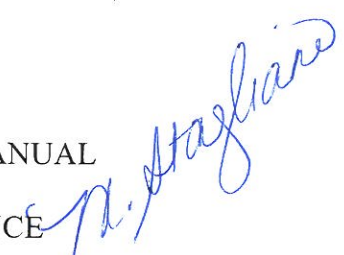


MEDICAID SERVICES MANUAL  
TRANSMITTAL LETTER

August 10, 2010

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL  
FROM: MARTA E. STAGLIANO, CHIEF, COMPLIANCE   
SUBJECT: MEDICAID SERVICES MANUAL CHANGES  
CHAPTER 2200 – HOME AND COMMUNITY-BASED WAIVER  
(HCBW) FOR THE FRAIL ELDERLY

**BACKGROUND AND EXPLANATION**

Medicaid Services Manual Chapter 2200 – Home and Community Based Waiver (HCBW) for the Frail Elderly has been revised for the following reasons:

- To establish program efficiencies and update existing policy for consistency with the current approved waiver, Code of Federal Regulations (CFR), Nevada Revised Statutes (NRS) and the Nevada Administrative Code (NAC) regulations.
- The existing policy has been updated to identify administrative case management activities separately from direct service case management.
- Added existing policy for Hospice Services.
- Provider requirements for Criminal Background Checks, Serious Occurrence Reporting and Training have been placed into one section to avoid duplication.
- A minor policy change was made regarding the Notification of Decision (NOD) section. The 30 and 60 day pending notifications were removed from policy.
- Nutrition Therapy Services is eliminated, as this service has not been utilized through this waiver. Medicaid recipients are able to receive nutrition services through their primary care physician.
- Nursing Facility (NF) has been eliminated as a provider for respite care. This service will continue to be provided in-home by agency providers.

Definitions have been updated for clarity and to be consistent with other relevant Medicaid Services Manual Chapters and references to Medicaid Services Manual Chapters and websites for contact information were added.

Throughout the chapter, grammar and punctuation changes were made, duplications removed, acronyms standardized, language reworded for clarity, Legally Responsible Adult/Guardian was replaced with Legally Responsible Individual and clarifications were made throughout the chapter to distinguish between the organization Division of Health Care Financing and Policy (DHCFP) and Nevada Medicaid (the health care program). Renumbering of many sections was necessary.

These policy changes are effective August 11, 2010.

**MATERIAL TRANSMITTED**

MTL 31/10  
CHAPTER 2200 – HOME AND  
COMMUNITY-BASED WAIVER (HCBW)  
FOR THE FRAIL ELDERLY

**MATERIAL SUPERSEDED**

MTL 06/09, 13/09  
CHAPTER 2200 – HOME AND  
COMMUNITY-BASED WAIVER (HCBW)  
FOR THE FRAIL ELDERLY

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
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**Addendum**

**Addendum**

Section was deleted and information moved throughout the chapter.

**2200**

**Introduction**

Removed reference to Nevada Check Up & clarified existing language.

**2201**

**Authority**

Clarified existing language

**2202**

**Definitions**

Removed individual definition numbering from this section.

The following definitions were added:

- Activities of Daily Living (ADLs)
- Administrative Case Management Activities
- Adult Day Care
- Aging and Disability Services Division (ADSD)
- Annual
- Applicant
- Direct Service Case Management
- Instrumental Activities of Daily Living (IADLs)
- Legally Responsible Individual
- Level of Care (LOC) Screening
- Patient Liability
- Prior Authorization (PA)
- Recipient
- Scope

The following definitions were deleted:

- Administrative Services
- Case Management
- CHIP
- Division of Aging Services (DAS)
- Individual Providers
- Nursing Facility Level of Care
- Nutrition Therapy Services
- Service Plan
- Social Model Adult Day Care

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2203.1	<b>Administrative Case Management Activities</b>	<p>Clarified the definitions of:</p> <ul style="list-style-type: none"> <li>• Daily Record</li> <li>• Plan of Care (POC)</li> <li>• Statement of Understanding (SOU)</li> </ul> <p>Added new section “Administrative Case Management Activities” and Administrative Activities policy and language regarding POC for clarity.</p> <p>Signature on Plan of Care was moved from Addendum section and additional information from section 2203.15B was added.</p>
2203.2	<b>Waiver Eligibility Criteria</b>  <b>Coverage and Limitations</b>       <b>Provider Responsibilities</b>	<p>Renamed section Eligibility Criteria to Waiver Eligibility Criteria.</p> <p>Updated wait list priorities and added existing policy for Hospice Services.</p> <p>Removed patient liability process section and reference to the LOC form - this is a process not policy.</p> <p>Added waiver requirement regarding applicants can be placed from a nursing facility, acute care facility or another waiver program and provision of one waiver service at least monthly and requirement cannot receive services under two or more programs at the same time.</p> <p>Removed ADSD responsibility for collecting patient liability and added Provider responsibility for prior authorization.</p>
2203.3	<b>Waiver Services</b>	<p>Additional service hours approved for temporary conditions was moved here from the Addendum section and additional information from section 2203.5B.1.c.</p> <p>Added the following information:</p> <ul style="list-style-type: none"> <li>• Provider Responsibility, HIPAA, Privacy and Confidentiality reference to comply with MSM Chapter 100.</li> <li>• Language referring to NRS 449.176 through</li> </ul>

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		<p>449.188 Criminal Background checks and Serious Occurrence Report for consistency with MSM.</p> <ul style="list-style-type: none"> <li>• ADSD/DHCFP may review exemption for appropriateness and Provider Agency requirement of obtaining and maintaining a State required business license.</li> <li>• Requirement for Recipient Responsibilities.</li> </ul> <p>Removed obsolete requirement - replaced with new language and renumbered language for consistency with the approved waiver, obsolete reference to Individual providers.</p> <p>Clarified provider responsibilities for Daily Records and updated Appendix reference number for Waiver Services Specifications for consistency with the approved waiver.</p>
2203.4	<p><b>Direct Service Case Management</b></p> <p><b>Coverage and Limitations</b></p> <p><b>Provider Responsibility</b></p> <p><b>Recipient Responsibility</b></p>	<p>Renamed Case Management to Direct Service Case Management</p> <p>Added language clarifying quality of care.</p> <p>Plan of Care does not need revision due to temporary conditions was moved here from the Addendum section, Case Management will be considered an “as needed” service was moved here from the Addendum section and removed language that is now obsolete, and additional information from section 2203.15A.1-2.</p> <p>Added language to clarify provider qualifications.</p> <p>Removed recipient responsibilities related to Administrative Activities and replaced with Direct Service Case Management recipient responsibilities.</p>
2203.5	<b>Homemaker Services</b>	<p>Clarified requirement for provider enrollment as Medicaid provider and Homemaker Services by listing into categories of service.</p> <p>Added language clarifying services are directed to recipient only and related to their health and</p>

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		welfare and information per ADSD request to clarify service.
		Removed obsolete information and language referring to ADSD.
2203.6	<b>Chore Services</b>	Added a heavy household chore, clarified and deleted non-applicable information.
2203.7	<b>Respite Care</b>	Removed language regarding nursing facility as a place of service and duplicate responsibilities already covered in All Provider responsibilities and references to Individual Providers.
2203.8	<b>Personal Emergency Response System (PERS)</b>	Reworded and added language per ADSD request to clarify service.
2203.9	<b>Adult Day Care Services</b>	Renamed section from Social Adult Day Care Service to Adult Day Care Services and added language to clarify services.
2203.10	<b>Adult Companion Services</b>	Removed Nutrition Therapy Service Section.  Added and clarified language for consistency with the approved waiver.
2203.11	<b>Provider Enrollment/ Termination</b>	Added language to be consistent with MSM Chapter 100.
2203.12	<b>Intake Procedures</b>	Slot Provision Section was deleted. The section was updated per ADSD request to clarify current process.  Changed language per ADSD request to clarify current process and to make process more efficient.  Removed language regarding 30 and 60 day pending notifications to reflect current policy and requirement per NRS 232.357 sharing information without a signed Authorization for Release of Information as HIPAA supersedes this statute.  Added language per ADSD clarifying effective date

