AD*vantage* PROGRAM SERVICE STANDARDS

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Home and Community Based (HCBS) Case Management Services Introduction

Home and Community Based services (HCBS) is a Medicaid waiver program providing long-term care in a Member's home to prevent premature or unnecessary institutionalization. An HCBS service delivery system, as mandated by federal regulations, is unique in the nation's health care as a result of the comprehensive service planning of medical, health, and social services and the provider coordination in the delivery of services.

The HCBS service delivery system's comprehensive planning and coordination of services allows states to assure quality at the higher federal standard of quality – **assuring the health and welfare of the Member.**

> "In home and community-based service, each state makes a commitment to assure the health and welfare of the person. This is a fundamental difference between the HCBS and other programs. Assuring the health and welfare of the person is a higher standard than the obligation to ensure the quality of each service provided under the Medicaid State Plan."
>
> *Centers for Medicare and Medicaid Services*

To build an infrastructure that can meet this higher standard, the Center for Medicare/Medicaid Services (CMS) is requiring a new Quality Framework for states' HCBS service delivery system. The Framework focuses attention on participant-centered desired outcomes along seven dimensions.

- Participant Access
- Participant-Centered Service Planning and Delivery
- Provider Capacity and Capabilities
- Participant Safeguards
- Participant Rights and Responsibilities
- Participant Outcomes and Satisfaction
- System Performance

The Medicaid Home and Community Based program in Oklahoma is the AD*vantage* Program, which provides eligible Oklahoma's a community alternative to nursing facility care.

AD*vantage* Case Management System

At the center of assuring quality in HCBS are case management services. Case managers play a leading role in quality assurance by monitoring and measuring Member health and welfare service outcomes with the help of other service providers based on the established service plan for the Member.

Case management is the cornerstone of quality assurance in the provision of AD*vantage* Program services. Case management is designed to minimize fragmentation in service delivery by coordinating multiple services provided to a Member. AD*vantage* Program case management is a standardized, statewide system of case management out contracted to existing community agencies and serves an important quality assurance function in the system.

The use of case management in the AD*vantage* Program is one of the State's methods for assuring the health and welfare of Members. The AD*vantage* Program assures Members' choice in their case management providers.

The AD*vantage* Program utilizes a statewide network of community providers to deliver authorized AD*vantage* services rather than the use of state agency employees. Community providers include private for-profit businesses, and not-for-profit businesses, some of which are Councils of Government, Independent Living Centers, and Area Agencies on Aging. In the AD*vantage* Program, Members must have 24 hour a day, 7-day a week access to Case Managers.

Case management agencies must be certified by LTCA-Oklahoma as qualified to provide Medicaid AD*vantage* Case Management services and have a valid Medicaid contract with the Oklahoma Health Care Authority (OHCA). A requirement of Case Management provider certification is the provider's assurance to comply with Case Management Service Standards, Conditions of Provider Participation, AD*vantage* Program Service Standards, and Member Assurances.

In addition, certification involves a review of general and administrative, financial, and programmatic components of the provider application to determine the provider's capacity to provide quality AD*vantage* services. The completion of a successful Continuous Quality Improvement (CQI) Plan is required for case management providers. See addendum A.

Each Case Management provider is required to staff four positions. The required positions are: Case Manager, Case Management Supervisor, Back-up Case Management Supervisor and Continuous Quality Improvement Manager (can be held by the Case Management Supervisor). Case management providers are required to have a minimum of three staff to cover the required four positions.

AD*vantage* Case Management

The National Advisory Committee (NAC), a group of case management experts from academia, provider organizations, and state and local government, agreed on an extensive and comprehensive definition of HCBS long-term care case management.

> "HCBS long-term care case management is a service that links and coordinates assistance from both formal {paid} service providers and informal {unpaid} help from family and friends to enable Members with chronic functional and/or cognitive limitations to obtain the highest level of independence consistent with their capacity and their preferences for care."

One of the key concepts is that HCBS long-term care case management is a service provided to the Member. Case managers are one of the service providers in the continuum of services provided to Members.

Core Functions in AD*vantage* Case Management

The case management process requires Case Managers to have specialized skills and competencies to perform, at minimum, five core functions. The core functions form an on-going and dynamic case management process. Case Management core functions are:

1) Comprehensive Assessment: Case Management requires a comprehensive, systematic, standardized, and multidimensional assessment of the Member's functional and cognitive capacity and limitations, need for services, strengths, abilities, supports and resources.

2) Service Planning: Service planning is a resource allocation process where a service prescription is developed for a Member that defines the types of services needed and the amount, frequency and duration of service delivery to meet assessed needs.

3) Service Plan Implementation: Service plan implementation is a process of contacting both formal and informal providers to arrange for services outlined in the service plan.

4) Monitoring: "the continuing contact the Case Manager has with providers and clients (Members) to ensure that services are provided in accordance with the [service] plan and to ascertain whether these services continue to meet the client's (Member's) needs." (Schneider & Weiss, 1982)

5) Reassessment: "scheduled or event-precipitated examination of the client's (Member's) situation and functioning to identify changes which occurred since the initial or most recent assessment and to measure progress toward the desired outcomes outlined in the [service] plan." (Schneider & Weiss, 1982)

Principles of AD*vantage* Case Management

Case managers must perform the core functions previously described and also adhere to HCBS long-term care case management principles. Performing the core functions and following the principles below assures continuity and quality of long-term care case management and services and supports to the Member.

1) **Principle #1 Case Management is Member-Centered**: Case Management is a Member–centered service that respects Members' rights, values, and preferences.

2) **Principle #2 Case Management Coordinates ALL Assistance**: Case Management coordinates all and any type of assistance to meet identified Member needs.

3) **Principle #3 Case Management Requires Knowledge, Skills & Competencies**: To perform well, Case Managers require specialized clinical skills, knowledge, and personal characteristics and competencies.

4) **Principle #4 Case Management Promotes Quality**: Case management promotes the quality of services provided.

5) **Principle #5 Case Management is Future Oriented**: Case management looks into the future, predicts, and makes plans based on today's indicators.

6) **Principle #6 Case Management Uses Resources Efficiently**: In the prescription of services to meet, but not exceed, assessed need and to efficiently coordinate services, Case management is a cost-effective service.

Employee Minimum Qualifications
AD*vantage* Case Management

AD*vantage* Case Manager (required)
The minimum qualifications for Case Managers are:
1. RN with one year paid professional experience
2. LPN with one year paid professional experience
3. Baccalaureate degree **and** one year paid **professional** experience with aging or disabled population, performing duties which encompass the core functions of case management. The core functions of case management include: assessment, planning, implementation, monitoring and reassessment.

AD*vantage* Case Management Supervisor (required)
The Case Management Supervisor must meet all of the requirements of the AD*vantage* Case Manager and be an experienced manager of people who has direct case management experience with home-based health care or case management services for in home long-term care populations.

AD*vantage* Back-up Case Management Supervisor (required)
The Back-up Case Management Supervisor must meet all of the requirements of the Case Management Supervisor.

Continuous Quality Improvement Manager (required)
The Continuous Quality Improvement Manager must: (1) be an individual in a managerial position in the agency with authority and responsibility for quality assurance activities, staff performance and agency strategic planning; (2) have previous administrative and/or supervisory experience; (3) meet the requirements to be an AD*vantage* Case Manager; (4) be an onsite employee with the authority to implement the provider's CQI Plan. This position is responsible for the agency's AD*vantage* Continuous Quality Improvement Plan and must attend all CQI AD*vantage* Trainings.

Case Coordinator (optional)
The Case Coordinator position requires an individual with a minimum of a high school diploma or a General Educational Development Certificate and one year of community-based experience. The Case Coordinator cannot perform clinical case management functions (e.g. assessment, reassessment and service plan development). The Case Manager can delegate non-clinical activities to the case coordinator.

