MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

May 10, 2011

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: MARTA E. STAGLIANO, CHIEF, COMPLIANCE

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

BACKGROUND AND EXPLANATION

Medicaid Services Manual (MSM) Chapter 1800 Adult Day Health Care Services (ADHC) has been revised for the following reasons: Changes to this chapter are a result of revisions made to the Social Security Act, specifically the Deficit Reduction Act, Section 6086, 1915 (i) Home and Community-Based Services (HCBS) State Plan Services attachment 3.1-G effective October 31, 2008. This amendment makes significant changes to the ADHC policy currently in place. These changes include:

- The use of a standardized tool called "The 1915(i) HCBS Universal Needs Assessment Tool" to evaluate functional deficits of individuals. Must be completed annually.
- The use of a form called "The Physician Evaluation Form" in place of physician's orders. Must be completed annually.
- The use of a service plan at part of the prior authorization process. The service plan must be pre-approved by the QIO-like vendor prior to authorizing services. Must be completed annually.
- The Plan of Care (POC), currently in use by ADHC facilities, must be individualized and use a person-centered planning approach to outline the specific services and activities to be provided to a recipient in ADHC. The plan of care must be updated within 30 days of all new prior authorizations or when a significant change occurs.
- DHCFP District Office Responsibility for approving "The 1915(i) HCBS Universal Needs Assessment Tool" and "The Physician Evaluation Form" for 100% of ADHC recipients.

These changes will be made on a go forward. New recipients will be required to follow this new policy for admission to an ADHC Facility. Recipients currently utilizing ADHC Services will be re-evaluated using this new policy.

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

These policy changes are effective May 11, 2011.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 04/11 CHAPTER 1800 – ADULT DAY HEALTH CARE	MTL 16/03, 12/04 CHAPTER 1800 – ADULT DAY HEALTH CARE

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1800	**Introduction**	Updated language for ADHC program and removed reference to Nevada Check Up.
1801	**Authority**	Added reference to 1915(i) HCBS State Plan Service and removed reference to 42 CFR 440.130(d) Rehabilitative Services.
1802	**Definitions**	Removed definition numbering. Clarified and streamlined definition for Adult Day Care Facility and ADHC Facility. Added the following definitions to be consistent across all of the waivers: • Attendance/Daily Record • Legally Responsible Individual (LRI) • Physician Evaluation • Plan of Care (POC) • Service Plan • Universal Needs Assessment
1803.1	**Adult Day Health Care Services** **Coverage and Limitations**	Moved ADHC Services from 1803.1B.3 to 1803.1 and added services identified under 1915(i). Updated Eligible Recipients section by adding eligibility requirements of Universal Needs Assessment Tool or a 1915(c) waiver, Physician's Evaluation, and the recipient must live in the community. Removed reference to physician's order and rehabilitation goal required for prior authorization. Added recipient not eligible if receiving services under CHIP waiver and ADHC services will not be provided at the same time another service is being provided and a recipient who is a resident of a state licensed facility who receives an all inclusive Medicaid rate may not receive Medicaid

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		reimbursement for ADHC Services. Clarified and streamlined provider requirements including reference to state licensing requirements of the HCQC, certification by the DHCFP and reference to MSM 100. Reworded reference to MSM 1900 for transportation policy.
	Provider Responsibilities	Added and/or streamlined the following: • References to MSM 100 throughout section. • DHCFP may review facility at least annually. • Requirements for criminal background checks, TB testing, records in employee files, experience with the senior population and individuals with disabilities. • Criteria for independent third party requirements and conflict of interest standards. • Route, frequency and dosage to medications, medical history requirement, tuberculosis testing, allergies, infectious diseases, and physicians order. • Reference to 1915(i) throughout seciton. • Conflict of interest requirements for conducting assessments. • Physicians may refer recipient to DHCFP DOs for lists of available ADHC providers. • Service Plan must be developed using a person center planning approach and include statement that recipient was offered a choice in ADHC providers. • Development of an individualized POC per NAC 449.4088. • 30 day time frame for ADHC to complete POC and the POC specifically outlines the services to be provided in the ADHC and must be maintained in recipient file. • Items required for employee and recipient files. • Provider liability responsibilities. • State law requirements for the reporting of suspected abuse and neglect for persons 18-59 and elderly over 60. Changed "Other Staff" to "Direct Care Staff" and