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		for waiver services.
2203.13	<b>Billing Procedures</b>	Added Definitions of Billing Procedures and language for clarifying process.
2203.15	<b>DHCFP's Annual Review</b>	Removed Case Manager Recipient Contacts section.
		Renumbered and renamed Medicaid's Annual Review to DHCFP's Annual Review.
	<b>Coverage and Limitations</b>	Added language for consistency with the CMS Technical Guide for the approved waiver.
2204	<b>Hearings</b>	Renamed to be consistent with all waiver Chapters.
2204.1	<b>Suspended Waiver Services</b>	Added language to clarify process.
2204.2	<b>Release from Suspended Waiver Services</b>	Added language per ADSD to clarify process.
2204.3	<b>Termination of Waiver Services</b>	Added sentence per ADSD request to clarify process.
2204.5	<b>Reduction of Waiver Services</b>	Changed language per ADSD request to make process more efficient and removed information that was not applicable.
2204.6	<b>Reauthorization within 90 days of Waiver Termination</b>	Deleted information as it was no longer applicable to this chapter.
2205	<b>Appeals and Hearings</b>	Added new section and reference to MSM Chapter 3100.
2206	<b>References and Cross References</b>	Added and deleted as applicable to this Chapter.

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2200 INTRODUCTION

The Home and Community-Based Waiver (HCBW) Program recognizes that many individuals at risk of being placed in hospitals or nursing facilities can be cared for in their homes and communities, preserving their independence and ties to family and friends at an **average** cost no higher than that of institutional care.

**Division of Health Care Financing and Policy's (DHCFP)** Waiver for the Frail Elderly originated in 1987. The provision of waiver services is based on the identified needs of the waiver recipient. Every biennium the service needs and the funded slot needs of the waiver program are reviewed by the Aging **and Disability Services Division (ADSD)** and by the DHCFP (also known as Nevada Medicaid) and presented to the Nevada State Legislature for approval. Nevada is committed to the goal of providing the elderly with the opportunity to remain in a community setting in lieu of institutionalization. Nevada understands that people who are elderly are able to lead satisfying and productive lives when they are provided the needed services and supports to do so. The **D**ivision is committed to the goals of self sufficiency and independence.

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2201 AUTHORITY

Section 1915 (c) of the Social Security Act permits states the option to waive certain Medicaid statutory requirements in order to offer an array of home and community-based services to eligible individuals who may require such services in order to remain in their communities and avoid institutionalization. **DHCFP** Home and Community-Based Waiver (**HCBW**) for the Frail Elderly is an optional service program approved by the Centers for Medicare and Medicaid Services (CMS). This waiver is designed to provide eligible Medicaid waiver recipients access to both state plan services as well as certain extended Medicaid covered services unique to this waiver. The goal is to allow recipients to live in their own homes, or community settings, when appropriate.

**DHCFP** has the flexibility to design this waiver and select the mix of waiver services that best meet the goals of the program. This flexibility is predicated on administrative and legislative support, as well as federal approval.

Statutes and Regulations:

- Social Security Act: 1915 (c)
- Social Security Act: 1902 (w)
- Omnibus Budget Reconciliation Act of, 1987
- Balanced Budget of Act of 1997
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- **42 CFR Part 441, Subparts G and H**
- 42 CFR Part 418
- 42 CFR Part 431, Subpart E
- State Medicaid Manual, Section 4440
- Nevada's Home and Community Based Waiver Agreement for the Frail Elderly
- Nevada Revised Statutes (NRS) Chapters **200, 427A, 422, 232.357, 449**
- Nevada Administrative Code (NAC) Chapters **427A, 441A, 449**

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2202 DEFINITIONS

These are brief definitions; full detail is located in the section addressing the definition.

**ACTIVITIES OF DAILY LIVING (ADLs)**

Basic personal everyday activities that include bathing, dressing, transferring, toileting, mobility and eating.

**ADMINISTRATIVE CASE MANAGEMENT ACTIVITIES**

Aging and Disability Services Division (ADSD) operates the Home and Community-Based Waiver (HCBW) for the Frail Elderly, including carrying out administrative activities such as data collection for eligibility verification, evaluation of Level of Care (LOC), Plan of Care (POC) development and annual reassessments. Administrative activities may not be billed as a direct service to the HCBW for the Frail Elderly.

**ADULT DAY CARE**

Adult Day Care provides socialization in a safe environment for frail, socially isolated, physically or cognitively impaired seniors in order for them to remain in the community. Services are provided for four or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting. Adult Day Care services include, supervision, monitoring of general well-being and social interaction through scheduled activities and peer contact.

Adult Day Care does not provide elements of health care, which differentiate Adult Day Care from Adult Day Health Care.

**AGING AND DISABILITY SERVICES DIVISION (ADSD)**

A State agency that is part of Nevada’s Department of Health and Human Services (DHHS) and is the operating agency for the HCBW for the Frail Elderly.

**ANNUAL**

For purposes of reassessing waiver recipients, annual means not to exceed 365 days.

**APPLICANT**

An individual who is applying for waiver services.

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## ASSESSMENT

A written evaluation of each waiver applicant/recipient that includes the individual's abilities to perform activities of daily living, the individual's medical and social needs, the individual's support system and all other services received currently by the individual. This assessment is used to develop the applicant's/recipient's **POC**.

## CHORE SERVICE

Extended homemaker service needed to maintain the recipient's living space as a clean, sanitary, and safe environment.

## COMPANION SERVICES

A non-medical care, supervision and socialization service provided to the functionally impaired adult in his/her home or place of residence, which **may** provide temporary relief for the primary caregiver.

## DAILY RECORD

The **Daily Record** is documentation completed by a provider, indicating the **scope and frequency** of the service provided. **The documentation will include 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 limitations, this will be clearly documented in the recipient file. The provider will initial after the daily services are delivered, with a full signature of the provider on each daily record.**

**Providers may use electronic signatures on the daily record documentation, but using an electronic signature does not remove the provider's responsibility for providing accurate and verifiable documentation indicating the scope and frequency of services provided.**

**If a provider elects to use electronic signatures, they must have weekly printouts of the daily record in the recipient's file.**

## DIRECT SERVICE CASE MANAGEMENT

**This service assists recipients in gaining access to needed HCBW services, Medicaid State Plan services, as well as needed medical, social, educational, and all other services, regardless of the funding source for the services to which access is gained.**

## HOMEMAKER SERVICE

Services consisting of **light housekeeping tasks** including cleaning, laundry, **essential** shopping, and meal preparation.

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### **INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)**

Activities related to independent living, including preparing meals, shopping for groceries or personal items, performing light or heavy housework, and communication.

### **LEGALLY RESPONSIBLE INDIVIDUAL**

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

### **LEVEL OF CARE (LOC) SCREENING**

The LOC screening is an assessment used to identify if an individual’s condition requires the level of care provided in a nursing facility. It is the screening that ADSD conducts to determine whether the applicant/recipient is eligible for the waiver. The same tool is utilized for admission to nursing facilities.

### **PATIENT LIABILITY**

“Patient Liability” is that portion of a recipient’s income that must be paid toward the cost of care.

