MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

June 28, 2022

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CASEY ANGRES
MANAGER OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 2200 – HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER FOR THE FRAIL ELDERLY

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 2200 are being proposed to align with the current Appendix K approved on March 14, 2022.

The proposed changes include adding Home Delivered Meals Service and its definition and coverage and limitations to the existing waiver services offered under the Frail Elderly Waiver similar to the Home Delivered Meals service offered under the Physically Disabled Waiver.

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

Entities Financially Affected: There is no anticipated fiscal impact known at this time.

Financial Impact on Local Government: Unknown at this time.

These changes are effective July 1, 2022.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL OL	MTL 03/21
CHAPTER 2200 – HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER FOR THE FRAIL ELDERLY	CHAPTER 2200 – HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER FOR THE FRAIL ELDERLY

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2203.2A	**Coverage and Limitations**	Services re-numbered and added Home Delivered Meals.
2203.2B	**Provider Responsibilities**	Added "Medicaid" and "58 Specialty Code 204" as a provider type.
2203.7	**Home Delivered Meals**	Created a new section to add Home Delivered Meals and description of this service.
2203.7A	**Coverage and Limitations**	Created a new section detailing the specific provisions for the Home Delivered Meal service.
2203.7B	**Provider Responsibilities**	Created a new section detailing the requirements for the Home Delivered Meal providers.
2203.7C	**Recipient Responsibilities**	Created a new section to detail the specific recipient responsibilities for the Home Delivered Meal service.

utilizes a wait list to prioritize applicants who have been presumed to be eligible for the waiver.

Wait List Priority:

a. Applicants currently in an acute care or NF and desiring discharge;

b. Applicants who require maximum assistance and/or are dependent in all three areas of eating, bathing, and toileting;

c. Applicants requiring services due to a crisis or emergency such as a significant change in support system;

d. Applicants transitioning from another waiver;

e. Applicants with a terminal illness; or

f. Applicants who do not meet the criteria for priority levels 1-5.

Applicants may be considered for an adjusted placement on the wait list based on significant change of condition/circumstances.

2203.1B PROVIDER RESPONSIBILITIES

Providers are responsible for confirming the recipient's Medicaid eligibility each month prior to rendering waiver services.

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

2203.2 WAIVER SERVICES

The DHCFP determines which services will be offered under the HCBS Waiver. Providers and recipients must agree to comply with all waiver requirements for service provision.

2203.2A COVERAGE AND LIMITATIONS

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

1. Case Management.

2. Homemaker Services.

3. Chore Services.

4. Respite Care Services.

5. Home Delivered Meals.

~~5.~~6. Personal Emergency Response System (PERS).

~~6.~~7. Adult Day Care Services.

~~7.~~8. Adult Companion Services.

~~8.~~9. Augmented Personal Care (provided in a residential facility for groups).

2203.2B PROVIDER RESPONSIBILITIES

1. All Service Providers:

a. Must obtain and maintain a Medicaid provider number (Provider Type 48, 57, 58 Specialty Code 204 or 59 as appropriate) through the DHCFP's Fiscal Agent.

b. All providers must meet all federal, state, and local statutes, rules and regulations relating to the services being provided.

c. In addition to this Chapter, the provider must also comply with rules and regulations for providers as set forth in the MSM Chapter 100 Medicaid Program. Failure to comply with any or all these stipulations may result in the DHCFP's decision to exercise its right to terminate the provider's contract.

d. Must understand the authorized service specification on the POC, record keeping responsibilities and billing procedures for provided waiver services.

e. 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.

f. Must understand that payment for services will be based on the level of service or specific tasks identified on the POC and will not be made to legally responsible individuals for furnishing waiver services.

g. All providers may only provide services that have been identified in the POC and that, if required, have a Prior Authorization (PA).

h. Providers must verify the Medicaid eligibility status of each FE Waiver recipient each month.

1. Have the ability to read and write and to follow written or oral instructions;

2. Have had experience in providing for the personal care needs of people with functional impairments;

3. Demonstrate the ability to perform the care tasks as prescribed;

4. Be tolerant of the varied lifestyles of the people served; and

5. Provide training in personal hygiene needs and techniques for assisting with ADLs, such as bathing, grooming, skin care, transferring, ambulating, feeding, dressing and use of adaptive aids and equipment, homemaking and household care.