AD*vantage* Program Case Management Training

An AD*vantage* provider agrees to the following training requirements:
Part A: New Employees

1. Case Managers must successfully complete the required training approved by the AD*vantage* Administrative Agent.

2. Case Management Supervisors and Back-up Case Management Supervisors must successfully complete the required case management training and supervisory training.

3. The CQI Manager must successfully complete case management training.

4. The Case Coordinator must successfully complete case management training but cannot perform clinical case management functions or be assigned to a case as an AD*vantage* Case Manager (due to lack of experience and education).

Part B: Employees with previous AD*vantage* Case Management experience

1. Case Managers who have previously completed training successfully, but who have not been actively employed as a Case Manager, Case Management Supervisor, or Back up Case Management Supervisor, by an AD*vantage* Program certified Provider for a period of nine months or greater, must attend and successfully complete Case Management training, prior to assuming any AD*vantage* related position.

2. The Provider will submit a reorientation plan to the AA for approval for a Case Manager, who has previously completed training successfully, but has not been actively employed by an AD*vantage* Program certified Provider as a Case Manager, Case Management Supervisor, Back up Case Management Supervisor for a period of six to nine months.

Agency ____

Authorized Agent ___________________________________ Date _______________

Adult Day Health Care

Service Definition: Services furnished on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the Member. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Services are authorized in 15 minute units, with no more than 24 units (6 hours) authorized per day.

Member *Provider Title:* Adult Day Care Center

Minimum Qualifications: The Facility shall have a current AD*vantage* Program certification and Oklahoma Medicaid contract to provide adult day health care services to AD*vantage* Program Members. Facility meets all training and certification requirements set forth in state regulation 56 O.S., Sec. 1-177 et seq. Direct care employees have completed an AD*vantage* Program approved training program, which incorporates the agency's Service Delivery Principles and a Bill of Member Assurances.

Agency ____

Authorized Agent ____________________________ Date ____________

Advanced Supportive/Restorative Assistance

Service Definition: Advanced Supportive/Restorative Care services are maintenance services provided to assist a Member with a stable, chronic condition with activities of daily living when such assistance requires devices and procedures related to altered body function.

Advanced Supportive/Restorative Care is a maintenance service and should never be used as a therapeutic treatment. Members who develop medical complications requiring skilled nursing services while receiving Advanced Supportive/Restorative Care services should be referred to their attending physician who may, if appropriate, order home health services.

Examples of Advanced Supportive/Restorative Care services which may be performed are:

- Routine Supportive/Restorative Care for persons with ostomies (including tracheotomies, gastrostomies and colostomies with well-healed stoma) and external, in dwelling, and suprapubic catheters which includes changing bags and soap and water hygiene around ostomy or catheter site;
- Remove external catheters, inspect skin and reapplication of same;
- Administer prescribed bowel program including use of suppositories and sphincter stimulation, and enemas (pre-packaged only) with Members without contraindicating rectal or intestinal conditions;
- Apply medicated (prescription) lotions or ointments, and dry, non-sterile dressings to unbroken skin;
- Use lift for transfers;
- Supervise/Assist with self-administration of oral medications which are set up by a registered or LPN; supervision/assistance may include opening a bottle cap for the Member, reading the medication label to the Member, checking the self-administration dosage against the label of the container and reassuring the Member that the dosage is correct and observing the Member while medication is taken;
- Provide passive range of motion (non-resistive flexion of joint) delivered in accordance with the plan of care, unless contraindicated by underlying joint pathology;

- Apply non-sterile dressings to superficial skin breaks or abrasions as directed by a registered or LPN; and
- Use Universal Precautions as defined by the Center for Disease Control.

Providers choosing to offer Advanced Supportive/Restorative Care will be required to provide all of the above services as well as Skilled Nursing and Personal Care.

Provider Title: Advanced Supportive/Restorative Aide

Minimum Qualifications: Provider has a current AD*vantage* Program certification and Oklahoma Health Care Authority contract to provide Advanced Supportive/Restorative Assistance and Skilled Nursing services to AD*vantage* Program Members. The Provider agency meets all licensure requirements as set forth in state regulations 63 O.S., Sec. 1-1961 et seq. The Advanced Supportive/Restorative Aide is at least 18 years of age, has not been convicted of a crime as defined in 63 O.S., Sec. 1-1950 et seq., has no pending notation of abuse or neglect as reported by the Oklahoma State Department of Health Nurse Aide Registry, name does not appear on the DHS Community Services Workers Registry, demonstrates the ability to understand and carry out assigned tasks, has verifiable work history and/or personal references, has verifiable identification and meets all Medicaid contractual and certification requirements, and has a current certification in CPR.

Authorization of Services

An AD*vantage* Program Case Manager must authorize all units of Advanced Supportive/Restorative Assistance before services can be delivered. The plan of care must be developed, reviewed, and updated by a RN in cooperation with the Case Manager.

The plan of care must include the following items:

- Identification of the specific Advanced Supportive/ Restorative Assistance tasks to be provided;
- Other activities permitted;
- Frequency of services and on what days those services will generally be provided;
- Functional limitations of the Member;
- Nutritional requirements if a special diet is necessary;
- Medications and treatments as appropriate;

- Any safety measures necessary to protect against injury; and
- Any other appropriate items.

<u>*Training Program Requirements*</u>*:* For the training program to be approved by the AD*vantage* Program, the Advanced Supportive/ Restorative Assistance provider shall have a written plan for providing training for new workers which shall include, at a minimum, the following requirements:

All Advanced Supportive/Restorative Assistance aides are required to receive the same basic Personal Care training as a Personal Care aide, and also must be given the following training prior to delivery of Advanced Supportive/ Restorative Assistance services:
The Provider must provide to its staff Advanced Supportive/Restorative Assistance training specific to the care needs of Member of Advanced Supportive/Restorative Assistance. The provider shall have written plans of the training; such training must include at a minimum the following topics:

- Observing the Member and reporting observations;
- Application of ointments/lotions to unbroken skin;
- Supervise/assist with oral medications:
- Prevention of decubiti;
- Bowel program;
- Basic Personal Care for persons with ostomies and catheters;
- Range of motion exercises;
- Use of lift for transfers;
- Applying non-sterile dressings to superficial skin breaks; and
- Universal precaution procedures as defined by the Center for Disease Control.

The provider must document the dates and hours of Advanced Supportive/Restorative Assistance training received by the Personal Care aide in the aide's personnel file.

Prior to performing any Advanced Supportive/Restorative Assistance task for any Member for the first time, the aide must demonstrate competency in the tasks on the Member's plan of care in an on-the-job training session conducted by the RN, or an LPN working under the direction of a RN. The nurse must document the aide's competency in

performing each task in the aide's personnel file. The RN/LPN visit required to conduct such training and testing is a billable visit.

The required demonstration of each Advanced Personal Care task during an on-the-job training session with a RN or LPN may not be waived. Advanced Supportive/Restorative Assistance aides must also receive annual in-service training.

The Advanced Supportive/Restorative Assistance provider shall have written documentation of all basic and in-service training provided which includes, at a minimum, a report of each employee's training in that employee's personnel record. The report shall document the dates of all classroom or on-the-job training, trainer's name, topics, number of hours, and location; the date of first unsupervised service delivery; and shall contain the worker's signature. If a provider waives the in-service training, the employee's training record shall contain supportive data for the waiver of training.

Supervision Requirements:

Nurse Supervision

RN supervision is essential to the safe provision of Advanced Supportive/Restorative Care services. Certain nurse functions for Advanced Supportive/Restorative Care Members may be performed by a LPN; others must be performed by a RN. The following outlines the nursing requirements for Advanced Supportive/Restorative Care Members:

The RN must:

- Conduct an initial assessment visit and develop the plan of care for Members with Advanced Supportive/Restorative Care needs, in collaboration with the Case Manager.

- Conduct on-site visits to all Advanced Supportive/Restorative Care Members at six-month intervals. During the visit, the RN shall conduct an evaluation of the adequacy of the authorized services to meet the needs and conditions of the Member, and shall assess the Advanced Supportive/Restorative Care Aides' ability to carry out the authorized services.

