

SECTION 2

**UTAH HOME AND COMMUNITY - BASED WAIVER SERVICES
New Choices Waiver
PROVIDER MANUAL**

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1 GENERAL POLICY

Under section 1915c of the Social Security Act, a State may request approval through the federal Centers for Medicare and Medicaid Services (CMS) to “waive” certain statutory requirements in order to use Medicaid funds for an array of home and community-based medical assistance services provided to eligible recipients as an alternative to institutional care. The State of Utah has requested Medicaid reimbursed home and community-based waiver services for individuals who are currently in Nursing Facilities and wish to return to the community, and who but for the provision of such services, would require continued Nursing Facility placement. On April 1, 2007 the Division of Medicaid and Health Financing received approval from CMS to begin operating the New Choices Waiver. The approval includes waivers of:

- the “state wideness” requirements in subsection 1902(a)(1) of the Social Security Act, and
- the “comparability” requirements in subsection 1902(a)(10)(B) of the Social Security Act, and
- the institutional deeming requirements in section 1902(a)(10)(C)(i)(III) of the Social Security Act .

Waiver of Statewideness

Under the waiver of State wideness the State is permitted to provide covered waiver services to eligible individuals who reside in limited geographic areas of the State. On May 1, 2007 New Choices Waiver began implementing services in the following counties: Beaver, Davis, Garfield, Iron, Kane, Morgan, Salt Lake, Tooele, Washington and Weber Counties. On January 1, 2008, six additional counties were added: Box Elder, Cache, Summit, Rich, Utah, and Wasatch Counties. Beginning July 1, 2008, the State’s remaining thirteen counties were added: Carbon, Daggett, Duchesne, Emery, Grand, Juab, Millard, Piute, San Juan, Sanpete, Sevier, Uintah, and Wayne Counties.

Waiver of Comparability

In contrast to Medicaid State Plan services requirements, under a waiver of comparability, the State is permitted to provide covered waiver services to eligible individuals who meet the State’s criteria for Medicaid reimbursement in a nursing facility (NF), and “Waiver services” need not be comparable in amount, duration, or scope to services covered under the State Plan. However, each year the State must demonstrate that the waiver is a “cost-neutral” alternative to institutional (NF) services. This means that, in the aggregate, the total annual Medicaid expenditures for waiver recipients, including their State Plan services, cannot exceed the estimated Medicaid expenditures had those same recipients received Medicaid-funded NF services.

Waiver of Institutional Deeming Requirements

Under the waiver of institutional deeming requirements the State uses more liberal eligibility income and resource calculations when determining recipients’ Medicaid eligibility.

1 - 1 Acronyms and Definitions

For purposes of the New Choices Waiver the following acronyms and definitions apply:

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| CMS | Centers for Medicare and Medicaid Services |
| DMHF | Division of Medicaid and Health Financing |
| HCBS | Home and Community-Based Services |
| New Choices Waiver | The Medicaid 1915c HCBS Waiver Program that was developed to assist Medicaid recipients living in a nursing institution return to a community setting. Services may be provided in a participants’ residence, a family members residence or in an assisted living that has directly contracted with the New Choices Waiver. |

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- NF** Nursing facility
- SFY** State Fiscal Year
- SMA** State Medicaid Agency

1 - 2 CMS Approved Waiver Implementation Plan

- A. The State Implementation Plan for the New Choices Waiver, approved by CMS, serves as the State's authority to provide home and community services to the target group under its Medicaid plan. That document and all attachments constitute the terms and conditions of the program.
- B. This manual does not contain the full scope of the Waiver State Implementation Plan. To understand the full scope and requirements of the New Choices Waiver program, the Waiver State Implementation Plan should be referenced.
- C. In the event provisions of this manual are found to be in conflict with the State Implementation Plan, the State Implementation Plan will take precedent.

2 SERVICE AVAILABILITY

- A. Home and community-based waiver services are covered benefits only when provided:
1. to an individual determined to meet the eligibility criteria defined in the CMS approved Waiver State Implementation Plan;
 2. pursuant to a written comprehensive care plan.

