# ANNUAL STATEWIDE CONSOLIDATED HCBS FE/PD WAIVER REVIEW FINAL REPORT

## *FE Review Waiver Year 4*
## *PD Review Waiver Year 1*

*Home and Community Based Services (HCBS) Waivers for the Frail Elderly (FE) and People with Physical Disabilities (PD) Quality Assurance Consolidated Review to ensure the waiver continues to meet essential Federal statutory assurances and effectively meet the recipient's needs.*

**State of Nevada**
**Division of Health Care Financing and Policy**
**Access & Quality Assurance Unit**

**September 2024**

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# ANNUAL STATEWIDE CONSOLIDATED HCBS FE/PD WAIVER REVIEW FINAL REPORT

*FE Review Waiver Year 4* *PD Review Waiver Year 1*

## Background/Introduction

The renewal of a waiver is contingent on the Centers for Medicare and Medicaid Services (CMS) determining that the State has effectively assured the health, safety, and welfare of waiver recipients during the period the waiver has been in effect.

Each State is expected to have systems in place to measure and improve performance in meeting the waiver assurances outlined in 42 CFR §441.301 and §441.302. The assurances address important dimensions of waiver quality, including assuring that service plans are designed to meet the needs of waiver recipients and that the State has effective systems in place to monitor recipient health, safety, and welfare.

The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in the waiver application. Through an ongoing process of discovery, remediation, and improvement, the State assures the health, safety, and welfare of the recipients by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) recipient health, safety, and welfare; (e) financial oversight; and (f) administrative oversight of the waiver.

## Aims & Objectives

The annual review monitoring activities provide the foundation for quality improvement by generating information regarding compliance, potential problems, and individual corrective actions. The results can be aggregated and analyzed to measure the overall system performance in meeting the waiver assurances.

## Methodology

CMS quality requirements are founded on an evidence-based approach. CMS requests evidence from the State that it meets the assurances and applies a continuous quality improvement approach to the assurances. The Division of Health Care Financing and Policy (DHCFP) Quality, Access and Availability (QAA) unit uses a representative sample producing a probability of a 95% confidence level with a +/- 5 confidence interval (95/5) to determine the statewide total of recipient files to be reviewed and Participant Experience Surveys (PES) to be completed. A 95/10 representative sample is used for

financial claims reviews. The Annual Statewide Consolidated Review for the Home and Community Based Services (HCBS) waivers for the Frail Elderly (FE) and Persons with Physical Disabilities (PD) for the State of Nevada was conducted monthly from July 1, 2023, through June 30, 2024. A combined random sample of three hundred ninety-six (396) case files were reviewed. One hundred eighteen (118) reviews were completed by the DHCFP Quality Assurance (QA) staff, and two hundred seventy-eight (278) reviews were completed by ADSD. Out of the one hundred eighteen (118) recipient reviews DHCFP QA staff reviewed, there were one hundred eight (108) recipients with financial claims, as ten (10) had no billed claims, which resulted in one hundred seventy-four (174) random financial claim reviews. One hundred thirty-five (135) recipient Participant Experience Surveys (PES) were completed. To avoid duplication of effort, reviews conducted by the Aging and Disability Services Division (ADSD) were obtained for a portion of the case file reviews and the PES for the 2023 review period. All provider reviews were completed by ADSD.

The following areas were evaluated during this year's annual review:

Case File Review:

1. Level of Care (LOC)
2. Social Health Assessment (SHA)
3. Plan of Care (POC)
4. Statement of Choice (SOC)
5. Acknowledgement Form
6. Monthly Contacts and Documentation
7. Designated Representative Attestation/Legal Representative Individual (LRI) Forms

Financial Review:

1. Eligibility
2. Prior Authorization
3. Daily Records
4. Payment

Participant Experience Surveys (PES)

1. Access to Care
2. Choice and Control
3. Respect/Dignity
4. Community Integration/Inclusion

Listed below are the specific HCBS FE/PD waivers, the Medicaid Services Manual (MSM) Chapters and Policy & Procedure (P&P) Transmittals that were used in the implementation of this annual review:

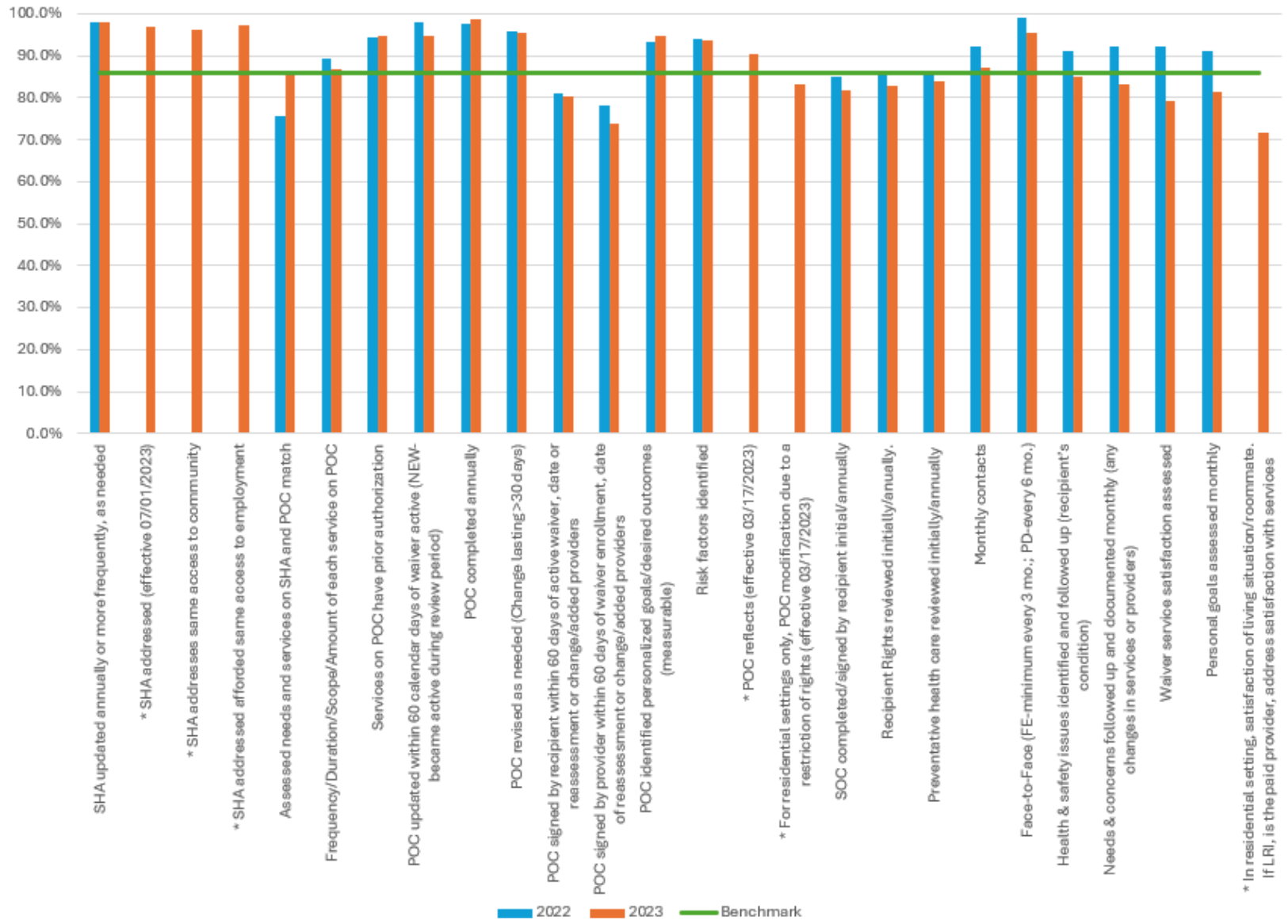
- 1915(c) Home and Community Based Services Waiver for the Frail Elderly (Effective 12/01/2020, 04/01/2023 and 01/01/2024)
- 1915(c) Home and Community Based Services Waiver for Persons with Physical Disabilities (Effective 12/01/2020, 01/01/2023 and 04/01/2024)
- MSM Chapter 2200 Home and Community Based Waiver for the Frail Elderly (Effective 07/01/2022, 07/01/2023 and 01/01/2024)
- MSM Chapter 2300 Home and Community Based Waiver for Persons with Physical Disabilities (Effective 07/01/2022, 06/28/2023 and 01/01/2024)
- Appendix K: Emergency Preparedness and Response COVID-19 Addendum (Issued 01/19/2021 and 03/01/2022)

The following results identify the areas and percentages of compliance with performance measures which are required from the approved waivers and requirements outlined in the above documents.

## 2023 Statewide Case File Review Results

| ***SHA*** | |
|---|---|
| SHA updated annually or more frequently, as needed | 98.1% |
| SHA addressed (effective 07/01/2023) | 96.8% |
| SHA addresses same access to community | 96.3% |
| SHA addressed afforded same access to employment | 97.3% |
| | |
| Assessed needs and services on SHA and POC match | 86.1% |
| Frequency/Duration/Scope/Amount of each service on POC | 86.9% |
| Services on POC have prior authorization | 94.9% |
| POC updated within 60 calendar days of waiver active (NEW-became active during review period) | 94.7% |
| POC completed annually | 98.8% |
| POC revised as needed (Change lasting >30 days) | 95.6% |
| POC signed by recipient within 60 days of active waiver, date or reassessment or change/added providers | 80.5% |
| POC signed by provider within 60 days of waiver enrollment, date of reassessment or change/added providers | 73.8% |
| POC identified personalized goals/desired outcomes (measurable) | 94.9% |
| Risk factors identified | 93.7% |
| POC reflects (effective 03/17/2023) | 90.5% |
| a. Show residence chosen by recipient | 95.6% |
| b. Opportunities to participate in community-employment/volunteer | 74.4% |
| c. POC is understandable | 96.8% |
| d. POC prevents unnecessary/inappropriate services | 95.3% |
| e. Recipient's strengths and preferences (including cultural considerations) (Both for services and personal) | 96.7% |
| f. Recipient's backup plan/strategies | 85.9% |
| For residential settings only, POC modification due to a restriction of rights (effective 03/17/2023) | 83.3% |
| a. Identify a specific & individualized need | 83.3% |
| b. Positive interventions and support | 83.3% |
| c. Document less intrusive methods (Tried did not work) | 83.3% |
| d. Clear description proportionate to needs | 83.3% |
| e. Collection/review of data to measure effectiveness of mod | 83.3% |
| f. Time limit to determine if still necessary or can be termed | 83.3% |
| | |
| SOC completed/signed by recipient initial/annual | 81.6% |
| Recipient Rights reviewed initially/annual | 82.8% |
| Preventative health care reviewed initial/annual | 84.0% |
| | |
| Contact | 87.2% |
| Face-to-Face | 95.4% |
| Health/safety issues identified/followed up | 85.2% |
| Needs/concerns followed-up documented | 83.3% |
| Waiver satisfaction assessed | 79.3% |
| Personal goals assessed | 81.5% |
| In residential setting, satisfaction of living situation/roommate. If LRI, is the paid provider, address satisfaction with services (effective 03/17/2023) | 71.8% |

## 2022 and 2023 Case File Chart Comparison




**Elements with no 2022 data noted above are policies that were not in affect within the review reporting period.*

## 2023 Case File Review Findings

For 2023, improvement is noted for five (5) components from the previous 2022 review period. These areas of improvement include:

- SHA updated annually or more frequently, as needed: 98.1%
  Increased point two percent (0.2%) from the last year.
- Assessed needs and services on SHA and POC match: 86.1%
  Increased ten point five percent (10.5%) from last year.
- Services on the POC have prior authorization: 94.9%
  Increased point six percent (0.6%) from last year.
- POC completed annually: 98.8%
  Increased one point three percent (1.3%) from last year.
- POC identified personalized goals/desired outcomes: 94.9%
  Increased one point six percent (1.6%) from last year.

Thirteen (13) review elements are at or above the eighty-sixth percentile (86%) with ten (10) elements remaining above ninety percent (90%).

One (1) element previously under eighty-sixth percentile (86%), “Assessed needs and services on SHA and POC match”, has now come into compliance.

CMS requires quality improvement projects/remediation when the threshold of compliance is below eighty-six percent (86%). For the 2023 review period, ten (10) elements have been identified as needing further analysis by the Quality Improvement (QI) committee.

- POC signed by recipient within 60 days of active waiver, date or reassessment or change/added providers: 81%
- POC signed by provider within 60 days of waiver enrollment, date of reassessment or change/added providers: 74%
- For residential settings only, POC modification due to a restriction of rights: 83%
- SOC completed/signed by recipient initial/annually: 82%
- Recipient Rights reviewed initially/annually: 83%
- Preventative health care information provided initially/annually: 84%
- Monthly contacts address needs & concerns followed up: 83%
- Monthly contacts address waiver service satisfaction: 79%
- Monthly contacts address personal goals: 82%
- Monthly contacts address satisfaction of living situation/roommate and/or if LRI, is the paid provider, address satisfaction with services: 72%

## Recommendations

- Use a calendar alert system to track time sensitive documentation if unable to get the documentation signed at the assessment meeting. This will remind case managers to follow up on any documentation that has not been signed or received.

