Section 2

Home and Community Based Services Waiver for Technology Dependent, Medically Fragile Individuals

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1 GENERAL POLICY

Section 1915 (c) of the Social Security Act permits States to offer, under a Waiver of statutory requirements, a Medicaid funded home and community based services (HCBS) Waiver to eligible individuals as an alternative to facility based care. Utah's HCBS Medicaid Waiver for technology dependent/medically fragile individuals (Tech Dependent Waiver) was initially approved by the Centers for Medicare and Medicaid Services effective January 1, 1995, for a three year period and has been continuously reauthorized at five year intervals since 1998. Admission to the Tech Dependent Waiver is limited to individuals who meet the targeting criteria found in Section 2-1 of this manual.

Federal approval includes authorization to "waive" Medicaid comparability requirements found at section 1902(a)(10)(B) of the Social Security Act. This allows the State to "target" Medicaid reimbursed home and community based services to a ***limited number*** of technology dependent, medically fragile individuals. Additionally, the State is authorized to waive certain income and resource rules found in Section 1902(a)(10)(c)(I)(III) of the Act when determining eligibility for the Tech Dependent Waiver.

1 - 1 Purpose

Medical technology makes it possible to enhance the lives of medically fragile individuals with complex needs. Historically, many families have found it necessary to place a medically fragile individual in facility based settings in order to obtain needed services and supports. Utah's Tech Dependent Waiver program is designed to offer these individuals and their families an option to premature or unnecessary facility based placements. Under the Tech Dependent Waiver program, individuals who would otherwise require a level of care provided in a nursing facility (NF) may instead be offered the choice to receive Medicaid reimbursed services at home and in their community. Tech Dependent Waiver recipients are eligible to receive home and community based services **in addition to** traditional medical services covered by Medicaid and other private insurers.

1 - 2 Tech Dependent Waiver Administration and Operation

A. Division of Medicaid and Health Financing: Administrative Authority and Responsibilities

The Division of Medicaid and Health Financing (DMHF) is the single State agency responsible to administer and supervise the administration of the Utah Medicaid program including Waiver programs. State funds appropriated by the Utah legislature to the DMHF are used to match Federal Medicaid funds in order to cover the costs of the Tech Dependent Waiver program.

The DMHF retains final administrative authority for the Tech Dependent Waiver as it currently exists or is hereafter amended.

B. Division of Family Health and Preparedness: Operational Authority and Responsibilities

The Division of Family Health and Preparedness (DFHP) is designated as the State's Maternal and Child Health Title V agency and has the statutory authority and responsibility to provide and/or arrange for the provision of services to children and youth with special health care needs. Under an interagency agreement with the DMHF, the DFHP provides "Waiver case management" and other essential activities necessary to

ensure the effective and efficient, day to day operations of the Tech Dependent Waiver program.

1 - 3 Acronyms and Definitions

For purposes of the Tech Dependent Waiver, the following definitions apply:

Applicant: A child who has applied for services under the Tech Dependent Waiver but who has not yet been determined eligible, or not yet received approval, for services under the Tech Dependent Waiver.

Certification: Level of Care determination

Child: An individual under the age of 21

DFHP: The Division of Family Health and Preparedness within the Utah Department of Health

DMHF: The Division of Medicaid and Health Financing within the Utah Department of Health

HCBS: Home and Community Based Services

ICF/ID: Intermediate Care Facility for People with Intellectual Disabilities. ICF/ID is equivalent to and replaces all instances of ICF/MR (Intermediate Care Facility for the Mentally Retarded), as described under federal law.

Medicaid Eligibility Worker: A qualified employee of the Department of Workforce Services who determines categorical and financial eligibility for Medicaid.

NF: Nursing Facility

Plan of Care: The plan of care describes all of the Waiver services the recipient is assessed to need and is authorized by the RN Waiver coordinator.

Prior Authorization: Authorization received BEFORE services are provided.

RN Waiver Coordinator: A qualified employee of the DFHP who performs required case management activities under the Tech Dependent Waiver.

Recertification: Periodic review of the Level of Care

Recipient: An individual who qualifies for and receives services under the Tech Dependent Waiver.

Tech Dependent Waiver or Waiver services: Utah's HCBS Medicaid Waiver program for technology dependent/medically fragile individuals and services covered under this Waiver.

Travis C. Waiver: A historical name for Utah's HCBS Medicaid Waiver program for technology dependent/medically fragile individuals

Waiting List: List of names identified as potential future recipients. The waiting list is utilized when the number of applicants, for the Tech Dependent Waiver, exceeds the number of approved openings.

1 – 4 Data Security and Privacy

Providers are expected to take steps to ensure that all personal information related to the individual being served is protected. This includes both Personal Health Information (PHI) as well as Personally Identifiable Information (PII). Providers should use appropriate administrative, technical and physical safeguards to preserve the integrity, confidentiality, and availability of PHI/PII that they create, receive, maintain or transmit. This includes using encrypted/secure email, fax, or other HIPAA compliant methods to transmit documents containing information about the individual being served. Providers shall ensure there is limited and controlled access to PHI/PII. In the performance of its services and operations, the provider shall make efforts to use, disclose and request only the minimum amount of PHI/PII considered reasonably necessary. The provider shall also identify and protect against reasonably anticipated threats to the security or integrity of the information, protect against reasonably anticipated, impermissible uses or disclosures; and ensure compliance by their workforce.

1 – 5 Breach Reporting/Data Loss

Providers must report to DFHP and DMHF, either by email or telephone, any breach or loss of PHI/PII. This report should be completed not more than 24 hours after the provider knows, or should have reasonably known about the breach. The provider must also submit a report in writing/by email to DFHP within 5 business days of the breach. The provider will also cooperate with any investigation of the breach or data loss.

2 SERVICE AVAILABILITY

Home and community based Waiver services for technology dependent, medically fragile individuals are covered benefits only when provided in accordance with the four criteria listed below.

