MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

February 14, 2012

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: MARTA E. STAGLIANO, CHIEF, COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER – 2400 HOME BASED HABILITATION SERVICES

BACKGROUND AND EXPLANATION

Changes, to this chapter, are a result of revisions made to the Social Security Act, specifically the Deficit Reduction Act, Section 6086, 1915(i) Home and Community-Based Services (HCBS) State Plan Services to incorporate 1915(i) HCBS program services and requirements. This revision makes significant changes to the policy which include the use of a standardized tool called The 1915(i) HCBS Universal Needs Assessment Tool to evaluate functional deficits of individuals. It must be completed annually. This chapter will be renamed Home Based Habilitation Services (HBHS), and was previously called Comprehensive Outpatient Rehabilitation Services.

The prior authorization process has been changed to include 1915(i) program services and requirements. This new process extends prior authorizations annually as long as program criteria are met. It still requires an interdisciplinary team to evaluate the recipient every 30 days.

Person centered planning is incorporated into this chapter with the use of an interdisciplinary team approach in the development of a service plan and plan of care.

Additional changes include a change to the definition of HBHS and the services offered. Updated eligibility criteria for Habilitation Services. In order to bring the chapter in line with 1915(i) State Plan Services, the statement "habilitation services" replaces the statement "rehabilitation" throughout the chapter. The goal is to bring the entire chapter in line with "community based habilitation services" and remove "comprehensive rehabilitation services".

The definitions section is removed from this chapter and placed in the addendum of the Medicaid Services Manual and the references section will be located in Chapter 100 of the Medicaid Services Manual.

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.

These changes are effective February 15, 2012.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 01/12 CHAPTER – 2400 HOME BASED HABILITATION SERVICES	MTL 26/03 CHAPTER – 2400 HOME BASED HABILITATION SERVICES

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2400	**Introduction**	Throughout the chapter, deleted Comprehensive Outpatient Rehabilitation (COR) and changed to Home Based Habilitation Services (HBHS). Deleted outdated language and added new language.
2401	**Authority**	Deleted outdated language and added new language and correct citations. The citation which interprets and implements this section of the Act is found in the 42 Code of Federal Regulations (CFR), Part 440.130. Statutes and Regulations: Social Security Act: 1915(i)" and references to 42 CFR and NAC.
2402	**Definitions**	Removed definitions and placed in Addendum.
2403.1	**Home Based Habilitation Services (HBHS) Day Treatment Program**	Renamed Comprehensive Day Treatment (CDT) Program to Home Based Habilitation Services (HBHS) Day Treatment Program. Deleted outdated language and added new language to match 1915 (i) requirements for HBHS services.
	Coverage and Limitations	Added updated requirements for HBHS services to incorporate 1915 (i) HCBS program services and requirements. Deleted outdated language throughout section.
	Home Based Habilitation Services (HBHS) Provider Responsibility	Clarified provider and staffing requirements, and initial evaluation language. Added the following information: • Requirements for background checks and TB testing. • Universal Needs Assessment section. • Service Plan section. • Plan of Care section. • Records Requirements section. • Confidentiality and Release of Recipient

		Records section. • Provider Liability section. • Notification of Suspected Abuse and Neglect section. Removed outdated language throughout section.
	Recipient Responsibility	Clarified language.
	Prior Authorization	Deleted outdated language. Added new process requirements.
2403.2	**Residential Habilitation Program (RHP)**	Clarified Requirements throughout the entire section.
2403.3	**Community Re-integration Services (CRS)**	Clarified Requirements throughout the entire section. Deleted outdated language Included reference to the previous section.
2404	**Quality Assurance**	Added new section.
2405	**Hearings**	Renumbered section. Removed References and Cross Reference section.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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COMPREHENSIVE OUTPATIENT REHABILITATION (COR) SERVICES

2400 INTRODUCTION

2400.1 HOME BASED HABILITATION SERVICES (HBHS)

Home Based Habilitation Services (HBHS) are medically prescribed treatment for improving or restoring functions, which have been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury.

HBHS include services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in a home and community-based settings. HBHS are prescribed by a physician and provided by the appropriate qualified staff.

2401 AUTHORITY

Home Based Habilitation Services (HBHS) is an optional Medicaid State Plan service authorized by the Nevada Medicaid Program under State Plan authority titled Nevada 1915(i) State Plan Home and Community-Based Services (HCBS). The State Plan was amended in 2008 in response to the Deficit Reduction Act, Section 6086. Congress amended the Social Security Act with Section 1915(i) allowing states to provide traditional 1915(c) services as covered State Plan benefits. Home Based Habilitation was covered under Nevada's State Plan as Comprehensive Outpatient Rehabilitation (COR) Services.

Statutes and Regulations:

- Social Security Act: 1915(i)
- 42 Code of Federal Regulations (CFR) 440.130
- 42 CFR 440.180
- 34 CFR 300.7
- Nevada Administrative Code (NAC) 388.134

2402 RESERVED

2403 POLICY

2403.1 HOME BASED HABILITATION SERVICES (HBHS) DAY TREATMENT PROGRAM

HBHS include a day treatment program in which services are designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. Habilitation Services are prescribed by a physician, provided by the appropriate qualified staff and include the following:

a. Care Coordination.

b. Adaptive Skill Development.

c. Assistance with Activities of Daily Living (ADLs).

d. Community Inclusion.

e. Transportation (not duplicative of State Plan Non-Emergency Transportation (NET)).

f. Adult Educational Supports.

g. Social and Leisure Skill Development.

h. Physical Therapy.

i. Speech Therapy.

j. Occupational Therapy.

