# CHAPTER IV

# COVERED SERVICES AND LIMITATIONS

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# GENERAL INFORMATION

The Commonwealth of Virginia offers the following waivers under the Medical Assistance Program:

Alzheimer's Assisted Living Waiver (AAL);
Building Independence Waiver formerly Day Support Waiver;
Community Living Waiver formerly ID Waiver;
Elderly or Disabled with Consumer Direction Waiver (EDCD);
Family and Individual Supports Waiver formerly DD Waiver; and
Technology Assisted Waiver (TW)

These waivers differ according to the populations they serve, the medical and functional criteria for eligibility for each waiver, the pre-admission screening (PAS) process for each waiver, and the services offered under each waiver. An individual shall not be simultaneously enrolled in more than one waiver program. Individuals may be enrolled in a waiver and on a waiting list for another waiver at the same time if they meet all waiver criteria.

The Commonwealth covers these optional categorically needy groups: Low Income families with Children, pregnant women, Children Under Age 19, SSI and SSA related individuals, aged, blind or disabled Medicaid eligible individuals under 42CFR435.121, and the home and community based services (HCBS) waiver group at 42CFR435. 217 that includes individuals who are eligible under the State Plan if they were institutionalized. The income level used for the HCBS waiver group at 42CFR435.217 shall be 300% percent of the current Supplemental Security Income (SSI) payment standard for one person. Medically needy Medicaid eligible individuals shall be eligible if they meet the medically needy financial requirements for income and resources.

HCBS shall be available through a 1915 (c) waiver of the Social Security Act. Under this waiver, DMAS has waived §1902(a)(10)(B) and (C) of the Social Security Act related to comparability of services, individuals will be considered as if they were institutionalized for the purpose of applying institutional deeming rules. All individuals under the waiver must meet the financial and non-financial Medicaid eligibility criteria and meet the institutional level of care criteria. An individual requesting Technology Assisted waiver (TW) shall meet specialized care, nursing facility (NF) criteria, including medical needs, be dependent on waiver services to avoid or delay facility placement and meet all criteria for the age appropriate assessments in order to be eligible for the waiver. Enrollment cannot occur unless skilled Private Duty Nursing (PDN) hours are ordered by the physician. The number of skilled PDN hours is based on the total technology and nursing score on the TW Pediatric Referral (for individuals less than 21 years of age Form 109). The number of skilled PDN hours for adults (21 years of age or greater- Form 108) is based on the skilled care needs of the adult individual.

Any individual who is eligible for third-party payment for skilled PDN services shall not be eligible for enrollment in TW services until the benefit is exhausted. If an individual or an

individual's legally responsible party voluntarily drops any insurance plan that would have provided coverage of skilled PDN in order to become eligible for these waiver services within one year prior to the date waiver services are requested, eligibility for the waiver shall be denied. From the date that such insurance plan is discontinued, such applicants shall be barred for one year (365 calendar days) from re-applying for waiver enrollment. After the passage of one year time period the individual may re-apply to DMAS for admission to the tech waiver.

In addition to the medical needs identified in this section, the Medicaid-eligible individual shall be determined to need substantial and ongoing skilled nursing care. The Medicaid eligible individual younger than 21 shall be enrolled in this waiver only if the anticipated cost to Medicaid of home care is expected to be less than or equal to the current aggregate cost to Medicaid if the individual were in an acute care hospital.

Individuals 21 years of age or older shall be enrolled in this waiver only if the anticipated cost to Medicaid of home care is expected to be less than or equal to the current aggregate cost to Medicaid if the Medicaid eligible individual were in a specialized care NF or long stay hospital (LSH).

Individuals who entered the waiver prior to their 21st birthday shall, on the date of their 21st birthday, conform to the adult medical criteria and cost-effectiveness standards.

Technology Assisted Waiver services are provided in accordance with the requirements of 12VAC30-120-1700; 12VAC30-120-1705; 12VAC30-120-1710; 12VAC30-120-1720 through VAC30-120-1780 and are available to all categorically and medically needy individuals determined to be eligible for assistance. TW services under Virginia Medicaid must not be of any less or greater duration, scope, or quality than that provided to individuals not receiving state and/or federal assistance for those services covered by Virginia Medicaid.

## FREEDOM OF CHOICE

Medicaid eligible individuals, family or caregiver must be offered the choice of TW services or specialized care nursing facility or long-stay hospital placement, as appropriate, as well as the provider of those services from the time an individual seeks waiver information or application and referral. Such provision of choice includes the right to appeal pursuant to 12VAC30-110 when applicable. Freedom of choice is a federal requirement and must be documented in the provider medical records.

All services chosen by the individual or primary caregiver (PCG) must be made freely and without interference from any provider.

## MEDALLION 3.0 MANAGED CARE PROGRAMS

Individuals who are enrolled in the Technology Assisted Waiver shall not simultaneously be in a managed care program. An individual shall not be simultaneously enrolled in more than one waiver program.

**EPSDT**

Private duty nursing services may be available through Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) for Medicaid eligible individuals under 21 years of age. EPSDT private duty nursing may not be used once an individual is enrolled in the TW. Information concerning EPSDT services may be found in the EPSDT supplement Appendix B of this manual.

**HOME AND COMMUNITY-BASED CARE**

The philosophy of the Commonwealth of Virginia is that all individuals may choose their setting for health care delivery whenever possible.

Medicaid funded Home and Community Based Services (HCBS) is an alternative to institutional placement, which must be approved under special waiver authority by the United States Secretary of Health and Human Services. Approval of Virginia's HCBS Waivers is also contingent upon projections, for each year of the waiver, for the number of individuals the Commonwealth expects to receive waiver services and the average per capita expenditures projected for waiver services.

Virginia offers Medicaid reimbursement for HCBS through several waivers granted by the Centers for Medicare and Medicaid Services (CMS). CMS may waive certain statutory requirements in order to allow states to offer HCBS that prevent institutionalization of Medicaid eligible individuals. Continued federal approval for waiver programs is contingent upon the state's ability to document that the population targeted to receive waiver services was, in fact, a population that would otherwise have required institutional care and that the cost of HCBS is equal to or less than the cost of such institutional care. Enrolled individuals must be authorized to receive services through one of the approved waivers. An enrolled individual cannot receive services if these services would duplicate other care the individual receives.

To ensure DMAS programs and waivers serve only individuals who are eligible for Medicaid and admission to a specialized care nursing facility, acute care hospital, long stay hospital or institutional care, HCBS must be the critical services that will enable the enrolled individual to remain at home rather than a facility placement.

TW services are not available to individuals who reside in the following: assisted living facilities, nursing facilities, rehabilitation hospitals, long stay hospitals, skilled or intermediate care nursing facilities, intermediate care facilities for the intellectually disabled, board and care facilities, acute care hospitals, group homes licensed by DBHDS or adult foster care homes.

## TECHNOLOGY WAIVER PROGRAM CRITERIA

Medical necessity for skilled PDN must be met in order to be approved and enrolled into this waiver. Reimbursement for the provision of waiver services is not allowable until the applicant's Medicaid eligibility process and the provider's enrollment process is completed and the DMAS authorization has been coordinated with the provider and the individual. DMAS has the ultimate responsibility for authorization of Medicaid reimbursement for TW nursing services, the number of skilled PDN hours, enrollment in and termination from the waiver.

Individuals enrolled in the Technology Assisted Waiver shall be referred to as the "individual" throughout this chapter. The individual authorized for skilled PDN must have a primary caregiver (PCG), as defined in 12VAC30-120-1700, who is trained in all aspects of the individual's care and who accepts responsibility for the individual's health, safety, and welfare (HSW).

The PCG shall be responsible for all hours not provided by a RN or a LPN. It is the responsibility of the PCG to assure and provide all care when the private duty nurse is not available. Documentation in the medical record must state the name and phone number of the trained PCG. This trained PCG shall also have a backup system available in emergency situations. Due to the complex medical care needed for this waiver population, the individual receiving TW services may not be left alone at any time.

When a Personal Care Attendant (PCA) is working with an adult, the PCG is responsible for providing all of the skilled nursing needs. The PCA may only provide the individual with personal care services. The PCA cannot be left alone with the individual at any time.

When the PCG is using skilled PDN and/or skilled PDN Respite Care, the trained PCG and a backup caregiver name and phone number should be documented in the medical record of the individual. The backup caregiver shall accept responsibility for the oversight and direct care of the individual in case of an emergency, and ensure the Health, Safety and Welfare of the individual when the PCG is ill, incapacitated, or unavailable for any reason. The back-up caregiver will do so without Medicaid compensation and shall be trained in the skilled technologies required by the individual. When a backup system is required and not available, Adult or Child Protective Services will be notified.

When care for enrolled individuals is interrupted due to their primary caregiver's emergency unavailability and an adequate backup system is not available, hospitalization or placement in a specialized nursing facility shall occur.

Skilled PDN will be provided in the primary residence, as determined on initial enrollment into the waiver, with some community integration. Skilled PDN may also be offered:

1. To accompany the individual to medical appointments
2. To work with the individual while attending school
3. To facilitate community integration as able (church, theater, etc.)

When the primary residence has changed or skilled PDN services are not being performed in the primary residence, the individual/PCG and the providers shall notify DMAS.

While waiver services in some instances can be authorized simultaneously with other non-waiver Medicaid and Medicare or school services, the services cannot be performed at the same time or duplicate any other care the individual is receiving.

Skilled PDN must be authorized as the primary TW service in order to be eligible for waiver enrollment and is the only "stand alone" service. Other TW services can be used in conjunction with skilled PDN such as personal care and skilled respite care, but may not be performed at the same time or duplicate any other service received.

TW services may not be provided to an individual who resides or travels outside of the physical boundaries of the Commonwealth of Virginia, with the exception of brief periods of time as pre-approved by DMAS. Brief periods may include vacation, family emergencies/illness or medical appointments and are limited to the same skilled PDN hours approved for home based skilled PDN.

Payments for TW services shall not be provided to any financial institution or entity located outside of the United States pursuant to the Social Security Act § 1902 (a)(80). Payments for Tech Waiver services furnished in another state shall (1) be provided for an individual who meets the requirements of 42 CFR§431.52 and (2) be limited to the same number of skilled PDN hours approved for the individual's home-based skilled PDN.

In order to qualify for TW services, the individual must demonstrate complex health care needs that require specific skilled nursing services ordered by a physician that cannot be otherwise accessed under the Title XIX State Plan for Medical Assistance

When skilled nursing or personal care services are covered for individuals enrolled in TW, it shall be provided through either a Home Health agency licensed by the Virginia Department of Health for Medicaid participation, or accredited through JCAHO, CHAP, etc., and with a signed Provider Agreement with DMAS for PDN.

PDN may be authorized through the TW for individuals who are chronically ill or have a significant disability, needing a medical device to compensate for the loss of a vital body function and substantial and ongoing nursing care to avert death or further disability. The technology assisted population may include one or more of the following categories:

1. Individuals who are younger than 21 years of age shall have the Technology Assisted Waiver Pediatric Referral Form (DMAS-109) completed and must require substantial and ongoing nursing care as indicated by a minimum score of at least 50 points to qualify for waiver enrollment. This individual shall require a medical device and ongoing skilled PDN by meeting the categories described in subdivision (A), (B), or (C) below:

   A. Applicants dependent on mechanical ventilators;

   B. Applicants requiring prolonged intravenous administration of nutritional

substances or drugs or requiring ongoing peritoneal dialysis; or

C. Applicants having daily dependence on other device-based respiratory or nutritional support, including tracheostomy tube care, oxygen support, or tube feeding.

2. Individuals who are 21 years of age or older shall have the Technology Assisted Waiver Adult Referral Form (DMAS-108) completed and must be determined to meet Category A- be dependent on a ventilator or Category B-must meet all eight (8) specialized care criteria (12VAC30-60-320) for complex tracheostomy care in order to qualify for waiver enrollment,:

Category A:
Individual dependent on mechanical ventilator; or

Category B:
Individuals who have a complex tracheostomy as defined by:

- Tracheostomy with the potential for weaning off of it, or documentation of attempts to wean with subsequent inability to wean;
- Nebulizer treatments ordered at least four times a day or nebulizer treatments followed by chest physiotherapy provided by a nurse or respiratory therapist at least four times a day;
- Pulse oximetry monitoring at least every shift due to unstable oxygen saturation levels;
- Respiratory assessment and documentation every shift by a licensed respiratory therapist or nurse;
- Have a physician's order for oxygen therapy with documented usage;
- Receives tracheostomy care at least daily;
- Has a physician's order for tracheostomy suctioning; and
- Deemed at risk to require subsequent mechanical ventilation

DMAS will monitor the individual's status and provision of nursing services by telephone contact with the provider as needed and review of required documentation routinely submitted by the provider. DMAS will perform semi-annual and annual Level of Care (LOC) assessments in the individual's home or school.

Skilled PDN hours are based on the assessed skilled needs of the individual as determined by the age appropriate referral form. These hours may be authorized up to a maximum of 112 hours per week.

Federal regulations governing Medicaid coverage of HCBS under an approved waiver specify that services must only be provided to an individual who has a need for the level of care provided in an alternative institutional placement or when there is a reasonable indication that an individual might need institutionalization unless he or she receives HCBS. Enrollment and waiver services may be furnished to individuals:

1. Who are eligible for Medicaid;

2. For whom an appropriate, cost-effective Plan of Care can be established;

3. For whom a physician has certified the need for this level of care to include skilled PDN;

4. When there are sufficient community resources to meet the individual's needs;

5. When Medicaid is the payer of last resort;

6. Whose health, safety, and welfare (HSW) in the home environment can be ensured.

## MEDICAID ELIGIBILITY DETERMINATION

Every individual who applies for Medicaid funded waiver services must have their Medicaid eligibility evaluated or re-evaluated, if already Medicaid eligible, by the local DSS in the city or county in which they reside. This determination shall be completed at the same time the Pre-Admission Screening (PAS) team completes its evaluation, via the use of the Uniform Assessment Instrument (UAI), of whether the applicant meets waiver criteria.

DMAS payment of waiver services shall be contingent upon the DSS' determination that the individual is eligible for Medicaid services for the dates that waiver services are to be provided and that DMAS or the designated service authorization contractor has authorized waiver enrollment and has prior authorized the services that will be required by the individual. Individuals who do not utilize Tech Waiver services at least once every 30 days shall be terminated from the wavier.

## PRE-ADMISSION SCREENING

A request for a pre-admission screening for the TW can be initiated by the individual who desires TW services, a family member, a physician, hospital staff, the local health department, a social services professional, or any other concerned individual in the community.

The Tech Waiver offers services to individuals regardless of age. PAS must be performed by either the Acute Care Hospital or the Local Community Based PAS Team. The screening team shall be composed as directed by Code of Virginia § 32.1-330. Once it is

determined that an individual meets waiver eligibility criteria and is Medicaid eligible, services may be authorized by DMAS.

Individuals moving to the Commonwealth of Virginia who are interested in TW services must establish residency in Virginia, apply for Virginia Medicaid, and have a screening completed for the Technology Assisted Waiver by their community based screening team. Waiver enrollment can only be authorized for individuals who reside in the Commonwealth of Virginia. If an individual is transferred from an out of state hospital to a Virginia hospital as part of a move to Virginia, the hospital receiving the individual will initiate the referral for TW services and complete a pre-admission screening. If an individual is a Virginia resident and is receiving care in an out of state hospital, the out of state hospital may initiate a referral for TW services by completing the DMAS Level of Care Review form (DMAS-99 LOC ), obtaining an MD order to admit to Technology Assisted Waiver, and completing an age appropriate referral form (DMAS 108/109).

For information regarding the pre-admission screening process (completion of the Uniform Assessment Instrument (UAI)), refer to the DMAS Pre-Admission Screening Manual. This manual can be accessed on the DMAS Medicaid web portal: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal. The pre- admission screening forms may be downloaded from the DMAS web portal at the following link: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderFormsSearch.

**PRIVATE DUTY NURSING AGENCY RESPONSE TO REFERRAL**

Providers shall not begin PDN services for which it expects reimbursement from DMAS, until the pre-admission screening packet is received from the PAS team or DMAS and **DMAS has approved skilled PDN nursing services**.

It is the provider's responsibility to review and ensure the receipt of a complete and accurate pre-admission screening packet. The provider must receive the TW enrollment date from DMAS.

The first date of skilled PDN services cannot be before the physician signature date on the DMAS 96 and must be on the same date as the DMAS TW service effective date on the Skilled Private Duty Nursing Authorization.

