

DEPARTMENT FOR MEDICAID SERVICES
ADULT DAY HEALTH CARE SERVICES MANUAL

Cabinet for Health Services
Department for Medicaid Services
Division of Long Term Care
275 East Main Street 6W-B
Frankfort, KY 40621

SECTION I

INTRODUCTION

SECTION II

COMMONWEALTH OF KENTUCKY MEDICAID PROGRAM

SECTION III

OVERVIEW OF HOME AND COMMUNITY BASED WAIVER PROGRAM
AND ADULT DAY HEALTH CARE SERVICES

SECTION IV

CONDITIONS OF PARTICIPATION

SECTION V
ADULT DAY HEALTH CARE COVERED SERVICES

Table of Contents

| | | |
|------|--|------|
| I. | INTRODUCTION..... | 1.1 |
| A. | Introduction..... | 1.1 |
| B. | Fiscal Agent..... | 1.1 |
| C. | General Information..... | 1.1 |
| II. | COMMONWEALTH OF KENTUCKY MEDICAID PROGRAM... .. | 2.1 |
| A. | Policy..... | 2.1 |
| B. | Appeal Process for Refund Process | 2.3 |
| C. | Timely Submission of Claims | 2.4 |
| D. | Kentucky Patient Access and Care System (KenPAC) | 2.5 |
| E. | Lock-In Program..... | 2.5 |
| F. | Early and Periodic Screening Diagnosis and Treatment (EPSDT) Program | 2.6 |
| G. | Kentucky Health Care Partnership Program..... | 2.6 |
| H. | Empower Kentucky Transportation Initiative | 2.7 |
| III. | OVERVIEW OF HOME AND COMMUNITY BASED WAIVER PROGRAM AND ADULT DAY HEALTH CARE SERVICES..... | 3.1 |
| A. | Waiver Requested | 3.1 |
| B. | Individual’s Freedom of Choice..... | 3.1 |
| C. | Target Population and General Financial and Waiver Eligibility Requirements | 3.2 |
| IV. | CONDITIONS OF PARTICIPATION..... | 4.1 |
| A. | Participation Overview..... | 4.1 |
| B. | Provider Freedom of Choice | 4.1 |
| C. | Overview of Record Requirements | 4.2 |
| D. | Provider Requirements..... | 4.5 |
| V. | ADULT DAY HEALTH CARE COVERED SERVICES..... | 5.1 |
| A. | General Information | 5.1 |
| B. | Conformance with Physican’s Orders..... | 5.2 |
| C. | Change in Condition..... | 5.3 |
| D. | ADHC Basic Services..... | 5.3 |
| E. | Reimbursement for Basic Services | 5.4 |
| F. | Therapy Services | 5.7 |
| G. | Reimbursement for Therapies | 5.13 |

Table of Contents

| | | |
|----|--|------|
| H. | Respite..... | 5.15 |
| I. | Reimbursement for Respite Service..... | 5.18 |

SECTION I - INTRODUCTION

I. INTRODUCTION

A. Introduction

The Kentucky Medicaid Program Adult Day Health Care Services Manual provides Medicaid providers with a tool to be used when providing services to qualified Medicaid recipients.

This manual shall provide basic information concerning coverage policy. It shall assist providers in understanding what procedures are reimbursable. Precise adherence to policy shall be imperative.

B. Fiscal Agent

The Department for Medicaid Services contracts with a fiscal agent for the operation of the Kentucky Medicaid Management Information System (MMIS). The fiscal agent receives and processes all claims for medical services provided to Kentucky Medicaid recipients.

C. General Information

The Department for Medicaid Services shall be bound by both Federal and State statutes and regulations governing the administration of the State Plan. The state shall not be reimbursed by the federal government for monies improperly paid to providers for non-covered, unallowable medical services. Therefore, Kentucky Medicaid may request a return of any monies improperly paid to providers for non-covered services.

The Kentucky Medicaid Program serves eligible recipients of all ages. Kentucky Medicaid coverage and limitations of covered health care services specific to the Home and Community Based Waiver Program shall be specified in the body of this manual in Sections IV, V, VI.

SECTION II – COMMONWEALTH OF KENTUCKY MEDICAID PROGRAM

II. COMMONWEALTH OF KENTUCKY MEDICAID PROGRAM

A. Policy

The basic objective of the Kentucky Medicaid Program shall be to ensure the availability and accessibility of quality medical care to eligible program recipients.

The Medicaid Program shall be the payor of last resort. If the recipient has an insurance policy, veteran's coverage, or other third party coverage of medical expenses, that party shall be primarily liable for the recipient's medical expenses. Accordingly, the provider of service shall seek reimbursement from the third party groups for medical services provided prior to billing Medicaid. If a provider receives payment from a recipient, payment shall not be made by Medicaid. If a payment is made by a third party, Medicaid shall not be responsible for any further payment above the Medicaid maximum allowable payment.

In addition to statutory and regulatory provisions, several specific policies have been established through the assistance of professional advisory committees. Principally, some of these policies are as follows:

All participating providers shall agree to provide medical treatment according to standard medical practice accepted by their professional organization and to provide Medicaid-covered services in compliance with federal and state statutes regardless of age, color, creed, disability, ethnicity, gender, marital status, national origin, race, religion, or sexual orientation.

Providers shall comply with the Americans with Disabilities Act and any amendments, rules and regulations of this act.

