MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

September 24, 2019

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: TAMMY MOFFITT, CHIEF OF OPERATIONS

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 2300 – HOME AND COMMUNITY BASED WAIVER (HCBW) FOR PERSONS WITH PHYSICAL DISABILITIES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 2300 – Home and Community Based Waiver (HCBW) for Persons with Physical Disabilities are being proposed to include mandate as per the 21st Century Cures Act.

In December 2016, Congress passed H.R. 34 - 21st Century Cures Act, mandating that all States require the use of an Electronic Visit Verification (EVV) System for all Medicaid funded personal care services that are provided under a State plan or a waiver of the plan, including services provided under section 1915(c).

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

Entities Financially Affected: Entities Financially Affected: This proposed change affects all Medicaid-enrolled providers delivering specific waiver services. Those provider types (PT) include but are not limited to: Waiver for Persons with Physical Disabilities (PT 58).

Financial Impact on Local Government: Unknown at this time.

These changes are effective September 25, 2019.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 19/19 MSM Ch 2300 – Home and Community Based Waiver (HCBW) for Persons with Physical Disabilities	MTL 08/13, 33/10 MSM Ch 2300 – Home and Community Based Waiver (HCBW) for Persons with Physical Disabilities

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2301	**Authority**	Added new authorities as per the new policy mandate.
2303.3B	**Provider Responsibilities**	Deleted information regarding prior authorization as not every waiver service requires a prior authorization. Added information regarding Electronic Visit Verification policy under new section 2303.3B.2b.
2303.3C	**Recipient Responsibilities**	Corrected/renumbered list at the end of this section and added two new recipient responsibilities.
2303.4B	**Homemaker Provider Responsibilities**	Added two new provider responsibilities related to EVV policy.
2303.5B	**Chore Services Provider Responsibilities**	Added provider responsibility related to EVV policy and further clarification regarding requirement, expectations and documentation.
2303.6B	**Respite Care Provider Responsibilities**	Added provider responsibility related to EVV policy and further clarification regarding requirement, expectations and documentation.
2303.7B	**Environmental Accessibility Adaptations Provider Responsibility**	Added specific service requirement regarding prior authorization.
2303.9B	**PERS Provider Responsibilities**	Added specific service requirement regarding prior authorization.
2303.10B	**Assisted Living Provider Responsibilities**	Added specific service requirement regarding prior authorization.
2303.11B	**Home Delivered Meals Provider Responsibilities**	Added specific service requirement regarding prior authorization.
2303.12B	**Attendant Care Provider Responsibilities**	Added two new provider responsibilities related to EVV policy.

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HOME AND COMMUNITY-BASED WAIVER (HCBW) FOR PERSONS WITH PHYSICAL DISABILITIES

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2300 INTRODUCTION

The Home and Community Based Waiver (HCBW) for Persons with Physical Disabilities 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.

The 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. 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.

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 Division of Health Care Financing and Policy's (DHCFP) Home and Community Based Waiver (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 (HIPAA)
- 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

- 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.

- 21st Century Cures Act, H.R. 34, Sec. 12006 – 114th Congress

- H.R. 6042 – 115th Congress

2302 RESERVED

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;

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. If attendant care services are medically necessary, the case manager is then responsible for implementation of services and continued authorization of services;

11. Completion of prior authorization form in the Medicaid Management Information System (MMIS).

12. Travel time to and from scheduled home visits.

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 Waiver. Professional or medical licensure recognized by a Nevada Professional State Board, such as social worker, registered nurse, occupational therapist or physical therapist is required. A Licensed Practical Nurse (LPN) 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.

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.

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 (HCBS) 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 (NF). Recipients on the waiver must meet and maintain waiver eligibility requirements for the waiver.

2. Persons with Physical Disabilities Waiver Eligibility Criteria

   Eligibility for the HCBW for Persons with Physical Disabilities is determined by the combined efforts of the DHCFP and the Division of Welfare and Supportive Services (DWSS).

   The following determinations must be made for eligibility purposes. Services will not be provided unless the applicant is found eligible in all areas:

   a. The applicant must be physically disabled.