Licensed professionals must perform an initial assessment, develop a plan of care, assess the recipient's progress and assume legal responsibility for the services provided.

2403.1A COVERAGE AND LIMITATIONS

1. Admission Criteria for Day Treatment Programs

   a. The recipient is Medicaid eligible;

   b. The recipient has a medically verifiable Traumatic Brain Injury (TBI) or Acquired Brain Injury (ABI);

   c. The individual must meet the eligibility requirements of the 1915(i) HCBS Universal Needs Assessment Tool or must qualify for a 1915(c) waiver;

d. The recipient has not previously completed a habilitation program for the same condition, unless a substantial intervening event has occurred that would require an abbreviated program to maintain community placement. The decision to impose such an exception is the sole determination of the Division of Health Care Financing and Policy (DHCFP) and requires supporting medical rationale;

e. The recipient's functional or cognitive impairment is the result of an illness or injury within the past 90 days, or 90 days from the original inpatient hospitalization, or directly after continuous outpatient therapy post the original inpatient hospitalization, or 90 days from Medicaid eligibility determination, or has a chronic illness or injury with recent exacerbation, or complication which resulted in a change in function, or has a more remote injury with recent improvement in condition and/or advancement in technology;

f. The recipient must be medically stable for intensive habilitation as evidenced by the absence of medical conditions requiring acute medical interventions (e.g., acute infectious process, uncontrolled irregular heartbeat, unstable diabetes mellitus, etc);

g. The recipient is willing, and demonstrates capacity for endurance for at least three (3) hours of habilitation services per day, five (5) days per week;

h. The recipient has a prognosis and potential to increase his or her functional independence towards returning to independent or assisted living after discharge, achievable within a reasonable period of time, as determined by the DHCFP or its QIO-like vendor;

i. The recipient has sufficient mental alertness and is able to actively participate in a complete therapy program on a daily basis;

j. The recipient is responsive to verbal or visual stimuli and can consistently follow single step commands in a meaningful way; and

k. The recipient's functional abilities indicate a potential for improvement.

2. Covered Services

a. Day Treatment programs are provided as Full Day – six (6) hours per day of habilitative services or as Half Day – a minimum of three (3) hours per day. All programs provide services five days per week, or more, and may occur in the recipient's home, inpatient settings who provide HBHS services, outpatient settings or in other community-based settings.

b. Day treatment programs must meet the following service requirements, when the specialty area is included in the individual plan of care approved by the primary physician after any needed consultation with the licensed/certified therapy provider (RN, PT, OT, SLP and case manager):

1. Physical Therapy services: Only a licensed physical therapist has the knowledge, training and experience required to evaluate and, as necessary, re-evaluate a recipient's level of function, determine whether a physical therapy program could reasonably be expected to improve, restore, or compensate for lost function. Implementation of a plan of care should be carried out pursuant to the Practice Act governing physical therapy.

2. Occupational Therapy services: Only a registered and licensed occupational therapist has the knowledge, training, and experience required to evaluate and, as necessary, re-evaluate a recipient's level of function; determine whether an occupational therapy program could reasonably be expected to improve, restore, or compensate for lost function. Implementation of a plan of care shall be carried out pursuant to the Practice Act governing occupational therapy.

3. Speech-Language Pathology (SLP) services: Only a SLP has the knowledge, training, and experience required to evaluate and, as necessary, re-evaluate a recipient's level of function; determine whether a speech therapy program could reasonably be expected to improve, restore, or compensate for lost function. Implementation of a plan of care shall be carried out pursuant to the Practice Act governing speech-language pathology.

4. Case Management services: Case management services must be provided by a licensed nurse or social worker, or Certified Case Manager (CCM), or other licensed individual eligible to apply for certification or who is working under the direct supervision of a CCM, who has the education, skills abilities and experience to perform case management services. The case manager may also need language skills, cultural sensitivity, and acquired knowledge and expertise unique to a geographic area. The case manager coordinates and implements individualized plans of care in conjunction with recipient's families or legal guardians physicians and others involved in the care of the individual.

5. Cognitive Therapy services:

The provision of this service is included as a component of a habilitation program for the severely neurologically impaired individual such as those

with TB. Other diagnoses that may require cognitive remediation include, but are not limited to, severe Cerebral Vascular Accident (CVA), anoxic injuries, and intracranial hemorrhage. For these diagnoses, as well as with TBI, major impairments exist in arousal or alerting, perception, selective attention, discrimination, orientation, organization, recall and high level thought processes, including convergent thinking, deductive reasoning, inductive reasoning, divergent thinking, and multiprocess reasoning.

6. Therapeutic Recreation services: Therapeutic recreation services are included as a component of a habilitation program when the service is directly related to the plan of care.

7. Prosthetic/Orthotic services: Refer to Medicaid Services Manual (MSM) Chapter 1300 for further information and program requirements.