- Include designated representative/LRI documentation to verify the individual was given permission to sign on the recipient's behalf.

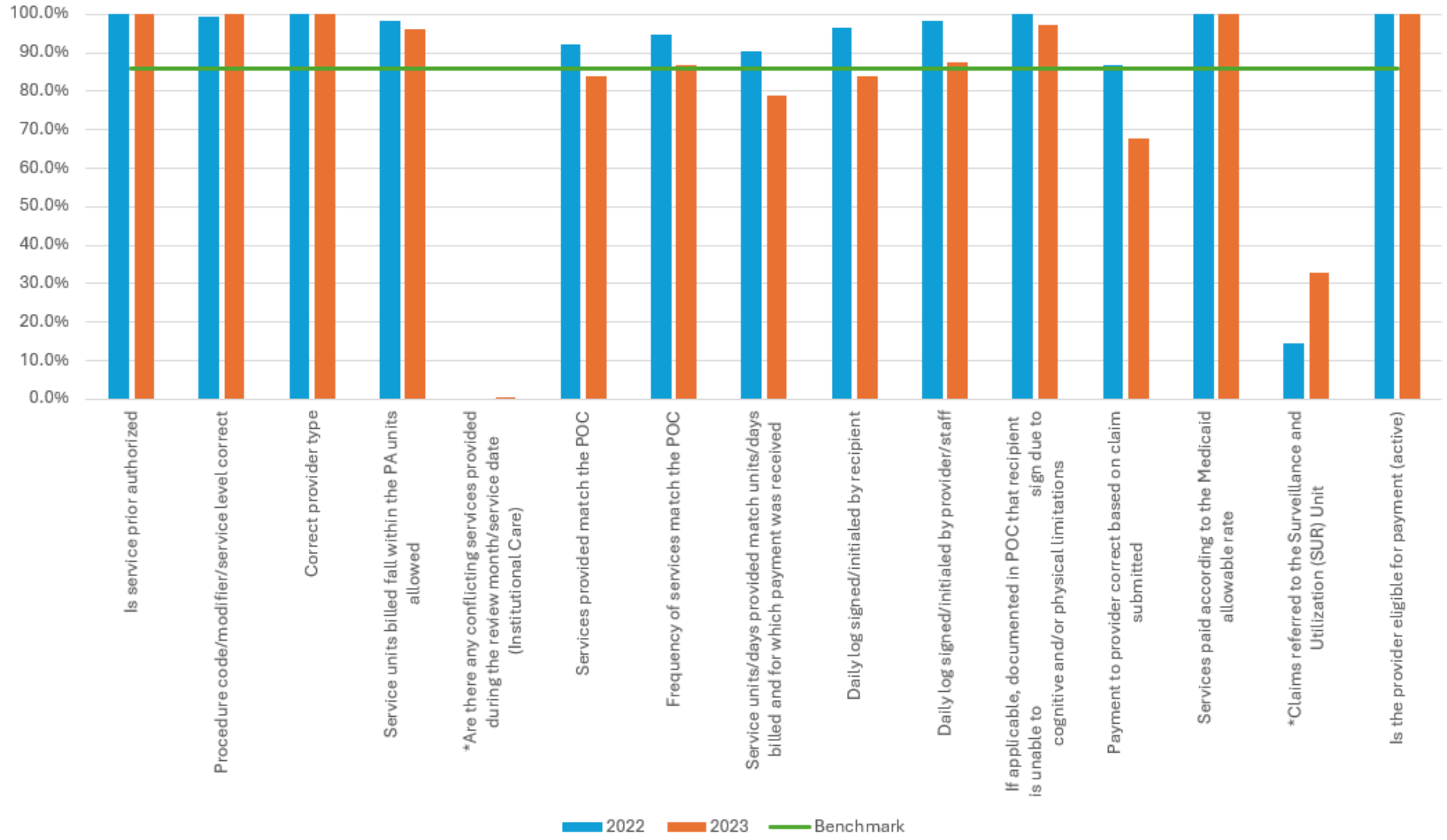
- Private Case Management, CareLync, was onboarded in August of 2023. DHCFP QA observed that the monthly contacts did not mention some of the specified areas, such as waiver satisfaction, personal goals and satisfaction with living situation/roommate. DHCFP QA and CareLync had a meeting, on 08/27/2024, to discuss monthly contacts. CareLync advised they have created a template for their monthly contacts to ensure the case managers cover all required areas with the recipient. This will assist with bringing the numbers into compliance.

## 2023 Statewide Financial Review Results

| | |
|---|---|
| ***PRIOR AUTHORIZATION*** | |
| Is service prior authorized | 100% |
| ***CLAIM*** | |
| Procedure code/modifier/service level correct | 100% |
| Correct provider type | 100% |
| Service units billed fall within PA units allowed | 96.0% |
| Any conflicting services provided during review service dates* | 0.6% |
| ***DAILY RECORD*** | |
| Services provided match the POC | 83.9% |
| Frequency of services match the POC | 86.8% |
| Service units/days provided match units/days billed and for which payment was received | 78.7% |
| Daily log signed/initialed by recipient | 83.9% |
| Daily record signed/initialed by provider/staff | 87.4% |
| If applicable, documented in POC recipient unable to sign due to cognitive or physical limitations | 97.1% |
| ***PAYMENT*** | |
| Payment to provider correct based on claim submitted | 67.8% |
| Services paid using Medicaid allowable rate | 100% |
| Referral made to SUR unit* | 32.8% |
| Provider eligible for payment at time of service | 100% |

**Denotes measures for which a lower number suggests a higher compliance rate.*

## 2022 and 2023 Financial Review Chart Comparison



## 2023 Financial Review Findings

For 2023, five (5) components were at 100% compliance. These areas include:

- Is service prior authorized
- Procedure code/modifier/service level correct
- Correct provider type
- Services paid according to the Medicaid allowable rate
- Is the provider eligible for payment

In addition, there are five (5) review elements that are at or above the eighty-sixth percentile (86%).

CMS requires quality improvement projects/remediation when the threshold of compliance is below eighty-six percent (86%). For the 2023 review period, four (4) elements have been identified as needing further analysis by the Quality Improvement (QI) committee.

- Services provided match the POC: 84%
- Service units/days provided match units/days billed and for which payment was received: 79%
- Daily log signed/initialed by recipient: 84%
- Payment to provider correct based on claim submitted: 68%

## Recommendations

- The Authenticare Electronic Visit Verification (EVV) system was phased out effective 12/15/2023. Visit verification was entered into a new system, Sandata, beginning 12/15/2023. DHCFP QA was unable to access the Authenticare system once it was phased out and unable to directly obtain EVV information for financial reviews from 07/01/2023 – 12/15/2023. DHCFP QA had to rely on the provider to submit the requested documentation which may have resulted in the drop in compliance, but with the new system onboarded, DHCFP QA expects to see these elements come back into compliance within this next waiver review period.

- Ensure providers are submitting all requested/necessary documentation for review.

## Quality Improvement Strategy (QIS) Project Performance

As part of the consolidated review process, DHCFP LTSS, DHCFP QA, ADSD Operations and Case Management Providers gathered monthly for a Consolidated Waiver Quality Improvement (QI) Committee meeting. DHCFP LTSS, DHCFP QA and ADSD operations meet quarterly to review areas that are below the threshold. CMS has mandated a threshold of less than eighty-six percent (86%) for any Performance Measure indicating a need for improvement to be addressed. Percentages are calculated by the total number provided and correct over the total number required.

**Appendix B - Level of Care**

- ***Sub-assurance b. The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

  2023 98.1%

  **Case File Review Question 1 - SHA updated annually or more frequently or as needed:** In comparison to the 2022 waiver year, this element increased by point two percent (0.2%). This element remains in compliance.

**Appendix D - Service Plan**

- ***Sub-assurance a. Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

  2023 86.1%

  **Case File Review Question 3 - Assessed needs and services on SHA and POC match:** In comparison to 2022 waiver year, this element shows a ten percent (10%) increase. This element has come into compliance.

  **Implementation:** ADSD has implemented a SHA that automatically populates the needs and services onto the POC. ADSD Operations and Case Management teams are working with Therap to create a new case management database. They are working to ensure the needs and services of the recipient are addressed and adding alerts to mandatory fields, so information is not missed. Beginning July 2024, DHCFP QA has aligned the review to reflect all the implemented changes in policy and will only conduct an in-depth review of the current SHA and POC to show a more accurate reflection of all the implemented trainings and policy changes, avoiding skewed numbers from inability to update prior years' documentation. DHCFP QA will review a percentage-based calculation, versus the previous "all or nothing" review, of assessed needs noted on the SHA to the addressed needs documented on the POC within the coming waiver year.

- ***Sub-assurance c. Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

  2023 98.8%

  **Case File Review Question 7 - POC completed annually:**

  In comparison to the 2022 waiver year, this element increased by one percent (1%). This element remains in compliance.

- ***Sub-assurance d. Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

  2023 86.9%

  **Case File Review Question 4 - Frequency/Duration/Scope/Amount of each service on POC:**

  In comparison to 2022 waiver year, this element decreased by two percent (2%). In most cases, the deficiencies were due to missing the frequency, duration and scope or had an incorrect duration. This element remains in compliance.

  **Implementation:** ADSD Operations and Case Management are working with Therap to create a new case management database. This new database will ensure the frequency, duration, scope and amount are mandatory fields within the POC.

- ***Sub-assurance e. Participants are afforded choice: Between/among waiver services and providers.***

  2023 81.6%

  **Case File Review Question 15 - Statement of Choice (SOC) completed/signed by recipient initial/annual:**

  In comparison to the 2022 waiver year, this element decreased by three percent (3%). In most cases the deficiencies were due to incomplete or missing SOCs. This element is out of compliance.

  **Recommendation:** Additional training, or a refresher training course, would be beneficial for those completing the SOCs and the importance of ensuring the document is completed entirely and timely. Additionally, if documentation is not signed during the assessment meeting, implementing a tracking system as a reminder to the case manager that the documentation is needed and verify the document is complete once received.

**Appendix G - Health and Welfare**

- ***Sub-assurance a. The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.***

2023 84.0%

**Case File Review Question 17 - Preventative health care reviewed initial/annual:**
In comparison to 2022 waiver year, this element decreased by two percent (2%). In most cases the deficiencies were due to incomplete or missing Acknowledgement forms. This element is out of compliance.

**Recommendation:** Additional training, or a refresher training course, would be beneficial for those completing the Acknowledgement forms and the importance of ensuring the document is completed entirely and timely. Additionally, if documentation is not signed during the assessment meeting, implementing a tracking system as a reminder to the case manager that the documentation is needed and verify the document is complete once received.

**Appendix I – Financial Accountability**

- ***Sub-assurance a. The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.***

  2023 78.7%

  **Financial Review Question 9 - Service units/days provided match units/days billed and for which payment was received:**
  In comparison to 2022 waiver year, this element decreased by twelve percent (12%). In most cases the deficiencies were due to missing documentation or billing incorrect units. This element is out of compliance.

  **Recommendation:** Additional trainings and/or refresher trainings for providers regarding documentation requirements. DHCFP QA implemented a new process to communicate policies that correlate with the issues noted during the financial review to the affected providers. This information will provide insight on areas that need additional training. Additionally, with the change of EVV vendors from Authenticare to Sandata on 12/15/2023, DHCFP QA was unable to access Authenticare and had to rely on the providers to submit the requested documentation, which contributed to the drop in compliance. With the new system, Sandata, onboarded DHCFP QA expects to see this element come back into compliance within this new waiver review period.

## Additional Recommendations

- Private Case Management, CareLync, was onboarded in August of 2023. As a new provider to the State of Nevada ensuring continued training and collaboration occur will be essential for not only program compliance, but for the continued health, welfare and safety of Nevada's recipients.

- During Quality Improvement meetings and Consistency meetings with DHCFP QA and Case Management Provider's supervisory staff, an overview on how to complete a case file review, noting policy for each question and which documentation relates to the specific question, including calculations of questions needing a percentage, has been conducted. This is to ensure DHCFP QA, and supervisory reviewers are answering the questions consistently. DHCFP QA will continue to discuss review questions as needed to help ensure consistency and accuracy.

- Case Management Providers will work to ensure they are submitting all required documentation for reviews. DHCFP QA and Case Management Providers streamlined the submission process to allow the ability to upload documentation directly to DHCFP QA.

- DHCFP LTSS, DHCFP QA and ADSD (both operations and the case management side) worked together to review policy to ensure all items reviewed are in accordance with regulations.

## Best Practices

Best practices are methods or techniques that represent the most efficient or prudent course of action. The following practices were observed contributing to the quality of health, safety, and welfare of waiver recipients:

- DHCFP QA has already implemented the tracking of the person-centered requirements for the HCBS Access Rule.

