Medicaid Services Manual
Transmittal Letter

October 29, 2024

To: Custodians of Medicaid Services Manual

From: Casey Angres *Casey Angres* Casey Angres (Dec 9, 2024 11:39 PST)
Chief of Division Compliance

Subject: Medicaid Services Manual Changes
Chapter 2300 – Home and Community Based Services Waiver for Persons with Physical Disabilities

Background And Explanation

Revisions to Medicaid Services Manual (MSM) Chapter 2300 – Home and Community Based Services (HCBS) Waiver for Persons with Physical Disabilities (PD) are being proposed to add language to reflect Senate Bill (SB) 511 mandating providers to adhere to the wage requirements established by federal or state law or applicable Medicaid requirements for direct care workers. Additionally, a process to ensure providers comply with the wage requirements was added indicating the DHCFP Audit Unit will be conducting audits.

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: None.

Financial Impact on Local Government: Unknown at this time.

These changes are effective November 1, 2024.

Material Transmitted	Material Superseded
MTL 21/24 MSM Chapter 2300 Home and Community Based Services Waiver for Persons with Physical Disabilities	MTL 10/23 MSM Chapter 2300 Home and Community Based Services Waiver for Persons with Physical Disabilities

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2303.5B(4)	**Provider Responsibilities**	Language added to align with SB511 wage requirements.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2303.6B(5)		Language added to align with SB511 wage requirements.
2303.7B(6)		Language added to align with SB511 wage requirements.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
TABLE OF CONTENTS

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

2300 INTRODUCTION

The Home and Community Based Services (HCBS) Waiver for Persons with Physical Disabilities (PD Waiver) recognizes many individuals are at risk of being placed in hospitals or Nursing Facilities (NF) can be cared for in their homes and communities, preserving their independence and ties to family and friends at an average cost no higher than that of institutional care.

The PD Waiver is an optional service approved by the Centers for Medicare and Medicaid Services (CMS), which authorizes the Division of Health Care Financing and Policy (DHCFP) the flexibility to design this waiver and select a mix of waiver services based on the identified needs and is designed to provide eligible Medicaid waiver recipients access to both State Plan Services and certain extended Medicaid covered services.

Nevada acknowledges that persons with disabilities can lead satisfying and productive lives, when they are provided the needed services and supports to do so.

2301 AUTHORITY

Section 1915(c) of the Social Security Act (SSA) permits states the option to waive certain Medicaid statutory requirements in order to offer an array of home and community-based services to eligible individuals who may require such services in order to remain in their communities and avoid institutionalization.

Statutes and Regulations

- SSA: 1915(c) (HCBS)
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Nevada Revised Statutes (NRS) Chapters, 200 (Crimes Against the Person), 426 (Persons with Disabilities), 427A (Services to Aging Persons and Persons with Disabilities), 422 (Health Care Financing and Policy), 449 (Medical and Other Related Facilities), 616 (Industrial Insurance), 706 (Motor Carriers), and 446 (Food Establishments)
- NRS 449A.114 – Patient Notification of Intent to Transfer
- 21st Century Cures Act, H.R. 34, Sec. 12006 – 114th Congress
- Section 3715 of The Coronavirus Aid, Relief, and Economic Security (CARES) Act
- 42 CFR 435.540 – Definition of Disability
- 42 CFR 441.301(c)(1) through (c)(5) – Federal Person-Centered Planning and Settings Requirements

2302 RESERVED

2303 POLICY

2303.1 WAIVER ELIGIBILITY CRITERIA

The PD Waiver waives certain statutory requirements and is offered to eligible recipients to assist them to remain in their own homes or community.

Eligibility for the PD Waiver is determined by DHCFP, Aging and Disability Services Division (ADSD), and the Division of Welfare and Supportive Services (DWSS):

A. Each applicant/recipient must meet and maintain a Level of Care (LOC) for admission into an NF and would require imminent placement in an NF (within 30 days or less) if HCBS or other supports are not available.

B. The applicant must have a physical disability as determined by the DHCFP Physician Consultant. For the disability determination process refer to Section 2303.1B.

C. Each applicant/recipient must demonstrate a continued need for the services offered under the PD Waiver to prevent placement in an NF or hospital. Utilization of State Plan Services only does not support the qualifications to be covered by the waiver.

D. Each applicant/recipient must require the provision of at least one ongoing waiver service monthly.

E. Each applicant/recipient must have an adequate support system. This support system must be in place to ensure the physical, environmental, and basic care needs of the applicant/recipient are met to provide a safe environment during the hours when HCBS are not being provided.

F. Applicants may be placed from an NF, acute care facility, another HCBS program, or the community.

G. Applicants must meet Medicaid financial eligibility as determined by DWSS initially and for redetermination.

2303.1A COVERAGE AND LIMITATIONS

1. Services are offered to eligible recipients who, without the waiver services, would require institutional care (provided in a hospital or NF) within 30 days or less.

2. Recipients on the waiver must meet and maintain Medicaid's eligibility requirements for the waiver for each month in which waiver services are provided.

3. Services shall not be provided and will not be reimbursed until the applicant/recipient is found eligible for waiver services. Services must be prior authorized.

4. If an applicant is determined to be eligible for more than one HCBS Waiver, the individual cannot receive services under two or more such programs at the same time. The applicant must choose one HCBS Waiver and receive services provided by that program.

5. Recipients of the HCBS Waiver who are enrolled or elect to enroll in a hospice program may be eligible to remain on the waiver if they require waiver services to remain in the community. Close coordination between the hospice agency and the case manager is required to prevent any duplication of services. Refer to Medicaid Services Manual (MSM) Chapter 3200 for additional information on hospice services.

6. Waiver services may not be provided while a recipient is an inpatient of an institution. Section 3715 of the CARES Act may be utilized where HCBS can be provided in an acute care hospital setting as long as those services are:

   a. Identified in an individual's person-centered plan (referred to throughout this chapter as the Plan of Care (POC);

   b. Provided to meet needs of the individual that are not met through the provision of hospital services;

   c. Not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and

   d. Designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functional abilities.

7. The PD Waiver is limited by legislative mandate to a specific number of recipients who can be served through the waiver per year (slots). When no waiver slots or case management providers are available, the ADSD utilizes a waitlist to prioritize applicants who have been presumed to be eligible for the waiver.

8. DHCFP must assure the Center for Medicare and Medicaid Services (CMS) that DHCFP's total expenditure for home and community-based and other State Plan Medicaid services for all recipients under this waiver will not, in any calendar/waiver year, exceed 100% of the amount that would be incurred by DHCFP for all these recipients if they had been in an institutional setting in the absence of the waiver. DHCFP must also document there are safeguards in place to protect the health and welfare of recipients.

2303.1B DISABILITY DETERMINATION PROCESS

The disability determination process is completed as follows:

1. Request and receive necessary medical evidence from the applicant's acceptable medical sources. Supporting documentation containing sufficient evidentiary information (medical, psychological, and applicable vocational and/or social information) to determine disability.

   Although the ADSD Intake Specialist will assist the applicant in obtaining medical records, each individual is responsible for providing medical evidence showing that they have a physical impairment as well as the severity of the impairment.

2. The applicant must provide acceptable medical evidence demonstrating a physical disability warranting the services needed, which may include one or more of the following:

   a. Primary care office visit notes;

   b. Clinical findings including medical history, diagnosis, physical, and/or discharge summary; and

   c. Treatment and prognosis.

   d. Copies of medical evidence from hospitals, clinics, or other health facilities where an individual has been treated.

3. All medical reports received are considered during the disability determination.

4. Acceptable Medical sources include:

   a. Licensed physicians (medical or osteopathic doctors), Advanced Practice Nurse (APRN), or Physician Assistant (PA/PA-C);

   b. Licensed optometrists, for purposes of establishing visual disorders only;

   c. Licensed podiatrists, for purposes of establishing impairments of the foot, or foot and ankles, depending on whether the state in which the podiatrist practices permit practice of podiatry on the foot only, or the foot and ankle.

5. The DHCFP Physician Consultant will review the application and determine eligibility based on the most recent edition of Disability Evaluation under Social Security Disability Standards within five business days.

6. Once the disability determination decision has been made by DHCFP, the ADSD Intake Unit must be notified of the decision via the HCBS Waiver Eligibility Status Form within ten business days from the date of the request.

7. The DISA screen located in the NOMADS system cannot be accepted as proof of disability.

NOTE: In the event the DHCFP Physician Consultant determines that the applicant does not meet the physical disability criteria, the DHCFP LTSS Unit will issue a NOD to the applicant indicating "The service(s) is/are not substantiated as medically necessary. Contact your Medicaid provider as there may be additional documentation to submit to demonstrate a medical necessity."

