unit rate is authorized the provider must bill for the exact number of units the recipient is in attendance. The maximum number of billable units per day is 24 units.~~

~~The POC must clearly identify the number of units a recipient is expected to be in attendance. Claims must reflect dates of service as indicated on the attendance records. Periodically, the DHCFP staff may request attendance/daily record documentation to compare to billings submitted.~~

~~Reimbursement is not available for services furnished by legally responsible individuals.~~

1804 RATES AND REIMBURSMENT

Refer to the provider billing guide for instructions and the reimbursement code table for specific billing codes.

~~1804~~1805 QUALITY ASSURANCE

The ~~Division of Health Care Financing and Policy (~~DHCFP~~)~~ will conduct an annual review ~~to assure the health and welfare of the recipients served by the Adult Day Health Care (ADHC) Facility. The review will~~ consisting of the quality measures ~~program~~ require~~dments identified~~ in the~~is chapter~~ Quality Improvement Strategy outlined in the 1915(i) HCBS State Plan.

~~Additionally, a review of the providers will be conducted annually to verify that the providers meet requirements established for each service, such as licensure, accreditation, etc, and to ensure claims are paid in accordance with the State Plan and all federal and state regulations. Providers must cooperate with the DHCFP's annual review process.~~

1806 ~~3.~~TRANSPORTATION

Refer to MSM Chapter 1900~~,~~ - Transportation Services, for requirements related to Emergency and Non-Emergency Transportation ~~of the Division of Health Care Financing and Policy (DHCFP) medical transportation program. Medicaid may reimburse for necessary and~~ to ~~essential medical transportation to and from medical~~ Medicaid ~~providers~~covered services.

180~~5~~7 HEARINGS

Refer~~ence~~ to ~~the Division of Health Care Financing and Policy (DHCFP)'s Medicaid Services Manual (~~MSM~~)~~ Chapter 3100, for the Medicaid ~~Recipient~~ Hearing proces~~sdures~~.