8. Durable Medical Equipment (DME): Refer to MSM Chapter 500 for DME coverage guidelines for recipients who reside in or will be discharged to an extended care facility.

3. Non-Covered Services

The following are not covered benefits under day treatment programs and therefore are not reimbursable by Nevada Medicaid:

a. A maintenance program is the point at which the recipient demonstrates no further improvement, or the skills of a qualified therapist are not required to carry out an activity to maintain function at the level to which it has been restored;

b. Duplicative services are not considered medically justified and will not be covered by Medicaid. An inquiry or referral for services does not indicate the necessity for services. If the Medicaid recipient is receiving services from another provider, it is the responsibility of the evaluating provider to determine if additional services are appropriate and request prior authorization as indicated;

c. Time spent conducting a team conference is included in the established all-inclusive rate and is not a separately billable service;

d. Pre-Admission screenings completed in order to determine the appropriateness of the recipient for a particular program is considered a cost of doing business and is not a reimbursable visit;

e. Admissions or continued stays for evaluation or training for solely vocational or educational purposes or for developmental or behavioral assessments are not covered services;

f. Admissions solely for the convenience of the recipient, their family or the provider, are not covered services;

g. Pain management services, i.e. relaxation techniques, stress management and biofeedback programs;

h. Day treatment programs are not covered for individuals who have been admitted to an institutional setting such as a hospital, nursing facility or an intermediate care facility; or

i. Day treatment programs will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including: Federal, State, local and private entities. For habilitation services, the State includes, within the record of each individual, an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

4. Continued Stay Criteria for Day Treatment Services

For continued day treatment services, prior authorization must be submitted to the DHCFP's QIO-like vendor in time to meet processing timelines so an interruption in services may be avoided. Supporting documentation must be provided, including the most recent team conference report, which demonstrates that the recipient continues to meet admission criteria and continues to:

a. demonstrate an ability to actively participate in the program;

b. have documented progression toward written goals; and

c. continue to need the services provided by the day treatment program.

Services provided without prior authorization are not reimbursable.

5. Discharge Criteria

A day treatment program is a medically prescribed treatment for improving or restoring functions and must be considered for termination, regardless of the approved length of

stay, when further progress toward the established goals is unlikely or further treatment can be achieved in a less intensive setting.

A maintenance program is not a covered benefit and services provided once this level has been reached will not be reimbursed. Specifically, if no further progress is observed, discharge would be required. A recipient in a habilitation program must be considered for discharge, when any one of the following conditions is met:

a. The recipient's needs exceed the scope of the day treatment program so transfer to an inpatient hospital or skilled nursing facility is indicated;

b. The recipient no longer meets the criteria for the day treatment program;

c. The specialized knowledge and skills of the interdisciplinary team are no longer required;

d. Lack of attendance and/or participation in the activities specific to the residential program setting for more than three (3) consecutive days;

e. The recipient has reached his or her goals and a safe and effective program has been developed with informal supports to allow the recipient to live at home or elsewhere in the community;

f. There is limited motivation on the part of the recipient or caregiver which is impacting the individual's progress for over one week; or

g. The established goals serve no purpose to increase functional or cognitive capabilities towards living in a community based setting.

2403.1B HOME BASED HABILITATION SERVICES (HBHS) PROVIDER RESPONSIBILITY

1. Provider Enrollment

a. Each provider of HBHS must enroll as a Provider Type 55 and enter into the agreement with the DHCFP, through the QIO-like vendor and must submit required licenses, registrations, certificates, etc., upon request, to determine that conditions of participation, as stated in MSM 100, are met.

b. Home Based Habilitation providers must hold current accreditation, in good standing, by the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission accreditation.

c. Providers must comply with all Internal Revenue Service (IRS), Federal Insurance Contributions Act (FICA) and Occupational Safety and Health Administration (OSHA), Local, State, and Federal regulations and applicable statutes.

d. Criminal Background Checks

Under Nevada Revised Statutes (NRS) 449.176 through NRS 449.188, people who have been convicted of certain crimes may not work at certain long term care facilities or agencies. The complete statute is available at: http://leg.state.nv.us/NRS/NRS-449.html and the requirements applying to agencies are discussed at length at the Bureau of Health Care Quality and Compliance (HCQC) website: http://health.nv.gov/HCQC_CriminalHistory.htm.

Agency personnel, including administrators, managers, employees and consultants must undergo State and Federal Bureau of Investigation (FBI) background checks upon licensure or accreditation and then at a minimum of every five (5) years thereafter to ensure no convictions of applicable offenses have been incurred.

Documentation of the request, and applicable results, must be maintained in each employee personnel record and made available to the DHCFP upon request. Employees must have the criminal background check through their State Department of Public Safety (DPS) or initiated by the hiring/employing agency prior to providing any Medicaid reimbursable services to a recipient.

Providers are required to initiate diligent and effective follow up for results of background checks within 90 days of submission of prints and continue until results are received. This is particularly important when an “undecided” result is received. Documentation must be maintained in the employee’s personnel file and submitted to the DHCFP upon request.

1. The DHCFP or their designee must not enroll any person or entity convicted of a felony or misdemeanor for any offense which the State agency determines is inconsistent with the best interests of recipients. Such determinations are solely the responsibility of the DHCFP.