2303.1C APPLICANT/RECIPIENT RESPONSIBILITIES

1. Applicants/recipients must meet and maintain all criteria to become eligible and remain on the PD Waiver.

2. Applicants and/or their designated representative/LRI must:

   a. Participate and cooperate with the Intake Specialist during the intake process;

   b. Provide medical records within 30 days of request; and

   c. Complete and sign all required waiver forms.

2303.2 WAIVER SERVICES

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.

2303.2A COVERAGE AND LIMITATIONS

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

1. Case Management;

2. Homemaker Services;

3. Respite;

4. Attendant Care Services;

5. Assisted Living (AL) Services;

6. Chore Services;

7. Environmental Accessibility Adaptations (EAA);

8. Home Delivered Meals;

9. Personal Emergency Response System (PERS);

10. Specialized Medical Equipment and Supplies;

2303.2B PROVIDER RESPONSIBILITIES

1. Must obtain and maintain a provider number (Provider Type (PT) 58) through DHCFP's Fiscal Agent

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

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

4. Provider Termination of Waiver Services

   a. The provider may terminate direct waiver services without notice for any of the following reasons:

      1. The recipient or another person in the household subjects the provider to physical or verbal abuse, sexual harassment and/or exposure to the use of illegal substances, illegal situations, or threats of physical harm;

      2. The recipient's Medicaid eligibility is found ineligible for waiver services;

      3. The recipient requests termination of services;

      4. The place of service is considered unsafe for the provision of waiver services;

      5. The recipient refuses services offered in accordance with the approved POC;

      6. The recipient is non-cooperative in the establishment or delivery of services, including the refusal to sign required forms;

      7. The provider is no longer able to provide services as authorized;

      8. The recipient requires a higher level of care that cannot be met by the waiver service;

      Note: A provider's inability to provide services for a specific recipient does not constitute termination or denial from the HCBS Waiver program. The recipient may choose another provider.

b. Notification Requirements

As appropriate, the provider must notify the recipient and/or designated representative/LRI and agencies of the date when services are to be terminated. The case manager should be notified thirty calendar days prior to the date services will be terminated. The basis for the action and the intervention/resolution(s) attempted must be documented prior to terminating services.

The provider is not required to send a written notice if the recipient has chosen to terminate services.

5. Discontinuation of Direct Waiver Service Provider Agreement

If a provider decides to discontinue providing waiver services for any reason not listed in 2303.2B(4) – Provider Termination of Waiver Services, the provider shall:

a. Provide the recipient with written notice at least 30 calendar days in advance of service discontinuation;

b. Provide the recipient's case manager with a copy of the written notice of intent to discontinue services, including a list of the affected recipients, at least 30 calendar days in advance of service discontinuation; and

c. Continue to provide services through the notice period or until all recipients are receiving services through another provider, whichever occurs sooner.

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

7. Flexibility of Service Delivery

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

8. 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.

9. Must understand that payment for services will be based on the level of service or specific tasks identified on the POC.

10. Legally Responsible Individuals (LRI) may be paid to provide activities that family caregivers would not ordinarily perform or are not responsible for performing. Additional dependence on LRIs is above the scope of normal daily activities such as assistance in bathing, dressing, and grooming, toileting, and with specialized medical care needs.

    LRIs may furnish attendant care, homemaker, respite, and chore services (refer to the direct waiver service type throughout this chapter for additional limitations). It must be the recipient's choice for the LRI to provide the services, which is achieved through the person-centered POC development.

    a. LRIs cannot provide State Plan PCS in conjunction with any of the waiver services. State Plan PCS does not allow payment of LRIs.

    b. The LRI must be an employee of a provider agency or Intermediary Service Organization (ISO) as a PT 58 with Specialty Code(s) 189, 039, 191, and/or 199.

    c. LRIs must utilize an Electronic Visit Verification (EVV) system for check in/check out.

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

12. Must have a backup mechanism to provide the recipient with their authorized service hours in the absence of a regular caregiver due to sickness, vacation, or any other unscheduled event.

    The provider must notify the recipient's case manager if there is a change in the established back-up plan.

13. Sign and date the finalized POC within 60 calendar days from waiver enrollment. If a service has been included on the POC and there is no provider assigned, the signature would not be required until the provider is selected by the individual and would be required by the next face-to-face visit.

14. Serious Occurrence Report (SOR):

    All direct waiver service providers are required to report a SOR within 24 hours of discovery. A written report must be submitted to the assigned case manager within five business days of the incident. All providers are required to maintain a copy of the reported SOR in the recipient's record. It is the provider's responsibility to understand the proper

reporting method to the assigned case management provider and participate with any requested follow-up timely.

Reporting of a SOR can be in paper form or electronic format which is accessible to all direct waiver service providers, public and State staff via the DHCFP's public website and the DHCFP Fiscal Agent's website. The process for reporting incidents will vary depending on the case management provider. The direct waiver service providers are responsible to know who the case manager is and the proper form of submission.

Due to the different databases utilized by case management providers, the process for submitting a SOR are as follows:

a. Public ADSD Case Management:

Providers must complete the web-based Nevada DHCFP SOR form, available at the Fiscal Agent's website (https://www.medicaid.nv.gov), under Providers - Forms. Upon receipt of the submitted electronic SOR, the ADSD case manager will perform the necessary follow-up.

b. Private Case Management (PCM):

Providers must complete the paper Nevada DHCFP SOR form, available at the Fiscal Agent's website (https://www.medicaid.nv.gov), under Providers - Forms. The completed SOR form must be submitted to the DHCFP LTSS inbox at hcbs@dhcfp.nv.gov. The paper form will be re-routed to the PCM agency who will enter the SOR in their database and perform the necessary follow-up.

Serious occurrences involving either the provider/employee or recipient may include, but are not limited to the following:

1. Suspected physical or verbal abuse;

2. Unplanned hospitalization;

3. Abuse, neglect, exploitation, isolation, abandonment, or unexpected death of the recipient;

4. Injuries requiring medical intervention;

5. Sexual harassment or sexual abuse;

6. Theft;

7. An unsafe living environment;

8. Elopement of a recipient;

9. Medication errors resulting in injury, hospitalization, medical treatment or death;

10. Death of the recipient while enrolled in the HCBS Waiver program;

11. Loss of contact with the recipient for three consecutive scheduled days;

12. Any event which is reported to the Division of Child and Family Services (DCFS) or the appropriate county agency (under 18 years old), Adult Protective Services (APS) (18 years old and above), or law enforcement agencies.

The State of Nevada has established mandatory reporting requirements of suspected incidents of abuse, neglect, isolation, abandonment, and exploitation. APS, DCFS and/or local law enforcement are the receivers of such reports. Suspected abuse must be reported as soon as possible, but no later than 24 hours after the person knows or has reasonable cause to believe that a person has been abused, neglected, isolated, abandoned or exploited. Refer to NRS 200.5091 to 200.50995 "Abuse, neglect, exploitation, abandonment, or isolation of older and vulnerable persons."

15. Criminal Background Checks

DHCFP policy requires all direct waiver service providers and its personnel, including owners, officers, administrators, managers, employees, and consultants to undergo State and Federal Bureau of Investigation (FBI) background checks upon licensure and then at a minimum of every five years thereafter to ensure no convictions of applicable offenses have been incurred. For complete instructions, refer to the Division of Public and Behavioral Health (DPBH) website at https://dpbh.nv.gov.

DHCFP's Fiscal Agent will not enroll any provider agency whose owner or operator has been convicted of a felony under State or Federal law for any offense which DHCFP determines is inconsistent with the best interest of recipients. Additional information may be found in MSM Chapter 100 – Medicaid Program.

16. Recipient Records

a. The number of units specified on each recipient's POC, for each specific service will be considered the maximum number of units allowed to be provided by the caregiver and paid by DHCFP's Fiscal Agent, unless the case manager has approved an increase in service due to a temporary condition or circumstance.

b. Cooperate with DHCFP, ADSD, and/or State or Federal reviews or inspections of the records.

c. Provider agencies who provide waiver services in the home must comply with the 21st Century CURES Act. Refer to section 2303.14 of this chapter for detailed information.

17. Adhere to Health Insurance Portability and Accountability Act (HIPAA) requirements. Refer to MSM Chapter 100 for information on HIPAA, privacy and confidentiality of recipient records, and other protected health information.