- Make monthly evaluation reports, paid for by AD*vantage*, available to the Case Manager within 48 hours.

- Conduct annual assessment/reassessment visits and develop the plan of care for all subsequent years for Members with Advanced

Supportive/Restorative Care needs, in collaboration with the Case Manager.

- Attend IDT meetings to establish or amend the Plan of Care.

- Be available, at least by telephone, during any period of time Advanced Supportive/Restorative Care is being provided.

- Observe the successful execution by the aide of each Advanced Supportive/Restorative Care task during an on-the-job training session, and certify the successful completion of the task in the aide's personnel record. This visit may be authorized and reimbursed.

The LPN may:

- Conduct the monthly-authorized nurse visits to evaluate the condition of the Advanced Supportive/Restorative Care Member. The visit reports must be forwarded to the RN supervisor for co-signatures.

Records

Providers participating in the delivery of Advanced Supportive/Restorative Care services must maintain all records and documentation required of the Medicaid Personal Care Program. In addition, participating providers must maintain the following records and documentation that pertain only to the delivery of Advanced Supportive/Restorative Care services.

The Personal Care Aide's personnel record shall contain:

- Documentation of the Advanced Supportive/ Restorative Care training including dates and topics.

- Signed statement(s) by the RN certifying that Personal Care Aide has successfully completed on-the-job training for each Advanced Supportive/Restorative Care task the aide is required to perform.

The case record of any Member receiving Advanced Supportive/Restorative Care services shall include:

- Written notes concerning any authorized-nurse visits including the six-(6) month supervisory visit and the monthly nurse visit report. In addition, notes of any verbal communication and copies of any written communication with the Member's physician or other health care professional, concerning the Member's care must be maintained in the Member's case record.

- A closing summary documenting that twenty-one (21) day notification was given to the AD*vantage* Case Manager and the Advanced Supportive/Restorative Member prior to the date of closing, the Member's authorization date, the most recent care plan including identified functional disabilities, the reason for closing, the date of closing and a follow-up plan, if applicable.

Agency ____

Authorized Agent ____________________________________ Date _______________

AD*vantage* Personal Care Assistance

Service Definition: Personal Care is a level of care for individuals who do not require care in a NF or ICF/MR. Personal Care service is by an agency holding a valid certification and contract to provide Title XIX AD*vantage* Program Personal Care service. Personal Care is defined as assistance to an individual in carrying out activities of daily living, such as bathing, grooming and toileting or in carrying out instrumental activities of daily living, such as preparing meals and doing laundry, to assure personal health and safety of the individual or to prevent or minimize physical health regression or deterioration. Personal Care services do not include service provision of a technical nature, i.e., tracheal suctioning, bladder catheterization, colostomy irrigation, and operation/maintenance of equipment of a technical nature.

Provider Title: Personal Care Assistant (PCA)

Minimum Qualifications: Provider has a current AD*vantage* Program certification and Oklahoma Health Care Authority contract to provide Title XIX AD*vantage* Program Personal Care services. The Provider agency meets all licensure requirements as set forth in state regulations 63 O.S., Sec. 1-1961 et seq. The PCA is at least 18 years of age, has not been convicted of a crime as defined in 63 O.S., Sec. 1-1950 et seq., has no pending notation of abuse or neglect as reported by the Oklahoma State Department of Health Nurse Aide Registry, demonstrates the ability to understand and carry out assigned tasks, has verifiable work history and/or personal references, has verifiable identification and meets all Medicaid contractual and certification requirements.

Training Requirements: Demonstrates competency to a qualified evaluator to meet the personal care assistance needs of the individual member.

PERSONNEL

A Personal Care administrative supervisor shall be designated by the provider ownership or administrative management to supervise the day-to-day delivery of direct Personal Care services. This position of responsibility may be assigned in conjunction with other duties within the provider organization.

The designated administrative supervisor shall be at least 21 years of age and have at least one year of supervisory experience in the field of health care or social services. In addition, the supervisor must meet at least one of the following criteria before performing the supervisory duties required by these standards. The administrative supervisor must:

- Be a RN licensed in the State of Oklahoma; or
- Have a Bachelor of Science or Bachelor of Arts degree; or

- Be a LPN, licensed in the state of Oklahoma with at least one year of experience with the direct care of the elderly, disabled, or infirm; or

- Have three years experience in the care of the elderly, disabled and infirm.

If the designated administrative supervisor is not a RN, the provider agency shall have an RN consultant available to fulfill the specific functions described later in this section. The RN consultant must be currently licensed in the State of Oklahoma.

Supervision

The duties of the designated supervisor will include the following:

- Utilize the plan of care to determine the training needs of the PCA for each member assigned and implement the plan of care that meets the needs of each member. Provide training, as necessary, based upon the needs of the PCA and/or the needs of the member. Arrange for a qualified evaluator to review and certify PCA competency to perform required plan of care tasks and confirm that this certification is documented on the PCA competency checklist maintained in the agency's PCA file. For all hands on personal care tasks, qualified PCA competency evaluators must be appropriately licensed health care professionals (RN, PT, etc.). Assure agency compliance with all requirements of the Occupational Safety and Health Act.

- Monitor the provision of Personal Care services and authorized RN visits to ensure that services are delivered in accordance with the services authorized by the AA. This shall include routine review and comparison of the PCA's logs of services with the service authorizations for each Member. The units of service authorized, the tasks specified, and the authorized frequency of delivery must be compared to the units, tasks and frequency of delivered services. A written explanation of any discrepancies and description of corrective action taken must be signed and dated by the supervisor and be readily available for monitoring or inspection. This requirement shall be met by the Supervisory Monitoring/Delivery Log. The Log must be completed monthly.

- Complete a written evaluation of each Personal Care Assistant's performance at least annually. The evaluation must be based in part on at least one on-site visit, unannounced to the aide beforehand. The PCA must be present during the visit. The written report of the evaluation should document the visit, containing the Member's name and address, the date and time of the visit, the PCA's name, and the supervisor's observations and notes from the visit. In addition to information from the on-site visit, the written evaluation should contain sufficient other data on the PCA's performance to demonstrate that the evaluation was based on qualified observation. The written evaluation should show what support and

supervision has been provided to the PCA and what support, supervision, and other intervention is planned as a result of the evaluation. The evaluation must be signed and dated by the supervisor who prepared it and by the aide.

- Communicate with the AD*vantage* Program Case Manager regarding changes in any Member's condition and recommended changes in scope or frequency of service delivery. The AD*vantage* Provider communication form should be used to transmit and document such communication.

- Report any PCA suspected of abuse, neglect or exploitation to the Adult Protective Services staff of the Oklahoma Department of Human Services, the Attorney General Medicaid Unit and the Oklahoma State Department of Health.

RN Supervision

RN supervision of Personal Care services is a state requirement of the AD*vantage* Program. Each AD*vantage* provider agency must have an RN available to perform specific supervisory functions. While some of the nursing supervision functions may be delegated to a LPN, the provider agency is responsible for having RN staff available to perform specified supervisory tasks.

Quality Assurance Framework

To assure the Member's health and welfare, Home Care providers must have a foundational Quality Assurance framework in place to lead to discovery, remediation and improvement of issues related to personal care service delivery. The key elements required for a foundational Quality Assurance framework include a process for Member Complaint and Grievance, Member Satisfaction Survey, Quality Self-Audit, Employee Education and Training Program and Personal Care Staffing.

Quality Self-Audit

At a minimum a Home Care provider agency must meet service quality monitoring and oversight requirements in accordance with OAC 310: 662-5-4. In addition as part of AD*vantage* certification as a qualified provider of Home Care services, agencies are required to develop and implement a Continuous Quality Improvement (CQI) plan that details the quality safeguards the provider has designed to meet the state requirements. The provider will be held accountable for following the Quality Self-Audit process for supervisory oversight of personal care services described in the individual provider's AA approved CQI plan. For Quality Self-Audit supervisory monitoring visits, the RN shall visit the Member at home or determine that an LPN make the visit based upon the type(s) of Personal Care services authorized in the Member's plan of care. Until providers have an approved CQI plan in place they will be required to continue to complete the RN

supervisory requirements as outlined in the October 2004 AD*vantage* Program Service Standards.