DMAS will coordinate with the chosen nursing provider to assist with a smooth transition to skilled PDN services. The skilled PDN provider shall make available any documentation requested by DMAS as part of the required assessments and home visits.

The RN or LPN providing PDN services will do so according to the nursing services ordered by the physician, in accordance with all Medicaid regulations, policies and provider policies.

Individuals receiving skilled PDN who wish to have additional services must have Service Authorization (SA) from DMAS or the DMAS SA Contractor as appropriate before reimbursement can occur. Service initiation cannot occur prior to the begin date on the

computer generated authorization letter from DMAS.
The letter is confirmation of the approved services and hours and allows the provider to seek reimbursement. If the provider does not receive this letter within 60 days, the provider should contact the provider HELPLINE at 1-800-552-8627 to check the status of the enrollment. This letter is not part of the required documentation and cannot be generated by DMAS.

Individuals choosing to receive skilled PDN services must do so by choosing a PDN provider enrolled with DMAS to provide the services. Once the agency has accepted the TW referral, the RN supervisor must make the initial home assessment visit on or before the actual initial start of services date. The DMAS 116 assessment MUST be completed in the primary place of residence as determined on enrollment into the waiver. The assessment and the Physician's Home Health Certification and Plan of Care – CMS485-POC (with or without MD signature) must be sent to DMAS within 2 business days of the visit. Once the assessment and POC485 is received and reviewed by DMAS, authorization will be completed. Medicaid reimbursement cannot be made until receipt of the SA from DMAS. Failure of the provider to ensure timely submission of the required assessments may result in retraction of all skilled PDN payments for the period of time of the delinquency.

**DEFINITION OF SKILLED PRIVATE DUTY NURSING**

Skilled PDN means in-home nursing services provided for individuals enrolled in the TW with a serious medical condition and/ or complex health care need. The individual requires specific skilled and continuous nursing care on a regularly scheduled or intermittent basis performed by a registered nurse (RN) or a licensed practical nurse (LPN) under the direct supervision of a registered nurse. Skilled PDN services may include consultation and training for the PCG, or other providers of care.

Services are authorized by DMAS and rendered according to a Plan of Care-CMS-485 form (POC-485) certified by a physician as medically necessary to enable the individual to remain at home, rather than in a hospital or nursing facility. Skilled PDN may be provided to individuals living in the community who have been authorized to receive certain HCBS as an alternative to receiving services in an institutional setting.

Skilled PDN may be offered to individuals as:

1. Continuous skilled PDN service required to supplement care rendered by a primary caregiver (PCG);

2. Skilled PDN Respite Care (RC) services offered as episodic relief to the caregiver of an individual receiving TW services.

The policies in this manual apply to the provision of skilled PDN care rendered as either private duty nursing (continuous nursing care) or as skilled respite care services. See "Respite Care" in this chapter for additional information regarding respite services.

Skilled PDN is available to:

1. Individuals (under 21 years of age) who would require hospitalization or long stay hospital or specialized care facility placement;

2. Individuals (21 years of age or older) who would require a specialized care nursing facility placement.

## INITIAL HOME ASSESSMENT VISIT

Upon receipt of a referral and prior to the delivery of skilled PDN services, the registered nurse supervisor from the provider agency must make an evaluation visit to the individual's home to introduce the nurse(s) to the individual receiving TW services and their PCG and orient the nurse(s) to the needs of the individual.

- If the nurse to be regularly assigned is not introduced to the individual at the time of the nurse supervisor's initial home visit and the nurse has not been previously oriented to the care needs of the individual, or a similar individual with the same needs, the nurse supervisor must make a return visit with the regularly assigned nurse to orient the private duty nurse to the individual's care and introduce the nurse(s).

  When the nurse has been previously oriented to the individual's care, or has rendered similar care to an individual with the same skilled nursing needs as the assigned individual, the nurse supervisor does not have to orient the regularly assigned nurse at the time of service initiation. **The RN Supervisor is still responsible for assuring the nurses skill level meets all of the individual's needs.**

- Discuss the individual's goals, needs and physician's orders to develop the POC- 485 with the individual/PCG and the private duty nurse(s) to ensure that there is complete understanding of the individual's goals and services to be provided. A copy of the current POC-485 must be kept in the individual's home at all times. The nurse(s) should be instructed to use the POC-485 as a guide for daily service provision. The most current 485 must accompany the individual and nurse to school and whenever they leave the primary residence.

  The nurse must chart PDN tasks, which are not included in the individual's POC-485 if the individual/PCG has a need for the task to be done. The nurse must note why this task was performed and whether the need for this task continues to exist. It is then the responsibility of the RN who must review nursing notes to determine whether there is a need for the task to be included in the POC-485 on an ongoing basis and to make necessary changes.

The provider's initial assessment required documentation includes all of the following:

- Individual's current functional status, current medications, primary caregiver and back-up caregiver, social support system, and other community services rendered to the individual as well as the overall condition of the environment;

- Review of the POC 485 and documentation needs discussed with the individual and nursing staff; and,

- Any special medical care (e.g., ventilator care) to be provided by the skilled PDN. The RN supervisor must indicate what care the nurse is providing, what instructions the nurse has received from the RN supervisor and the RN supervisor's observation of the nurse's demonstration of the correct techniques involved in this care. It is the provider nursing supervisor's responsibility to assure all nurses providing care meet the requirements for TW skilled PDN at all times.

Skilled PDN provider responsibility and timeframes for submission of documentation to DMAS:

1. Initial assessment visit note (DMAS 116) shall be sent to DMAS within 2 business days of the visit.
2. Initial POC 485- A copy of the initial 485 shall be sent to DMAS within 2 business days of the initial assessment visit.
3. The re-certification POC 485- completed every 60 days shall be sent to DMAS within 21 calendar days of completion.

The home medical record shall be easy to find, organized and legible. The provider shall assure the information in the home is current. The agency may purge the record but must assure the last 2 weeks of data remain in the home at all times. Nursing providers who use electronic records for daily nursing documentation must provide primary caregiver and DMAS access to this documentation.

The skilled PDN provider may not bill DMAS until the MD has signed and dated the 485. A signed copy of the current 485 must be kept in the individual's home record.

It is the skilled PDN provider's responsibility to determine whether the agency can adequately provide services to an individual prior to accepting a TW referral.

If, during the initial assessment, the RN supervisor determines the individual is not appropriate for PDN services because of health, safety, or welfare reasons or because the provider is unable to staff the case, the agency should not open the case to PDN. The provider RN should contact DMAS staff to discuss the situation and explore possible alternatives for provision of care. If the provider decides not to accept the referral, the RN must notify the individual and DMAS of the reason for this decision.

**RN SUPERVISOR RESPONSIBLITIES**

Using a person centered planning team approach to nursing services the provider RN

supervisor shall:

- Ensure choice of services is made by the individual, legally authorized guardian, or responsible party if a minor;
- Ensure personal goals of the individual are respected;
- Conduct the initial evaluation visit to initiate TW PDN services in the primary residence;
- Regularly evaluate the individual's status and nursing needs and notify DMAS if the individual no longer meets the LOC criteria for the waiver;
- Complete the POC-485 every 60 days and as necessary for revisions. The new POC-485 should be sent to DMAS at the beginning of each new certification period;
- Assure provision of those services requiring substantial and specialized nursing skill and that assigned nurses have the necessary licensure;
- Initiate appropriate preventive and rehabilitative nursing procedures;
- Perform monthly skilled nursing assessment, at least every 30 days, using the Technology Assisted Waiver Supervisory Monthly Summary (DMAS 103) (the monthly nursing assessment cannot be made by the nurse providing care in the home); RN Monthly Supervisory Visits shall be completed in the primary residence at least every other visit. Pediatric visits may be conducted in the school every other visit if necessary;
- Coordinate services;
  - Inform the physician, DMAS and other personnel of changes in the individual's condition and needs;
  - Contact DMAS if an individual does not meet TW criteria;
  - Educate the individual/PCG in meeting nursing and related goals; and
  - Supervise and educate other personnel involved in the individual's care.
- Ensure all nurses have a Technology Assisted Waiver Nursing Skills Checklist (DMAS 259) form completed by the RN supervisor *prior* to assignment to an individual;
- Review with each nurse all skills listed on the DMAS 259 and have the nurse demonstrate or explain in detail how they would perform each task. Nurses may not complete the DMAS 259 form on themselves. PDN staff may not complete this form on their nursing peers;
- Ensure the completed DMAS 259 form accurately represents the nurse's competence, education, training and experience;

- Ensure availability of a supervising RN 24 hours per day to address concerns that may arise with TW individuals;
- Notify DMAS of any major problem or changes in an individual's family/social situation or primary residence;
- Ensure nurse supervisors do not work as a private duty nurse on cases they supervise;
- Complete in its entirety, the Technology Assisted Waiver Supervisory Monthly Summary (DMAS 103) form and send to DMAS within 5 days after the end of the month reported;
- Complete an annual LOC review (99LOC series and age appropriate referral form) on each individual receiving TW services;
- Ensure that required documentation is in the individual's agency record (screening, PDN authorization, admit letter);
- Ensure that all employees are aware of the requirements to report suspected abuse, neglect, or exploitation immediately to APS or CPS, as appropriate. A civil penalty may be imposed on mandated reporters who do not report suspected abuse, neglect or exploitation to VDSS as required;
- Ensure services are provided in a manner that is in the best interest of the individual and does not endanger the individual's health, safety, or welfare;
- Recommend staff changes when needed;
- Report to DMAS any unethical or incompetent practices that jeopardize public safety or cause a risk of harm to individuals, including household issues that may jeopardize the safety of the PDN;
- Ensure that all nurses and caregivers are aware that timesheets must be accurate with arrival and departure time of the nurse and that falsifying timesheets is Medicaid fraud;
- Ensure that respite documentation is kept separate from regular nursing documentation and labeled as respite; and,
- Submit a (99LOC) Series, DMAS 108 and MD order to continue Tech Waiver services per adult criteria when an individual turns 21 years old. If the individual meets the adult Tech Waiver criteria, services will be continued. If the individual does not meet the adult Tech Waiver criteria, DMAS will initiate termination from the waiver.

When two providers share an individual's care, the following applies:

- Coordination of services must be assured;
- Both providers shall maintain an individual's medical record with all required documentation;
- Both providers must have a coordinated POC-485 and medication sheets;
- Both providers must send all verbal orders to the co-sharing agency;
- Both providers must track the annual Respite hours being used;
- Both providers must perform monthly supervisory visits at least every 30 days; and.
- Weekly communication between agencies in shared cases is encouraged regarding PDN hours, billing, and health, safety or welfare issues.

**PHYSICIAN SUPERVISION/CERTIFICATION AND RECERTIFICATION FOR THE PLAN OF CARE**

Individuals receiving TW services must be under the care of a physician in the community who is legally authorized to practice and act within the scope of his or her medical license. The physician shall be currently certified by the Board of Medicine and have a currently valid license to practice medicine in the Commonwealth of Virginia. The Physician shall have experience in the needs and care of technology assisted persons (adults and children).

A written physician's statement, which may be on the POC-485, in the form of physician orders must be in the individual's medical record in the provider's office and at the individual's home and must include:

- Physician certification of the individual's need for skilled PDN care;
- ID of primary care physician in community who has agreed to manage the medical care of the individual;
- Medical orders obtained as a result of modifications to the previous service plan and existing orders that remain in effect. Order must include the identification of the type, scope, amount, duration and frequency of services;
- Name and current address of individual;
- Individual's date of birth, Medicaid ID, TW start of care date as well as the 60 day certification period;
- Choice of services made by the individual;

- Personal goals of the individual are respected;
- A plan for furnishing services to the individual which is reviewed and signed by the physician every 60 days;
- All waiver services needed by the individual to include the identification of the type, scope, amount, duration and frequency of services ordered by the physician (this includes the amount of PDN hours);
- A statement of the appropriateness for HCBS;
- The diagnosis of the individual which is directly associated with the services ordered and ICD code;
- A list of current medications, treatments, allergies and equipment ordered;
- Measurable goals for care/ services;
- Both the dated RN and Physician signatures;
- Provider agencies that elect not to use the POC-485, may develop their own form that must contain all of the elements and requirements as set forth in regulation and this manual for the POC-485. The statement of certification of medical necessity must be found on the form;
- Current signed 485 to be kept in the individual's home.

A physician shall review and re-certify the POC-485 every 60 days. The physician must sign the re-certification before the provider agency may bill DMAS. The re-certification POC-485 must include, but is not limited to, all of the orders from the end date of previous POC-485 and must include the type, scope, amount, frequency and duration for all services ordered on the POC-485.

All new or modified orders must be signed and dated by the physician and kept with the current POC-485. These orders must be included on the next POC-485 if appropriate.

Verbal orders may be received by a registered nurse. When a verbal order is taken by a LPN, the agency provider RN Supervisor must assure the accuracy of the order and its inclusion in the next POC-485. All verbal orders must be signed and dated by the physician.

To assure all of the care needs of the individual are met, the most recent POC-485 must be kept in the individual's home and easily accessible at all times. This POC-485 will assist the nurse in cases of emergencies, substitution or when there is more than one nurse

providing care. A new POC-485 must be in the home record within 21 days of the expiration date of the current plan. Failure to provide a new POC-485 after 21 days is considered a HSW issue by DMAS.

**Orders for Skilled Care (CMS-485, Block 21)**

Discipline and Treatments orders must include the following information for these specific technologies:

**BIPAP/ CPAP/ Ventilators**

- Machine or Vent model
- Current MD ordered Vent settings
- Orders for Vent use, i.e. time to be used, weaning schedule (if ordered)

**Tracheostomy**

- Trach manufacturer, size, and back up trach size
- With cuff use – Please specify when cuff is to be inflated (with vent use, with sleep only, while eating, etc.) Inflate with air or water and amount
- Trach Care to include:
  Frequency of change and LOCATION if not done at home
  Specific ostomy site care and frequency per day
  Inner cannula care or change if applicable
  Trach suction catheter size and frequency

**Oxygen**

- Should be ordered as a medication to include dose/amount, time to be used (PRN /with sleep/continuous), route

**Pulse Oximeter**

- Include high/low limits and orders in response to exceeding those limits
- Frequency of use

**Nutrition**

- Specify PO, enteral feeding or TPN
- Include specific PO diet, i.e. consistency and indicate if thickener is required for liquids
- Enteral feeding should specify formula name, amount , frequency and delivery method
- Gastrostomy site care, frequency of care, tube size, and changing schedule must be ordered

**Catheter Care**

- Foley , size, change frequency, irrigation if ordered
- Straight catheter, size, scheduled or PRN, irrigation if ordered

**Wound Care**

- Site, type, specific treatment orders, measurements of wound if applicable
- Include name and phone # of any agency that provides RN skilled wound care visits

**Infusion Therapy**

- Type of infusion fluids
- IV site, care orders
- Dosage and daily time schedule for giving the infusion
- Include name and phone # of any agency that provides infusion therapy visits

**DMAS INITIAL REVIEW PROCESS**

DMAS Enrollment Review: Enrollment review begins with the receipt of the complete screening packet and continues throughout the process until all of the required documentation is received and the final determination of waiver eligibility is made. Once DSS determines an individual meets financial eligibility, then DMAS determines the following:

- TW criteria is met
- Nursing services are available
- All Third Party insurance coverage for PDN is exhausted
- Enrollment can be initiated

DMAS will work with the screening entities, the physician, the individual/PCG and providers to assure a safe and smooth transition to HCBS. In conjunction with the referral assessment for eligibility criteria, the enrollment review shall also include:

1. Verification that the PCG / individual's training needs have been met to ensure the safety of the individual while living in the community;

2. Verification that the discharge planner has included the delivery of medical equipment to the home;

3. Verification that the Skilled PDN provider initial assessment home visit has been performed and completed by the RN supervisor;

4. Verification that all third party insurance benefits have been exhausted as set forth in regulations; and,

5. Verification of the DMAS authorized first date of skilled PDN services.

The initial assessment is completed by the provider agency RN supervisor. Documentation shall include all of the requirements for the Initial Assessment visit as stated in this chapter under "Provider Documentation Requirements-Skilled Private Duty Nursing Visits." The assessment (DMAS 116 as well as the 485) is submitted to DMAS as part of the skilled PDN enrollment review. Upon completion of this review process, DMAS will enter the waiver enrollment on the LOC file in MMIS and complete the SA for skilled PDN services. This will allow the provider to bill for services rendered. The authorization for enrollment into the TW is not completed until all requirements are met and a safe and effective POC-485 is assured by DMAS.