      1. Applicants 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 must meet and maintain an LOC for admission into an NF within 30 days if HCBW services or other supports were not available.

      1. The applicant must require provision of at least one ongoing waiver service monthly to be determined to need waiver services as documented in the POC.

   c. Applicants must meet financial eligibility for Medicaid as determined by 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, the 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 Nevada Revised Statute (NRS) 426.721 to 731. Applicants must be dependent or require assistance in the functional areas of eating, bathing and toileting as identified on the LOC screening assessment.

   c. All other applicants not listed above.

5. The DHCFP must assure the Center for Medicare and Medicaid Services (CMS) that the 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 100% of the amount that would be incurred by the DHCFP for all these recipients if they had been in an institutional setting in the absence of the waiver. The 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.

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 (MSM) Chapter 3200 for additional information on hospice services.

8. HBCS are not a substitute for natural and informal supports provided by family, friends or other available community resources. Waiver services alone may not address all of the applicant's identified needs.

9. 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/recipient must choose one HCBW program and receive services provided by that program.

2303.2B 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.

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

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 MSM Chapter 100.

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 total weekly authorized hours for Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) may be combined and tailored to meet the needs of the recipient, as long as the plan does not alter medical necessity. The provider and recipient will determine how to use the weekly authorized hours on an ongoing basis; however, any changes that do not increase the total authorized hours can be made within a single week without an additional authorization. Flexibility of services may not take place solely for the convenience of the provider.

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

2. Provider Agencies

a. 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, if applicable;

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.

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, the 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 years after the date the claim is paid.

11. Flexibility of service delivery which does not alter medical necessity may occur within a single week period without an additional authorization. Reference Section 2303B.e.

b. ELECTRONIC VISIT VERIFICATION (EVV):

The 21st Century Cures Act requires the use of an EVV system to document services that are provided for all personal care services under a Medicaid State plan or waiver program. This mandate requires provider agencies to use an EVV system to record service delivery visit information. Nevada Medicaid utilizes the open-system model, procuring a vendor but also allows agencies to utilize their own if it meets the 21st Century Cures Act requirements for documentation.

All service information must be recorded in an electronic system that interfaces with either a telephone or an electronic device that generates a timestamp. The provider agency must verify the EVV record, including any visit maintenance, prior to submitting a claim associated with the EVV record. All claims must be supported by an EVV entry into an EVV system prior to claim submission.

Agencies must ensure each personal care attendant has a unique identifier (National Provider Identification – NPI) associated with their worker profile in the EVV system.

1. STATE OPTION:

a. The EVV system electronically captures:

1. The type of service performed, based on procedure code;

2. The individual receiving the service;

3. The date of the service;

4. The location where service is provided;

5. The individual providing the service;

6. The time the service begins and ends.

b. The EVV system must utilize one or more of the following:

1. The agency/personal care attendant's smartphone;

2. The agency/personal care attendant's tablet;

3. The recipient's landline telephone;

4. The recipient's cellular phone (for Interactive Voice Response (IVR) purposes only);

5. Other GPS-based device as approved by the DHCFP.

2. DATA AGGREGATOR OPTION:

a. All Personal Care Agencies that utilize a different EVV system (as approved by the DHCFP) must comply with all documentation requirements of this chapter and must utilize the data aggregator to report encounter or claim data.

1. Appropriate form must be approved by the DHCFP before use of system to ensure all data requirements are being collected to meet the 21st Century Cures Act.

2. At a minimum, data uploads must be completed monthly into data aggregator.

c. All waiver providers must provide the local DHCFP District Office Waiver Case Manager with written notification of serious occurrences involving the recipient within 24 hours of discovery.

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

1. Unplanned hospital or Emergency Room (ER) visit;

2. Injury or fall requiring medical intervention;

3. Alleged physical, verbal, sexual abuse or sexual harassment;

4. Alleged theft or exploitation;

5. Medication error;

6. Death of the recipient or significant care giver; or

7. 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

   b. has one or more physical or mental limitations that restrict the ability of the person to perform the normal ADLs," contact local law enforcement agencies.

e. Before initial employment, an employee must have a:

1. Physical examination or certification from a licensed physician that the person is in a state of good health, is free from active Tuberculosis (TB) and any other communicable disease in a contagious stage; and

2. TB screening test within the preceding 12 months, including persons with a history of Bacillus Calmett-Guerin (BCG) vaccination.