Each eligible medical professional shall be given the choice of whether or not to participate in the Kentucky Medicaid Program in accordance with 907 KAR 1:672. From those professionals who

SECTION II – COMMONWEALTH OF KENTUCKY MEDICAID PROGRAM

have chosen to participate, recipients may select the provider from whom they choose to provide their medical care.

If the Department makes payment for a covered service and the provider accepts this payment in accordance with the Department's fee structure, the amounts paid shall be considered payment in full; a bill for the same service shall not be tendered to the recipient, and a payment for the same service shall not be accepted from the recipient. The provider may bill the recipient for services not covered by Kentucky Medicaid.

Providers of medical service or authorized representatives attest by their signatures, that the presented claims are valid and in good faith. Fraudulent claims shall be punishable by fine, imprisonment or both. Facsimiles, stamped or computer generated signatures shall not be acceptable.

The recipient's Kentucky Medical Assistance Identification Card should be carefully checked to see that the recipient's name appears on the card and that the card is valid for the period of time in which the services are to be rendered. If there is any doubt about the identity of the recipient, you may request a second form of identification. A provider can not be paid for services rendered to an ineligible person. Failure to validate the identity of a Medicaid recipient prior to a service being rendered may result in being out of compliance with 907 KAR 1:671. Any claims paid by the Department for Medicaid Services on behalf of an ineligible person may be recouped from the provider.

The provider's adherence to the application of policies in this manual shall be monitored through either on-site audits, postpayment review of claims by the Department, computer audits or edits of claims. When computer audits or edits fail to function properly, the application of policies in this manual shall remain in effect. Therefore, claims shall be subject to postpayment review by the Department.

SECTION II – COMMONWEALTH OF KENTUCKY MEDICAID PROGRAM

All providers shall be subject to rules, laws, and regulations issued by appropriate levels of federal and state legislative, judiciary and administrative branches.

All services provided to Medicaid recipients shall be on a level of care that is equal to that extended private pay individuals or others, and on a level normally expected of a person serving the public in a professional capacity.

All recipients shall be entitled to the same level of confidentiality afforded persons NOT eligible for Medicaid benefits.

Claims shall not be allowed for services outside the scope of allowable benefits within a particular program specialty. Likewise, claims shall not be paid for services that required and were not granted prior authorization by the Kentucky Medicaid Program. In addition, providers are subject to provisions in 907 KAR 1:671, 907 KAR 1:672, and 907 KAR 1:673.

Claims shall not be paid for medically unnecessary items, services, or supplies. The recipient may be billed for non-covered items and services. Providers shall notify recipients in advance of their liability for the charges for non-medically necessary and non-covered services.

If a recipient makes payment for a covered service, and that payment is accepted by the provider as either partial payment or payment in full for that service, responsibility for reimbursement shall not be attached to the Department and a bill for the same service shall not be paid by the Department. However, a recipient with spenddown coverage may be responsible for a portion of the medical expenses they have incurred.

B. Appeal Process for Refund Requests

Inappropriate overpayments to providers that are identified in the postpayment review of claims shall result in a refund request.

SECTION II – COMMONWEALTH OF KENTUCKY MEDICAID PROGRAM

If a refund request occurs subsequent to a postpayment review by the Department for Medicaid Services or its agent, the provider may submit a refund to the Kentucky State Treasurer or appeal the Medicaid request for refund in writing by providing clarification and documentation that may alter the agency findings. This information relating to clarification shall be sent to :

DIVISION OF LONG TERM CARE
DEPARTMENT FOR MEDICAID SERVICES
CABINET FOR HEALTH SERVICES
275 EAST MAIN STREET
FRANKFORT KY 40621

If no response (refund or appeal) has been filed with Medicaid by the provider within thirty (30) days of the refund request, assent to the findings shall be assumed. If a refund check or request for a payment plan is not received within sixty (60) days, Medicaid shall deduct the refund amount from future payments.

C. Timely Submission of Claims

According to federal regulations, claims shall be billed to Medicaid within twelve (12) months of the date of service or six (6) months from the adjudication date of the Medicare payment date or other insurance. Federal regulations define "Timely submission of claims" as received by Medicaid "no later than twelve (12) months from the date of service." Received is defined in 42 CFR 447.45(d)(5) as follows, "The date of receipt is the date the agency receives the claim, as indicated by its date stamp on the claim." To consider those claims twelve (12) months past the service date for processing, the provider shall attach documentation showing **RECEIPT** by Medicaid, the fiscal agent and documentation showing subsequent billing efforts. Claim copies alone shall not be acceptable documentation of timely billing. Claims shall not be considered for payment if more than twelve (12) months have elapsed between **EACH RECEIPT** of the aged claim by the program.

SECTION II – COMMONWEALTH OF KENTUCKY MEDICAID PROGRAM

Claims should be submitted to:

Unisys Corporation
P.O. Box 2100
Provider Services
Frankfort, KY 40602-2100
1-877-838-5085 – Provider Enrollment
1-800-807-1232 – Provider Assistance

D. Kentucky Patient Access and Care System (KenPAC)

KenPAC is a statewide patient care system which provides Medicaid recipients with a primary care provider. The primary care provider shall be responsible for providing or arranging for the recipient's primary care and for referral of other medical services. KenPAC recipients shall be identified by a green Medical Assistance Identification (MAID) card.

Medicaid recipients receiving waiver services, as well as nursing facility and Long Term Care services, are exempt from participation in KenPAC.

E. Lock-In Program

The Department shall monitor and review utilization patterns of Medicaid recipients to ensure that benefits received are at an appropriate frequency and are medically necessary given the condition presented by the recipient. The Department shall investigate all complaints concerning recipients who are believed to be over-utilizing the Medicaid Program.

