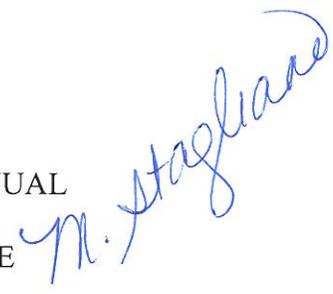


MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

November 8, 2011

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL
FROM: MARTA E. STAGLIANO, CHIEF, COMPLIANCE
SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 2300 – HOME AND COMMUNITY BASED WAIVER
(HCBW) FOR PERSONS WITH PHYSICAL DISABILITIES



BACKGROUND AND EXPLANATION

Medicaid Services Manual (MSM) Chapter 2300, Home and Community-Based Waiver (HCBW) for Persons with Physical Disabilities, has been revised to remove the Definitions and References/Cross References sections. The Definitions were moved to the MSM Addendum and the References/Cross References to MSM Chapter 100.

These policy changes are effective November 9, 2011

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MSM 28/11 CHAPTER 2300 – HOME AND COMMUNITY-BASED WAIVER (HCBW) FOR PERSONS WITH PHYSICAL DISABILITIES	MTL 33/10 CHAPTER 3900 – HOME AND COMMUNITY-BASED WAIVER (HCBW) FOR PERSONS WITH PHYSICAL DISABILITIES

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2302	Reserved	Removed Definition Section.
2305	References and Cross References	Removed References.

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2300 INTRODUCTION

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

Division of Health Care Financing and Policy's (DHCFP) HCBW for Persons with Physical Disabilities originated in 1990. Waiver service provision is based on the identified needs of waiver recipients. Every biennium the service needs and the funded slot needs of the waiver program are reviewed by DHCFP and presented to the Nevada State Legislature for approval. Nevada is committed to the goal of integrating persons with disabilities into the community. Nevada understands persons with disabilities are able to lead satisfying and productive lives, and are able to self-direct care when provided needed services and supports to do so.

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2301 AUTHORITY

Section 1915(c) of the Social Security Act permits states to waive certain Medicaid statutory requirements in order to offer an array of home and community-based services that an individual requires to remain in a community setting and avoid institutionalization. The DHC FP HCBW for Persons with Physical Disabilities is an optional program approved by the Centers for Medicare and Medicaid Services (CMS). The waiver is designed to provide to eligible Medicaid waiver recipients State Plan Services and 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.

Nevada has the flexibility to design this waiver and select the mix of waiver services best meeting the goal to keep people in the community. Such flexibility is predicated on administrative and legislative support, as well as federal approval.

Statutes and Regulations

- Social Security Act: 1915 (c)
- Social Security Act: 1916 (e)
- Social Security Act: 1902 (w)
- Omnibus Budget Reconciliation Act of 1987
- Balanced Budget Act of 1997
- Health Insurance Portability and Accountability Act of 1996 (HIPPA)
- State Medicaid Manual, Section 44442.3.B.13
- State Medicaid Director Letter (SMDL) #01-006 attachment 4-B
- Title 42, Code of Federal Regulations (CFR) Part 441, subparts G
- 42 CFR Part 431, Subpart E
- 42 CFR Part 431, Subpart B
- 42 CFR 489, Subpart I

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- Nevada’s Home and Community Based Waiver Agreement for People with Physical Disabilities Nevada Revised Statutes (NRS) Chapter 449, 706, 446, 629, 630, 630a, and 633
- Nevada Administrative Code (NAC) Chapters 441A.375 and 706.

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2302 **RESERVED**

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2303 POLICY

2303.1 ADMINISTRATIVE CASE MANAGEMENT ACTIVITIES

Administrative case management occurs prior to an applicant being determined eligible for a waiver and during a re-evaluation or reassessment of eligibility. Administrative case management may only be provided by qualified staff.

2303.1A COVERAGE AND LIMITATIONS

Administrative case management activities include:

1. Intake referral;
2. Facilitating Medicaid eligibility, which may include assistance with the Medical Assistance for 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 Plan of Care (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 (LOC), 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 a Notice of Decision (NOD) when a waiver application is denied;
5. Coordination of care and services to collaborate in discharge planning to transition applicants from facilities;

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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) for reassessment 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).

2303.1B ADMINISTRATIVE CASE MANAGEMENT PROVIDER RESPONSIBILITIES

Employees of the Division of Health Care Financing and Policy (DHCFP), Health Care Coordinator (HCC) I, II, or III are qualified Medicaid case managers for the Physically Disabled Waiver Program. Professional or medical licensure recognized by a Nevada Professional State Board, such as social worker, registered nurse, occupational therapist, physical therapist is required. A licensed practical nurse may complete back up case management, operating under a previously developed LOC and POC under the supervision of the primary case manager.

2303.1C RECIPIENT RESPONSIBILITIES

1. Participate in the waiver assessment and reassessment process, accurately representing your skill level needs, wants, resources, and goals.
2. Participate in monthly contacts and home visits with the case manager.
3. Together with the waiver case manager, develop and/or review the POC.
4. If services documented on the POC are approved by the recipient and the case manager and the recipient signature cannot be obtained due to extenuating circumstances, services can commence or continue 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.

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2303.2 ELIGIBILITY CRITERIA

The DHCFP Home and Community-Based Waiver (HCBW) for Persons with Physical Disabilities waives certain statutory requirements and offers home and community-based services to eligible recipients to assist them to remain in the community.

2303.2A 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 the waiver must meet and maintain Medicaid's eligibility requirements for the waiver.
2. Persons with Physical Disabilities Waiver Eligibility Criteria

Applicants or recipients must meet and maintain all criteria to be eligible and to remain on the HCBW for Persons with Physical Disabilities. Eligibility for the HCBW for Persons with Physical Disabilities is determined by the combined efforts of DHCFP and the Division of Welfare and Supportive Services (DWSS).

Three separate determinations must be made for eligibility for the HCBW for Persons with Physical Disabilities. Services for the HCBW for Persons with Physical Disabilities cannot be provided until and unless the applicant is found eligible in all three determination areas:

- a. The applicant must be physically disabled.
 1. Applicants/recipients must be certified as physically disabled by the DHCFP Central Office Physician Consultant. Disabling impairments must result from anatomical or physiological abnormalities and must be demonstrable by medically acceptable clinical and laboratory diagnostic techniques and be established by competent medical evidence.
 2. The DHCFP Physician Consultant and other health care professionals (Disability Determination Team) review medical and non-medical documentation, and determine whether an applicant qualifies as physically disabled.
- b. The applicant/recipient must meet the waiver services criteria, which is determined by the DHCFP District Office (DO) staff with oversight by the Central Office Waiver Unit.
 1. Each recipient must meet and maintain a level of care category for admission into a nursing facility. The applicant would require imminent placement in a nursing facility if HCBW services or other supports were

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not available.