### **PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)**

An electronic device that enables certain individuals at high risk of institutionalization to secure help in an emergency.

### **PLAN OF CARE (POC)**

A written document which specifies the amount, duration, frequency and type of provider for all waiver services, as well as other ongoing community support services that are furnished to meet the assessed needs of the recipient, regardless of the funding source. In addition, the POC documents the recipient’s identified risk factors and personal goal(s) related to waiver services.

### **PRIOR AUTHORIZATION (PA)**

Refer to Medicaid Services Manual Chapter 100, Section 103.2.

### **RECIPIENT**

An individual who is enrolled in the Waiver for the Frail Elderly.

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### RESPITE SERVICE

Refers to those services provided to eligible recipients who are unable to care for themselves. These services are furnished on a short-term basis **due to** the absence or need for relief of those persons normally providing the care.

### SCOPE

The types of activities that are undertaken on behalf of a waiver recipient. The definition of the service is termed the “scope” of the service.

### SLOT

The number of available openings **which** may be offered to eligible recipients during each **fiscal year**. The number of slots available is determined by the **level of** legislative funding approved per **fiscal year** and through an agreement with **Centers for Medicare and Medicaid Services (CMS)**.

Open slots refer to the number of **people** on the waiver **in** any one day.

### STATEMENT OF UNDERSTANDING (SOU)

The **SOU is the form used to inform** applicants of their right to choose between the **HCBW** for the Frail Elderly or placement in a nursing facility, as well as their right to file a grievance. The form must be signed by the applicant or the applicant’s authorized representative if the applicant is not capable to sign the document.

### WAIT LIST

The list of waiver applicants who have been pre-screened and deemed eligible for the waiver and are waiting for a funded waiver slot.

### WAIVER YEAR

For the **HCBW** for the Frail Elderly, the waiver year begins July 1 and ends on June 30.

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2203 POLICY

**2203.1 ADMINISTRATIVE CASE MANAGEMENT ACTIVITIES**

Administrative case management activities are performed by Aging and Disability Services Division (ADSD) case managers and refer to data collection for eligibility verification, Level of Care (LOC) evaluation, Plan of Care (POC) development, and other case management activities that are not identified on the POC.

**2203.1A COVERAGE AND LIMITATIONS**

Administrative case management activities include:

1. Intake referral;
2. Facilitating Medicaid eligibility, which may include assistance with the Medical Assistance to the Aged, Blind and Disabled (MAABD) application and obtaining documents required for eligibility determination;
3. Preliminary and ongoing assessments, evaluations and completion of forms required for service eligibility:
  - a. The POC identifies the waiver services as well as other ongoing community support services that the recipient needs in order to live successfully in the community. The POC must reflect the recipient's service needs and include both waiver and non-waiver services in place at the time of POC completion, along with informal supports that are necessary to address those needs.
  - b. The recipient's level of care, functional status and needs addressed by the POC must be reassessed annually or more often as needed. The recipient must also be reassessed when there is a significant change in his/her condition which influences eligibility. The reassessment is to be conducted during a face-to-face visit.
  - c. If services documented on a POC are approved by the recipient and the case manager and the recipient signature cannot be obtained due to extenuating circumstances, services can commence with verbal approval from the recipient. Case managers must document the recipient's verbal approval in the case notes and obtain the recipient signature on the POC as soon as possible.
4. Issuance of Notices of Actions (NOA) to Division of Health Care Finance and Policy (DHCFP) Central Office Waiver Unit staff to issue a Notice of Decision (NOD) when a waiver application is denied;



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5. Coordination of care and services to collaborate in discharge planning to transition applicants from facilities;
6. Documentation for case files prior to applicant's eligibility;
7. Case closure activities upon termination of service eligibility;
8. Outreach activities to educate recipients or potential recipients on how to enter into care through a Medicaid Program;
9. Communication of the POC to all affected providers;
10. Conduct the Functional Assessment (FA) and Service Plan development on behalf of those recipients who have identified personal care needs;
11. If attendant care services are medically necessary, the case manager is then responsible for implementation of services and continued authorization of services;
12. Determination of the cost effectiveness of each waiver service for each applicant/recipient;
13. Completion of prior authorization form prior to submission into the Medicaid Management Information System (MMIS).

**2203.1B PROVIDER RESPONSIBILITIES**

1. Administrative case management providers (social workers, nurses, certified case managers, etc.) must meet the professional or medical licensure as recognized by a Nevada State Board. These professionals must have experience in functional assessments and assisting recipients in the development of POCs to meet their basic needs and attainment of their goals while in the waiver program.
2. Must have one year of experience working with seniors in a home based environment. The case manager does not have to have this experience if the agency supervisor or administrator who supervises the case manager meets these qualifications.
3. Must have the ability to conduct home visits. If applicable, has a business license as required by city, county or state government.
4. Must follow Health Insurance Portability and Accountability (HIPAA) requirements.
5. Must have an FBI criminal history background check.

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### 2203.1C RECIPIENT RESPONSIBILITIES

1. Applicant/recipients and/or their authorized representative must cooperate with the ADSD by assisting with the assessment and reassessment process, accurately representing skill level needs, wants, resources and goals.
2. Applicants/recipients together with the case manager must develop and/or review the POC.

### 2203.2 WAIVER ELIGIBILITY CRITERIA

DHCFP's Home and Community-Based Waiver (HCBW) for the Frail Elderly waives certain statutory requirements and offers waiver services to eligible recipients to assist them to remain in their own homes or community.

### 2203.2A COVERAGE AND LIMITATIONS

1. Services are offered to eligible recipients who, without the waiver services, would require institutional care provided in a hospital or nursing facility. Recipients on this waiver must meet and maintain Medicaid's eligibility requirements for the waiver.
2. The HCBW for the Frail Elderly is limited by legislative mandate to a specific number of recipients who can be served through the waiver per year (slots). When all waiver slots are full, the ADSD utilizes a wait list to prioritize applicants who have been presumed to be eligible for the waiver.
3. When funding becomes available, the applicant will be processed for the program based on LOC score, risk factors, and date of referral. Applicants will be considered for a higher advancement on the Wait List based on whether they meet additional criteria. The following criteria may be utilized:
  - a. Applicants currently in an acute care or nursing facility and desiring discharge;
  - b. Applicants with the highest LOC score indicating greatest functional deficits;
  - c. Applicants requiring services due to a crisis or emergency such as a significant change in support system;
  - d. Applicants transitioning from another waiver;
  - e. Applicants with a terminal illness; or

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- f. Applicants requiring at least minimal essential personal care assistance (bathing, toileting, and eating) as defined by NRS 426.723.
4. Waiver services may not be provided while a recipient is an inpatient of an institution.
  5. **HCBW** for the Frail Elderly Eligibility Criteria:
    - a. Eligibility for Medicaid’s **HCBW** for the Frail Elderly is determined by the **DHCFP**, **ADSD**, and the Division of Welfare and Supportive Services (DWSS). These three State agencies collaboratively determine eligibility for the Frail Elderly Waiver as follows:
      1. Waiver benefit plan eligibility is determined by **ADSD** and authorized by **DHCFP** Central Office Waiver Unit by confirming the following criteria:
        - a. Applicants must be 65 years of age or older;
        - b. Each applicant/recipient must meet and maintain a level of care for admission into a nursing facility and would require imminent placement in a nursing facility (within 30 days **or less**) if **HCBW** services or other supports were not available;
        - c. Each applicant/recipient must demonstrate a continued need for the services **offered under the HCBW** for the **Frail Elderly** to prevent placement in a nursing facility or hospital. Utilization of State Plan Services only does not support the qualifications to be covered by the waiver;
        - d. **The applicant/recipient must require the provision of one (1) waiver service at least monthly;**
        - e. The applicant/recipient must have an adequate support system. This support system must be in place to ensure the physical, environmental, and basic care needs of the **applicant/recipient** are met in order to provide a safe environment during the hours when home and community-based services are not being provided; **and**
        - f. **Applicants may be placed from a nursing facility, an acute care facility, another HCBW program, or the community.**
      2. **Waiver applications** must be approved by **DHCFP** Central Office Waiver Unit **to ensure the level of care criteria is met.**