DMAS will perform an initial home assessment within 14 business days of TW enrollment. The purpose of this assessment is to assure services are rendered according to the MD orders and the assessed needs of the individual. This assessment will include all documentation submitted to DMAS and the required documentation in the home. DMAS will assure the individual is living in a safe environment, verifies the PCG/back-up caregiver and ensure choice of services and providers.

As part of the assessment process, DMAS will assure the individual's rights and responsibilities are reviewed, signed and dated by the individual/PCG. DMAS assures the medical care the individual is to receive in the home is agreed to by the PCG and all others involved in the assessment process and that all caregivers have received training needed to maintain the individual in the home.

DMAS Ongoing Review: DMAS will monitor the individual's status and the provision of nursing services by telephone contact with the provider, review of provider Supervisor Monthly Visit Notes, skilled nursing notes and will perform the semi-annual DMAS visits.

Semi-annual eligibility assessment visits, performed by DMAS for all individuals receiving TW services, shall include, but are not limited to:

- Reviewing the most recent POC-485 for appropriateness of the level, amount, type, and quality of services provided;
- Monitoring the cost-effectiveness of the individual's care in the community;
- Reviewing the last three months of Supervisory Monthly Summary notes (DMAS 103);
- Discussing customer satisfaction and choice;
- Assessing that health, safety and welfare needs are being identified and met by the provider; and,
- Reviewing skilled nurses notes.

## ENROLLMENT AND INITIATION OF TECH WAIVER SERVICES

Medicaid reimbursement for skilled PDN services shall not occur prior to:

- Completion of the UAI screening by the PAS Team with authorization from DMAS for TW services;
- The physician's dated signature on the DMAS 96;
- The Department of Social Services (DSS) determination that the individual is Medicaid eligible for medical assistance for the dates of service; and

- The date of the DMAS level of care determination and authorization for enrollment into the TW as noted on the skilled PDN Authorization

DMAS has the authority to request the POC-485 and/or any supporting documentation as needed to make a decision. Copies of all POC-485 must be maintained in the individual's medical record by the provider. The POC-485 and documentation of service delivery must be consistent with the information submitted to DMAS and with the hours billed for reimbursement.

Individuals choosing to receive skilled PDN services must do so by choosing a PDN provider enrolled with DMAS. Once the provider has accepted the referral, the RN supervisor must make the initial assessment visit on or before the start of care.

An assessment visit must also be made when an individual is re-admitted after discharge from services, is a transfer from another provider, or is enrolled in the TW from another payer source for skilled PDN (i.e. private insurance or EPSDT). This assessment MUST be conducted only in the primary place of residence as determined on enrollment into the waiver.

- A copy of all preadmission screening packets are forwarded to DMAS who will assure the accuracy of all forms submitted for enrollment, that LOC criteria/ eligibility requirements are met, as well as the appropriateness of TW skilled PDN services.

- The DMAS Team in conjunction with the PAS Team must explore the medical and social needs of the individual. Recommendations for a service or combination of existing services to meet the nursing needs of the individual and assure alternative settings and services are developed before waiver enrollment and authorization of services occurs.

- As the final authorization mechanism for Medicaid funded HCBS, DMAS shall, within 14 business days of receiving all supporting documentation, approve Medicaid coverage or deny waiver enrollment. Provider reimbursement of waiver services cannot be initiated before both enrollment into the waiver and skilled PDN SA has occurred by DMAS.

Tech Waiver Services Include:

| **Service** | **Services Authorization** |
|---|---|
| Skilled Private Duty Nursing | DMAS performs SA |
| Personal Care- (agency-directed) Adults only | DMAS performs SA |
| Transition services | DMAS performs SA |
| Congregate Services | DMAS performs SA |
| Skilled Private Duty Respite Care | DMAS contractor function SA |
| Assistive Technology | DMAS contractor function SA |
| Environmental Modification | DMAS contractor function SA |

SA for the TW Services: This process is handled through DMAS or the DMAS SA Contractor depending on the service being requested. Please refer to the SA Chapter of this manual (Appendix D) for details regarding the service authorization process. Durable medical equipment and supplies, including nutritional supplements, are made available through the State Plan Option (SPO). Items and supplies not covered under the SPO may be covered under Assistive Technology or Environmental Modifications when the criteria is met.

Individuals may be authorized to receive one or more waiver services, either solely or in combination, based on the documented need for the service(s), the individual's choice of services and the requirements met as set forth in this manual and federal regulations. Skilled PDN is the only standalone service offered in the TW.

The provider should not initiate TW skilled PDN services if it is determined that at least one of the following conditions is met:

- The individual is not appropriate for services due to health, safety or welfare concerns;
- The individual is no longer Medicaid eligible;
- The individual does not have a physician in the community to manage their care and sign the 485;
- An appropriate service plan cannot be developed.

If the provider determines during the initial assessment visit that skilled PDN services should not be initiated, the provider must notify the PAS Team and LDSS immediately and must send the documentation supporting this decision to DMAS within 24 hours of this decision. If DMAS agrees with the provider assessment DMAS will send a letter of denial including appeal rights to the individual.

The provider may discharge a Tech Waiver individual from their agency BUT termination from waiver enrollment is a **DMAS function only.**

## SPECIALIZED CARE NURSING FACILITY/LONG STAY HOSPITAL REFERRALS TO THE TECHNOLOGY ASSISTED WAIVER

When an individual has been admitted to a Long Stay Hospital or a Specialized Care Facility and is seeking TW enrollment, the individual would meet the Level of Care criteria for the TW.

In order to assure a smooth transition with an appropriate and safe POC-485, the facility discharge planner will forward a copy of the facility admitting UAI to DMAS and the skilled PDN provider. Due to the complex health care needs of the individuals the following additional documentation must be forwarded to DMAS before waiver enrollment

can be authorized:

1. Physician orders to include referral for enrollment into the Technology Assisted Waiver;

2. Department of Medical Assistance Services Level of Care Review (DMAS 99 LOC form);
3. Department of Medical Assistance Services Pediatric Referral form (DMAS 109) for all individuals under 21 years of age;

4. Department of Medical Assistance Services Adult Referral form (DMAS 108) for all individuals 21 years of age or older; and,

5. Medical documentation such as Physician Progress Notes; Discharge Orders and any other medical documentation/ information required to make a decision for waiver enrollment/eligibility

Facilities should contact DMAS prior to discharge regarding documentation requirements to re-enroll an individual to the Technology Assisted Waiver.

**RIGHTS AND RESPONSIBILITIES**

DMAS and the provider shall ensure the following individual rights and responsibilities:

1. Each individual shall receive, and the provider and provider staff shall provide the necessary care and services, to the extent of provider availability, to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the individual's comprehensive assessment and POC-485.
2. Individuals have the right to receive services from the provider with reasonable accommodation for their needs and preferences except when DMAS makes a determination that the health, safety, or welfare of the individual would be endangered.
3. Individuals shall be provided by their healthcare providers at the time of their enrollment in this waiver, written information regarding their rights to participate in medical care decisions, including the right to accept or refuse medical treatment and the right to formulate Advanced Directives.
4. All individuals shall have the right to:

    a. Participate in the Person Centered Service Plan that demonstrates choices made and the personal goals of the individual;

    b. Voice grievances to the provider or provider staff without discrimination or reprisal. Such grievances include those with respect to services that have been furnished or have not been furnished;

c. Prompt efforts by the provider or staff, as appropriate, to resolve any grievances the waiver individual may have;

d. Be free from verbal, sexual, physical, and mental abuse, neglect, exploitation, and misappropriation of property;

e. Be free from any physical or chemical restraints, of any form, that may be used as a means of coercion, discipline, convenience, or retaliation, and that are not required to treat the individual's medical symptoms, and;

f. Their personal privacy and confidentiality of their personal and clinical records.

5. Individuals shall be provided by their healthcare providers at the time of their enrollment in this waiver, written information regarding their rights to participate in medical care decisions, including the right to accept or refuse medical treatment and the right to formulate Advanced Directives.

6. The individual, the individual's legal guardian, or the parent (natural, adoptive or foster) of the minor child shall have the right to:

a. Choose whether the individual wishes to receive HCBS instead of institutionalization in accordance with the assessed needs of the individual. The PAS team shall inform the individual of all available waiver service providers in the community in which the individual resides. Individuals shall have the option of selecting the provider agency and services of their choice. This choice must be documented in the individual's medical record;

b. Choose his own primary care physician in the community in which he lives;

c. Be fully informed in advance about the waiver POC and treatment needs as well as any changes in that care or treatment that may affect the individual's well-being;

d. Participate in the care planning process, choice and scheduling of providers and services.

**DMAS-225 LONG TERM CARE (LTC) COMMUNICATION FORM**

The DMAS-225 is used by the LDSS to inform enrollees of Medicaid eligibility. It is also used by providers and the LDSS to exchange information regarding the responsibility of an individual to make payment toward the cost of services or other information that may affect the eligibility status of an individual.

Immediately upon initiation of services, DMAS will send a DMAS-225 to the eligibility unit of the appropriate LDSS indicating the agency provider's first date of skilled PDN service delivery, pending Medicaid verification.

The LDSS eligibility worker will complete the DMAS-225 process and notify the individual when a patient pay obligation is required. The eligibility determination may be viewed on line at any time via the ARS Web System or Medi-Call (AVRS). All providers will be responsible for the patient pay collection and assurance that the most current patient pay is being collected.

The waiver individual will receive a notification letter from the DMAS VACMS system.

The DMAS 225 must be used as a communication tool between the provider, LDSS and DMAS to report changes such as:

| **Function** | **Responsible Agency** |
|---|---|
| Enrollment in Tech Waiver | DMAS function |
| Agency admission to waiver services | Agency function |
| Agency discharge from waiver services | Agency function |
| Transfer to another waiver provider | Agency function |
| Interruptions in service greater than 30 days | Agency function |
| Information known to the provider which may cause a change in the eligibility status or patient pay amount | Agency function |
| Death or TW termination | DMAS function |

These occurrences will prompt the LDSS to evaluate eligibility for Medicaid coverage of Tech Waiver services and calculation of patient pay in the Virginia Case Management System (VACMS).

It shall be the provider agency's responsibility to adhere to all rules and regulations set forth for the DMAS 225 and patient pay obligations.

The web-based Internet option (ARS) may be used to access information regarding Medicaid or FAMIS eligibility, claims status, check status, service limits, service authorization and pharmacy information at the following address: www.virginiamedicaid.dmas.virginia.gov. MediCall voice response system will provide the same information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996.

When more than one provider furnishes services to an enrollee or the provider responsible for collecting patient pay changes, the DMAS 225 shall be used to notify the LDSS which provider is responsible for patient pay collection. The DMAS 225 when completed by the LDSS shall be used to inform the LTC Provider of their responsibility.

The provider with the greatest number of billable skilled PDN hours shall be responsible for the collection and coordination of patient pay obligation and to request the required annual DMAS 225 from the LDSS. This provider shall also forward a copy of the updated DMAS-225 to all other service providers when obtained.

When two providers are providing the same number of billable skilled PDN hours, the

primary provider who accepted the original referral for services will coordinate and communicate with the secondary provider of PDN services.

The provider must ensure that a completed DMAS-225 for the current service year is on file in the individual's record prior to billing when a patient pay is applicable. A new DMAS-225 is generated by the LDSS at least annually, or when the individual's patient pay obligation changes.

**LAPSE OF SERVICES 30 DAYS OR MORE**

When an individual starts then stops services for a period of time exceeding 30 consecutive calendar days, the PAS team will need to complete a revised screening prior to service resumption if the individual has not received any Medicaid funded long-term care services during the break in service delivery. (Refer to the DMAS Pre-Admission Screening Manual)

Providers must send a DMAS-225 to the LDSS eligibility worker and DMAS when PDN services are not received for 30 consecutive days or more. In order to maintain eligibility for the TW program, PDN services MUST be utilized at some time during every 30 day period.

**TECHNOLOGY ASSISTED WAIVER RE-ENROLLMENT**

When an individual enrolled in TW is admitted to a NF, Specialized Care Facility, Long Stay Hospital, or Inpatient Rehabilitation, the TW enrollment is ***automatically*** terminated. Upon discharge, the provider must coordinate with DMAS to initiate re-enrollment into the waiver. All individuals who have been discharged from the provider will be re-assessed upon re-admission to skilled PDN services. The provider RN supervisor will complete the home assessment evaluation and document on the following assessment forms:

- The Provider RN Initial Home Assessment (DMAS 116);
- The Home Health Care Certification Plan of Care-485;
- The LTC Communication form-DMAS 225 and
- The DMAS 97T- Tech Waiver Adult Aide Plan of Care when personal care is ordered.

In order for reimbursement to occur, the provider shall request SA for services as for a new enrollment from DMAS.

It is the responsibility of the provider to request pre-approval from DMAS to re-start services and submit the required documentation to DMAS within 2 business days of the re-start of services to obtain SA for skilled PDN services.

Upon review of the required documentation and determination that the individual needs substantial and ongoing skilled nursing care, the skilled PDN hours are authorized by DMAS.

Previous Tech Waiver individuals may be re-enrolled in the waiver by contacting DMAS prior to the start of nursing care. The RN supervisor is responsible for contacting DMAS to assure that DMAS has received required documents for re-enrollment. Prior to the start of services, DMAS will review the skilled needs, Medicaid eligibility and any private third party insurance available to the individual to assure:

- DMAS is the payer of last resort
- There is no duplication of service
- Tech Waiver criteria are met
- There is a safe, effective plan of care

Upon receiving approval for re-enrollment from DMAS, the provider must complete a home assessment visit. The SA number will not be provided prior to receiving this documentation. The first day nursing services are provided will be the start of care date for Tech Waiver services.

Following re-enrollment and the start of care, the provider must send a DMAS 225 to the local DSS office and DMAS. Providers are responsible for knowledge of any patient pay amount and collection of payment.

Medicaid will not reimburse for private duty nursing hours provided prior to the authorization date on the DMAS skilled PDN authorization.

**END OF SERVICE DELIVERY**

The provider must immediately notify the local DSS via the DMAS 225 form and DMAS via the telephone of the provider's last date of service delivery when any of the following circumstances occurs:

- An individual no longer meets criteria for the services;
- An individual dies (include the date of death);
- An individual is discharged or discontinued from skilled PDN services. The date of discharge or discontinuation should be the last date services were rendered to the individual. This includes when the individual is discharged from one provider and admitted to another; and
- Any other circumstances (including hospitalization) that cause services to cease or become interrupted for more than thirty (30) days.

  EXAMPLE: The provider delivered services to an individual through the third of the month, and then the individual was hospitalized and died on the fifteenth of the month. Even though the provider kept the case open to see if the individual would need services post-hospitalization, the date submitted on the DMAS-225 would be the third since this was the last day the individual received waiver services.

**PROVIDER DOCUMENTATION REQUIREMENTS-SKILLED PRIVATE DUTY**

**NURSING SERVICES**

At a minimum, supporting documentation in the form of physician's orders on the POC-485, PCA plans of care (97T), daily skilled PDN nurses notes and Technology Assisted Waiver Supervisory Monthly Summary (DMAS-103) forms must clearly describe the following:

- The type of skilled procedures to be performed by the skilled private duty nurse and the type of personal care services being performed;
- The complexity of steps needed to complete each procedure; and
- The extent to which the skilled private duty nurse is called upon to use nursing knowledge and expertise to make an assessment, follow-up with a physician, or adjust orders/plans of care and
- Documentation of all care provided by the skilled private duty nurse.

Initial Assessment visit is performed by the provider RN Supervisor before the start of skilled PDN or any other waiver services. This visit serves as the admission visit and involves an assessment of all of the health care needs, social and psychological needs and additional service needs found as a result of this visit. This visit must occur only in the individual's home and serves as an introduction to the waiver. A copy of this assessment (DMAS-116) must be sent to DMAS within 2 business days of the visit.

An assessment visit must also be made when an individual is re-enrolled after discharge from services or is a transfer from another provider or another payer source.

Skilled PDN visit is performed by the provider agency staff RN or LPN primarily in the home of the individual with some community integration. This service is performed as ordered by the Physician on the POC-485 and in accordance with the type, scope, duration and frequency ordered dependent upon nurse availability. These services are documented on the Skilled Nursing Notes for dates rendered in accordance with the physician orders.

Skilled PDN includes specific treatments, procedures and individual/PCG training/ education related to the developed and certified POC goals. These visits will include post-hospital teaching sessions where the primary focus is to assist the individual/PCG in the transition to meet the individual's medical needs in the home environment. Skilled PDN services will also meet the medical needs and ensure the health, safety and welfare of the individual while residing in the community.