The RN has the responsibility of determining the status of the present plan of care in meeting the Member's needs. The LPN is under the direct supervision of the RN. This supervision includes a review and co-signature by the RN for all reports prepared by the LPN and consultation between RN and LPN as needed.

Written notes concerning the on-site visit must be maintained in the Member's case record. In addition, the RN must keep an on-site visiting log, which lists, for each visit, the name of the Member visited and the date the visit was made and whether the visit was made by an LPN or RN.

PERSONNEL RECORD

The provider must maintain an individual record for each Personal Care Assistant. A personnel record is a confidential record and shall be protected from damage, theft and/or unauthorized inspection. An individual personnel record shall include, at a minimum, the following:

- Employment application and employment record including the PCA's signature, date of birth, education, work experience, date employed, job titles or positions and dates held, and, if applicable, date terminated by the service provider;

- Documentation of at least 2 references contacted;

- Documentation of all members served and that a task specific competency checklist for each Member served exists for the PCA in each employee file;

- Annual performance evaluation which includes observations from an on-site visit;

- Signed statement(s) verifying that the PCA received a copy of the Member's Rights and the Provider's Code of Ethics, and that the provider's policy regarding confidentiality of Member information was explained prior to service delivery;

- Returned ID card for a terminated PCA, or documentation of why it is not available.

The provider must maintain the supervisor's and the RN's on-site visiting log.

Copies of the Supervisory Monitoring/Delivery Log, explaining discrepancies between authorized and delivered services, and describing the corrective action taken, must be maintained in a central location and available for monitoring or inspection by the AD*vantage* Program.

Providers must retain for six (6) years fiscal and service records, which coincide and fully document services billed to the Medicaid agency. Failure to retain and submit upon request adequate documentation for all services billed to the Medicaid agency may result in recovery of the Medicaid payments for those services not adequately documented and may result in sanctions to the provider's Medicaid participation. The provider must make records available to the Center for Medicare/Medicaid Services, the Oklahoma Health Care Authority, the Department of Human Services, or their designees for unannounced inspections and audits, with access during normal business hours.

Agency ____

Authorized Agent ________________________________ Date _____________

Consumer-Directed Personal Assistance Services and Support

(CD-PASS)

Consumer-Directed Personal Assistance Services and Supports are Personal Services Assistance and Advanced Personal Services Assistance that enable an individual in need of assistance to reside in their home and in the community of their choosing rather than in an institution and to carry out functions of daily living, self care, and mobility. CD-PASS services are delivered as authorized on the service plan. The Member employs the Personal Services Assistant (PSA) and/or the Advanced Personal Services Assistant (APSA) and is responsible, with assistance from ADvantage Program Administrative Financial Management Services (FMS), for ensuring that the employment complies with State and Federal Labor Law requirements. The Member may designate an adult family member or friend, an individual who is not a PSA or APSA to the Member, as an "authorized representative" to assist in executing these employer functions.

Member as employer:

- recruits, hires and, as necessary, discharges the PSA or APSA;
- provides instruction and training to the PSA or APSA on tasks to be done and works with the Consumer Directed Agent/Case Manager to obtain AD*vantage* skilled nursing services assistance with training when necessary. Prior to performing an Advanced Personal Services Assistance task for the first time, the APSA must demonstrate competency in the tasks in an on-the-job training session conducted by the Member and the Member must document the attendant's competency in performing each task in the APSA's personnel file;
- determines where and how the PSA or APSA works, hours of work, what is to be accomplished and, within Individual Budget Allocation limits, wages to be paid for the work;
- supervises and documents employee work time; and,
- provides tools and materials for work to be accomplished.

Personal Services Assistance (PSA)

Service Definition: Personal Services Assistance may include:

- assistance with mobility and with transfer in and out of bed, wheelchair or motor vehicle, or both;

- assistance with routine bodily functions that may include:
    - bathing and personal hygiene;
    - dressing and grooming;
    - eating including meal preparation and cleanup;
- assistance with homemaker type services that may include shopping, laundry, cleaning and seasonal chores;
- companion type assistance that may include letter writing, reading mail and providing escort or transportation to participate in approved activities or events. "Approved activities or events" means community civic participation guaranteed to all citizens including but not limited to, exercise of religion, voting or participation in daily life activities in which exercise of choice and decision making is important to the Member that may include shopping for food, clothing or other necessities, or for participation in other activities or events that are specifically approved on the service plan.

Provider Title: Personal Service Aide (PSA)

Minimum Qualifications: The PSA is at least 18 years of age, has not been convicted of a crime as defined in 63 O.S., Sec. 1-195 et seq., has no pending notation of abuse or neglect as reported by the Oklahoma State Department of Health Nurse Aide Registry and name does not appear on the OKDHS Community Services Workers Registry. Demonstrates the ability to understand and carry out assigned tasks, has verifiable work history and/or personal references, has verifiable identification, and has Medicaid Provider contract.

Training Requirements: Demonstrates competence to perform required tasks to employer/participant satisfaction.

Advanced Personal Services Assistance (APSA)

Service Definition: Advanced Personal Services Assistance are maintenance services provided to assist a Member with a stable, chronic condition with activities of daily living when such assistance requires devices and procedures related to altered body function if such activities, in the opinion of the attending physician or licensed nurse, may be performed if the individual were physically capable, and the procedure may be safely performed in the home. Advanced Personal Services Assistance is a maintenance service and should never be used as a therapeutic treatment. Members who develop medical complications requiring skilled nursing services while receiving Advanced Personal Services Assistance should be referred to their attending physician who may, if

appropriate, order home health services. The service of Advanced Personal Services Assistance includes assistance with health maintenance activities that may include:

- routine personal care for persons with ostomies (including tracheotomies, gastrostomies and colostomies with well-healed stoma) and external, in dwelling, and suprapubic catheters which includes changing bags and soap and water hygiene around ostomy or catheter site;
- remove external catheters, inspect skin and reapplication of same;
- administer prescribed bowel program including use of suppositories and sphincter stimulation, and enemas (Pre-packaged only) with Members without contraindicating rectal or intestinal conditions;
- apply medicated (prescription) lotions or ointments, and dry, non-sterile dressings to unbroken skin;
- use lift for transfers;
- manually assist with oral medications;
- provide passive range of motion (non-resistive flexion of joint) delivered in accordance with the plan of care, unless contraindicated by underlying joint pathology;
- apply non-sterile dressings to superficial skin breaks or abrasions; and
- use Universal precautions as defined by the Center for Disease Control.

Provider Title: Advanced Personal Service Aide (APSA)

Minimum Qualifications: The APSA is at least 18 years of age, has not been convicted of a crime as defined in 63 O.S., Sec. 1-195 et seq., has no pending notation of abuse or neglect as reported by the Oklahoma State Department of Health Nurse Aide Registry and name does not appear on the OKDHS Community Services Workers Registry. Demonstrates the ability to understand and carry out assigned tasks, has verifiable work history and/or personal references, has verifiable identification, and has Medicaid Provider contract.

Training Requirements: Demonstrates competence to perform required tasks to employer/participant satisfaction.

Prior to performing any Advanced Personal Services Assistance task for any Member for the first time, the APSA must demonstrate competency in the tasks in an on-the-job training session conducted by the Member. The Member must document the attendant's competency in performing each task in the APSA's personnel file. When deemed necessary by the CM/CDA, AD*vantage* Skilled Nursing services are authorized to provide assistance with training of the APSA and/or to provide skilled nursing oversight monitoring for the delivery of APSA services. If required by the CM/CDA, a nurse is required to observe the successful execution by the APSA of each Advanced Personal Services Assistance task during an on-the-job training session, and certify the successful completion of the task in the APSA's personnel record. This visit may be authorized and reimbursed.