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

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

2203.6C RECIPIENTS RESPONSIBILITIES

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

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

2203.7 HOME DELIVERED MEALS

Home delivered meals are the provision of meals to persons at risk of institutional care due to inadequate nutrition. Home delivered meals include the planning, purchase, preparation and delivery or transportation costs of meals to a person's home. Recipients who require home delivered meals are unable to prepare or obtain nutritional meals without assistance or are unable to manage a special diet recommended by their physician.

2203.7A COVERAGE AND LIMITATIONS

1. Home delivered meals must be prepared by an agency and be delivered to the recipient's home.

2. Meals provided by or in a child foster home, adult family home, community based residential facility or adult day care are not included, nor is meal preparation.

3. The direct purchase of commercial meals, frozen meals, Ensure or other food or nutritional supplements is not allowed under this service category.

4. Home delivered meals are not intended to meet the full daily nutritional needs of a recipient. More than one provider may be used to meet a recipient's need.

5. Case managers determine the need for this service based on a Standardized Nutritional Profile, or assessment, and by personal interviews with the recipient related to individual nutritional status.

6. All meals must comply with the Dietary Guidelines for Americans published by the Secretaries of the Department of Health and Human Services (DHHS) and the United States Department of Agriculture; and provide a minimum of 33 1/3% of the current daily Recommended Dietary Allowances (RDA) as established by the Food and Nutrition Board, National Research Council of the National Academy of Sciences.

7. Nutrition programs are encouraged to provide eligible participants meals which meet particular dietary needs arising from health or religious requirements or the ethnic background of recipients.

2203.7B PROVIDER RESPONSIBILITIES

1. Meals are provided by governmental or community providers who meet the requirements of a meal provider under NRS 446 and who are enrolled with DHCFP as a Medicaid Provider.

2. Pursuant to NRS 446: All nutrition sites which prepare meals must have a Food Service Establishment Permit as follows

   a. All Nutrition Programs must follow the Health and Safety Guidelines established for Food and Drink Establishments in NAC, Chapter 446 or local health code regulations.

   b. All kitchen staff must hold a valid health certificate if required by local health ordinances.

   c. Report all incidents of suspected food borne illness to the affected recipients and local health authority within 24 hours and to the DHCFP District Office case manager by the next business day.

3. Provide proof of business license issued from the state of operation.

4. Provide documentation of taxpayer identification number.

5. The service must be prior authorized.

2203.7C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2203.2C, the recipient must:

1. The recipient must notify the Case Manager timely if they need to make any changes to their Home Delivered Meal Service.

2. The recipient must confirm with their Case Manager that they are receiving the authorized number of meals.

2203.~~7~~8 PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

PERS is an electronic device, which enables certain recipients at high risk of institutionalization to secure help in an emergency. The recipient may also wear a portable "help" button to allow for mobility. The system is connected to the recipient's phone and programmed to signal a response center once a "help" button is activated.

2203.~~7A~~8A COVERAGE AND LIMITATIONS

1. PERS services are limited to those recipients who live alone in a private residence, or who are alone for significant parts of the day in that residence, have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. The recipient must be physically and cognitively capable of using the device in an appropriate and proper manner.

2. The service component includes both, the installation of the device and monthly monitoring. Two separate authorizations are required for payment, the initial installation fee for the device and a monthly fee for ongoing monitoring; both are covered under the waiver.

3. The necessity for this type of emergency safety measure to prevent institutionalization will be identified in the assessment and included in the POC.

2203.~~7B~~8B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.2B, PERS Providers must:

1. Be responsible for ensuring that the response center is staffed by trained professionals at all times;

2. Be responsible for any replacement or repair needs that may occur and monthly monitoring of the device to ensure is working properly;

3. Utilize devices that meet Federal Communication Commission standards, Underwriter's Laboratory, Inc. (UL) standards or equivalent standards;

4. Inform recipients of any liability the recipient may incur as a result of the recipient's disposal of provider property.

2203.~~7C~~8C RECIPIENT RESPONSIBILITIES

1. The recipient is responsible to utilize the leased PERS equipment with care and caution and to notify the PERS provider and Case Manager if the equipment is no longer working.

2. The recipient must return the equipment to the provider when the recipient no longer needs or utilizes the equipment, when the recipient terminates from the waiver program or when the recipient moves from the area.