The Department shall assign one (1) physician to serve as a case manager and one (1) pharmacy. The recipient shall be required to utilize only the services of these providers, except in cases of emergency services and appropriate referrals by the case manager. In addition, provider and recipients shall comply with the provisions set forth in 907 KAR 1:677, Medicaid Recipient Lock-In.

SECTION II – COMMONWEALTH OF KENTUCKY MEDICAID PROGRAM

Providers who are not designated as lock-in case managers or pharmacies shall not receive payment for services provided to a recipient assigned to the lock-in program, unless the case manager has pre-approved a referral or for emergency services. Recipients assigned to the lock-in program shall have a pink MAID card and the name of the case manager and pharmacy shall appear on the face of the card.

F. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program

Under the EPSDT program, Medicaid eligible children, from birth through the end of the child's birth month of his twenty-first (21) year, may receive preventative, diagnostic and treatment services by participating providers. The goal of the program is to provide quality preventative health care by performing prescribed screenings at specified time intervals according to age (termed a periodicity schedule) to identify potential physical and mental health problems. These screenings shall include a history and physical examination, developmental assessment, laboratory tests, immunizations, health education and other tests or procedures medically necessary to determine potential problems. Another goal of the program is to reimburse for medically necessary services and treatments, even if the service or treatment is not normally covered by Kentucky Medicaid. However, the service or treatment must be listed in 42 USC Section 1396_d(a) which defines what services can be covered by state Medicaid programs. More information regarding the EPSDT program can be obtained by calling the EPSDT program within the Department for Medicaid Services.

G. Kentucky Health Care Partnership Program

In accordance with 907 KAR 1:705, the Department shall implement, within the Medicaid Program, a capitation managed care system for physical health service for persons residing in Region 3 (Shelby, Spencer, Trimble, Wayne, Marion, Meade, Nelson, Oldham, Hardin, Henry, Jefferson, LaRue, Breckinridge, Bullitt, Carroll, and Grayson counties).

SECTION II – COMMONWEALTH OF KENTUCKY MEDICAID PROGRAM

Medicaid recipients receiving waiver services, as well as nursing facility and Long Term Care services, are exempt from participation in a capitation managed care system. These recipients receive services through the traditional Medicaid program.

H. EMPOWER Kentucky Transportation Initiative

In accordance with 907 KAR 3:065, the Department shall implement, within the Medicaid Program, as an EMPOWER Kentucky Initiative, a capitation non-emergency medical transportation delivery system excluding ambulatory stretcher services. The Department has entered into a contract with the Transportation Cabinet, along with three other Cabinets, to implement this program incrementally statewide beginning in June 1998. This new system is designed to extend service to areas of the state currently under-served, provide transportation alternatives to more people, encourage efficiency and discourage fraud and abuse.

SECTION III – OVERVIEW OF THE HOME AND COMMUNITY BASED
WAIVER PROGRAM AND ADULT DAY HEALTH CARE SERVICES

III. OVERVIEW OF HOME AND COMMUNITY BASED WAIVER PROGRAM
AND ADULT DAY HEALTH CARE SERVICES

A. Waiver Requested

The Department for Medicaid Services (DMS) requested that the Secretary of the United States Department of Health and Human Services (HHS) exercise his authority under Section 1915(c) of the Social Security Act to grant a waiver of certain federal requirements that would permit Medicaid coverage under the State Plan for a broad array of home and community based services that may be required by the Medicaid recipient who would otherwise require Nursing Facility (NF) level of care. Among the services available under the Home and Community Based Waiver is Adult Day Health Care (ADHC).

B. Individual's Freedom of Choice

An individual eligible to receive waiver services shall be given a choice to:

1. Receive waiver services or NF services; and
2. Select participating ADHC providers from whom he/she wishes to receive services.

The MAP-350 form is utilized to document that choice(s) were given to the individual.

C. Target Population and General Financial and Waiver Eligibility Requirements

The target groups for ADHC services are persons who are aged and disabled and who would, without these services, be admitted to a NF for which the cost may be reimbursed under the existing State Plan. Persons who meet the financial eligibility and the NF level of care criteria may receive waiver services.

SECTION III – OVERVIEW OF THE HOME AND COMMUNITY BASED
WAIVER PROGRAM AND ADULT DAY HEALTH CARE SERVICES

The eligibility groups include the mandatory categorically needy and optional categorically needy. This shall include the aged, blind and disabled individuals and persons determined eligible under the Aid to Families with Dependent Children (AFDC) category and AFDC related categories.

1. Medicaid Eligibility Process

- (a) The DMS shall notify the individual, the provider and the Department for Community Based Services (DCBS) when the individual has been determined appropriate for waiver services, the effective date and the monthly cost of the requested services.
- (b) The individual and family or responsible party shall be advised to make application for eligibility at the DCBS office in the county where the individual lives in order to ensure Medicaid coverage for services. At the time of application, the applicant (spouse or interested party representing the recipient) should bring proof of social security number, income (unearned or earned), resources, life insurance, and medical bills.
- (c) The DCBS is required to complete an assessment of the countable resources of the individual and the spouse. This assessment includes a comparison of the combined countable resources to the current Medicaid resource allowance for the waiver recipient and the non-waiver spouse to determine if the recipient meets resource eligibility for Medicaid.
- (d) Resources are defined as cash money, and any other personal property or real property that an individual or couple owns; has the right,

SECTION III – OVERVIEW OF THE HOME AND COMMUNITY BASED
WAIVER PROGRAM AND ADULT DAY HEALTH CARE SERVICES

authority or power to convert to cash; and is not legally restricted from using for support and maintenance. Resources may include but are not limited to: checking and savings accounts, stocks or bonds, certificates of deposit, automobiles, land, buildings, burial reserves, and life insurance policies.