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3. DWSS validates the applicant is eligible for Medicaid waiver services using institutional income and resource guidelines.
  - a. Recipients of the HCBW for the Frail Elderly must be Medicaid eligible for full Medicaid benefits for each month in which waiver services are provided.
  - b. Services for the HCBW for the Frail Elderly shall not be provided and will not be reimbursed until the applicant is found eligible for benefit plan services, full Medicaid eligibility, and prior authorization as required.
  - c. Medicaid recipients in the HCBW for the Frail Elderly may have to pay for part of the cost of the waiver services. The amount they are required to pay is called patient liability.
4. If an applicant is determined eligible for more than one HCBW program, the individual cannot receive services under two or more such programs at the same time. The applicant must choose one HCBW program and receive services provided by that program.
5. Recipients of the HCBW for the Frail Elderly who are enrolled or elect to enroll in a hospice program may be eligible to remain on the waiver if they require waiver services to remain in the community. Close coordination between the hospice agency and the waiver case manager is required to prevent any duplication of services. Refer to Medicaid Services Manual (MSM) Chapter 3200 for additional information on hospice services.

#### 2203.2B PROVIDER RESPONSIBILITIES

1. Providers are responsible for confirming the recipient's Medicaid eligibility each month prior to rendering waiver services.
2. Providers are responsible for assuring prior authorization is established before services are provided.

#### 2203.2C RECIPIENT RESPONSIBILITIES

Applicants/recipients must meet and maintain all eligibility criteria to become eligible and to remain on the HCBW for the Frail Elderly.

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**2203.2D** MEDICAID EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)

Recipients of this waiver are not eligible for EPSDT.

**2203.3** WAIVER SERVICES

**DHCFP** determines which services will be offered under the **HCBW** for the Frail Elderly. Providers and recipients must agree to comply with all program requirements for service provision.

**2203.3A** COVERAGE AND LIMITATIONS

Under this waiver, the following services are covered if identified in the **POC** as necessary to avoid institutionalization.

1. **Direct Service** Case Management
2. Homemaker Services
3. Chore Services
4. Respite Care Services
5. Personal Emergency Response System (PERS)
6. Adult Day Care Services
7. Adult Companion Services

**2203.3B** PROVIDER RESPONSIBILITIES

1. All Service Providers:
  - a. Must obtain and maintain a **HCBW** for the Frail Elderly provider number (**Provider Type 48**) through the **DHCFP** fiscal agent.
  - b. In addition to this Chapter, the provider must also comply with rules and regulations for providers as set forth in the **MSM** Chapter 100.
  - c. Must understand the authorized service specification on the **POC**, record keeping responsibilities and billing procedures for provided waiver services.

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- d. Payments will not be made to legally responsible individuals for furnishing waiver services.
- e. All providers may only provide services that have been identified in the POC and that have a prior authorization.
- f. Providers must verify the Medicaid eligibility status of each HCBW for Frail Elderly recipient each month.
- g. **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 Provider Agencies are discussed at length at the Bureau of Health Care Quality and Compliance (HCQC) website: [http://health.nv.gov/HCQC\\_CriminalHistory.htm](http://health.nv.gov/HCQC_CriminalHistory.htm).

All agency personnel, including owners, officers, administrators, managers, employees and consultants must undergo State and FBI background check 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 the employee 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

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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](http://health.nv.gov/HCQC_CriminalHistory.htm)
- h. Providers must be able to: perform the duties of the job; demonstrate maturity of attitude toward work assignments; **communicate** effectively; work under intermittent supervision; deal with minor emergencies arising in connection with the assignment **and act accordingly**, reporting these to the proper supervisor; **demonstrate** ability to understand, respect and maintain confidentiality in regards to the details of case circumstances.
- i. Each provider must **have a file** for each recipient. **In the recipient's file, the provider must have a copy of the current POC and maintain daily records, fully documenting the scope and frequency of services as specified on the POC. The documentation will include the recipient's initials with a full signature of the recipient on each daily record. If the recipient is unable to provide a signature due to cognitive and/or physical limitations, this will be clearly documented in the recipient file. The provider will initial after the daily services are delivered, with a full signature of the provider on each daily record. If a provider elects to use electronic signatures, they must have weekly printouts of the daily record in the recipient's file.**



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Periodically, Medicaid Central Office/**ADSD** staff may request this documentation to compare it to submitted **claims**. These records must be maintained by the provider for at least six (6) years after the date the claim is paid.

- j. The number of hours specified on each recipient POC, for each specific service (except Case Management), will be considered the maximum number of hours allowed to be provided by the caregiver and paid by DHCFP fiscal agent, unless the case manager has approved additional hours due to a temporary condition or circumstance. If caregivers provide fewer services than authorized on the POC, the reason must be adequately documented in the daily record and communicated to the case manager.
- k. The provider must have service specific training prior to performing a waiver service.
- l. Cooperate with **ADSD** and/or State or Federal reviews or inspections.
- m. **Serious Occurrence Report (SOR):**

Providers must report any recipient incidents, or issues regarding the provider/employee's ability to deliver services to the **ADSD** case manager by telephone/fax within 24 hours of discovery. A completed SOR form report must be made within five (5) working days and maintained in the agency's recipient record.

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

1. Suspected physical or verbal abuse;
2. Unplanned hospitalization;
3. Neglect of the recipient;
4. Exploitation;
5. Sexual harassment or sexual abuse;
6. Injuries requiring medical intervention;
7. An unsafe working environment;
8. Any event which is reported to Child or Elder Protective Services or law enforcement agencies;

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9. Death of the recipient during the provision of waiver services; or

10. Loss of contact with the recipient for three consecutive scheduled days.

The State of Nevada has established mandatory reporting requirements of suspected incidents of Elder Abuse, Neglect, Isolation and Exploitation. ADSD and local law enforcement are the receivers of such reports. Suspected elder abuse must be reported as soon as possible, but no later than 24 hours of identification/suspicion. Refer to NRS 200.5091 to 200.50995 regarding elder abuse or neglect.

n. HIPAA, Privacy and Confidentiality

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

2. Aging and Disability Services Division (ADSD):

a. Maintains compliance with the Interlocal Agreement with the DHCFP to operate the HCBW for the Frail Elderly.

b. Must comply with Appendix C-3: Waiver Service Specifications in HCBW for the Frail Elderly.