Consumer Directed Agent

Service Definition: A Consumer Directed Agent (CDA) is an AD*vantage* Certified Case Manager that has successfully completed additional training on CD-PASS, Independent Living Philosophy and Person-Centered Planning. The role of the CDA is to assist the Member through the CD-PASS services process through Person Centered Planning.

Person-centered planning is a process directed by the participant, with assistance as needed from an "authorized representative" or support team. The process supports the Member to exercise choice and control and to assume a responsible role in developing, implementing and managing their services and supports. The process is intended to identify the strengths, capacities, preferences, needs and desired outcomes of the participant and it may enlist assistance from individuals freely chosen by the participant to serve as important contributors. The person centered planning process enables the participant to identify and access a personalized mix of paid and non-paid services and supports to help her/him achieve personally-defined outcomes in the most inclusive community setting. The focus of person-centered planning is on the individual's development of personal relationships, positive roles in community activities, and self-empowerment skills. Decisions are made and outcomes controlled by the participant. Strengths, preferences and an individualized system of support are identified to assist the individual to achieve functional and meaningful goals and objectives.

Principles of Person-Centered Planning are as follows:

- The person is the center of all planning activities.
- The Member and their representative, or support team, are given the requisite information to assume a controlling role in the development, implementation and management of the Member's services.
- The individual and those who know and care about him or her are the fundamental sources of information and decision-making.

- The individual directs and manages a planning process that identifies his or her strengths, capacities, preferences, desires, goals and support needs.
- Person-centered planning results in *personally-defined* outcomes.

Provider title: Consumer Directed Agent/Case Manager (CDA/CM)

Minimum Qualifications: The Case Manager must meet all of the minimum qualifications as an AD*vantage* Case Manager, successfully complete case management orientation and additional training specifically related to CD-PASS. Case Manager must demonstrate knowledge regarding CD-Pass service delivery model, "Independent Living Philosophy" and demonstrate competency in Person-centered planning. Providers must have a Case Management Supervisor, Back-up Supervisor and Case Manager all trained on CD-Pass services in order to provide case management services as a Consumer – Directed Agent/Case Manager to AD*vantage* Members who choose to utilize CD-Pass services.

Financial Management Services

Service Definition: The service Financial Management Services are program administrative services provided to participating CD-PASS employer/Members by the AD*vantage* Program Administrative Agent. Financial Management Services are employer related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:

- employer payroll, at a minimum of semi monthly, and associated withholding for taxes or for other payroll withholdings performed on behalf of the Member as employer of the PSA or APSA;
- other employer related payment disbursements as agreed to with the Member and in accordance with the Member's Individual Budget Allocation;
- responsibility for obtaining criminal and abuse registry background checks, on behalf of the Member, on prospective hires for PSAs or APSAs;
- providing to the Member, as needed, assistance with employer related cognitive tasks, decision-making and specialized skills that may include assistance with Individual Budget Allocation planning and support for making decisions including training and providing reference material and consultation regarding employee management tasks such as recruiting, hiring, training and supervising the Member's Personal Services Assistant

or Advanced Personal Services Assistant; and

- for making available Hepatitis B vaccine and vaccination series to PSA and APSA employees in compliance with OSHA standards.

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Environmental Modifications

Service Definition: Physical adaptations to the home, required by the Member's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the Member would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the Member, but shall exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the waiver Member, such as carpeting, roof repair, central air conditioning, etc. All services shall be provided in accordance with applicable State or local building codes and conform to ADA Accessibility Guidelines – 28 CFR Part 36 Appendix A.

The service is authorized by the Member's AD*vantage* Service Plan and is necessary to prevent institutionalization.

Provider Title: Architect, Electrician, Engineer, Mechanical Contractor, Plumber, Builder, or Remodeler

Minimum Qualifications: Provider holds a current AD*vantage* Program certification and Oklahoma Medicaid contract to provide environmental modification services for AD*vantage* Program Members.

Provider holds current professional license and/or registration where applicable:

Architects – Oklahoma Administrative Code Title 55, Chapter 10

Electricians – Electricians Licensing Act, 59 O.S., Sec. 1680 et seq.

Engineers – An Act Regulating Professional Engineers and Land Surveyors, 59 O.S., Sec. 475.1 et seq.

Mechanical Contractors – Mechanical Licensing Act, 59 O.S., Sec. 1850.1-1850.15

Plumbers – Plumbing Licensing Act, 59 O.S., Sec. 1001-1021

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Home-Delivered Meal Services

<u>Service Definition</u>: A home delivered meal is a meal prepared in advance and brought to the Member's home. Each meal must have a nutritional content equal to at least one-third of the Recommended Daily Allowance as established by the Food and Nutrition Board of the National Academy of Sciences. Member Provision of Home-delivered Meals reduces the need for reliance on paid staff during some mealtimes by providing meals in a cost-effective manner.

Home-delivered Meals shall be included in the individual service plan only when it is necessary to prevent the permanent institutionalization of an individual.

The Provider must obtain a signature from the Member or the Member's representative at the time the meals are delivered. In the event that the Member is temporarily unavailable (i.e. doctor's appointment, etc.) and the meal is left the Provider must document the reason a signature is not obtained. The signature logs must be available for review.

<u>The goals of Home-Delivered Meals</u>

(1) To facilitate Member independence by allowing Members the choice to remain in their own homes rather than enter a nursing facility.

(2) To provide one daily nutritious meal to persons at risk of being institutionalized.

(3) To provide a daily social contact to ensure the Member's safety and well being.

<u>Additional Eligibility Requirements for Home-Delivered Meals</u>

In order to receive Home-delivered Meals under the waiver, a Member must:

(1) Be unable to prepare some or all of his/her own meals, or requires a special diet and is unable to prepare it; or

(2) Have no other individual available to prepare Member's meals, or the provision of a Home-delivered Meal is the most cost-effective method of ensuring a nutritionally adequate meal; and

(3) Have the provision of meals included in the individual's Plan of Care.

<u>Provider Title</u>: Meal/Nutrition Service Provider

Minimum Qualifications: The provider of Home-delivered Meals must meet the following requirements:

(1) Be a nutrition service provider whose kitchen is approved by the Health Department and whose meals provide one-third of the Recommended Daily Allowance as approved by a dietitian.

(2) Comply with all federal, state, county and local laws and regulations concerning the preparation, handling and transportation of food as well as meeting additional standards established for Title III Program Home-Delivered Meal Providers.

(3) Be capable of providing modified or special diet meals and/or provide counseling by a registered dietitian.

(4) Procure and have available all necessary licenses, permits, and food handlers' cards as required by law.

(5) Provide menu cycles, which ensure variety of content of meals delivered.

(6) Have a current AD*vantage* Program certification and Oklahoma Medicaid contract to provide Home-Delivered Meal services to AD*vantage* Program Members.

(7) All subcontractors shall comply with all standards.

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Hospice Care Services

Service Definition: Hospice is palliative and/or comfort care provided to the Member and his/her family when a physician certifies that the Member has a terminal illness and has six (6) months or less to live and orders Hospice Care. A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The Member signs a statement choosing hospice care instead of routine medical care that has the objective to treat and cure the Member's illness. Once the Member has elected hospice care, the hospice medical team assumes responsibility for the Member's medical care for the terminal illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the Member and/or family.

A Hospice plan of care must be developed by the hospice team in conjunction with the Member's AD*vantage* Case Manager before hospice services are provided. The hospice services must be related to the palliation or management of the Member's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills.

AD*vantage* Hospice may be provided to the Member in a Nursing Facility (NF) only when the Member is placed in the NF for AD*vantage* Facility Based Extended Respite. Hospice provided as part of Facility Based Extended Respite may not be reimbursed for more than five (5) days during any thirty (30) day period.

A Member that is eligible for Medicare Hospice provided as a Medicare Part A benefit is not eligible to receive AD*vantage* Hospice services.