A. To individuals eligible for the Waiver and residing in the State of Utah;

B. To individuals who are not inpatients of a hospital, NF, or intermediate care facility for people with intellectual disabilities (ICF/ID).

C. Pursuant to a written plan of care;

D. Through a qualified, enrolled Medicaid provider as described in Section 3, SCOPE OF SERVICE.

Details concerning the eligibility process and these four criteria are explained in the remainder of this chapter.

2 - 1 Eligible Individuals

A. To be eligible for services under the Tech Dependent Waiver, the technology dependent, medically fragile individual must meet all six of the following "targeting criteria":

1. Be under the age of 21 at the time of admission;

2. Qualify for Medicaid based on his or her income and resources;

3. Have at least one care giver trained (or willing to be trained) and available to provide care in a home that is safe and able to accommodate the necessary medical equipment and personnel needed to safely care for the individual;

4. Meet admission criteria for NF care;

5. Choose to receive home and community-based services; and

6. Require skilled nursing or rehabilitation services (or a combination of both) at least five days per week. The services ordered must be, singly or in the aggregate, so inherently complex that they can be safely and effectively performed only by, or under the supervision of, professional or technical personnel. For purposes of this Waiver, the inherent complexity of services is evidenced by the individual's dependence on one or more of the following:

    a. Daily dependence on a mechanical ventilator;

    b. Daily dependence on tracheostomy-based respiratory support (or, at reevaluation, dependence within the past 6 months on tracheostomy-based respiratory support);

    c. Daily dependence on Continuous Positive Airway Pressure (C-PAP) or Bi-level Positive Airway Pressure (Bi-PAP); or

    d. Dependence on intravenous administration of nutritional substances or medications through a central line, which the physician anticipates will be necessary for a period of at least six months.

B. An individual's eligibility for benefits and services under this Waiver can continue as long as he or she continues to meet the targeting criteria.

2 - 2 Access to the Tech Dependent Waiver

The first point of contact for all Waiver services is the DFHP RN Waiver coordinator. Prior to an applicant receiving Waiver services, the RN Waiver coordinator must:

A. Certify that the applicant meets the level of care requirements, and that there are feasible alternatives available under the Tech Dependent Waiver;

B. Ensure the applicant has been determined financially eligible for Medicaid based on Waiver eligibility requirements; and

C. Offer the eligible applicant the choice of Waiver services or NF services.

2 - 3 Level of Care Determination

A. The RN Waiver coordinator, through consultation with the child's medical home and other health professionals, and with the assistance of the applicant and/or the applicant's legal representative, will obtain pertinent information needed to thoroughly evaluate the applicant's medical condition and technology.

B. An applicant meets level of care determination (certification) criteria when documentation supports the following:

1. The applicant's condition and technology needs meet the targeting criteria defined in Chapter 2-1, *Eligible Individuals*; and

2. The applicant's needs can be appropriately met in the community with the currently available Waiver and other state plan services.

C. Individuals who meet the Tech Dependent Waiver targeting criteria but whose needs cannot be met appropriately in the community with Waiver and other available state plan services will receive written notice from the RN Waiver coordinator specifying the reason(s) for ineligibility, and the applicant's rights to request a hearing. Hearing rights are described in Chapter 2-10.

D. To support the certification, the following documentation must be included in the applicant's file:

1. Comprehensive assessment completed by the RN Waiver coordinator which documents the individual's medical history, current technologies, treatments, services and identified needs.

2. The Waiver Level of Care Evaluation Form and the Initial and Annual Level of Care/Freedom of Choice Certification Form.

3. Other pertinent medical information which supports that the individual meets the Waiver targeting criteria and the required NF level of care.

2 - 4 Medicaid Eligibility Determination

A. Once an applicant has been certified by the RN Waiver coordinator as meeting the Tech Dependent Waiver targeting and level of care criteria specified in Chapters 2-1 and 2-3, he or she will be referred by the RN Waiver coordinator (using completed HCF-927 form) to the Department of Workforce Services, for a determination of Medicaid eligibility.

B. The Medicaid eligibility worker will contact the family and RN Waiver coordinator to obtain all necessary documentation to complete the Medicaid application. The eligibility worker will notify the RN Waiver coordinator of the Medicaid eligibility determination, again using the form 927.

2 - 5 Individual's Freedom of Choice

A. Once an applicant has been certified by the RN Waiver coordinator to meet the certification criteria for the Waiver and the eligibility worker has determined the individual meets Medicaid categorical and financial eligibility requirements, the applicant or his or her legal representative will be:

1. Informed by the RN Waiver coordinator of feasible and available services under the Waiver;

2. Advised if there is a waiting list for admission to Waiver services (Refer to Chapter 2-6, *Limit on Number of Tech Dependent Waiver Recipients*; and

3. Offered the choice of NF or home and community based Waiver services.

B. If the eligible applicant chooses NF services, the RN Waiver coordinator will provide the applicant with information and assistance necessary to access such facilities.

C. If the applicant chooses home and community based Waiver services and there is an available opening, the RN Waiver coordinator will notify the eligibility worker to open the case and the effective date of Waiver services. The applicant will then be given the opportunity to choose the provider(s) of Waiver services if more than one qualified provider is available to render the services.

D. The RN Waiver coordinator and the applicant, or legal representative, must document the applicant's decision by completing the Initial and Annual Level of Care/Freedom of Choice Certification Form.

2 - 6 Limit on Number of Tech Dependent Waiver Recipients

The number of recipients who may be served at any point in time through the Tech Dependent Waiver is limited. When the number of applicants for the Tech Dependent Waiver exceeds the number of approved openings (or "replaceable slots"), a waiting list will be established. Generally, priority for admission to the Tech Dependent Waiver from the waiting list will be given to the applicant with the highest numerical ranking based on the following:

Targeting Condition(s)	**Weight Factor**
Trach/Ventilator dependent	18
Bi-PAP > 18 hours/day	9
Trach Dependent	8
C-PAP/Bi-PAP	2* See (note)
Central Line	2* See (note)

[***NOTE**: In considering these conditions, if the applicant is receiving skilled nursing care 3 or more times per week, add 2 points; if the applicant is receiving enteral feeding or total parenteral nutrition, add 1 point]

Length of time on the waiting list will be used in determining who is selected if more than one applicant has the same "highest" score.