- ADSD case management supervisors provide continual guidance to staff regarding clear documentation during contacts and assessments.

- Clear contact notes make it easier to follow the recipient's progress and demonstrate the efforts the case manager makes to respond to the recipient's needs.

- Staff training for newly hired case managers and ongoing refresher trainings are being held to review processes and policy changes within ADSD case management. The following were provided by ADSD to their internal staff:
    - 07/19/2023 – Policy Review – Change Innovations

    - 09/20/2023 – Language Access Plan, how it affects our recipients.
    - 10/19/2023 – SHA and POC Policy Review

- ADSD recently separated into two (2) distinct sides, operations and case management, to eliminate any potential conflict of interest with intake, oversight and assignment of the case management providers due to the onboarding of the private case management company, CareLync.

- ADSD Case Management had created a SHA that auto-populates to the POC, which should decrease the errors of needs from the assessment not matching the plan that was created. ADSD is working with Therap to create a new case management database. This database will flag mandatory fields to ensure they are addressed.

- Elko case file and financial reviews were not included in this waiver years' review as they were being reviewed at one hundred percent (100%) bi-annually. Beginning next waiver year, effective July 2024, Elko has been included in the annual review process ongoing.

- Assurances that are below eighty-six percent (86%) for the review period are assigned to a priority grid. The Quality Improvement (QI) Committee members are assigned projects to analyze and identify the probable cause of deficiencies and develop plans to improve performance and track improvement. The QI Committee is responsible for conducting the QI Projects for the Consolidated Waiver Review as issues are identified, as well as at the time of the final Consolidated Annual Waiver Review Report. The committee will conduct all QI Projects related to the waiver reviews using the following the CMS guidance:
    - Identify probable challenges to meeting compliance.
    - Develop interventions designed to improve performance.
    - Allow enough time for intervention to have an effect.

## LTSS Waiver Unit

### DHCFP Central Office- LTSS Waiver Unit

The 1915(c) HCBS Waiver for Persons with Physical Disabilities was renewed with an effective date of 01/01/2023 and the Waiver for the Frail Elderly was renewed with an effective date of 04/01/2023.

MSM Chapters 2200 and 2300 were both updated and approved effective 01/01/2024.

## Participant Experience Surveys (PES)

The focus of the HCBS Waiver Programs is to ensure the recipient is satisfied with their services and achievement of desired outcomes. Recipients were interviewed regarding their experiences and satisfaction with their waiver services and providers. The interviews were conducted by the DHCFP QA staff and the ADSD QA staff using the Participant Experience Survey (PES) interview tool developed by The MedStat Group, Inc. under a contract from the CMS. Indicators used for monitoring quality within the waiver programs are calculated using the data captured from these surveys.

The HCBS FE and PD Waiver recipients who were randomly selected for case file reviews were asked to participate in the annual PES interviews for Carson City, Las Vegas and Reno. PES interviews were conducted by ADSD QA monthly and on a biannual basis by DHCFP QA. PES interviews included within this report cover July 2023 through June 2024. Four hundred sixteen (416) recipients were selected to meet a 95/5 sample size. DHCFP QA staff completed PES interviews via telephone and advised recipients they could be completed and mailed back on their own if they chose to do so. Of the four hundred sixteen (416) possible surveys, one hundred thirty-five (135) PES interviews were completed for a thirty-three percent (33%) completion rate. Sixty-two (62) recipients chose not to complete the survey for a fifteen percent (15%) refusal rate. Seventy-six (76) cases were no longer receiving services due to the recipient being terminated/closed, moving or the recipient passing away for eighteen percent (18%). One hundred forty-three (143) were not completed as recipients were unable to be reached after three (3) attempted phone calls or invalid phone numbers for thirty-four percent (34%), totaling sixty-seven percent (67%) rate of unable to complete.

Recipient issues determined to be critical and in need of immediate attention were promptly communicated to the appropriate staff.

The top areas with the highest recipient satisfaction were:

- ✓ Staff Time
- ✓ Ability to Contact Case Manager
- ✓ Case Manager Helpfulness
- ✓ Overall Satisfaction with Case Manager and Services
- ✓ Respect by Home Care Staff, Day Program Staff, and Transportation Staff
- ✓ Careful Listening by Home Care Staff, Day Program Staff, and Transportation Staff
- ✓ Access to Care Regarding Eating and Medication

The areas with the highest adverse responses indicating an unmet need were:

- ✓ Access to Care Regarding Bathing, Dressing, Groceries, Housework, and Equipment/Modifications
- ✓ Choice in Staff

- ✓ Directing Staff
- ✓ Contact for Reporting Staff Problems
- ✓ Ability to Identify Case Manager
- ✓ Community Involvement

The DHCFP QA staff understands that due to the nature of the population interviewed, inconsistencies or circumstantial answers were noted in responses from the HCBS FE/PD waiver recipients. The State has experienced staffing shortages in many of the provider fields which does impact the choice of staff and unmet need responses. Positive feedback was noted from recipients and designated representatives expressing satisfaction with their providers, including case managers.

| FE/PD CASE FILE REVIEW REQUIREMENTS | |
|---|---|
| **Quality Improvement Sub Assurances, NAC, CFR, State Plan, MSM** | |
| ***SHA*** | |
| **1) SHA updated annually or more frequently, as needed.** | **Sub Assurance: Appendix B-6 Quality Improvement: Level of Care (a)(i)(b)(FE 04/01/2023)(PD 01/01/2023):**<br>The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.<br><br>**CFR § 441.303(c)(4)(effective 10/01/2023):**<br>The agency's procedure to ensure reevaluations of need at regular intervals.<br><br>**Waiver Appendix B-6 Evaluation/Reevaluation (g)(FE 04/01/2023)(PD 01/01/2023):**<br>Reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (12 Months).<br><br>**MSM, FE Chapter 2200, Section 2203.4A(5)(a)(07/01/2023) and PD Chapter 2300, Section 2303.4A(5)(a)(07/01/2023):**<br>The recipient's LOC and SHA must be reassessed at a minimum annually.<br><br>**MSM, FE Chapter 2200, Section 2203.12A(3)(b)(07/01/2022) and PD Chapter 2300, Section 2303.1A(3)(b)(07/01/2022):**<br>The recipient's 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. |
| **2) SHA addressed (Effective 07/01/2023)**<br>**a. SHA addressed same access to community.**<br><br>**b. SHA addressed afforded same access to employment.** | **MSM, FE Chapter 2200, Section 2203.4A(2)(e)(07/01/2023) and PD Chapter 2300, Section 2303.4A,2(e, f)(07/01/2023):**<br>Ensures recipients are afforded the same access to the greater community as individuals who do not receive Medicaid HCBS, regardless of where they reside.<br><br>**MSM, PD Chapter 2300, Section 2303.4A,2(f)(07/01/2023):**<br>Ensures recipients are afforded employment opportunities as desired, regardless of where they reside.<br><br>**MSM, FE Chapter 2200, Section 2203.4A(3)(a)(2)(07/01/2023):**<br>Reflect opportunities to participate in integrated community settings and seek employment or volunteer activities. |
| ***Plan of Care (POC)*** | |
| **3) Assessed needs and services on SHA and POC match.** | **Sub Assurance: Appendix D-2 Quality Improvement, Service Plan (a)(i)(a)(FE 04/01/2023)(PD 01/01/2023):**<br>Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.<br><br>**Performance Measure: Appendix D-2 Quality Improvement, Service Plan (a)(i)(a)(FE 04/01/2023)(PD 01/01/2023):**<br>POCs that address the assessed needs identified in the social health assessment (SHA).<br><br>**CFR § 441.301(c)(2)(effective 10/01/2023):**<br>The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need.<br><br>**Waiver Appendix D-1 Service Plan Development (d) (FE 04/01/2023)(PD 01/01/2023):**<br>Case managers develop the Plan of Care (POC), in conjunction with the LOC and Social Health Assessment (SHA).<br><br>**MSM, FE Chapter 2200, Section 2203.4A(5)(b)(07/01/2023) and PD Chapter 2300, Section 2303.4A(5)(b)(07/01/2023):**<br>The POC is updated using the SHA.<br><br>**MSM, FE Chapter 2200, Section 2203.4A(3)(c)(07/01/2023) and PD Chapter 2300, Section 2303.4A(3)(c)(07/01/2023):**<br>The POC must identify all authorized waiver services, as well as other ongoing community-support services that the recipient needs to remain in their home and live successfully in the community. |

| | |
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| | **MSM, FE Chapter 2200, Section 2203.1A(3)(a)(07/01/2022) and PD Chapter 2300, Section 2303.12A(3)(b)(07/01/2022):**<br>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. |
| **4) Frequency/Duration/ Scope/Amt of service on POC.** | **Sub Assurance: Appendix D-2 Quality Improvement, Service Plan (a)(i)(d)(FE 04/01/2023)(PD 01/01/2023):**<br>Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.<br><br>**CFR § 441.301(c)(2)(effective 04/10/2023):**<br>Commensurate with the level of need of the individual, and the scope of services and supports available.<br><br>**Waiver Appendix D-1 Service Plan Development (c)(PD 01/01/2023):**<br>The Person-Centered approach includes involvement and choice by the recipient and/or designated representative to establish the frequency, scope, duration, and method of service delivery.<br><br>**Waiver Appendix D-1 Service Plan Development (c)(FE 04/01/2023):**<br>The POC identifies the services required, including type, amount, duration, scope, and frequency of services.<br><br>**MSM, FE Chapter 2200, Section 2203.12B(4)(a)(07/01/2023) and PD Chapter 2300, Section 2303.8B(4)(a)(07/01/2023):**<br>Each provider must have a file for each recipient. In the recipient's file, the provider must have a copy of the current POC and maintain daily records, fully documenting the scope and frequency of services as specified on the POC.<br><br>**MSM, FE Chapter 2200, Section 2203.4A(3)(b)(07/01/2023) and PD Chapter 2300, Section 2303.4A(3)(b)(07/01/2023):**<br>The recipient is afforded choice of service and providers, establishing the frequency, duration and scope, and method of service delivery are integrated in the planning process to the maximum extent possible.<br><br>**MSM, FE Chapter 2200, Section 2203.11B(3)(a)(07/01/2022):**<br>Each provider must have a file for each recipient. In the recipient's file, the provider must have a copy of the current POC and maintain daily records, fully documenting the scope and frequency of services as specified on the POC. |
| **5) Services on POC have prior authorization.** | **Waiver Appendix C-2 General Service Specifications (d)(6)(FE 04/01/2023)(PD 01/01/2023):**<br>Services must be authorized, and provision of services is in accordance with the Plan of Care as determined by the Case Manager and recipient/designated rep.<br><br>**Waiver Appendix C Quality Improvement: Qualified Providers (b)(i)(PD 01/01/2023):**<br>The Case Manager ensures that the services on the POC are assigned the appropriate prior authorization.<br><br>**Waiver Appendix D-1 Service Plan Development (f)(FE 04/01/2023)(PD 01/01/2023):**<br>If a service provider change is requested or a new service need identified, the case manager will coordinate and update the POC and authorizations as indicated.<br><br>**MSM, FE Chapter 2200, Section 2203.2B(11)(07/01/2023) and PD Chapter 2300, Section 2303.2B(11)(07/01/2023):**<br>All providers may only provide services that have been identified in the POC and have a Prior Authorization (PA), if required.<br><br>**MSM, FE Chapter 2200, Section 2203.2B(1)(g)(07/01/2022):**<br>All providers may only provide services that have been identified in the POC and that, if required, have a Prior Authorization (PA).<br><br>**PD Chapter 2300, Section 2303.3B(1)(d)(07/01/2022):**<br>May only provide services that have been identified in the recipient POC and, if required, have prior authorization. |
| **6) POC updated within 60 calendar days of waiver active.** | **Waiver Appendix D-1 Service Plan Development (d)(a)(FE-04/01/2023)(PD 01/01/2023):** |