2. The DHCFP applies the requirements of NRS 449.176 through NRS 449.188 and will deny a provider contract to any applicant, or may suspend or revoke all associated provider contracts of any provider, to participate in the Medicaid program if the requirements of the referenced NRS sections are not met. In addition, see MSM Chapter 100.

a. If the Provider receives information related to NRS 449.176 through NRS 449.188 resulting from the criminal background check or from any other source and continues to employ a person who has been convicted of an offense as listed above, the DHCFP will take appropriate action, which may include suspension or termination of the agency's Medicaid provider contract.

b. If the hiring/employing agency does not take timely and appropriate action on the results of the background check as defined in NRS 449.176 through 449.188 and on the HCQC website, the DHCFP will take appropriate action, which may include suspension or termination of the agency's Medicaid provider contract.

If an employee believes that the information provided as a result of the criminal background check is incorrect, the individual must immediately inform the employing agency and the DHCFP in writing. Information regarding challenging a disqualification is found on the HCQC website at: http://health.nv.gov/HCQC_CriminalHistory.htm.

NOTE: Out of state providers must obtain background checks through their local DPS.

e. Tuberculosis (TB) Testing

Employees of provider facilities must complete either a QuantiFERON R-TB Gold blood test (QFT-G) or a two step (TB) Tuberculin skin test prior to initiation of services for a Medicaid recipient. If the employee tests negative on initial test, prior to the annual expiration of the initial test, they must receive either a QFT-G blood test or a one step TB skin test. Annually, thereafter, as long as the result is negative, prior to the expiration of the year's previous test, a QFT-G blood or a one step TB skin test must be performed. If the employee tests positive on the initial QFT-G blood test or the two step TB skin test (+10 mm induration or larger), or if the employee has a prior history of a positive test, the individual must have clearance by a chest X-ray prior to initiation of services for a Medicaid recipient. Annually, thereafter, prior to the date of initial clearance by the chest X-ray, the individual must have documentation which demonstrates no signs or symptoms of active tuberculosis (see Nevada Administrative Code (NAC) 441A.375).

If the employee has been medically cleared after a documented history of a positive QFT-G or TB skin test which was 10 mm or larger and then by chest x-ray, the employee must have documentation annually which demonstrates they

are not exhibiting any signs or symptoms of active 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 three (3) weeks;

2. Has a cough which is productive;

3. Has blood in his sputum;

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

5. Is experiencing night sweats;

6. Is experiencing unexplained weight loss; or

7. Has been in close contact with a person who has active tuberculosis. Annual screening for signs and symptoms of active disease must be completed prior to the one year anniversary of the last screening.

Documentation of the annual screening, when required as defined herein, and the results must be maintained in the employee's file.

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

2. Staffing Requirements

a. A provider of HBHS must employ persons with the necessary education, skills and training to provide the Medicaid required services. Medical services must be provided by licensed/certified professional. Copies of current licensure, certificates, and education must be maintained in employee files.

b. Habilitation Aides may provide personal assistance services, supervisory care, direction and guidance to assist recipients, following written plan of care and clinical protocols under the direct supervision of the licensed/certified therapy provider.

Habilitation aides must have:

1. a high school diploma or General Education Diploma (GED);
2. some post-secondary educational experience is desired;
3. a minimum of two positive, verifiable employment experiences;
4. two years of related experience is desired
5. job experience that demonstrates the ability to teach, work independent of constant supervision, and demonstrate regard and respect for recipients and co-workers;
6. verbal and written communication skills;
7. the ability to handle many details at the same time;
8. the ability to follow through with designated tasks; and
9. knowledge of the philosophy and principles of independent living for people with disabilities.

Supporting Qualifications include:

10. dependability, able to work with minimal supervision;
11. demonstrates problem solving ability;
12. the ability to perform the functional tasks of the job; and
13. the ability to identify emergency situations and act accordingly including Cardiopulmonary resuscitation (CPR) certification, which may be obtained outside the agency.

3. Initial Evaluation

The intent of HBHS is to increase the individual's functional abilities in order to eventually live in a community setting. The initial evaluation must contain all of the following information and be signed by the treating physician to be considered for authorization:

a. Origin and rationale of referral, including a copy of the order;

b. The principal and significant associated diagnosis;

c. Brief history including the date of onset of illness or injury;

d. Current medical status and confirmation of medical stability;

e. Current and pre-morbid functional status, including baseline evaluation, prognosis and potential for improvement;

f. Indication of medical necessity;

g. Identified barriers;

h. Short and long-term goals that are functional, objective and measurable;

i. The composition of the team, the plan of care and the duration of the habilitation program;

j. Summary of any previous treatment received and results of such treatment;

k. Anticipated time for completion of the program;

l. If the recipient is to participate in any group therapy sessions, documentation must include:

1. the description of the purpose of the group;

2. number of patients and staff members in group;

3. the minimum ratio of staff to patients;

4. duration on each session; and

5. the number of group sessions anticipated per week.

m. A viable, written discharge plan with appropriate post placement resources, including the identified support system that will facilitate community re-entry.

The proposed plan of care must include specific goals, how those goals will be achieved and the duration of achievement.