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		reference to required experience with the senior population and individuals with disabilities, records requirements for staff, and 6 months to annually. Removed the following: • Old requirement for physician's orders. • Requirement for "Admission Orders" and 6 month time frame and included 1915(i) requirements for independent physician evaluation. • Interdisciplinary development of POC and reference to daily progress notes and physician's order.
	Recipient Responsibilities	Deleted reference to reimbursement for services if all requirements are met. Added recipient responsibilities for assisting ADHC facility in obtaining the Universal Needs Assessment and Physician Evaluation forms, participating in person centered planning, and TB requirements.
	DHCFP District Office (DO) Responsibilities	Added section for DHCFP responsibility to include approval of 100% of Universal Needs Assessments and Physician Evaluations.
	Prior Authorization and Billing	Added the following: • DHCFP approved Universal Needs Assessment, Physician Evaluations Form and Service Plan with statement of choice. • Retro request must be made within 90 days. • Eligibility requirements based on the Universal Needs Assessment Tool. • Services not to exceed 6 hours per day which is maximum allowed under Medicaid and a maximum of "365 days" based on meeting the eligibility criteria of the Universal Needs Assessment and Physician Evaluation. • Claims match dates and times of services received, providers must bill for actual units below 6 hours and nothing in excess of 6 hours. DHCFP will periodically request records to review against claims. • Reimbursement will not be made to LRI.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Changed requirement for incomplete information from 24 hours to 72 hours and stated the prior auth will be denied if information is not provided in 72 hours.
1804	**Quality Assurance**	Added DHCFP will conduct quality assurance reviews of program requirements and provider requirements.
1805	**Hearings**	Clarified and streamlined reference to MSM 3100.
1806	**References and Cross References**	Updated MSM chapter names to reflect current names. Added reference to Program Integrity, Chapter 3300. Replaced First Health to Magellan and removed reference to Pharmacy Point of Sale Department.

DIVISION OF HEALTH CARE FINANCING AND POLICY

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ADULT DAY HEALTH CARE SERVICES

1800 INTRODUCTION

ADULT DAY HEALTH CARE (ADHC)

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 are provided by the Nevada Medicaid Program 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 Deficit Reduction Act, Section 6086. Congress amended the Social Security Act with Section 1915(i) allowing states to provide traditional 1915(c) services as covered State Plan benefits. ADHC was covered under Nevada's State Plan.

1802 DEFINITIONS

ADULT DAY CARE FACILITY

Adult Day Care Facility is defined by Nevada Revised Statutes (NRS) 449.004 as an establishment operated and maintained to provide care during the day, temporary or permanent, for aged or infirm persons, but does not include halfway houses for recovering alcoholics or drug abusers. The emphasis is social interaction in a safe environment. Adult Day Care Facilities are required by NRS to be licensed by the Bureau of Health Care Quality and Compliance (HCQC), Nevada State Health Division. Refer to Medicaid Services Manual (MSM) Chapter 2200.

ADULT DAY HEALTH CARE (ADHC) FACILITY

ADHC Facilities provide medical services on a regularly scheduled basis as specified in the plan of care. Services must be provided in a non-institutional community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. The inclusion of "health" in a day care setting should indicate they provide elements of health care and are not just a model of socialization for seniors. Facilities providing these services are licensed by the HCQC, Nevada State Health Division. ADHC Facilities must meet the criteria set forth by Medicaid for reimbursement for Adult Day Health Services.

ATTENDANCE RECORD/DAILY RECORD

The attendance/daily record is documentation by a facility, indicating the time the recipient arrived at the facility and the time the recipient left the facility. The documentation includes the recipient's initials daily with a full signature of the recipient on each record. If the recipient is unable to provide a signature due to cognitive and/or physical limitation, this will be clearly documented in the recipient file.