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| **(New-became active during review period)** | The POC is completed no more than 60 calendar days from waiver enrollment. The finalized POC must be signed and dated by the recipient acknowledging participation in the development of the POC. Ongoing POCs are updated and revised when there is a significant change expected to last more than 30 days that occurs outside of the annual review.<br><br>**MSM, FE Chapter 2200, Section 2203.2B(13)(07/01/2023) and PD Chapter 2300, Section 2303.2B(13)(07/01/2023):**<br>Sign and date **the finalized POC** within 60 calendar days from waiver enrollment. |
| **7) POC completed annually.** | **Sub Assurance: Appendix D-2 Quality Improvement, Service Plan (a)(i)(c)(FE 04/01/2023)(PD 01/01/2023):**<br>Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.<br><br>**CFR § 441.301(c)(3)(effective 04/10/2023):**<br>The person-centered service plan must be reviewed and revised upon reassessment of functional need as required by §441.365(e), at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.<br><br>**Waiver Appendix D-1 Service Plan Development (h)(FE 04/01/2023)(PD 01/01/2023):**<br>The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change.<br><br>**Waiver Appendix D-1 Service Plan Development (d)(g)(PD 01/01/2023):**<br>The POC is reviewed and updated at a minimum annually.<br><br>**MSM, FE Chapter 2200, Section 2203.4A(3)(07/01/2023) and PD Chapter 2300, Section 2303.4A(3)(07/01/2023):**<br>The person-centered POC is developed in conjunction with the case manager, recipient/designated representative/LRI, and/or a person of their choosing initially, annually, and when changes occur.<br><br>**MSM, FE Chapter 2200, Section 2203.12A(3)(b)(07/01/2022) and PD Chapter 2300, Section 2303.1A(3)(b)(07/01/2022):**<br>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. |
| **8) POC revised as needed (Change lasting >30 days)** | **Sub Assurance: Appendix D-2 Quality Improvement, Service Plan (a)(i)(c)(FE 04/01/2023)(PD 01/01/2023):**<br>Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.<br><br>**Waiver Appendix D-1 Service Plan Implementation and Monitoring (a)(b)(FE 04/01/2023):**<br>The POC is monitored and reviewed/revised through a face-to-face annual re-assessment or when the recipient has a significant change lasting longer than 30 days.<br><br>**Waiver Appendix D-1 Service Plan Development (d)(g)(PD 01/01/2023):**<br>POCs are updated and revised when there is a significant change expected to last more than 30 days that occurs outside of the annual review.<br><br>**MSM, FE Chapter 2200, Section 2204.2(B)(07/01/2023) and PD Chapter 2300, Section 2304.2(B)(07/01/2023):**<br>Complete a new POC if there has been a change in waiver services. If a change in services is expected to be resolved in less than 30 days, a new POC is not necessary. Documentation of the temporary change must be noted in the case manager's narrative. The date of resolution must also be documented in the case manager's narrative.<br><br>**MSM, FE Chapter 2200, Section 2203.4A(3)(e)(1)(07/01/2023) and PD Chapter 2300, Section 2303.4A(3)(e)(1)(07/01/2023):**<br>If there is a change (as defined in the MSM Addendum) to the established LOC, the recipient must be reassessed and the LOC and POC must be updated within 30 days of the reported change.<br><br>**MSM, FE Chapter 2200, Section 2204.2(B)(07/01/2022) and PD Chapter 2300, Section 2304.1B(2)(07/01/2022):**<br>Complete a new POC if there has been a change in services (medical, social or waiver). If a change in services is expected to resolve in less than 30 days, a new POC is not necessary. |

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| **9) POC signed by recipient within 60 days of active waiver, date of reassessment or significant change.** | **Waiver Appendix D-1 Service Plan Development (d)(a)(FE 04/01/2023)(PD 01/01/2023):**<br>The POC is completed no more than 60 calendar days from waiver enrollment. The finalized POC must be signed and dated by the recipient acknowledging participation in the development of the POC. Ongoing POCs are updated and revised when there is a significant change expected to last more than 30 days that occurs outside of the annual review.<br><br>**MSM, FE Chapter 2200, Section 2203.4A(3)(c)(1, 2)(07/01/2023) and PD Chapter 2300, Section 2303.4A(3)(c)(1, 2)(07/01/2023):**<br>1. During the initial or annual POC development, there is no chosen direct wavier provider. The service must still be listed on the POC to include the other elements with the providers To Be Determined (TBD) and must be signed and dated by the recipient or designated representative/LRI. Documentation to support the efforts made by the case manager and the recipient to choose and assign a provider must be in the recipient's electronic record.<br>2. Once a provider has been selected, the POC listing the provider must be updated with the date and signatures from the recipient and/or designated representative/LRI and provider during the next face-to-face visit.<br><br>**MSM, FE Chapter 2200, Section 2203.4A(3)(e)(3)(07/01/2023) and PD Chapter 2300, Section 2303.4A(3)(e)(3)(07/01/2023):**<br>When the case manager needs to update the current POC, the case manager can print the current POC and note any changes for the recipient and/or designated representative/LRI to sign. The case manager will formalize the updated POC within the electronic case file.<br><br>**MSM, FE Chapter 2200, Section 2203.4A(3)(f)(07/01/2023) and PD Chapter 2300, Section 2303.4A(3)(f)(07/01/2023):**<br>The POC must be finalized within 60 calendar days from waiver enrollment, date of reassessment, or significant change. The finalized POC must be signed and dated by the recipient and/or designated representative/LRI, case manager, and provider.<br><br>**MSM, FE Chapter 2200, Section 2203.2C(5)(07/01/2023) and MSM PD Chapter 2300, section PD: 2303.2C(5)(07/01/2023):**<br>Sign and date the provider(s) record(s) as appropriate to verify services were provided. If the recipient is unable to provide a signature due to cognitive and/or physical limitations, this will be clearly documented on the Statement of Choice (SOC) and/or POC, as appropriate.<br><br>**MSM, FE Chapter 2200, Section 2203.2C(5)(07/01/2023) and PD Chapter 2300, section PD: 2303.4C(2)(07/01/2023):**<br>Together with the case manager, develop and/or review and sign, and date the POC. If the recipient is unable to provide a signature due to cognitive and/or physical limitations, this will be clearly documented in the recipient file.<br><br>**MSM, PD Chapter 2300, Section 2303.3G(2)(07/01/2022):**<br>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. |
| **10) POC signed by provider within 60 days of waiver enrollment, date of reassessment or change/added providers** | **Waiver Appendix C-2 General Service Specifications (e)(FE 04/01/2023):**<br>Plan of Care must be developed and signed by all applicable participants: recipient, relative caregiver, and case manager.<br><br>**MSM, FE Chapter 2200, Section 2203.2B(13)(07/01/2023) and PD Chapter 2300, Section 2303.2B(13)(07/01/2023):**<br>Sign and date the finalized POC within 60 calendar days from waiver enrollment.<br><br>**MSM, FE Chapter 2200, Section 2203.12(4)(b)(07/01/2023) and PD Chapter 2300, Section 2303.8B(4)(b)(07/01/2023):**<br>The provider will initial after the daily services are delivered, with a full signature of the provider on each daily record. If a provider elects to use electronic signatures, they must have weekly printouts of the daily record in the recipient's file or make them available upon request. For electronic signatures, systems and software products must include protection against modifications, with administrative safeguards that correspond to policies and procedures of ADSD. The individual whose name is on the alternate signature method and the provider bear the responsibility for the authenticity of the information being attested to.<br><br>**MSM, FE Chapter 2200, Section 2203.4A(3)(f)(07/01/2023) and PD Chapter 2300, Section 2303.4A(3)(f)(07/01/2023):**<br>The POC must be finalized within 60 calendar days from waiver enrollment, date of reassessment, or significant change. The finalized POC must be signed and dated by the recipient and/or designated representative/LRI, case manager and provider.<br><br>**MSM, PD Chapter 2300, Section 2303.3G(2)(07/01/2022):** |

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| | 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. |
| **11) POC identified personalized goals/desired outcomes (measurable)** | **Sub Assurance: Appendix D-2 Quality Improvement, Service Plan (a)(i)(a)(FE 04/01/2023)(PD 01/01/2023):**<br>Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.<br><br>**Waiver Appendix D-1 Service Plan Development (d)(b)(FE 04/01/2023)(PD 01/01/2023):**<br>Personal goals are identified by the recipient and documented on the POC initially and each time the POC is updated.<br><br>**Waiver Appendix D-1(c) Service Plan Development (FE 04/01/2023)(PD-01/01/2023):**<br>Person Centered planning includes convenience to the recipient, cultural considerations, use of plain language, strategies for solving any disagreements, identification of what is important to and for the individual, personal preferences, choice of caregivers, strategies to facilitate health and welfare and remediate identified risks, identified goals, outcomes, preferences related to relationships, community integration and opportunities to participate in integrated settings, opportunities to seek employment or volunteer activities, control over personal resources.<br><br>**MSM, FE Chapter 2200, Section 2203.4A(1)(g)(07/01/2023) and PD Chapter 2300, Section 2303.4A(1)(g)(07/01/2023)**<br>Monitoring the overall provision of waiver services, to protect the safety and health of the recipient and to determine that the POC personalized goals are being met.<br><br>**MSM, FE Chapter 2200, Section 2203.4A(3)(a)(4)(07/01/2023) and PD Chapter 2300, Section 2303.4A(3)(a)(4)(07/01/2023):**<br>The initial and annual written POC must reflect…. identified personalized goals and desired outcomes and reflect the services and supports (paid and unpaid) that will assist the recipient in achieving their identified goals.<br><br>**MSM, FE Chapter 2200, Section 2203.3A(3)(07/01/2022) and PD Chapter 2300, Section 2303.3E(3)(07/01/2022):**<br>Monitoring the overall provision of waiver services, to protect the safety and health of the recipient and to determine that the POC personalized goals are being met. |
| **12) Risk factor identified.** | **Sub Assurance: Appendix D-2 Quality Improvement, Service Plan (a)(i)(a) (FE-04/01/2023)(PD 01/01/2023):**<br>Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.<br><br>**CFR §441.301(c)(2)(vi)(effective 04/10/2023):**<br>Reflect risk factors.<br><br>**Waiver Appendix D-1 Service Plan Development (e)(FE 04/01/2023)(PD-01/01/2023):**<br>Risks must be identified on the SHA and POC and must include strategies to mitigate those risks.<br><br>**Waiver Appendix D-1(c) Service Plan Development (FE 04/01/2023)(PD-01/01/2023):**<br>Person Centered planning includes convenience to the recipient, cultural considerations, use of plain language, strategies for solving any disagreements, identification of what is important to and for the individual, personal preferences, choice of caregivers, strategies to facilitate health and welfare and remediate identified risks, identified goals, outcomes, preferences related to relationships, community integration and opportunities to participate in integrated settings, opportunities to seek employment or volunteer activities, control over personal resources.<br><br>**MSM, FE Chapter 2200, Section 2203.4A(1)(g)(07/01/2023) and PD Chapter 2300, Section 2303.4A(1)(g)(07/01/2023)**<br>Monitoring the overall provision of waiver services, to protect the safety and health of the recipient and to determine that the POC personalized goals are being met.<br><br>**MSM, FE Chapter 2200, Section 2203.4A(3)(a)(5) (07/01/2023) and PD Chapter 2300, Section 2303.4A(3)(a)(5) (07/01/2023):**<br>Reflect risk factors and measures in place to minimize them, including back-up plans and strategies. |

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| **13) POC reflects (effective 03/17/2023)** | **Sub Assurance: Appendix D-2 Quality Improvement, Service Plan (a)(i)(a)(FE-04/01/2023)(PD 01/01/2023):**<br>Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.<br><br>**Waiver Appendix D-1(c) Service Plan Development (FE 04/01/2023)(PD 01/01/2023):**<br>Person Centered planning includes convenience to the recipient, cultural considerations, use of plain language, strategies for solving any disagreements, identification of what is important to and for the individual, personal preferences, choice of caregivers, strategies to facilitate health and welfare and remediate identified risks, identified goals, outcomes, preferences related to relationships, community integration and opportunities to participate in integrated settings, opportunities to seek employment or volunteer activities, control over personal resources.<br><br>**MSM, FE Chapter 2200, Section 2203.4A(3)(a)(07/01/2023) and PD Chapter 2300, Section 2303.4A(3)(a)(07/01/2023):**<br>The initial and annual written POC must reflect the services and supports that are important for the recipient to meet the needs identified through the SHA, as well as what is important to the recipient regarding preference for the delivery of such services and supports. |
| **a. Shows residence chosen by recipient.** | **42 CFR §441.301(c)(2)(i)(effective 10/01/2023):**<br>Reflect that the setting in which the individual resides is chosen by the individual. The State must ensure that the setting chosen by the individual is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.<br><br>**MSM, FE Chapter 2200, Section 2203.4A(3)(a)(1)(07/01/2023) and PD Chapter 2300, Section 2303.4A(3)(a)(1)(07/01/2023):**<br>Reflect that the setting in which the recipient resides was chosen by the recipient. |
| **b. Opportunities to participate in community-employment/volunteer.** | **42 CFR §441.301(c)(2)(i) (effective 10/01/2023):**<br>Reflect that the setting in which the individual resides is chosen by the individual. The State must ensure that the setting chosen by the individual is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.<br><br>**MSM, FE Chapter 2200, Section 2203.4A(3)(a)(2)(07/01/2023) and PD Chapter 2300, Section 2303.4A(3)(a)(2)(07/01/2023):**<br>Reflect opportunities to participate in integrated community settings and seek employment or volunteer activities. |
| **c. POC is understandable.** | **42 CFR §441.301(c)(2)(vii)(effective 10/01/2023):**<br>Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with § 435.905(b) of this chapter.<br><br>**MSM, FE Chapter 2200, Section 2203.4A(3)(a)(6)(07/01/2023) and PD Chapter 2300, Section 2303.4A(3)(a)(6)(07/01/2023):**<br>Be understandable to the recipient receiving the services and supports. |
| **d. POC prevents unnecessary/inappropriate services.** | **42 CFR §441.301 (c)(2)(xii)(effective 10/01/2023):**<br>Prevent the provision of unnecessary or inappropriate services and supports.<br><br>**MSM, FE Chapter 2200, Section 2203.4A(3)(a)(7)( 07/01/2023) and PD Chapter 2300, Section 2303.4A(3)(a)(7)(07/01/2023):**<br>Prevent the provision of unnecessary, duplicative, or inappropriate services and supports. |
| **e. Recipient's strengths and preferences (including cultural considerations) (both for services and personal).** | **42 CFR §441.301 (c)(2)(ii)(effective 10/01/2023):**<br>Reflect the individual's strengths and preferences.<br><br>**Waiver Appendix D-1(f) Service Plan Development (FE 04/01/2023) (PD-01/01/2023):**<br>The case manager works with the applicant/recipient to ensure that individualized preferences are maintained.<br><br>**MSM, FE Chapter 2200, Section 2203.4A(3)(a)(3)(07/01/2023) and PD Chapter 2300, Section 2303.4A(3)(a)(3)(07/01/2023):** |