18. Obtain and maintain a business license as required by city, county, or state government, if applicable.

19. Providers must obtain and maintain required Health Care Quality and Compliance (HCQC) licensure, if required.

20. Qualifications and Training:

a. All service providers must arrange training for employees who have direct contact with recipients of the PD Waiver and must have service specific training prior to performing a waiver service. Training at a minimum must include, but is not limited to:

1. Policies, procedures, and expectations of the agency relevant to the provider, including recipient and provider rights and responsibilities;

2. Record keeping and reporting including daily records and SORs;

3. Information about the specific needs and goals of the recipients to be served;

4. Interpersonal and communication skills and appropriate attitudes for working effectively with recipients to include; understanding care goals; respecting recipient rights and needs; respect for age, cultural and ethnic differences; tolerant of the varied lifestyles of the people served, recognizing family relationships; confidentiality; and abuse. Neglect, and exploitation, including signs, symptoms, and prevention; respecting personal property; ethics in dealing with the recipient, family, and other providers; handling conflict and complaints; and other topics as relevant; and

5. Paid and unpaid staff must receive one hour of training related to the rights of the rights of the individual receiving services and individual experience as outlined in the HCBS Final Regulation.

2303.2C RECIPIENT RESPONSIBILITIES

The recipient, or if applicable, the recipient's designated representative/LRI will:

1. Notify the provider(s) and case manager of any change in Medicaid eligibility, upon discovery;

2. Notify the direct service provider(s) and DWSS of current insurance information, including the name of the insurance coverage, such as Medicare;

3. Notify the direct service provider(s) and case manager of changes in medical status, support systems, service needs, address, or location changes, and/or any changes in status of designated representative/LRI.

4. Treat all providers and staff members appropriately. Provide a safe, non-threatening and healthy environment for caregiver(s) and the case manager(s);

5. 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;

6. Notify the provider and case manager when scheduled visits cannot be kept or services are no longer required;

7. Notify the provider agency or case manager of any missed appointments by the provider agency staff;

8. Notify the provider agency or case manager of any unusual occurrences, complaints regarding delivery of services, specific staff, or to request a change in caregiver or provider agency ;

9. Furnish the provider agency with a copy of their Advance Directive if appropriate;

10. Work with the provider agency to establish a back-up plan in case the caregiver is unable to work at the scheduled time, and report to the case manager if there is a change to the established back-up plan;

11. Not request a provider to work more than the hours authorized in the POC;

12. Understand that a provider may not work or clean for a recipient's family, household members or other persons living in the home with the recipient;

13. Not request a provider to perform services not included in the POC;

14. Contact the case manager to request a change of provider agency;

15. Complete, sign, date and submit all required forms within ten calendar days;

16. Understand that at least one annual face-to-face visit is required;

17. Be physically available for authorized waiver services, face-to-face visits, and assessments.

18. Agree to utilize an approved Electronic Visit Verification (EVV) system for the waiver personal care like services being received from the provider agency; and

19. Confirm services were provided by electronically signing or initialing, as appropriate per POC, the EVV record that reflects the service rendered. If Interactive Voice Response (IVR) is utilized, a vocal confirmation is required.

20. Actively participate in the development of the POC which allows the recipient to make informed choices.

2303.3 INTAKE ACTIVITIES

Intake activities are a function of the ADSD Operations Agency and occur prior to an applicant being determined eligible for a waiver.

2303.3A COVERAGE AND LIMITATIONS

1. Intake Referral Process

ADSD Operations Agency has developed policies and procedures to ensure fair and adequate access to services covered under the PD Waiver. All new referrals will be submitted to the ADSD Intake Unit for evaluation and processing.

a. Referral/Application

1. A referral for the PD waiver may be initiated by completing an ADSD Program Application and submitting it to the appropriate ADSD District Office by mail, email, fax, or in person by the applicant and/or designated representative/LRI.

Note: An inquiry for the PD Waiver may be made via phone, mail, email, fax or in person through any ADSD District Office. An inquiry is not considered an application for the PD Waiver and does not initiate the application process.

2. When an application is received and assigned, the ADSD Intake Specialist will make phone/email/verbal contact with the applicant and/or designated representative/LRI within 15 working days of receipt of the application.

   During the initial phone/email/verbal contact, the applicant is advised they have 30 calendar days to gather medical records demonstrating their physical disability in order to continue the application process.

3. Once medical records have been received, a face-to-face visit is scheduled by the ADSD Intake Specialist within 45 days of the application date to assess the LOC and complete all necessary intake forms. The LOC assessment will determine the applicant's eligibility for waiver services and placement on the waitlist, if appropriate.

4. If the applicant is determined to meet NF LOC criteria, ADSD will provide medical records and LOC determination to DHCFP LTSS for the disability determination. Refer to MSM 2303.1B for more information on the disability determination process.

5. If the applicant does not meet the waiver requirements, the applicant must be sent a Denial NOD issued by the DHCFP LTSS Unit, and verbally informed of the right to continue the Medicaid application process through DWSS. The applicant will also be referred to other agencies and community resources for services and/or assistance.

2. Placement on the Wait List when No Waiver Slot is Available

   a. If no Waiver slot is available, and the ADSD Intake Specialist has determined the applicant meets NF LOC, and has a Waiver service need, the applicant will be placed on the wait list according to priority and referral date.

      Wait List Priority:

      Level 1 Applicants previously in a hospital or NF and who have been discharged to the community within six months and have a significant change in support systems and are in a crisis situation;

      Level 2: Applicants who have a significant change in support systems and/or are in a crisis situation and require at least maximum assistance in a combination of four or more of the following ADLs: eating, bathing, toileting, transfers, and mobility;

Level 3: Applicants who have a significant change in support system and/or are in a crisis situation and require assistance with a combination of five or more of the following ADLs as identified on the LOC screening: medication administration, special needs, bed mobility, transferring, dressing, eating and feeding, hygiene, bathing, toileting, and locomotion;

Level 4: Applicants who do not meet the criteria for priority levels 1-3.

b. Applicants may be considered for an adjusted placement on the waitlist based on a significant change of condition/circumstances.

c. A denial NOD is sent to applicants who are placed on the waitlist indicating "no slot available" and will indicate the applicant's priority level on the waitlist.

3. Waiver Slot Allocation

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

The procedure used for processing an applicant is as follows:

a. The ADSD Intake Specialist will work with the applicant to complete any paperwork that was not collected during the initial assessment.

b. The applicant/designated representative/LRI must understand and agree that personal information may be shared with providers of services and others, as specified on the form.

c. The applicant will be given the right to choose waiver services in lieu of placement in a NF. If the applicant /designated representative/LRI prefers placement in a NF, the ADSD Intake Specialist will provide information and resources to the applicant on who to contact to arrange facility placement.

d. The applicant will be given the right to request a Fair Hearing if not given a choice between HCBS Waiver services and NF placement.

4. The ADSD Intake Specialist will send the NMO-3010 "HCBS Waiver Eligibility Status Form" to DWSS for review and approval of the Medicaid application.

5. Once DWSS has approved the application, waiver services can be initiated.

Note: If an applicant is denied for financial eligibility, DWSS will send a denial NOD to the applicant.

6. If the applicant is denied by ADSD for program eligibility, ADSD will submit a request to the DHCFP LTSS Unit requesting a denial NOD be sent to the applicant. The request must include the reason(s) for the denial. The DHCFP LTSS Unit will send the applicant the denial NOD. DHCFP will return a copy of the NOD to ADSD for their record.

7. Effective Date for Waiver Services

   The effective date for waiver services is determined by eligibility criteria verified by ADSD, the financial eligibility approval date by DWSS, or 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.

8. All applicants as applicable will be provided information regarding choice of case management providers by the ADSD Intake Specialist during the initial assessment and allowed the opportunity to choose a case management provider to be assigned once approved for waiver services. If a case management provider is not selected by the applicant/recipient, upon waiver approval one will be assigned by the ADSD Operations Agency based upon rotation and geographical location.

   Once an applicant has been approved and a case management provider is assigned, the ADSD Intake Specialist will forward all supporting documents within five business days to that provider for ongoing case management services.

   Supporting documents include a signed and dated SOC, a signed and dated HCBS Acknowledgement Form, copy of the ADSD Program Application, copy of the LOC, copy of the Disability Determination indicated on the NMO-3010, any supporting medical records, any notes from the Intake Specialist needed to support ongoing services, and a copy of the MAABD application submitted to DWSS.

   Note: If a case management provider is not selected within ten business days by the applicant, one will be assigned by the ADSD Operations Agency based upon a rotation schedule and provider capacity.

2303.4 CASE MANAGEMENT

Case Management services assist participants in gaining access to needed waiver and other state plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services to which access is gained.