Providers may use electronic signatures on the attendance/daily record documentation, but using an electronic signature does not remove the provider's responsibility for providing accurate and verifiable documentation of services provided and the time spent providing those services.

If a provider elects to use electronic signatures, they must have weekly printouts of the daily record in the recipient's file, or have the ability to make available upon request.

LEGALLY RESPONSIBLE INDIVIDUAL (LRI)

Individuals who are legally responsible to provide medical support, including spouses of recipients, legal guardians, parents of minor recipients including stepparents, foster parents, and adoptive parents.

PHYSICIAN EVALUATION

An evaluation completed by a physician to evaluate an individual's complete medical history.

PLAN OF CARE

The plan of care is the operational tool which is developed within 30 days of attendance in ADHC. The plan of care must meet the requirements of Nevada Administrative Code (NAC) 449.4088 and include objectives and directives for all medical treatment, medication administration and management, restorative therapy, social and recreational activities, case management and nutritional services. The plan of care outlines the services to be provided to the recipient while in attendance in an ADHC Facility and is updated anytime there is a change in status or services.

SERVICE PLAN

The service plan is an authorization tool that is developed by the facility using the Physician Evaluation Form and the Universal Needs Assessment Tool. The service plan addresses the delivery of services, provides guidelines for monitoring recipient's progress and identifies the title of the staff that will be providing the specific services identified in the plan of care. The service plan requires pre-approval for services to be provided, authorization for new treatment, and is part of the prior authorization process.

UNIVERSAL NEEDS ASSESSMENT

The Universal Needs Assessment is a needs based assessment that is completed by an independent third party. It is person-centered and focuses on the level of support needed, not deficits in skill.

1803 POLICY

1803.1 ADULT DAY HEALTH CARE (ADHC) SERVICES

ADHC 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 non-institutional or community-based setting. Services provided by the appropriate professional staff include the following:

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

b. restorative therapy and care;

c. nutritional assessment and planning;

d. 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;

e. recipient training in Activities of Daily Living (ADLs);

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

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

h. meals provided as a part of these services shall not constitute a "full regimen" which is three (3) meals per day.

1803.1A COVERAGE AND LIMITATIONS

1. ELIGIBLE RECIPIENTS

a. The individual must be Medicaid eligible.

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

c. The individual must meet the 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. 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.

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 will 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 habilitation 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) and are certified by the Division of Health Care Financing and Policy (DHCFP). 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 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

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 DHCFP, through the Quality Improvement Organization (QIO)-like vendor and must submit required licenses, registrations, certificates, etc., as stated in MSM 100.

As part of the contracting process, DHCFP staff will conduct an onsite review of the ADHC facility to determine whether the additional requirements are met.

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

Subsequent to the initial review, DHCFP may schedule an onsite review at any given time (at least annually) without cause to assure the facility maintains compliance with the Medicaid criteria.

a. Criminal Background Checks

Under NRS 449.176 through NRS 449.188, people who have been convicted of certain crimes may not work at certain long term care facilities or agencies. The complete statute is available at http://leg.state.nv.us/NRS/NRS-449.html and the requirements applying to ADHC facilities are discussed at length at the HCQC website: http://health.nv.gov/HCQC_CriminalHistory.htm.

All agency personnel, including owners, officers, administrators, managers, employees and consultants must undergo State and Federal Bureau of Investigation (FBI) background checks upon licensure and then at a minimum of every five (5) years thereafter to ensure no convictions of applicable offenses have been incurred.

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

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 DHCFP upon request.

1. The DHCFP or their designee will not enroll any person or entity convicted of a felony or misdemeanor for any offense which the State agency determines is inconsistent with the best interests of recipients. Such determinations are solely the responsibility of DHCFP.