Provider Title: Hospice

Minimum Qualifications: Provider holds a current Medicare Hospice certification, AD*vantage* Program certification and Medicaid contract to provide Hospice services to AD*vantage* Program recipients. Provider meets all training, certification and licensure requirements as set forth in state regulations 63 O.S. 1991, Sec. 1-860 et seq.

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In-Home Respite Care

<u>*Service Definition for Home Health Agencies*</u>*:* Services provided to individuals unable to care for themselves; provided on a short-term episodic basis because of the temporary absence or need for relief of those persons normally providing the care. The cost of room and board will not be covered except when provided as part of respite care in a facility approved by the State that is not a private residence.

Prior to the use of the AD*vantage* Program Respite Care Services, optimal utilization will be made of informal supports and community/volunteer organization and agency resources. Respite Care shall be included in the individual service plan only when it is necessary to prevent the permanent institutionalization of the individual. The minimum number of hours of respite that will prevent institutionalization shall be used.

Regular respite is a period of service of at least two-(2) hours duration but no more than seven (7) hours duration. Regular respite may be offered within the home by agencies certified for providing the AD*vantage* Program In-Home Care services or regular respite may be offered within an AD*vantage* Program certified Adult Day Health Care Center for the number of people and hours allowed by law.

Extended respite is any single period of service in excess of seven (7) hours per day. Extended respite may be offered within the home by agencies certified for providing the AD*vantage* Program In-Home Care services or extended respite may be offered within an AD*vantage* Program certified Nursing Facility.

<u>*Provider Title*</u>*:* In-Home Respite Aide

<u>*Minimum Qualifications*</u>*:* Provider has a current AD*vantage* Program certification and Oklahoma Medicaid contract to provide In-home respite care services to AD*vantage* Program Members. In-home respite provider meets certification requirements as set forth in state regulations 63 O.S., Sec. 1-1961 et seq. The In-home Respite Aide shall meet minimum requirements for Title XIX Personal Care Assistance workers.

<u>Nursing facility</u> - 63 O.S., Sec. 1-1901 et seq.;

<u>Adult Day Care Center</u> - 56 O.S., Sec. 1-177 et seq.

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In-Home Skilled Therapy Services

Service Definition: Skilled Therapy Services

A. General Principles Governing Reasonable and Necessary Utilization of Skilled Therapy Services.

1. A service is a skilled therapy service if the inherent complexity of the service is such that it can be performed safely and/or effectively only by or under the general supervision of a skilled therapist. To be covered, the skilled services must also be reasonable and necessary to the treatment of the Member's illness or injury or to the restoration of maintenance of function affected by the Member's illness or injury. It is necessary to determine whether individual therapy services are skilled and whether, in view of the Member's overall condition, skilled management of the services provided is needed although many or all of the specific services needed to treat the illness or injury do not require the skills of a therapist.
2. The development, implementation, management, and evaluation of an individual care plan based on the physician's orders constitute skilled therapy services when, because of the Member's condition, those activities require the involvement of a skilled therapist to meet the Member's needs, promote recovery, and ensure medical safety. When the skills of a therapist are needed to manage and reevaluate periodically the appropriateness of a maintenance program because of an identified danger to the member, such services would be covered, even if the skills of a therapist are not needed to carry out the activities performed as part of the maintenance program.

   Skilled management involves a finding that the member's recovery and/or safety cannot be assured unless the total care, skilled or not, is planned and managed by skilled rehabilitation personnel. Documentation of the precautions needed, as well as the medical complications and safety factors present which warrant skilled management, is necessary.

   The skills of a therapist are needed to establish a reasonable and necessary maintenance program until it can be safely and effectively carried out by non-skilled individuals. If a danger to the member's safety warrants the skills of a therapist to management and reevaluate periodically the appropriateness of the maintenance furnished, the services may be covered because the program is not yet fully established for safety and effectiveness.

3. While a Member's particular medical condition is a valid factor in deciding if skilled therapy services are needed, a Member's diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled. The key

issue is whether the skills of a therapist are needed to treat the illness or injury or whether non-skilled personnel can carry out the services.

The decision must be based on the documented need for the skills of a therapist.

4. A service that is ordinarily considered non-skilled could be considered a skilled therapy service in cases in which there is clear documentation that because of special medical complications skilled rehabilitation personnel are required to perform or supervise the services or to observe the Member.

5. The skilled therapy services must be reasonable and necessary to the treatment of the Member's illness or injury within the context of the Member's unique medical condition. To be considered reasonable and necessary for the treatment of the illness or injury:

a. The services must be consistent with the nature and severity of the illness or injury and the Member's particular medical needs, including the requirement that the amount, frequency, and duration of the services must be reasonable;

b. The services must be considered, under accepted standards of medical practice, to be specific and effective treatment for the member's condition; and

c. The services must be provided with the expectation, based on the assessment made by the physician of the Member's rehabilitation potential, that:

- the condition of the Member will improve materially in a reasonable and generally predictable period of time; or

- the services are necessary to the establishment of a safe and effective maintenance program.

If there is not a reasonable expectation of improvement in a member's condition, there may still be a need for skilled services to establish a maintenance program. A special medical complication might also necessitate skilled services to perform exercises or treatments that are normally considered non-skilled, even when no rehabilitation potential is present.

d. Services of skilled therapists, which are for the purpose of teaching the member or the member's family or caregivers necessary techniques, exercises, or precautions, are covered to the extent that they are reasonable and necessary to treat the illness or injury. However, visits made by skilled therapists to the Member's home solely to train other home health agency staff (e.g., home health aides) are not billable as visits since the home health agency is responsible for ensuring that its staff is properly trained to perform any services it furnishes. The

cost of a skilled therapist's visit for the purpose of training home health agency staff is an administrative cost to the home health agency.

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Institution Transition Services

<u>*Service Definition*</u>: Institution Transition Services are those services that are necessary to enable an individual to leave the institution and receive necessary support through AD*vantage* waiver services in their home and/or in the community.

Institution Transition Case Management Services are services as described in OAC 317:30-5-763(1) required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or to enable the individual to function with greater independence in the home, and without which, the individual would continue to require institutionalization. AD*vantage* Transition Case Management Services assist institutionalized individuals that are eligible to receive AD*vantage* services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services to assist in the transition, regardless of the funding source for the services to which access is gained. Transition Case Management Services may be authorized for periodic monitoring of an AD*vantage* Member's progress during an institutional stay, and for assisting the Member transition from institution to home by updating the service plan, including necessary Institution Transition Services to prepare services and supports to be in place or to start on the date the Member is discharged from the institution. Transition Case Management Services may be authorized to assist individuals that have not previously received AD*vantage* services but have been referred by the AA or OKDHS to the Case Management Provider for assistance in transitioning from the institution to the community with AD*vantage* services support.

Institutional Transition Services may be authorized and reimbursed under the following conditions:

- The service is necessary to enable the individual to move from the institution to their home;
- The individual is eligible to receive AD*vantage* services outside the institutional setting;
- Institutional Transition Services are provided to the individual within 180 days of discharge from the institution;
- Transition Services provided while the individual is in the institution are to be claimed as delivered on the day of discharge from the institution.

If the Member has received Institution Transition Services but fails to enter the waiver, any Institution Transition Services authorized and provided are reimbursed as

"Medicaid administrative" costs and providers follow special procedures specified by the AA to bill for services provided.

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Occupational Therapy Services

Service Definition: Occupational Therapy services are those that increase functional independence by enhancing the development of adaptive skills and performance capacities of individuals with physical disabilities and related psychological and cognitive impairments. Services are provided in the Member's home and are intended to help the Member achieve greater independence to reside and participate in the community. Treatment involves the therapeutic use of self-care, work and play activities and may include modification of the tasks or environment to enable the patient to achieve maximum independence, prevent further disability, and maintain health. Under a physician's order, a licensed occupational therapist evaluates the recipient's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional occupational therapy assistant services within the limits of their practice, working under the supervision of the licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the recipient's rehabilitative progress and will report to the recipient's Case Manager and physician to coordinate necessary addition and/or deletion of services, based on the Member's condition and ongoing rehabilitation potential.