2 – 1 Eligibility for Waiver Program

- A. Home and community-based New Choices Waiver services are covered benefits only for Medicaid participants who at the time of admission:
1. have reached the month after their 21st birthday;
 2. are receiving Medicaid reimbursed nursing facility care on an extended stay basis of 90 days or more;
 3. are currently receiving Medicare or Medicaid reimbursed care in a licensed Utah medical institution other than a Medicaid certified nursing facility, on an extended stay of at least 30 days, and will discharge to a nursing facility for an extended stay of at least 60 days absent enrollment into the waiver program; or
 4. are receiving Medicaid reimbursed services through another of Utah's 1915 (c) waivers and have been identified in need of immediate (or near immediate) nursing facility placement absent enrollment into the New Choices Waiver program.
- *In the case of acute care hospitals, specialty hospitals, and Medicare skilled nursing facilities, participation is limited to individuals who are admitted for the purpose of receiving a medical, non-psychiatric level of care more acute than the Medicaid nursing facility level of care provided in R414-502.*
 - *Individuals who meet the intensive skilled level of care as provided in R414-502 are not eligible for participation in the New Choices Waiver.*
 - *Individuals who meet the level of care criteria for admission to an Intermediate Care Facility for Individuals with Mental Retardation (ICF-MR) as provided in R414-502 are not eligible for participation in the New Choices Waiver.*

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- B. In determining whether the applicant has mental or physical conditions that can only be cared for in a nursing facility or the equivalent care provided through the New Choices Waiver; the individual responsible for assessing level-of-care shall, in accordance with R414-502, document that at least two of the following factors exist:
1. Due to diagnosed medical conditions, the individual requires substantial physical assistance with activities of daily living above the level of verbal prompting, supervision, or setting up;
 2. The attending physician has determined that the individual's level of dysfunction in orientation to person, place, or time requires nursing facility care; or equivalent care provided through the New Choices Waiver; or
 3. The medical condition and intensity of services indicate that the care needs of the individual cannot be safely met in a less structured setting, or without the services and supports of the New Choices Waiver
- C. An individual will not be enrolled if it is determined during the eligibility assessment process that the health, welfare, and safety of the individual cannot be maintained through the New Choices Waiver program.
- D. Inpatients of hospitals or nursing facilities are not eligible to receive waiver services (except as specifically permitted for case management discharge planning in the 180-day period before their discharge to the New Choices Waiver).

2 - 2 Applicant Freedom of Choice of Nursing Facility or New Choices Waiver

- A. Medicaid recipients who meet the eligibility requirements of the New Choices Waiver may choose to continue to receive services in a Nursing Facility (NF) or through the New Choices Waiver.
- B. A pre-enrollment review of eligibility will be completed by a representative from the Long Term Care Bureau. The applicant or their chosen representative will be advised of available services and given the opportunity to choose to receive services through a NF or the New Choices Waiver. The applicant's choice will be documented in writing on the New Choices Waiver Freedom of Choice Consent Form , signed by the applicant or their representative, and maintained as part of the individual record.
- C. New Choices Waiver participants have the option to choose institutional (NF) care at any time and voluntarily disenroll from the New Choices Waiver.

2 - 3 New Choices Waiver Participants' Freedom of Choice of Service Providers

- A. Upon initial determination of eligibility for the New Choices Waiver, a representative from the Long Term Care Bureau will provide the participant with a list of available waiver case management agencies. The applicant's choice will be documented in the case record and the application will be sent to the selected case management agency.
- B. Upon completion of the comprehensive needs assessment by the Registered Nurse from the case management agency selected by the participant, a Comprehensive Care Plan will be developed to address the participant's identified needs.
- C. The participant will sign a Freedom of Choice of Providers form acknowledging that they were given a choice of service providers. This form will clearly list all available services and service providers in the participants' County of residence. The participant will be required to select from this list of service providers. The Case Management Agency will be responsible for maintaining a signed copy of this notice in their case records.