2. The DHCFP applies the requirements of NRS 449.176 through NRS 449.188 and will deny a provider contract to any applicant, or may suspend or revoke all associated provider contracts of any provider, to participate in the Medicaid program if the requirements of the referenced NRS sections are not met. In addition, see MSM Chapter 100.

    a. If the Provider receives information related to NRS 449.176 through NRS 449.188 resulting from the criminal background check or from any other source and continues to employ a person who has been convicted of an offense as listed above, DHCFP will take appropriate action, which may include suspension or termination of the agency's Medicaid provider contract.

    b. If the hiring/employing agency does not take timely and appropriate action on the results of the background check as defined in 449.176 through NRS 449.188 and on the HCQC website, DHCFP will take appropriate action, which may include suspension or termination of the agency's Medicaid provider contract.

    c. 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 and DHCFP 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

Facility employees must complete either a QuantiFERON®-TB Gold blood test (QFT-G) or a two step (TB) Tuberculin skin test prior to initiation of services with a Medicaid recipient in accordance with NAC 441.375. Thereafter, each employee must receive a QFT-G blood test or one step TB skin test, annually, prior to the expiration of the initial test. If the employee has a documented history of a positive

QFT-G or TB skin test (+10 mm induration or larger) they must have clearance by a chest x-ray prior to initiation of services with a Medicaid recipient.

If the employee has been medically cleared after a documented history of a positive QFT-G or TB skin test which was 10 mm or larger and then by chest x-ray, the employee must have documentation annually which demonstrates they are not exhibiting any signs or symptoms of active TB. 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 3 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 tuberculosis.

Annual screening for signs and symptoms of active disease must be completed prior to the one year anniversary of the last screening. Documentation of the annual screening, when required as defined herein, and the results must be maintained in the employee's file.

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.

2. STAFFING REQUIREMENTS

An ADHC facility 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. Refer to MSM Chapter 100, section 102.1 for more information.

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 must employ a RN to oversee and provide medical services ordered by a physician. The RN must have at least one (1) year of experience with the senior population and individuals with disabilities. The RN is responsible for conducting a recipient's health assessment within the first thirty days of admission and is responsible for developing the plan of care and the management of each recipient's care and treatment. A RN or Licensed Practical Nurse (LPN) under the supervision of an RN, will administer medications provided to the recipient while in the facility's care. An RN, or LPN under the supervision of an RN, must be on duty during the hours in which a Medicaid Eligible recipient is in attendance at the facility.

b. PROGRAM DIRECTOR

The facility must employ a Program Director who has a minimum of two (2) or more years of education and/or experience with the senior population and individuals with disabilities.

The duties of the Program Director will include at a minimum the development of plans and policies for the facility'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 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 must have direct care staff who observe 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.

The facility 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 will 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's functioning and treatment needs every 365 days.

4. UNIVERSAL NEEDS ASSESSMENT

The "1915(i) HCBS Universal Needs Assessment Tool" must be used to evaluate and reevaluate 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 2 or more ADLs;

b. the need for significant assistance to perform ADLs;

c. risk of harm;

d. the need for supervision; and

e. functional deficits secondary to cognitive and/or behavioral impairments.

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:

f. related by blood or marriage to the individual;

g. any paid caregiver of the individual;

h. financially responsible for the individual;

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

j. service providers or individuals or corporations with financial relationships with any providers.

The physician must re-evaluate the recipient's eligibility annually.

5. SERVICE PLAN

A service plan will 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 will 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 treatment 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, DHCFP will review a representative sample of participant service plans each year.

6. PLAN OF CARE

A plan of care must be developed within 30 days after the admission of the recipient to the ADHC facility 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 plan of care must be developed and meet the requirement of NAC 449. 4088.

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

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 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 at least every 365 days when a new prior authorization has been approved, or as needed when there is significant change in the individual's circumstances.

The plan of care must be kept in a file maintained for the recipient.

7. 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.

In compliance with NAC 449.40835, the facility must maintain records on recipients including daily progress notes. 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 progress notes.

Recipient records must include:

d. 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.

e. Physician Evaluation.

f. Universal Needs Assessment.

g. Service Plan.

h. Statement indicating recipient made an informed choice in providers.

i. Plan of Care.

j. Attendance Records/Daily Records.