If the employee has only completed the first step of a 2-step Mantoux Tuberculin skin test within the preceding 12 months, then the second step of the 2-step Mantoux Tuberculin skin test or other single-step TB screening test must be administered. A single annual TB screening test must be administered thereafter. An employee who tests positive to either of the 2-step Mantoux Tuberculin skin tests must obtain a chest x-ray and medical evaluation for active TB.

An employee with a documented history of a positive TB screening test is exempt from skin testing and chest x-rays unless he/she develops symptoms suggestive of active TB.

An employee who is exempt from skin testing and chest x-rays must submit to an annual screening for signs and symptoms of active disease which must be completed prior to the one-year anniversary of the last screening. Documentation of the annual screening and the results must be maintained in the employee's file. The annual screening must address each of the following areas of concern and must be administered and/or reviewed by a qualified health care professional.

1. Has had a cough for more than three weeks;

2. Has a cough which is productive;

3. Has blood in his/her sputum;

4. Has a fever which is not associated with a cold, flu or other apparent illness;

5. Is experiencing night sweats;

6. Is experiencing unexplained weight loss; or

7. Has been in close contact with a person who has active TB.

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 employee's file.

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

In addition, providers must also comply with the TB requirements outlined in Nevada Administrative Code (NAC) 441A.375 and 441A.380.

f. All waiver providers, including owners, officers, administrators, managers, employees (who have direct contact with recipients) and consultants must undergo State and Federal Bureau of Investigation (FBI) background checks upon enrollment as a provider and then at a minimum of every five years thereafter to ensure no convictions of applicable offenses have been incurred and the safety of recipients is not compromised.

1. The DHCFP policy requires all waiver providers have State and Federal criminal history background checks completed. The DHCFP fiscal agent will not enroll any provider agency whose owner or operator has been convicted of a felony under State or Federal law for any offense which the DHCFP determines is inconsistent with the best interest of recipients. Additional information may be found in MSM Chapter 100, Section 102.2.

2. Criminal background checks must be conducted through the Nevada Department of Public Safety (DPS). Agencies do not have to have a DPS account. Individuals may request their own personal criminal history directly from DPS and the FBI and must have the results sent directly to the employer. Information and instructions may be found on the Health website at: http://health.nv.gov/HCQC_CriminalHistory_Fingerprints.htm.

3. The employer is responsible for reviewing the results of employee criminal background checks and maintaining the results within the employee's personnel records. Continued employment is at the sole discretion of the servicing agency. However, the DHCFP has determined certain felonies and misdemeanors to be inconsistent with the best interests of recipients. The employer should gather information regarding the circumstances surrounding the conviction when considering ongoing employment and have this documented in the employee's personnel file. These convictions include (not all inclusive):

    1. murder, voluntary manslaughter or mayhem;

    2. assault with intent to kill or to commit sexual assault or mayhem;

    3. sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexually related crime;
    4. abuse or neglect of a child or contributory delinquency;

5. a violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in NRS 454;

6. a violation of any provision of NRS 200.700 through 200.760;

7. criminal neglect of a patient as defined in NRS 200.495;

8. any offense involving fraud, theft, embezzlement, burglary, robbery, fraudulent conversion or misappropriation of property;

9. any felony involving the use of a firearm or other deadly weapon;

10. abuse, neglect, exploitation or isolation of older persons;

11. kidnapping, false imprisonment or involuntary servitude;

12. any offense involving assault or battery, domestic or otherwise;

13. conduct inimical to the public health, morals, welfare and safety of the people of the State of Nevada in the maintenance and operation of the premises for which a provider contract is issued;

14. conduct or practice detrimental to the health or safety of the occupants or employees of the facility or agency; or

15. any other offense that may be inconsistent with the best interests of all recipients.

g. 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. An "undecided" result is not acceptable. If an employee believes that the information provided as a result of the criminal background check is incorrect, the individual must immediately inform the employing agency in writing. Information regarding challenging a disqualification is found on the DPS website at: http://dps.nv.gov under Records and Technology.