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- D. The Case Management Agency will review the contents of the Care Plan with the participant and submit it to the Waiver Operating Agency prior to implementation. The approval of the Care Plan by the Waiver Operating Agency will constitute formal authorization of the services to be provided to the participant.
- E. The Comprehensive Care Plan will include a statement notifying the participant of their right to appeal any denial of service decision, for a service that they are eligible to receive, to the State Medicaid Agency. The participant must acknowledge receipt of the notice of decision and right to a fair hearing by signing the Comprehensive Care Plan. The case management agency will be responsible for maintaining a written copy or electronic facsimiles of these plans of care for a minimum period of 3 years as required by 45 CFR 74.53.
- F. Subsequent revision of the participant's Comprehensive Care Plan as a result of an annual re-assessment or a significant change in the participant's health, welfare, or safety requires proper notice to the participant as described above in C. In addition, participant must be advised that they have the right to select to receive services in a Medicaid NF in lieu of continued participation in the waiver.
1. A significant change is defined as a major change in the participant's status that:
 - is not self-limiting;
 - impacts on more than one area of the participant's health status; and
 - requires interdisciplinary review and/or revision of the plan of care.

NOTE: A condition is defined as self-limiting when the condition will normally resolve itself without intervention by waiver personnel. Generally, if the condition has not resolved within approximately two weeks, staff should begin a comprehensive reassessment.

2. A comprehensive reassessment is required if a significant change is consistently noted in two or more areas of decline, or two or more areas of improvement.

2 - 4 Termination of Home and Community-Based Waiver Services

The Waiver Operating Agency will compile information on voluntary disenrollments, and routine involuntary disenrollments and will conduct reviews of proposed special circumstance disenrollments from the waiver.

- A. Voluntary disenrollments are cases in which participants choose to initiate disenrollment from the waiver. These cases require written notification to the Waiver Operating Agency, by the case management agencies within 10 days from date of disenrollment. Documentation will be maintained by the contracted waiver case management agency detailing the discharge planning activities completed with the waiver participant as part of the disenrollment process.
- B. Pre-Approved involuntary disenrollments are cases in which participants are involuntarily disenrolled from a home and community based waiver program for any one or more of the specific reasons listed below:
- Participants' death;
 - Participant I has entered a Nursing Home on an extended stay;
 - Participant no longer meets financial requirement for Medicaid program eligibility;
 - Participant has moved out of the State of Utah; or
 - Participants' whereabouts are unknown.

Pre-Approved involuntary disenrollments require written notification to the Waiver Operating Agency by the contracted case management agency within 10 days from the date of disenrollment. Waiver Operating Agency prior review or approval of the decision to disenroll in these situations is not required. Documentation will be maintained by the contracted case management agencies detailing the discharge planning activities completed with the waiver participant as part of the disenrollment process, as appropriate.

Special circumstance disenrollments are cases that are non-routine in nature and involve circumstances that are specific to the participant involved. Examples of this type of disenrollment include the waiver

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participant no longer meets the institutional level of care requirements, the participant's health and safety needs cannot be met by the current program's services and supports, or the 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.

E. Special circumstance disenrollments require review and authorization **prior** to disenrollment to facilitate:

1. Appropriate movement among programs;
2. Effective utilization of program potential;
3. Effective discharge and transition planning;
4. Provision of information, affording participants the opportunity to exercise all rights; and
5. Program quality assurance/quality improvement measures.

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

1. The contracted case management agency recommending disenrollment will compile information to articulate the disenrollment rationale.
2. The contracted case management agency will then submit the information to the Waiver Operating Agency for review of the documentation of case management activities and of the disenrollment recommendation.
3. The Waiver Operating Agency will review and assure the available array of Medicaid waiver and non-waiver services, and other available resources have been fully utilized to meet the individual's health and safety needs.
4. The Waiver Operating Agency will facilitate case staffing meetings with appropriate parties, as needed, to complete the review and make an appropriate final decision on the proposed disenrollment.
5. The Waiver Operating Agency's final disenrollment decision will be communicated to the case management agency in writing.

G. If the disenrollment is approved, the case management agency will provide to the participant the required written notification of agency action and right to fair hearing information.

H. The case management agency will initiate discharge planning activities sufficient to assure smooth transition to an alternate Medicaid program or to other services.

2 - 5 Fair Hearings

A. The State Medicaid Agency provides an eligible individual applying for or receiving waiver services an opportunity for a hearing upon written request, if the eligible individual is:

1. Not given the choice of institutional (NF) care or HCBS waiver services.
2. Denied the waiver provider(s) of choice if more than one provider is available to render the service(s).
3. Denied access to waiver services, that they are eligible to receive, identified as necessary to prevent institutionalization.