RN Waiver coordinators have discretion to consider extraordinary psycho-social or medical needs of an

applicant/family when establishing priority for admission to the Tech Dependent Waiver. In such cases, documentation will be maintained by the RN Waiver coordinator to include: 1) a description of the specific, extraordinary psycho-social/medical need(s) of the applicant/family member; 2) feasible alternatives (including formal and informal support systems and services) considered/available at the time to help meet the extraordinary need(s) and maintain the child in the community while waiting for Tech Dependent Waiver coverage; 3) an estimate of the likelihood of 'imminent' out-of-home placement of the child if Tech Dependent Waiver admission is delayed; and 4) the RN Waiver coordinator's judgment regarding the potential risks to the applicant's/caregiver's health and welfare if Tech Dependent Waiver admission is delayed.

Discretionary priority for admission will only be authorized when the RN Waiver coordinator's documentation indicates one or more of the following: 1) the applicant/care-giver lacks any feasible/available family or community based support; 2) the applicant is at imminent risk of out-of-home placement; or 3) there is a likelihood that the health and welfare of the applicant/care-giver will be compromised by delaying admission and there are no others ahead of the applicant on the waiting list with equal or greater 'priority needs'.

2 - 7 Prior Authorizations and Plan of Care

A. All Waiver services must be authorized by a written plan of care developed by the RN Waiver coordinator with input from the recipient and/or the recipient's legal guardian, and others as appropriate, prior to the receipt of waiver services. The plan of care describes the Waiver services that the individual needs, and the non-Waiver services the individual is receiving. The plan of care includes the type, amount, duration and estimated frequencies of Waiver services and the provider(s) who will furnish the services.

B. The plan of care is reviewed as frequently as necessary to ensure it meets the needs of the individual. A formal review of the plan is required at least every six months and must be completed by the RN Waiver coordinator during the calendar month in which it is due.

2 – 8 Plan of Care Unit Calculation

A. The comprehensive care plan is intended to be an estimate of the service units required to meet the assessed needs of each recipient over the course of the plan of care year. DMHF recognizes that a recipient's needs may change periodically due to temporary or permanent conditions which may require amendments to the recipient's care plan.
B. DFHP is responsible to monitor service utilization for each recipient for whom DFHP created a comprehensive care plan. When DFHP determines that the assessed service needs of a recipient exceed the amount that has been approved on that recipient's existing plan of care, DFHP should submit an amendment to increase the number of units to meet the need. Amendments must be made prior to the expiration of the plan of care.
C. The plan of care year is the sum of all approved units including amendments over the entire year. In this way, Utah Medicaid applies an annualized aggregate of all plan of care units.
D. Providers may not exceed the annualized aggregate of all approved plan of care units. Billing in excess of the approved number of units will be subject to recovery of funds by Utah Medicaid.

2 - 9 Periodic Review of the Level of Care

A. The RN Waiver coordinator must periodically conduct a comprehensive reassessment (recertification) to document the individual's current level of care and to assure that home and community based Waiver services remain a feasible alternative to facility-based care and continue to meet the individual's needs. The recertification updates and documents the individual's medical history and current technology as well as psycho-social needs. Recertification of the individual's level of care must occur at least once a year (12 months from the individual's entry into the Waiver or within 12 months of the most recent level of care determination). Recertification must be completed within the calendar month in which it is due.

B. The recertification provides the information necessary for the RN Waiver coordinator to determine whether the recipient continues to meet the Tech Dependent Waiver targeting criteria or not. If the RN Waiver coordinator determines that the recipient continues to meet the Tech Dependent Waiver targeting criteria and chooses to continue receiving home and community based Waiver services, the RN Waiver coordinator will recertify the recipient's Tech Dependent Waiver level of care. If the RN Waiver coordinator determines that the recipient no longer meets the Tech Dependent Waiver targeting criteria or the recipient chooses NF placement rather than home and community based services, the recipient will not be recertified.

2 - 10 Reduction or Termination of Home and Community Based Waiver Services

The RN Waiver coordinator will provide written notices with appeal rights to the recipient or legal representative when taking an adverse action resulting in a denial, reduction, suspension or termination of home and community based Waiver services.

A. When the need arises, participants are separated from the Home and Community Based waiver program through a disenrollment process.

1. The disenrollment process is a coordinated effort by DFHP staff that is expected to facilitate the following:

i. Verification that the disenrollment is appropriate for the waiver participant;

ii. Movement among waiver programs (when applicable);

iii. Ensuring effective utilization of waiver program services;

iv. Effective discharge and transition planning;

v. Distribution of information to participants describing all applicable waiver rights; and

vi. Program quality assurance.

B. All of the various circumstances for which it is permissible for individuals to be disenrolled from the waiver program can be grouped into three distinct disenrollment categories.

1. Voluntary disenrollments are cases in which participants, or their legal representative (when applicable), choose to initiate disenrollment from the waiver. Disenrollments are also considered voluntary when the waiver participant enters a skilled nursing facility for a stay of less than 90 days and chooses not to transition back to the original waiver program. This includes cases in which the participant transitions to another waiver program from the skilled nursing facility.

   Voluntary disenrollments are managed by DFHP RN Waiver coorindators and do not require approval by DMHF.

   Additional documentation will be maintained DFHP that includes a written statement signed by the participant, or their legal representative (when applicable) describing their intent to disenroll from the waiver program. This documentation should also outline discharge planning activities completed by the RN Waiver coordinator with the waiver participant as part of the disenrollment process.