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| | Reflect the recipient's strengths and preferences, and cultural considerations of the recipient. |
| **f. Recipient's backup plan/strategies.** | **42 CFR §441.301 (c)(2)(vi)(effective 10/01/2023):**<br>Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.<br><br>**Waiver Appendix D-1(e) Service Plan Development (FE 04/01/2023)(PD-01/01/2023):**<br>Providers are required to provide a backup plan.<br><br>**MSM, FE Chapter 2200, Section 2203.4A(3)(a)(5)( 07/01/2023) and PD Chapter 2300, Section 2303.4A(3)(a)(5)(07/01/2023):**<br>Reflect risk factors and measures in place to minimize them, including back-up plans and strategies. |
| **14) For residential settings only, POC modification due to a restriction of rights. (effective 03/17/23)** | **42 CFR 441.301(c)(4)(vi)(F)(10/01/2023):**<br>Any modification of the additional conditions, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan.<br><br>**MSM, FE Chapter 2200, Section 2203.4A(3)(h)(07/01/2023) and PD Chapter 2300, Section 2303.4A(3)(h)(07/01/2023):**<br>When a modification is made on the POC that restricts a recipient's freedom of choice, it must be supported by a specific assessed need and justified in the POC. The direct service provider must notify the case manager to request modifications of the POC. |
| **a. Identify specific & individualized need.** | **42 CFR 441.301(c)(4)(vi)(F)(1)(10/01/2023):**<br>Identify a specific and individualized assessed need.<br><br>**MSM, FE Chapter 2200, Section 2203.4A(3)(h)(1)(07/01/2023) and PD Chapter 2300, Section 2303.4A(3)(h)(1)(07/01/2023):**<br>Identify a specific and individualized assessed need. |
| **b. Positive interventions and supports.** | **42 CFR 441.301(c)(4)(vi)(F)(2)(10/01/2023):**<br>Document the positive interventions and supports used prior to any modifications to the person-centered service plan.<br><br>**MSM, FE Chapter 2200, Section 2203.4A(3)(h)(2)(07/01/2023) and PD Chapter 2300, Section 2303.4A(3)(h)(2)(07/01/2023):**<br>Document the positive interventions and supports used prior to any modification to the POC. |
| **c. Document less intrusive methods (tried did not work).** | **42 CFR 441.301(c)(4)(vi)(F)(3)(10/01/2023):**<br>Document less intrusive methods of meeting the need that have been tried but did not work.<br><br>**MSM, FE Chapter 2200, Section 2203.4A(3)(h)(3)(07/01/2023) and PD Chapter 2300, Section 2303.4A(3)(h)(3)(07/01/2023):**<br>Document less intrusive methods of meeting the need that have been tried but did not work out. |
| **d. Clear description proportionate to need.** | **42 CFR 441.301(c)(4)(vi)(F)(4)(10/01/2023):**<br>Include a clear description of the condition that is directly proportionate to the specific assessed need.<br><br>**MSM, FE Chapter 2200, Section 2203.4A(3)(h)(4)( 07/01/2023) and PD Chapter 2300, Section 2303.4A(3)(h)(4)(07/01/2023):**<br>Include a clear description of the condition that is directly proportionate to the specific assessed need. |
| **e. Collection/review of data to measure effectiveness of mod.** | **42 CFR 441.301(c)(4)(vi)(F)(5)(10/01/2023):**<br>Include regular collection and review of data to measure the ongoing effectiveness of the modification.<br><br>**MSM, FE Chapter 2200, Section 2203.4A(3)(h)(5)(07/01/2023) and PD Chapter 2300, Section 2303.4A(3)(h)(5)(07/01/2023):**<br>Include regular collection and review of data to measure the ongoing effectiveness of the modification. |
| **f. Time limit to determine if still necessary or can be termed.** | **42 CFR 441.301(c)(4)(vi)(F)(6)(effective 10/01/2023):**<br>Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.<br><br>**MSM, FE Chapter 2200, Section 2203.4A(3)(h)(6)( 07/01/2023) and PD Chapter 2300, Section 2303.4A(3)(h)(6)(07/01/2023):**<br>Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated. |

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| **15) SOC completed/signed by recipient initial/annual.** | **Waiver Appendix D-1(c) Service Plan Development (FE 04/01/2023) (PD-01/01/2023):**<br>The Statement of Choice (SOC) form is used to inform applicants of their rights and the right to choose between home and community-based waiver services or placement in an institutional setting and is signed by the recipient or designated representative.<br><br>**MSM, FE Chapter 2200, Section 2203.14(3)(07/01/2023) and PD Chapter 2300, Section 2303.15(3)(07/01/2023):**<br>The SOC complete with signature and dates.<br><br>**MSM, FE Chapter 2200, Section 2203.13A(5)(b) (07/01/2022):**<br>the Statement of Understanding/Choice (SOU) must be complete with signature and dates. |
| **16) Recipient rights reviewed initial/annual.** | **Waiver Appendix D-1(c) Service Plan Development (FE 04/01/2023)(PD-01/01/2023):**<br>The Recipient Rights form is reviewed with and provided to the recipient and or/designated representative which include choice of service provider and may request a change in services or service provider at any time.<br><br>**MSM, FE Chapter 2200, Section 2203.14(4)(07/01/2023) and PD Chapter 2300, Section 2303.15(4)(07/01/2023):**<br>The HCBS Acknowledgement Form is complete including initials, signature, and date.<br><br>**MSM, FE Chapter 2200, Section 2205(07/01/2023) and PD Chapter 2300, Section 2305(07/01/2023):**<br>Refer to MSM Chapter 3100 for specific instructions regarding notice and hearing procedures. Recipients are informed of their rights to a fair hearing at the initial face-to-face visit and annually thereafter when they are given the Recipients Rights Form.<br><br>**MSM, FE Chapter 2200, Section 2203.13A(5)(e)(07/01/2022):**<br>The applicant has been informed of their right to participate in the development of the POC using the person-centered approach with the support systems, friends, family of their choice involved. Applicants will be given free choice of all qualified Medicaid providers of each Medicaid covered service included in the written POC. Current POC information as it relates to the services provided must be given to all service providers. |
| **17) Preventative health care reviewed initial/annual.** | **Waiver Appendix C-2(d)(2) General Service Specifications (FE 04/01/2023)(PD-01/01/2023):**<br>Acknowledgement form indicating the recipient has been provided with "Recipient Rights Form", information about "Advance Directives" and "Preventative Care."<br><br>**MSM, FE Chapter 2200, Section 2203.14(4)(07/01/2023) and PD Chapter 2300, Section 2303.15(4)(07/01/2023):**<br>The HCBS Acknowledgement Form is complete including initials, signature, and date.<br><br>**MSM, FE Chapter 2200, Section 2203.13A(5)(c)(07/01/2022):**<br>The HCBS Acknowledgement Form completed including initials, signature, and date. |
| | ***MONTHLY CONTACTS AND DOCUMENTATION*** |
| **• Contact (monthly if CM only)** | **Waiver Additional information (Case Management Activities)(15)(FE 04/01/2023)(PD-01/01/2023):**<br>Case Managers must provide recipients with the appropriate amount of case management services necessary to ensure the recipient is safe and receives sufficient services. Case management is an as needed service. Case managers must, at a minimum, have an annual face-to-face visit and ongoing contact that is sufficient to meet the needs of the recipient. The amount of case management services must be adequately documented and substantiated by the case manager's notes.<br><br>**MSM, FE Chapter 2200, Section 2203.4(4)(a)(07/01/2023) and PD Chapter 2300, Section 2303.15(4)(a)(07/01/2023):**<br>Person-centered contacts are required to be delivered by the case management provider as agreed to in the signed POC. At a minimum, there must be a face-to face visit with each recipient and/or designated representative/LRI annually. All other ongoing contact methods may be determined by the recipient.<br>NOTE: When case management is the only waiver service received, the case manager will continue to have monthly contact with the recipient and/or designated representative/LRI to ensure the health and welfare of the recipient. The duration, scope, and frequency of case management services billed to DHCFP must be adequately documented and substantiated by the case manager's narratives.<br><br>**MSM, FE Chapter 2200, Section 2203.4(4)(b)(3)(07/01/2023) and PD Chapter 2300, Section 2303.15(4)(b)(3)(07/01/2023):** |

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| | Case managers must demonstrate due diligence to hold ongoing contacts as outlined in the POC (frequency and method). Ongoing contacts are required, and every attempt to contact the recipient should be documented. At least three telephone calls must be completed on separate days, if no response is received after the third attempt, a letter must be sent to the recipient requesting a return contact. If the recipient fails to respond by the date indicated in the letter, the recipient may be terminated.<br><br>**MSM, FE Chapter 2200, Section 2203.3A(4)(a) (07/01/2022):**<br>The case manager must have ongoing contact with each waiver recipient and/or the recipient's designated representative/LRI; this may be a telephone contact. At a minimum, there must be one face-to-face visit with each recipient annually. All other ongoing contacts may be by telephone, fax, e-mail, or face-to-face.<br><br>**PD Chapter 2300, Section 2303.3E(4)(a)(07/01/2022):**<br>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.<br><br>**MSM, FE Chapter 2200, Section 2203.2C(14)(07/01/2022):**<br>Understand that if case management is the only HCBS Waiver service, a monthly contact with the Case Manager is required. |
| **• Face-to-Face (annually unless on POC** | **Waiver Appendix D-2(a)(c) Service Plan Implementation and Monitoring (FE 04/01/2023)(PD-01/01/2023):**<br>Case managers must, at a minimum, complete one annual face-to-face visit with the recipient, and using the person-centered approach, the recipient is given the option for the frequency and method of ongoing contact that is sufficient to meet the needs of the recipient.<br><br>**MSM, FE Chapter 2200, Section 2203.4(4)(a)(07/01/2023) and PD Chapter 2300, Section 2303.15(4)(a)(07/01/2023):**<br>Person-centered contacts are required to be delivered by the case management provider as agreed to in the signed POC. At a minimum, there must be a face-to face visit with each recipient and/or designated representative/LRI annually. All other ongoing contact methods may be determined by the recipient.<br><br>**MSM, FE Chapter 2200, Section 2203.3A(4)(a)(07/01/2022):**<br>The case manager must have ongoing contact with each waiver recipient and/or the recipient's designated representative/LRI; this may be a telephone contact. At a minimum, there must be one face-to-face visit with each recipient annually. All other ongoing contacts may be by telephone, fax, e-mail, or face-to-face.<br><br>**PD Chapter 2300, Section 2303.3E(4)(a)(07/01/2022):**<br>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. |
| **• Health/Safety issues identified/follow up (recipient's condition)** | **Waiver Appendix D-1(f) Service Plan Development (FE 04/01/2023)(PD-01/01/2023):**<br>Contacts must be made to sufficiently verify that services are being provided appropriately or as outlined in the POC and identify changes in condition or service needs.<br><br>**MSM, FE Chapter 2200, Section 2203.4(4)(b)(2)(a)(07/01/2023) and PD Chapter 2300, Section 2303.15(4)(b)(2)(a)(07/01/2023):**<br>Quality of care included the identification, remediation, and follow-up of health and safety, risk factors, needs and concerns (to include changes in provider and/or back-up plan or support network) of the recipient, waiver service, satisfaction and whether the services are promoting the personalized goals stated in the POC. The case manager also assesses the need for any change in services or providers.<br><br>**MSM, FE Chapter 2200, Section 2203.3A(4)(c)(07/01/2022) and PD Chapter 2300, Section 2303.3E(4)(c)(07/01/2022):**<br>During the ongoing contact or face-to-face visit, the case manager monitors and documents the quality of care of the recipient. Quality of care includes the identification, remediation and follow-up of health and safety, risk factors, needs and concerns of the recipient, waiver service satisfaction and whether the services are promoting personalized goals stated in the POC. The case manager also assesses the need for any change in services or providers. If the recipient is utilizing a private case management agency, this information must be communicated to the ADSD for PA adjustment. |