Providers may only bill for skilled PDN services rendered.

Monthly Supervisory Visit is performed at least every 30 days to provide oversight for all TW services in the home. These visits are the provider's responsibility in accordance with regulation and code and will include:

1. An assessment of the individual based on their skilled needs
2. Review of the home medical record
3. A determination that health care needs are met in the home
4. Documentation of the individual's satisfaction and choice of services
5. Documentation of satisfaction of service plan meeting their personal goals
6. A review of the POC (485) to ensure physician orders are accurate, current and being followed
7. An assessment of personal care services when provided

The individual receiving TW services must be present during every supervisor monthly visit.

These visits are documented on the Technology Assisted Waiver Supervisory Monthly Summary form (DMAS-103). At least every other month, the supervisory visit shall be made in the primary residence of the individual.

Skilled Respite Care includes all ordered skilled PDN care to include assistance with daily care needs, medication administration and monitoring of the health status and condition as well as the welfare and safety of the individual. Medicaid reimbursement is available only for skilled PDN Respite services provided when the individual is present and for the relief of the unpaid primary caregiver.

All skilled Respite Care documentation may be kept in the individual's medical record BUT must be clearly labeled on the notes and kept in a separate and distinct section of the medical record.

Skilled Respite supervisory visits are performed by the provider RN Supervisor. These visits provide oversight for all TW skilled PDN RC services in the home. These visits are the provider's responsibility in accordance to regulation and code and are documented on the Supervisory Monthly Summary form DMAS-103.

Visits are required at least every 30 days when RC is being provided on a routine basis and may be made in conjunction with the skilled PDN supervisory visits or personal care (PC) supervisory visits. The supervisory RC visit must meet the documentation requirements for skilled PDN supervisory visits. This documentation must be clearly defined as skilled Respite supervisory notes.

For any Tech Waiver services provided, the Supervisory Monthly Summary (DMAS-103) must be submitted to DMAS within 5 days following the end of the month in which the visit is due. Failure to complete the Monthly Supervisory Report may result in nonpayment for all skilled PDN visits associated with the missing monthly visit note. When the PCG is available, the monthly supervisory form shall be signed and dated by the individual/PCG.

The RN or LPN providing the skilled PDN or Respite services will do so according to the nursing services ordered by the physician, in accordance with all Medicaid regulation and criteria as well as the provider agency policies.

## PROVISION OF PRIVATE DUTY NURSING SERVICES

First 15 Day Period

For individuals under 21 years of age, who are going home from an original hospital stay whether living separately or in a congregate setting, skilled PDN may be covered for up to 24 hours per day during the first fifteen (15) calendar days after initial enrollment into the TW program. These additional hours may be utilized, if required and appropriate to assist the family in adjustment to the care associated with technology assistance.

When the individual is entering the program from the community, it is assumed the PCG is already familiar with the care of a technology assisted individual and would require less than 24 hours of PDN per 24-hour period for the initial 15 days.

Subsequent Private Duty Nursing Services

After the first 15 calendar days, skilled PDN shall be reimbursed up to a maximum of 112 hours per week per household based on the individual's total technology and nursing scores and provided that the aggregate cost-effectiveness standard is not exceeded for the individual's care

It is the provider's responsibility to recommend a decrease in hours once the waiver individual has adjusted and is stable in the home environment. The amount of skilled PDN hours cannot at any time exceed the annual cost aggregate standard for the individual's care.

The Department may grant exceptions for individuals less than 21 years of age, not to exceed 15 total days per annum, to these maximum limits based on documented emergency needs of the individual, however these exceptions must continue to meet aggregate cost.

Such consideration of documented emergency needs shall not include applicable additional emergency costs. Requests for an extension of care must include an updated assessment by the provider supervisor. The assessment must clearly state the reason for the extension including documentation that all respite hours have been exhausted. DMAS will determine approval for all extensions of care.

Determining Skilled PDN Hours of Care

Individuals being considered for the TW must have the age appropriate "Technology Assisted Waiver Referral" form completed to ensure the minimum skilled nursing requirements are met. The individual will be assessed on all of the required elements and must meet the established criteria in order to be authorized for skilled PDN and for the continuation of services.

In no instance will DMAS approve an ongoing PDN authorization or multiple PDN authorizations per household which results in approval of more than the individual's number of total weekly nursing hours authorized.

DMAS has the authority to approve or deny a skilled PDN provider's or family's request for a change in the amount of skilled private duty nursing hours.

In order to ensure the health, safety, and welfare of the individual, a maximum of 16 hours of care can be provided by the same nurse within a 24-hour period.

Parents (natural, adoptive, foster, legal guardians), spouses, siblings, grandparents, grandchildren, adult children, other legal guardians, or any person living under the same roof with the individual shall not provide skilled PDN/RC services for the purpose of Medicaid reimbursement for the waiver individual.

Criteria, instructions and definitions for all Tech Waiver forms may be found on the DMAS website at www.dmas.virginia.gov/ or the DMAS Portal at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal .

Skilled Private Duty Nursing Hours - Children (under 21 years of age)

Once the minor individual's composite score (total score) is derived, a LOC is designated for the individual as a Level A, B, or C. This LOC designation determines the maximum number of hours per week of skilled PDN a pediatric individual may have allocated on the DMAS skilled PDN authorization form (Department of Medical Assistance Services Internal Document). Any hours beyond the maximum for such individual's LOC must be medically necessary and service authorized by DMAS. Any POC submitted without approval for hours beyond the maximum for any particular LOC will only be entered for the maximum for that LOC. The results of the scoring assessment (Pediatric Referral form - DMAS 109) determine the maximum amount of hours available and authorization shall occur as follows:

- Category A – 50-56 points – Maximum Skilled PDN hours per week- 70
- Category B – 57-79 points – Maximum Skilled PDN hours per week - 84
- Category C – 80 or more points - Maximum Skilled PDN hours per week -112

This score is the total sum of rating for nursing needs and technology. To determine eligibility for the waiver, this score shall be 50 or more points.

The maximum skilled PDN hours authorized per week shall include all skilled nursing hours provided in the schools and at home. For example, when 70 hours per week of skilled PDN is authorized and 8 nursing hours are also provided by the school, the 4 total hours provided by the Tech Waiver program. per week shall be 70 hours. The school hours are included in the TW total hours per week.

Skilled Private Duty Nursing Hours- Adults (21 years of age and older)

Adults are eligible for a maximum of 112 hours per week of skilled PDN hours due to

complex care needs and must be ventilator dependent or meet complex tracheostomy criteria on the Technology Assisted Waiver Adult Referral form (DMAS-108).

**PRIVATE DUTY NURSING SA REVISIONS**

DMAS staff is responsible for authorizing any change in the amount of skilled nursing hours. The nursing supervisor can request an increase or decrease in nursing hours by writing or telephoning DMAS. DMAS will authorize the change by completing the skilled PDN authorization and sending a copy to the provider. This copy must be retained in the individual's file. In no instance will Medicaid reimbursement occur before DMAS authorization for the amount of skilled PDN hours and the effective date on the MMIS SA letter. The provider cannot submit a claim for Medicaid services before they have a POC-485 signed by a physician.

Decrease or Increase in Hours

DMAS or its designated agent shall have the final authority to approve or deny a requested change to an individual's skilled PDN and PC hours. Any request for an increase to an individual's skilled PDN or PC hours that exceeds the number of hours allowed for that individual's LOC shall be service authorized by DMAS staff and accompanied by adequate documentation justifying the increase.

The provider may decrease the amount of authorized care if the revised skilled PDN hours are appropriate and based on the needs of the individual. The provider agency shall work with the DMAS staff for coordination and final approval of any decrease in service delivery. A revised Tech Waiver skilled PDN authorization shall be completed by DMAS for final authorization and forwarded to the provider agency.

When the RN Supervisor determines that a decrease/increase in hours of service is warranted, he or she will contact the DMAS Health Care Coordinator (HCC) assigned to the individual immediately. DMAS will work with the RN Supervisor to re- evaluate the needs of the individual based on the assessed information from the provider.

A skilled PDN authorization will be provided by DMAS to the nursing agency and will include the number of skilled PDN hours to be provided per week and the effective date the change will occur.

The provider shall be responsible for documenting the physician's verbal orders and for inclusion of the changes on the recertification POC in accordance with the DMAS skilled PDN Authorization form. The provider agency's RN supervisor, who is responsible for supervising the individual's care, shall use a person-centered approach in discussing the change in care with the individual and individual' representative to include documentation in the individual's record. The DMAS staff or the DMAS designated service authorization contractor shall notify in writing the individual or individual representative of the change. Reimbursement will not occur without authorization from DMAS staff. The provider must ensure tasks performed meet the current needs of the individual.

If the decision is to deny, reduce, terminate, delay, or suspend a covered service, written notice will identify the individual's right to appeal the denial, in accordance with 42 CFR §200 *et seq* and 12VAC30-120-1780 *et seq*. The provider also has the right to appeal adverse decisions to the Department.

Regardless of the type of change (increase/decrease of hours/services), DMAS will send a letter to the individual/ PCG with the change in hours, the effective date of the change, and include appeal rights. Appeal rights can be found at the end of this chapter. A copy of this letter must be filed in the individual's record at the agency.

When a change in the individual's condition occurs and an increase to the POC- 485 is needed, the RN supervisor will perform a home visit and complete the DMAS 108 or 109 form. This form must be sent to DMAS to justify the change in PDN hours. This form must be retained in the individual's medical record.

DMAS will enter any changes in the DMAS MMIS system. Once the entry has been made, the provider and individual will receive a computer-generated letter notifying them of the decision. Individuals have the right to appeal any adverse action taken by DMAS or the DMAS SA contractor. A copy of this letter must be maintained in the individual's record at the nursing agency.

## TERMINATION OF TECHNOLOGY ASSISTED WAIVER ENROLLMENT

Tech Waiver termination is performed only by DMAS.

Reasons for Tech Waiver termination may include:

- Tech Waiver services are no longer the alternative to institutional placement
- The individual is no longer Medicaid eligible
- The individual's environment does not provide for his/her health, safety and welfare
- The individual no longer meets Tech Waiver criteria- when this occurs, the individual may be eligible for private duty nursing hours as previously approved, not to exceed 14 days (plus 3 days for mailing) from the date the physician certifies the cessation of technology assistance. When appropriate, the RN supervisor should coordinate with DMAS a decrease in hours during this termination period.
- The individual is no longer a Virginia resident
- Tech Waiver services have been interrupted for greater than 30 days
- The individual is admitted to a nursing facility, specialized care facility; long stay hospital or inpatient rehab facility.

- Individuals admitted to a medical facility for less than 30 days are waiver eligible upon discharge if they continue to meet Tech Waiver criteria. The provider must contact DMAS prior to beginning nursing services at home.

**PROVIDER AGENCY DISCHARGE**

Providers may discontinue services and discharge an individual from their agency when they can no longer meet the needs of the individual; they have not provided services for more than thirty (30) days or when the individual or their representative requests the agency no longer provide services.

The provider shall be responsible for submitting the DMAS-225 form to the local department of social services when the following situations occur: (i) when Medicaid eligibility status changes; (ii) when the individual's level of care changes; (iii) when the individual is admitted to or discharged from an institution, a home and community based waiver, or a provider agency's care, or (iv) the individual dies.

The individual shall be terminated from the waiver when no longer meeting TW criteria as certified by the physician for either children or adults. In such cases, a reduction of skilled PDN hours may occur that shall not exceed two weeks in duration as long as such skilled PDN was previously approved in the individual's POC. The agency provider of skilled PDN for such individuals shall document with DMAS the decrease in skilled PDN hours and prepare for cessation of skilled PDN hours and waiver services. DMAS must be notified immediately if the supervisor believes the individual no longer meets TW criteria. Supervisors must contact DMAS immediately if technology (i.e. tracheostomies, ventilators, feeding tubes) is discontinued for a tech waiver individual.

**The provider must notify DMAS immediately if a Tech Waiver individual dies.**
The provider shall notify DMAS immediately upon its decision to discharge or transfer any individuals receiving TW services if the provider can no longer staff the case. If the enrolled individual chooses to remain with the current provider while the provider attempts to hire more staff, the enrolled individual must be informed of progress or lack of progress and alternatives.

Provider Discharge – Notice Required

In a non-emergency situation (i.e. when the health, safety or welfare of the individual or provider personnel are not endangered) the providers may discontinue services to an individual after giving the individual and the individual's representative fourteen (14) days (plus three days for mailing) written notification. The letter shall provide the reasons for and the effective date services will be discontinued. This notice must not contain appeal rights since the individual has not been terminated from Medicaid services. A copy of this discharge letter must be sent to DMAS within five (5) business days of the date of the notification.

It is the provider's responsibility to send a LTC form-225 to DMAS and to the appropriate local DSS for notification of the discontinuance date, which is the provider's last date of

service.

NOTE: Failure to notify DMAS within 5 days that an individual does not meet level of care criteria could result in retraction of payments.

DMAS will end date the authorization for services allowing for the 14 day notice and 3 days for mailing. A computer generated letter will be mailed to the individual and will contain the right to appeal. If the individual wishes to appeal the decision, the individual must request an appeal, in writing, within 30 days of the notification of discharge, and submit the written request to the Appeals Division at DMAS.

Provider Discharge - Notice Not Required

The provider may discontinue TW services immediately when any of the following occur:

1. The agency's staff are in immediate danger;
2. The individual requests immediate discontinuation of services

Immediate Danger includes: an emergency situation when the health, safety and welfare of the provider staff is endangered, the provider agency may immediately initiate discharge of the individual and contact the DMAS staff. The provider must issue written notification containing the reasons for and the effective date of the termination of services. Other entities (e.g. licensing authorities, APS, CPS) shall also be notified as appropriate. A copy of this letter shall be forwarded to the DMAS staff within five business days of the letter's date. If the provider feels health, safety or welfare issues exist for the individual; a referral to Adult/Child Protective Services must be made.

When an individual/PCG requests immediate discontinuation of TW services, the provider must notify DMAS and state the reasons for the requested discharge. The provider is required to notify the individual/PCG in writing but appeal rights are not given as this is a voluntary discharge and TW enrollment still exists. DMAS will end date the SA in the MMIS system.

When a provider does not agree with the discharge or feels the individual is not safe, a referral to Adult/Child Protective Services must be made.

If the provider does not have staff, the provider must attempt to transfer services to another provider of the individual's/PCG's choice. If the individual has adequate back-up support and requests the provider not transfer the case, the provider may discharge the individual from its services. The provider will issue a discharge letter to the individual stating the date services ended. A copy of this letter must go to DMAS, and Adult Protective Services and/or CPS, if applicable.

If DMAS decides that waiver services continue to be appropriate, DMAS will advise the individual to contact another approved skilled PDN/Respite Care/Personal Care provider for continued services. The provider will complete the discharge letter and assure this letter is filed in the individual's record and a copy of the letter with a LTC-225 is sent to the appropriate local DSS, giving the discontinuation date as the last date of service rendered.

Individual Health and Safety Issues

If the provider becomes aware that the services being provided and the individual's current support system may not adequately provide for the individual's safety, the provider should immediately contact CPS or APS and then DMAS to discuss the case specifics. The intent of this discussion with CPS or APS is to determine whether the individual's current status represents a potential risk or an actual threat to his or her health, safety, and welfare (HSW).

A potential risk is identified as deterioration in either the individual's condition or environment, or both, which, in the absence of additional support, could result in harm or injury to the individual.

An actual threat is the presence of harm or injury to the individual which can be attributed to the individual's deterioration and lack of adequate support (e.g., the individual becomes anemic, malnourished, or dehydrated due to the inability to obtain food and water; the individual develops decubitus due to lying in urine or feces, etc.).

To determine whether an actual threat may exist, the provider should consider the following:

1. Is the individual capable of calling for help when needed?
2. Is there a support system available for the individual to call?
3. Has some harm or injury to the individual been reported?
4. Does the individual express fear or concern for his or her welfare?
5. Is the individual under the care of a physician?
6. Is the Plan of Care being followed in a manner to sustain or improve the individual's life?

When a real threat to the individual's HSW exists the provider must call CPS/APS immediately. DMAS will attempt to assess whether additional services can be obtained to maintain the individual in a home environment. If continued maintenance in the home is not possible, DMAS will initiate procedures to terminate services and advise the individual/PCG that facility placement should be considered. (Information regarding the procedures to transfer an individual from TW to a facility is included in this chapter.)