- (e) Certain types of resources are excluded and are not considered in the Medicaid eligibility determination. These resources include: homestead property and adjoining land, household goods and personal effects, a burial arrangement, one automobile used for employment, to obtain medical treatment or by the community spouse, burial spaces and plots, life estate interests, IRA, KEOGHS, and retirement funds which meet the Internal Revenue Service's (IRS) guidelines for tax deferral.
- (f) The resources of an individual requesting or receiving services through the waiver must be within Medicaid Program guidelines. The resources of the recipient's spouse are considered.
- (g) Income is defined a money received from statutory benefits (Social Security, VA pension, Black Lung benefits, Railroad Retirement benefit), pension plans, rental property, investments or wages for labor or services. Income may be unearned or earned. The income of the individual requesting or receiving services through the waiver must be within Medicaid Program guidelines. Only the income of the recipient is considered. The special income limit is equal to 300% of the Supplemental Security Income (SSI) standard.

SECTION III – OVERVIEW OF THE HOME AND COMMUNITY BASED
WAIVER PROGRAM AND ADULT DAY HEALTH CARE SERVICES

- (h) The institutional deeming rules shall be applied to the recipient. Waiver recipients shall be allowed to retain from their own income for their basic maintenance needs an amount equal to the SSI basic benefit rate plus the SSI general disregard. This allowable maintenance amount shall change if the SSI benefit rate or standard deduction changes. The patient liability for the month of admission to the waiver, however, would usually be zero with the following exceptions:
 - (1) Community deeming rules for Medicaid eligibility shall be used for the month of admission for all waiver recipients who are either married or under the age of eighteen (18). This means that the income and resources of the spouse or parent shall be considered to be available for the month of admission only. For the second month and each succeeding month of waiver participation, only the income and resources of the recipient shall be used to determine Medicaid eligibility.
 - (2) The recipient has been discharged from a nursing facility, ICF/MR/DD facility, hospice program or another waiver program, within thirty (30) days of the effective date for Home and Community Based (HCB) Waiver services.
- (i) The individual should indicate to the DCBS that they are applying for eligibility under the special income category of the waiver.

SECTION III – OVERVIEW OF THE HOME AND COMMUNITY BASED
WAIVER PROGRAM AND ADULT DAY HEALTH CARE SERVICES

- (j) The recipient and family or responsible party shall be advised of the importance of contacting the local DCBS office in the following situations:
 - (1) The recipient's Medicaid eligibility was based upon a recent nursing facility admission.
 - (2) The recipient's Medicaid eligibility was based upon the "Spend-Down" category of eligibility.
 - (3) The recipient's Medicaid eligibility was based upon SSI eligibility.
 - (4) Whenever there is a change in the recipient's circumstance.

2. Recipient's Continuing Income Liability

If it is determined by the local DCBS office that a recipient has a continuing income liability, this amount shall be paid to the Adult Day Health Care (ADHC) provider by the recipient or responsible party and shall be deducted monthly from the Title XIX payments to the provider. Notification of the amount of the continuing income shall be forwarded to the ADHC provider from Medicaid Services on the MAP-552. It is the responsibility of the provider to collect this money from the recipient.

NOTE: The provider may not collect more than the actual amount of the service provided during the month by the agency.

3. Waiver Eligibility Determination

SECTION III – OVERVIEW OF THE HOME AND COMMUNITY BASED
WAIVER PROGRAM AND ADULT DAY HEALTH CARE SERVICES

- (a) An individual may be referred for waiver services by the individual themselves, the individual's legal representative or the individual's attending physician.
- (b) To be eligible for participation in the HCB Waiver program, recipient shall meet the level of care criteria for NF services in accordance with 907 KAR 1:022. The recipient's attending physician shall recommend waiver services and certify that without waiver services the recipient would be admitted by a physician's order to a nursing facility.
- (c) The Peer Review Organization (PRO) shall perform a level of care determination for all recipients who wish to be considered for participation in the HCB Waiver program. The level of care determination shall be made at least every twelve (12) months.

The HCB Waiver provider shall telephone the PRO to provide the information necessary to perform the level of care determination. The level of care certification form shall be completed by the PRO based upon the information provided to them over the telephone. It is very important that the individual contacting the PRO be knowledgeable about the recipient's condition and able to answer questions. The PRO shall forward the form to the HCB Waiver provider.

- (d) The HCB Waiver provider, individual recipient, and DCBS shall receive notification from the PRO of the denial for NF level of care. If the individual/recipient or legal representative disagrees with the adverse determination, the

SECTION III – OVERVIEW OF THE HOME AND COMMUNITY BASED
WAIVER PROGRAM AND ADULT DAY HEALTH CARE SERVICES

recipient shall have the right to an appeal in accordance with 907 KAR 1:563.