2303.4A COVERAGE AND LIMITATIONS

Case managers must provide the recipient with the appropriate amount of case management services necessary to ensure the recipient is safe and receives sufficient services. The case management service is on an as needed basis. 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.

1. Case management is provided to eligible recipients enrolled in HCBS Waiver programs and must be identified as a service on the POC. Case management providers are responsible for confirming the recipient's eligibility each month prior to rendering waiver services. The recipient has a choice of case management providers who are actively enrolled with DHCFP under Provider Type (PT 58).

   There are two components of case management services: administrative activities, and those activities that are considered billable:

   Administrative activities include:

   a. Travel

   b. Follow-up conducted resulting from a negative Participant Experience Survey (PES) finding.

   c. Request a NOD when a negative action is taken (denial, suspension, termination, and reduction of services).

   d. Activities related to program eligibility including denials/Fair Hearings.

   e. Activities related to coordination of care for recipients in a suspended status.

   f. General administrative tasks including but not limited to scheduling of visits, voicemails, email communications with DHCFP, scanning and uploading documents, mailing provider lists and/or resources to recipient, telephoning providers for general availability, and outreach activities for solicitation.

2. Billable case management activities include:

   a. Completion of the SHA and LOC with the recipient (annual reassessment of eligibility and any change of condition).

   b. POC development and follow-up for initiation of waiver services, including any activity related to the Prior Authorization (PA) requests approval and/or follow-up.

c. POC monitoring/follow-up (includes provider changes, a change in services/delivery, change in condition resulting in an amended POC, etc.).

d. Any mandated reporting activity (APS, HCQC, Law Enforcement, etc.)

e. Direct contact with recipients to aid in resource navigation, facilitation, and coordination with waiver and community resources.

f. Care Conference: collaboration and involvement in discharge planning from a long-term care setting; interdisciplinary meetings; collaboration with other entities on shared cases; coordination of multiple services and/or providers based on the identified needs in the SHA.

g. Monitoring the overall provision of waiver services, to protect the health, welfare, and safety of the recipient and to determine that the POC goals are being met.

h. Monitoring and documenting the equality of care through contacts with recipients.

i. Ensuring that the recipient retains freedom of choice in the provision of services.

j. Notifying all affected providers of changes in the recipient's medical status, service needs, address, and location, or of changes of the status of the designated representative/LRI.

k. Notifying all affected providers of any unusual occurrence or change in status of a waiver recipient.

l. Notifying all affected providers of any recipient complaints regarding delivery of service or specific provider staff.

m. Notifying all affected providers if a recipient requests a change in the provider staff or provider agency.

n. Any adverse actions resulting in suspensions, terminations and/or reductions in services.

3. Upon assignment of an HCBS PD Waiver recipient, the case manager is responsible for conducting a face-to-face Social Health Assessment (SHA) and is used for the following:

a. Address the recipient's needs, preferences, and individualized goals.

b. Address ADLs, IADLs, service needs, and support systems.

c. Gathering information regarding health status, medical history, and social needs.

d. Consider risk factors, equipment needs, behavioral status, current support system, and unmet service needs.

e. Ensures recipients are afforded the same access to the greater community as individuals who do not receive Medicaid HCBS, regardless of where they reside.

f. Ensures recipients are afforded employment opportunities as desired, regardless of where they reside.

4. 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.

If the recipient chooses to have a designated representative/LRI, they must complete the Designated Representative Attestation form. The case manager is required to document the designated representative/LRI who can sign documents and be provided information about the recipient's care.

a. 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 and:

1. Reflect that the setting in which the recipient resides was chosen by the recipient;

2. Reflect opportunities to participate in integrated community settings, and seek employment or volunteer activities;

3. Reflect the recipient's strengths and preferences, and cultural considerations of the recipient;

4. Include 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;

5. Reflect risk factors and measures in place to minimize them, including back-up plans and strategies;

6. Be understandable to the recipient receiving the services and supports; and

7. Prevent the provision of unnecessary, duplicative, or inappropriate services and supports.

b. 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.

Note: During the POC development, if the recipient chooses an LRI to provide personal care-like services, the case manager will provide a Designated Representative Attestation form to be signed by the recipient and/or the designated representative/LRI (who is NOT the paid caregiver) to guard against self-referral of LRIs. The designated representative/LRI indicated on the form is responsible for directing, monitoring, and supervising the provision of services by the caregiver.

c. 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.

1. During the initial or annual POC development, and there is no chosen direct waiver provider, the service must still be listed on the POC to include the other elements with the provider as "to be determined (TBD)" and must be signed and dated by the recipient and/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.

2. Once a provider has been selected, the POC must be updated to list the provider, along with signatures and date from the recipient and/or designated representative/LRI and provider during the next face-to-face visit.

d. The POC must include the recipient's chosen method and frequency of scheduled contacts (refer to section 2303.4A.4 – Person-Centered contacts for further information on frequency).

e. Changes to the POC

1. If there is a significant 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.

2. The POC does not need to be revised when a recipient's waiver service needs change due to a temporary condition or circumstance lasting eight weeks or less. The case manager must document the change in the electronic case record.

3. 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.

    a. The POC with the handwritten changes/amendments containing the recipient and case manager's signature and date must be attached to the formalized POC and kept in the recipient's electronic case file.

    b. A copy of the formalized POC and signed handwritten POC must be provided to the recipient and/or designated representative/LRI.

f. 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.

g. The case manager is responsible to distribute the section of the POC which pertains to the specific waiver provider including the scope, frequency, duration, method of service delivery, the recipient's identified goals, and risk factors and mitigation.

h. Residential and Non-Residential Facilities (Assisted Living Facilities only)

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.

The case manager must document the following requirements on the POC:

1. Identify a specific and individualized assessed need;

2. Document the positive interventions and supports used prior to any modification to the POC;

3. Document less intrusive methods of meeting the need that have been tried but did not work;

4. Include a clear description of the condition that is directly proportionate to the specific assessed need;

5. Include regular collection and review of data to measure the ongoing effectiveness of the modification;

6. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;

7. Include an assurance that interventions and supports will cause no harm to the individual; and

8. Include the informed consent of the individual.

5. Person-Centered Contacts

a. 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.
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.

b. Person-centered contacts must be documented in the recipient's electronic record and must include at a minimum:

1. Monitoring of the overall provision of waiver services and determine that the personalized goals identified in the POC are being met.

2. Monitoring and documenting the quality of care to include assurance that the health and safety of the recipient is maintained:

a. Quality of care includes 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.

b. If a recipient resides in a residential setting (AL facility), the case manager must inquire on the recipient's satisfaction in the residential setting.

3. 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.

4. 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.

6. Annual Reassessments

a. The recipient's LOC and SHA must be reassessed at a minimum annually.

1. Once the case manager has completed the reassessment including the LOC, SHA and POC, the case manager will submit the completed LOC to the ADSD Operations Agency for approval.

2. Once received by the ADSD Operations Agency, a review of the LOC will be conducted, and a decision will be supplied to the case manager provider within five business days.

3. Upon receipt of the approval from the ADSD Operations Agency, the case manager will complete the PA process for continued services.

4. If the ADSD Operations Agency determines the LOC is not approved, communication will be delivered to the case management provider within five business days identifying the outcome and the next steps as appropriate.

b. The POC is updated using the SHA which is completed in collaboration with the case manager and the recipient and/or designated representative/LRI, and/or person of their choosing, who may not be the paid caregiver.

c. The annual POC is required to be signed no more than 60 calendar days from the date of the reassessment.

7. The case manager may provide support to the recipient and/or designated representative/LRI by assisting with the completion of the DWSS Annual Redetermination (RD).

8. Ensure recipients retain freedom of choice in the provision of services. During the ongoing contact with the recipient the case manager must narrate if a recipient indicates that they are not satisfied with their current waiver services;

9. Notifying all affected providers of any unusual occurrences or changes in the recipient's medical status, service needs, address, or designated representative LRI;

10. Notifying all affected providers of any recipient complaints regarding delivery of service or specific provider staff;

11. Notifying all affected providers if a recipient requests a change in the provider staff or provider agency.

12. Case closure activities upon termination of service eligibility, to include notifying DWSS and DHCFP LTSS, and closing any existing prior authorizations.

13. If an ongoing recipient chooses to change case management providers, they may request this by contacting the ADSD Operations Agency as outlined in the SOC. The ADSD Operations Agency will provide the recipient with a list of case management providers for them to choose from. If a new case management provider is not chosen within ten calendar days, the currently assigned case manager will continue to provide the service.

    a. Upon provider selection by the recipient and/or designated representative/LRI, the Operations Agency will notify the selected case management provider agency of the assignment.

    b. The previous case management agency will be given ten business days to provide all requested documentation to the ADSD Operations Agency to assist with the transfer of the recipient to the chosen case management provider.

    c. The new case management provider agency must be reflected on the POC which is required to be signed during the next face-to-face visit.