If the individual/PCG refuses facility placement, the provider must report the situation to APS/CPS. For the provider's protection, a letter from the provider should follow up a telephone call to APS/CPS. Waiver services may be terminated and/ or discontinued if a safe POC cannot be developed. Whenever a threat to the individual's HSW exists, **the provider staff is required by state law to contact APS/CPS.**

Providers must maintain and monitor for HSW of all individuals served. Failure to take action in identified HSW cases may indicate abuse or neglect by the agency. Examples of agency related HSW concerns include medication errors or nurses sleeping during work hours. DMAS may intervene in instances such as these if agencies fail to take appropriate action. Any services documented as provided and not provided will not be reimbursed by

DMAS.

**TRANSFER OF PRIVATE DUTY NURSING SERVICES**

The PDN provider must transfer an individual's care to another PDN agency whenever the provider is no longer able to sufficiently staff the individual's case or the individual requests a transfer to another provider of their choice.

- The transferring skilled PDN provider is instructed to contact DMAS to inform them of the need to transfer the individual, the provider chosen to accept the transfer and the effective date of the transfer.
- The transferring skilled PDN provider must send to the accepting skilled PDN provider and DMAS:

1. The last date of service to be rendered by the transferring provider and the reason for the transfer;
2. A copy of the current POC-485;
3. The individual's Technology Assisted Waiver Needs Assessment or the screening authorization package including the DMAS 96, 97, UAI and age appropriate referral form as appropriate for the individuals admission date to the Technology Assisted Waiver;
4. Any information regarding private duty nursing coverage through third party insurance;
5. The most recent Technology Assisted Waiver Supervisory Monthly Summary (DMAS-103) form;
6. The number of Skilled Respite hours used within the current year; and,
7. The DMAS-225 to DMAS and DSS

The accepting provider is responsible for ensuring the above information is received and seeking approval from DMAS BEFORE the initiation of services. Once services start, the accepting provider must send DMAS the RN Initial Home Assessment form (DMAS-116) and a copy of their initial POC-485. These should be sent to DMAS within 2 business days of service initiation.

**PRIVATE DUTY NURSING SERVICE UNITS AND LIMITATIONS**

Skilled PDN is billed in hourly units.

A day is defined as 24 hours which begins at 12:00 AM and ends at 11:59 PM.

A week is defined as Sunday through Saturday for the purpose of authorization.

Payment is available for allowable activities which are authorized and provided by qualified providers and in accordance with an approved POC-485.

Skilled PDN hours are limited to the hours approved by DMAS in the skilled PDN authorization and in accordance with the physician certified POC- 485.

In no instance shall DMAS reimburse for PDN hours worked which were not authorized on the PDN authorization. The provider has the responsibility for scheduling the staff they employ according to the skilled PDN authorization from DMAS. Any change in the weekly hours or shifts must be initiated by the provider and not at the discretion of the private duty nurse.

Services are billed in whole hours. A provider may bill for services more than one time each month per individual. However, the rounding up of hours is for the total monthly hours and not each time the provider bills DMAS. For additional information on billing see chapter V of this manual.

All TW services and skilled PDN hours approved for coverage shall be limited by medical necessity, cost effectiveness or both.

Medicaid reimbursement shall not be made for services furnished by other family members living under the same roof as the individual receiving services.

Reimbursement of skilled PDN hours will occur when the services are provided in the primary care residence of the individual with some community integration (medical appointments, recreational activity and school permitted).

Due to the complex needs of the enrolled individual, the PDN shall provide all of the skilled and activities of daily living (ADL) needs of the individual while on duty.

Medicaid re-imbursement shall not be made for hours authorized but not provided.

Nurses shall not transport technology assisted individuals. Medicaid will not reimburse for transportation to school, or other localities as these are the primary caregiver's responsibility. DMAS may not be billed for any time a nurse spends driving an individual.

In no instances are skilled PDN services to be provided for the convenience of other family members living in the individual's home.

Private duty nursing services cannot be provided simultaneously with RN or LPN respite care or TW personal care.

When skilled PDN is being provided in the school, the private duty nurse must be in the same room as the individual.

Skilled PDN hours shall not be billed to include time the individual is receiving emergency care or during emergency transport of the individual to such facilities and/or hospitalization. The RN or LPN shall not transport the waiver individual to such facilities.

Missed Shifts

**It is the responsibility of the provider to notify the caregiver if a shift cannot be staffed.**

Congregate Skilled PDN

Congregate skilled Private Duty Nursing is skilled nursing provided to three or fewer waiver individuals who reside in the same primary residence.

Congregate skilled PDN may be authorized in conjunction with skilled PDN in instances when individuals attend school or must be out of the home for part of the authorized PDN hours. For example: Congregate skilled PDN is authorized for two children in the same home and one child attends school. Skilled PDN is authorized to allow for school hours but when the child returns home all PDN hours are authorized as congregate PDN. Congregate skilled PDN hours will be determined and approved according to skilled nursing needs documented on the appropriate referral form.

When two or more individuals reside in the same home, the same provider or providers shall be chosen to provide all skilled PDN services for all waiver individuals in the home.

Only one nurse shall be authorized to care for no more than two waiver individuals in such arrangements. When three individuals share a home, nursing ratios shall be determined by DMAS or its designated agent, based on the care needs of all of the individuals who are living together.

Congregate skilled PDN hours shall be provided during the same scheduled shifts.

The PCG shall be responsible for all hours not provided by a RN or a LPN.

Congregate care is billed as "congregate nursing" and reflective of a congregate rate which is higher than the regular skilled PDN hourly rate.

**SKILLED PRIVATE DUTY NURSING RESPITE CARE**

Skilled Respite Care (RC) is the provision of skilled private duty nursing care to a technology assisted individual for short period(s) of time (a maximum of 15 days or 360 hours per calendar year, per household), to provide the unpaid PCG a break from caregiver responsibilities, as a supplement to the daily POC-485. This maximum coverage begins on the first day of the calendar year regardless of whether the individual changes waivers or agency providers. Caregivers are strongly encouraged to use skilled RC carefully and reserve some time for use in case of emergencies. Skilled RC must be provided in the same manner that skilled PDN is in the home or community per the POC-485.

The purposes of Skilled RC are:

- To relieve the unpaid PCG of the care of the individual
- To meet planned or emergency PCG needs

The focus of skilled RC is on the need of the unpaid PCG and their need for temporary relief or coverage for emergencies instead of the needs of the individual enrolled in the TW program.

The individual receiving skilled RC services must meet the same long-term care criteria as for skilled PDN; the need for skilled PDN services must be continuous, whereas the need for skilled RC is periodic.

The PCG should request skilled RC when needed. The provider must document the reason for respite, the dates provided, and the number of hours provided each time respite is used. The provider should request authorization of skilled RC from the DMAS SA contractor.

Skilled RC shall not be provided to individuals who reside in board and care facilities, adult care residences, inpatients in general acute care hospitals, skilled or intermediate nursing facilities, or ICF/IID. **Respite services may not be provided by DSS approved Adult Foster Care/Family Care providers to an individual residing in that home**.

Medicaid payment is available only for services authorized and provided according to the POC-485 and by a qualified provider.

Skilled RC requirements include:

- Must be provided by a licensed nurse (RN or LPN);
- A physician's order must be obtained prior to the start of skilled RC services and must be kept in the individual's record;
- The individual receiving care has a need for skilled care that cannot be provided by unlicensed personnel (e.g., patients on a ventilator, patients requiring naso-gastric or gastrostomy feedings, suctioning, etc.);
- No other PCG in the individual's support system is able to provide the skilled component of the individual's care during the caregiver's absence;
- Skilled RC is not a standalone service. PDN must be authorized before skilled RC can be authorized; and
- Respite hours should be billed only after all authorized PDN hours have been used for the week.

Respite care provided by an aide, PCA, or CNA is not a covered service under the TW.

Under skilled RC services, a LPN can perform the skilled services under the direction and supervision of a RN and in accordance with the licensure requirements of the Virginia Department of Health Professions.

If the individual receives skilled RC services, a separate file or a separate section of the individual's file must contain the forms, records, and necessary documents addressing respite services and authorization. These include:

- A physician's order for skilled RC services on the POC-485. The order must specify the skilled services that the nurse will render
- The skilled RC authorization from the DMAS SA contractor
- Documentation of all care provided by the skilled RC nurse must be signed and dated by the nurse

Individuals authorized for congregate skilled RC shall share the respite hours and are limited to 360 hours per calendar year per household. For example: There are two waiver enrollees with skilled PDN ordered living in the same home with the same PCG. Both individuals qualify for a combined total of 360 hours of congregate skilled RC per year. The same nurse will provide the congregate skilled RC hours to both individuals.

Congregate skilled RC authorization is requested from DMAS.

Supervision of Skilled Respite Nursing

When skilled RC services are received, the minimum acceptable frequency of supervisory visits shall be every 30 days.

When skilled RC services are offered in conjunction with skilled PDN or skilled PDN and personal care, the 30 day supervisory visit may serve as the supervisory visit for all Tech Waiver services. The RN must document on the Supervisory Monthly Summary (DMAS 103) whether respite is being used and why. Documentation must also include that the supervisory visit is for skilled PDN, personal care, and respite care.

When the individual is currently receiving skilled PDN services and it is going to continue during the respite care period, the RN Supervisor does not have to make a second visit during the respite care period regardless of the length of the period.

## PERSONAL CARE SERVICES

Provided that the cost effectiveness standard will not be exceeded, personal care services as defined in 12VAC30-120-1700, shall be covered for individuals 21 years of age or older who have demonstrated a need for assistance with ADLs and IADLs and who have a trained primary caregiver and an authorization for skilled PDN. Due to the complex medical needs of this waiver population and the need for 24-hour supervision, the trained primary caregiver shall be present in the home and rendering the required skilled care during the entire time that the PCA is providing non-skilled care.

Personal Care (PC) services may be offered in the TW to assist the individual/PCG when full coverage of skilled PDN hours is not available from a provider. When skilled PDN hours can be covered, the PC hours will be decreased or discontinued.

PC services must be rendered by a provider who has a DMAS agreement to provide skilled PDN. At a minimum, the staff providing PC must have been certified through coursework as either a personal care aide or home health aide. These services are billed under the PDN provider number.

In order to receive PC, the individual must require assistance with monitoring of health status and physical condition. PC services may be provided in home or community settings to enable an individual to maintain the health status and functional skills necessary to live in the community, or participate in community activities.

Due to the complexity of care needed for this waiver population, the individual may not be left alone at any time and requires the presence of the PCG in the home at all times while PCA services are being provided. Reimbursement will not be made for IADL services expected to be performed by the PCG such as shopping, housekeeping and laundry.

PC services are either of a supportive or health-related nature and may include, but are not limited to, assistance with ADLs/IADLs, community access (such as, but not necessarily limited to going to medical appointments), monitoring of self-administration of medication or other medical needs, and monitoring of health status and physical condition.

Personal Care hours may not provide supervision time for individuals. In order to receive PC, the individual must require assistance with ADLs/IADLs. When specified in the TW Adult Aide POC (DMAS 97T), PC services may also include assistance with IADLs to include making or changing beds, and cleaning areas used by the individual. Assistance with IADLs must be essential to the health and welfare of the individual, rather than the individual's representative, as applicable. This assistance does not mean intervention except to inform the primary caregiver who is providing direct supervision of the PCA.

Service Units and Limitations

The unit of service for PC shall be one hour. The hours that are authorized by DMAS shall be based on the individual's need as documented in the individual's POC-485 and assessed on the Technology Assisted Waiver Adult Aide Plan of Care (DMAS-97T). Payment is available only for allowable activities authorized and provided by a qualified provider in accordance with an approved Adult Aide POC (DMAS 97T) when the individual is present. **PC services are limited to the hours specified in the TW Adult Aide POC-97T** for the week. . Regardless of the combination of skilled PDN and PC hours, the total combined number of hours that shall be reimbursed by DMAS shall not exceed 112 hours per week.

Individuals may have skilled PDN, PC and skilled RC in their plans of care but shall not be authorized to receive these services simultaneously.

PC services shall not include either practical or professional nursing services or those practices regulated in Chapters 30 (§ 54.1-3000 *et seq*.) and 34 (§ 54.1-3400 *et seq*.) of Title 54.1 of the *Code of Virginia*, as appropriate, with the exception of skilled nursing tasks that may be delegated in accordance with 18VAC90-20-420 et seq. The PCA may perform ADL functions such as assistance to the PCG but shall not perform any nursing duties or roles except as permitted by 18VAC90-20-420 et seq.

Allowable Activities

The allowable activities for personal care services include:

1. Assistance with activities of daily living (ADLs) such as: bathing or showering, toileting, dressing, transferring and eating/feeding by mouth;

2. Assistance with monitoring health status and physical condition;

3. Assistance with self-administration of medication (not to include in any way determining the dosage of medication) and other medical needs;

4. General support to assure the safety of the individual;

5. Providing routine skin care, such as applying lotion to dry skin, not to include topical medications or any type of product with an "active ingredient";

6. Accompanying the individual to appointments, meetings or community activities, when personal care is needed and the PCG is present to perform skilled nursing care;

7. Administration of bowel program under special training and supervision. The PCA may be authorized to administer physician-ordered bowel programs to individuals when the PCG is always present in the home. This authorization can only be given if the provider has documented (i) the aide has received special training in bowel program management, (ii) the aide has knowledge of the circumstances that require immediate reporting to the RN Supervisor, and (iii) the RN Supervisor has observed the aide performing this function. (This requirement applies to substitute aides as well);

8. Certain conditions exist that would contraindicate having the aide perform a bowel program (i.e., patients prone to dysreflexia such as high level quadriplegics, head and spinal cord injured patients, and some stroke patients). The bowel program may include, if necessary, a laxative, enema, or suppository to stimulate defecation, however, the laxative cannot be "administered" by the aide even though part of the bowel program. Suppositories are an exception to this and can be administered if ordered by the physician as part of a bowel program. Replacement of a colostomy bag as part of the bath is allowed. Digital stimulation and removal of feces within the rectal vault may be a necessary part of the bowel maintenance or training program, however, removal of impacted material is not permitted. The above procedures must only be administered with

a physician order. A new physician's order must be obtained every sixty (60) days or more frequently if changes in the individual's condition occur. **The RN Supervisor must be available to the aide and be able to respond to any complications immediately;**

9. Administration of range-of-motion (ROM) exercises by the aide when instructed and supervised by the RN Supervisor. A physician must order ROM exercises every 60 days or more frequently if changes in the individual's condition occur. The physician order must specify that the individual requires ROM and the frequency to be administered. The aide may perform ROM after instruction by the RN Supervisor in the administration of ROM exercises, and the aide's correct performance of these exercises has been witnessed and documented by the RN Supervisor. Documentation must state the aide is trained in the performance of these exercises, and is competent in performing the ROM exercises. (This requirement applies to substitute aides as well.) This does not include strengthening, resistance, or exercises aimed at retraining muscle groups, but includes only those exercises used to maintain current ROM without encountering resistance. The RN Supervisor will check the ROM on the supervisory visits and make adjustments to the exercises as often as necessary according to the physician's orders;

10. Routine wound care by the aide, which does not include sterile technique. A physician must order wound care (even routine) every sixty days (60) or more frequently if changes in the individual's condition occurs;

This includes care of a decubitus, which is superficial or does not exceed Stage I.

Normal wound care includes washing, drying the area, and applying dry dressing as instructed by the RN Supervisor. This does not include the application of any cream, ointment, spray, powder, or occlusive dressing (such as hydrocolloids and transparencies); and

NOTE: Whenever an aide is performing any physician-ordered procedure, the RN must document on the Supervisory Monthly Summary note (DMAS-103) that the aide's correct performance of the procedure has been observed and supervised by the RN Supervisor. This must be documented at least every 30 days during the RN Supervisor's home visit; and

11. Checking the temperature, pulse, respiration, and blood pressure and recording and reporting as required.

Home Maintenance Activities: These activities are related to the maintenance of the home or preparation of meals, and are not included in the POC-485. Caregivers living in the home with the individual, would be expected to perform housekeeping and cooking activities for themselves, and should also provide the individual's home maintenance activities.

DMAS will pay the provider only for services rendered to the individual. DMAS will not pay the provider for services rendered to or for the convenience of other members of the individual's household (e.g., cleaning rooms used equally by all family members, cooking meals for the family, washing family dishes, family laundering, etc.).

Personal care services will not be authorized for family members to sleep during the day or night.

The aide is not allowed to push the button on a medication infusion pump to release the pre-measured dose of medication, as this is delivery of medication, which is not allowed.