- (e) For acute care hospital inpatients whose care needs indicate that nursing facility services may be required, hospital discharge planners are requested to refer the individual to an HCB Waiver provider of their choice.
- (f) It shall be the NF's responsibility to ensure that all recipients are informed of the availability of waiver services as an alternative prior to admission to the NF and annually thereafter.
- (g) Waiver services shall not be provided to an individual who is an inpatient of a hospital, NF, intermediate care facility for individuals with mental retardation or developmental disabilities (ICF/MR/DD) or enrolled in a Medicaid covered Hospice program. An individual who is a resident of a licensed personal care home or who is receiving a service in another Medicaid waiver program shall not be eligible to receive HCB Waiver services.
- (h) A waiver provider shall notify the local DCBS office and the PRO on a MAP-24 form if a recipient is terminated from the waiver program or if the recipient is admitted for less than sixty (60) consecutive days to a NF and is returning to the waiver program. A recipient who remains in a NF longer than sixty (60) consecutive days shall be terminated from the waiver program. If the recipient requests readmission to the waiver program after sixty (60) consecutive days all procedures for a new admission shall be followed.

SECTION III – OVERVIEW OF THE HOME AND COMMUNITY BASED
WAIVER PROGRAM AND ADULT DAY HEALTH CARE SERVICES

- (i) The DMS may exclude an individual for whom the aggregate cost of waiver services would reasonably be expected to exceed the cost of NF services.

4. ADHC Eligibility

- (1) It is the responsibility of the HCB waiver provider to initiate the assessment process, which includes certification of nursing facility level of care and complete process, to determine if the individual is eligible to receive HCB services including ADHC. The HCB waiver provider is responsible for obtaining:

- ?? The physician's recommendation for HCB Waiver services including ADHC and certification regarding need for nursing facility level of care and the prior authorization to provide services (MAP 109 HCBW);

- ?? The level of care confirmation from the PRO;

- (2) The HCB provider is responsible for providing at least one (1) case management contact per month to assess the service delivery. From this contact the case manager is responsible for determining if the service provision is adequate, or if the service needs to be modified to better meet the needs of individual. This contact may be by telephone or face-to-face. However, a face-to-face contact with the recipient must be made at least every other month. The face-to-face contact with the ADHC recipient may be made while the recipient is at the ADHC center.

- (3) The HCB waiver provider is responsible for the reassessment of the recipient to determine the continuing need for HCB services at least every

SECTION III – OVERVIEW OF THE HOME AND COMMUNITY BASED
WAIVER PROGRAM AND ADULT DAY HEALTH CARE SERVICES

twelve (12) months. An ADHC provider shall not be reimbursed for a service provided during any period of time the ADHC recipient is not covered by a valid level of care certification. If more than sixty (60) days have elapsed since the end of the previous certification period, the ADHC recipient will be considered terminated from the HCB waiver program and is not eligible for ADHC services.

NOTE: It shall be the responsibility of the ADHC provider to assure that all of their ADHC recipients have been appropriately reassessed and re-certified by the HCB waiver provider.

SECTION IV – CONDITIONS OF PARTICIPATION

IV. CONDITIONS OF PARTICIPATION

A. Participation Overview

To provide adult day health care services, an Adult Day Health Care (ADHC) provider shall meet the licensure requirements to provide nursing services in accordance with 902 KAR 20:066. Also, an ADHC shall comply with 907 KAR 1:160, 907 KAR 1:671, 907 KAR 1:672 and 907 KAR 1:673.

An agency desiring to participate as an ADHC provider must submit a completed enrollment packet and verification of their license to:

Provider Enrollment
Unisys Corporation
P.O. Box 2110
Frankfort, Kentucky 40602

Services shall be furnished by the participating ADHC provider or by others under contractual arrangement with the ADHC provider. Recipients shall not be enrolled for services which the agency cannot provide. Arrangements made by an ADHC provider with other agencies to provide services shall be in writing and shall stipulate that receipt of payment by the ADHC provider for the service (whether in its own right or as an agent) discharges the liability of the recipient or the Medicaid Program to make any additional payment for service.

B. Provider Freedom of Choice

The freedom of choice concept has always been a fundamental principle governing the Kentucky Medicaid Program. Providers shall have the freedom to decide whether or not to accept eligible Medicaid recipients and to bill the Program for the medical care provided.

SECTION IV – CONDITIONS OF PARTICPATION

C. Overview of Record Requirements

The ADHC provider shall retain fiscal reports, service and clinical records, and incident reports regarding services provided for a period of at least five (5) years from the date that a covered service is provided, except in the case of a minor child, whose records shall be retained for three (3) years after the recipient reaches age of majority under state law, whichever is longest.

1. Clinical Records

The ADHC provider shall be required to maintain for each ADHC recipient a clinical record which covers the services provided directly and/or those provided through arrangements with other agencies. The provider shall develop a system of identification and filing to ensure prompt location of the recipient's record. All ADHC recipient records shall be in ink or typed and shall be legible. ADHC recipient records shall be treated with the strictest confidentiality.

The ADHC clinical record shall contain:

- (a) The ADHC recipient's name, address and MAID number;
- (b) Name, address, and telephone number of the recipient's HCB waiver case manager;
- (c) Name, address, and telephone number of next of kin or other responsible party;
- (d) Name and telephone number of the attending physician;
- (e) ADHC's recipient's medical, nursing and social history;
- (f) Known food and medication allergies;
- (g) Date of ADHC admission and discharge;