2. Pre-Approved involuntary disenrollments are cases in which participants are involuntarily disenrolled from the waiver for any of the following reasons including:

   a. Death of the Participant;

   b. Participant has been determined to no longer meet the financial requirements for Medicaid program eligibility by the Department of Workforce Services;

   c. Participant enters a skilled nursing facility, and the expected length of stay will exceed 90 days (as verified by a physician); or

   d. Pre-Approved involuntary disenrollments require that RN Waiver coordinators notify DMHF within 10 days from the date of disenrollment. No DMHF prior review or approval of the decision to disenroll is required, as the reasons for pre-approved involuntary disenrollment have already been approved. Documentation will be maintained by the RN Waiver coorindator, detailing the discharge planning activities completed with the waiver participant as part of the disenrollment process when appropriate.

3. Special circumstance disenrollments are cases in which participants are involuntarily disenrolled for reasons that are non-routine in nature and involve circumstances that are specific to the participant. These cases require prior review and second level approval DMHF. Examples of this type of disenrollment include:

   a. Participant no longer meets the level of care requirements for the Waiver;

   b. Participant's health and safety needs cannot be met by the Waiver program's services and supports;

   c. Participant has demonstrated non-compliance with the agreed upon care plan and is unwilling to negotiate a plan of care that meets minimal safety standards;

d. Participant has demonstrated non-compliance with a signed health and safety agreement with Tech Waiver or the case management agency; or

e. Participant's whereabouts are unknown for more than 30 days, and a decision regarding ongoing financial eligibility from the Department of Workforce Services has not been rendered.

The special circumstance disenrollment review process will consist of the following activities:

- The RN Waiver coordinator shall compile information to articulate the disenrollment rationale;
- This information will then be submitted to DMHF for review of the support coordination activities, as well as the disenrollment recommendation;
- DMHF will review and assure that all State Plan, waiver, non-waiver and other available services/resources have been fully utilized to meet the participant's needs;
- DMHF/DFHP may facilitate meetings with appropriate parties, as needed, to complete the review and make an appropriate final decision on the proposed disenrollment; and
- DMHF will communicate a final disenrollment decision to the DFHP.

If the special circumstance disenrollment request is approved, DFHP will provide the participant, or their legal representative (when applicable), with the required written Notice of Action (NOA) and right to fair hearing information.

The case management agency will initiate discharge planning activities sufficient to assure a smooth transition to an alternate Medicaid program and/or to other services. Discharge planning activities shall be documented in the participant's case record.

2 - 12 Fair Hearings

Waiver applicants and recipients will be given the opportunity for a hearing if:

A. Determined eligible but not offered the choice of facility-based care or community-based Waiver services;

B. Denied the home and community-based Waiver services of their choice;

C. Denied the Waiver provider(s) of their choice if more than one provider is available to render the service(s); or

D. The RN Waiver coordinator takes an adverse action as described in Sections 2-9 and 2-10 of this provider manual;

3 SCOPE OF SERVICE

Waiver recipients are eligible to receive all regular State Plan Medicaid program benefits such as private duty nursing services, pharmaceuticals, and medical equipment and supplies. In addition, when necessary to prevent nursing facility placement and delivered pursuant to an approved plan of care, the following "Waiver services" are available:

Skilled Nursing Respite Care: Provided on behalf of the technology dependent recipient for the purpose of relieving the primary care-giver(s) from the stress of providing continuous care.

Family Support Services: Includes counseling and child-life services provided to the recipient and/or family members to help them cope with the stress that goes with the daily care of their technology dependent family member.

In-Home Feeding Therapy: Assessment and treatment services provided by a speech or occupational therapist to promote oral intake and self-feeding.

Home Health Certified Nursing Assistant: Provided under the Waiver when Home Health Aide services are required on the same day as a State plan home health service (and may be provided at the same time).

Financial Management Services: Authorized in conjunction with respite services when using the family-directed services model to facilitate employment of Registered Nurses by the individual or family.

Family Directed Support: Designed to provide education and instruction for Waiver families to ensure they are prepared to manage their own respite services and providers.

Extended Private Duty Nursing: Authorized for recipients 21 years of age and older who are denied Medicaid State plan private duty nursing solely based on age [no longer eligible for the Early and Periodic Screening Diagnosis and Treatment (EPSDT) program].

Details concerning coverage of these services are contained in the remainder of this chapter.

3 - 1 Skilled Nursing Respite Care

A. Definition

Skilled Nursing Respite Care is an intermittent service provided on behalf of an eligible individual to relieve the primary care giver from the stress of providing continuous care, thereby avoiding premature or unnecessary placement in a facility-based care setting. Skilled Nursing Respite Care may be provided by a Medicaid enrolled Home Health Agency or through the Family Directed Service model. Skilled Nursing Respite Care coverage includes an initial RN assessment to establish a new client. Skilled nursing Respite Care may be provided in the home or other approved com m unity settings.

B. Qualified Providers

Qualified respite care providers include:

1. Medicaid enrolled, licensed home health agencies which:

    a. Employ or contract with registered nurses, licensed practical nurses (licensed in accordance with Title 58, Occupational and Professional Licensing, Utah C ode Annotated, 1953 as am ended) and home health aides (certified in accordance with Utah Administrative Code R 432-700-22); and

    b. Are capable of providing respite care services to technology dependent, medically fragile individuals in their homes and other approved com m unity-based settings.

2. Registered Nurses in the State of Utah which:

    a. Are licensed in accordance with Title 58, Chapter 31b, Part 3, Occupational and Professional Licensing, Utah Code Annotated 1953 as amended (records kept by FMS);

    b. Complete and pass a background and criminal investigation check (records kept by FMS);

    c. Are covered under an individual nursing malpractice insurance policy (records kept by FMS);

    d. Have a current basic CPR certification (records kept by FMS);

    e. Are enrolled with a Financial Management Agency; and

    f. Demonstrate ability to perform the necessary skilled nursing functions to safely care for the recipient (Parent/Guardian/Client responsible for completing this function).