DMAS will pay for any PC services that the PC aide gives to individuals to assist them in preparing for school or when they return home. DMAS shall not pay for the PC aide to assist the individual with any functions related to the individual completing post-secondary school functions or for supervision time during school.

Personal Care Exclusions:

- Time spent driving the individual shall not be reimbursed. The consumer directed services model shall not be covered for any services provided in the Tech Waiver.
- Spouses, parents (natural, adoptive, foster), legal guardians, siblings, grandparents, grandchildren, adult children, other legal guardians, or any person living under the same roof with the individual shall not provide PC services for the purpose of Medicaid reimbursement.

Development of the TW Adult Aide Plan of Care (DMAS-97 T): Agency Directed

The DMAS-97T must be completed by the provider's RN Supervisor prior to the start of PC services for any adult. The provider should allocate time for the four service categories listed on the DMAS-97T. The RN Supervisor's assessment visit should note any special considerations for service provision and the support available to the individual.

Each individual is assigned a level of care based on his or her composite ADL score. The composite ADL score is the minimum sum of a rating of the ADL categories an individual requires in order to receive services in an institutional setting under the SPO or to receive waiver services.

These categories are bathing/showering, dressing, transfers, ambulation, eating/feeding, toileting, and continence. An individual's degree of independence in performing these activities helps determine the appropriate level of care and service needs. The provider should assign a rating for each ADL category that best describes the individual based on the RN's observation at the time of the initial home evaluation.

Once the individual's composite score is derived, a level of care is designated for that individual as a Level A, B, or C. The designation of a level of care is important because the level of care determines the **maximum** number of hours per week of personal care

services the individual may have allocated to the DMAS-97T. All hours of PC for Tech Waiver must be pre-authorized by DMAS staff.

If there is an increase in care needs, DMAS can increase the PC hours. However, the increase in hours will not be made retroactive. Each level of care category has a **maximum** amount of hours for that level. The categories, composite scores, and **maximum** hours are as follows:

| **Level of Care** | **Score** | **Maximum Hours Per Week** |
|---|---|---|
| A | 0-6 | 25 |
| B | 7-12 | 30 |
| C | 9+ wounds, tube feedings, etc. | 35 |

Prior to designating the LOC, the provider should develop the DMAS-97T to reflect the needs of the individual and not the **maximum amount** of service the individual is able to have based on the level of care.

This **maximum** is based on a seven-day-per-week Adult Aide POC.

Reimbursement for the full amount of services included in the TW Adult Aide POC (DMAS-97-T) and rendered by the provider may be denied when the individual's Adult Aide POC (DMAS-97-T) is inflated beyond the needs of the individual.

**Level of Care A** (LOC-A) – The individual's score is 6 or less on the ADL composite rating and the individual has a medical nursing need. Individuals in LOC-A is the most functionally capable group and should usually require the least amount of services (anywhere from 7.5 to 17.5 hours per week).

The **maximum amount** of time per week that an individual in LOC-A may be provided is 25 hours per week. This **maximum** is based on a seven-day-per-week Adult Aide POC (DMAS-97-T) with an average daily need for ADL care of two (2) hours/day.

Although the provider may use the **maximum** allowed for the LOC, it is expected that individuals will not routinely require **maximum amounts** of care. Within the level of care, the amount of time required to perform ADL and housekeeping tasks will vary.

The following guidelines are intended to assist the provider to determine the appropriate allocations of ADL time for individuals within LOC-A.

1. Minimal Needs – Individuals often borderline in meeting the criteria for NF care (ADL score 2-3). The individual may require prompting rather than hands-on assistance, may use mechanical help more than human help with a need for standby assistance:

Suggested time allocated for ADLs – .75 – 1 hour/day

2. Average Needs – Individuals have somewhat more need for hands-on help, standby assistance, and are more dependent (ADL score 3-4):
   Suggested time allocated for ADLs – 1 – 1.5 hours/day

3. Heavy Needs – Individuals will require some help in all areas of ADL's. Usually mobile and can probably eat without assistance (ADL score 4-6):
   Suggested time allocated for ADLs – 1.5 – 2 hours/day

**Level of Care B** (LOC-B) – The individual's score is between 7-12 on the ADL composite rating and has a medical nursing need. These individuals will require an average of 15 to 28 hours per week.

The **maximum amount** of time per week that an individual in LOC-B may be provided is 30 hours per week, with an average daily need for ADL care of 2.5 hours/day. This **maximum** is based on a seven-day-per-week Adult Aide POC (DMAS 97-T). Although the provider may use the **maximum** allowed for the LOC, it is expected that individuals will not routinely require **maximum amounts** of care.

The following guidelines are intended to assist the provider to determine the appropriate allocations of ADL time for individuals within LOC B. Within this LOC, the amount of time required to perform ADL and housekeeping will vary.

1. Minimal Needs – These individuals may require assistance to ambulate, but are still able to perform some tasks for themselves (ADL score 7-8):
   Suggested time allocated for ADLs – 1.5 – 2 hours/day

2. Average Needs – These individuals may require assistance to transfer as well as ambulate, eat, toilet, most ADLs (ADL score 9-10):
   Suggested time allocated for ADLs – 2 – 2.5 hours/day

3. Heavy Needs – These individuals require the maximum amount of help in all ADL's. Usually bed-confined but may take less time to render services than the individual who performs some self-care but requires assistance (ADL score 11-12):
   Suggested time allocated for ADLs – 1.5 – 2.5 hours/day

**Level of Care C** (LOC-C) – Due to the complex needs of the individuals enrolled in TW, these individuals will usually score a level of care "C". The individual's score is 9 or more on the ADL composite rating and has a skilled medical nursing need. Examples of skilled needs are wound care (greater than Stage I decubitus), tube feedings, trach care, suctioning, and ventilator care. Note: These needs merely qualify an individual to be rated as LOC-C. PCA cannot participate in assisting individuals with these needs, with the exception of tasks delegated pursuant to the Nurse Practices Act and Virginia Administrative Code 18VAC90-20-420 through 18VAC90-20-460.

Individuals in LOC-C require the greatest amount of supports and services. These

individuals will probably require an average of 20 to 30 hours per week. The recommended amount of time per week that an individual in LOC-C may be provided has been established at 35 hours per week, with an average daily need for ADL care of three (3) hours per day.

Although the provider may use the **maximum** allowed for the LOC, it is expected that individuals will not routinely require **maximum amounts** of care.

The following guidelines are intended to assist the provider with determining the appropriate allocations of ADL time for individuals within LOC-C. Within this level of care, the amount of time required to perform ADL and housekeeping tasks may vary.

1. Minimal Needs - These individuals may have **maximum** in-home support and fewer special maintenance needs. Some of the individuals in this minimum range of needs may need support with all ADLs, however support is not complex and takes minimal time:
   - Suggested time allocated for ADLs - 1.5 - 2 hours/day

2. Average Needs - These individuals will generally require more ADL time to prevent skin breakdown by frequent turning, may require wound care, feedings completed by the family, etc., and have only moderate support to assist with this care:
   - Suggested time allocated for ADLs - 2 - 3 hours/day

3. Heavy Needs - These individuals may have a significant disability such as quadriplegia, or a degenerative disease. Service and support needs are complex and require additional time and attention.
   - Suggested time allocated for ADLs - 2 - 3 hours/day

Any unusual circumstance that would indicate an individual needs additional assistance should be clearly documented on the DMAS-97T. The provider is expected to use professional judgment to determine the amount of service needed by the individual.

Personal Care Aide Service Initiation

During this initial home visit, the RN Supervisor is responsible for performing and documenting the following activities:

- Introduction of the aide to be assigned to the individual - Each regularly assigned aide must be introduced to the individual by the RN Supervisor and oriented to the individual's Adult Aide POC (DMAS-97-T) on or prior to the aide's start of care.

- The RN Supervisor must closely monitor every situation when a new aide is assigned to an individual so that any difficulties or questions are dealt with promptly.

- Completion of the DMAS-97T and review of this with the individual/PCG, to ensure that there is complete understanding of the services that will be provided.

- The DMAS-97T must be completed with the individual's name, 12-digit Medicaid number, provider name and identification number, ADL composite score, RN signature, and start of service date

- A copy of the current provider DMAS-97T must be kept in the individual's home. The aide should be instructed to use the provider DMAS-97T (either the individual's copy designating time increments or a copy that shows only the tasks checked) as a guide for daily service provision

- It is appropriate for the aide to chart tasks that are not included in the individual's DMAS-97T if there is a need for the task to be done. The aide should note why this task was performed. If the need for this task continues, it is the responsibility of the RN, who reviews the aide records, to determine if the task should be included on the DMAS-97T on an ongoing basis and make the appropriate changes

- The RN shall return for a follow-up visit no later than 30 calendar days after the initial assessment visit. Tech Waiver requires individuals have supervisory visits at least every 30 calendar days. The RN Supervisor shall make supervisory visits as often as needed to ensure both quality and appropriateness of personal care

- Based on continuing evaluations of the aide's performance and the individual's needs, the RN Supervisor shall identify any gaps in the aide's ability to function competently and shall provide training as indicated. The RN Supervisor must also perform any subsequent reassessments or changes to the supporting documentation

Changes to the TW Adult Aide Plan of Care (DMAS-97T)

The provider is responsible for making modifications to the DMAS-97T as needed to ensure the PCA and individual/PCG are aware of the tasks to be performed and that the hours and type of care are appropriate to meet the current needs of the individual.

Any time the number of hours of services an individual receives needs to be changed; the provider must notify DMAS and develop a new DMAS-97T. The most recent DMAS-97T must always be easily accessible in the individual's home. The provider must complete a new Adult Aide POC (DMAS-97T) at least annually or document on the current DMAS-97T annually that it was reviewed and no changes are necessary. The DMAS-97T shall be sent to DMAS. Copies of all DMAS-97T must be maintained in the individual's file.

The DMAS-97T and documentation of service delivery must be consistent with the information submitted or communicated to DMAS when contacted for an authorization.

Change of hours must be submitted to DMAS along with a new DMAS-97T reflecting the revised hours and updated composite ADL score and the change in LOC. It should be noted that it is at DMAS's discretion to request the DMAS-97T or any supporting documentation at any time.

Providers are required to submit changes in hours when they occur. The provider must follow the procedures to request an authorization whenever a change in the individual's condition (physical, mental, or social) indicates that an increase in hours is needed. When it is identified, either upon admission of a new individual or after services have been initiated, that an individual requires a change to the DMAS-97T, as outlined above, the providers involved in the individual's care must consult with each other to coordinate the changes. Each provider must document this communication in the individual's record.

Scheduled Personal Care Services Not Provided

The personal care aide is responsible for following the current DMAS-97T. The total amount of combined skilled PDN and personal care hours worked during the week shall not exceed the number of authorized hours for the week. Personal care aides may not provide make up hours.

Supervision of Personal Care Aides

The RN supervisor must provide supervision of personal care aides. The provider must offer quarterly in-service training totaling a minimum of 12 hours within a calendar year. Another qualified provider may provide this in-service instruction, but the provider must offer in-service training that is appropriate in content and is offered to all staff providing personal care.

The RN Supervisor or other appropriate agency personnel must provide in-service training to include Medicaid requirements, policies, and overall aide responsibilities to all personal care aides prior to their assignment to a Medicaid individual and must document the training in the aide's personnel file.

The aide must be present during the RN Supervisor's visit at least every other visit. If the aide is present during all supervisory visits, the RN Supervisor must contact the individual/ PCG by telephone during non-personal care hours to assess the individual's satisfaction with services and document the conversation in the individual's record.

If weekends are the only time when the services are provided, the RN Supervisor must make a visit at least every other month during the time the aide is working.

A RN Supervisor must be available to the aides by telephone at all times that an aide is providing services to an individual. A provider may contract with a RN Supervisor to provide this service or find other means to meet this requirement. The provider cannot be without a RN Supervisor.

The PCG must be present and available at **all times** to provide the individual's skilled needs while the Personal Care Aide is present.

Ongoing assessment of the aide's performance by the RN Supervisor is also expected to ensure the health, safety, and welfare of the individual.

Inability of the Personal Care Aide to Provide Services or PCA Substitution

When a provider cannot supply an aide to render authorized services, the provider may obtain a substitute aide from another provider, if the lapse in coverage is expected to be less than two weeks in duration, or may transfer the individual's services to another provider. If the provider obtains a substitute aide from another agency, the TW providers are responsible for negotiating the financial arrangements of paying the substitute aide.

When a substitute aide is secured from another provider, the following requirements apply:

- The authorized provider must ensure that all DMAS requirements continue to be met;
- The authorized provider is responsible for providing the RN supervision for the substitute aide;
- Only the authorized provider may bill DMAS for services rendered by the substitute aide;
- The agency providing the substitute aide must send to the authorized provider a copy of the aide's daily records signed by the individual and the substitute aide;
- All documentation of services rendered by the substitute aide must be in the individual's record. The documentation of the substitute aide's qualifications must also be obtained and recorded in the personnel files of the authorized provider.

If no other provider can supply an aide, the provider shall notify the individual/PCG and DMAS. Service authorization is required in cases in which the services are transferred to another provider.

Transfer of Personal Care Services

The transferring provider must send a copy of the Technology Assisted Waiver Needs Assessment or UAI Screening Assessment Package, DMAS-97T, Supervisory Monthly Summary (DMAS-103), the DMAS-225 and a transferring letter from the previous provider indicating the last billable date of service, and the reason for any changes made by the transferring admitting provider to the individual's DMAS-97T.

The new provider must complete a new assessment and POC-485 and a new DMAS-97T for authorization of services.

**REQUIRED DOCUMENTATION**

HIPAA Privacy Rule regulates how and when individually identifiable health information may be shared. Skilled PDN staff, RN Supervisors and other provider employees must use caution when dealing with an individual's private health care information to avoid violating HIPAA regulations. Nurses must be in compliance with privacy rules and in most cases,

must not disclose identifiable health information unless the patient gives consent. (There are some exceptions to this rule, such as in the event of abuse or neglect, if the patient has a disease that affects the safety of the public, or for law enforcement purposes.)

The nursing provider should have specific policies regarding the oversight and handling of documentation in the home and when it is appropriate for nurses to remove documentation from the home. The provider should offer nurses and staff training to ensure they are aware of all agency policies, exceptions and can be in full compliance with HIPAA laws.

Refer to the U.S. Department of Health and Human Services website at www.hhs.gov for information regarding HIPAA.

Provider Required Documentation - Office Records

The provider shall maintain all records of each individual receiving skilled PDN services, skilled Respite Care (RC) and Personal Care (PC) services. These records shall be separated from those of non-HCBS, such as companion or home health services. These records shall be reviewed periodically by personnel who are authorized by DMAS. At a minimum these records shall contain:

1. The most recently updated Long-Term Care Uniform Assessment Instrument (UAI), the Medicaid-Funded Long-Term Care Services Authorization form (DMAS-96), the Screening Team Plan of Care for Medicaid-Funded Long-Term Care (DMAS-97), all assessments and PC plans of care (DMAS-97T), all PC aide records (DMAS-90), all skilled PDN and Skilled Respite records all LTC Communication forms (DMAS-225), all medical orders-verbal orders as well as the POC-485 authorizing PDN , and the age appropriate DMAS Tech Waiver Referral forms (DMAS-108 and 109); Individuals enrolled prior to July 2008 will have the Technology Assisted Waiver Needs Assessment forms instead of the UAI;

2. The physician's certification for services- POC-485 obtained prior to the service start date and updated every sixty days;

3. The initial assessment (DMAS-116) completed in the home by a registered nurse;

4. The Supervisory Monthly Summary (DMAS-103) completed at least every 30 days;

- Registered nurse supervisor's notes documented and dated during significant contacts with the case and during supervisory visits to the individual's home;

- When the supervisory visit is missed, documentation must include the reason and the make-up assessment must occur within five days. When there is an interruption in services such as hospitalization, the post hospital RN supervisory visit may serve as the supervisory visit and following visits will resume accordingly;

- Supervisory visits may on occasion be performed at school for individuals receiving TW services with the skilled private duty nurse present. When the supervisory visits are made in the school, the RN supervisor shall call the PCG to discuss satisfaction with services and any problems/ issues. The visit must be made in the home at least every other visit. The individual must be present during every monthly supervisor visit;

5. The PDN note must include, but is not limited to, all skilled nursing care as ordered on the POC 485, assistance with activities of daily living, administration of medications or other medical needs and the monitoring of the individual's health status and physical condition. When there are health, safety and welfare concerns, documentation must indicate supervisory and DMAS notification and the appropriate Adult Protective Services/Child Protective Services referrals. The skilled notes must be signed and dated by the nurse providing the care;

6. All correspondence with the individual, DMAS, and the designated SA contractor;

7. Reassessments made during the provision of services;

8. Contacts made with family, physicians, formal and informal service providers, and all professionals involved in the individual's Medicaid services or medical care;

9. The daily arrival and departure times of the PCA with at least weekly verification of hours by the PCG or individual;

10. The name and phone number of a back-up caregiver who will provide the alternate care usually provided by the trained PCG;

11. Comments or observations recorded about the individual. The nurse's comments shall include but not be limited to observation of the individual's physical and emotional condition, daily activities, and the individual's response to services rendered;

12. To assure all services are rendered, the signatures of the individual or PCG and the private duty nurse must be documented once each shift for skilled PDN and Respite. Signatures, times, and dates shall not be placed on the notes prior to the delivery of service for that day. An employee of the provider shall not sign for the individual or caregiver. Documentation verified by signature of the individual or primary caregiver must include arrival and departure time of the nurse; and

13. Documentation signed by the PCA must be reviewed and signed by the supervising RN.

Provider Required Documentation – Home Records

Documentation in the home record shall be kept in the home at all times. Documentation

should be kept in a binder which is kept organized and in a designated place in the home. Caregivers should know the location of the nursing binder. This binder shall include the following:

1. Current POC-485
2. Medication Administration Records (MAR)
3. Two (2) weeks of nursing shift notes
4. Additional physicians orders received during the certification period
5. Treatment records
6. Nursing assessments and documentation
7. Emergency contact information
8. DNR orders (if applicable)

Nursing documentation should be completed during the shift the care is provided. Information documented after the shift care is provided must be identified as a "late entry".