SECTION IV – CONDITIONS OF PARTICPATION

- (h) Associated risk(s) documented with discharge summary, if appropriate (i.e. explanation that all services provided by ADHC to recipient will be lost);
- (i) Documentation that recipient was provided a copy of the ADHC's posted hours of operation.
- (j) Physician orders;
- (k) A current ADHC plan of treatment
- (l) A medication administration sheet which shall contain:
 - (1) The date and time medication was given;
 - (2) Name of medication;
 - (3) Dosage and route;
 - (4) Name of prescribing physician; and
 - (5) Signature and title of ADHC staff administering the medication.
- (m) Documentation of each service provided which shall include:
 - (1) Properly corrected erroneous documentation (i.e. no correction tape/inks or illegal write-overs);
 - (2) The date the service was provided;
 - (3) The duration of the service;
 - (4) The arrival and departure time of the ADHC recipient;
 - (5) Description of all service(s) provided; and

SECTION IV – CONDITIONS OF PARTICPATION

- (6) The title and signature of the service provider.
 - (7) If the care or treatment was denied by ADHC recipient, associated risks were explained by staff and freedom of choice was given.
 - (n) Evaluation of the ADHC recipients progress which shall include:
 - (1) Assessment of goals and interventions identified on the ADHC plan of treatment.
 - (2) Documentation of changes in appetite, attitude, behavior, condition, and responses;
 - (3) Logical sequence (identification of problem, desired goal, action/intervention, outcome).
 - (4) Signature and title of ADHC staff performing evaluation.
 - (o) A copy of current MAP 350 from HCB waiver provider,
 - (p) A copy of current MAP 351A from HCB waiver provider;
 - (q) A copy of the current MAP 109 HCBW;
 - (r) The current letter of prior authorization;
 - (s) If applicable, a written description of any incident that occurred with the ADHC recipient. The description should include at a minimum the details of the occurrence, the outcome and measures for prevention; and
2. Personnel Records

The ADHC provider shall be required to retain a confidential personnel record for each staff person. Personnel records at minimum should include a copy of current license, if

SECTION IV – CONDITIONS OF PARTICPATION

applicable, and documents as specified in 902 KAR 20:066, Section 2(4). Documentation shall be maintained in each personnel file that the staff member is free of communicable disease. If the employee contracts a communicable disease, they shall not be permitted to provide a service to a recipient until the condition is determined not to be contagious. The personnel file may be subject to review by the department.

3. Records Accessibility

The ADHC provider shall make information regarding service and financial records available to:

- (a) The Department for Medicaid Services, or its designee;
- (b) The Commonwealth of Kentucky, Cabinet for Health Services, Office of Inspector General, or its designee;
- (c) The United States Department for Health and Human Services, or its designee;
- (d) The United States General Accounting Office, or its designee;
- (e) The Commonwealth of Kentucky, Office of the Auditor of Public Accounts, or its designee; and
- (f) The Commonwealth of Kentucky, Office of the Attorney General, or its designee.

D. Provider Requirements

ADHC providers shall maintain a policy and procedures manual outlining policies which includes agency hours of operation, emergency contact, contingency plan(s) for emergencies (such as inclement weather and to accommodate back-up when usual care is unavailable), agency fee schedule and other pertinent agency operational information. ADHC providers shall ensure availability of their manual to agency staff, recipients, family members or any

SECTION IV – CONDITIONS OF PARTICPATION

other interested parties. Agency policy and procedure manuals may be subject to review by the Department.

ADHC providers are required to inform the Department, in writing of their posted hours of operation. Failure of this notification may jeopardize an ADHC provider's participation in the Medicaid program. Should an ADHC provider change their posted hours of operation, then the Department must receive notification within ten (10) calendar days of the effective date of the change. Hours of operation shall be posted in an accessible area for both ADHC recipients and the general public. ADHC providers shall not receive reimbursement for services outside their posted hours of operation.

ADHC providers shall be responsible for implementing a procedure which ensures the reporting of all incidences. Incidences may include, but are not limited to, the following:

1. Abuse, neglect or exploitation of a recipient;
2. Falls;
3. Medication errors;
4. Medical emergencies;
5. Equipment malfunction;
6. Breakage or damage to recipient's property;
7. Alleged/suspected theft;
8. Adverse/allergic drug reactions;
9. Communication errors;
10. Accidents involving recipients or visitors
11. Incidents caused by the recipient such as verbal and/or physical abuse of staff or other recipients, destruction or damage of property and recipient self-abuse.

SECTION IV – CONDITIONS OF PARTICPATION

ADHC providers shall develop a process for reporting and resolving all incidents. This process shall include the development of a standardized form and instructions to be utilized by agency staff members when reporting an incident. ADHC providers shall maintain a copy of the incident report in the ADHC provider's central file. The central file shall contain all of the ADHC provider's incident reports in chronological order in a binder for a period of one (1) year. After which time, the incident reports shall be kept readily available for review in an accessible storage area for five (5) years. ADHC providers shall ensure that the incident, the outcome and the prevention plan are communicated to the recipient or legal representative and to the attending physician, PA, or ARNP. The communication shall be documented in the ADHC recipient's clinical record and signed and dated by staff member making entry. Incident reports shall be subject to review by the department.

ADHC providers shall ensure agency staff are trained in the prevention, identification, and reporting of abuse, neglect and exploitation. Cases of suspected abuse, neglect or exploitation shall be immediately reported to DCBS. The state hotline number for reporting suspected abuse, neglect or exploitation is 1-800-752-6200. ADHC providers shall ensure agency staff document each contact with DCBS. This documentation, at a minimum, shall include date of contact, name of ADHC recipient the report is being made on behalf of, brief synopsis of allegations, name of the DCBS employee taking the report.

ADHC providers shall be responsible for implementing a procedure which ensures the reporting and resolving of a complaint against an agency or its personnel by an ADHC recipient or interested party. ADHC providers shall make available to agency staff, ADHC recipients or interested parties the Office of Inspector General Hotline number which is 1-800-635-6290.