Occupational Therapy Services shall be included in the individual service plan only when it is necessary to prevent or delay the permanent institutionalization of an individual.

The services of an occupational therapist would be necessary to assess the Member's needs, to develop goals (to be approved by the physician), to manufacture or adapt the needed equipment to the Member's use, to teach compensatory techniques, to strengthen the Member as necessary to permit use of compensatory techniques, and to provide activities which are directed toward meeting the goals that govern increased perceptual and cognitive function. Occupational therapy services would be covered at a duration and intensity appropriate to the severity of the impairment and the Member's response to treatment.

The planning, implementing, and supervision of therapeutic programs, including but not limited to those listed below, are occupational therapy services if reasonable and necessary to the treatment of the Member's illness or injury.

a. Selecting and teaching task-oriented therapeutic activities designed to restore physical function.

b. Planning, implementing, and supervising therapeutic tasks and activities designed to restore sensory-integrative function.

c. Teaching compensatory techniques to improve the level of independence in the activities of daily living.

d. The designing, fabricating, and fitting of orthotic and self-help devices.

Occupational Therapy Service Components:

1. Evaluation

   Visit made to determine occupational therapy needs of the member at the home. Includes physical and psychosocial testing, establishment of plan of treatment, rehabilitation goals, and evaluating the home environment for accessibility and safety and recommending modifications.

2. Independent Living/Daily Living Skills (ADL) Training

   Refers to the skills and performance of physical cognitive and psychological/emotional self care, work, and play/leisure activities to a level of independence appropriate to age, life-space, and disability and includes instruction of the member, family or other caregivers regarding training techniques.

3. Muscle Re-education

   Includes therapy designed to restore function lost due to disease or surgical intervention.

4. Perceptual Motor Training

   Refers to enhancing skills necessary to interpret sensory information so that the individual can interact normally with the environment. Training designed to enhance perceptual motor function usually involves activities that stimulate visual and kinesthetic channels to increase awareness of the body and its movement.

5. Fine Motor Coordination

   Refers to enhancing the skills and performance in fine motor and dexterity activities.

6. Neurodevelopmental Treatment

   Refers to enhancing the skills and the performance of movement through eliciting and/or inhibiting stereotyped, patterned, and/or involuntary responses that are coordinated at subcortical and cortical levels.

7. Sensory Treatment

Refers to enhancing the skills and performance in perceiving and differentiating external and internal stimuli such as tactile awareness, stereognosis, kinesthesia, proprioceptive awareness, ocular control, vestibular awareness, auditory awareness, gustatory awareness, and olfactory awareness necessary to increase function.

8. Orthotics/Splinting

Refers to the provision of dynamic and static splints, braces, and slings for relieving pain, maintaining joint alignment, protecting joint integrity, improving function, and/or decreasing deformity.

9. Adaptive Equipment (fabrication and training)

Refers to the provision of special devices that increase independent functions.

10. Maintenance Therapy Program

Repetitive services required to maintain function and prevent regression do not usually require the skills of an occupational therapist.

A maintenance program may be established if, after an evaluation, the restorative potential of the member is judged to be insignificant. In such situations, the evaluation, the instruction of the member or caregivers, and reevaluations until the program can be safely and effectively carried out are all considered to be covered therapy services.

Provider Title: Occupational Therapist, Occupational Therapist Assistant

Minimum Qualifications: Provider holds a current AD*vantage* Program certification and Medicaid contract to provide physical therapy services to AD*vantage* Program recipients. Occupational therapy services are provided by a licensed Occupational Therapist or an Occupational Therapy Assistant working under the direction of a licensed Occupational Therapist and meeting all training and certification requirements as set forth in state regulations 59 O.S., Sec. 888.1 et seq.

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Personal Care and Therapy Enhancement to Adult Day Health Care

<u>*Service Definition*</u>*:* Service Enhancements to Adult Day Health Care are: personal care, physical, occupational, speech/language, and/or respiratory therapy.

Personal care service enhancement in Adult Day Health Care is assistance in bathing and associated hair and nail care as part of the bathing assistance service. Assistance with eating, mobility and toileting are personal care services that are integral to the Adult Day Health Care service and are covered by the Adult Day Health Care basic reimbursement rate. Assistance with bathing, and associated hair and nail care, are not usual and customary adult day health care services. Enhanced personal care in adult day health care for assistance with bathing will be authorized when an AD*vantage* waiver Member who uses adult day health care requires assistance with bathing and associated hair and nail care to maintain health and safety.

Physical, occupational, speech and respiratory therapies are defined under skilled therapy services. Therapy service enhancements, when indicated in the recipient's plan of care, will be furnished as a component of Adult Day Health Care. As a cost-containment measure, enhanced personal care and/or therapies in Adult Day Health Care are reimbursable on a per unit basis as an Enhancement to basic Adult Day Health Care.

<u>*Provider Title*</u>*:* Adult Day Health Care Center.

<u>*Minimum Qualifications*</u>*:* The provider shall have a current AD*vantage* Program and Oklahoma Medicaid contract to provide Adult Day Health Care to AD*vantage* Program Members. Facility and caregiver staff meets all training and certification requirements set forth in state regulation 56 O.S., Sec. 1-177 et seq.

Therapy services are provided by a licensed physical, occupational, respiratory, and/or speech therapist as specified by the physician's orders or by an appropriate certified therapy aide working under the direction of the licensed therapist.

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Personal Emergency Response System (PERS)

Service Definition: An electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals who are employees of the PERS company.

Service criteria: PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. The individual will also need to meet the established authorization criteria.

Provider Title: Durable Medical Equipment Provider

Minimum Qualifications: The Provider shall have a current AD*vantage* Program certification and Oklahoma Medicaid contract to provide Durable Medical and/or Rehabilitative Equipment and/or supplies. All items provided or modified shall meet applicable general standards of manufacture, design, and installation.

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Physical Therapy Services

Service Definition: Physical Therapy services are those that prevent physical disability through the evaluation and rehabilitation of individuals disabled by pain, disease or injury. Services are provided in the Member's home and are intended to help the Member achieve greater independence to reside and participate in the community. Treatment involves use of physical therapeutic means such as: massage, manipulation, therapeutic exercise, cold heat, hydrotherapy, electrical stimulation and light. Under a physician's order, a licensed physical therapist evaluates the recipient's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional physical therapy assistant services within the limits of their practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the recipient's rehabilitative progress and will report to the recipient's Case Manager and physician to coordinate necessary addition and/or deletion of services, based on the Member's condition and ongoing rehabilitation potential.

Physical Therapy Services shall be included in the individual service plan only when it is necessary to prevent or delay the permanent institutionalization of an individual.

Physical Therapy Service Components:

1. Assessment

Visits by a physical therapist to assess a member's rehabilitation needs and potential or to develop and/or implement a physical therapy home program. Assessment should include objective tests and measurements such as, but not limited to, range of motion, strength, balance, coordination, endurance, or functional ability.

Visits for management of a care plan should also be included as assessment visits.

2. Therapeutic Exercises

Therapeutic exercise which, due either to the type of exercise or the condition of the member, must be performed by or under the supervision of a physical therapist to ensure the member's safety and the effectiveness of the treatment.

3. Gait Training

Gait evaluation and training are covered when reasonable and necessary for a member whose ability to walk has been impaired by neurological, muscular, or skeletal abnormalities if they can be expected to improve materially the member's ability to walk.

4. Range of Motion

Only a qualified therapist may perform range of motion tests and therefore such tests are skilled physical therapy. Range of motion exercises are covered only if they are part of the active treatment for a specific disease state, illness or injury which has resulted in a loss or restriction of mobility. Physical therapy notes should document the degree of motion lost and the degree to be restored.

Range of motion exercises that are not related to the restoration of a specific loss of function may usually be provided safely and effectively by a non-skilled individual.

5. Maintenance Therapy Program

Repetitive services required to maintain function and prevent regression do not usually require the skills of a physical therapist.