4. Universal Needs Assessment

a. The 1915(i) HCBS Universal Needs Assessment Tool must be used to evaluate and reevaluate whether an individual is eligible for the Nevada 1915(i) HCBS state plan services. In order to qualify for services, the individual meets at least two of the following:

1. the inability to perform 2 or more ADL's;

a. Bathing/Dressing/Grooming;

b. Mobility;

c. Toileting;

d. Eating; and/or

e. Transferring.

2. cognitive and/or behavioral impairments;

3. medical needs;

4. supervision needs;

5. substance abuse; and/or

6. multiple social service system involvement.

This evaluation must be face-to-face.

b. A physician within the scope of their professional practice as defined and limited by Federal and State law with experience in conducting assessments will be responsible for conducting the face-to-face independent assessments and reassessments of an individual's support needs and capabilities.

The individual performing the assessment must be an independent third party and must not be:

1. related by blood or marriage to the individual;

2. any paid caregiver of the individual;

3. financially responsible for the individual;

4. empowered to make financial or health-related decisions on behalf of the individual; or

5. service providers or individuals or corporations with financial relationships with any providers.

The physician must re-evaluate the recipient's eligibility annually.

5. Service Plan

The service plan is developed by the service provider. An interdisciplinary team will formulate the plan in conjunction with the recipient. The team must include staff trained in person centered planning, and must include a licensed health care professional and may include other individuals who can contribute to the plan development.

The service plan must include the identified need from the Universal Needs Assessment.

The provider must ensure the recipient, or the recipient's legal representative, is fully involved in the treatment planning process and choice of providers. Recipient, family (when appropriate) and/or legal representative participation in treatment planning must be documented on the service plan. The service plan must include a written statement that the recipient was offered a choice of HBHS providers, if applicable, and must be kept in a file maintained for the recipient.

A service plan must be completed and submitted as part of the prior authorization process. The service plan requires pre-approval by the QIO-like vendor prior to authorizing services and must include the description of services, amount of time (hourly, daily, weekly) and the title of the staff that will be providing the specific services.

The recipient must provide a signature on the service plan. If the recipient is unable to provide a signature due to cognitive and/or physical limitation, this must be clearly documented in the recipient file. A legal representative may sign for the recipient.

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

Additionally, the DHCFP must review a representative sample of participant service plans each year.

The Service Plan must be re-evaluated annually or when a significant change occurs.

6. Plan of Care

A plan of care must be initiated on the day of admission to HBHS. The plan of care must be in agreement with the Service Plan, and the 1915(i) HCBS Universal Needs Assessment Tool. The individualized plan of care must be developed and meet the requirement of NAC 449.4088.

The plan of care specifically outlines the services and activities of a recipient and must be available to all staff members providing home based habilitation services.

The Plan of Care:

a. is developed by the licensed interdisciplinary habilitation team using a person-centered process involving the individual, and where appropriate, the individual's family, caregiver, or representative, and the DHCFP care coordinator;

b. identifies the necessary services to be furnished to the individual;

c. includes objectives and directives for HBHS services needed;

d. takes into account the extent of, and need for, any family or other supports for the individual;

e. prevents the provision of unnecessary or inappropriate care;

f. is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and

g. is reviewed and updated by the licensed interdisciplinary habilitation team annually or as needed or when there is significant change in the individual's circumstances.

The plan of care must be kept in a file maintained for the recipient and must include a signature of the recipient. If the recipient is unable to provide a signature due to cognitive and/or physical limitation, this must be clearly documented in the recipient file. A legal representative may sign for the recipient.

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

7. Records Requirements

In compliance with NAC 449.40835, the facility must maintain records on each employee.

a. Employee Records must include:

1. finger prints and background results;

2. annual TB tests; and

3. training, required licenses, registrations, and certificates.

In compliance with NAC 449.40835, the facility must maintain records on recipients including daily records and attendance records. All entries made in the recipient's file must be signed and dated by the employee making the entry. The delivery of specific services including those required by Medicaid must be documented in the daily records.

b. Recipient records must include the following:

1. Medicaid Eligibility - The facility must maintain proof of each recipient's Medicaid eligibility. Verification of eligibility is the provider's responsibility. Eligibility should be verified monthly. Refer to MSM Chapter 100 for additional information regarding verification of eligibility.

2. Universal Needs Assessment.

3. Service Plan.

4. Statement indicating recipient made an informed choice in providers.

5. Plan of Care.

6. Attendance Records.

7. Daily Records.

8. Annual TB tests.

The case manager is responsible for maintaining a record for the recipient.

The facility must maintain an accurate record of the recipient's attendance by using an attendance record as defined in the MSM Addendum. The record must also reflect any absence from the facility by the recipient for purposes of obtaining other services must be

documented. This record is to include date, duration of absence and destination or purpose for absence.

8. Confidentiality and Release of Recipient Records

The facility is required to comply with applicable state and federal laws, rules and regulations regarding privacy and protection of an individual's health information.

9. Provider Liability

Provider liability responsibilities are included in the Medicaid and Nevada Check Up (NCU) Provider Contract and are incorporated in this chapter by reference.

10. Notification of Suspected Abuse and Neglect

State law requires that persons employed in certain capacities must make a report to the appropriate agency immediately, but in no event later than 24 hours after there is reason to suspect abuse or neglect. The DHCFP expects that all providers be in compliance with the intent of all applicable laws.