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| **• Needs/Concerns follow-up documented (change in services/ providers including back- up plan)** | **Waiver Appendix D-1(f) Service Plan Development (FE 04/01/2023)(PD 01/01/2023):**<br>Contacts must be made to sufficiently verify that services are being provided appropriately or as outlined in the POC and identify changes in condition or service needs.<br><br>**MSM, FE Chapter 2200, Section 2203.4(4)(b)(2)(a)(07/01/2023) and PD Chapter 2300, Section 2303.15(4)(b)(2)(a)(07/01/2023):**<br>Quality of care included the identification, remediation, and follow-up of health and safety, risk factors, needs and concerns (to include changes in provider and/or back-up plan or support network) of the recipient, waiver service, satisfaction and whether the services are promoting the personalized goals stated in the POC. The case manager also assesses the need for any change in services or providers.<br><br>**MSM, FE Chapter 2200, Section 2203.3A(4)(c)(07/01/2022) and PD Chapter 2300, Section 2303.3E(4)(c)(07/01/2022):**<br>During the ongoing contact or face-to-face visit, the case manager monitors and documents the quality of care of the recipient. Quality of care includes the identification, remediation and follow-up of health and safety, risk factors, needs and concerns of the recipient, waiver service satisfaction and whether the services are promoting personalized goals stated in the POC. The case manager also assesses the need for any change in services or providers. If the recipient is utilizing a private case management agency, this information must be communicated to the ADSD for PA adjustment. |
| **• Waiver satisfaction assessed** | **Waiver Appendix D-1(f) Service Plan Development (FE 04/01/2023)(PD 01/01/2023):**<br>Contact with recipients is required to be initiated by the Case Manager to discuss the authorized services and evaluate the recipient's level of satisfaction.<br><br>**MSM, FE Chapter 2200, Section 2203.4(4)(b)(2)(a)(07/01/2023) and PD Chapter 2300, Section 2303.15(4)(b)(2)(a)(07/01/2023):**<br>Quality of care included the identification, remediation, and follow-up of health and safety, risk factors, needs and concerns (to include changes in provider and/or back-up plan or support network) of the recipient, waiver service, satisfaction and whether the services are promoting the personalized goals stated in the POC. The case manager also assesses the need for any change in services or providers.<br><br>**MSM, FE Chapter 2200, Section 2203.3A(4)(c)(07/01/2022) and PD Chapter 2300, Section 2303.3E(4)(c)(07/01/2022):**<br>During the ongoing contact or face-to-face visit, the case manager monitors and documents the quality of care of the recipient. Quality of care includes the identification, remediation and follow-up of health and safety, risk factors, needs and concerns of the recipient, waiver service satisfaction and whether the services are promoting personalized goals stated in the POC. The case manager also assesses the need for any change in services or providers. If the recipient is utilizing a private case management agency, this information must be communicated to the ADSD for PA adjustment. |
| **• Personal goals assessed** | **Appendix D-1(d) Service Plan Development (FE-04/01/2023)(PD 01/01/2023):**<br>Personal goals are identified by the recipient and documented on the POC initially and each time the POC is updated.<br><br>**MSM, FE Chapter 2200, Section 2203.4(4)(b)(1)(07/01/2023) and PD Chapter 2300, Section 2303.15(4)(b)(1)(07/01/2023):**<br>Monitoring of the overall provision of waiver services and determining that the personalized goals identified in the POC are being met.<br><br>**MSM, FE Chapter 2200, Section 2203.4(4)(b)(2)(a)(07/01/2023) and PD Chapter 2300, Section 2303.15(4)(b)(2)(a)(07/01/2023):**<br>Quality of care included the identification, remediation, and follow-up of health and safety, risk factors, needs and concerns (to include changes in provider and/or back-up plan or support network) of the recipient, waiver service, satisfaction and whether the services are promoting the personalized goals stated in the POC. The case manager also assesses the need for any change in services or providers.<br><br>**MSM, FE Chapter 2200, Section 2203.3A(4)(c)(07/01/2022) and PD Chapter 2300, Section 2303.3E(4)(c)(07/01/2022):**<br>During the ongoing contact or face-to-face visit, the case manager monitors and documents the quality of care of the recipient. Quality of care includes the identification, remediation and follow-up of health and safety, risk factors, needs and concerns of the recipient, waiver service satisfaction and whether the services are promoting personalized goals stated in the POC. The case manager also assesses the need for any change in services or providers. If the recipient is utilizing a private case management agency, this information must be communicated to the ADSD for PA adjustment. |
| **• If in residential setting, satisfaction of living situation/roommate.** | **MSM, FE Chapter 2200, Section 2203.4(4)(b)(2)(b)(07/01/2023) and PD Chapter 2300, Section 2303.15(4)(b)(2)(b)(07/01/2023):**<br>If a recipient resides in a residential setting (AL facility), the case manager must inquire on the recipient's satisfaction in the residential setting. |

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| **• If LRI, is the paid provider, address satisfaction with service.** | **Waiver Appendix C-2(d) General Service Specifications (FE 04/01/2023)(PD 01/01/2023):**<br>CM will conduct at least one (1) face-to-face visit contact with the recipient annually. However, if the LRI is chosen by the recipient to provide paid personal care assistance, the case manager will conduct more frequent home visits (no less than bi-annually in person and quarterly via telephone) to ensure recipients are satisfied with the waiver services and caregiver (LRI).<br><br>**MSM, FE Chapter 2200, Section 2203.4(4)(b)(4)(07/01/2023) and PD Chapter 2300, Section 2303.15(4)(b)(4)(07/01/2023):**<br>If an LRI is chosen by the recipient to provide paid personal care like services in their private home, the case manager will conduct more frequent home visits (no less than bi-annually in person and quarterly by telephone) to ensure the recipient is satisfied with the waiver services and caregiver. |
| **FE/PD FINANCIAL CLAIM REVIEW REQUIREMENTS** | |
| Quality Improvement Sub Assurances, NAC, CFR, Waiver, MSM | |
| ***ELIGIBILITY*** | |
| **1) Enrollee eligible on the date of service** | **Waiver Appendix I-2(d)(a) Rates, Billing and Claims (3 of 3), (FE 04/01/2023) (PD-01/01/2023):**<br>The Medicaid Management Information System (MMIS) assures that all claims for payment are made when the recipient was eligible for the Medicaid Waiver on the date of service and that there was an active prior authorization for the service in question.<br><br>**MSM, FE Chapter 2200, Section 2203.18(07/01/2023) and PD Chapter 2300 Section 2303.20(06/28/2023):**<br>The DHCFP assures that claims for payment of waiver services are made only when a recipient is Medicaid eligible, when the service(s) are identified on the approved POC, and the service(s) have been prior authorized. |
| **2) Conflicting services provided during review service dates (Institutional care)** | **MSM, FE Chapter 2200, Section 2204.1(a) (07/01/2023) and PD Chapter 2300 Section 2204.1(06/28/2023):**<br>When a recipient is institutionalized less than 60 days, their waiver services must be suspended.<br><br>**FE/PD- In accordance with 42 CFR 441.301(b)(1) (ii),**<br>(1) Provide that the services are furnished (ii) Only to beneficiaries who are not inpatients of a hospital, NF, or ICF/II. |
| ***PRIOR AUTHORIZATION*** | |
| **3) Is service prior authorized** | **Waiver Appendix I-2(d)(a) Rates, Billing and Claims (FE 04/01/2023) (PD-01/01/2023):**<br>The Medicaid Management Information System (MMIS) assures that all claims for payment are made when the recipient was eligible for the Medicaid Waiver on the date of service and that there was an active prior authorization for the service in question.<br><br>**MSM, FE Chapter 2200 Section 2203.18(07/01/2023) and PD Chapter 2300 Section 2303.20(06/28/2023):**<br>The DHCFP assures that claims for payment of waiver services are made only when a recipient is Medicaid eligible, when the service(s) are identified on the approved POC, and the service(s) have been prior authorized.<br><br>**MSM Chapter 100 Medicaid Program, Section 103.2(D) (effective 08/28/2019 & 04/26/2023):**<br>If a PA is required, it is the responsibility of the provider to request before providing services.<br><br>**MSM Chapter 3300 Program Integrity, Section 3303.3A(2)(l)(1) (effective 05/01/2019):**<br>Requirement for all services to be prior authorized to be eligible for reimbursement. |
| **4) Correct provider type** | **MSM, FE Chapter 2200 Section 2203.2B(1) (07/01/2023):**<br>Must obtain and maintain a Medicaid provider number (Provider Type 48,57,58 Specialty Code 204 or 59 as appropriate) through DHCFP's Fiscal Agent.<br><br>**MSM, PD Chapter 2300 Section 2303.2B(1)(06/28/2023):**<br>Must obtain and maintain a provider number (Provider Type (PT) 58) through DHCFP's Fiscal Agent. |
| ***CLAIM*** | |
| **5) Procedure code/modifier/ service level correct** | **Waiver Appendix I(b)(i) Quality Improvement: Financial Accountability (FE 04/01/2023)(PD-01/01/2023):**<br>All Medicaid Providers are responsible to validate billing and ensure integrity of all claims submitted to the DHCFP Fiscal Agent. Factors reviewed include recipients, dates of service, authorization, procedure code, Medicaid Provider number, eligibility effective date, modifier (if applicable), and rate. |

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| | **MSM, PD Chapter 2200 Section 2203.18(07/01/2023) and PD Chapter 2300 Section 2303.20(06/28/2023):**<br>The DHCFP assures that claims for payment of waiver services are made only when a recipient is Medicaid eligible, when the service(s) are identified on the approved POC, and the service(s) have been prior authorized.<br><br>**MSM Chapter 100, Section 105.1(F) (effective 08/28/2019):**<br>Appropriate billings must include the current year procedure codes and ICD diagnostic codes or the HIPAA of 1996 compliant codes. Complete billing information may be obtained by contacting the Medicaid Field Representative at Medicaid's fiscal agent. Refer to Section 108 of this chapter for additional contact information.<br><br>**MSM Chapter 100, Section 105.1(F) (effective 04/26/2023):**<br>All claims submitted for payment must use the appropriate and current CPT, HCPCS, and ICD codes, and the claims must adhere to national coding standards. Additionally, the provider must comply with the Nevada Medicaid Billing Manual and Billing Guidelines.<br><br>**MSM Chapter 3300 Program Integrity, Section 3303.2A(4)(a)(1)(b) (effective 05/01/2019)**<br>Claim billed with incorrect procedure code.<br><br>**MSM Chapter 3300 Program Integrity, Section 3303.4 (effective 05/01/2019):**<br>Improper payments include but are not limited to: payments where the incorrect procedure code was billed (up-coding). |
| **6) Service units billed fall within PA units allowed** | **Waiver Appendix I-2(b) Rates, Billing and Claims (1 of 3) (FE 04/01/2023) (PD-01/01/2023):**<br>Providers do not receive reimbursement over what is authorized.<br><br>**MSM, FE Chapter 2200 Section 2203.2B (11)(07/01/2023) and PD Chapter 2300, Section 2303.2B(11)(06/28/2023):**<br>All providers may only provide services that have been identified in the POC and have a Prior Authorization (PA), if required.<br><br>**MSM Chapter 100 Medicaid Program, Section 103(B)(4) (effective 08/28/2019 & 04/26/2023)**<br>Claims submitted are only for services rendered.<br><br>**MSM Chapter 3300 Program Integrity, Section 3303.2A(4)(a)(1)(d) (effective 05/01/2019)**<br>The number of units billed was incorrect.<br><br>**MSM Chapter 3300 Program Integrity, Section 3303.4 (effective 05/01/2019):**<br>Improper payments include but are not limited to: payments where an incorrect number of units were billed. |
| | ***DAILY RECORD*** |
| **7) Services provided match the POC** | **Waiver Appendix I-2(d)(c) Rates, Billing and Claims (3 of 3) (FE 04/01/2023) (PD-01/01/2023):**<br>Waiver providers keep a record or signed timesheet to verify that services were provided in accordance with the POC.<br><br>**MSM, FE Chapter 2200 Section 2203.2B (11)(07/01/2023) and PD Chapter 2300, Section 2303.2B(11)(06/28/2023):**<br>All providers may only provide services that have been identified in the POC and have a Prior Authorization (PA), if required.<br><br>**MSM Chapter 100 Medicaid Program, Section 105.1(L) (effective 01/12/2019):**<br>Providers are required to keep any records necessary to disclose the extent of services the provider furnishes to recipients and to provide these records, upon request, to the Medicaid agency, the Secretary of Health and Human Services (HHS), or the state Medical Fraud Control Unit (MFCU).<br><br>**MSM Chapter 3300 Program Integrity, Section 3303.2B(1) (effective 05/01/2019):**<br>The DHCFP policy and the DHCFP provider agreement to cooperate and provide any and all documentation (e.g., medical records, charts, billing information and any other documentation) requested by the DHCFP or other state and/or federal officials or their authorized agents for the purpose of determining the validity of claims and the reasonableness and necessity of all services billed to and paid by the DHCFP. |
| **8) Frequency of services match the POC** | **Waiver Appendix D (a)(d) Quality Improvement: Service Plan (FE 04/01/2023) (PD-01/01/2023):** |