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- B. An eligible individual and the individual's legal representative, as applicable, will receive a written Notice of Agency Action from the Waiver Operating Agency if the individual is denied a choice of institutional or New Choices Waiver program, or subsequently found ineligible for the waiver program.
- C. An eligible individual and the individual's legal representative, as applicable, will receive a written Notice of Agency Action from the Waiver Operating Agency if the individual is denied access to the provider of choice for a covered waiver service. The Notice of Agency Action delineates the individual's right to appeal the decision.
- D. An aggrieved participant may request a formal hearing within 30 calendar days from the date written notice is issued or mailed, whichever is later. The State Medicaid Agency may reinstate services for participants or suspend any adverse action for providers if the aggrieved person requests a formal hearing not more than ten calendar days after the date of action.
- E. The participant is encouraged to utilize an informal dispute resolution process to expedite equitable solutions but may forgo or interrupt the available informal resolution process at any time by completing a request for hearing and directing the request be sent to the State Medicaid Agency for a formal hearing and determination.
- F. An informal dispute resolution process does not alter the requirements of the formal fair hearings process. The individual must still file a request for hearing and a request for continuation of services within the mandatory time frames established by the State Medicaid Agency. An informal dispute resolution must occur prior to the deadline for filing the request for continuation of service and/or the request for formal hearing, or be conducted concurrent with the formal hearing process.

3 PROVIDER PARTICIPATION

3 - 1 Provider Enrollment

- A. Home and community-based waiver services for participants who are seeking deinstitutionalization from a NF are covered benefits only when delivered by a provider enrolled with the State Medicaid Agency to provide the services as part of the New Choices Waiver, and authorized by a New Choices Waiver case management agency.
- B. Any willing provider that meets the qualifications defined in the New Choices Waiver Implementation Plan, Appendix C-2, may enroll at any time to provide a New Choices Waiver service by contacting the Waiver Operating Agency. The Waiver Operating Agency will facilitate completion and submission of the required Medicaid provider application. The provider is only authorized to provide the waiver services specified and approved in Attachment A of the Medicaid provider agreement.

3 - 2 Provider Reimbursement

- A. A unique provider number is issued for each of the waiver Service Providers. When submitting claims for reimbursement, the Provider must use the proper provider number associated with the waiver for the waiver participant receiving the services. Claims containing a provider number that is not associated with the proper waiver will be denied.
- B. Providers will be reimbursed according to the specified reimbursement rate(s). (see rate table)
- C. Providers may only claim Medicaid reimbursement for services that are ordered by the responsible New Choices Waiver Case Management Agency. The Case Management Agency will supply the provider with a service authorization form clearly identifying the New Choices Waiver service requested, the HCPC billing code, as well as the amount and frequency of the service ordered. Claims must be consistent with the amount and frequency ordered by the waiver Case Management Agency in order to be paid. Any services provided that exceed the amount authorized will not be considered reimbursable.

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D. Providers are accountable for all Terms of Agreements as defined in the Utah Department of Health Division of Medicaid and Health Financing Provider Agreement, which was signed upon enrollment with the New Choices Waiver.

3 - 3 Standards of Service

Providers must adhere to service standards and limitations described in this manual, the terms and conditions of the Medicaid provider agreement, and the terms and conditions of the New Choices Waiver Implementation Plan.

3 - 4 Provider Rights to a Fair Hearing

The Department provides hearing rights to providers who have had any adverse action taken by the Long Term Care Bureau, Division of Medicaid and Health Financing, Utah Department of Health, who submit a written request for a hearing to the agency. Please refer to Utah Department of Health, Division of Medicaid and Health Financing Provider Manual, General Information, Section 1, Chapter 6 – 15, Administrative Review/Fair Hearing. This includes actions relating to enrollment as a waiver provider, contract reimbursement rates, sanctions or other adverse actions related to provider performance, or improper conduct of the agency in performing delegated waiver responsibilities.