2. A written assessment will be conducted for each waiver applicant including the individual's abilities to perform Activities of Daily Living (ADLs), the individual's medical and social needs, the individual's support system and all other services received.
 3. The applicant must require provision of at least one (1) waiver service monthly to be determined to need waiver services as documented in the POC.
 4. Applicants may be placed from a nursing facility, an acute care facility, another HCBW program, or the community.
- c. Eligibility determination for full Medicaid benefits is made by the DWSS.
3. The HCBW for Persons with Physical Disabilities is limited, by legislative authority to a specific number of recipients who can be served through the waiver per year (slots). When all waiver slots are full, DHCFP utilizes a wait list for applicants who have been pre-determined to be eligible for the waiver.
 4. Wait List Prioritization
 - a. Nursing facility residents.
 - b. Applicants who have a severe functional disability as defined by NRS 426.721 to 731. All applicants meeting this priority must require assistance, be dependant or a combination of the two under the functional areas of eating, bathing and toileting as identified on the LOC screening assessment.
 - c. Applicants on the wait list for the HCBW for Persons with Physical Disabilities.
 5. DHCFP must assure the Center for Medicare and Medicaid Services (CMS) that DHCFP's total expenditure for home and community-based and other State Plan Medicaid services for all recipients under this waiver will not, in any calendar/waiver year, exceed one-hundred percent (100%) of the amount that would be incurred by DHCFP for all these recipients if they had been in an institutional setting in the absence of the waiver. DHCFP must also document there are safeguards in place to protect the health and welfare of recipients.
 6. Waiver services may not be provided while a recipient is an inpatient of an institution.

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7. Recipients of the HCBW for Persons with Physical Disabilities 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 case coordination between the hospice agency and the waiver case manager is required to prevent any duplication of services. Refer to Medicaid Services Manual Chapter (MSM) 3200 for additional information on hospice services.
8. The applicant/recipient must have an adequate support system to provide a safe environment during the hours when home and community based services are not being provided. Home and community based services are not a substitute for natural and informal supports provided by family, friends or other available community resources.
9. If an applicant/recipient 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/recipient must choose one HCBW program and receive services provided by that program.

2303.2B RECIPIENT RESPONSIBILITIES

1. Applicants or recipients must meet and maintain all criteria to be eligible, and to remain on the HCBW for Persons with Physically Disabilities.
2. Recipients may have to pay patient liability. Failure to pay is grounds for termination of waiver services.

2303.2C MEDICAID EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)

The children made eligible for Medicaid through their enrollment in the HCBW for Persons with Physical Disabilities receive all medically necessary Medicaid covered services available under EPSDT. A child's enrollment in the waiver will not be used to deny, delay, or limit access to medically necessary service(s) required to be available to Medicaid-eligible children under federal EPSDT rules. The waiver service package is a supplement to EPSDT services.

2303.3 WAIVER SERVICES

The DHCFP determines which services will be offered under the HCBW for Persons with Physical Disabilities. Providers and recipients must agree to comply with the requirements for service provision.

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2303.3A COVERAGE AND LIMITATIONS

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

1. Case Management;
2. Homemaker Services;
3. Chore Services;
4. Respite;
5. Environmental Accessibility Adaptations;
6. Specialized Medical Equipment and Supplies;
7. Personal Emergency Response System (PERS);
8. Assisted Living Services;
9. Home Delivered Meals; and/or
10. Attendant Care Services.

2303.3B PROVIDER RESPONSIBILITIES (AGENCY)

1. All Providers
 - a. Providers are responsible for confirming the recipient's Medicaid eligibility each month prior to rendering service.
 - b. Providers must meet and comply with all provider requirements as specified in Chapters 100 and/or 3500 of the MSM.
 - c. Must enroll and maintain an active HCBW for Persons with Physical Disabilities provider number (type 58).
 - d. May only provide services that have been identified in the recipient POC and, if required, have prior authorization.
 - e. The number of hours specified on each recipient POC for each specific service will be considered the maximum number of hours allowed to be provided by the

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caregiver and paid by the DHCFP, unless the case manager has approved additional hours due to a temporary condition or circumstance. Caregivers are allowed to provide fewer services than stated on the POC if the reason for providing fewer services is adequately documented on the daily record.

- f. Payments will not be made for services provided by a recipient's legally responsible individual.

2. Provider Agencies

- a. Payment for services must be authorized by the DO case manager utilizing a Prior Authorization (PA).
- b. Agencies employing providers of service for the waiver program must arrange training in at least the following subjects:
 - 1. policies, procedures and expectations of the contract 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;
 - 4. information about the specific disabilities of the persons to be served and, more generally, about the types of disabilities among the populations the provider will serve, including physical and psychological aspects and implications, types of resulting functional deficits, and service needs;
 - 5. recognizing and appropriately responding to medical and safety emergencies;
 - 6. working effectively with recipients including: understanding recipient direction and the independent living philosophy; respecting consumer rights and needs; respect for age, cultural and ethnic differences; recognizing family relationships; confidentiality; respecting personal property; active listening and responding; emotional support and empathy; ethics in dealing with the recipient, legally responsible individual and other providers; handling conflict and complaints; dealing with death and dying; and other topics as relevant.

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7. Exemptions from Training

- a. The agency may exempt a prospective service provider from those parts of the required training where the agency verifies the person possesses adequate knowledge or experience, or where the provider's duties will not require the particular skills.
- b. The exemption and its rationale must be provided in writing and a copy of the exemption must be placed in the recipient's and caregiver's case record. Where the recipient or other private third party functions as the employer, such individuals may exercise the exemption authority identified above.

8. Recipients Providing Training

- a. Where a recipient desires to provide training and the recipient is able to state and convey his/her needs to a caregiver, the agency will allow the recipient to do so.
- b. Any such decision shall be agreed to by the recipient and documented in the case record as to what training the recipient is to provide.
- c. Where the recipient or other private third party functions as the employer such individual may exercise the exemption from training authority identified above.

9. Completion and Documentation of Training

The provider shall complete required training within six months of beginning employment. Training as documented in the MSM 2303.2 B.2.b., except for the service areas requiring completion of Cardiopulmonary Resuscitation (CPR) (as listed in the specific service area sections of this chapter) which should be completed in a six month timeframe, and 2303.2 B.2.b.(6-8), which must be completed prior to service provision.