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| | Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.<br><br>**MSM, FE Chapter 2200 Section 2203.2B(11)(07/01/2023) and PD Chapter 2300, Section 2303.2B(11)(06/28/2023):**<br>All providers may only provide services that have been identified in the POC and have a Prior Authorization (PA), if required. |
| **9) Service units/days provided match units/days billed and for which payment was received** | **Waiver Appendix I(a)(i)(a) Quality Improvement: Financial Accountability (FE 04/01/2023) (PD-01/01/2023):**<br>Performance Measure: Number and percent of recipients claims that are coded and paid correctly in accordance with the service plan, daily record, and prior authorization. N: Number of recipients claims that are coded and paid correctly in accordance with the service plan, daily record, and prior authorization.<br><br>**MSM, PD Chapter 2200 Section 2203.2B(8)(07/01/2023) and FE Chapter 2300, Section 2303.2B(8)(06/28/2023):**<br>Must be responsible for any claims submitted or payment received on the recipient's behalf; such claims should be made under penalties of perjury. Any false claims, statement or documents, or concealment of material facts may be prosecuted under applicable federal or state laws.<br><br>**MSM Chapter 3300 Program Integrity, Section 3303.1A(2)(x)(2) (effective 05/01/2019)**<br>False statements include submitting a bill for a service not provided.<br><br>**MSM Chapter 3300 Program Integrity, Section 3303.2A(4)(a)(1)(a) (effective 05/01/2019)**<br>No documentation or insufficient documentation provided within specified timeframes to support the service billed and paid by the DHCFP.<br><br>**MSM Chapter 3300 Program Integrity, Section 3303.2A(4)(a)(1)(d) (effective 05/01/2019):**<br>The number of units billed was incorrect. |
| **10) Daily log signed/initialed by recipient** | **Waiver Appendix I-2(d)(c) (3 of 3) Rates, Billing and Claims (FE 04/01/2023) (PD-01/01/2023):**<br>Waiver providers keep a record or signed timesheet to verify that services were provided in accordance with the POC.<br><br>**MSM, FE Chapter 2200 Section 2203.12B (4)(a)(07/01/2023):**<br>Each provider must have a file for each recipient. In the recipient's file, the provider must have a copy of the current POC and maintain daily records, fully documenting the scope and frequency of services as specified on the POC and lease or other agreement. The documentation will include the recipient's acknowledgment of service. If the recipient is unable to provide the acknowledgment due to cognitive and/or physical limitations, this will be clearly documented on the POC.<br>**MSM, PD Chapter 2300 Section 2203.8B (4)(a)(06/28/2023):**<br>Each provider must have a file for each recipient. In the recipient's file, the provider must have a copy of the current POC and maintain daily records, fully documenting the scope and frequency of services as specified on the POC and lease or other agreement. The documentation will include the recipient's acknowledgment of service. If the recipient is unable to provide the acknowledgment due to cognitive and/or physical limitations, this will be clearly documented on the POC. |
| **11) Daily record signed/initialed by provider/staff** | **Waiver Appendix I-2(d)(c) (3 of 3) Rates, Billing and Claims (FE 04/01/2023) (PD-01/01/2023):**<br>Waiver providers keep a record or signed timesheet to verify that services were provided in accordance with the POC.<br><br>**MSM, FE Chapter 2200 Section 2203.12B (4)(b)(07/01/2023) and PD Chapter 2300, Section 2303.8B(4)(b)(06/28/2023):**<br>The provider will initial after the daily services are delivered, with a full signature of the provider on each daily record. If a provider elects to use electronic signatures, they must have weekly printouts of the daily record in the recipient's file or make available upon request. For electronic signatures, systems and software products must include protection against modifications, with administrative safeguards that correspond to policies and procedures of the ADSD. |
| **12) If applicable, documented in POC recipient unable to sign due to cognitive or physical limitations** | **Waiver Appendix C-2(e) General Service Specifications (FE 04/01/2023)(PD-01/01/2023):**<br>Each Waiver participant must have a file which contains the POC, which, if applicable, includes justification and narration to support why a recipient is unable to sign or initial required documentation.<br><br>**MSM, FE Chapter 2200 Section 2203.12B (4)(a) (07/01/2023) and PD Chapter 2300, Section 2303.4c(2) (06/28/2023):**<br>If the recipient is unable to provide the acknowledgment due to cognitive and/or physical limitations, this will be clearly documented on the POC. |
| | ***PAYMENT*** |

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| **13) Payment to provider correct based on claim submitted** | **Waiver Appendix I:1 Financial Integrity and Accountability (FE 04/01/2023) (PD-01/01/2023):**<br>In addition to the Interchange audit, DHCFP QA staff completes an annual financial review. The objective of this review is to confirm the accuracy of provider payments made by examining claims paid and comparing those claims with recipient files, Plans of Care, waiver requirements, and waiver policy.<br><br>**MSM, FE Chapter 2200, Section 2203.2B(3) (07/01/2023) and PD Chapter 2300, Section 2303.2B(3) (06/28/2023):**<br>In addition to this chapter, provider must also comply with rules and regulations as set forth in the MSM Chapter 100 Medicaid Program. Failure to comply with any or all these stipulations may result in DHCFP's decision to exercise its right to terminate the provider's contract.<br><br>**MSM Chapter 100 Medicaid Program, Section 105.1(F) (effective 04/27/2017):**<br>Appropriate billings must include the current year procedure codes and ICD diagnostic codes or the HIPAA of 1996 compliant codes. Complete billing information may be obtained by contacting the Medicaid Field Representative at Medicaid's fiscal agent. Refer to Section 108 of this chapter for additional contact information.<br><br>**MSM Chapter 100 Medicaid Program, Section 105.1(F) (effective 04/26/2023):**<br>All claims submitted for payment must use the appropriate and current CPT, HCPCS, and ICD codes, and the claims must adhere to national coding standards. Additionally, the provider must comply with the Nevada Medicaid Billing Manual and Billing Guidelines.<br><br>**MSM Chapter 3300 Program Integrity, Section 3303.2A(4)(1)(a)(2)(d) (effective 05/01/2019):**<br>The incorrect rate was used to pay the claim.<br><br>**MSM Chapter 3300 Program Integrity, Section 3302.4 (effective 05/01/2019):**<br>Improper payments include but are not limited to: payments that cannot be substantiated by appropriate or sufficient medical or service record documentation. |
| **14) Services paid using Medicaid allowable rate** | **Waiver Appendix I-2(a) Rates, Billing and Claims (FE 04/01/2023) (PD-01/01/2023):**<br>An established fee-schedule or Fee-for-Service (FFS) reimbursement type is utilized by Nevada Medicaid for the PD Waiver, paying uniform rates across all providers.<br><br>**MSM, FE Chapter 2200, Section 2203.2B(3) (07/01/2023) and PD Chapter 2300, Section 2303.2B(3) (06/28/2023):**<br>In addition to this chapter, provider must also comply with rules and regulations as set forth in the MSM Chapter 100 Medicaid Program. Failure to comply with any or all these stipulations may result in DHCFP's decision to exercise its right to terminate the provider's contract.<br><br>**MSM Chapter 100 Medicaid Program, Section 105.1(F) (effective 08/28/2019):**<br>Appropriate billings must include the current year procedure codes and ICD diagnostic codes or the HIPAA of 1996 compliant codes. Complete billing information may be obtained by contacting the Medicaid Field Representative at Medicaid's fiscal agent. Refer to Section 108 of this chapter for additional contact information.<br><br>**MSM Chapter 100 Medicaid Program, Section 105.1(F) (effective 08/28/2019):**<br>All claims submitted for payment must use the appropriate and current CPT, HCPCS, and ICD codes, and the claims must adhere to national coding standards. Additionally, the provider must comply with the Nevada Medicaid Billing Manual and Billing Guidelines.<br><br>**MSM Chapter 3300 Program Integrity, Section 3302.4 (effective 05/01/2019):**<br>An improper payment is any payment that is payments over Medicaid allowable amounts.<br><br>**MSM Chapter 3300 Program Integrity, Section 3303.2B(4) (effective 05/01/2019):**<br>Improper payments include but are not limited to: Payments where the incorrect procedure code was billed (up-coding); payments over Medicaid allowable amounts. |
| **15) Referral made to SUR unit** | **Waiver Appendix I(a)(b)(ii) Quality Improvement: Financial Accountability (FE 04/01/2023):**<br>If errors are discovered during the financial month's review, the information is forwarded to DHCFP SUR unit, wherein they conduct an independent and expanded review to see if it is an education issue or a more systemic and/or possible fraud issue.<br><br>**Waiver Appendix E-1(iv) Overview (8 of 13) (PD 01/01/2023)** |

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| | Any findings which resulted in potential error of claims submission not matching the POC, possible overpayment, etc., will be referred to DHCFP's Surveillance and Utilization Review (SUR)<br><br>**MSM, FE Chapter 2200, Section 2203.2B(3) (07/01/2023) and PD Chapter 2300, Section 2303.2B(3) (06/28/2023):**<br>In addition to this chapter, provider must also comply with rules and regulations as set forth in the MSM Chapter 100 Medicaid Program. Failure to comply with any or all these stipulations may result in DHCFP's decision to exercise its right to terminate the provider's contract.<br><br>**MSM Chapter 100 Medicaid Program, Section 106.5(C) (effective 08/28/2019 & 04/26/2023):**<br>The DHCFP may initiate a corrective action plan against a provider as the result of an investigation, audit and/or review. Investigations, audits or reviews may be conducted by one or more of the following (not all inclusive): c. Nevada Medicaid Surveillance Utilization and Review (SUR) staff.<br><br>**MSM Chapter 3300 Program Integrity, Section 3302.4 (05/01/2019):**<br>An improper payment is any payment that is billed to or paid by the DHCFP that is not in accordance with: The Medicaid or Nevada Check Up policy governing the service provided; fiscal agent billing manuals; contractual requirements; standard record keeping requirements of the provider discipline; and federal law or state statutes. An improper payment can be an overpayment or an underpayment. Improper payments include but are not limited to: improper payments discovered during federal PERM reviews or Financial and Policy Compliance Audits; payments for ineligible recipients; payments for ineligible, non-covered or unauthorized services; duplicate payments; payments for services that were not provided or received; payments for unbundled services when an all-inclusive bundled code should have been billed; payments not in accordance with applicable pricing or rates; data entry errors resulting in incorrect payments; payments where the incorrect procedure code was billed (up-coding); payments over Medicaid allowable amounts; payments for non-medically necessary services; payments where an incorrect number of units were billed; submittal of claims for unauthorized visits; and payments that cannot be substantiated by appropriate or sufficient medical or service record documentation. Improper payments can also be classified as fraud and/or abuse. |
| | ***Provider*** |
| **16) Provider eligible for payment at time of service** | **MSM, Chapter 2200 Section 2203.2B(1) (07/01/2023) and PD Chapter 2300, Section 2303.2B(3) (06/28/2023):**<br>Must obtain and maintain a Medicaid provider number (Provider Type 48, 57, 58 Specialty Code 204 or 59 as appropriate) through DHCFP's Fiscal Agent.<br><br>**MSM Chapter 100 Medicaid Program, Section 102 (effective 08/28/2019):**<br>All individuals/entities providing services to Medicaid recipients under the FFS or Medicaid Managed Care program must be enrolled as a Medicaid provider in order to receive payment for services rendered.<br><br>**MSM Chapter 100 Medicaid Program, Section 102(2) (effective 04/26/2023):**<br>All individuals/entities who provide services to Nevada Medicaid recipients under the FFS and/or Medicaid Managed Care Organization (MCO) program shall be enrolled as a Nevada Medicaid provider in order to receive payment for services rendered. |