3. Agency Providers:

a. Agencies employing providers of service to the waiver program must arrange training in the following subjects:

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 SORs;

4. information about the specific needs and goals of the recipients to be served;

5. interpersonal and communication skills and appropriate attitudes for working effectively with recipients including: understanding care goals; respecting recipient rights and needs; respect for age, cultural and ethnic differences; recognizing family relationships; confidentiality; respecting

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personal property; ethics in dealing with the recipient, family and other providers; handling conflict and complaints; and other topics as relevant;  
**and**

6. any other training as designated by **ADSD**.
- b. Exemptions from Training
1. The **provider** agency may exempt a prospective service provider from those parts of the required training where the agency judges the person to possess adequate knowledge or experience, or where the provider's duties will not require the particular skills.
  2. The exemption and its rationale must be provided in writing and a copy of the exemption must be placed in the recipient's case record.
  3. **ADSD/DHCFP may review exemptions for appropriateness.**
- c. Complete an American with Disabilities Act (ADA) Self Evaluation to assure compliance with the Act.
- d. **Obtain and maintain a State required business license.**

### 2203.3C RECIPIENT RESPONSIBILITIES

The recipient or the recipient's authorized representative will:

1. notify the provider(s) and the **ADSD** case manager of any change in Medicaid eligibility;
2. notify the provider(s) and **the ADSD** case manager of current insurance information, including the name of the insurance coverage, such as Medicare;
3. notify the provider(s) and **the ADSD** case manager of changes in medical status, service needs, address or location changes, and/or any change in status of authorized or legal representative;
4. treat all providers and their staff members appropriately;
5. **initial and** sign the daily record(s) to verify that services were provided;
6. notify the provider or **the ADSD** case manager when scheduled visits cannot be kept or services are no longer required;

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7. notify the provider agency or **ADSD** of any missed appointments by the provider agency staff;
8. notify the provider agency or the **ADSD** case manager of any unusual occurrences, complaints regarding delivery of services, specific staff or to request a change in caregiver or provider agency;
9. furnish the provider agency with a copy of his or her Advance Directive;
10. not request any provider to work more than the hours authorized in the **POC**;
11. not request a provider to work or clean for a non-recipient, family or household members;
12. not request a provider to perform services not included in the **POC**;
13. contact the case manager to request a change of provider agency;
14. complete, sign and submit all required forms on a timely basis; **and**
15. **be physically available in their residence for authorized waiver services, quarterly home visits, and assessments.**

#### 2203.4 **DIRECT SERVICE CASE MANAGEMENT**

Direct service case management is provided to eligible recipients in the HCBW program when case management is identified as a service on the POC. The recipient has a choice of direct service case management provided by **ADSD** or provider agencies.

#### 2203.4A **COVERAGE AND LIMITATIONS**

These services include:

1. **Identification of resources and assisting recipients in locating and gaining access to waiver services, as well as needed medical, social, educational and other services regardless of the funding source;**
2. **Coordination of multiple services and/or providers;**
3. **Monitoring the overall provision of waiver services, in an effort to protect the safety and health of the recipient and to determine that the POC goals are being met;**

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4. **Monitoring and documenting the quality of care through monthly contact:**
  - a. The case manager must have a monthly contact with each waiver recipient and/or the recipient's authorized representative; this may be a telephone contact. At a minimum, there must be a face-to-face visit with each recipient once every three months. More contacts may be made if the recipient has indicated a significant change in his or her health care status or is concerned about his or her health and/or safety.
  - b. When recipient service needs increase, due to a temporary condition or circumstance, the case manager must thoroughly document the increased service needs in their case notes. The POC does not need to be revised for temporary conditions or circumstances. A temporary condition or circumstance is defined as an increase or decrease in service needs for a period not to exceed 30 days.
  - c. During the monthly contact, the case manager monitors and documents the quality of care of the recipient. Quality of care includes the identification, remediation and follow-up of health and safety issues, needs and concerns of the recipient, waiver service satisfaction and whether the services are promoting goals stated in the POC. The case manager also assesses the need for any change in services or providers and communicates this information to the ADSD administrative case manager.
5. **Making certain that the recipient retains freedom of choice in the provision of services;**
6. **Notifying all affected providers of changes in the recipient's medical status, services needs, address, and location, or of changes of the status of legally responsible individuals or authorized representative;**
7. **Notifying all affected providers of any unusual occurrence or change in status of a waiver recipient;**
8. **Notifying all affected providers of any recipient complaints regarding delivery of service or specific provider staff;**
9. **Notifying all affected providers if a recipient requests a change in the provider staff or provider agency; and**
10. **Case Managers must provide recipients with appropriate amount of case management services necessary to ensure the recipient is safe and receives sufficient services. Case management will be considered an "as needed" service. Case managers must continue to have monthly contact with recipients and/or the recipients authorized representative of at least 15 minutes, per recipient, per month. The amount of case management services billed**

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to the DHCFP must be adequately documented and substantiated by the case manager's notes.

#### 2203.4B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.3B, Case Managers must:

1. meet and maintain the minimum qualifications per the State of Nevada Board of Examiners for Social Workers, NRS 641 A, B, or C or the Nevada State Board of Examiners for Registered Nursing, NRS 632. Private case managers must also provide evidence of taxpayer ID number, Workman's Compensation Insurance, Unemployment Insurance Account, Commercial General Liability, Business Automobile Liability Coverage, and Commercial Crime Insurance;
2. have the ability to conduct home visits. If applicable, has a business license as required by city, county or state government; and
3. have one year experience of working with seniors in a home based environment. The case manager does not have to have this experience if the agency supervisor or administrator who supervises the case manager meets these qualifications.

#### 2203.4C RECIPIENT RESPONSIBILITIES

1. Each recipient and/or his or her authorized representative must cooperate with the implementation of services and the implementation of the POC.
2. Each recipient is to comply with the rules and regulations of the DHCFP, ADSD, DWSS and the HCBW for the Frail Elderly.

#### 2203.5 HOMEMAKER SERVICES

##### 2203.5A COVERAGE AND LIMITATIONS

1. Homemaker services are provided by agencies enrolled as a Medicaid provider.
2. Homemaker services are provided when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and is necessary to avoid placement in an institution. Services must be directed to the individual recipient and related to their health and welfare.
3. DHCFP/ADSD is not responsible for replacing goods which are or become damaged in the provision of service.

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4. Homemaker services include:
  - a. meal preparation: menu planning, storing, preparing, serving of food, cutting up food, buttering bread and plating food;
  - b. laundry services: washing, drying and folding the recipient's personal laundry and linens (sheets, towels, etc.) excludes ironing. Recipient is responsible for all laundromat and/or cleaning fees;
  - c. light housekeeping: changing the recipient's bed linens, dusting, vacuuming the recipient's living area, cleaning kitchen and bathroom areas;
  - d. essential shopping to obtain: prescribed drugs, medical supplies, groceries, and other household items required specifically for the health and maintenance of the recipient; or
  - e. assisting the recipient and family members or caregivers in learning homemaker routine and skills, so the recipient may carry on normal living when the homemaker is not present.
  
5. Activities the homemaker shall not perform and for which Medicaid will not pay include the following:
  - a. transporting the recipient in a private car;
  - b. cooking and cleaning for the recipient's guests, other household members or for the purposes of entertaining;
  - c. repairing electrical equipment;
  - d. ironing and mending;
  - e. giving permanents, dyeing or cutting hair;
  - f. accompanying the recipient to appointments, social events or in home socialization;
  - g. washing walls and windows;
  - h. moving heavy furniture, climbing on chairs or ladders;
  - i. purchasing alcoholic beverages that were not prescribed by the recipient's physician;



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j. doing yard work such as weeding or mowing lawns, trimming trees, shoveling non-essential snow covered areas, and vehicle maintenance; **or**

k. **care of pets except in cases where the animal is a certified service animal.**

**2203.5B PROVIDER RESPONSIBILITIES**

**In addition to the provider responsibilities listed in Section 2203.3B, Homemaker Providers must:**

1. arrange and receive training related to household care, including good nutrition, special diets, meal planning and preparation, shopping information, housekeeping techniques, and maintenance of a clean, safe and healthy environment; **and**
2. inform recipients that **DHCFP or its fiscal agent** is not responsible for replacement of goods damaged in the provision of service.