3. The recipient must not dispose or damage the PERS equipment. This is leased equipment and belongs to the PERS provider.

2203.~~8~~9 ADULT DAY CARE SERVICES

Adult Day Care services are provided in a non-institutional community-based setting, including outpatient settings. It encompasses social service needs to ensure the optimal functioning of the recipient.

It is provided on a regularly scheduled basis, in accordance with the goals in the recipient's POC.

2203.~~8A~~9A COVERAGE AND LIMITATIONS

1. The emphasis is on social interaction in a safe environment. The POC must indicate the number of days per week the recipient will attend.

2. Meals provided are furnished as part of the FE Waiver but must not constitute a "full nutritional regime" (i.e., three meals per day). Meals must be served in a manner suitable for the recipient and prepared with regard for individual preferences. Special diets and nourishments must be provided as ordered by the client's physician.

3. Service utilization and billing method (per diem/unit rate) will be prior authorized as indicated in the recipient's POC. The per diem rate is authorized when the recipient is in attendance for six or more hours per day, and the unit rate is authorized for attendance of a minimum of four hours and up to six hours per day. Providers must bill in accordance with the approved PA, even if the recipient occasionally attends less than six hours. If the recipient's overall pattern changes and consistently attends less than six hours a day, a change to the POC and PA will be required to update the service utilization and billing method.

4. Providers must not bill for days a recipient is not in attendance, even if it is a regularly scheduled day. Providers must keep attendance records for each recipient. Claims must reflect dates and times of service as indicated on the attendance records.

2203.~~8B~~9B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.2B, Adult Day Care Providers must:

Meet and maintain the service specifications as an adult day care provider as outlined in NAC 449 "Medical Facilities and other Related Entities."

2203.~~9~~10 ADULT COMPANION SERVICES

Adult Companion Services provides non-medical care, supervision and socialization to a functionally impaired recipient in his or her home or place of residence, which are furnished on a short-term basis or to meet the need for relief for the primary caregiver.

2203.~~9A~~10A COVERAGE AND LIMITATIONS

1. Adult companions may assist or supervise the recipient with tasks as meal preparation and clean up, light housekeeping, shopping and facilitate transportation/escort as needed. These services are provided as an adjunct to the Adult Day Care Services and must be incidental to the care and supervision of the recipient.

2. The provision of Adult Companion Services does not entail hands-on medical care.

3. This service is provided in accordance with the personalized goal in the POC and is not purely diversional in nature.

4. Transportation is not a covered service. Reference MSM Chapter 1900 Transportation Services for transportation policies.

2203.~~9B~~10B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.2B, Adult Companion Providers must:

1. Be able to read, write and follow written or oral instructions; and

2. Have experience or training in how to interact with recipients with disabling and various health conditions.

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

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

2203.~~9C~~10C RECIPIENTS RESPONSIBILITIES

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

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

2203.~~10~~11 AUGMENTED PERSONAL CARE

Augmented Personal Care (APC) provided in a licensed Residential Group Homes for Seniors or Assisted Living Facility is a 24-hour in home service that provides assistance for functionally impaired elderly recipients with basic self-care and ADLs that include as part of the service:

A. Homemaker Services;

B. Personal Care Services;

C. Chore Services;

D. Companion Services;

E. Therapeutic social and recreational programming;

F. Medication oversight (to the extent permitted under State Law); and

G. Services which will ensure that residents of the facility are safe, secure, and adequately supervised.

This care is over and above the mandatory service provision required by regulation for Residential Group Homes for Seniors and Assisted Living Facility.

2203.~~10A~~11A COVERAGE AND LIMITATIONS

1. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence; and provides supervision, safety, and security.

2. Once a FE Waiver recipient/applicant expresses an interest in a residential group setting, they are provided with a list of qualified providers. A case manager is available to provide additional information and guidance related to the individual's specific needs. Consideration may include size of the home, geographic location, proximity to friends and family, available support, activities, food, staff, other residents, likes and dislikes, medical

e. Designed to foster a social climate that allows the recipient to develop and maintain personal relationships with fellow residents and with persons in the general community.

f. Minimize the need for its recipients to move out of the facility as their respective physical and mental conditions change over time.

g. Foster a culture that provides a high-quality environment for the recipients, their families, the staff, any volunteers, and the community at large.