4 PRIOR AUTHORIZATION OF WAIVER SERVICES

All waiver services must be authorized by the Waiver Operating Agency prior to being provided in order to be eligible for payment. The selected Case Management Agency will submit the individual Comprehensive Care Plan to the Waiver Operating Agency for approval prior to implementation. The signature of an authorized Waiver Operating Agency representative on the Comprehensive Care Plan and its return to the Case Management Agency will constitute prior approval. The Case Management Agency will provide the selected service provider with a New Choices Waiver Service Provider Authorization. The Provider Authorization form clearly identifies participants name, Medicaid number, service start date, approved waiver service, approved service units, and HCPC code. Units listed on the Service Provider Authorization form may not exceed units approved by the Waiver Operating Agency. Any services provided in excess of approved amounts are not billable to Medicaid and recoupment of any paid claims in excess of approved amounts will be made.

5 CASE MANAGEMENT

5 - 1 Case Management Encounters

To better focus primary attention on providing the specific level of case management intervention needed on an individualized basis, as determined during the initial and ongoing comprehensive needs assessment process, the individual comprehensive care plan will be the vehicle through which the level of assessed need for case management will be detailed in terms of amount, duration and frequency.

5 - 2 MDS-HC Assessment Instrument

The Inter RAI MINIMUM DATA SET - HOME CARE (MDS-HC) serves as the standard comprehensive assessment instrument used in the New Choices Waiver. It includes all the data fields necessary to measure the participant's level of care as defined in the State's Medicaid nursing facility admission criteria. Registered Nurses responsible for collecting the needed information and for making the level of care determinations are trained by staff of the State Medicaid Agency in the proper application of the MDS-HC instrument and the proper analysis of the MDS-HC data to perform level of care evaluations.

6 Self Administered Services

A. The self administered employer authority requires the waiver participant to use a Waiver Financial Management Services Agent as an integral component of the waiver services to assist with managing the employer-related financial responsibilities associated with the employer-employee relationship. The Waiver Financial Management Services Agent is a person or organization that assists waiver participants and their

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representatives, when appropriate, in performing a number of employer-related tasks, without being considered the common law employers of the service providers. Tasks performed by the Waiver Financial Management Services Agent include documenting service provider's qualifications, collecting service provider time records, preparing payroll for participants' service providers, and withholding, filing, and depositing federal, state, and local employment taxes.

- B. Participant employed service providers complete a time sheet for work performed. The participant confirms the accuracy of the time sheet, signs it, and forwards it to the Waiver Personal Services Agent for processing. The Waiver Financial Management Agent files a claim for reimbursement through the Medicaid MMIS system and upon receipt of payment, completes the employer-related responsibilities, deducts the established administrative fee, and forwards payment directly to the service provider for the services documented on the time sheet.

7 Service Provider Interaction with Case Management Agency

Service providers participating in the New Choices Waiver must adhere to the following requirements covering interactions with the participant selected Case Management Agency.

- A. All negative incidents involving a waiver participant must be reported within twenty four hours to the Case Management Agency. This is in addition to APS reporting requirements and does not negate the individual providers' obligation to report when the incident involves abuse, neglect or exploitation. Negative incidents may include, but are not limited to:
 1. Death of a waiver participant.
 2. Events that resulted in the need to obtain direct intervention by a medical professional. (IE: physician office visit, emergency room visit, or hospitalization)
 3. Events in which the waiver participants injures another waiver participant or staff of a waiver services provider if the injury results in seeking direct intervention by a medical professional. (IE: physician office visit, emergency room visit, or hospitalization)
 4. Events requiring law enforcement intervention.
- B. Providers may only provide waiver services as ordered by the waiver participants' Case Management Agency and approved by the Long Term Care Bureau, Department of Health. Any concerns regarding ordered services should initially be addressed with the Case Management Agency.
- C. All services must be coordinated through the Case Management Agency in order to ensure maximum benefit and Care Plan adherence.

8 WAIVER COVERED SERVICES RATE SETTING METHODOLOGY

The State uses four principal methods to set the Maximum Allowable Rate level. Each method is designed to determine a fair market rate. Additionally, the process may be adjusted on occasion to account for common factors such as the geographical location of service delivery, absentee factors, or budget constraints, etc.

- A. Existing Market Survey or Cost Survey of Current Providers.

