MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

January 8, 2015

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: TAMMY MOFFITT, CHIEF OF PROGRAM INTEGRITY

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

BACKGROUND AND EXPLANATION

Revisions to MSM Chapter 1800 are being proposed to clarify policy regarding provider enrollment requirements, retro eligibility authorizations and provider billing.

Current policy requires the DHCFP to conduct onsite reviews and inspections prior to enrollment as a Medicaid provider. However, the Bureau of Health Care Quality and Compliance conducts a similar review when initially licensing the facility. The proposed change will eliminate the need for an additional inspection by the DHCFP.

Retro-eligibility authorization wording is being removed as retro-eligibility authorization is not available for this service. Chapter changes also provide clarification for when it is appropriate to bill a per diem rate versus a unit rate.

There is no anticipated financial impact anticipated from these policy changes.

These changes are effective February 1, 2015.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 02/15 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
1803.1B.1	**Provider Responsibilities**	Removed references to initial site review of ADHC facilities by DHCFP as this is completed by the Bureau of Health Care Quality and Compliance (BHCQC) during the initial licensing of the facility.
1803.1E.1	**Prior Authorization and Billing**	Removed reference to retro-eligibility authorization, as it does not apply to this service.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1803.1E.2	**Prior Authorization and Billing**	Included the following clarification due to rates development of a daily rate and a unit rate: Providers are responsible for requesting the appropriate number of days or units the recipient requires for attendance. If a recipient is expected to be in attendance full time which is six or more hours per day, five days per week, the daily rate will be utilized. If the recipient is expected to be in attendance less than full time, the unit rate will be utilized. The provider must bill for the exact number of units the recipient is in attendance. The POC must clearly identify the number of days or units a recipient is expected to be in attendance. Claims must reflect dates of service as indicated on the attendance records.

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 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 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 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

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:

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

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

3. 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. 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 full time RN to oversee and provide medical services ordered by a physician. The RN must have at least one 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 30 days of admission and is responsible for developing the Plan of Care (POC) and 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 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 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.

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 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.

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 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. ATTENDANCE RECORD AND PROGRESS/NURSING NOTES

The facility must have documentation of daily attendance and notes that document the health component of this service. This documentation is verification of service provision and may be used to review claims paid.

The recipient and a facility 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. An authorized representative may sign on behalf of 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.

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:

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.

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 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 POC using a person centered process.

4. Obtaining required TB testing per NAC 441.380.

1803.1D RESERVED

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.

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 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 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 the DHCFP's annual review process.

1805 HEARINGS

Reference the Division of Health Care Financing and Policy (DHCFP)'s Medicaid Services Manual (MSM) Chapter 3100 for Medicaid Recipient Hearing procedures.