10. Each provider agency must have a file for each recipient. In the recipient's file, the agency must maintain the daily records. Periodically, DHCFP Central Office staff may request this documentation to compare to billings submitted. These records must be maintained by the provider for at least six (6) years after the date the claim is paid.

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11. Flexibility of service delivery which does not alter medical necessity may occur within a single week period without an additional authorization or change in the service plan. This flexibility must demonstrate and document the needs of the recipient, as documented in the approved service plan, and must not take place solely for the convenience of the Provider or the Personal Care Attendant (PCA). Documentation of flexibility within a single week must be reflected in the recipient's file.
12. Individual Providers for Homemaker, Chore, Respite, PCS and Attendant Care:
 - a. Must understand and follow the authorized service plan in the delivery of care, billing procedures for waiver services, not exceed the allotted time allowed for services, and complete the daily record.
 - b. Must be signed by the provider and the recipient or the recipient's authorized representative and be available for the case manager's review or DHCFP staff annual review. If the recipient is not capable of signing, there must be documentation on the POC the recipient is not capable to sign the document. The daily record must be maintained by the provider for at least six (6) years after the date the claim is paid.

Individual homemaker service, attendant care service, chore service, and respite providers require meeting the conditions of participation as stated in this chapter.

Provider requirements and forms for enrollment can be located at: <http://dhcfp.nv.gov>.

- c. The Provider must provide the local DHCFP DO Waiver Case Manager with written notification of serious occurrences involving the recipient. The DHCFP DO Case Manager must be notified of serious occurrences by telephone/fax within 24 hours of discovery. A summary report of serious occurrences must be submitted in January and July of each year to the DHCFP Central Office Personal Care Services (PCS) Program Specialist.

Serious occurrences include, but are not limited to the following:

1. Suspected physical or verbal abuse;
2. Unplanned hospitalization;

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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;
 9. Death of the recipient during the provision of PCS; or
 10. Loss of contact with the recipient for three consecutive scheduled days.
- d. State law requires that persons employed in certain capacities must make a report to a child protective service agency or law enforcement agency immediately, but in no event later than 24 hours after there is reason to suspect a child has been abused or neglected. The DHCFP expects that all providers be in compliance with the intent of all applicable laws.

For recipients under the age of 18, the Division of Child and Family Services (DCFS) or the appropriate county agency accepts reports of suspected child abuse and neglect. 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.

1. Child Abuse - Refer to NRS 432B regarding child abuse or neglect.
2. Elder Abuse - Refer to NRS 200.5091 to 200.50995 regarding elder abuse or neglect.
3. Other Age Groups - For all other individuals or vulnerable persons (NRS 200.5091 to 200.50995) 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

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- b. has one or more physical or mental limitations that restrict the ability of the person to perform the normal activities of daily living” contact local law enforcement agencies.
- e. PCA providers must complete either a QuantiFERON®-TB Gold blood test (QFT-G) or a two step (TB) Tuberculin skin test prior to initiation of services for a Medicaid recipient. Thereafter, each PCA provider of services must receive a QFT-G blood test or one step TB skin test annually, prior to the expiration of the initial test. If the employee has a documented history of a positive QFT-G or TB skin test (+10 mm induration or larger), they must have clearance by a chest X-ray prior to initiation of services for a Medicaid recipient.

If the PCA has been medically cleared after a documented history of a positive QFT-G or TB skin test which was 10 mm or larger and then by chest X-ray, the PCA must have documentation annually which demonstrates no signs or symptoms of active tuberculosis. The annual screening for signs and symptoms must address each of the following areas of concern and must be administered by a qualified health care provider.

1. Has had a cough for more than 3 weeks;
2. Has a cough which is productive;
3. Has blood in his sputum;
4. Has a fever which is not associated with a cold, flu or other apparent illness;
5. Is experiencing night sweats;
6. Is experiencing unexplained weight loss; or
7. Has been in close contact with a person who has active tuberculosis.

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

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

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f. Provider agencies are responsible for securing criminal history clearances obtained from the State and Federal Bureau of Investigation (FBI) through the submission of fingerprints to the Central Repository for Nevada Records of Criminal History and the FBI. 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. Specifications for complying with criminal history background checks are documented in NRS 449.176 through NRS 449.188. These requirements are available on the Bureau of Health Care Quality and Compliance (HCQC) website: http://healthdev.webtest.nv.gov/HCQC_CriminalHistory.htm.

1. DHCFP will not enroll any person or entity convicted of a felony or misdemeanor under Federal or State Law for any offense which the state agency determines is inconsistent with the best interest of recipients. Such determinations are solely the responsibility of the Division.
2. DHCFP policy requires all waiver providers, except environmental adaptation providers, have State and Federal criminal history background checks completed. DHCFP fiscal agent will not enroll any provider agency whose operator has been convicted of a felony under State or Federal law for any offense which DHCFP determines is inconsistent with the best interest of recipients.
3. DHCFP Fiscal Agent will also not enroll, as a provider, any applicant convicted of any felony or misdemeanor involving fraud or abuse in any government programs, or 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.
4. 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.

If the Provider receives information related to NRS 449.176 through NRS 449.188 resulting from the criminal background check or from any other sources 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.

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Please see NRS 449.176 and MSM Chapter 100 for additional information regarding requirements.

5. When an employee or independent contractor believes the information provided as a result of the State and/or FBI criminal history background check is incorrect, he or she must immediately inform the employing agency or the Division (respectively) in writing. An employing agency and the Division so informed within five (5) days may give the employee, or independent contractor, a reasonable amount of time, but not more than 60 days, to provide corrected information before terminating the employment, or contract, pursuant to this section.

2303.3C RECIPIENT RESPONSIBILITIES

The recipient or the recipient's authorized representative will:

1. notify the provider(s) and case manager of a change in Medicaid eligibility.
2. notify the provider(s) and case manager of changes in medical status, service needs, address, and location, or of changes of status of legally responsible individual(s) or authorized representative.
3. treat all staff and providers appropriately.
4. if capable, sign the provider daily record to verify services were provided.
5. notify the provider when scheduled visits cannot be kept or services are no longer required.
6. notify the provider agency of missed visits by provider agency staff.
7. notify the provider agency of unusual occurrences, complaints regarding delivery of services, specific staff, or to request a change in caregiver.
8. furnish the provider agency with a copy of their Advance Directives.
9. establish a back-up plan in case a waiver attendant is unable to work at the scheduled time.
10. not request a provider to work more than the hours authorized in the service plan.
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 care plan.

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13. contact the case manager to request a change of provider.

14. sign all required forms.