This methodology surveys existing providers to determine their actual cost to render a service. This would include direct labor, supervision, administration, non-labor costs allocated to the purchased service and the basis of cost allocations. The surveys are designed to assure all providers are reporting costs in a standardized manner and within allowable costs parameters established. Surveys are examined to determine if cost definitions, allocations and reporting are consistent among respondents and accurately include reasonable costs of business. The rate is set using a measure of central tendency such as median, mode or weighted average and adjusted if necessary to reflect prevailing market conditions.

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B. Component Cost Analysis

The estimated cost of each of the various components of a service code (treatment, administration, direct labor, non-labor costs allocated to the service, etc.) are determined and added together to determine a provisional rate. This method is often used for a new or substantially modified service that does not currently exist in the market place. Provisional rates are designed to determine a fair market rate until historical data becomes available. At a later date when historical cost data does become available a market survey may be undertaken to confirm or adjust the rate.

C. Comparative Analysis

This method may be used when a similar service exists. Adjustments are made to reflect any differences in the new service. Where possible and to provide consistency of payments in the provider community, rates are set to maintain common rates for common services purchased by various agencies. If a proposed service duplicates an existing service being used by another agency or program, the existing rate may be used to provide consistency of payments in the provider community, if the companion agency rate is considered to be in line with the market.

D. Community Price Survey

Where a broad based market exists for a service, existing service providers may be surveyed to determine the prevailing market price for the service. Again, measures of central tendency such as median, mode or weighted average are used and adjusted if necessary to reflect prevailing market value.

9 USE OF "TN" RURAL ENHANCEMENT MODIFIER

A. The use of the TN rural enhancement modifier is authorized in the New Choices Waiver for the purpose of assuring access to waiver covered services in rural areas of the State where waiver service providers are required to travel extended distances to deliver services. The rate enhancement adjusts the per unit rate of reimbursement to account for the additional travel-related expenses not included in the normal rate setting process. For purposes of the rural enhancement rate, rural counties are all counties in Utah except Weber County, Davis County, Salt Lake County, and Utah County.

B. The following limitations are imposed on the use of the rural enhancement:

1. The Case Management Agency must authorize use of the rural enhancement rate at the time the services are ordered.
2. The location assigned as the provider's normal base of operation must be in a county designated as rural;
3. The location from which the service provider begins the specific trip must be in a county designated as rural;
4. The location where the service is provided to the waiver participant must be in a county designated as rural; and
5. The direct distance traveled by the provider from the starting location of the trip to the waiver participant must be a minimum of 25 miles with no intervening stops to provide waiver or State plan services to other Medicaid participants. When a single trip involves service encounters for multiple Medicaid participants, each leg of the trip will be treated as an independent trip for purposes of qualifying for the rural enhancement (i.e. each leg must involve a direct travel distance of 25 miles or more).

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C. Uniform Authorization of the Rural Enhancement Rate

1. It is the responsibility of the Case Management Agency to authorize any provider to bill for services using the rural enhancement code modifier. The Case Management Agency will complete the Service Authorization Form and send it to the Service Provider to be maintained in their files as proof of service authorization. The Case Management Agency will maintain a copy in their files as well as submit a copy to the Waiver Operating Agency.
2. If the initial authorization was verbal, the Case Management Agency will follow up with a written service authorization that includes the authorization for rural enhanced reimbursement. The Case Management Agency will maintain a copy of the written authorization form in their case files and submit a copy of any Authorization Forms that include authorization for enhanced billing to the Waiver Operating Agency.
3. The Waiver Operating Agency is responsible to monitor the Medicaid billing statements to assure providers are appropriately using the rural enhancement rate. In the event of inappropriate use of the rural enhancement rate, the provider and the Case Management Agency will be notified by the Waiver Operating Agency. Recoupment will be made for any inappropriate use of the rural enhancement rate.

D. When possible, providers must coordinate service delivery to minimize the use of the TN modifier by combining multiple service encounters in a single trip. Waiver case managers must take into account the opportunity to coordinate service delivery among waiver participants served by a common provider when scheduling services as part of plan of care implementation.