SECTION V – ADULT DAY HEALTH CARE COVERED SERVICES

V. ADULT DAY HEALTH CARE COVERED SERVICES

A. General Information

A Home and Community Based Waiver recipient shall be twenty-one (21) years of age or older to received ADHC services. An ADHC covered service shall be prior authorized (PA) by the Peer Review Organization (PRO) to ensure that the service or modification is adequate in relation to the recipient's needs. Services provided without a PA letter are subject to non-payment. Coverage shall not continue for ADHC recipients who have not received services on a regular basis as ordered during the previous certification period. ADHC shall be provided in accordance with the ADHC recipients approved HCB waiver plan of care. Services rendered to an ADHC recipient while attending an ADHC center shall be stipulated on an ADHC plan of treatment. The ADHC plan of treatment shall:

1. Be developed by the ADHC staff in consultation with the ADHC recipient's attending physician, PA, or ARNP;
2. At a minimum, document that an opportunity for caregiver/recipient to review and be involved with the plan of treatment was given;
3. Clearly addresses the needs as identified on the ADHC recipient's MAP 351A, and states goals, interventions and outcomes;
4. Documents changes as appropriate to ADHC recipient's needs.
5. Identify the following:
 - (a) Service(s) to be provided;
 - (b) Frequency of service(s);
 - (c) Pertinent diagnoses;
 - (d) Mental status;

SECTION V – ADULT DAY HEALTH CARE COVERED SERVICES

- (e) Rehabilitation potential;
 - (f) Functional limitations;
 - (g) Activities permitted;
 - (h) Nutritional requirements;
 - (i) Medications;
 - (j) Treatments;
 - (k) Safety measures to protect against injury;
 - (l) Instructions for timely discharge; and
 - (m) Other pertinent information;
- 6. Be signed by the ADHC recipient's physician, PA or ARNP;
 - 7. Reviewed and sent to PRO at least every ninety (90) days.

Additions or modifications to the original plan of treatment must be indicated on a change of order form, signed by the physician, PA, ARNP and included in the recertification.

Orders for therapy services shall include the specific procedures and modalities to be used and the amount, frequency and duration of such therapy service. Individual plans shall be developed for therapy services.

B. Conformance with physician's orders

Drugs and treatments shall be administered by ADHC staff only as ordered by the physician. The nurse or therapist shall immediately document and sign an oral order and obtain the physician's countersignature within forty-eight (48) hours. ADHC staff shall evaluate and monitor all patient medications for possible adverse reactions, significant side effects, drug allergies and contraindicated medication. Problems must be immediately reported to the physician.

SECTION V – ADULT DAY HEALTH CARE COVERED SERVICES

C. Change in Condition

Should an ADHC recipient's condition become such that a different type of care would be more beneficial, the ADHC provider shall make the necessary transfer or referral and advise the HCB waiver provider of the referral or transfer. The HCB waiver provider shall notify the department of discontinuance of ADHC.

D. ADHC Basic Services

ADHC Basic Services shall be provided during the ADHC provider's posted hours of operation. ADHC Basic Services include:

1. Skilled nursing services provided by an RN or LPN which may include:
 - (a) Ostomy care;
 - (b) Urinary catheter care;
 - (c) Decubitus care;
 - (d) Tube feeding;
 - (e) Venipuncture;
 - (f) Insulin injections;
 - (g) Tracheotomy care; and
 - (h) Medical monitoring
2. Meal service corresponding with hours of operation with a minimum of one (1) meal per day and therapeutic diets as required;
3. Snacks;
4. Age and diagnosis appropriate daily activities which shall include:

SECTION V – ADULT DAY HEALTH CARE COVERED SERVICES

- (a) A variety of planned activities for ADHC recipients according to age, functional level and their plan of care. The activities should be designed to maximize strengths and appeal to present and former interests;
 - (b) A program that may be led by various ADHC staff members but the ultimate responsibility for the planning and implementation of the program is that of the ADHC's health team;
 - (c) A monthly activity calendar provided for the convenience of recipients, families, ADHC staff and potential ADHC recipients. It shall be posted in an accessible, visible location and enlarged so that it may be easily read.
5. Routine services that meet the daily personal and health care needs of an ADHC recipient and shall include, but are not limited to:
- (a) Monitoring of vital signs;
 - (b) Assistance with activities of daily living;
 - (c) Monitoring and administration of self-administered medications;
 - (d) Therapeutic programs; and
 - (e) Incidental supplies and equipment needed by the ADHC recipient.
- E. Reimbursement for Basic Services

One (1) unit is equal to a minimum of three (3) hours per day or a minimum of two (2) hours if the recipient has occupied the ADHC center for two (2) hours prior to leaving the center due to a documented illness or emergency. Reimbursement is limited to two (2) units per day.

SECTION V – ADULT DAY HEALTH CARE COVERED SERVICES

Reimbursement for ADHC services is based on two (2) levels. Reimbursement for Level I ADHC unit shall be up to \$28. Reimbursement for Level II ADHC unit shall be up to \$34.

An ADHC may apply for Level II reimbursement if the center's average daily census is limited to individuals designated as HCB waiver, private pay or covered by insurance. In order to qualify for the Level II reimbursement, the center must have a minimum of eighty (80) percent of its individuals who meet the criteria for developmental disability (DD). If the ADHC was not a Medicaid provider prior to July 1, 2000, the center must have an average daily census of at least twenty (20) individuals who are designated as HCB waiver participants, private pay or covered by insurance.