2303.3D DIRECT SERVICE CASE MANAGEMENT

Direct Service Case Management is limited to eligible participants enrolled in HCBW services program, when case management is identified as a service on the POC. The recipient has a choice to have direct service case management services provided by qualified state staff or qualifying provider agency staff.

2303.3E 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;
4. Monitoring and documenting the quality of care through monthly contact:
 - a. The direct service 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 6 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 direct service 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 direct service 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

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concerns of the recipient, waiver service satisfaction and whether the services are promoting goals stated in the POC. The direct service case manager also assesses the need for any change in services or providers and communicates this information to the 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, service 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 must be adequately documented and substantiated by the case manager's notes.

2303.3F DIRECT SERVICES CASE MANAGEMENT PROVIDER RESPONSIBILITIES

Verification of compliance with these administrative requirements must be provided:

1. A fixed business landline telephone number published in a public telephone directory.
2. A business office accessible to the public during established and posted business hours.

Employees of the case management provider agency who provide direct service case management services must be licensed as a Social Worker by the State of Nevada Board of Examiners for Social Workers, licensed as a Registered Nurse by the State of Nevada Board of Nursing, or have a professional license or certificate in a medical specialty applicable to the assignment, have at least one year experience as a case manager and must have a valid driver's license. Employees must pass a State and FBI criminal background check. In addition, providers must meet and comply with all provider requirements as specified in Chapters 100 and/or 3500 of the MSM.

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2303.3G RECIPIENT RESPONSIBILITIES

1. Participate in the waiver assessment, monthly contacts and reassessment process, accurately representing his or her skill level needs, wants, resources, and goals.
2. Together with the waiver case manager, develop and/or review and sign the POC. If the recipient is unable to provide a signature due to intellectual 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.
3. Choose to have direct service case management provided by qualifying state staff or qualifying provider agency staff.

2303.4 HOMEMAKER SERVICES

2303.4A COVERAGE AND LIMITATIONS

1. Homemaker services are provided by individuals or agencies under contract with DHCFP.
2. Homemaker services are provided when the individual regularly responsible for these activities is temporarily absent or unable to manage the home.
3. DHCFP is not responsible for replacing goods damaged in the provision of service.

Homemaker services include:

- a. general cleaning, including mopping floors, vacuuming, dusting, cleaning the stove, changing and making beds, washing dishes, defrosting and cleaning the refrigerator, keeping bathrooms and the kitchen clean, and washing windows as high as the homemaker can reach while standing on the floor;
- b. shopping for food and needed supplies;
- c. planning and preparing varied meals, considering both cultural and economic standards of the recipient, preparing tray meals when needed, and preparing special diets under medical supervision;
- d. washing, ironing and mending the recipient's personal laundry. The recipient pays any laundromat and/or cleaning fees;
- e. assisting the recipient and legally responsible individuals or caregivers in learning a homemaker routine and skills, so the recipient may carry on normal living when the homemaker is not present;

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- f. accompanying the recipient to homemaker activities such as shopping or the laundromat which must be made using public transportation at the recipient's expense, or as a companion (not the driver) in another's private car;
 - g. routine clean-up after up to 2 household pets.
4. Activities the homemaker shall not perform and for which Medicaid will not pay include, but are not limited to the following:
- a. transporting (as the driver) the recipient in a private car;
 - b. cooking and cleaning for the recipient's guests, other household members, or for entertaining;
 - c. repairing electrical equipment;
 - d. ironing sheets;
 - e. giving permanents, dying or cutting hair;
 - f. accompanying the recipient to social events;
 - g. washing walls;
 - h. moving heavy furniture, climbing on chairs or ladders;
 - i. purchasing alcoholic beverages which were not prescribed by the recipient's physician;
 - j. doing yard work such as weeding or mowing lawns, trimming trees, shoveling non-essential snow covered areas, and vehicle maintenance.

2303.4B HOME MAKER PROVIDER RESPONSIBILITIES

In addition to the following requirements listed, please reference section 2303.3B of this chapter regarding Individual Provider Responsibilities.

- 1. Persons performing homemaker tasks shall meet the standards established by State Homemaker Programs operated by the ADSD. Providers are required to 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.

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2. A legally responsible individual may not be paid for homemaker services.
3. Providers will inform recipients DHCFP is not responsible for replacement of goods damaged in the provision of service.

2303.5 CHORE SERVICES

2303.5A 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 heaving items.
 - e. minor home repairs.
 - f. removing trash and debris from the yard.
 - g. packing and unpacking boxes.
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.
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.

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2303.5B CHORE SERVICES PROVIDER RESPONSIBILITIES

In addition to the following requirements listed, reference Section 2303.3B of this Chapter regarding Individual Provider Responsibilities.

1. Persons performing heavy household chores and minor home repair services need to maintain the home in a clean, sanitary, and safe environment. All individuals performing these services must:
 - a. be a U.S. citizen or a legal alien.
 - b. be at least 18 years of age;
 - c. have a valid Social Security card.
 - d. be able to read, write, and to follow written or oral instructions.
 - e. be physically capable of performing heavy household and/or yard activities (e.g. snow shoveling).
 - f. have experience and/or training in performing heavy household activities and minor home repair (e.g., carpet cleaning, etc).

2303.6 RESPITE CARE

2303.6A COVERAGE AND LIMITATIONS

1. Respite care is provided for relief of the primary caregiver.
2. Respite care is limited to 120 hours per waiver year per individual.
3. Respite care is only provided in the individual's home or place of residence.

2303.6B RESPITE CARE PROVIDER RESPONSIBILITIES

In addition to the following requirements listed, reference Section 2303.3B of this Chapter regarding Individual Provider Responsibilities.

1. Respite providers must:
 - a. perform general assistance with ADLs and Instrumental Activities of Daily Living (IADLs) and provide supervision to functionally impaired recipients in their homes to provide temporary relief for a primary caregiver;

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- b. have the ability to read and write and to follow written or oral instructions;
- c. have had experience and or training in providing the personal care needs of people with disabilities;
- d. meet the requirements of NRS 629.091, Section 2303.3B of this Chapter, and MSM 2600 if a respite provider is providing attendant care services that are considered skilled services;
- e. demonstrate the ability to perform the care tasks as prescribed;
- f. be tolerant of the varied lifestyles of the people served;
- g. identify emergency situations and act accordingly, including completion of CPR certification which may be obtained outside the agency;
- h. have the ability to communicate effectively and document in writing services provided;
- i. maintain confidentiality regarding details of case circumstances;
- j. arrange training in personal hygiene needs and techniques for assisting with activities of daily living, such as bathing, grooming, skin care, transfer, ambulation, exercise, feeding, dressing, and use of adaptive aids and equipment, homemaking and household care.