HIPAA law shall be observed regarding all documentation and medical records. All nursing documentation must be maintained in the home record.

**PROVIDER REQUIREMENTS**

In addition to meeting the general conditions and requirements and in order to be approved for enrollment as a skilled PDN provider, HCBS providers, as specified in 12VAC30-120-1740, must:

1. Be a home health agency licensed by the VDH for Medicare/Medicaid participation or have accreditation through JCAHO, CHAP or ACHC;
2. Have a current, signed, DMAS provider participation agreement for skilled PDN;
3. Demonstrate a prior successful health care delivery business or practice; and,
4. Operate from a business office.

**PERSONNEL QUALIFICATION REQUIREMENTS**

All services provided by a Home Health Agency, whether provided directly by the agency's qualified staff or in coordination with another agency, must be provided by or

under the supervision of qualified personnel as required by part 484 of Title 42 of the Code of Federal Regulations and professional licensing requirements by the Code of Virginia.

The provider must assure the RN supervisor as well as the LPN or RN providing the skilled PDN services is currently and validly licensed to practice nursing in the Commonwealth of Virginia and the Licensed Practical Nurse (LPN) is under the direct supervision of a RN at all times. A LPN cannot be assigned to perform activities which fall outside of the nursing practices allowed by their license and which should be performed by a RN.

RN supervisors must have at least one year of related clinical nursing experience that may include work in an acute care hospital, long stay hospital, rehabilitative hospital or specialized care nursing facility.

All RNs and LPNs who provide skilled private duty nursing (PDN) services shall have either: a minimum of six months of related clinical experience (documented in their history), that may include work in acute care hospitals, long stay hospitals, rehabilitation facilities, or specialized care nursing facilities; (or) have completed a provider training program – related to the care and technology needs of the assigned tech waiver individual (Technology Assisted Waiver manual Chapter II, page 11). Nursing agencies that do not have a training program that meets the DMAS training program criteria shall provide nurses with at least six (6) months of experience in the skills needed to provide safe care to TW individuals.

The nurse assigned to TW individuals must be deemed competent and trained to care for individuals who have nutritional needs and those with tracheostomies and/or ventilator dependence and have complex medical needs prior to assignment to such individuals. The PCA must be trained to provide PC services to individuals with complex medical needs.

Providers must ensure all employees who provide services to individuals enrolled in TW have documentation in the personnel file which assures annual CPR certification/ recertification, annual Flu shot and annual TB testing.

The DMAS 259 skills check list must be completed on all Tech Waiver nurses by the RN supervisor. The RN supervisor is responsible for ensuring the nurse's competency on all cases.

Providers must perform a criminal background check and sex offender registry check on all employees, including the business owner, who may have any contact or provide services to the individual. Such record checks shall include national searches and the Virginia State Police. Searches shall also be made of the Virginia CPS Central Registry, adult protective services, the National Sex Offender Registry, and the Virginia Nurse Aide Registry.
Medicaid reimbursement shall not be made for provider's employees who have findings in the Nurse Aide Registry, with the Virginia Board of Nursing of the Department of Health Professions, concerning abuse, neglect, mistreatment of individuals or misappropriation of their property.

Providers may contract with nurses to provide clinical care or supervisory services. Contract employees must meet all DMAS requirements.

Providers must screen all new and existing employees and contractors to determine whether any of them have been excluded from participation in federal programs. Search the HHS-OIG List of Excluded Individuals and Entities (LEIE) website monthly by name for employees, contractors and entities to validate such persons and entities eligibility for federal programs.
Immediately report to DMAS any exclusion information identified. Such information shall be sent in writing and shall include the individual or business name, provider identification number (if applicable) and what, if any, action has been taken.

Such information shall be sent to:

DMAS, ATTN: Program Integrity/Exclusions
600 E. Broad St., Suite 1300
Richmond, VA 23219

Email to providerexclusion@dmas.virginia.gov.

**BACKGROUND CHECKS**

Criminal History and Sex Offender Record Checks:

All employees providing waiver services to individuals must undergo a criminal history and sex offender records check.

In accordance with Virginia Code § 32.1-162.9:1, any licensed home care organization as defined in § 32.1-162.7 or any home care organization exempt from licensure under subdivision 3 a or b of § 32.1-162.8 or any licensed hospice as defined in § 32.1-162.1, shall, within 30 days of employment, obtain for any compensated employees an original criminal record clearance with respect to convictions for offenses specified in Code of Virginia § 32.1-162.9:1 or an original criminal history record from the Central Criminal Records Exchange. However, no employee shall be permitted to work in a position that involves direct contact with a patient until an original criminal record clearance or original criminal history record has been received, unless such person works under the direct supervision of another employee for whom a background check has been completed in accordance with the requirements of § 32.1-162.9:1 of the Code of Virginia.
Subsection C. of Virginia Code § 32.1-162.9:1 states as follows: "A person who complies in good faith with the provisions of this section shall not be liable for any civil damages for any act or omission in the performance of duties under this section unless the act or omission was the result of gross negligence or willful misconduct." Accordingly, this provision does not apply to audits or administrative actions by DMAS to recover a Medicaid overpayment made to a provider.

If any employee has been convicted of "barrier crimes" described in the *Code of Virginia,*

*§32.1-162.9:1,* Medicaid shall not reimburse for the services provided by such individual effective the date the criminal record was confirmed. Providers must also submit the sex offender and crimes against minors search forms on the employee to the Virginia State Police prior to the start of service provision. All checks must be maintained in the employee's records. The provider will provide the employee with the results of the criminal record history request and document in the employee's personnel record that the employee was informed of the results.

A provider who has been convicted of a felony, or who has otherwise pled guilty to a felony, in Virginia or in any other of the 50 states, the District of Columbia or the U.S. Territories must, within 30 days of such conviction, notify DMAS of this conviction and relinquish its provider agreement. DMAS may terminate any Medicaid provider agreement pursuant to Code of Virginia, §32.1-325 and as may be required for federal financial participation. The provider agreement terminations shall also conform to 12VAC30-10-690 and 12VAC30-20-400.

CPS Central Registry Check:

If an employee is providing services to an individual under 18 years of age, a check of the VDSS Central Registry must be conducted. The provider is responsible for submission of the forms to VDSS. If the CPS Registry confirms a valid complaint on the employee, Medicaid shall no longer reimburse for the services provided by such an individual effective the date the CPS Registry check was confirmed.

Mandated reporters for Adult Protective Services (APS) and Child Protective Services (CPS) are any person licensed, or certified by health regulatory boards listed in § 54.1-2503, which includes but is not limited to the Board of Nursing: Registered Nurse (RN), Licensed Practical Nurse (LPN), Certified Nurse Aide (CNA). For the purpose of this waiver, any person employed by or contracted with a public or private agency or facility and working with adults or children in an administrative, supportive or direct care capacity are also mandated reporters.

All Private Duty Nurses and PCAs must have a satisfactory work record, as evidenced by references from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated – older adults and children. Providers are responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks. The criminal record check shall be available for review by authorized DMAS personnel.

## ENVIRONMENTAL MODIFICATIONS

Service Definition

Environmental modifications or "EM" means physical adaptations to an individual's primary residence or primary vehicle which are necessary to ensure the individual's health, safety, or welfare or which enable the individual to function with greater independence and without which the individual would require institutionalization.

Criteria

Individuals who qualify for these services must have a demonstrated need for modifications of a remedial nature or medical benefit to the primary residence to specifically improve the individual's personal functioning. These physical adaptations shall be necessary to ensure the health, welfare and safety of the individual. These services are not considered a "stand alone" service and can only be authorized in conjunction with authorized skilled PDN services. Such modifications may include, but shall not necessarily be limited to, the installation of ramps and grab-bars, widening of doorways and other adaptations to accommodate wheelchairs, modification of bathroom facilities to accommodate wheelchairs (but not strictly for cosmetic purposes), or installation of specialized electrical and plumbing systems required to accommodate the medical equipment and supplies that are necessary for the individual's welfare.

Modifications may include a generator for individuals who are dependent on mechanical ventilation for 24 hours a day and when the generator is used to support the medical equipment and supplies necessary for the individual's welfare.

These services shall be covered as defined in 12VAC30-120-1700 and in accordance with applicable state and county building codes. Medicaid reimbursement shall not occur before service authorization of EM services is completed by DMAS or the DMAS designated SA contractor. EM service shall entail limited physical adaptations to pre-existing structures and shall not include new additions to an existing structure that simply increase the structure's square footage.

The provider and individual could possibly work with multiple providers in order to complete one modification, for example:

1. A Physical Therapist, Speech Therapist or Occupational Therapist, available through the *State Plan for Medical Assistance* may be utilized to evaluate the needs for environmental modifications. (NOTE: Under the *State Plan for Medical Assistance*, Physical, Occupational, and Speech Therapy services must be preauthorized through the DMAS SA Contractor if more than 5 visits have been provided to the individual. Visits are individual-specific, not provider-specific.);
2. A building contractor may design and complete the structural modification;
3. A vendor who supplies the necessary materials may be separately reimbursed or supplies may be included in the bill of the building contractor; or
4. A durable medical equipment provider enrolled with DMAS may be used to bill for modifications.

Service Units and Service Limitations

a. EM shall be available costing up to a maximum amount of $5,000 per household per

b. calendar year for individuals who are receiving skilled PDN services.

c. Costs for EM shall not be carried over from one calendar year to the next. Each item shall be service authorized by the DMAS-designated agent for each calendar year. Unexpended portions of this maximum amount shall not be accumulated across one or more years to be expended in a later year.

d. When two or more individuals receiving TW services live in the same home (congregate living arrangement), the EM shall be shared to the extent practicable consistent with the type of requested modification.

e. Only the actual cost of material and labor is reimbursed. There shall be no additional markup.

f. EM shall be carried out in the most cost effective manner possible to achieve the goal required for the individual's health, safety, and welfare. The cost of EM waiver services shall be included in the individual's costs of all other waiver services, which shall not exceed the total annual cost for placement in an institution.

g. All services shall be provided in the individual's primary residence in accordance with applicable state or local building codes and appropriate permits or building inspections which shall be provided to DMAS or the DMAS contractor.

h. Proposed modifications that are to be made to rental properties must have prior written approval of the property's owner. Modifications to rental properties shall only be valid if it is an independently operated rental facility with no direct or indirect ties to any other Medicaid service provider.

i. Modifications may be made to a vehicle if it is the primary vehicle used by the individual. This service shall not include the purchase of, or the general repair of, vehicles (repairs of modifications which have been reimbursed by DMAS shall be covered).

j. The EM provider shall ensure that all work and products are delivered, installed and in good working order prior to seeking reimbursement from DMAS. The date of service on this provider's claim shall be within the service authorization approval dates, which may be prior to the completion date as long as the work commenced during the approval dates.

k. The service authorization shall not be modified to accommodate installation delays. All requests for cost changes (either increases or decreases) shall be submitted to DMAS or the DMAS designated SA contractor for revision to the previously issued service authorization and shall include justification and supporting documentation of medical needs.

l. A copy of the provider's cost estimate for labor and materials for an environmental modification must be submitted to DMAS.

EM Exclusions

EM shall not be covered by Medicaid if payment for the EM is available from another source, for example, the Fair Housing Act (42 USC §3601 et seq.), the Virginia Fair Housing Law (§39-96.1 et seq. of the Code of Virginia) or the Americans with Disabilities Act (42 USC § 12101 et seq.) requires the modification and the payment for such modifications be made by a third party.

(1) There shall be no duplication of EM services within the same residence such as multiple wheelchair ramps or previous modifications to the same room. (There shall be no duplication of EM within the same plan year).
(2) Adaptations or improvements to the primary home that are of general utility and are not of direct medical or remedial benefit to the waiver individual shall be excluded, including , but not limited to, carpeting, flooring, roof repairs, central air conditioning or heating, general maintenance and repairs to a home, additions or maintenance of decks, maintenance/replacement or addition of sidewalks, driveways, carports, or adaptations that only increase the total square footage of the home.

(3) EM shall not be covered by Medicaid for general leisure, or diversion items, or those items that are recreational in nature or those items that may be used as an outlet for behavioral supports. Such non-covered items include, but shall not be limited to, swing sets, playhouses, climbing walls, trampolines, protective matting or ground cover, sporting equipment or exercise equipment, such as special bicycles or tricycles.

(4) EM shall not include the costs of removal or disposal, or any other costs, of previously installed modifications, whether paid for by DMAS or any other source.

(5) Providers of EM shall not be the individual's spouse, parent (natural, adoptive, foster), legal guardians), other legal guardians, or conservator. Providers who supply EM to waiver individuals shall not perform consultations or write EM specifications for such individuals.

(6) The contractor providing the modification must complete an assessment and quote before performing any work.

Provider Documentation Requirements

1. Supporting documentation, must demonstrate the need for the service, the process to obtain the service (contacts with potential contractors of service, costs, etc.), and the time frame during which the service is to be provided. This includes a separate notation of the evaluation, design, labor, and supplies or materials, or both. The supporting documentation must include documentation of the reason that a Rehabilitation Engineer is needed, if one is to be involved;

2. Documentation of the date services are rendered and the amount of services and supplies;

3. Any other relevant information regarding the modification;

4. Documentation of the completion of the modification and satisfaction of the individual/PCG with the service provided;

5. Instructions provided to the individual/PCG regarding warranty coverage, repairs, maintenance and complaint resolution.

A copy of the above documentation shall be submitted to the DMAS Tech Waiver unit. More than one cost estimate may be required by DMAS.

## ASSISTIVE TECHNOLOGY

Service Definition

Assistive Technology (AT) services shall be available for enrolled individuals who are receiving skilled PDN. AT services are the specialized medical equipment and supplies, including those devices, controls, or appliances, that are not available under the State Plan for Medical Assistance, that enable individuals to increase their ability to perform ADLs/IADLs, or to perceive, control or communicate with the environment in which they live. This service includes ancillary supplies and equipment necessary for the proper functioning of such items. AT shall not be authorized as a standalone service.

Assistive technology devices, as defined in 12VAC30-120-1700, shall be portable and shall be authorized per calendar year.

AT shall be covered in the least expensive, most cost effective manner. The cost of AT services shall be included in the total cost of waiver services.

Criteria

In order to be eligible for these services, the individual must have a demonstrated need for equipment for remedial or direct medical benefit primarily in the individual's primary residence to specifically serve to improve the individual's personal functioning.

The maximum Medicaid funded expenditure per individual for all AT covered procedure codes combined shall be $5,000 per individual per calendar year. Unexpended portions of the maximum amount shall not be accumulated across one or more calendar years to be expended in a later year. Each item shall be service authorized by the DMAS designated SA contractor for each calendar year prior to payment. Assistive Technology services cannot be authorized retroactively. The usual and customary charge is payment in full.

The service authorization shall not be modified to accommodate delays in product deliveries. In such situations, new service authorizations must be sought by the provider.