C. Reimbursement for Services

Respite care services must be prior authorized by the RN Waiver coordinator and be based on the needs of the individual and family. The RN Waiver coordinator in conjunction with the family and other professionals, if necessary, will determine the appropriate level of respite provider, the location and number of units that will be authorized.

D. Procedure Codes for Home Health Agency Respite Care

Unit of Service	Procedure Code	Modifier 1	Modifier 2	Provider Type(s)
RN, per 15 min	T 1005	U7		58 – Home Health Agency

RN (2 clients in home), per 15 min	T 1005	U7	TN	
LPN, per 15 min	T 1005	U7	TE	
Home Health Aide, per 15 min	T 1005	U7	52	

E. Procedure Codes for Family Directed (Individual) Respite Care

U nit of Service	Procedure Code	Modifier 1	Modifier 2	Provider Type(s)
Family Directed RN Respite	T1005		U7	

3 - 2 Family Support Services

A. Definition

Family Support Services include counseling and child life services. These supportive services are provided to the Waiver recipient and/or family members and are designed to guide and help them cope with the recipient's illness and the related stress that accompanies the continuous, daily care. Family Support services provide families, including siblings, with various methods and means to express themselves in ways that can bridge differences in age, language, abilities and cultural boundaries. Through support and coping strategies, the family is enabled to manage their stress which improves the likelihood that the recipients will continue to be cared for in the com m unity.

1. Family counseling provides counseling and emotional support to assist with psychosocial, spiritual, and economic needs. Examples beyond supportive need include accessing com m unity resources, decision-making, anticipatory and end-of-life planning.

2. Child life services enable the Waiver recipient and sibling(s) expressive outlets for dealing with stress and emotional issues. Child life specialists use various medium s, including art, music, play, and other forms of expression that are age and developmentally appropriate to facilitate communication of thoughts and feelings related to an illness, specific procedure or event.

3. All family support services are provided pursuant to a comprehensive assessment and treatment plan.

B. Qualified Providers

1. Medicare/Medicaid certified and enrolled home health agencies and Family Counseling Centers that employ or contract with a licensed MSW, LCSW and Child Life Specialists who have a minim um of a Bachelor's degree, specialized training and relevant work experience.

2. The Maternal and Child Health agency, and other qualified individuals or agencies only with approval of the State's Maternal and Child Health agency.

C. Reimbursement for Services

1. Services are authorized by the Waiver coordinator on the basis of family need. Whenever possible, the provider must contact the Waiver coordinator in advance of the counseling session to obtain authorization. If the provider delivers services to a family in crisis, the provider must notify the Waiver coordinator within 3 working days of the emergency to request authorization for payment of the service.

2. Family support services are limited to recipients and family members. Family members are defined as the persons who live with or directly provide care to the individual, and m ay include a parent, spouse, children, relatives, foster family, or in-laws. Family members do not include individuals who are employed to care for the individual.

D. Procedure Codes

U nit of Service	Procedure Code	Modifier 1	Modifier 2	Provider Type(s)
Child Life Services, per 15 minutes	H 2032	U7		46 - Agency, and 58 - Home Health Agency
Counseling, per 15 minutes	T 1027	U7		46 - Agency, and 58 - Home Health Agency

3 - 3 In-Home Feeding Therapy

A. Definition

In-Home Feeding Therapy is a service provided by a qualified professional to enhance the ability of an individual who cannot obtain adequate nutrition through ordinary means (oral intake of adequate food and nutritional substances). A licensed speech therapist or occupational therapist collaborates with the recipient's medical home and other professionals to assess function and provide options and instruction on promoting oral intake, evaluates self-feeding skills and modification of equipment for self-feeding and develops and instructs the caregiver on an in-home feeding program.

B. Qualified Providers

1. Medicare/Medicaid certified and enrolled home health agencies that employ or contract with licensed speech therapists and licensed occupational therapists with demonstrated ability to perform in-home feeding therapy.

2. The State's Maternal and Child Health agency and agencies under contract with the Maternal and Child Health agency.

C. Reimbursement for Services

In-Home Feeding Therapy must be prior authorized by the RN Waiver coordinator and be included in the plan of care. Services will be authorized on the basis of assessed need.

D. Procedure Codes

U nit of Service	Procedure Code	Modifier 1	Modifier 2	Provider Type(s)
In-Home Feeding Therapy per 15 minutes	G 0270	U7		46 - Agency, and 58 - Home Health Agency

3 - 4 Home Health Certified Nursing Assistant

A. Definition

The Home Health Certified Nursing Assistant will provide services under the Waiver when Home Health Aide service are required on the same day as a State plan home health nursing service (and may be provided at the same time). The certified nursing assistant will be employed by a Home Health Agency, supervised by an RN, and have the following responsibilities:

1. Provide only those services written in the home health agency's plan of care and receive written instructions from the RN supervisor;

2. Perform normal household services essential to health care at home;

3. Make occupied or unoccupied beds;

4. Perform basic diagnostic activities such as vital signs;

5. Perform activities of daily living as written in the home health agency's plan of care ;

6. Observe and record food and fluid intake when ordered;

7. Change dry dressings according to written instructions from the RN supervisor;

8. Administer emergency first aid;

9. Write clinical notes in individual patient records; and

10. Provide social interaction and reassurance to the recipient and family in accordance with the home health agency's plan of care. Write clinical notes in individual patient records; and

The Home Health Certified Nursing Assistant shall not perform duties defined as the practice of nursing according to Utah Code 58-31B. When providing Home Health Certified Nursing Assistant services for recipients under the Waiver program, a paid nursing professional, a trained parent or legal guardian, or a designated caregiver trained by the parent, guardian or responsible person must be present in the home. The Home Health Certified Nursing Assistant shall not be left alone to care for the technology dependent/medically fragile recipient.