2303.7 ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS

2303.7A COVERAGE AND LIMITATIONS

1. Adaptations may include the purchase of environmental controls, the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems necessary to accommodate the medical equipment and supplies needed for the welfare of the recipient. Adaptations must be prior authorized and are subject to legislative budget constraints.
2. All services, modifications, improvements or repairs must be provided in accordance with applicable state or local housing and building codes.
3. Excluded Adaptations
 - a. Improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central

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air conditioning, etc.

- b. Adaptations which increase the total square footage of the home except when necessary to complete an adaptation, for example, in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair.

2303.7B ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS PROVIDER RESPONSIBILITIES

1. All agencies contracting with DHCFP who provide environmental accessibility adaptation assessments will employ persons who have graduated from an accredited college or university in Special Education, rehabilitation, rehabilitation engineering, occupational or speech therapy or other related fields and who are licensed to practice if applicable and have at least one year experience working with individuals with disabilities and their families or graduation from high school and three years experience working with individuals with disabilities and their families as a technologist and possess a Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) Technology Certification.
2. All sub-contractors must be licensed or certified if applicable. Modifications, improvements or repairs must be made in accordance with local and state housing and building codes.
3. Durable medical equipment providers must meet the standards to provide equipment under the Medicaid State Plan Program.
4. All providers must be in good standing with the local Better Business Bureau.

2303.8 SPECIALIZED MEDICAL EQUIPMENT

2303.8A COVERAGE AND LIMITATIONS

1. Specialized medical equipment and supplies are those devices, controls, or appliances specified in the plan of care that enable recipients to increase their abilities to perform ADLs.
2. This service also includes devices, controls, or applications which enable the recipient to perceive, control, or communicate with the environment in which they live; items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan.

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3. Items reimbursed with waiver funds shall be, in addition to any medical equipment and supplies, furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the recipient.

4. All items shall meet applicable standards of manufacture, design, and installation and where indicated, will be purchased from and installed by authorized dealers.

5. Vehicle Adaptations

All modifications and equipment must be purchased from authorized dealers, meet acceptable industry standards, and have payment approved by the case manager.

6. Assistive Technology

All equipment must be purchased from authorized dealers when appropriate. Equipment must meet acceptable standards (e.g., Federal Communications Commission and/or Underwriter's Laboratory requirements when applicable, and requirements under the Nevada Lemon Law NRS 597.600 to 597.680).

7. Supplies

Supplies must be purchased through a provider enrolled to provide such services under the existing state Medicaid plan or as otherwise approved by DHCFP for services under this waiver.

2303.8B SPECIALIZED MEDICAL EQUIPMENT PROVIDER RESPONSIBILITIES

DHCFP requires any non-exempt business that intends to provide durable medical equipment to Nevada Medicaid recipients, either directly or indirectly, be licensed by the State Board of Pharmacy as a Medical Devices, Equipment and Gases (MDEG) provider or wholesaler pursuant to the provisions of Nevada Administrative Code (NAC) Chapter 639.

2303.9 PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS)

2303.9A 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 the "help" button is activated.

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2. PERS services are limited to those recipients who live alone, 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.
3. The necessity for this type of emergency safety measure to prevent institutionalization will be identified and explained in the POC. The need for PERS will be explained in the Social/Health Assessment.
4. The waiver service pays for the device rental and funds ongoing monitoring on a monthly basis.

2303.9B PERS PROVIDER RESPONSIBILITIES

1. The provider must provide documentation showing tax identification number.
2. The provider is responsible for ensuring that the response center is staffed by trained professionals at all times.
3. The provider is responsible for any replacement or repair needs that may occur.
4. Providers of this service must utilize devices that meet Federal Communication Commission standards, Underwriter's Laboratory standards or equivalent standards, and be in good standing with the local Better Business Bureau (BBB).
5. Providers must inform recipients of any liability the recipient may incur as a result of the recipient's disposal of provider property.

2303.9C RECIPIENT RESPONSIBILITIES

1. The recipient is responsible to utilize the leased PERS equipment with care and caution and to notify the PERS provider when the equipment is no longer working.
2. The recipient must return the equipment to the provider when it is no longer needed or utilized, when the recipient terminates from the waiver program, or when the recipient moves out of state.
3. The recipient may not throw away the PERS equipment. This is leased equipment and belongs to the PERS provider.

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2303.10 ASSISTED LIVING SERVICES

2303.10A COVERAGE AND LIMITATIONS

1. Assisted living services are all inclusive services furnished by the assisted living provider. Assisted living services are meant to provide all support services needed in the community and may include personal care, homemaker, chore, attendant care, meal preparation, companion, medication oversight (to the extent permitted under state law), transportation, diet and nutrition, orientation and mobility, community mobility/ transportation training, advocacy for related social services, health maintenance, active supervision, home and community safety training, therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility. Services provided by a third party must be coordinated with the assisted living facility. This service may include skilled or nursing care to the extent permitted by state law. Nursing and skilled therapy services are incidental, rather than integral to the provision of assisted living services. Payment is not to be made for 24 hour skilled care. If a recipient chooses assisted living services, other individual waiver services may not be provided, except case management services.
2. The service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way promoting maximum dignity and independence, and to provide supervision, safety and security.
3. Assisted living providers are expected to furnish a full array of services except when another Federal program is required to provide the service. Other individuals or agencies may also furnish care directly, or under arrangement with the assisted living provider, but the care provided by other entities supplements that provided by the assisted living provider and does not supplant it.
4. Federal Financial Participation (FFP) is not available for room and board, items of comfort, or the cost of facility maintenance, upkeep and improvement.

2303.10B ASSISTED LIVING PROVIDER RESPONSIBILITIES

1. The assisted living environment must evidence a setting providing:
 - a. living units that are separate and distinct from each other;
 - b. a central dining room, living room or parlor and common activity center(s) except in the case of individual apartments;
 - c. 24 hour on-site response staff.

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2. All persons performing services to recipients from this category must have criminal history clearances obtained from the FBI through the submission of fingerprints to the FBI. In addition, provider agencies are required to conduct routine screenings on all applicants who will perform services to recipients to ensure the health and welfare of recipients and to make every effort possible to prevent recipient abuse. Reference Section 2303.3B2.d.
3. Providers must arrange training in personal hygiene needs and techniques for assisting with activities of daily living such as bathing, dressing, grooming, skin care, transfer, ambulation, exercise, feeding, use of adaptive aids and equipment, identifying emergency situations and how to act accordingly.
4. Must have current CPR certification which may be obtained outside the agency prior to initiation of services to a Medicaid recipient.
5. Caregiver Supervisors will:
 - a. possess at least one (1) year of supervisory experience and a minimum of two (2) years experience working with adults with physical disabilities, including traumatic brain injury.
 - b. demonstrate competence in designing and implementing strategies for life skills training and independent living.
 - c. possess a bachelor's degree in a human service field preferably, or education above the high school level combined with the experience noted in paragraph (a) above.