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.

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

14. sign all required forms.

15. meet and maintain all criteria to be eligible, and to remain on the HCBW for Persons with Physical Disabilities.

16. may have to pay patient liability. Failure to pay is grounds for termination from the waiver.

17. agree to utilize an approved EVV system for the waiver services being received from the provider agency.

18. confirm services were provided by electronically signing or initialing, as appropriate per service plan, the EVV record that reflects the service rendered. If IVR is utilized, a vocal confirmation is required.

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 six 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 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.
   NOTE: If a recipient has an independent contractor, the direct service case manager may review the recipient daily record for completion and accuracy. The case

manager will provide training to independent contractors in the completion and use of daily records if needed.

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 MSM Chapters 100 and/or 3500.

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 the DHCFP.

2. Homemaker services are provided when the individual regularly responsible for these activities is temporarily absent or unable to manage the home.

3. The 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;

f. accompanying the recipient to homemaker activities such as shopping or the laundromat. Any transportation to and from these activities is not reimbursable as a Medicaid expense;

g. routine clean-up after up to two household pets. Walking a pet is not included unless it is a service animal.

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 HOMEMAKER PROVIDER RESPONSIBILITIES

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

1. 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.

2. A legally responsible individual may not be paid for homemaker services.

3. The DHCFP is not responsible for replacement of goods damaged in the provision of service.

4. Service must be prior authorized and documented in an approved EVV.

5. Providers are responsible to ensure that EVV requirements and expectations are met, including the documentation of all services in approved EVV system.

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; and

   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.

2303.5B CHORE SERVICES PROVIDER RESPONSIBILITIES

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

2. Service must be prior authorized and documented in an approved EVV.

Providers are responsible to ensure that EVV requirements and expectations are met, including the documentation of all services in approved EVV system.

2303.6 RESPITE CARE

2303.6A COVERAGE AND LIMITATIONS

1. Respite care is provided for relief of the primary unpaid 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 Provider Responsibilities.

1. Respite providers must:

   a. perform general assistance with ADLs and IADLs and provide supervision to functionally impaired recipients in their homes to provide temporary relief for a primary caregiver;

   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 Chapter 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 ADLs, such as bathing, grooming, skin care, transfer, ambulation, exercise, feeding, dressing, and use of adaptive aids and equipment, homemaking and household care.

k. Services must be prior authorized and documented in an approved EVV System.

l. Providers are responsible to ensure that EVV requirements and expectations are met, including the documentation of all services in approved EVV system.

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 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 the 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 (DME) providers must meet the standards to provide equipment under the Medicaid State Plan Program.

4. The service must be prior authorized.

2303.8 SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES

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.

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 (FCC) 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 the DHCFP for services under this waiver.

2303.8B SPECIALIZED MEDICAL EQUIPMENT PROVIDER RESPONSIBILITIES

Providers must be licensed through the Nevada State Board of Pharmacy (BOP) as a Medical Device, Equipment, and Gases (MDEG) supplier, with the exception of a pharmacy that has a Nevada State Board of Pharmacy license and provides DME, Prosthetic Devices, Orthotic Devices and Disposable Medical Supplies (DMEPOS). Once licensed, providers must maintain compliance with all Nevada BOP licensing requirements.

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 a landline and programmed to signal a response center once the "help" button is activated.

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 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 FCC standards, Underwriter's Laboratory standards or equivalent standards.

5. Providers must inform recipients of any liability the recipient may incur as a result of the recipient's disposal of provider property.

6. The service must be prior authorized.

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.

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.

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 ADLs 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 year of supervisory experience and a minimum of two 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.

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 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.

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.

8. The service must be prior authorized.

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 1/3% 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 are enrolled with the DHCFP as a Medicaid Provider.

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 NAC, 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 District Office case manager by the next business day.

3. All employees must pass State/FBI background checks.

4. Provide documentation of taxpayer identification number.

5. The service must be prior authorized.

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 services 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 through an Intermediary Services Organization (ISO). Refer to MSM Chapter 2600. When the recipient recruits and selects a caregiver, the individual is referred to the ISO for hire. The recipient may also terminate the assistant. When utilizing this option, the recipient will work with his/her case manager to identify an appropriate back up plan. If this option is not used, the recipient will choose a provider agency that will otherwise recruit, screen, schedule assistants, provide backup and assurance of emergency assistance.