B. Qualified Providers

Medicare/Medicaid certified and enrolled home health agencies that employ certified nursing assistants.

C. Reimbursement for Services

Home Health Certified Nursing Assistant services must be prior authorized by the Waiver coordinator and be included in the plan of care. Services will be authorized on the basis of assessed need.

D. Procedure Codes

U nit of Service	Procedure Code	Modifier 1	Modifier 2	Provider Type(s)
Home Health Certified Nursing Assistant per visit	T1021	U7		58 - Home Health Agency

3 - 5 Financial Management Services

A. Definition

This service will be authorized in conjunction with Waiver services under the approved family-directed services model. Services rendered under this definition include those to facilitate the employment of approved and qualified providers by the individual or family. Services include: (a) provider qualification verification, (b) employer-related activities including federal, state, and local tax withholding/payments, unemployment compensation fees, wage settlements, fiscal accounting and expenditure reports, (c) Medicaid claims processing and reimbursement distribution, and (d) providing monthly accounting and expense reports to the family and RN Waiver coordinators.

B. Qualified Providers

Medicaid enrolled Financial Management Agencies in compliance with State and local licensing, accreditation and certification requirements (Utah Code R58-26a).

C. Reimbursement for Services

Financial Management Services must be prior authorized by the Waiver coordinator and be included in the plan of care.

D. Financial Management Services Reimbursement
Reimbursement for self-administered services includes reimbursement for all mandatory employer payroll taxes, and workman's compensation insurance premiums. These costs should be paid in addition to the self-administered service rate established between the waiver participant and the employee. For example, if a waiver participant negotiates an hourly wage of $10 per hour with their self-administered services employee, mandatory employer burden costs (e.g. Social Security and Medicare taxes, Federal Unemployment Taxes, and Worker's Compensation Insurance premiums) are paid in addition to the $10 per hour wage. The employee's income tax withholding should be deducted from the negotiated wage.

E. Procedure Codes

U nit of Service	Procedure Code	Modifier 1	Modifier 2	Provider Type(s)
Financial Management Services per month	T2040	U7		

3 - 6 Family Directed Support

A. Definition

This service is designed to ensure Waiver families are prepared to manage their own respite service and providers. Family Directed Support services include:

1. Information to ensure that the recipient/family understands the responsibilities in directing their own care;

2. Instruction in how to effectively communicate with service providers;

3. Instruction in the management of service providers including interviewing, selecting, scheduling, termination, time sheeting, and evaluating performance

4. Information on individual rights, filing grievances, and risk management;
5. Advocacy training;
6. Developing emergency plans; and
7. Developing forms and maintaining documentation.

Family Directed Support services do not include educational, vocational or prevocational components.

B. Qualified Provider

1. Clinical Social Worker licensed in the State of Utah, per Utah Code 58-60 Part 2, who is enrolled as a Medicaid Waiver provider with demonstrated ability to perform Family Directed Support functions.
2. Medicare/Medicaid certified and enrolled Family Counseling Centers who employ Clinical Social Workers licensed in the State of Utah per Utah Code 58-60 Part 2 with demonstrated ability to perform Family Directed Support functions.
3. Medicaid enrolled Financial Management Agencies in compliance with State and local licensing, accreditation and certification requirements (Utah Code R58-26a).

C. Reimbursement for Services

Family Directed Support services must be prior authorized by the RN Waiver coordinator and be included in the plan of care.

D. Procedure Codes

U nit of Service	Procedure Code	Modifier 1	Modifier 2	Provider Type(s)
Family Directed Support per session	S5111	U7		

3 - 7 Extended Private Duty Nursing

A. Definition

Extended private duty nursing services will be authorized for recipients 21 years of age and older who are denied Medicaid state plan private duty nursing solely based on age [no longer eligible for the Early and

Periodic Screening, Diagnosis and Treatment (EPSDT) program].

Eligibility and access for this service are based on the following State Plan requirements:

1. The recipient must require more than four continuous skilled nursing hours of care per day;

2. The recipient must have a written physician order for private duty nursing service; and

3. Providers shall submit prior authorization request to the RN Waiver coordinators with the required medical documentation (Home Health Agency Form 485, the Medicaid approved PDN acuity grid and skilled nursing assessment form, nursing notes and other relevant documentation) which demonstrates the need for the service.

B. Qualified Provider

Medicare/Medicaid certified and enrolled licensed home health agencies who:

1. Employ or contract with registered nurses and licensed practical nurses (licensed in accordance with Title 58, Occupational and Professional Licensing, Utah Code Annotated, 1953 as amended).

2. Are capable of providing private duty nursing services to technology dependent, medically fragile individuals in their homes.

C. Reimbursement for Services

Extended private duty nursing services will be prior authorized by the RN Waiver coordinators. Limits on the amount, frequency and/or duration are specified in the individual's plan of care and are based on assessed needs.

D. Procedure Codes

U nit of Service	Procedure Code	Modifier 1	Modifier 2	Provider Type(s)

RN - Extended Private Duty Nursing per unit	T1000	U7		58 - Home Health Agency
LPN - Extended Private Duty Nursing per unit	T1000	TE	U7	58 - Home Health Agency

4 RECORD KEEPING

A. All home and community-based Waiver service providers must develop and maintain written documentation for each billed service that indicates the following:

1. The name of the individual;
2. The specific services rendered as they relate to the plan of care;
3. The date each service was rendered;
4. The amount of time it took to deliver the service(s);
5. The setting in which the services were rendered (e.g. home, office, etc.); and
6. The qualified individual who rendered the services.

B. The record must be kept on file and made available as requested for State of Federal auditing and assessment purposes.

5 PROCEDURE CODES (SUMMARY)

The following list of procedure codes is a summary of codes covered by Medicaid under the Home and Community-Based Waiver for Technology Dependent, Medically Fragile Individuals. All services are limited to the provider types noted for each procedure code.