## Acronyms & Definitions

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| ACK | Acknowledgment Form | Used as shorthand for Acknowledgment Form NMO-7075 |
| ADC/ADHC | Adult Day Care/Adult Day Health Care | An organized program of services during the day in a group setting for the purpose of supporting the personal independence of older adults and promoting their social, physical, and emotional well-being. |
| ADL | Activities of Daily Living | Self-care activities routinely performed daily, such as bathing, dressing, grooming, toileting, transferring, mobility, continence and eating. |
| ADSD | Aging and Disability Services Division | A State agency in Nevada's Department of Health and Human Services (DHHS) responsible for operating the Home and Community Based Services (HCBS) Waivers for the Frail Elderly, Physically Disabled, and Individuals with Intellectual Disabilities. |
| AL | HCBS Waiver for Assisted Living | A 1915(c) Waiver Program that provides assisted living services to individuals who are age 65 and older who, but for the provision of such services, would require a Nursing Facility (NF) level of care (LOC). This waiver was merged with the Waiver for the Frail Elderly (FE) effective July 1, 2015. Also used to refer to the service Assisted Living. |
| ALiS | Aithent Licensing System | Centralized database for provider reviews. |
| APC | Augmented Personal Care | Includes assistance and supervision with activities of daily living. |
| CFR | Code of Federal Regulations | The CFR is a codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the Federal government. The Code is divided into 50 titles which represent broad areas subject to federal regulation. |
| CM | Case Management/ Case Manager | Case management is a process by which an individual's needs are identified and social and medical services to meet those needs are located, coordinated, and monitored. Case management may be targeted to certain populations in certain areas of the state under the authority of Section 1905(a)(19) of the Social Security Act. |
| CMS | Centers for Medicare and Medicaid Services | The Federal government entity that monitors state programs to assure minimum levels of public health service are provided, as mandated in CFR Title 42. |
| CP | Care Plan | Person Centered Service Plan (POC) or Plan of Care (POC) |
| CPAP | Continuous Positive Airway Pressure | Medical device |
| CPR | Cardiopulmonary Resuscitation | Cardiopulmonary resuscitation is a lifesaving technique useful in many emergencies, including heart attack or near drowning, in which someone's breathing or heartbeat has stopped. The American Heart Association recommends that everyone, untrained bystanders, and medical personnel alike, begin CPR with chest compressions. |
| CSHA/SHA | Comprehensive Social Health Assessment/Social Health Assessment | An assessment that addresses the recipient's activities of daily living (ADLs), which are self-care activities, such as bathing, dressing, grooming, transferring, toileting, ambulation, and eating. Instrumental activities of daily living (IADLs), which capture more complex life activities, are also assessed, including meal preparation, light housework, laundry, and essential shopping. In addition, this assessment includes information regarding the recipient's medical history and social needs. The assessment includes risk factors, back-up plans, equipment needs, behavioral status, current support system and unmet service needs. |
| DHCFP | Division of Health Care Financing and Policy | A State agency in Nevada's Department of Health and Human Services (DHHS) that works in partnership with the Centers for Medicare & Medicaid Services (CMS) to assist in providing quality medical care for eligible individuals and families with low incomes and limited resources. |
| DHHS | Department of Health and Human Services | The Department of Health and Human Services (DHHS) is an office of the Executive Branch of the State Government and is led by a director appointed by the Governor. DHHS is one of the largest departments in State government comprised of five Divisions including: Aging and Disability Services, Child and Family Services, Health Care Financing and Policy (Medicaid), Public and Behavioral Health, and Welfare and Supportive Services. |

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| DME | Durable Medical Equipment | Medically necessary durable medical equipment that a doctor prescribes for use in the home. |
| DR/LRI | Designated Representative/ Legally Responsible Individual | Individuals who are legally responsible to provide medical support including: spouses of recipients, legal guardians, and parents of minor recipients, including: stepparents, foster parents, and adoptive parents. |
| DSS | Decision Support System | Database of Medicaid recipients and providers utilized by DHCFP QA for recipient selection for the review year as well as financial claims. |
| EAP | Energy Assistance Program | Program that provides a supplement to assist qualifying low-income Nevadans with the cost of home energy. |
| EVV | Electronic Visit Verification | AuthentiCare database containing information about clients, services, authorizations, providers, and workers used to verify claims created by providers and services received by recipients. |
| FBI | Federal Bureau of Investigation | The mission of the FBI—as a national security and intelligence organization—is to protect and defend the United States against terrorist and foreign intelligence threats, to uphold and enforce the criminal laws of the United States, and to provide leadership and criminal justice services to federal, state, municipal, and international agencies, and partners. |
| FE | HCBS Waiver for the Frail/Elderly | A 1915(c) Waiver Program (formerly Community Home Base Initiative Program) that provides the option of home and community-based services as an alternative to institutional nursing facility care and allows for maximum independence for the frail elderly who would otherwise need institutional nursing facility services. |
| GH | Group Home | A group home is a residence model of medical care for those with complex health needs. |
| HCBS/HCBW | Home & Community Based Services/Home & Community Based Waiver | Home and community-based services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community. These programs serve a variety of targeted populations groups, such as the frail elderly, people with mental illnesses, intellectual or developmental disabilities, and/or physical disabilities. |
| HCQC | Health Care Quality and Compliance | The Bureau of Health Care Quality and Compliance (HCQC) protects the safety and welfare of the public through the promotion and advocacy of quality health care through licensing, regulation enforcement, and education. |
| HIPAA | Health Insurance Portability and Accountability Act | The HIPAA of 1996 is a law to improve the efficiency and effectiveness of the health care system. HIPAA included a series of "administrative simplification: procedures that establish national standards for electronic health care transactions, and requires health plans (i.e., Medicaid and Nevada Check Up) and health care providers that process claims and other transactions electronically to adopt security and privacy standards to protect personal health information. |
| HMKR | Homemaker | Waiver service that includes assistance with general household chores. It can include housekeeping, laundry, shopping for groceries and other essential items, as well as the preparation of meals. |
| HUD | Department of Housing and Urban Development | The agency responsible for national policy and programs that address America's housing needs. |
| HV | Home Visit | Contact between case manager and recipient to assess services, goals, waiver satisfaction and any new needs. |
| IA | Initial Assessment | This assessment is conducted as an administrative function of the waiver program and evaluates service needs based on functional deficits, support systems, and imminent risk of institutionalization. |
| IADL | Instrumental Activities of Daily Living | Activities related to independent living including preparing meals, shopping for groceries or personal items, performing light or heavy housework, communication, and money management. |
| ICF | Intermediate Care Facility | Intermediate Care Facilities for individuals with Intellectual disability (ICF/ID) is an optional Medicaid benefit that enables states to provide comprehensive and individualized health care and rehabilitation services to individuals to promote their functional status and independence. |
| IID/MR | Intellectual Disabilities | A term used when there are limits to a person's ability to learn at an expected level and function in daily life. |

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| LOC | Level of Care | The specification of the minimum amount of assistance that an individual must require in order to receive services in an institutional setting under the State Plan and home and community-based services waiver. LOCs are based on current assessments showing the level of functional skills and support needs. The assessments include psychological evaluation, medical records, nursing, and social assessments completed by professionals. |
| LTSS | Long Term Services and Supports | A unit within the Division of Health Care Financing and Policy that provides services specifically to Medicaid eligible recipients. This includes services for a diverse group of Nevadans including the elderly and people living with disabilities and special health care needs. LTSS provides both institutional and home and community-based care. |
| MC | Monthly Contact | Contact between case manager and recipient to assess services, goals, waiver satisfaction and any new needs. |
| MD | Medical Doctor | A licensed medical practitioner. |
| MDO | Medical/Dental/Ocular | A grouping of insurance coverage types/services noted within the SAMS system. |
| MFCU | Medicaid Fraud Control Unit | Statewide program that investigates and prosecutes Medicaid providers that obtain Medicaid funds through fraudulent means. |
| MMIS | Medicaid Management Information System | A computer system designed to help managers plan and direct business and organizational operations. |
| MSM | Medicaid Services Manual | The policies that govern Medicaid services. |
| MTM/MM | Medication Therapy Management/ Medication Management | MTM is a group of services that pharmacists and others can provide to find, treat, and educate patients with chronic conditions. |
| N/A | Not Applicable | Not Applicable |
| NF | Nursing Facility | NF is a general Nursing Facility, free-standing or hospital-based, which is licensed and certified by the Division of Public and Behavioral Health, Health Care Quality and Compliance, and provides both skilled and intermediate nursing services. |
| NMO | Nevada Medicaid Office | The Nevada Medicaid Office is responsible for policy, planning and administration of the Nevada Medicaid program; also known as the Division of Health Care Financing and Policy. |
| NOD | Notice of Decision | A Notice of Decision is sent to a waiver recipient for the following reasons: denial, suspension, reduction, and termination. The Notice of Decision outlines the recipient's right to a Fair Hearing. |
| P&P Transmittal | Policy & Procedure Transmittal | The Policy and Procedure Transmittals are designed to provide a consistent format for communicating policy clarification within the Division of Health Care Financing and Policy and among sister agencies. |
| PA | Prior Authorization | A review conducted to evaluate medical necessity, appropriateness, location of service and compliance with Medicaid's policy, prior to the delivery of service. |
| PCA/PCS | Personal Care Assistant/Service | Personal care assistants, also known as caregivers, home health or personal care aides, give assistance to people who are sick, injured, mentally or physically disabled, or the elderly and fragile. Hands-on assistance with activities of daily living (ADLs) (such as eating, bathing, dressing, and bladder and bowel requirements) or instrumental activities of daily living (IADLs) (such as taking medications and shopping for groceries). |
| PD | HCBS Waiver Serving People with Physical Disabilities | A 1915(c) Waiver Program that provides the option of home and community-based services as an alternative to institutional nursing facility care and allows for maximum independence for persons with physical disabilities who would otherwise need institutional nursing facility services. |
| PERS | Personal Emergency Response System | 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. |

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| PES | Participant Experience Survey | An interview tool developed by Medstat Group, Inc. under a contract from the Centers for Medicare and Medicaid Services. The surveys capture data that can be used to calculate indicators for monitoring quality within the waiver programs. |
| POA | Power of Attorney | The authority to act for another person in specified or all legal or financial matters. |
| POC aka<br>PCSP | Plan of Care aka<br>Person Centered Service Plan | A written document identifying the recipient's health and welfare needs, along with goals and interventions to meet the identified needs. It specifies the level of assistance, type, amount, scope, duration, and frequency for all services, as well as other ongoing community support services that may meet the assessed needs of the recipient, regardless of the funding source. |
| PT/OT/ST | Physical Therapy/Occupational Therapy/Speech Therapy | Physical Therapy (PT) focuses on the acquisition and/or improvement of skills related to gross motor movement, such as sitting, standing, walking, jumping, running, and lifting. Occupational Therapy (OT) focuses on the acquisition of basic, self-help skills required for daily living. Speech-Language Therapy (ST) focuses on the acquisition and use of language. |
| QA | Quality Assurance | A structured, internal monitoring and evaluation process designed to improve quality of care. QA involves the identification of quality-of-care criteria, which establishes the indicators for program measurements and corrective actions to remedy any deficiencies identified in the quality of direct patient, administrative and support services. |
| QI | Quality Improvement | A critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement. |
| QIO | Quality Improvement Organization | The QIO program focuses on three aims: better patient care, better population health, and lower health care costs through improvement. |
| QTC | Quarterly Telephone Contact | Contact between case manager and recipient to assess services, goals, waiver satisfaction and any new needs. |
| RA | Re-Assessment | Annual assessment of recipient eligibility and needs for waiver/non-waiver services. |
| SAMS | Social Assistance Management Software | Social Assistance Management Software or SAMS® manages consumer (recipient) and service data for social assistance organizations. |
| SNAP | Supplemental Nutrition Assistance Program | SNAP provides nutrition benefits to supplement the food budget of needy families so they can purchase healthy food and move towards self-sufficiency. |
| SOR | Serious Occurrence Report | A report of any actual or alleged event or situation involving either the provider/employee or recipient that relates substantial or serious harm to the safety or well-being of the provider/employee or recipient. Serious occurrences may include, but are not limited to the following: suspected physical or verbal abuse, unplanned hospitalization, neglect of the recipient, exploitation, sexual harassment or sexual abuse, injuries requiring medical intervention, an unsafe working environment, any event which is reported to Child or Elder Protective Services or law enforcement agencies, death of the recipient during the provision of Waiver Services, or loss of contact with the recipient for three consecutive scheduled days. |
| SOU/SOC | Statement of Understanding/Statement of Choice | A form given to all applicants describing the services offered under the waiver during the intake process and as required by each waiver. The assigned case manager informs the applicant of their choice between waiver services and placement in a long-term care facility, in addition to their choice of qualified providers. |
| SP | Service Plan | Person Centered Service Plan (PCSP)_ or Plan of Care (POC) |

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| SUR | Surveillance and Utilization Review | A statewide program that safeguards against unnecessary or inappropriate use of services by preventing excess payments in the Nevada Medicaid and Nevada Check Up programs. The SUR unit analyzes claims data to identify potential fraud, waste, overutilization, and abuse; collects provider overpayments and refers appropriate cases to the Medicaid Fraud Control Unit (MFCU) for criminal investigation and prosecution. |
| SW | Social Worker | Social Worker |
| TB | Tuberculosis | Tuberculosis is a potentially serious infectious disease that mainly affects the lungs. The bacteria that cause tuberculosis are spread from one person to another through tiny droplets released into the air via coughs and sneezes. |
| TBD | To Be Determined | To Be Determined |
| YTD | Year to Date | Year to Date |