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

2303.4B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2303.2B:

1. Public case managers must meet the following qualifications:

    a. Be currently licensed as a Social Worker by the State of Nevada Board of Examiners for Social Workers, licensure as a RN by the Nevada State Board of Nursing or have a professional license or certificate in a medical specialty applicable to the assignment.

    b. Have a valid driver's license and means of transportation to enable face-to-face visits.

c. Adhere to HIPAA requirements.

d. Complete an FBI criminal background check.

2. Private case management provider agencies must:

a. Provide documentation showing taxpayer identification number (SS-4 or CP575 or W-9).

b. Provide proof of Nevada Secretary of State Business license

c. Provide proof of Worker's Compensation Insurance

d. Provide proof of an Unemployment Insurance Account

e. Provide proof of Commercial General Liability of not less than $2 million general aggregate and $1million each occurrence, with the Nevada DHCFP named as an additional insured. DHCFP's address is 1100 E. William St., Ste. 101, Carson City, Nevada 89701.

f. Provide proof of Commercial Crime Insurance for employee dishonesty with a minimum of $25,000 per loss. The policy must name DHCFP as an additional insured.

g. If you provide transportation in any owned, leased, hired and non-owned vehicles you must also provide:

1. Proof of Business Automobile Insurance, with a minimum coverage of $750,000 combined single limit for bodily injury and property damage for any owned, leased, hired and non-owned vehicles used in the performance of the Medicaid provider's contract. The policy must name DHCFP as an additional insured and shall be endorsed to include the following language: "The State of Nevada shall be named as an additional insured with respect to liability arising out of the activities performed by, or on behalf of the Contractor, including automobiles owned, leased, hired or borrowed by the Contractor."

h. Provide a signed Business Associate Addendum (NMH-3820). The Addendum is available at https://www.medicaid.nv.gov on the "Provider Enrollment" webpage under "Required Enrollment Documents."

i. Establish a fixed business landline telephone number published in a public telephone directory.

j. Have a business office accessible to the public during established and posted business hours.

k. Case managers/employees of the private case management agency must also meet the following qualifications:

1. Be currently licensed as a Social Worker by the State of Nevada Board of Examiners for Social Workers, licensure as a RN by the Nevada State Board of Nursing or have a professional license or certificate in a medical specialty applicable to the assignment.

2. Have a valid driver's license and means of transportation to conduct home visits.

3. Adhere to HIPAA requirements.

4. Complete an FBI criminal background check.

2303.4C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2303.2C, the recipient must:

1. Participate in the ongoing contacts and reassessment process, accurately representing their skill level needs, preferences, resources, and goals.

2. 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.

3. Choose a Medicaid enrolled case management provider.

2303.5 HOMEMAKER SERVICES

Homemaker services consist of IADLs such as general household tasks, meal preparation, essential shopping, and laundry. These services are provided when the individual regularly responsible for these activities is temporarily absent or unable to manage their private residence and is necessary to avoid placement in an institution. These services are provided to individuals who are not authorized to receive State Plan PCS and require assistance with IADLs.

2303.5A COVERAGE AND LIMITATIONS

1. Homemaker services are provided at the recipient's home, or place of residence (community setting

2. Services must be directed to the individual recipient and related to their health and welfare.

3. DHCFP or its Fiscal Agent and case management providers are not responsible for the replacement of goods damaged in the provision of service.

4. Homemaker services include:

   a. General household tasks: including mopping floors, vacuuming, dusting, changing and making beds, washing dishes, defrosting and cleaning the refrigerator, cleaning bathrooms and kitchens, and washing windows as high as the homemaker can reach while standing on the floor;

   b. Essential shopping to obtain prescribed drugs, medical supplies, groceries, and other household items required specifically for the health and maintenance of the recipient;

   c. Meal preparation: menu planning, storing, preparing, serving food, buttering bread and plating food;

   d. Laundry services: washing, drying, and folding the recipient's personal laundry and linens (sheets, towels, etc.), excluding ironing. The recipient is responsible for any laundromat and/or cleaning fees;

   e. Assisting the recipient and family members or caregivers in learning a homemaker routines and skills, so the recipient may carry on normal living when the homemaker is not present;

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

   g. Routine clean-up of waste for up to two household pets. Walking a pet is not included unless it is a service animal.

   h. Additional homemaker activities may be approved on a case-by-case basis.

5. Activities the homemaker shall not perform and for which Medicaid will not pay include the following:

   a. Transporting the recipient in a private car;

   b. Cooking and cleaning for the recipient's guests, other household members or for the purpose of entertaining;

c. Repairing electrical equipment;

d. Ironing and mending;

e. Giving permanents, dying, or cutting hair;

f. Accompanying the recipient to appointments, social events, or in-home socialization;

g. Washing walls;

h. Moving heavy furniture, climbing on chairs or ladders;

i. Purchasing alcoholic beverages that are not prescribed by the recipient's physician;

j. Doing yard work such as weeding or mowing lawns, trimming trees, shoveling non-essential snow-covered areas and vehicle maintenance; or

k. Providing care to pets unless the animal is a certified service animal.

6. Live-in LRIs are limited to up to two hours per week, for non-live-in LRIs, the service hours will be based on the case manager's assessment of the recipient's living conditions (e.g. living alone, risk level).

2303.5B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2303.2B, Homemaker Providers must:

1. Provide adequate training related to homemaking assistance appropriate for recipients with physical disabilities completed initially and annually;

2. Ensure that EVV requirements and expectations are met, including the documentation of all services in approved EVV system;

3. The service must be prior authorized by the case manager and documented in an approved EVV system.

4. As mandated by Nevada statute, federal law or any other applicable Medicaid authority, providers must adhere to all wage requirements established by federal or state law or applicable Medicaid requirements for direct care workers. Specific wage requirements are referenced in the Waiver for Persons with Physical Disabilities, Appendix C - Participant Services and are outlined in the provider's enrollment contract. The DHCFP Audit Unit will conduct audits to ensure compliance with any wage requirement. As part of these audits, documents requested may include but are not limited to:

a. payroll records such as timesheets or timecards;

b. detailed paystubs including hours and rates per direct care worker;

c. employment documentation used to verify identification and authorization to work;

d. financial records needed to verify a provider's wage expense.

If a provider is determined to not be in compliance with paying their direct care workers a required wage, a provider will be subject to corrective action. Initial violations for non-compliance may result in provider education as well as recoupment of overpayment due to a provider not paying a direct care worker the mandated wage. Continued violations may trigger corrective action including additional penalties up to termination.

2303.5C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2303.2C, the recipient must:

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 POC, the EVV record that reflects the service rendered. If IVR is utilized, a vocal confirmation is required.

2303.6 RESPITE CARE

Respite Care Services are provided to recipients unable to care for themselves. This service is provided on a short-term basis because of the absence or need for relief of those persons normally providing the care. Respite providers perform general assistance with ADLs and IADLs as well as provide supervision to functionally impaired recipients in their private home or place of residence (community setting).

2303.6A COVERAGE AND LIMITATIONS

1. Respite services may be for 24-hour periods.

2. Respite care is limited to 120 hours for the duration of the POC.

3. Services must be prior authorized by the case manager.

2303.6B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in, Section 2303.2B, Respite providers must:

1. Provide adequate training related to personal care assistance appropriate for recipients with physical disabilities completed initially and annually to include training on personal hygiene needs and techniques for assisting with ADLs, such as bathing, grooming, skin care, transfer, ambulation, exercise, feeding, dressing, and use of adaptive aids and equipment, homemaking, and household care;

2. Meet the requirements of NRS 629.091, Section 2303.3B of this Chapter, and MSM Chapter 2600 if a respite provider is providing attendant care services that are considered skilled services; and

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

4. Services must be prior authorized by the case manager and documented in an approved EVV system.

5. As mandated by Nevada statute, federal law or any other applicable Medicaid authority, providers must adhere to all wage requirements established by federal or state law or applicable Medicaid requirements for direct care workers. Specific wage requirements are referenced in the Waiver for Persons with Physical Disabilities, Appendix C - Participant Services and are outlined in the provider's enrollment contract. The DHCFP Audit Unit will conduct audits to ensure compliance with any wage requirement. As part of these audits, documents requested may include but are not limited to:

   a. payroll records such as timesheets or timecards;

   b. detailed paystubs including hours and rates per direct care worker;

   c. employment documentation used to verify identification and authorization to work;

   d. financial records needed to verify a provider's wage expense.