For adults aged 60 and over, the Aging and Disability Services Division (ADSD) accepts reports of suspected abuse, neglect or self-neglect, exploitation or isolation. Refer to NRS 200.5091 to 200.50995 regarding elder abuse or neglect.

2403.1C RECIPIENT RESPONSIBILITY

1. Medicaid recipients are required to maintain and provide a valid Medicaid eligibility card to their service providers and to notify their providers of any changes to the type of eligibility, or other insurance benefits that may be in effect such as Medicare.

2. Medicaid recipients are expected to comply with and participate in their development of their plan of care including making and keeping medical appointments.

3. The recipient is responsible to notify the provider of changes in medical status, service needs address, and location.

4. In accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, protected health information may be disclosed for the purposes of treatment, payment, or health care operations without a signed Authorization for Disclosure from the participant or designated representative. However, most other disclosures require authorization. Additional details about allowable uses and disclosures are available to participants in the DHCFP Notice of Privacy Practices, which is provided to all new enrollees.

Additionally, in accordance with NRS 232.357, an individual's health information may be shared without an Authorization for Disclosure among the divisions of the Department of Human Resources in the performance of official duties and with local governments that help the Department carry out official duties as long as the disclosure is related to treatment, payment, or health care operations.

2403.1D PRIOR AUTHORIZATION

The purpose of prior-authorization is to validate that the service being requested is medically necessary and meets Medicaid criteria for reimbursement.

1. Prior authorization is not a guarantee of payment for the service; payment is contingent upon passing all edits contained within the claims payment process; the recipient's continued Medicaid eligibility; and the ongoing medical necessity for the service being provided.

2. Prior authorizations are specific to a recipient, a provider, a service code, and established quantity of units, and for specific dates of service.

3. Prior authorization is required for all services and must be obtained regardless of whether or not Medicaid is the primary payer, except for Medicare-crossover claims.

4. Prior Authorization Process

HBHS must be prior authorized. The HBHS provider must submit the completed 1915(i) HCBS Universal Needs Assessment Tool and Service Plan (including the statement that the recipient was offered a choice of HBHS providers) and all relevant assessments to the QIO-like vendor before services are provided. All prior authorization requests must be complete and accurate. If insufficient information is provided to support the completion of a request, the HBHS provider must supply the needed information within 72 hours of notification. When complete information is submitted, the QIO-like vendor must make a decision within five (5) business days.

In the case when an individual becomes eligible for Medicaid during the course of treatment or after services were provided, the HBHS provider may request a retro-eligible authorization by submitting the completed 1915(i) HCBS Universal Needs Assessment Tool and Service Plan (including the statement that the recipient was offered a choice of HBHS providers) and all relevant assessments to the QIO-like vendor.

The retro-eligible request must be submitted within 90 days of the notice of decision from Division of Welfare and Supportive Services (DWSS) on Medicaid eligibility determination. When complete information is submitted, the QIO-like vendor must make a determination within five (5) days.

The QIO-like vendor must review and provide a determination for all service plans and provide a written authorization to the HBHS provider which includes a prior authorization number and service authorization. The prior authorization number must be included on all claims.

Types of prior authorization requests include:

a. An initial prior authorization request must be submitted before providing services to a Medicaid recipient for the first time.

b. A concurrent prior authorization is required if a provider believes it is medically necessary for additional services to be rendered beyond that of the current authorization. The concurrent prior authorization must be submitted in time to meet QIO-Like processing timelines so an interruption in services may be avoided.

c. A retro-eligible request-may occur when an individual becomes eligible for Medicaid after services have been provided. Retro-eligible requests must be submitted within 90 days from the eligibility determination date (date of decision).

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

Prior authorization may be approved for a maximum of one (1) year through the end of the eligibility month. The prior authorization is dependent upon meeting the eligibility criteria using the 1915(i) HCBS Universal Needs Assessment Tool and medical necessity as described by medical evidence relating to a TBI/ABI. If services are needed after the current authorization ends, the facility must submit a new prior authorization request to the QIO-like vendor and include the same information that is required with an initial prior authorization request.

Services provided without prior authorization are not reimbursable.

A prior authorization number is required on all claims and must correspond directly to all dates of service on the claim. No dates of service billed outside of the dates approved on the corresponding prior authorization will be paid.

The QIO-like vendor will provide a written authorization to the HBHS facility which includes a prior authorization number and service authorization.

Reimbursement is not available for services furnished by legally responsible individuals.

2403.2 RESIDENTIAL HABILITATION PROGRAM (RHP)

RHPs are a covered benefit when medically necessary services are furnished in a safe, efficient and cost-effective setting to Medicaid eligible recipients who require services 24 hours per day in a normalized living environment.

2403.2A COVERAGE AND LIMITATIONS

Reimbursement is available for time limited RHPs which have been prior authorized by Nevada Medicaid's QIO-like vendor. Programs must include a day treatment program and a 24-hour residential component for those eligible recipients who are not ready to return to independent, or supported independent, living due to their functional or cognitive impairments.

