MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

September 13, 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 (ADHC) Services has been revised to provide clarification within the chapter for the difference between attendance records and daily records as they are two different forms under ADHC. This revision includes a list of training requirements for employees of ADHC facilities, includes requirement of recipient signature on plans of care and service plans, clarifies when the plan of care must be created by the ADHC facility and provides clarity between a daily record and an attendance record. There were changes in the Prior Authorization section to provide clarity. A statement that the QIO-like vendor will review and provide approval of service plans, prior to issuing a prior authorization was added. There is additional clarification regarding the four types of prior authorizations. Lastly added statutory requirements for the Social Security Act, 1915(i) and references to section 449 of the NRS and 449 of the NAC.

The Definitions and References and Cross References sections have been removed to be consistent with the MSM Chapters.

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

These policy changes are effective September 14, 2011.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 19/11 CHAPTER 1800 – ADULT DAY HEALTH CARE	MTL 04/11 CHAPTER 1800 – ADULT DAY HEALTH CARE

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1801	**Authority**	Added ADHC is an optional Medicaid State Plan

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Benefit and statutes/regulations for Social Security Act 1915(i), NRS 449 and NAC 449.
1802	**Definitions**	Removed and Reserved for future use.
1803	**Adult Day Health Care Services**	Added ADHC Facilities provide medical services on a regularly scheduled basis as specified in the Service Plan and clarification that ADHC must be in a community-based setting and not an institutional setting.
	Provider Responsibilities	Added the following information: • Training Requirement subsection. • Prior authorization request form is an acceptable service plan for provider clarification. • Service plan must include the identified needs from the Universal Needs Assessment and the Physician Evaluation. • Recipient signature requirement. • Annual TB tests. Clarified physician reevaluation within 365 days, eligibility for Universal Needs Assessment and first day of attendance.
	Prior Authorization and Billing	Clarified pre-authorization procedure. Added the following information: • District Office Approval Letter. • QIO-like vendors must review and approve all services plans and provide a written authorization to the ADHC facility. The prior authorization number must be included on all claims. • A type of prior authorization.
1806	**References and Cross References**	Section was removed.

DIVISION OF HEALTH CARE FINANCING AND POLICY

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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 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 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.

Statutes and Regulations:

- Social Security Act: 1915(i)
- Nevada Revised Statutes (NRS) Chapter 449
- Nevada Administrative Code (NAC) Chapter 449

1802 RESERVED

1803 POLICY

1803.1 ADULT DAY HEALTH CARE (ADHC) SERVICES

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:

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 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 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 must 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.

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:

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

2. procedures for billing and payment;

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

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

   a. understanding care goals;

   b. respecting recipient rights and needs;

   c. respect for age, cultural and ethnic differences;

   d. recognizing family relationships;

   e. confidentiality;

   f. respecting personal property;

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

   h. handling conflict and complaints; and

   i. 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

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 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 within 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;

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 every 365 days.

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 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 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 plan of care and any other signature requirements. If the facility uses a signature page, it must be included in the packet to the DHCFP district office and the QIO-like vendor for prior authorization.

6. PLAN OF CARE

A plan of care 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 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 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 plan of care and any other signature requirements. If the facility uses a signature page, it must be included in the packet to the DHCFP District Office and the QIO-like vendor for prior authorization.

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 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.

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.

k. Daily Records.

l. Annual TB tests.

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 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 must approve all HCBS Universal Needs Assessments, Physician Evaluation and Service Plans Form for prior authorization consideration.

This approval must 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 must 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

with:

a. the Physician Evaluation;

b. 1915(i) HCBS Universal Needs Assessment Tool;

c. Service Plan (including the statement that the recipient was offered a choice of ADHC providers);

d. plan of care;

e. District Office approval letter; and

f. daily records encompassing the time period for which the retro eligibility 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.

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 for continued service 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).

4. unscheduled changes to a current prior authorization are required when a recipient's needs change during the current authorization period. If this occurs, a revision prior authorization must be submitted for approval.

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.

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 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.