**2203.6 CHORE SERVICES**

**2203.6A COVERAGE AND LIMITATIONS**

1. This service includes heavy household chores such as:
  - a. cleaning windows and walls;
  - b. shampooing carpets;
  - c. tacking down loose rugs and tiles;
  - d. moving heavy items of furniture in order to provide safe access;
  - e. **packing and unpacking for the purpose of relocation;**
  - f. minor home repairs; **or**
  - g. removing trash and debris from the yard.
2. Chore services are intermittent in nature and may be authorized as a need arises for the completion of a specific task which otherwise left undone poses a home safety issue. These services are provided only in cases where neither the recipient, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency or third party payer is capable of, or responsible for, their provision and without these services the recipient would be at risk of institutionalization. This is not a skilled, professional service.

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3. In the case of rental property, the responsibility of the landlord pursuant to the lease agreement, must be examined and confirmed prior to any authorization of service. The legal responsibility of the landlord to maintain and ensure safety on the rental property shall supersede any waiver program covered services.

#### 2203.6B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.3B, individuals performing chore services must:

1. be able to read, write, and follow written or oral instructions;
2. have experience and/or training in performing heavy household activities and minor home repair; and
3. maintain the home in a clean, sanitary and safe environment if performing heavy household chores and minor home repair services.

#### 2203.7 RESPITE CARE

##### 2203.7A COVERAGE AND LIMITATIONS

1. Respite care is provided on a short-term basis because of the absence or need for relief of the primary caregiver.
2. Respite care may occur in the recipient's home or place of residence.
3. Respite care is limited to 336 hours per waiver year.

##### 2203.7B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.3B, Respite Providers must:

1. perform general assistance with ADLs and IADLs and provide supervision to functionally impaired recipients in their home or place of residence;
2. have the ability to read and write and to follow written or oral instructions;
3. have had experience and/or training in providing for the personal care needs of people with functional impairments;
4. demonstrate the ability to perform the care tasks as prescribed;

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5. be tolerant of the varied lifestyles of the people served; **and**
6. **arrange** training in personal hygiene needs and techniques for assisting with **ADLs**, such as bathing, grooming, skin care, transferring, ambulating, exercise, feeding, dressing and use of adaptive aids and equipment, homemaking and household care.

**2203.8 PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)**

**2203.8A COVERAGE AND LIMITATIONS**

1. PERS is an electronic device, which enables certain recipients at high risk of institutionalization to secure help in an emergency. The recipient may also wear a portable “help” button to allow for mobility. The system is connected to the recipient’s phone and programmed to signal a response center once a “help” button is activated.
2. PERS services are limited to those recipients who live alone, or who are alone for significant parts of the day, have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. **The recipient must be physically and cognitively capable of using the device in an appropriate and proper manner.**
3. The necessity for this type of emergency safety measure to prevent institutionalization will be identified in the assessment and included in the **POC**.

**2203.8B PROVIDER RESPONSIBILITIES**

**In addition to the provider responsibilities listed in Section 2203.3B, PERS Providers must:**

1. **be responsible for ensuring that the response center is staffed by trained professionals at all times;**
2. **be responsible for any replacement or repair needs that may occur;**
3. **utilize devices that meet Federal Communication Commission standards, Underwriter’s Laboratory, Inc. (UL) standards or equivalent standards, and be in good standing with the local Better Business Bureau; and**
4. **inform recipients of any liability the recipient may incur as a result of the recipient’s disposal of provider property.**

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**2203.8C RECIPIENT RESPONSIBILITIES**

1. The recipient is responsible to utilize the leased PERS equipment with care and caution and to notify the PERS provider **and** the **ADSD** case manager **if** the equipment is no longer working.
2. The recipient must return the equipment to the provider when the recipient no longer needs or utilizes the equipment, when the recipient terminates from the waiver program or when the recipient moves from the area.
3. The recipient must not throw away the PERS equipment. This is leased equipment and belongs to the PERS provider.

**2203.9 ADULT DAY CARE SERVICES**

**2203.9A COVERAGE AND LIMITATIONS**

1. **Adult day care facilities provide services in a non-institutional community-based setting on a regularly scheduled basis. The emphasis is on social interaction in a safe environment. It is provided for four or more hours per day, one or more days per week, and is provided in accordance with the goals in the recipient's POC. The POC must indicate the number of days per week the recipient will attend.**
2. It is provided in an outpatient setting.
3. It encompasses social service needs to ensure the optimal functioning of the recipient.
4. Meals provided are furnished as part of **the** program but must not constitute a "full nutritional regime" (i.e., three meals per day).
5. **Service utilization and billing method (per diem/unit rate) will be prior authorized as indicated on the recipient's POC. The per diem rate is authorized when the recipient is in attendance for six (6) or more hours per day, and the unit rate is authorized for attendance less than six (6) hours per day. Providers must bill in accordance with the approved PA, even if the recipient occasionally attends less than six (6) hours. If the recipient's overall pattern changes and consistently attends less than six (6) hours a day, a new POC and PA will be required to update the service utilization and billing method.**
6. **Providers must not bill for days a recipient is not in attendance, even if it is a regularly scheduled day. Providers must keep attendance records for each recipient. Claims must reflect dates and times of service as indicated on the attendance records.**
7. **Reference MSM Chapter 1900 for transportation policies.**

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2203.9B PROVIDER RESPONSIBILITIES

**Adult Day Care Providers must:**

Meet and maintain specifications as an **adult** day care provider as outlined in NAC 449 “**Facilities for Care of Adults During the Day**”.

2203.10 ADULT COMPANION SERVICES

2203.10A COVERAGE AND LIMITATIONS

1. Provides non-medical care, supervision and socialization to **a** functionally impaired recipient in his or her home or place of residence, which **may** provide temporary relief for the primary caregiver.
2. **Adult companions may** assist the recipient with such tasks as meal preparation and clean up, light housekeeping, shopping and **facilitate** transportation/escort as needed. These services are provided as an adjunct to the Adult Companion Services and must be incidental to the care and supervision of the recipient.
3. The provision of Adult Companion Services does not entail hands-on medical care.
4. This service is provided in accordance with a goal in the **POC** and is not purely diversional in nature.
5. **Transportation is not a covered service.**

2203.10B PROVIDER RESPONSIBILITIES

**In addition to the provider responsibilities listed in Section 2203.3B, Adult Companion Providers must:**

1. be able to read, write **and** follow written or oral instructions; **and**
2. have experience or training in the care of recipients with disabling conditions.

2203.11 PROVIDER ENROLLMENT/TERMINATION

All providers must comply with all DHCFP provider enrollment requirements, provider responsibilities/qualifications, and DHCFP provider agreement limitations. Provider non-compliance with any or all of these stipulations may result in **DHCFP’s** decision to exercise its right to terminate the provider’s contract.

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2203.11A COVERAGE AND LIMITATIONS

All providers are to refer to the MSM Chapter 100 for enrollment procedures.

2203.11B PROVIDER RESPONSIBILITY

1. All providers must maintain an active **Medicaid** provider number and must meet all **federal, state and local statutes, rules and regulations relating to the services being provided.**
2. **ADSD must have an Interlocal Agreement with the DHCFP in order to provide services.**
3. All Other Service Providers must:
  - a. **apply for and maintain a contract with DHCFP through its Fiscal Agent; and**
  - b. **apply for and maintain any State required licenses.**

2203.12 INTAKE PROCEDURES

**ADSD** has developed policies and procedures to ensure fair and adequate access to the Home and Community-Based Waiver for the Frail Elderly.