2. 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.

3. Flexibility of Services

Flexibility of service delivery which does not alter medical necessity may occur within a single week period without an additional authorization. Reference 2303.3B.1.e of this chapter.

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 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.

5. Service must be prior authorized and documented in an approved EVV System.

6. Provider is responsible to ensure that EVV requirements and expectations are met, including the documentation of all services in approved EVV System.

2303.13 PROVIDER ENROLLMENT/TERMINATION

All providers must comply with all the DHCFP provider enrollment requirements, provider responsibilities/qualifications, and the 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

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

2303.14A COVERAGE AND LIMITATIONS

1. Slot Provisions

a. The allocation of waiver slots is maintained statewide based on priority and referral date. Slots are allocated by priority based on the earliest referral date.

b. Recipients must be terminated from the waiver when they move out of state, fail to cooperate with program requirements or request termination; their slot may be given to the next person on the waitlist.

c. When a recipient is placed in an NF or hospital, they must be sent a NOD terminating them from the waiver 45 days from admit date. Their waiver slot must be held for 90 days from the NOD date. They may be placed back in that slot if they are released within 90 days of the NOD date and request reinstatement. They must continue to meet program eligibility criteria. After 90 days, their slot may be given to the next individual on the waitlist.

2. Referral Pre-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 District Office. The DHCFP District Office staff will discuss waiver services, including the eligibility requirements, with the referring party or potential applicant.

b. If the case manager determines the applicant does not appear to meet the waiver criteria, the individual may proceed with the application process if they choose to. Once the application is denied, they will receive a NOD which includes the right to a fair hearing. The case manager will provide referrals to other community resources.

c. If the case manager determines the applicant does appear to meet waiver criteria, a face-to-face home visit is scheduled to conduct an LOC screening and medical records are obtained for a disability determination.

NOTE: If the applicant does not meet LOC, they will receive a NOD which includes the right to a fair hearing.

3. Placement on the Wait List

a. All applicants who meet program criteria must be placed on the statewide waitlist by priority and referral date. The following must be completed prior to placement on the waitlist.

1. The applicant must meet LOC criteria for placement in an NF.

2. The applicant must require at least one ongoing waiver service.

3. The applicant must be certified as physically disabled by Medicaid's Central Office Disability Determination Team.

4. Applicants must be sent a NOD indicating "no slot available."

4. Waiver Slot Allocation

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

a. Intake:

1. The DHCFP District Office staff will schedule a face-to-face home visit with the recipient to complete the full waiver assessment.

2. The case manager will obtain all applicable forms, including the Authorization for Release of Information Form.

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.

The case manager will provide an application to apply for Medicaid benefits through the DWSS. The recipient is responsible for completing the application and submitting all requested information to the DWSS. The case manager will assist upon request.

3. The applicant is given the right to choose waiver services in lieu of placement in an NF. When the applicant or designated legal representative prefers placement in an NF, the case manager will assist the applicant in arranging for facility placement.

4. The applicant is given the right to request a hearing if not given a choice between HCBS and NF placement.

5. When the applicant is approved for the waiver:

   a. A written POC is developed in conjunction with the recipient by the DHCFP District Office 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 representative is included 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.

6. All forms must be complete with signature and dates when required.

7. If an applicant is denied waiver services, the case manager sends the NOD.

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 determination date made by the DWSS, whichever is later. When the recipient resides in an institution, the effective date cannot be prior to the date of discharge from the institution.

6. Waiver Costs

The DHCFP must assure CMS the average per capita expenditures under the waiver do not exceed 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

The DHCFP must assure CMS all claims for payment of waiver services are made only when an individual is Medicaid eligible, when the service(s) are identified on the approved POC, and if 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 the DHCFP's fiscal agent. If the wrong form is submitted it is also returned to the provider by the DHCFP's fiscal agent.

2303.15B PROVIDER RESPONSIBILITY

Providers must submit claims to the DHCFP's QIO-like vendor.