In order for an individual to be considered as DD the following criteria must be met:

- (a) The individual must have a substantial disability that manifested before the individual reaches twenty-two (22) years of age;
- (b) The individual must have a disability that shall be attributable to mental retardation or a related condition which shall include:
 - (1) Cerebral palsy;
 - (2) Epilepsy;
 - (3) Autism; or
 - (4) A neurological condition that results in an impairment of general intellectual functioning or adaptive behavior, such as mental retardation, which significantly limits the individual in two (2) or more of the following skill areas:
 - a) Communication;

SECTION V – ADULT DAY HEALTH CARE COVERED SERVICES

- b) Self-care;
 - c) Home-living;
 - d) Social skills;
 - e) Community use;
 - f) Self direction;
 - g) Health and safety;
 - h) Functional academics;
 - i) Leisure; or
 - j) Work; and
- (5) An adaptive behavior limitation similar to that of a person with mental retardation, including:
- a) A limitation that directly results from or is significantly influenced by substantial cognitive deficits; and
 - b) A limitation that may not be attributable to only a physical or sensory impairment or mental illness.

In order to apply for a Level II reimbursement the ADHC center must contact the PRO on the first (1st) of the month prior to the end of the current calendar quarter in order to request consideration for Level II reimbursement for the following quarter. If the first of the month is on a weekend or holiday, then the ADHC center must contact the PRO on the next business day.

The PRO is responsible for randomly determining the date each quarter for conducting a Level II assessment of the ADHC center. In order for the ADHC center to qualify for a Level II reimbursement the center must:

SECTION V – ADULT DAY HEALTH CARE COVERED SERVICES

- (a) Document on a MAP-1021 form that it meets the Level II reimbursement criteria;
- (b) Submit the completed MAP-1021 form to the PRO via facsimile or mail no later than ten (10) working days prior to the end of the current quarter in order to be approved for Level II reimbursement for the following quarter; and
- (c) Attach to the MAP-1021 form a completed and signed copy of the “Adult Day Health Care Attending Physician Statement” for each individual listed on the MAP-1021 form.

The PRO will review the submitted MAP-1021 form and determine if the ADHC center qualifies for Level II reimbursement. The Department for Medicaid Services (DMS) will review a sample of the ADHC center’s Level II assessments and validate the PRO’s determination. If DMS invalidates an ADHC center Level II reimbursement assessment, DMS will:

- (a) Reduce the ADHC center’s current rate to the Level I rate; and
- (b) Recoup any overpayment made to the ADHC center.

If an ADHC center disagrees with an invalidation of a Level II reimbursement determination, the center may appeal in accordance with 907 KAR 1:671, Sections 8 and 9.

LIMITATIONS: ADHC basic services are limited to ten (10) units per week.

F. Therapy Services

The ADHC shall provide therapy services in accordance with 907 KAR 1:023. As appropriate, physical, occupation or speech therapy may be provided by ADHC provider under contractual arrangement with a qualified therapist in accordance with the plan

SECTION V – ADULT DAY HEALTH CARE COVERED SERVICES

of treatment. It is expected that these services shall consist of evaluation (reevaluation), for the purpose of developing a plan which could be carried out by the ADHC recipient or ADHC staff. However, individualized therapy services provided by the therapist to an ADHC recipient in accordance with the plan of treatment may be covered. The qualified therapist shall assist the physician in evaluating the level of function, help develop the plan of treatment (revising as necessary), prepare clinical and progress notes, advise and consult with other ADHC personnel and participate with in-service programs. Therapy services shall be reasonable, rehabilitative, and necessary for the ADHC recipient's condition and of such complexity that the service must be performed by a qualified therapist. A maintenance program must be developed for the performance of procedures, which could be safely and effectively carried out by the ADHC recipient, caregiver or ADHC staff. Each ADHC center shall have a private area for therapy services to be provided.

Therapy services must be ordered by a physician, PA or ARNP and individual therapy treatment plans must be developed. Therapy services include:

1. Physical therapy provided by a physical therapist who is qualified and appropriately licensed by the Commonwealth of Kentucky as established in 902 KAR 20:066.
2. Occupational therapy provided by an occupational therapist who is qualified and appropriately licensed by the Commonwealth of Kentucky as established in 902 KAR 20:066.
3. Speech therapy provided by a speech pathologist who is qualified and appropriately licensed by the Commonwealth of Kentucky as established in 902 KAR 20:066.

G. Reimbursement for Therapies

Therapies shall be billed as one (1) unit per patient encounter. Reimbursement for each therapy codes shall be up to \$75 per unit.

SECTION V – ADULT DAY HEALTH CARE COVERED SERVICES

H. Respite Service

A respite care service is short-term care based on the absence or need for relief of the primary caregiver. Respite care services may be provided to a recipient, if the skill level is beyond normal babysitting, at the ADHC.

I. Reimbursement for Respite Service

One (1) unit is equal to one (1) hour to one (1) hour and fifty-nine (59) minutes. Two (2) units is equal to two (2) hours to two (2) hours and fifty-nine (59) minutes.

Reimbursement for respite services shall be up to \$2,000 per six (6) months (beginning January 1 through June 30 and July 1 through December 31, not to exceed \$4,000 per calendar year).

To be reimbursed for respite services an ADHC provider shall maintain adequate records of the respite care provided to a recipient, which includes:

1. Documentation of provision; and
2. Documentation of actual time spent for each billable unit.