The RN is responsible for the recipient's care and treatment.

The facility must maintain an accurate record of the recipient's attendance by using an attendance/daily 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.

8. 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.

9. 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.

10. 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:

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

b. 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.

11. HIPAA, PRIVACY AND CONFIDENTIALITY

Refer to MSM Chapter 100 for information on HIPAA, privacy and confidentiality of recipient records and other protected health information.

1803.1C RECIPIENT RESPONSIBILITIES

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 plan of care using a person centered process.

4. Obtaining required TB testing per NAC 441.380.

1803.1D DHCFP DISTRICT OFFICE RESPONSIBILITIES

The DHCFP District Office will approve all HCBS Universal Needs Assessments and Physician Evaluation Form for prior authorization consideration.

This approval will be done for all new ADHC recipients and current ADHC recipients who are due a redetermination.

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 seventy-two (72) hours of notification. When complete information is submitted, the QIO-like vendor will make a decision within five (5) business days.

In the case when an individual becomes eligible for Medicaid during the course of treatment or after services were provided, the ADHC provider may request a retro-eligible authorization by submitting the "ADHC Prior Authorization Request Form" accompanied by the medical record including the Physician Evaluation, 1915(i) HCBS Universal Needs Assessment Tool, Service Plan (including the statement that the recipient was offered a

choice of ADHC providers), plan of care and progress notes encompassing the time period for which the authorization is requested.

The retro-eligible request must be submitted within ninety (90) days of the notice of decision. When complete information is submitted, the QIO-like vendor will make a determination within thirty (30) days.

a. 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 provider believes it is medically necessary for additional services to be rendered beyond that of the current authorization. The new prior authorization must be submitted no less than fifteen (15) days prior to the end of the current authorization period so an interruption in services may be avoided.

3. A retro-eligible request may occur when an individual becomes eligible for Medicaid after services have been provided. Retro-eligible requests must be submitted within ninety (90) days from the eligibility determination date (date of decision).

b. 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.

5. Approval of DHCFP District Office Health Care Coordinator (HCC) on the Universal Needs Assessment and Physician Evaluation.

Prior authorization may be approved for a maximum of 365 days. 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.

A prior authorization number is required on all claims and must correspond directly to all dates of service on the claim. No dates of service billed outside of the dates approved on the corresponding prior authorization will be paid.

The QIO-like vendor will 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.

Claims must reflect dates of service as indicated on the attendance/daily records. If a recipient is expected to be in attendance six (6) or more hours per day, five (5) days per week, the provider may bill the maximum daily rate. If the recipient is expected to be in attendance under 6 hours per day, and less than 5 days per week, the provider must bill for the exact number of units the recipient is in attendance. The plan of care must clearly identify the number of hours a recipient is expected to be in attendance daily. Periodically, 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 QUALITY ASSURANCE

The DHCFP will conduct an annual review to assure the health and welfare, of the recipients served by the ADHC Facility. The review will consist of the program requirements identified in this chapter.

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 DHCFP's annual review process.

1805 HEARINGS

Reference DHCFP's MSM Chapter 3100, for Medicaid Recipient Hearing procedures.

1806 REFERENCES AND CROSS REFERENCES

Reference other chapters of the MSM which may correlate with Chapter 1800, Adult Day Health Care.

Chapter 100, Medicaid Program
Chapter 1900, Transportation
Chapter 3100, Hearings
Chapter 3300, Program Integrity
Chapter 3600, Managed Care Organization

Nevada Check Up Manual

Chapter 1000, Nevada Check Up

1806.1 PROVIDER RELATIONS UNITS

Magellan Medicaid Administration, Inc.
PO Box 30026
Reno, Nevada 89520-3026
Toll Free within Nevada (877) NEV-FHSC (638-3472)

PRIOR AUTHORIZATION DEPARTMENTS

Magellan Medicaid Administration, Inc.
HCM
4300 Cox Road
Glen Allen, VA 23060
(800) 525-2395