2203.~~10B~~11B AUGMENTED PERSONAL CARE PROVIDER RESPONSIBILITIES

In addition to the responsibilities listed in Section 2203.2B providers must:

1. Be licensed and maintain standards as outlined by, HCQC under NRS/NAC 449 "Medical and other related entities."

2. The provider for a Residential Group Homes or Assisted Living Facility must:

a. Notify the ADSD Case Manager within three business days when the recipient states the desire to leave the facility.

b. Participate with the ADSD Case Manager in discharge planning.

c. Notify the ADSD Case Manager within one working day if the recipient's living arrangements have changed, eligibility status has changed or if there has been a change in health status that could affect recipient's health, safety, or welfare.

d. Notify the ADSD of any incidents pertaining to a waiver recipient that could affect the health, safety, or welfare.

e. Notify the ADSD of any recipient complaints regarding delivery of service or specific staff of the setting. If the recipient is not satisfied with their living arrangements or services, the Case Manager will work with the recipient and the provider to resolve any areas of dissatisfaction. If the recipient makes the decision to relocate to another setting, the Case Manager will provide information and facilitate visits to other contracted settings.

f. Provide the ADSD with at least a 30-calendar days' notice before discharging a recipient unless the recipient's condition deteriorates and warrants immediate discharge. When the Case Manager is notified, they assist in relocation and working with staff on transfers/discharges.

g. Privacy, dignity, and respect are maintained during the provisions of services. Living units are not entered without permission.

a. Each provider must have a file for each recipient. In the recipient's file, the provider must have a copy of the current POC and maintain daily records, fully documenting the scope and frequency of services as specified on the POC.

The documentation will include the recipient's 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, indicating the designated representative or LRI. Recipients without an LRI can select an individual to act on their behalf by completing the Designated Representative Attestation Form. The Case Manager will be required to document the designated representative who can sign documents and be provided information about the recipient's care.

b. 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. 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.

c. Periodically, DHCFP and/or ADSD staff may request daily service documentation to compare it to submitted claims. These records must be maintained by the provider for at least six years after the date the claim is paid.

d. Services for waiver recipients residing in a Residential Facility for Groups and Assisted Living Facility should be provided as specified on the POC and at the appropriate authorized service level.

e. If fewer services are provided than what is authorized on the POC, the reason must be adequately documented in the daily record and communicated to the Case Manager.

2203.~~10C~~11C RECIPIENT RESPONSIBILITIES

1. Recipients are to cooperate with the providers of Residential Group Home for Seniors or Assisted Living Facility in the delivery of services.

2. Recipients are to report any problems with the delivery of services to the Residential Group Homes for Seniors or Assisted Living Facility administrator and/or ADSD Case Manager.

2201.~~11~~12 ADMINISTRATIVE CASE MANAGEMENT ACTIVITIES

Administrative case management activities are performed by ADSD case managers and refer to data collection for eligibility verification, LOC evaluation, POC development, and other case management activities that are not identified on the POC.

2203.~~11A~~12A COVERAGE AND LIMITATIONS

Administrative case management activities include:

1. Processing of Intake referrals;

2. Facilitating Medicaid eligibility, which may include assistance with the Medical Assistance to the Aged, Blind and Disabled (MAABD) application and obtaining documents required for eligibility determination;

3. Preliminary and ongoing assessments, evaluations and completion of forms required for service eligibility such as:

   a. Screening assessment for the LOC to determine if the individual has functional deficits and requires the level of service offered in a NF or a more integrated service that may be community-based.

   b. Development of the POC identifying the waiver services as well as other ongoing community support services that the recipient needs to live successfully in the community.

   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.

4. Request issuance of Notices of Decision (NOD) to the DHCFP LTSS when a waiver application is denied;

5. Coordination of care and services and collaboration in discharge planning to transition applicants;

6. Obtaining the necessary documentation for case files prior to applicant's eligibility;

7. Case closure activities upon termination of service eligibility;

8. Outreach activities to educate recipients or potential recipients on how to access into care and services through various Medicaid Program;

9. Distribution of the POC to all affected providers;

10. Ensure completion of PA form, if required, for all waiver services identified on the POC for submission into the Medicaid Management Information System (MMIS) Inter-Change.

2203.~~11B~~12B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in MSM Section 2203.2B Case Manager:

1. Must be currently licensed as a Social Worker by the State of Nevada Board of Examiners for Social Workers or as a Registered Nurse by the Nevada State Board of Nursing.