Supporting Qualifications of the Caregiver Supervisor are:

1. experience in collecting, monitoring, and analyzing service provision; ability to identify solutions and satisfy staff/resident schedules for site operations.
2. ability to interpret professional reports.
3. knowledge of life skills training, personal assistance services, disabled advocacy groups, accessible housing, and long-term care alternatives for adults with physical disabilities and/or traumatic brain injuries.
4. dependable, possess strong organization skills and have the ability to work independent of constant supervision.

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6. Assisted Living Attendants

Assisted living attendants shall provide personal care services, community integration, independent living assistance, and supervisory care to assist the recipient in following the POC. Assisted living attendants shall possess:

- a. a high school diploma or GED.
- b. some post-secondary educational experience is desired.
- c. a minimum of two positive, verifiable employment experiences.
- d. two (2) years of related experience is desired.
- e. job experience demonstrating the ability to teach, work independently without constant supervision, and demonstrating regard and respect for recipients and co-workers.
- f. verbal and written communication skills.
- g. the ability to handle many details at the same time.
- h. the ability to follow-through with designated tasks.
- i. knowledge in the philosophy and techniques for independent living for people with disabilities.
- j. if the attendant is providing attendant care services, that include skilled services, the attendant must meet the requirements of NRS 629.091 and meet the requirements of NRS 629.091 if the attendant is providing attendant care services that include skilled services.
- k. a current CPR certificate.

7. Supporting Qualifications of the assisted living attendant are:

- a. dependability, able to work with minimal supervision;
- b. demonstrates problem solving ability;
- c. the ability to perform the functional tasks of the job.

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2303.11 HOME DELIVERED MEALS

2303.11A COVERAGE AND LIMITATIONS

Home delivered meals are the provision of meals to persons at risk of institutional care due to inadequate nutrition. Home delivered meals include the planning, purchase, preparation and delivery or transportation costs of meals to a person's home.

Recipients who require home delivered meals are unable to prepare or obtain nutritional meals without assistance or are unable to manage a special diet recommended by their physician.

1. Home delivered meals must be prepared by an agency, and be delivered to the recipient's home.
2. Meals provided by or in a child foster home, adult family home, community based residential facility, or adult day care are not included, nor is meal preparation.
3. The direct purchase of commercial meals, frozen meals, Ensure, or other food or nutritional supplements is not allowed under this service category.
4. Home delivered meals are not intended to meet the full daily nutritional needs of a recipient. More than one provider may be used to meet a recipient's need.
5. Case managers determine the need for this service based on a Standardized Nutritional Profile, or assessment, and by personal interviews with the recipient related to individual nutritional status.
6. All meals must comply with the Dietary Guidelines for Americans published by the Secretaries of the Department of Health and Human Services (DHHS) and the United States Department of Agriculture; and provide a minimum of 33 and 1/3 percent of the current daily Recommended Dietary Allowances (RDA) as established by the Food and Nutrition Board, National Research Council of the National Academy of Sciences.
7. Nutrition programs are encouraged to provide eligible participants meals which meet particular dietary needs arising from health or religious requirements or the ethnic background of recipients.

2303.11B HOME DELIVERED MEALS PROVIDER RESPONSIBILITIES

1. Meals are provided by governmental or community providers who meet the requirements of a meal provider under NRS 446 and who hold a Physical Disability Waiver provider contract with the DHCFP.

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2. Pursuant to NRS 446: All nutrition sites which prepare meals must have a Food Service Establishment Permit as follows:
 - a. All Nutrition Programs must follow the Health and Safety Guidelines established for Food and Drink Establishments in Nevada Administrative Code, Chapter 446, or local health code regulations.
 - b. All kitchen staff must hold a valid health certificate if required by local health ordinances.
 - c. Report all incidents of suspected food borne illness to the affected recipients and local health authority within 24 hours and to the DHCFP DO case manager by the next business day.
3. All employees must pass State/FBI background checks.
4. Provide documentation of taxpayer identification number.

2303.12 ATTENDANT CARE

2303.12A COVERAGE AND LIMITATIONS

Extended State plan personal care attendant service may include assistance with eating, bathing, dressing, personal hygiene, ADLs, shopping, laundry, meal preparation and accompanying the recipient to appointments as necessary to enable the individual to remain in the community. The service may include hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically disabled individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. This service may include skilled or nursing care to the extent permitted by State law. This service may include an extension of task completion time allowed under the state plan with documented medical necessity.

1. Where possible and preferred by the recipient, he/she will direct his/her own service either with an independent contractor, an Intermediary Services Organization (ISO), or a provider agency. Otherwise, a provider agency will supervise the assistants. When the recipient recruits and selects a caregiver, the individual is referred to the provider agency for hire. The recipient may also terminate the assistant. When utilizing an independent contractor the recipient will work with his/her case manager to identify an appropriate back up plan. The agency will otherwise recruit, screen, schedule assistants, provide backup and assurance of emergency assistance.
2. Allows an extension to the State Plan hours authorized under the functional assessment (Form NMO 3244) for a specific functional area when there is documentation by a

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licensed provider the service is necessary based on medically appropriate standard of care. The maximum allowable increase (above the state plan covered hours) for tasks on an ongoing basis will not exceed the nursing facility standard rate, the nursing facility ventilator dependent rate, or the nursing facility pediatric specialty care rate, whichever rate is the rate the state would pay for the recipient in a nursing facility. Short-term increases based on time limited acute situation may exceed this rate. Increases are provided in 30 day increments, based on a review of the treatment plan and progress towards outcomes. Documentation must be provided by the case manager in the case notes.

3. Extended personal care attendant services in the recipient's plan of care may include assistance with:
 - a. eating;
 - b. bathing;
 - c. dressing;
 - d. personal hygiene;
 - e. ADLs;
 - f. hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically disabled individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function.

4. Flexibility of Services

Flexibility of service delivery which does not alter medical necessity may occur within a single week period without an additional authorization or change in the service plan. This flexibility must demonstrate and document the needs of the recipient in the approved service plan, and must not take place solely for the convenience of the Provider or the PCA. Documentation of flexibility within a single week must be reflected in the recipient's file.

2303.12B ATTENDANT CARE PROVIDER RESPONSIBILITIES

In addition to the following requirements listed, reference Section 2303.3B of this Chapter regarding Individual Provider Responsibilities.