1. Admission Criteria

   In addition to the admission criteria identified in Section 2403.1A, of this Chapter, the following criteria apply for residential habilitation programs:

   a. Eligible recipients are unable to return to independent living due to a significant cognitive or physical impairment which requires intensive, short-term specialized intervention to reintegrate into the community;

   b. A program must consist of an interdisciplinary coordinated team approach, based on supporting medical rational, to improve the recipient's ability to function as independently as possible;

   c. The recipient has a viable discharge plan with appropriate post placement resources, including a support system identified that will facilitate community re-entry and a realistic expectation and plan for non-institutional living post-discharge; and

   d. Documentation is made available, upon request, to support that the individual's goals cannot be safely and adequately carried out at a less intensive level such as a day treatment program.

2. Covered Services

   a. A residential habilitation program must include a medically necessary day treatment program component focused on community reintegration. This program may consist of community reintegration training, personal care assistance and supervision in a 24 hour residential setting.

b. The residential component of the RHP must provide continued training, supervision and personal care services appropriate in amount and frequency to meet the needs of the recipient in a safe environment 24 hours per day, 7 days per week.

c. The interdisciplinary team must establish a plan of care which is developed and updated annually, or as needed, for each resident.

d. Nevada Medicaid does not reimburse for costs associated with room and board in the residential setting. Arrangements for reimbursement of such costs must be made with the recipient, or their family, prior to the program admission.

e. A component of community reintegration includes community visits. Payment for community visits must be properly documented, and prior authorized subject to the following conditions:

1. The purpose of community visits is for preparation for discharge to the community.

2. The recipient's primary physician authorizes the visit and the plan of care provides for such absences.

The community visit is to be reimbursed the lesser of billed charges or the established community visit per diem rate for a maximum of 2 days per month. For this purpose, a month is any continuous 31 day period.

3. Continued Stay Criteria for Residential Habilitation Program

For continued residential habilitation services, prior authorization must be submitted to Medicaid's QIO-like vendor a minimum in time to meet processing timelines so an interruption in services may be avoided. To be considered for continued stay, supporting documentation must be provided including the most recent team conference report, which demonstrates that the recipient continues to meet RHP admission criteria and continues to:

a. demonstrate the ability to actively participate in the program;

b. have documented progression toward written goals;

c. need 24-hour habilitation services as described in 2403.1A and 2403.1A.2.a.

If continuation of services is determined to be medically appropriate, a new length of stay will be assigned and continued in this manner until the discharge of the recipient is indicated. Services provided without prior authorization are not reimbursable.

4. Discharge Criteria

A recipient in a residential habilitation program must be considered for discharge, regardless of the authorized length of stay or program completion, when the following conditions are met:

a. The recipient's needs exceed the scope of the residential habilitation program so transfer to an inpatient hospital or skilled nursing facility is indicated;

b. The recipient no longer meets the criteria for the program;

c. The specialized knowledge and skills of the interdisciplinary team are no longer required;

d. Lack of attendance and/or participation in the activities specific to the residential program setting for more than three consecutive days;

e. The recipient has reached his or her goals and a safe and effective program has been developed with informal supports to allow the recipient to live at home or elsewhere in the community;

f. There is limited motivation on the part of the recipient or caregiver which is impacting the individual's progress for over one week; or

g. The established goals serve no purpose to increase functional or cognitive capabilities towards independent or assisted living.

2403.2B PROVIDER RESPONSIBILITY

In addition to the policies discussed in Section 2403.1B "Provider Responsibility" of this Chapter, the following policies apply to the Residential Habilitation Program.

1. Providers must maintain compliance with all regulatory requirements for a residential habilitation provider for the State in which they operate;

2. Providers must maintain either CARF or the Joint Commission accreditation as a residential facility to be in good standing;

3. The provider shall provide qualified habilitation aides at the appropriate staffing ratios as determined by applicable licensure, certification and/or accreditation requirements;

4. Providers establish, maintain and update an emergency plan specific to the recipient, including appropriate emergency information on-site for each recipient at all times;

5. Providers must establish a mechanism for residents or their families to report, without retribution, any complaints or occurrences that may compromise the safety or well being of the residents within the home; and

6. Providers must establish and enforce policies to ensure the safety and well being of all residents of the facility.

2403.2C RECIPIENT RESPONSIBILITY

In addition to the policies discussed in Section 2403.1C "Recipient Responsibility" of this Chapter, the following policies apply to residents of the Residential Habilitation Program:

1. Recipients and their guests must comply with all reasonable and necessary posted "house rules" as established by the provider, in order to maintain a safe environment for all residents.

2. Recipients should notify the provider and the DHCFP of any occurrences that may compromise the safety or well being of residents within the home.

2403.2D AUTHORIZATION PROCESS

The policies discussed in Section 2403.1D "Authorization Process" of this Chapter, apply to the Residential Habilitation Program.

2403.3 COMMUNITY RE-INTEGRATION SERVICES (CRS)

Community reintegration services are designed to provide temporary assistance and support to those recipients with significant neurological impairment, incorporating those skills developed during a Habilitation program into their daily lives as they become reintegrated into their community.

Appropriate services are intended to enable the individual to function with greater independence, to prevent additional disabilities or an increase in the severity of an existing disability, without which the individual would require institutionalization.