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.

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 HCBS.

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. ensure health and welfare of all recipients.

2303.17A PROVIDER RESPONSIBILITIES

Providers must cooperate with the DHCFP's annual review process.

2304 HEARINGS

2304.1A SUSPENDED WAIVER SERVICES

1. Recipients must be suspended when they are admitted to a hospital or Nursing Facility (NF).

2. If the recipient has not been removed from suspended status 45 days from the admit date, the case must be closed. A Notice of Decision (NOD) must be sent identifying the 60th day of the admit date as the effective date for closure.

2304.1B RELEASE FROM SUSPENDED WAIVER SERVICES

When a recipient is released from the hospital, an NF or other institutional setting, within 60 days of the admit date, the case manager must do the following within five working days:

1. complete a new Level of Care (LOC), if there has been a significant change in the recipient's condition;

2. complete a new Plan of Care (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;

3. contact the service provider(s) to reestablish services.

2304.1C DENIAL OF WAIVER SERVICES

Reasons to deny applicant request for waiver services:

1. The applicant does not meet physical disability criteria as determined by the DHCFP's physician consultant.

2. The applicant does not meet the LOC criteria for an NF 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 (HCBS) 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 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. The DHCFP has lost contact with the applicant.

7. The applicant fails to show a need for Home and Community Based Waiver (HCBW) services.

8. The applicant would not require NF placement if HCBS were not available.

9. The applicant has moved out of state.

10. Another agency or program will provide the services.

11. The DHCFP District Office has filled the number of positions allocated to the HCBW for Persons with Physical Disabilities. The applicant will be approved for the waiver waitlist and will be contacted when a slot is available.

12. The applicant has failed to provide adequate medical documentation for a disability determination within 45 days of the request.

13. The applicant has reached their annual limit for Environmental Adaptations.

14. The requested adaption, equipment or supply is not medically necessary to prevent institutionalization.

15. The landlord has not approved requested adaption or modification.

16. The recipient's needs can be met by a legally responsible individual.

When an application for waiver services is denied the case manager sends a NOD indicating the reason for denial.

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 as determined by the DHCFP's physician consultant.

3. The recipient no longer meets the LOC criteria for NF placement.

4. The recipient has requested termination of waiver services.

5. The recipient has failed to cooperate with the DHCFP case manager or HCBS 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).

6. The recipient fails to show a continued need for HCBW services.

7. The recipient no longer requires NF placement if HCBS were not available.

8. The recipient has moved out of state.

9. The recipient has submitted fraudulent documentation on Attendant Care provider time sheets and/or forms.

10. Another agency or program will provide the services.

11. The recipient has been, or is expected to be, institutionalized over 60 days (in a hospital, NF, intermediate facility for persons with mental retardation or incarcerated).

12. The DHCFP has lost contact with the recipient.

13. The recipient's needs can be met by a legally responsible individual.

When a recipient is terminated from the waiver program, the case manager sends a NOD indicating the reason for termination. The NOD must be mailed to the recipient at least 13 calendar days before the Date of Action. 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 authorized.

2. The recipient no longer needs the service previously authorized.

3. The recipient has requested the reduction of services.

4. The recipient's ability to perform Activities of Daily Living (ADLs) has improved.

5. Another agency or program will provide the service.

6. The recipient fails to cooperate with the waiver service provider.

7. The recipient's needs can be met by a legally responsible individual.

When there is a reduction of waiver services the case manager will send a NOD indicating the reason for the reduction. The NOD must be mailed to the recipient at least 13 calendar days before the Date of Action.

2304.2 REAUTHORIZATION WITHIN 90 DAYS OF WAIVER TERMINATION

A. If a recipient is placed in an NF or hospital, and waiver services have been terminated, the recipient may request reinstatement within 90 days of the notice date. The case manager must complete the following:

1. A new LOC;

2. A new Social Health Assessment;

3. The new Statement of Understanding; and

4. The new POC.

B. If 90 days from the notice date has elapsed, the slot is allocated to the next person on the waitlist. An individual who requests reinstatement after 90 days from the notice date must be processed as a new referral.

2304.3 APPEALS AND HEARINGS

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