   If a provider is determined to not be in compliance with paying their direct care workers a required wage, a provider will be subject to corrective action. Initial violations for non-compliance may result in provider education as well as recoupment of overpayment due to a provider not paying a direct care worker the mandated wage. Continued violations may trigger corrective action including additional penalties up to termination.

2303.6C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2303.2C, the recipient must:

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 POC, the EVV record that reflects the service rendered. If IVR is utilized, a vocal confirmation is required.

2303.7 ATTENDANT CARE SERVICES

Attendant Care Services are an extension of State Plan Personal Care Services (PCS) intended to support an individual to remain independent within the community. These services are authorized by case managers to assist the recipient's need for ADL and IADL assistance based upon functional deficits.

2303.7A COVERAGE AND LIMITATIONS

The scope and nature of these services do not otherwise differ from State Plan PCS furnished under the State Plan. Attendant Care Services are only provided to individuals aged 21 and over when the limits of the State Plan Option PCS are exhausted. Refer to MSM chapter 3500 for further information.

1. Where possible and preferred, recipients will direct their own service through an ISO. Refer to MSM Chapter 2600. Under the ISO model, the recipient can recruit, select, or terminate a caregiver. If this option is not used, the recipient will choose a provider agency that will otherwise recruit, screen, schedule caregivers, provide backup and assurance of emergency assistance.

2. Extended personal care attendant services in the recipient's POC may include assistance with ADLs and IADLs.

   Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically disabled individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function.

3. Flexibility of Services

   Flexibility of service delivery, which does not alter medical necessity, may occur within a single week period without an additional authorization. Reference 2303.2B.7 of this chapter for details.

2303.7B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in 2303.2B, the provider must:

1. When the provision of services includes self-directed skilled, qualifications and requirements must be followed in accordance with NRS 629.091, and MSM Chapter 2600.
2. Demonstrate the ability to:

    a. Perform the care tasks as prescribed;

    b. Identify emergency situations and to act accordingly and;

    c. Maintain confidentiality regarding the details of case circumstances.

3. Provide adequate training related to personal care assistance appropriate for recipients with physical disabilities completed initially and annually to include:

    a. Procedures for arranging backup when not available, agency contact person(s), and other information as appropriate. (Note: This material may be provided separate from a training program as part of the provider's orientation to the agency.)

    b. Personal hygiene needs and techniques for assisting with ADLs, such as bathing, grooming, skin care, transfer, ambulation, exercise, feeding, dressing, and use of adaptive aids and equipment.

    c. Home making and household care, including good nutrition, special diets, meal planning and preparation, essential shopping, housekeeping techniques, and maintenance of a clean, safe, and healthy environment.

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

5. Services must be prior authorized by the case manager and documented in an approved EVV system.

6. As mandated by Nevada statute, federal law or any other applicable Medicaid authority, providers must adhere to all wage requirements established by federal or state law or applicable Medicaid requirements for direct care workers. Specific wage requirements are referenced in the Waiver for Persons with Physical Disabilities, Appendix C - Participant Services and are outlined in the provider's enrollment contract. The DHCFP Audit Unit will conduct audits to ensure compliance with any wage requirement. As part of these audits, documents requested may include but are not limited to:

    a. payroll records such as timesheets or timecards;

b. detailed paystubs including hours and rates per direct care worker;

c. employment documentation used to verify identification and authorization to work;

d. financial records needed to verify a provider's wage expense.

If a provider is determined to not be in compliance with paying their direct care workers a required wage, a provider will be subject to corrective action. Initial violations for non-compliance may result in provider education as well as recoupment of overpayment due to a provider not paying a direct care worker the mandated wage. Continued violations may trigger corrective action including additional penalties up to termination.

2303.7C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2303.2C, the recipient must:

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 POC the EVV record that reflects the service rendered. If IVR is utilized, a vocal confirmation is required.

2303.8 ASSISTED LIVING SERVICES

Assisted Living (AL) services are all inclusive services furnished by an AL services provider that meet the HCBS setting requirements. AL services are intended to provide all support service needed in the community and may include personal care, homemaker, chore, attendant care, meal preparation, companion, medication oversight (to the extent permitted under state law), transportation, diet and nutrition, orientation and mobility, community mobility/transportation training, advocacy for related social services, health maintenance, active supervision, home and community safety training, provided in a home-like environment in a licensed community care facility.

This service may include skilled nursing care to the extent permitted by state law, nursing and skilled therapy services are incidental rather than integral to the provision of AL services.

2303.8A COVERAGE AND LIMITATIONS

1. AL are all inclusive services furnished by the assisted living provider. Payment is not to be made for 24-hour skilled care. If a recipient chooses AL services, other individual waiver services may not be provided, except case management services.

2. 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.

3. AL providers are expected to furnish a full array of services except when another Federal program is required to provide the service. Other individuals or agencies may also furnish care directly, or under arrangement with the AL provider, but the care provided by other entities supplements that provided by the AL provider and does not supplant it.

4. Federal Financial Participation (FFP) is not available for room and board, items of comfort, or the cost of facility maintenance, upkeep, and improvement.

5. Personalized care furnished to individuals who choose to reside in an AL facility based on their individualized POC, which is developed with the recipient, people chosen by the recipient, caregivers, and the case manager. Care must be furnished in a way that fosters the independence of each recipient.

2303.8B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2303.2B providers must:

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

2. Adhere to all HCQC and ADSD training requirements specific to the waiver population being cared for at the AL facility completed initially and annually.

3. AL facility providers must:

   a. Ensure that HCBS Settings requirements and expectations are followed. The HCBS Settings Regulation supports enhanced quality in HCBS programs, adds protections for individuals receiving services and supports through Medicaid's HCBS programs have full access to the benefits of community living and can receive services in the most integrated setting.

   b. Notify the case manager within three business days when the recipient states the desire to leave the facility.

   c. Participate with the case manager in discharge planning.

   d. Notify the 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.

e. Notify the case manager 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. Maintain privacy, dignity, and respect during the provisions of services, and ensure living units are not entered without permission.

g. Allow recipients to have visitors of their choosing and access to food at any time.

h. Ensure the facility is physically accessible to the recipient.

i. Conduct business in such a way that the recipient is free from coercion and restraint and retains freedom of choice. AL Facilities must render services based on the recipient's choice, direction, and preferences.

j. Coordinate transportation to and from the setting to the hospital, a NF, routine medical appointment, and social outings organized by the facility. Recipients may choose to enjoy their privacy, participate in physical activities, relax, or associate with other residents. Recipients may go out with family members or friends at any time and may pursue personal interests outside of the residence.

NOTE: For all Medicaid covered services refer to MSM Chapter 1900 – Transportation Services.

k. Accept only those residents who meet the requirements of HCQC licensure and certification.

l. Provide services to PD Waiver recipients in accordance with the recipient's POC.

m. Not use or disclose any information concerning a recipient for any purpose not directly connected with the administration of the PD Waiver except by written consent of the recipient or designated representative/LRI.

n. Have sufficient caregivers present at the facility to conduct activities and provide care and protective supervision for the residents at all times. The provider must comply with HCQC staffing requirements for the specific facility type.

o. Have 24-hour on-site staff to meet scheduled or unpredictable needs and provide supervision, safety, and security.

p. Not use Medicaid waiver funds to pay for the recipient's room and board.

q. Ensure that recipients are provided the opportunity to seek employment and work in competitive integrated settings, engage in community life, control personal resources (such as access to bank accounts), and receive services in the community to the same degree as individuals not receiving Medicaid HCBS.

r. Allow each recipient privacy in their sleeping or living unit:

1. Units or rooms have lockable doors. A bedroom or bathroom door in a residential group setting which is equipped with a lock must open with a single motion from the inside. Staff must knock before entering; recipients have the right to choose who enters the bedroom.

2. Recipients sharing units have a choice of roommate.

3. Encourage recipients to utilize personal furniture, furnishing, photo and decorative items to personalize their living space.

s. Not have a lease or other agreement that differs from those individuals who do not receive Medicaid HCBS.

The provider must have a written agreement that includes the following:

1. Provide at least a 30-calendar day notification to the recipient before transferring or discharging them with the exception of a voluntary transfer or discharge, or the requirement to transfer or discharge the recipient to another facility because the condition of the recipient necessitates a higher level of care;

2. Provide the recipient and case manager with written notice of the intent to transfer or discharge the recipient; and

3. Allow the recipient and other person authorized by the recipient the opportunity to meet in person with the administrator of the facility to discuss the proposed transfer of discharge within 10-calendar days after providing written notice.

t. Notify the recipient's case manager when a modification is made on the POC that restricts the recipient's freedom of choice.