1. Personal care attendants may be members of the individual's family. However, payment

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will not be made for services furnished by legally responsible individuals.

2. When the provision of services includes an unskilled provider completing skilled care, qualifications and requirements must be followed as in NRS 629.091, and MSM Chapter 2600.
3. Providers must demonstrate the ability to:
 - a. perform the care tasks as prescribed;
 - b. identify emergency situations and to act accordingly, including CPR certification which may be obtained outside the agency;
 - c. maintain confidentiality in regard to the details of case circumstances; and
 - d. document in writing the services provided.
4. Provider Agencies must arrange training in:
 - a. procedures for arranging backup when not available, agency contact person(s), and other information as appropriate. (Note: This material may be provided separate from a training program as part of the provider's orientation to the agency.)
 - b. personal hygiene needs and techniques for assisting with ADLs, such as bathing, grooming, skin care, transfer, ambulation, exercise, feeding, dressing, and use of adaptive aids and equipment.
 - c. home making and household care, including good nutrition, special diets, meal planning and preparation, essential shopping, housekeeping techniques and maintenance of a clean, safe and healthy environment.

2303.13 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 all or any of these stipulations may result in Nevada Medicaid's decision to exercise its right to terminate the provider's contract. Refer to MSM Chapter 100 for general enrollment policies.

2303.14 INTAKE PROCEDURES

DHCFP developed procedures to ensure fair and adequate access to services covered under the HCBW for Persons with Physical Disabilities.

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2303.14A COVERAGE AND LIMITATIONS

1. Slot Provisions

- a. The allocation of waiver slots is maintained by the DHCFP DO. DO's provide wait list data to DHCFP Central Office on a monthly basis.
- b. When a physically disabled waiver recipient voluntarily terminates from the waiver, e.g., moves out of state, fails to cooperate, or requests waiver services be terminated, then at a later date, wants to be reconsidered for the waiver, the person's name is placed on the wait list based on the new referral date.
- c. When a physically disabled waiver recipient involuntarily terminates from the waiver (e.g., has been placed in a nursing facility or hospital), and wants to be reconsidered for the waiver after discharge from the hospital or nursing home. The following applies:
 1. if the discharge occurred in the same waiver year; and
 2. if the person still meets the eligibility criteria, that recipient will be placed back on the HCBW for Persons with Physical Disabilities.

2. Telephone referral/Preliminary Screening

- a. A referral or inquiry for the waiver may be made by the potential applicant or by another party on behalf of the potential applicant by contacting the local DHCFP DO. DO staff will discuss waiver services, including the eligibility requirements, with the referring party or applicant.
- b. When the potential applicant requests to apply for the waiver, the case manager assists the individual in completing and submitting a DWSS application, if needed.
- c. During the referral process, if the case manager determines the applicant does not appear to meet the waiver criteria of financial eligibility, LOC, or disability determination, the applicant will be referred to other agencies for needed services.
- d. When the applicant does not appear eligible for the waiver, verbal information is relayed regarding the right to continue the application process and, if still deemed ineligible, the applicant has the right to a fair hearing.

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3. Wait List/No Waiver Slot Available

- a. After the preliminary screening by DHCFP DO staff is completed, the staff determines if the applicant appears to meet the criteria to qualify for the waiver.

The applicant must also submit an application for Medicaid through the DWSS if necessary.

After an application is received by DWSS, and the applicant appears to meet the criteria to qualify for the waiver, the DHCFP DO staff schedules a face-to-face home visit with the applicant to conduct LOC and service need screening.

1. The applicant must meet the criteria for nursing facility LOC.
2. The applicant must require at least one waiver service to be eligible for the waiver.
3. The applicant must be certified as physically disabled by Medicaid's Central Office Disability Determination Team.
4. If the applicant does not meet the program eligibility requirements and is denied, the case manager will send the NOD to the applicant.
5. If the applicant would be eligible given an available slot, they are denied due to "no slot available", and the date of the initial referral is the wait list ranking date.

4. Waiver Slot Availability

Once a slot for the waiver is available, an applicant who has been assigned a waiver slot will be reprocessed for the waiver.

- a. Reprocessing for the waiver:
1. If the DWSS application is over 30 days old, the DO staff will assist the applicant with providing an updated application to DWSS within 10 days of DHCFP's waiver approval.
 2. The DHCFP DO staff will schedule a face-to-face home visit with the recipient to complete the full waiver assessment.
 3. An Authorization for Release of Information Form is needed for all waiver recipients and provides written consent for the DHCFP to release

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information about the recipient to others as necessary to obtain waiver services.

The applicant or designated 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/recipient is given the right to choose waiver services in lieu of placement in a nursing facility. When the applicant or designated legal representative prefers placement in a nursing facility, the case manager will assist the applicant in arranging for facility placement.
5. The applicant/recipient is given the right to request a hearing if not given a choice between home and community based services and nursing facility placement.
6. When the applicant/recipient is approved for the waiver:
 - a. A written POC is developed in conjunction with the recipient by the DO case manager for each recipient under the waiver. The POC is based on the assessment of the recipient's health and welfare needs.
 - b. The recipient or legally responsible individual should participate in the development of the POC.
 - c. The POC is subject to the approval of the DHCFP's Central Office Waiver Unit.
 - d. Recipients are given free choice of all qualified Medicaid providers for each Medicaid covered service included in the POC. Current POC information as it relates to the services provided must be given to all service providers.
7. All forms must be complete with signature and dates when required.
8. If an applicant/recipient is denied waiver services, the case manager sends the NOD to the applicant.

5. Effective Date For Waiver Services

The effective date for waiver services approval is the completion date of all the intake forms and the Medicaid eligibility date, whichever is later. When the recipient resides in

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an institution, the effective date cannot be prior to the date of discharge from the institution.

6. Waiver Costs

DHCFP must assure CMS the average per capita expenditures under the waiver do not exceed 100 percent (100%) 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.

2303.15 BILLING PROCEDURES

DHCFP must assure CMS all claims for payment of waiver services are made only when an individual is Medicaid eligible, when the service(s) is identified in the approved POC, and if necessary the service(s) has been prior authorized.

2303.15A COVERAGE AND LIMITATIONS

Provider type 58, HCBW for Persons with Physical Disabilities, must complete the CMS 1500 for payment of waiver services. Incomplete or inaccurate claims are returned to the provider by DHCFP's fiscal agent. If the wrong form is submitted it is also returned to the provider by DHCFP's fiscal agent.