PROCEDURE CODE	MODIFIER 1	MODIFIER 2	DESCRIPTION	PROVIDER TYPE

T1005 T1005 T1005	U7 TE 52	 U7 U7	**Respite Care, Agency** RN, per 15 min LPN, per 15 min HH Aide, per 15 min	58 – Home Health Agency
T1005	U7	TN	RN, per 15 min (2 clients in home)	58- Home Health Agency
T1005 T1005	U7 U7		**Respite Care, Family-Directed** RN, per 15 min RN, per 15 min (2 clients in home)	
H2032 T1027	U7 U7		**Family Support Services** Child Life Service, per 15 min Counseling, per 15 min	46 – Agency and 58 – Home Health Agency
G0270	U7		**In-Home Feeding Therapy** Speech Therapist, per 15 min Occupational Therapist, per 15 min	46 – Agency and 58 – Home Health Agency
T1021	U7		**Home Health Certified Nursing Assistant** Certified Nursing Assistant, per visit	58 – Home Health Agency
T2040	U7		**Financial Management Services** per month	
S5111	U7		**Family Directed Support** per session	

T1000 T1000	U7 TE	U7	**Extended Private Duty Nursing** RN, per 15 min LPN, per 15 min	58 – Home Health Agency

5 - 1 Electronic Visit Verification

Electronic visit verification (EVV) requirements, defined in section 12006 of the 21st Century Cures Act, are effective for Utah Medicaid beginning July 1, 2019. EVV requirements apply to all personal care services and home health care services provided under a 1915 (c) Home and Community Based Waiver.

Choice of reporting systems for EVV are by provider preference, but must meet all federal requirements, including the standards set in the Health Insurance Portability Accountability Act. The State will not implement a mandatory model for use. All provider choice EVV systems must be compliant with requirements of the Cures Act including:

1) type of service performed;
2) individual receiving the service;
3) date of the service;
4) location of service delivery;
5) individual providing the service;
6) time the service begins and ends; and
7) the date of creation of the electronic record.

Additional information including technical specifications for file creation/submission and EVV resources can be found at https://medicaid.utah.gov/evv

6 INCIDENT REPORTING PROTOCOL

I. Purpose:

The State Medicaid Agency (SMA) has the administrative authority over all 1915(c) Medicaid Home and Community Based Services (HCBS) Waivers (Waivers). Waiver programs must provide adequate and appropriate services that safeguard the health and welfare of all enrolled recipients. Waiver programs must also assure financial accountability for funds expended for HCBS services. While these responsibilities are delegated to the Operating Agencies (OA), the SMA retains final authority and has the final responsibility to: 1) assure that appropriate actions have taken place when a critical incident or event occurs; and 2) in cases where appropriate safeguards were not in place, that an analysis is conducted and appropriate strategies have been implemented to safeguard recipients.

The Critical Incidents and Events Program is a collaborative effort between the OAs for each of the 1915(c) Waivers and the SMA. The program has two levels. Level one describes the critical incidents/events that are required to be reported by the OA to the SMA for investigation, resolution and closure. Level two describes the critical incidents/events that are required to be reported to the OA for investigation, resolution and closure. This Standard Operating Procedure stipulates:

- Level One incidents and events required to be reported to the SMA;
- Level Two incidents and events that are required to be reported to the OA;
- The agency responsible for completing the review; and
- Associated reporting requirements.

II. Reportable Critical Incidents/Events

Level One Incidents and Events – Reportable to the SMA
The following list of the incidents/events (incidents) must be reported by the OA to the SMA. This is not an all-inclusive list. Other incidents that rise to a comparable level must be reported to the SMA.

1. Abuse/Neglect (Either Alleged or Substantiated)
Incidents of abuse or neglect, that resulted in the recipient's **admission to a hospital.**

2. Attempted Suicides
Suicide attempts that resulted in the recipient's **admission to a hospital**.

3. Human Rights Violations
Human rights violations such as the *unauthorized* use of restraints (physical, mechanical or chemical), seclusion rooms or infringement of personal privacy rights experienced by the recipient. (Infringement of personal privacy rights is defined as an unwanted restriction imposed upon the recipient.) Reporting is not required for Emergency Behavioral Interventions as defined in R539-4-6.

4. Incidents Involving the Media or Referred by Elected Officials
Incidents that have or are anticipated to receive public attention (i.e. events covered in the media or referred by the Governor, legislators or other elected officials).

5. Medication Errors
Errors relating to a recipient's medication that resulted in the recipient's **admission to a hospital**.

6. Missing Persons
For reporting purposes, the following recipients are considered to be missing:
a. Recipients who have been missing for at least twenty-four hours; or
b. Regardless of the number of hours missing – any recipient who is missing under unexplained, involuntary or suspicious circumstances and is believed to be in danger because of age, health, mental or physical disability, environment or weather or who could be in the company of a potentially dangerous person or some other factor that places the recipient in peril.

7. Unexpected Deaths
All deaths are considered unexpected *with the exception of:*
a. Recipients receiving hospice care; and/or
b. Deaths due to natural causes, general system failure or terminal/chronic health conditions.

8. Unexpected Hospitalization
Serious burns, self-injurious behavior or injuries resulting in loss of physical or mental function such as a loss of limb, paralysis, brain injury or memory loss experienced by a recipient that resulted in **admission to a hospital**

for medical treatment.

9. Waste, Fraud or Abuse of Medicaid Funds
Incidents that involve alleged or confirmed waste, fraud or abuse of Medicaid funds by either a provider or a recipient of Medicaid services.

Procedure for Reporting to the State Medicaid Agency:

- On the first business day after a critical incident has occurred[1], a representative from the OA will notify a member of the SMA Quality Assurance Team via email, telephone or in person. If the OA has any question about whether a case meets the criteria for reporting to the SMA, the OA will contact the SMA for technical assistance.

- Within ten business days after notification, the OA will submit a completed Critical Incident Investigation form to the SMA.