2403.3A COVERAGE AND LIMITATIONS

Reimbursement is available for CRS which have been prior authorized by the DHCFP's QIO-like vendor. Services must be ordered by a physician as a reasonable and medically necessary part of the recipient's treatment plan and must be determined safe, efficient and cost-effective by the DHCFP or its QIO-like vendor.

1. Admission Criteria

   a. The recipient must be eligible for services under Medicaid and must have behaviors which are manageable in the community re-integration environment;

   b. Eligible recipients have successfully progressed through their habilitation plan of care, but they require specialized transition assistance to fully reintegrate into the community;

   c. Community reintegration services are required, based on supporting medical rational, to ensure the recipient's ability to function as independently as possible in the community; and

   d. Documentation is provided, to support that the reintegration goals cannot be safely and adequately carried out utilizing more informal supports, such as willing family members and neighbors;

   e. The recipient has a viable written discharge plan, established by the multidisciplinary team, with appropriate resources in place, including the support system that will facilitate the community reintegration process and a realistic expectation of successful non-institutional living.

   f. The medical condition is stable and compatible with an active reintegration program.

2. Covered Services

   a. Community reintegration services are a covered benefit for recipients admitted within 14 days of completing a habilitation program or from the date determined to be eligible for Medicaid;

   b. Services may be provided in the recipient's residence (non-institutional setting), work environment, or other appropriate community-based setting;

   c. Habilitation aides must assist the recipient in utilizing those skills taught by the interdisciplinary team and involve coaching, advising, supporting and cueing recipients in Instrumental Activities of Daily Living (IADLs) such as:

      1. household management;

      2. behavioral management;

      3. safety;

4. navigating in their immediate community using public transportation; and

5. socialization skills.

3. Service Limitations

a. Services must be provided in accordance with individualized plan of care under the direction of a habilitation provider;

b. Community reintegration services are limited to a maximum of 20 hours per week, and must be prior authorized.

4. Non Covered Services

a. Maintenance Therapy – is defined as the point where the recipient demonstrates no further significant improvement, or the skills of a qualified rehabilitative aide are not required to carry out an activity or a home program to maintain function at the level to which it has been restored. Services in this category are non-covered.

b. Duplicative Services are not considered medically justified and will not be covered by Nevada Medicaid. An inquiry or referral for services does not indicate the necessity for services.

c. Community reintegration services solely for vocational, educational or convenience purposes or for developmental or behavioral concerns is not covered services within this program.

5. Continuing Stay Criteria

a. All services must be part of, and specifically related to, an active plan of care that the physician reviews periodically, but not less than every 30 days or when deemed necessary;

The physician is responsible for certifying that the service is medically necessary and that the treatment prescribed is in accordance with standards of best medical practice;

b. The re-integration plan of care must incorporate the written discharge plan established during the habilitation program or re-integration stay, identifying formal and informal resources that are currently in place, as well as the identified support system that will be facilitating the community re-entry.

1. The plan of care must also contain:

   a. Identified barriers; and corresponding short and long-term goals that are functional, objective and measurable;

   b. Specific services to be provided, including the frequency, duration and modalities to be implemented; and

   c. The proposed plan of care must include specific functional goals and a reasonable estimate of when they will be reached (e.g., 6 weeks). It is not adequate to estimate "1 to 2 months on an ongoing basis."

c. Ongoing documentation of discharge planning including appropriate follow-up care with consideration of physical, emotional and mental status needs at time of discharge. Since discharge planning is an integral part of any habilitation program and should begin upon the patient's admittance to the program, an extended period of time for discharge action is not reasonable after established goals have been reached, or a determination made that further progress is unlikely.

d. The recipient must demonstrate the ability and willingness to actively participate in goal oriented interventions developed with the interdisciplinary team. This shall be evidenced by regular attendance in interventions that are a part of the reintegration action plan and documented progression toward the established goals;

e. Documentation must reflect that the community reintegration activities are reduced as the recipient's level of independence increases.

6. Discharge Criteria

Community reintegration services must be considered for termination regardless of the pre-authorized length of stay when any one of the following conditions are met:

b. The recipient has a safe discharge plan to the community.

c. The recipient has met all of their established goals.

d. The recipient requires a more restrictive setting.

e. The recipient has an unstable condition that affects their ability to participate in community reintegration activities.

2403.3B PROVIDER RESPONSIBILITY

The policies discussed in Section 2403.1B "Provider Enrollment" of this Chapter, apply to Community Re-integration Services.

2403.3C RECIPIENT RESPONSIBILITY

The policies discussed in Section 2403.1C "Recipient Responsibility" of this Chapter, apply to Community Re-integration Services.

2403.3D PRIOR AUTHORIZATION

The policies discussed in Section 2403.1D "Prior Authorization" of this Chapter, apply to Community Re-integration Services.

2404 QUALITY ASSURANCE

The DHCFP will conduct an annual review to assure the health and welfare, of the recipients served by HBHS. The review will consist of the program requirements identified in this chapter.

Additionally, a review of the providers will be conducted annually to verify that the providers meet requirements established for each service, such as licensure, accreditation, etc, and to ensure claims are paid in accordance with the State Plan and all federal state regulations. Providers must cooperate with the DHCFP's annual review process.

2405 HEARINGS

Please reference Nevada MSM, Chapter 3100, for Medicaid Hearing Process.