4. Recipient Records

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, 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, indicating the designated representative/LRI. Recipients without a designated representative/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/LRI 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 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.

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 an AL Facility should be provided as specified on the POC.

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

2303.8C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2303.2C, the recipient must:

1. Cooperate with the providers of an AL Facility in the delivery of services.

2. Report any problems with the delivery of services to the AL Facility administrator and/or case manager.

2303.9 CHORE SERVICES

Chore services are intermittent in nature and may be authorized as a need arises for the completion

of a specific task which otherwise left undone poses a home safety issue. These services are provided only in cases where the recipient, anyone else in the household, landlord, community volunteer/agency, or third-party payer is not capable of performing nor responsible for the provision of these services, or financially able to provide these services, and without these services, the recipient would be at risk of institutionalization.

2303.9A COVERAGE AND LIMITATIONS

1. The service must be identified in the POC and approved by the case manager.

2. This service includes heavy household chores such as:

   a. Cleaning windows and walls;

   b. Shampooing carpets, tacking down loose rugs and tiles;

   c. Moving heavy items of furniture to provide safe access;

   d. Minor home repairs;

   e. Removing trash and debris from the yard; and

   f. Packing and unpacking for the purpose of relocation.

3. This is not a skilled, professional service.

4. In the case of rental property, the responsibility of the landlord pursuant to the lease agreement, must be examined and confirmed prior to any authorization of service. The legal responsibility of the landlord to maintain and ensure safety on the rental property shall supersede any waiver covered services.

2303.9B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed, in Section 2303.2B, individuals performing Chore Services must:

1. Provide adequate training appropriate for recipients with physical disabilities completed initially and annually to include training in performing heavy household activities and minor home repair; and

2. Maintain the home in a clean, sanitary, and safe environment. if performing heavy household chores and minor home repair services.

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

4. Services must be prior authorized by the case manager and documented in an approved EVV system.

2303.9C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2303.2C, the recipient must:

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 POC, the EVV record that reflects the service rendered. If IVR is utilized, a vocal confirmation is required.

2303.10 ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS (EAA)

Environmental Accessibility Adaptations are physical adaptations to the residence of the recipient or the recipient's family that have been identified within the recipient's POC. These adaptations must ensure the health, welfare, and safety of the recipient and/or enable the recipient to function with greater independence within their own home.

2303.10A COVERAGE AND LIMITATIONS

1. Adaptations may include the purchase of environmental controls, the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems necessary to accommodate the medical equipment and supplies needed for the welfare of the recipient.

2. All services, modifications, improvements, or repairs must be provided in accordance with applicable state or local housing and building codes.

3. Providers who are furnishing EAA services to PD waiver recipients will be able to bill for an assessment fee (maximum of one hour) and a flat rate mileage for a single transport over 30 miles. The purpose of the addition of the assessment fee is to ensure recipients receive maximum services and for waiver providers to have the ability to properly identify needed adaptations. The assessment and travel fees can be billed separately from the maximum amount limit per calendar year to complete the job (material and labor costs).

4. Rental properties must receive written approval from the landlord prior to authorizing any EAA.

5. Excluded Adaptations

   a. Improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc.

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

2303.10B PROVIDER RESPONSIBILITIES

1. All sub-contractors must be licensed or certified if applicable. Modifications, improvements, or repairs must be made in accordance with local and state housing and building codes.

2. Must have a contractor's license if completing installation.

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

4. The service including assessment and travel fees must be prior authorized by the case manager.

2303.10C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2303.2C, the recipient must:

1. The recipient is responsible for notifying the provider and/or case manager of any issues or problems regarding the installation of any authorized equipment or modifications.

2. The recipient may not request any additional modifications that have not been authorized.

3. The recipient must notify their case manager once the modifications have been completed.

2303.11 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.

2303.11A COVERAGE AND LIMITATIONS

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

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

2. Meals provided by or in a child foster home, 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 and are not to exceed two meals per day.

5. More than one provider may be used to meet a recipient's assessed need; the case manager is responsible for ensuring the PA does not exceed two meals per day.

6. Case managers determine the need for this service based on the assessment, and by personal interviews with the recipient related to individual nutritional status.

7. 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.

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

2303.11B PROVIDER RESPONSIBILITIES

1. 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.

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

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

4. The service must be prior authorized by the case manager.

2303.11C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2303.2C, the recipient must:

1. The recipient must notify the case manager timely if they need to request any changes to their Home Delivered Meals service.

2. The recipient must notify their case manager if the authorized number of meals is not received.

2303.12 PERSONAL EMERGENCY RESPONSE SYSTEMS (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 programmed to signal a response center once the "help" button is activated.

2303.12A 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 their residence, have no regular caregiver for extended periods of time and who would otherwise require extensive routine supervision or as identified to mitigate other safety risks and concerns. The recipient must be capable of using the device in an appropriate and proper manner.

2. The initial installation fee and a monthly fee for ongoing monitoring are covered under this service.

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

2303.12B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2303.2B, PERS providers must:

1. Ensuring that the response center is staffed by trained professionals at all times;

2. Complete any replacement or repair needs that may occur and provide monthly monitoring to ensure the device is working properly;

3. Devices must meet Federal Communication Commission (FCC) standards, Underwriter's Laboratory (UL) standards or equivalent standards; and

4. Inform recipients of any liability they may incur as a result of the disposal or loss of provider property.

5. This service must be prior authorized by the case manager.

2303.12C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2303.2C, the recipient must:

1. Be responsible for utilizing the leased PERS equipment with care and caution and to notify the PERS provider when the equipment is no longer working.

2. Return the equipment to the provider when it is no longer needed or utilized, or when the recipient terminates from the waiver program.
3. Not dispose of or damage the PERS equipment. This is leased equipment and belongs to the PERS provider.

2303.13 SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES

Specialized medical equipment and supplies are those devices, controls, or appliances specified in POC that enable recipients to increase their abilities to perform ADLs.

2303.13A COVERAGE AND LIMITATIONS

1. Items reimbursed with waiver funds shall exclude those items which are not of direct medical or remedial benefit to the recipient.

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

3. This service includes:

   a. Devices, controls, or applications which enable the recipient to perceive, control, or communicate with the environment in which they live;

   b. Items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items; and

   c. Vehicle adaptations, assistive technology, and supplies.

4. Durable and non-durable medical equipment that has been exhausted, not available, or covered under the Medicaid State Plan, refer to MSM Chapter 1300 – DME Disposable Supplies and Supplements.

2303.13B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2303.2B, providers must:

1. Meet the standards to provide equipment under the Medicaid State Plan Program; and

2. The service must be prior authorized by the case manager.

2303.13C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2303.2C, the recipient must:

1. Notify the provider and/or case manager of any issues or problems regarding the installation or delivery of any authorized equipment or supplies.

2. Not request any additional specialized medical equipment or supplies that have not been authorized.

3. Notify their case manager once the specialized medical equipment or supplies have been received.

2303.14 ELECTRONIC VISIT VERIFICATION (EVV)

Refer to Addendum B for more information regarding EVV system requirements.

2303.15 DHCFP LTSS INITIAL REVIEW

Once the applicant has been approved for the waiver, the DHCFP LTSS Unit will review all initial eligibility packets for completeness to ensure waiver requirements are being met. The eligibility packet for review must include:

1. The NF LOC screening to verify the applicant meets the NF LOC criteria;

2. At least one waiver service need identified;

3. The SOC complete with signature and dates; and

4. The HCBS Acknowledgement Form is complete including initials, signature, and date.

Note: Electronic signatures are acceptable pursuant to NRS 719.350 “Acceptance and distribution of electronic records by governmental agencies” on forms that require a signature.

2303.16 WAIVER COSTS

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.

2303.17 QUALITY ASSURANCE WAIVER REVIEW

The state conducts an annual review of active waiver participants. CMS has designated waiver assurances and sub-assurances that 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 PD Waiver to evaluate operation.

Case management and direct waiver service providers must cooperate with ADSD Operations and DHCFP's review process.

2303.18 MEDICAID EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)

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

2303.19 PROVIDER ENROLLMENT

All providers must maintain a Medicaid services provider agreement and comply with the criteria set forth in the Nevada MSM Chapter 100 and Chapter 2300. Provider Enrollment checklists and forms can be found on the Fiscal Agent's website https://www.medicaid.nv.gov.

2303.20 BILLING PROCEDURES

DHCFP assures that all 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.