2303.15B PROVIDER RESPONSIBILITY

Providers must submit claims to DHCFP's QIO-like vendor. Claims must meet the requirements stated in the CMS-1500 Claim Form Instructions which is located on the Magellan's website (select "Billing Information" from the "Providers" menu at <http://nevada.fhsc.com>).

Providers may also refer to the DHCFP's website for a complete list of codes/modifiers billable under Provider Type 58 (select "Rates" from the main menu, then click on Provider Type 58 – HCBW for Persons with Physical Disabilities).

2303.16 ADVANCE DIRECTIVES

Section 1902(w) of the Social Security Act requires licensed provider agencies providing personal care aide services to give clients' information regarding each individual's decision-making rights about health care, declarations (living wills) and durable powers of attorney for health care decisions. Refer to MSM Chapter 100 for further information.

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2303.17 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 recipient satisfaction with the waiver, and assurance of the cost effectiveness of these services.

The state will conduct an annual review; and

1. provide CMS with information on the impact of the waiver. This includes the type, amount, and cost of services provided under the waiver and provided under the State Plan and the health and welfare of the recipients served on the waiver.
2. assure financial accountability for funds expended for Home and Community Based services.
3. evaluate all provider standards are continuously met and plans of care are periodically reviewed to assure services furnished are consistent with the identified needs of the recipients.
4. evaluate the recipients' satisfaction with the waiver program.
5. further assure all problems identified by this monitoring are addressed by the provider in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

2303.17A PROVIDER RESPONSIBILITIES

Providers must cooperate with DHCFP's annual review process.

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2304 HEARINGS

2304.1A SUSPENDED WAIVER SERVICES

1. When 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 a recipient's case may be suspended, instead of closed,). A NOD identifying the effective date and the reason for suspension will be sent to the recipient by the District Office.
2. If at the end of the 45 days the recipient has not been removed from suspended status, the case must be closed. A NOD identifying the 60th day of suspension as the effective date and the reason for termination will be sent to the recipient by the District Office.

2304.1B RELEASE FROM SUSPENDED WAIVER SERVICES

When a recipient is released from the hospital, nursing facility or an Intermediate Care Facility for the Mentally Retarded (ICF/MR) before 60 days, the case manager, within 5 working days of release must:

1. complete a new LOC/Social Health Assessment, if there has been a significant change in the recipient's condition or if it appears they may not meet a level of care;
2. complete a new POC if there has been a change in services (medical, social, or waiver). When 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 noted in the case record. The date of resolution must also be documented in the case manager's notes;
3. complete a new Cost Projection form when there is a change in the POC;
4. contact the service provider(s) to reestablish services.

2304.1C DENIAL OF WAIVER APPLICATION

Reasons to deny an applicant for waiver services:

1. The applicant does not meet the criteria for being physically disabled.
2. The applicant does not meet the level of care criteria for a nursing facility placement.
3. The applicant has withdrawn their request for waiver services.
4. The applicant fails to cooperate with the DHCFP Case Manager or home and community based services providers in establishing and/or implementing the POC, implementing

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waiver services, or verifying eligibility for waiver services. (The recipient's or the recipient's authorized representative's signature is necessary for all required paperwork).

5. The applicant's support system is not adequate to provide a safe environment during the time when home and community based services are not being provided.
6. DHCFP has lost contact with the applicant.
7. The applicant fails to show a need for home and community based waiver services.
8. The applicant would not require nursing facility placement if home and community based services were not available.
9. The applicant has moved out of state.
10. Another agency or program will provide the services.
11. The DHCFP DO has filled the number of positions allocated to the HCBW for Persons with Physical Disabilities. The applicant will be approved for the waiver wait list and will be contacted when a slot is available.

When the application for waiver services is denied the case manager sends a NOD for Prior Authorization Request (Form 3582) to the applicant or the applicant's legal representative. The case manager will submit the form within 5 days of the date of denial of waiver services.

2304.1D TERMINATION OF WAIVER SERVICES

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

1. The recipient has failed to pay his/her patient liability.
2. The recipient no longer meets the physical disability criteria.
3. The recipient no longer meets the level of care criteria for nursing facility placement.
4. The recipient has requested termination of waiver services.
5. The recipient has failed to cooperate with the DHCFP case manager or home and community based services providers in establishing and/or implementing the plan of care, 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).

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6. The recipient's support system is not adequate to provide a safe environment during the time when home and community based services are not being provided.
7. The recipient fails to show a continued need for home and community based waiver services.
8. The recipient no longer requires nursing facility placement if home and community based services were not available.
9. The recipient has moved out of state.
10. The recipient has submitted fraudulent documentation on Attendant Care provider time sheets and/or forms.
11. Another agency or program will provide the services.
12. 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, or incarcerated).
13. Medicaid has lost contact with the recipient.

When a recipient is terminated from the waiver program, the case manager sends to the recipient or the recipient's legal representative a NOD Form 3582. The form must be mailed by the agency to the recipient at least 13 calendar days before the Date of Action on the form. Refer to MSM Chapter 3100 for exceptions to the advance notice.

2304.1E REDUCTION OF WAIVER SERVICES

Reasons to reduce waiver services:

1. The recipient no longer needs the number of service hours which were previously provided.
2. The recipient no longer needs the service previously provided.
3. The recipient's support system is providing the service.
4. The recipient has failed to cooperate with the DHCFP case manager or home and community based services 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).

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5. The recipient has requested the reduction of services.
6. The recipient's ability to perform activities of daily living has improved.
7. Another agency or program will provide the service.
8. Another service will be substituted for the existing service.
9. The recipient fails to cooperate with the necessary procedures and signatures for enrolling any physically disabled waiver service provider.

When there is a reduction of waiver services the case manager will send a NOD Form 3582 to the recipient or the recipient's legal representative. The form must be mailed by the agency to the recipient at least 13 calendar days before the Date of Action on the form.

2304.2 REAUTHORIZATION WITHIN 90 DAYS OF WAIVER TERMINATION

- A. If waiver services have been terminated and the recipient/applicant is eligible for readmission to the waiver as defined in Section 2304.1B and is requesting re-approval within 90 days of closure the case manager must complete the following:
 1. A new LOC/Social Health Assessment Tool;
 2. A Social/Health Assessment/Adjunct;
 3. The Statement of Understanding;
 4. The POC; and
 5. The Disability Waiver Cost Projections. All forms must be complete with signatures and dates.
- B. If a recipient is terminated from the waiver for more than 90 days, and slots are available, and the recipient/applicant is eligible for readmission to the waiver a complete waiver packet for a new authorization must be forwarded to the DHCFP Central Office Waiver Unit.

2304.3 APPEALS AND HEARINGS

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