All products must be delivered, demonstrated, installed and in working order prior to submitting any claim to Medicaid. The date of service on the claim must be within the service authorization approval dates, which may be prior to the delivery date as long as the initiation of services commenced during the approved dates.

When two or more individuals receiving waiver services live in the same home (congregate living arrangement), the AT shall be shared to the extent practicable consistent with the type of AT.

Equipment or supplies already covered by the *State Plan for Medical Assistance* may not be purchased under Assistive Technology. A copy of the Durable Medical Equipment and Supplies list is available from DMAS and should be used to ascertain whether an item is covered through the *State Plan for Medical Assistance* before requesting it through the Tech Waiver. All questionable items should be verified with the DMAS HELPLINE (800-552-8627 or 800-852-6080). DME information can also be found on the DMAS web site by reviewing the *DME* Provider Manual at www.virginiamedicaid.dmas.virginia.gov/wps/portal.

An independent, evaluation must be obtained from qualified professionals who are knowledgeable of the recommended item for each AT request prior to approval by the DMAS designated SA contractor. All evaluations must be signed by the qualified professional. The professional evaluation includes the trial period of time for the individual to use the device and documentation of any follow up training that is going to be provided for the recommended items. Individual professional consultants include speech/language therapists, physical therapists, occupational therapists, physicians, certified rehabilitation engineers or rehabilitation specialists. A prescription alone shall not meet the standard of an evaluation.

| **Examples of Assistive Technology Devices (not a comprehensive list)** | **Professional Evaluation Required** |
| --- | --- |
| Organizational Devices | Occupational Therapist, Psychologist, or Psychiatrist |
| Computer/software or Communication Device | Speech Language Pathologist or Occupational Therapist |
| Orthotics, such as braces for hands, arms, feet, legs, etc. | Physical Therapist, Physician or Orthotist |
| Writing Orthotics | Occupational Therapist or Speech Language Pathologist |
| Support Chairs | Physical Therapist or Occupational Therapist |
| Specialized Toilets | Occupational Therapist or Physical Therapist |

| | |
| --- | --- |
| Other Specialized Devices/Equipment | Physician, Speech Language Pathologist, Behavioral Consultant, Psychologist, Psychiatrist, Physical Therapist, or Occupational Therapist; depending on the device or equipment |
| Specially Designed Utensils for Eating | Occupational Therapist or Speech Language Pathologist |
| Weighted Blankets/Vests | Physical Therapist, Occupational Therapist, Psychologist, or Behavioral Consultant |

For a specific request, contact DMAS for assistance with determining the appropriate professional making the recommendation. Items such as furniture shall not be approved if they are of general utility and are not of direct medical benefit.

The Assistive Technology provider's quote must be compatible with the evaluation completed by the qualified professional. Vendors shall ensure that requests for software are compatible with the individual's current computer.
A Rehabilitation Engineer may be utilized if, for example:

- The Assistive Technology will be initiated in combination with Environmental Modifications involving systems which are not designed to go together; or
- An existing device must be modified or a specialized device must be designed and fabricated.

Service Units and Service Limitations

(1.) Medicaid shall not reimburse for any AT devices or services which may have been rendered prior to authorization from the DMAS designated SA contractor.

(2.) Providers of AT shall not be spouses, parents (natural, adoptive, or foster), or legal guardians, or stepparents of the individual who is receiving waiver services.

(3.) Providers that supply AT for the individual may not perform the professional evaluation, or write specifications for that individual.

(4.) Any request for a change in cost (either an increase or a decrease) requires justification and supporting documentation of medical need and service authorization by DMAS or the DMAS designated SA contractor.

(5.) The vendor must receive a copy of the professional evaluation in order to purchase the items recommended by the professional. If a change is necessary then the vendor must notify the assessor to ensure the changed items meet the individual's needs.

(6.) AT shall not be covered for purposes of convenience for the caregiver or restraint of the individual, recreation, leisure, diversional purposes, an outlet for behavioral

supports, or educational purposes. Such items including but not limited to, swing sets, playhouses, bowling balls, tricycles/bicycles, trampolines, television sets, video equipment/games, computer games, playing cards, printers, scanners, musical, educational, vocational software or hardware, sporting equipment, exercise equipment, etc. are not covered

(7.) AT equipment and supplies shall not be rented but shall be purchased through Medicaid-enrolled durable medical equipment provider.

(8.) DMAS does not repurchase items paid for with AT funds unless those items have specific time frames or usefulness (i.e. computer-5 years). DMAS does not pay for duplicate items such as software and later updates to original purchases. This is considered carry over from one year to the next.

(9.) Computer software purchased for a TW individual must be owned by the individual and accessible by the individual/caregiver to make changes, download updates, etc.

(10.) Shipping/freight/delivery charges are not billable to DMAS or the individual; as such charges are considered non-covered items. The usual and customary charge is payment in full.

(11.) The service unit is always one, for the total cost of all AT requested for a specific timeframe. The service unit is the total cost of the item and any supplies, or hourly Rehabilitation Engineering costs. The maximum Medicaid funded expenditure per individual for all AT covered procedure codes combined must be pursuant to 12VAC30-120-762.

Provider Documentation Requirements

The document requirements are:

1. The evaluation completed by the independent professional consultant;

2. Supporting documentation, which includes the need for the service, the process to obtain this service (contacts with potential vendors or contractors, or both, of service, costs, etc.); and the time frame during which the service is to be provided. This includes separate notations of design, labor, supplies, and materials. The supporting documentation must include the reason that a Rehabilitation Engineer or Certified Rehabilitation Specialist is needed, if one is to be involved. A Rehabilitation Engineer or Certified Rehabilitation Specialist may be involved if a need for such expertise is documented;

3. Written documentation regarding the process and results of ensuring that the item is not covered by the *State Plan for Medical Assistance* as Durable Medical

Equipment and Supplies and that it is not available from a DME provider when purchased elsewhere;

4. Documentation of the date services are rendered and the amount of service needed;

5. Any other relevant information regarding the device or modification;

6. Documentation of the individual/PCG's receipt of and satisfaction with the AT provided as well as any training provided to the individual/PCG on the usage of the AT;
7. Instructions provided to the individual/PCG regarding warranty coverage, repairs, maintenance and complaint resolution.

A copy of the above documentation shall be submitted to the DMAS Tech Waiver unit. More than one cost estimate may be required by DMAS.

**MONEY FOLLOWS THE PERSON (MFP) DEMONSTRATION GRANT**

Transition services means set-up expenses for individuals who are transitioning from an institution or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. 12VAC30-120-2010 provides the service description, criteria, service units and limitations, and provider requirements for MFP.

Transition services shall be covered two ways as defined in 12VAC30-120-1700:

- to provide for applicants to move from institutional placements to community private homes. This service shall be authorized by DMAS or the designated service authorization contractor in order for reimbursement to occur. These services shall include those set out in the MFP demonstration grant, and

- for applicants who have moved from an institution to the community within the last 30 days. The applicant's transition from an institution to the community shall be coordinated by the facility's discharge planning team. The discharge planner shall coordinate with the DMAS staff to ensure that technology assisted waiver eligibility criteria shall be met.

For the purposes of transition funding for the TW, an institution means an ICF/IID, a specialized care nursing facility or a long-stay hospital as defined at 42 CFR 435.1009. Transition funding shall not be available for individuals who have been admitted to an acute care hospital.

When the Money Follows the Person demonstration is terminated (or expires) by federal action, the portion of this service covered through MFP shall also terminate. The remaining transition services shall continue until modified.

## OTHER COMMUNITY PROGRAMS

Virginia currently offers two other home-based services through the Virginia *State Plan for Medical Assistance*: Home Health and Hospice care.

## APPROPRIATE USE OF HOME HEALTH VERSUS WAIVER SERVICES

Home health providers must determine whether an individual referred for home health skilled nursing or home health aide services has been screened and authorized for services under one of the waiver programs.

DMAS does not consider skilled nursing and home health aide services under the Medicaid home health program to be reasonable and necessary for reimbursement purposes in those instances where the individual qualifies for the comparable service(s) available under one of the Home and Community-Based Waivers. While individuals may qualify for services under more than one program category, it is essential to the wellbeing of individuals and the cost effectiveness and integrity of the programs that individuals are directed to the best possible alternatives.

Home health services are provided by a certified home health agency on a part-time or intermittent basis to an individual. The services must be reasonable and necessary for the diagnosis or treatment of an illness or injury or to establish a program to restore or maintain functions which have been lost or reduced by illness or injury. Home health aide services are intended to assist the individual or caregiver during a period of time in which they are adjusting to a change in the individual's ability to conduct his or her activities of daily living.

Private duty nursing, personal care, and respite care are services delivered by Medicaid-approved providers on an ongoing basis to individuals who are eligible for technology assisted waiver services. When an individual has **ongoing** skilled nursing or aide service needs which are available under a Medicaid waiver program, and the individual meets the criteria, the nursing or aide services must be provided through the waiver rather than through the home health program.

If the individual has been authorized to receive waiver services, and the home health provider receives a request for nursing or aide services, the home health provider must refer the individual to DMAS to discuss the nursing care which is needed but not already provided by the private duty nursing staff in the home. Home Health skilled visits may be appropriate when the service ordered falls outside of the expertise of the Tech Waiver skilled private duty nurse. Examples of this may include complex wound care, wound vacs, lab work and intravenous infusions. Home health services are not appropriate for

reimbursement for an individual who receives a comparable technology assisted waiver service.

## HOSPICE CARE

Hospice is an autonomous, centrally administered, medically directed program providing a continuum of home, outpatient, and homelike inpatient care for the terminally ill patient and his or her family. It employs an interdisciplinary team to assist in providing palliative care to meet the special needs arising out of the physical, emotional, spiritual, social, and economic stresses which are experienced during the final stages of illness and during bereavement. The goal is to maintain the individual at home for as long as possible while providing the best care available to the individual, thereby avoiding institutionalization. For additional information and covered hospice services, refer to the Department of Medical Assistance Services Hospice Manual.

Simultaneous Provision of Tech Waiver Services and Hospice Services

The following information is applicable regardless of whether the hospice receives reimbursement from Medicare or Medicaid for the services covered under the hospice benefit. An individual on the TW can receive private duty nursing, and private duty respite care services in conjunction with hospice services. The hospice personal care aide and the Tech Waiver skilled PDN/RC nurse cannot be in the home at the same time. Waiver services must be authorized by DMAS.

The hospice benefit provides comprehensive services to persons with terminal illness. The hospice provider must offer homemaker/home health aide services as a part of the hospice benefit. Based upon the Medicare policy establishing the hospice reimbursement rates, it has been determined that the daily reimbursement rate covers the cost of providing a minimum of three hours per day of homemaker/home health aide services. The hospice provider must cover all hours per week of homemaker/home health aide services for any individual who requires those services.

Any personal care hours needed shall be provided by Hospice.

Hospice must coordinate with the TW provider to establish and agree upon one Plan of Services and Supports for both providers that reflects the hospice philosophy and is based on an assessment of the individual's needs and unique living situation.

The individual and service providers must be involved in any and all decisions that affect the individual's care. DMAS must be involved in any and all decisions that affect Tech Waiver services for an individual.

The election of the hospice benefit is the individual's choice rather than the hospice's choice. The hospice benefit is not designed to meet the needs of every terminally ill individual. The individual and family must be fully informed of the services available and any limitation on those services prior to electing the benefit.

Some individuals' needs may be more effectively met by utilizing other state and local programs and services. Once an individual has been accepted for care, the hospice may not

discharge the individual at its discretion, even if the individual's care becomes costly or inconvenient. The individual must sign a revocation of hospice benefits in order for him or her to be discharged from hospice services.

After admission to hospice services, the individual may continue to receive community-based RC. The hospice benefit only provides coverage for facility-based respite and is limited to five consecutive days. The decision to choose this option is the individual's. If the individual wants community-based respite services, they will be allowed to use the 360 hours through the TW. If the individual chooses facility-based respite, the individual must use the hospice benefit first.

## HOSPITALIZATION OF WAIVER INDIVIDUALS

When an individual, regardless of age, requires admission to a hospital, the provider should notify DMAS of the date and reason for admission. The provider should contact the hospital discharge planner to facilitate discharge planning and notify DMAS once a discharge date is determined. Individuals must continue to meet the age appropriate TW criteria to resume TW services upon discharge. If the individual will not be returning to community-based services, the provider must discontinue services and send a DMAS-225 to DMAS as well as the local DSS indicating the individual's last date of service with the provider.

If the individual/PCG requests an increase in hours following a hospitalization, the RN must make a post-hospitalization visit to the individual's home and assess the need for the increase.

Anytime a hospitalization for an individual exceeds 30 days, the provider must notify DMAS who will initiate discharge of the individual from the Technology Assisted Waiver. Once a discharge date for the individual is established, the hospital discharge planner should notify DMAS to determine what paperwork will be required for re-admission to the Technology Assisted Waiver.

## REFUSAL OF SERVICES BY THE INDIVIDUAL

Individuals have the right to choose the services they want and who they receive them from. This includes the right to refuse services. This refusal must be documented in the individual's record. If all services for the day are refused, the agency staff member should leave the home and document the early departure time.

If services are refused frequently, a reduction in hours may be warranted (see "Decrease in Hours" in this chapter). The refusal must be documented in the individual's record and an evaluation should be conducted, with immediate notification to DMAS.

The provider may not bill Medicaid or the individual for any time services are scheduled, but the staff member is not able to provide care (e.g., the nurse arrives and the individual is not home).

## CHANGE OF RESIDENCE

If an individual's residence changes, the provider must record this in the individual's record and notify DMAS. This notification must be immediate and in writing to DSS via the LTC-DMAS 225 form and to DMAS TW staff by phone.

## INDIVIDUALS WITH COMMUNICABLE DISEASES

Current information regarding the transmission of Acquired Immune Deficiency Syndrome (AIDS) and other similar communicable diseases indicates that these diseases are not transmitted through casual contact, and isolation techniques or procedures are not required for providing care to individuals in their homes.

However, certain routine hygienic precautions designed to prevent the spread of all communicable diseases, including blood borne infections, shall be taken by all providers when rendering care to any individual, regardless of his or her known medical illness. These precautions should include care in handling sharp objects such as needles, the wearing of disposable gloves when one could become exposed to blood or other body fluids, and scrupulous hand washing before and after caring for each individual.

Providers are prohibited from discriminating against individuals who have been diagnosed as having Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) and other communicable diseases.

All agency providers are required by OSHA to provide their staff with protective equipment (gloves, masks, gowns, etc.).

## INDIVIDUALS WITH MENTAL ILLNESS, INTELLECTUAL DISABILITIES, DEVELOPMENTAL DISABILITIES, OR RELATED CONDITIONS APPROVED FOR SERVICES

Federal waiver programs are designed to serve a specific targeted population. The Tech Waiver can only serve individuals who are at risk of nursing facility placement and meet all eligibility requirements for the waiver.

## REPORTING ABUSE, NEGLECT, EXPLOITATION AND MISAPPROPRIATION OF PROPERTY

Abuse means the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, sexual abuse or exploitation of a waiver individual. Types of abuse include:

a) physical abuse (a physical act by a person that may cause physical injury to an individual);

b) psychological abuse (an act, other than verbal, that may inflict emotional harm, invoke fear or humiliate, intimidate, degrade or demean an individual);

c) sexual abuse (an act or attempted act such as rape, incest, sexual molestation, sexual exploitation or sexual harassment and/or inappropriate or unwanted touching of an individual); and

d) verbal abuse (using words to threaten, coerce, intimidate, degrade, demean, harass, or humiliate an individual).

Pursuant to 63.2-1606 *et seq.* and 63.2-1508 through 1513 of the *Code of Virginia*, a provider or the provider's staff must report all suspected violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of individual property immediately to Adult Protective Services (APS) or Child Protective Services (CPS), as appropriate, and to other officials in accordance with State law. If sexual abuse of adults or children is suspected, law enforcement shall also be contacted.

As mandated reporters for vulnerable adults and children, providers shall inform their staff that they are mandated reporters and provide education regarding how to recognize and report suspected abuse, neglect, or exploitation of children, the elderly, and individuals with a disability. A civil penalty may be imposed on mandated reporters who do not report suspected abuse, neglect, or exploitation to VDSS as required.

The provider must ensure that all employees are aware of the requirements to report suspected abuse, neglect, or exploitation immediately to APS or CPS, or Human Rights as appropriate.

**CLIENT APPEALS**

**For client appeals information, see Chapter III.**

**PROVIDER APPEALS**

**For provider appeals information, see Chapter II.**