2203.12A COVERAGE AND LIMITATIONS

1. Referral
  - a. A referral or inquiry for the waiver may be **initiated** by **phone, mail, fax, in person** or by another party on behalf of the potential applicant.
  - b. **ADSD will make phone/verbal contact with the applicant/representative within seven working days of the referral date. If a potential applicant appears to be eligible, a face to face visit is scheduled to assess eligibility including a level of care screening.**
  - c. If the intake worker determines during the referral process that the potential applicant does not appear to meet the waiver criteria of financial eligibility, level of care, or waiver service need, the applicant will be referred to other agencies for any needed services or assistance.
  - d. Even if the potential applicant does not appear eligible **or if no slot is available** for the **HCBW** for the Frail Elderly, he or she must be verbally informed of the right to continue the Medicaid application process through DWSS. If DWSS determines

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the applicant to be ineligible for Medicaid, the applicant may have the right to a fair hearing through the DWSS.

**2. Wait List/No Waiver Slots Are Available**

- a. Once **ADSD** has identified that the potential applicant appears eligible and there are no waiver slots available:
  - 1. The applicant will be placed on the waiver wait list **based on priority criteria. Refer to Section 2203.2A.3.**
  - 2. **If it has been determined no slot is expected to be available within the 90 day determination period, ADSD will notify DHCFP Central Office Waiver Unit to deny the application due to no slot available and send out a NOD stating the reason for the denial. The applicant will remain on the wait list.**

**3. A Waiver Slot is Available**

Once a slot for the waiver is available, the applicant will be processed for the waiver.

- a. The procedure used for processing an applicant **is** as follows:
  - 1. The **ADSD** case manager will make certain that the Medicaid application, through DWSS, has been completed or updated and will assist in this process as needed.
  - 2. The **ADSD** case manager will schedule a face-to-face interview with the applicant to complete the assessment.
  - 3. An Authorization for Release of Information form is needed for all waiver **applicants** and provides written consent for **ADSD** to release information about the **applicant** to others.
 

The applicant and/or authorized representative must understand and agree that personal information may be shared with providers of services and others as specified on the form.
  - 4. The applicant will be given the right to choose waiver services in lieu of placement in a nursing facility. If the applicant and/or legal representative prefers placement in a nursing facility, the case manager will assist the applicant in arranging for facility placement.



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5. The applicant will be given the right to request a hearing if not given a choice between **HCBW** services and nursing facility placement.
6. **ADSD** will forward an initial assessment (IA) packet to the **DHCFP Central Office Waiver Unit** which will include:
  - a. **LOC** screening;
  - b. a written **POC** is developed in conjunction with the applicant/authorized representative based on the assessment of the applicant's health and welfare needs;
  - c. the **Statement of Understanding (SOU)** must be complete with signature and dates where required; and
  - d. a **HCBW Eligibility Status Form NMO-2734**.
7. **Applicants** will be given free choice of all qualified Medicaid providers of each Medicaid covered service included in his/her written **POC**. Current **POC** information as it relates to the services provided must be given to all service providers.
8. The **POC** is subject to the approval by the **DHCFP Central Office Waiver Unit** staff.
9. All forms must be complete with signature and dates where required.

If the **DHCFP Central Office Waiver Unit** approves the application, the following will occur:

- a. Form **NMO-2734** is sent by the **DHCFP Central Office Waiver Unit** to **ADSD** and **DWSS** stating the application has been approved; and
- b. Once the **DHCFP Central Office Waiver Unit** and **DWSS** have approved the application, waiver service can be initiated;

If the application is not approved by the **DHCFP Central Office Waiver Unit**, the following will occur:

- a. A **NOD** stating the reason(s) for the denial will be sent to the applicant by the **DHCFP Central Office Waiver Unit** via the **DHCFP Hearings and Policy Unit**; and

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b. **Form NMO-2734** will be sent to **ADSD** and DWSS by the **DHCFP** Central Office Waiver Unit stating that the application has been denied and the reason(s) for that denial.

10. If the applicant is denied by **ADSD** for waiver services, **the following will occur:**

a. The **ADSD** case manager will send a NOA to the **DHCFP** Central Office Waiver Unit;

b. The **DHCFP** Central Office Waiver Unit will send a NOD to the applicant via the **DHCFP** Hearings and Policy Unit stating the reason(s) why the application was denied by **ADSD**; and

c. The **DHCFP** Central Office Waiver Unit will send **Form NMO-2734** to **ADSD** and DWSS stating that the application was denied and the reason(s) for the denial.

#### 4. Effective Date for Waiver Services

The effective date for waiver services is **determined by eligibility criteria verified by ADSD, intake packet approval by DHCFP, and financial eligibility approval by DWSS**, whichever is later. If the applicant is in an institution, the effective date cannot be prior to the date of discharge from the institution.

#### 5. Waiver Cost

**DHCFP** must assure CMS that the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the institutional level of care under the state plan that would have been made in that fiscal year, had the waiver not been granted.

### 2203.13 BILLING PROCEDURES

**The State assures that claims for payment of waiver services are made only when an individual is Medicaid eligible, when the service is included in the approved POC or Service Plan, and prior authorization is in place when required.**

### 2203.13A COVERAGE AND LIMITATIONS

All providers (**Provider Type 48**) for the **HCBW** for the Frail Elderly must **submit claim forms to DHCFP's Fiscal Agent. Claims must meet the requirements in the CMS 1500 Claim Form. Claims must be complete and accurate.** Incomplete or inaccurate claims will be returned to the

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provider by **DHCFP**'s fiscal agent. If the wrong form is submitted it will also be returned to the provider by **DHCFP**'s fiscal agent.

#### 2203.13B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.3B, all Providers must:

1. refer to the **QIO-like vendor Provider Billing Procedure Manual** for detailed instructions for completing the **CMS 1500 form**; and
2. maintain documentation to support claims billed for a minimum of 6 years from the date the claim is paid.

#### 2203.14 ADVANCE DIRECTIVES

Section 1902(w) of the Social Security Act requires licensed provider agencies give their clients information about their decision-making rights about health care, declarations (living wills) and durable powers of attorney for health care decisions. Refer to MSM 100 for further information.

**ADSD** will provide information on Advance Directives to each applicant and/or the authorized/legal representative. The signed form is kept in each **applicant**'s file at the local **ADSD** office. Whether an **applicant** chooses to write his or her own Advance Directives or complete the Advance Directives form in full is the individual choice of each applicant and/or each applicant authorized/legal representative.

#### 2203.15 **DHCFP'S ANNUAL REVIEW**

The State has in place a formal system in which an annual review **is** conducted to assure the health and welfare of the recipients served on the waiver, the recipients' satisfaction with the waiver, **the qualifications of waiver providers to deliver services/supports**, and assurance of the cost effectiveness of these services.

#### 2203.15A COVERAGE AND LIMITATIONS

The State conducts an annual review, which is collaboratively conducted by **ADSD** and **DHCFP**, with **DHCFP** being the lead agency. **The DHCFP:**

1. provides CMS annually with information regarding the impact of the waiver on the type, amount, and cost of services provided under the waiver and under the State plan, and **through an ongoing process of discovery, remediation and improvement, the State assures** the health and welfare of the recipients served on the waiver;
2. assures financial accountability for funds expended for **HCBW** services;

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3. evaluates that all provider standards are continuously met, and that the POCs are periodically reviewed to assure that the services furnished are consistent with the identified needs of the recipients;
4. evaluates the recipients' satisfaction with the waiver program; and
5. further assures that all problems identified by this monitoring will be addressed by the provider in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

2203.15B PROVIDER RESPONSIBILITIES

ADSD and waiver providers must cooperate with DHCFP's annual review process.