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

2303.21 ADVANCE DIRECTIVES

Section 1902(w) of the Social Security Act requires licensed providers to provide their recipients with information regarding their decision-making rights about health care, declarations (living wills) and durable powers of attorney for health care decisions. Refer to MSM Chapter 100 for further information.

The case manager must provide information on Advance Directives to each recipient and/or designated representative/LRI during the initial assessment and annually thereafter. The signed Acknowledgement form is kept in each recipient's file. Whether a recipient chooses to write their

own Advance Directive or complete an Advance Directive form in full is the individual choice of each recipient and/or designated representative/LRI.

2304 HEARINGS REQUESTS DUE TO ADVERSE ACTIONS

An adverse action refers to denials, terminations, reductions, or suspensions of the applicant's/recipient's request for services or an applicant's/recipient's eligibility determination. DHCFP must grant an opportunity for a hearing to an applicant/recipient/designated representative in the event an adverse action is taken by DHCFP.

2304.1 SUSPENDED WAIVER SERVICES

When a recipient is institutionalized less than 60 days, their waiver services must be suspended.

A. Upon receipt of the suspension notification from the case management provider, DHCFP LTSS will issue a suspension NOD to the recipient.

B. Waiver services will not be paid for the days that a recipient's eligibility is in suspension.

C. If the recipient continues to be institutionalized for 45 days, on the 46th day, the case manager will request DHCFP LTSS to send a termination NOD to the recipient indicating termination from the waiver on the 61st day from the admission date.

2304.2 RELEASE FROM SUSPENDED WAIVER SERVICES

When a recipient has been released from an institution, before the 60th day from the admit date, the case manager must do the following within five business days of the recipient's discharge:

A. Complete a reassessment if there has been a significant change in the recipient's condition or status;

B. 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; and

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

2304.3 DENIAL OF WAIVER ELIGIBILITY

Basis of denial for waiver eligibility:

A. The service(s) is/are not substantiated as medically necessary. Contact your Medicaid provider as there may be additional documentation to submit to demonstrate a medical necessity.

B. The applicant does not meet the LOC criteria for NF placement.

C. The applicant has withdrawn their request for waiver services.

D. The applicant fails to cooperate with the case manager in establishing program eligibility or waiver services (the applicant/recipient's and/or designated representative/LRI's signature is necessary for all required paperwork).

E. The applicant's support system is not adequate to provide a safe environment during the time waiver services are not being provided.

F. The case manager has lost contact with the applicant.

G. The applicant/recipient fails to show a need for ongoing waiver services.

H. The applicant would not require NF placement within 30 days or less if waiver services were not available.

I. The applicant has moved out of the state.

J. Another agency or program will provide the services.

K. ADSD has filled the number of positions (slots) allocated. The applicant will be approved for the waiver waitlist and will be contacted when a slot is available.

Wait List Priority:

Level 1: Applicants previously in a hospital or NF and who have been discharged to the community within six months and have a significant change in support system and are in a crisis situation;

Level 2: Applicants who have a significant change in support system and/or in a crisis situation and require at least maximum assistance in a combination of four or more of the following ADLs: eating, bathing, toileting, transfers, and mobility;

Level 3: Applicants who have a significant change in support system and/or in a crisis situation and require assistance with a combination of five or more of the following ADLs as identified on the LOC screening: medication administration, special needs, bed mobility, transferring, dressing, eating and feeding, hygiene, bathing, toileting, and locomotion;

Level 4: Applicants who do not meet the criteria for priority levels 1-3.

L. There are no enrolled Medicaid providers or facilities in the applicant's area.

M. The applicant is in an institution (e.g. hospital, nursing facility, correctional facility, ICF/IID) and discharge within 60 calendar days is not anticipated.

N. The applicant has chosen a provider or facility that is not an enrolled or qualified Medicaid provider. Note: The case manager should provide a list of Medicaid providers to the applicant. The case manager will inform the provider that all entities providing services must be enrolled as a Medicaid provider and facilitate contact information to the DHCFP's Fiscal Agent.

When the application for waiver services is denied, the case manager will send a NOD request to DHCFP LTSS Unit. The DHCFP LTSS Unit sends a NOD to the applicant/recipient informing them of the reason for denial.

2304.4 REDUCTION OR DENIAL OF DIRECT WAIVER SERVICES

Basis of reduction or denial of direct waiver services:

A. The recipient no longer requires the waiver service, number of service hours, or level of service which was previously authorized.

B. The recipient has requested a reduction of services, or a specific waiver service to be discontinued.

C. Another service will be substituted for the existing service, or there is a reduction or termination of a specific waiver service.

D. The recipient has reached or will exceed their annual amount limit for Environmental Adaptations and/or Specialized Medical Equipment.

E. The requested adaptation for the recipient, equipment or supply is not medically necessary to prevent institutionalization.

F. The landlord has not approved requested adaption or modification for the recipient.

G. The recipient does not demonstrate a need or have the capacity/ability for the requested waiver services.

Note: A reduction includes when a specific waiver service's hours are reduced to zero.

When there is a reduction of waiver services, the case manager will identify the reason for the reduction and what the service will be reduced to and request the DHCFP LTSS Unit to send a NOD. DHCFP LTSS will issue a reduction NOD indicating the reason and the date of action which is at least 13 calendar days from the notice date. Refer to MSM Chapter 3100 Hearings, for specific instructions regarding notification and recipient hearings.

When the request for a direct waiver service(s) is denied, the case manager will send a NOD request to the DHCFP LTSS Unit. The DHCFP LTSS Unit sends a NOD to the applicant/recipient informing them of the reason for denial.

2304.5 TERMINATION OF WAIVER PROGRAM ELIGIBILITY

Reasons to terminate waiver program eligibility:

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

B. The recipient and/or designated representative/LRI have requested termination of waiver services.

C. The recipient and/or designated representative/LRI has failed to cooperate with the case manager or HCBS waiver service provider(s)

D. The recipient fails to show a continued need for HCBS waiver services.

E. The recipient no longer requires NF placement within 30 calendar days if HCBS were not available.

F. The recipient has moved out of state.

G. The recipient and/or designated representative/LRI has participated in activities designed to defraud the waiver program.

H. Another agency or program is providing duplicative services.

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

J. The case manager has lost contact with the recipient.

K. Death of the recipient.

L. The recipient's support system is not adequate to provide a safe environment during the time when HCBS waiver services are not being provided.

M. HCBS waiver services are not adequate to ensure the health, welfare, and safety of the recipient.

N. The recipient has failed to cooperate with the case manager or HCBS waiver service provider(s) in establishing and/or implementing the POC, implementing waiver services or verifying eligibility for waiver services (the recipient and/or designated representative/LRI's signature is necessary on all required paperwork.).

When a recipient is terminated from the waiver program, the case manager will request the DHCFP LTSS Unit to send a NOD. DHCFP LTSS will issue a termination NOD indicating the reason and the date of action which is at least 13 calendar days from the notice date. Refer to MSM Chapter 3100 - Hearings for specific instructions regarding advance notification and recipient hearings.

2304.6 REAUTHORIZATION WITHIN 90 DAYS OF WAIVER TERMINATION

If a recipient is placed in a NF, hospital, or is incarcerated and waiver eligibility has been terminated, the recipient may request to be reinstated within 90 days from the date of action on the NOD.

2304.6A COVERAGE AND LIMITATIONS

1. The waiver slot must be held for 90 days from the date of action listed on the NOD.

2. The recipient may request to be placed back on the waiver if:

   a. They still meet LOC; and

   b. They are released/discharged within 90 days.

3. If 91 calendar days has elapsed, from the date of action on the NOD, the slot is allocated to the next person on the waitlist.

2304.6B PROVIDER RESPONSIBILITIES

The last known case management provider is responsible for resuming case management responsibilities for the recipient within three business days, to include the following:

1. Contact DWSS via the NMO-3010 to reinstate eligibility;

2. Contact DHCFP LTSS Unit via the NMO-3010 to reinstate the waiver benefit line;

3. Contact ADSD Operations Agency to notify of the reinstatement of waiver slot placement; and

4. Notify all direct waiver service providers of waiver reinstatement.

If the case manager determines that there has been a significant change in the recipient's condition as appropriate, refer to MSM section 2303.4A.3.e. for requirements.

2304.6C RECIPIENT RESPONSIBILITIES

1. Recipients must cooperate fully with the reauthorization process to assure approval of request for readmission to the waiver.

2. If the recipient is discharged after the 90th day from the date of action on the NOD, they must reapply for waiver services.

2305 APPEALS AND HEARINGS

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 Recipient Rights form.