10 CLAIMS AND REIMBURSEMENT

10 - 1 Time Limit to Submit Claims

Payment for services will be made only if claims are submitted to Medicaid within one year from the date of service. Payment will be made for Medicare/Medicaid Crossover claims only if claims are submitted within six months from the date of Medicare payment stated on the Medicare Explanation of Medical Benefits (EOMB). Code of Federal Regulations 42 (CFR), Section 447.45(d) (1). Utah Administrative Code, Rule R414-25x.

10 - 2 Calculating Claims Using TN Modifier

When using the TN rural enhancement modifier for a claim, providers should bill the total eligible amount to be reimbursed (base amount and 1.75 increase). The Medicaid MMIS system computes the Maximum Allowable Base Rate in the MMIS system reference file multiplied by 1.75 and compares that number to the actual billed amount. The MMIS system then pays the actual billed amount up to the Maximum Allowable Rate X 1.75.

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11 SERVICE PROCEDURE CODES

The procedure codes listed below are covered by Medicaid under the Home and Community-Based Services Waiver for Individuals seeking deinstitutionalization.

| WAIVER SERVICE | CODE | UNIT OF SERVICE |
|---|-------------|------------------------|
| Case Management | T1016 | per unit (15 min) |
| Homemaker services | S5130 | per hour |
| Adult Day Care (Adult Day Health) | S5102 | per day |
| Habilitation Services | T2017 | per hour |
| Respite Care Services | | |
| • Respite care services | S5150 | per hour |
| • Respite care services, daily (six hours or more within a day) | S5151 | per day |
| • Respite care services-Out of Home/Room and Board Included | H0045 | per day |
| Adult Residential Services | | |
| • Adult Host Homes | S5140 | per day |
| • Assisted Living Facilities | T2031 | per day |
| • Licensed Community Residential Care | T2033 | per day |
| • Certified Residential Care | T2016 | per day |
| Attendant Care Services | S5125 | per unit (15 min) |
| Caregiver Training | S5115 | per unit (15 min) |
| Chore Services | S5120 | per unit (15 min) |
| Environmental Accessibility Adaptations | | |
| • Home Modifications | S5165 | per episode |
| • Vehicle Modifications | T2039 | per episode |
| Home Delivered Meals | S5170 | per meal |
| Institutional Transition Services | T2038 | per service |

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| Medication Administration Assistance Service | | |
| <ul style="list-style-type: none"> Medication Reminder Systems (not face to face) | S5185 | per month |
| <ul style="list-style-type: none"> Medication Set Up | H0034 | per unit (15 min) |
| Personal Emergency Response Systems | | |
| <ul style="list-style-type: none"> Personal emergency response systems purchase, rental & repair | S5162 | each |
| <ul style="list-style-type: none"> Personal emergency response systems response center service | S5161 | per month |
| <ul style="list-style-type: none"> Personal emergency response system installation, testing & removal, base | S5160 | each |
| Specialized medical equipment/supplies/assistive technology | T2029 | each |
| Transportation- Non- Medical | | |
| <ul style="list-style-type: none"> Transportation -Non-Medical- mile | S0215 | per mile |
| <ul style="list-style-type: none"> Transportation -Non-Medical – one way trip | T2003 | one way trip |
| <ul style="list-style-type: none"> Public Transit Pass | T2004 | month |
| Personal Budget Assistance | H0038 | per unit (15 min) |
| Assistive Technology Devices | T2028 | per Item |
| Specialized Behavioral Health Services (Extended State Plan Service) | | |
| <ul style="list-style-type: none"> Level I | H2019 | per hour |
| <ul style="list-style-type: none"> Level II | H2019 | per hour |
| <ul style="list-style-type: none"> Level III | H2019 | per hour |
| Supportive Maintenance (Home Health Aide) Services (Extended State Plan Service) | T1021 | per hour |
| Consumer Preparation Services | S5108 | per unit (15 min) |
| Financial Management Services | T2040 | per month |

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12 Mandatory Adult Protective Services Reporting Requirements

All suspected incidents of abuse, neglect or exploitation must be reported in accordance with Utah State Law 76-5-111, Utah Code annotated 62A-3-305 and State Rule R510-302.