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2204 HEARINGS

2204.1 SUSPENDED WAIVER SERVICES

- a. A recipient's case may be suspended, instead of closed if it is likely the recipient will be eligible again for waiver services within the next 60 days (for example, if a recipient is admitted to a hospital or nursing facility). After receiving written documentation from the case manager (Form NMO-2734) of the suspension of waiver services, a NOD identifying the effective date and the reason for suspension will be sent to the recipient by the DHCFP Central Office Waiver Unit.
- b. Waiver services will not be paid for the days that a recipient's case is in suspension.
- c. If at the end of the 45 days the recipient has not been removed from suspended status, the case must be closed. ADSD sends a NOA to the DHCFP Central Office Waiver Unit on or before the 45<sup>th</sup> day of suspension, identifying the 60<sup>th</sup> day of suspension as the effective date of termination and the reason for the waiver termination.
- d. DHCFP Central Office Waiver Unit sends a NOD, via the DHCFP Hearings Unit, to the recipient or the recipient's authorized representative advising him or her of the date and reason for the waiver closure/termination.

2204.2 RELEASE FROM SUSPENDED WAIVER SERVICES

If a recipient has been released from the hospital or nursing facility before 60 days have elapsed, within five working days of the recipient's discharge, the case manager must:

- a. assess the LOC for continued eligibility and complete a new form if it appears the recipient no longer meets a LOC;
- b. complete a reassessment if there has been a significant change in the recipient's condition or status;
- c. complete a new POC if there has been a change in services (medical, social or waiver). If a change in services is expected to resolve in less than 30 days, a new POC is not necessary. Documentation of the temporary change must be made in the case manager's notes. The date of resolution must also be documented in the case manager's notes; and
- d. contact the service provider(s) to reestablish services.

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**2204.3 DENIAL OF WAIVER APPLICATION**

Basis of denial for waiver services:

- a. The applicant is under the age of 65 years.
- b. The applicant does not meet the **LOC** criteria for nursing facility placement.
- c. The applicant has withdrawn his or her request for waiver services.
- d. The applicant fails to cooperate with **ADSD** or **HCBW** service providers in establishing and/or implementing the **POC**, implementing waiver services or verifying eligibility for waiver services. (The **applicant** or **applicant's** authorized representative's signature is necessary for all required paperwork.)
- e. The applicant's support system is not adequate to provide a safe environment during the time when **HCBW** services are not being provided.
- f. **ADSD** has lost contact with the applicant.
- g. The applicant fails to show a need for **HCBW** services.
- h. The applicant would not require nursing facility placement **within 30 days** if **HCBW** services were not available.
- i. The applicant has moved out of state.
- j. Another agency or program will provide the services.
- k. **ADSD** has filled the number of positions (slots) allocated to the **HCBW** for the Frail Elderly. The applicant has been approved for the waiver wait list and will be contacted when a slot is available.
- l. The applicant is in an institution (e.g. hospital, nursing facility, correctional, ICF/MR) and discharge within 30 days is not anticipated.

When the application for waiver services is denied, the case manager sends a NOA to the **DHCFP** Central Office Waiver Unit. The **DHCFP** Central Office Waiver Unit sends a **NOD** to the applicant, via the **DHCFP** Hearings Unit letting them know that waiver services have been denied and the reason for the denial.

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#### 2204.4 TERMINATION OF WAIVER SERVICES

Reasons to terminate a recipient from the waiver or to terminate the recipient from the waiver wait list:

- a. The recipient has failed to pay his/her patient liability.
- b. The recipient no longer meets the level of care criteria for nursing facility placement.
- c. **The recipient no longer meets other eligibility criteria.**
- d. The recipient/**authorized representative** has requested termination of waiver services.
- e. The recipient has failed to cooperate with **ADSD** or **HCBW** service providers in establishing and/or implementing the **POC**, implementing waiver services, or verifying eligibility for waiver services. (The recipient's or the **recipient's** authorized representative's signature is necessary on all required paperwork).
- f. The recipient's support system is not adequate to provide a safe environment during the time when **HCBW** services are not being provided.
- g. The recipient fails to show a continued need for **HCBW** services.
- h. The recipient **is** no longer **at risk of imminent placement in a nursing facility within 30 days** if **waiver** services were not available.
- i. The recipient has moved out of state.
- j. The recipient has **signed** fraudulent documentation on one or more of the provider time sheets and/or forms.
- k. Another agency or program will provide the services.
- l. The recipient has been, or is expected to be, institutionalized over 60 days (in a hospital, nursing facility, intermediate facility for persons with mental retardation).
- m. **ADSD** has lost contact with the recipient.

When a recipient is terminated from the waiver program, the **ADSD** case manager sends **DHCFP** Central Office Waiver Unit a NOA stating the date of termination and the reason(s) for the termination. **DHCFP** Central Office Waiver Unit sends a NOD via the Hearings Unit to the recipient or to the recipient's authorized representative. The NOD must be mailed by the **DHCFP**,

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Hearings Unit, at least 13 calendar days before the listed date of action on the form. Refer to MSM, Chapter 3100, for specific instructions regarding notice and recipient hearings.

**2204.5 REDUCTION OF WAIVER SERVICES**

Reasons to reduce services are:

- a. The recipient no longer **requires** the number of service hours which were previously provided.
- b. The recipient no longer **requires** the service previously provided.
- c. The recipient's support system is **capable of** providing the service.
- d. The recipient has failed to cooperate with the **ADSD** case manager or **HCBW** service provider(s) in establishing and/or implementing the **POC**, implementing waiver services or verifying eligibility for waiver services (the recipient's or the recipient's authorized representative's signature is necessary on all required paperwork.)
- e. The recipient has requested the reduction of services.
- f. The recipient's ability to perform activities of daily living has improved.
- g. Another agency or program will provide the service.
- h. Another service will be substituted for the existing service.

When there is a reduction of waiver services, the **updated prior authorization will be submitted and a NOD will be generated. A hearing can be requested** through the Hearings Unit **by** the recipient or the recipient's authorized representative. The form must be mailed by the Hearings Unit to the recipient at least 13 calendar days before the Date of Action on the form.

Refer to MSM, Chapter 3100, for specific instructions regarding notice and recipient hearings.



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**2204.6 REAUTHORIZATION WITHIN 90 DAYS OF WAIVER TERMINATION**

**2204.6A COVERAGE AND LIMITATIONS**

1. If waiver services have been terminated and the recipient is eligible for readmission to the waiver as defined in **Section 2203.12.A** and is requesting re-approval within 90 days of closure, the **ADSD** case manager completes and sends to the Medicaid Central Office Waiver Unit the following:
  - a. A **LOC** form;
  - b. Reassessment;
  - c. A new **SOU** if there has been a change in the authorized/legal representative;
  - d. A new **POC** if services have changed; and
  - e. A Form **NMO-2734** requesting **DHCFP** Central Office Waiver Unit approval with the date of approval indicated.

All forms must be complete with signatures and dates **as applicable**.

**2204.6B RECIPIENT RESPONSIBILITIES**

Recipients must cooperate fully with the reauthorization process to assure approval of his/her request for readmission to the waiver.

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2205 APPEALS AND HEARINGS

Refer to MSM Chapter 3100 for specific instructions regarding notice and hearing procedures.

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2206 REFERENCES AND CROSS REFERENCES

2206.1 PROVIDER SPECIFIC INFORMATION

Specific information about each provider type can be found in the following chapters:

Medicaid Services Manuals:

- Chapter 100           **Medicaid Program**
- Chapter 500           **Nursing Facilities**
- Chapter 1400**       **Home Health Agency**
- Chapter 3100       Hearings
- Chapter 3200       Hospice
- Chapter 3300       **Program Integrity**
- Chapter 3500       Personal Care

Division of Welfare and Supportive Services  
Section 360           MAABD Manual

2206.2 CONTACTS

For contact and office locations information for the Aging and Disability Services Division (ADSD), please visit <http://aging.state.nv.us>.