- Within five business days after receiving the Critical Incident Investigation form the SMA will review the investigation form submitted by the OA and will contact the OA if additional information or action is required.

- When the SMA determines the investigation is complete, the SMA will document any findings or corrective action requirements on the SMA portion of the investigation form. The SMA will send the OA a copy of the finalized document, closing the case. In some cases, the SMA may continue to monitor findings or corrective actions.

- Within two weeks after closing the case, the SMA will notify the client or the client's representative of the investigation results. A copy of the notification letter will be provided to the OA. The following types of incidents are excluded from the notification letter requirement: suicide, death and investigations that conclude with dis-enrollment.

III. Level Two Incidents and Events - Reportable to the OA

The following incidents must be reported by providers, recipients and/or their representatives to the OA, but are not required to be reported to the SMA. This is not an all-inclusive list. Other incidents that rise to a comparable level must be reported to the OA.

1. Abuse/Neglect/Exploitation (Either Alleged or Substantiated)
a. Incidents of abuse or neglect, that resulted in medical treatment at a medical clinic or emergency room.
b. Exploitation of recipient's funds.

[1] In some cases it will not be possible to report the incident by the next business day after occurrence. In those cases, the incident must be reported the first business day after discovery. The SMA will review cases that are reported after discovery to evaluate whether the case should have been reported after occurrence, and if so, where the breakdown in reporting occurred. [2] In some cases it will not be possible to report the incident by the next business day after occurrence. In those cases, the incident must be reported the first business day after discovery. The SMA will review cases that are reported after discovery to evaluate whether the case should have been reported after occurrence, and if so, where the breakdown in reporting occurred.

2. Attempted Suicides
Suicide attempts that **did not** result in the recipient being admitted to a hospital.

3. Compromised Working or Living Environment
An event in which the recipient's working or living environment (e.g. roof collapse, fire, etc.) is compromised and the recipient(s) require(s) evacuation.

4. Law Enforcement Involvement
Activities perpetrated by the recipient resulting in charges filed by law enforcement. For this category, the date of the incident will be recorded as the date on which the filing of charges occurred.

5. Medication Errors
Errors relating to a recipient's medication which result in the recipient experiencing adverse side effects requiring medical treatment at a medical clinic or emergency room.

6. Unexpected Hospitalization
Injuries, aspiration or choking experienced by recipients that resulted in **admission to a hospital**. *(These do not include serious burns, self-injurious behavior or injuries resulting in loss of physical or mental function such as a loss of limb, paralysis, brain injury or memory loss experienced by a recipient that resulted in **admission to a hospital for medical treatment** .which is reportable to the SMA).*

Procedure for Reporting to the Operating Agency

- On the first business day after a critical incident has occurred[2], a representative from the case management or support coordination agency (case manager) will notify the OA via email, telephone or in person.

- Within ten business days after notification, the case manager will submit a completed Critical Incident Investigation form to the OA.

- Within five business days after receiving the Critical Incident Investigation form the OA will review the investigation form submitted by the case manager and will contact the case manager if additional information or action is required.

- When the OA determines the investigation is complete, the OA will document any findings or corrective action requirements on the OA portion of the investigation form. The OA will send the case manager a copy of the finalized document, closing the case. In some cases, the OA may continue to monitor findings or corrective actions.

- Within two weeks after closing the case, the case manager will notify the client or the client's representative (in person, phone or in writing) of the investigation results and document notification in the client's record. The following types of incidents are excluded from the notification requirement: suicide, death and investigations that conclude with dis-enrollment.

[2] In some cases it will not be possible to report the incident by the next business day after occurrence. In those cases, the incident must be reported the first business day after discovery. The SMA will review cases that are reported after discovery to evaluate whether the case should have been reported after occurrence, and if so, where the breakdown in reporting occurred.

IV. Required Reports

OA Quarterly Report

The OA will submit a Waiver specific quarterly report to the SMA, no later than one month after the end of the quarter (October 31, January 31, April 30, July 31) that includes:

- name of the client
- date of the incident
- date the incident was reported to the OA
- category of the incident: incidents such as abuse/neglect/exploitation, law enforcement involvement, medication errors and unexpected hospitalization should be further categorized by type
- brief summary of the incident and its resolution
- date the case was closed
- brief description of any corrective action required of the case manager or other provider

OA Annual Report

The OA will submit a Waiver specific annual report to the SMA, no later than two months after the end of the fiscal year (August 31) that includes:

- total number of incidents
- number of incidents by category: incidents such as abuse/neglect/exploitation, law enforcement involvement, medication errors and unexpected hospitalization should be further categorized by type
- number of incidents that resulted in corrective action by the case manager or other provider
- number of corrective actions that were implemented
- number of incidents where the client/representative was informed of the investigation results, and the number of incidents where the contact was made within 14 days of the investigation closure
- summary analysis of whether any systemic trends were noted that may require additional intervention or process improvement steps
    - If trends were noted, the report will include a description of the process improvement steps that will be implemented

State Medicaid Agency Annual Report

For incidents that are reportable to the SMA, the SMA will submit an annual report to the State Medicaid Director and OA Division Directors that includes:

- For each Waiver:
    - number of incidents
    - number of incidents by category: incidents such as abuse/neglect/exploitation, law enforcement involvement, medication errors and unexpected hospitalization should be further categorized by type
    - number of incidents that resulted in corrective action by the OA, case manager or other provider
    - number of corrective actions that were implemented

- Summary of all Waivers:

- number of incidents
- number of incidents by category: incidents such as abuse/neglect/exploitation, law enforcement involvement, medication errors and unexpected hospitalization should be further categorized by type
- number of incidents that resulted in corrective action by the case manager or other provider
- number of corrective actions that were implemented
- summary analysis of whether any systemic trends were noted that may require additional intervention or process improvement steps
- If trends were noted, the report will include a description of the process improvement steps that will be implemented.