2. Must have a valid driver's license and the ability to conduct home visits.

3. Must adhere to HIPAA requirements.

4. Must have a Federal Bureau of Investigation (FBI) criminal history background check.

2203.~~11C~~12C RECIPIENT RESPONSIBILITIES

1. Applicant/recipients and/or their designated representative/LRI must cooperate with the ADSD by assisting with the assessment and reassessment process, accurately representing skill level needs, wants, resources and personalized goals.

2. Applicants/recipients and/or their designated representative/LRI together with the case manager must develop and/or review the POC.

2203.~~12~~13 INTAKE PROCEDURES

ADSD has developed policies and procedures to ensure fair and adequate access to the FE Waiver.

2203.~~12A~~13A COVERAGE AND LIMITATIONS

1. Referral

   a. A referral or inquiry for the FE waiver may be initiated by phone, mail, fax, in person, email or by an applicant or another party on behalf of the applicant.

   b. The ADSD intake specialist will make phone/verbal contact with the applicant/ designated representative/LRI within 15 working days from the referral date.

   c. If the applicant appears to be eligible, a face-to-face visit must be scheduled and completed within 45 calendar days from the referral date to assess eligibility including the NF LOC determination.

   If the ADSD intake specialist determines during the face-to-face visit the applicant does not appear to meet the FE waiver criteria financial eligibility, LOC, or waiver service need, the applicant will be referred to other agencies for any needed services or assistance.

The effective date for waiver services is determined by eligibility criteria verified by ADSD, and financial eligibility approval date by DWSS, and the residential facility for groups placement move in date, whichever is later.

If the applicant is in an institution, the effective date cannot be prior to the date of discharge from the institution.

9. Waiver Cost

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

2203.~~13~~14 ANNUAL WAIVER REVIEW

The DHCFP and ADSD have formal systems in place to conduct annual reviews. The purpose of the review is to assure the health and welfare of the recipients, the recipients' satisfaction with the waiver services and providers, the qualifications of waiver providers to deliver services/supports, and assurance of the cost effectiveness of these services.

2203.~~13A~~14A COVERAGE AND LIMITATIONS

The State conducts an annual review; collaboratively with the ADSD, with the DHCFP being the lead agency. The CMS has designated waiver assurances and sub-assurances which states must include as part of an overall quality improvement strategy. The annual review is conducted using the state specified performance measures identified in the approved FE waiver to evaluate operation.

The DHCFP:

1. Provides CMS annually with information regarding the impact of the waiver on the type, amount, and cost of services provided under the waiver and under the State Plan, and through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of the recipients served on the waiver;

2. Assures financial accountability for funds expended for HCBS Waiver services;

3. Evaluates that all provider standards are continuously met, and that the POCs are periodically reviewed to assure that the services furnished are consistent with the identified needs of the recipients;

4. Evaluates the recipients' satisfaction with the waiver using Personal Experience Survey (PES) conducted with a random sampling of the recipients to ensure waiver satisfaction. Interviews will be completed throughout the year; and

5. Further assures that all problems identified by this monitoring will be addressed by the provider in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

2203.~~13B~~14B PROVIDER RESPONSIBILITIES

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

2203.~~14~~15 ELECTRONIC VISIT VERIFICATION (EVV):

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

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

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

A. STATE OPTION:

1. The EVV system electronically captures:

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

   b. The individual receiving the service;

   c. The date of the service;

   d. The location where service is provided;

   e. The individual providing the service;

   f. The time the service begins and ends.

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

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

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

c. The recipient's landline telephone;

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

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

B. DATA AGGREGATOR OPTION:

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

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

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

2203.~~15~~16 PROVIDER ENROLLMENT

To become a Waiver provider, as a Provider Type (PT) 48, PT 57 or PT 59, providers must comply with all the DHCFP fiscal agents. Enrollment checklist and forms can be found on the fiscal agent's website at www.medicaid.nv.gov.

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

2203.~~16~~17 BILLING PROCEDURES

The DHCFP assures that claims for payment of waiver services are made only when a recipient is Medicaid eligible, when the service is included in the approved POC and PA is in place when required.

Refer to the Fiscal Agent's website at: www.medicaid.nv.gov for the Provider Billing Guide Manual.

2203.~~17~~18 ADVANCE DIRECTIVES

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