1. Any person who has reason to believe that any vulnerable adult has been the subject of abuse, neglect, or exploitation shall immediately notify Adult Protective Services intake or the nearest law enforcement agency. When the initial report is made to law enforcement, law enforcement shall immediately notify Adult Protective Services intake. Adult Protective Services and law enforcement shall coordinate, as appropriate, their efforts to provide protection to the vulnerable adult.
2. When the initial report or subsequent investigation by Adult Protective Services indicates that a criminal offense may have occurred against a vulnerable adult, it shall notify the nearest local law enforcement agency. That law enforcement agency shall initiate an investigation in cooperation with Adult Protective Services.
3. Anyone who in good faith makes a report or otherwise notifies a law enforcement agency, the division, or Adult Protective Services of suspected abuse, neglect, or exploitation is immune from civil and criminal liability in connection with the report or other notification.
4. Any person who willfully fails to report suspected abuse, neglect, or exploitation of a vulnerable adult is guilty of a class B misdemeanor.
5. Under circumstances not amounting to a violation of Section 76-8-508, a person who threatens, intimidates, or attempts to intimidate a vulnerable adult who is the subject of a report, a witness, the person who made the report, or any other person cooperating with an investigation conducted pursuant to this chapter is guilty of a class B misdemeanor.
6. The physician-patient privilege does not constitute grounds for excluding evidence regarding a vulnerable adult's injuries, or the cause of those injuries, in any judicial or administrative proceeding resulting from a report made in good faith pursuant to this part.
7. An adult is not considered abused, neglected, or a vulnerable adult for the reason that the adult has chosen to rely solely upon religious, non medical forms of healing in lieu of medical care

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13 CONTACT PHONE NUMBERS

| | | |
|---|--|--|
| Adult Protective Services (DHS/DAAS) | <p align="center">Adult Protective Services Salt Lake County 1-801-264-7669 All other counties 1-800-371-7897</p> <p>Please be prepared to offer the following information: <i>(note: all information is not necessary, but helpful)</i></p> <ul style="list-style-type: none"> • Name, address, and phone number of victim. • Identifying information of the victim such as: birth date, social security number, age, ethnicity.... • Name, address, and phone number of alleged perpetrator (if applicable). • Identifying information regarding alleged perpetrator. (if applicable). • Your name, phone number and address. • Provide information on any disability, health problem or mental illness. • Reason for concern (alleged abuse, neglect or exploitation). | |
| Disenrollments | <p align="center">Utah Department of Health Division of Medicaid and Health Financing Long Term Care Bureau Attn: New Choices Waiver Disenrollment Staff PO Box 143101 Salt Lake City Utah 84114-3101 Fax: 801-323-1586</p> | |
| HPR - Constituent Services | Randa Pickle | Phone: 1-801-538-6417 Toll Free: 1-877-291-5583 Email: RANDAPICKLE@utah.gov |
| Health Program Representatives | <p align="center">http://health.utah.gov/umb/documents/hpr.php</p> | |
| Incident Report Form | <p align="center">Utah Department of Health Division of Medicaid and Health Financing Long Term Care Bureau Attn: New Choices Waiver Incident Reporting PO Box 143101 Salt lake City Utah 84114-3101 Fax: 801-323-1586</p> | |
| Medicaid Health Plans | Healthy U Customer Service: Molina Customer Service: Select Access Customer Service: | Phone: 1-888-271-5870 1-801-587-6480 http://uuhsc.utah.edu/uhealthplan/healthyU/members.html Phone: 1-888-483-0760 www.molinahealthcare.com Phone: 1-800-662-9651 www.ihc.com |
| Medicaid Client Education | http://health.utah.gov/medicaid/Medicaid_Benefits/Training/medicaid.html | |
| Medicaid Information Line | 801-538-6155 or 1-800-662-9651 http://health.utah.gov/medicaid | |
| New Choices Waiver | Kathleen Bowman | Phone: 1-801-538-6497 Fax: 1-801-323-1586 |
| | Vicki Ruesch | Phone: 1-801-538-6148 Fax: 1-801-323-1586 |
| | | newchoiceswaiver@utah.gov |

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| Request for Hearing | Utah Department of Health Director's Office / Formal Hearings Division of Medicaid and Health Financing PO Box 143105 Salt Lake City Utah 84114-3105 Fax: 801-538-6412 |

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