A maintenance program may be established if, after an evaluation, the restorative potential of the member is judged to be insignificant. In such situations, the evaluation, the instruction of the member or caregivers, and reevaluations until the program can be safely and effectively carried out are all considered to be covered therapy services.

Provider Title: Physical Therapist, Physical Therapist Assistant;

Minimum Qualifications: Provider holds a current AD*vantage* Program certification and Medicaid contract to provide physical therapy services to AD*vantage* Program recipients. Physical therapy services are provided by a licensed Physical Therapist or a Physical Therapy Assistant working under the direction of a licensed Physical Therapist and meeting all training and certification requirements as set forth in state regulations 59 O.S., Sec. 887.1 et seq.

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Respiratory Therapy Services

Service Definition: Respiratory therapy services assist a Member's breathing functions through a plan of treatment, including instruction of the Member, family or other caregivers regarding use of respiratory equipment, supplies and techniques. Under a physician's order, a respiratory therapist will evaluate the Member's rehabilitation potential and develop an appropriate, written therapeutic regimen. The regimen will include only those services and equipment necessary to prevent institutionalization of the Member, as determined by the therapist's and physician's evaluations. The regimen will include education and training for informal caregivers to assist with services, where appropriate. The therapist will monitor and document the Member's rehabilitative progress and report to the Member's Case Manager and physician to coordinate necessary addition and/or deletion of services, based on the Member's condition and ongoing rehabilitation potential.

Respiratory therapy services are provided for an individual who, but for the availability of in-home respiratory care services, would require respiratory care as an inpatient in a hospital or NF and would be eligible to have payment made for inpatient care under the State plan.

Respiratory Therapy Service Components:

1. Evaluation

   Visit made to evaluate the member's level of function and to determine whether respiratory therapy is reasonable and necessary and to establish, in consultation with the member's physician, the goals, treatment plan, and estimated frequency and duration of treatment.

2. Respiratory Treatments

   Providing respiratory therapy in accordance with the plan of treatment, including instruction of the member, family or other caregivers regarding use of respiratory equipment, supplies and techniques.

3. Chest Physiotherapy

   Chest physiotherapy (postural drainage, chest percussion and vibration, pulmonary exercises) is a skilled service and would be considered covered if a cardio-pulmonary condition is present.

4. Maintenance Therapy Program

Repetitive services required to maintain function and prevent regression do not usually require the skills of a therapist.

A maintenance program may be established if, after an evaluation, the restorative potential of the member is judged to be insignificant. In such situations, the evaluation, the instruction of the member or caregivers, and reevaluations until the program can be safely and effectively carried out are all considered to be covered therapy services.

Provider Title: Respiratory Therapist

Minimum Qualifications: Provider holds a current AD*vantage* Program certification and Medicaid contract to provide Respiratory therapy services to AD*vantage* Program Members. Respiratory therapy services are provided by a Respiratory Therapist meeting all training and certification requirements as set forth by the National Board for Respiratory Care Registration.

Agency ____

Authorized Agent ____________________________ Date __________

Skilled Nursing Services

Service Definition: Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a RN, licensed to practice in the State. The provision of this service will prevent institutionalization of the Member.

The nursing services, which may be authorized, are services of a maintenance or preventative nature provided to Members with stable, chronic conditions. These services are not intended as treatment for an acute health condition and may not include services, which would be reimbursable as skilled nursing care under either the Medicare or Medicaid Home Health Programs. Should the Personal Care nurse detect a need for services that would meet the definition of reimbursable skilled nursing care under the Home Health Program, he/she must alert the Member's physician and the AD*vantage* Program Administration. If the need for skilled nursing services exceed the scope of the Medicaid State Plan Home Health Benefit, AD*vantage* waiver skilled nursing services may be authorized to ensure the health and safety of the recipient.

The AD*vantage* skilled nurse's primary role is to assess the Member's health and safety, develop and implement the personal care plan, provide training and supervision to the Personal Care Assistant and/or Advanced Supportive/Restorative aide and ongoing assessment of the suitability of the care plan to meet the Member's needs. This is accomplished through the Interdisciplinary Team (IDT) planning process which includes the Member, Case Manager, and other members of the IDT as appropriate. It is the responsibility of the RN to attend IDT Meetings required to develop or amend the Plan of Care.

To comply with the Oklahoma Home Care Act, an initial RN evaluation must precede personal care service delivery, must be part of the assessment and each reassessment supporting the plan of care for personal care services provided by an in-home care provider and must be performed by the entity that provides or contracts with personal care workers to provide the personal care services. To promote continuity of care and timely service delivery, the AD*vantage* Program regards an agreement by a provider to produce a nurse evaluation as an agreement, as well, to provide those Medicaid in-home care services identified by the assessment/reassessment that the provider is certified and contracted to provide. Reimbursement for a nurse evaluation shall be denied if the provider that produced the nurse evaluation fails to provide the Medicaid in-home care services identified by the assessment when the provider is certified and contracted to provide those services.

Nursing Supervision: As referenced in the ASR Supervision Standards.
Additional skilled services may include one or more of the following where appropriate to the needs of the Member is authorized by the AD*vantage* Program Administrative Agent:

Filling a one-week supply of insulin syringes for a blind diabetic who can self-inject the medication but cannot fill his own syringe. This service would include monitoring the patient's continued ability to self-administer the insulin;

Setting up oral medications in divided daily compartments for a Member who self-administers prescribed medications but needs assistance and monitoring due to a minimal level or disorientation or confusion;

Monitoring a Member's skin condition when a Member is at risk of skin breakdown due to immobility or incontinence or the Member has a chronic stage II decubitis requiring maintenance care and monitoring;

Conducting general health evaluations;

Providing nail care for the diabetic Member or Member with circulatory or neurological deficiency;

Making a monthly on-site visit to each Member for whom Advanced Supportive/Restorative Care services are authorized to evaluate the condition of the Member. A monthly visit report will be made to the AD*vantage* Program Case Manager, to report the Member's condition or other significant information concerning each Advanced Supportive/Restorative Care Member; and

Provide on-the-job training and competency testing for Advanced Supportive/Restorative Care aides.

Provide to the Case Manager a copy of each Nursing Evaluation (within 24 hours) or monitoring visit (within 48 hours) paid for by the AD*vantage* Program.

The AD*vantage* Program Case Manager may recommend authorization of RN visits in other similar situations.

It is the responsibility of the RN to contact the Member's physician to obtain any necessary information or orders pertaining to the care of the Member. If the Member has an ongoing need for service activities, which require more or less units than authorized, the RN shall recommend, in writing, that the Plan of Care be revised.

Provider Title: In-Home Care Agency

Minimum Qualifications: Provider has a current AD*vantage* Program certification and Oklahoma Medicaid contract to provide Skilled Nursing services to AD*vantage* Program Members. Provider meets all training and certification requirements as set forth in state regulations 63 O.S., Sec. 1-1961 et seq. Direct care staff for skilled nursing services are RNs or LPNs working under the direction of an RN and meeting all training and

certification requirements as set forth in state regulations 59 O.S., Sec. 567.1 through 567.16.

The Comprehensive Home Care Skilled Nurse shall meet all training and certification requirements as set forth in state regulations 59 O.S., Sec. 567.1 through 567.16.

Agency ____

Authorized Agent ______________________ Date __________

Special Medical Equipment and Supplies

Service Definition: Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable Members to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the Medicaid State plan and shall exclude those items which are not of direct medical or remedial benefit to the Member. This service is to secure medical equipment and supplies necessary for the welfare of the Member, but shall exclude any equipment and/or supply items which are not of direct medical or remedial benefit to the waiver Member. The service is authorized by the Member's AD*vantage* Service Plan for equipment and supply items not available to the Member under Medicare or the Medicaid State Plan and is necessary to prevent institutionalization. All items shall meet applicable standards of manufacture, design and installation.

Reoccurring services which are shipped to the Member, are compensable only when the Member remains eligible for waiver services, continues to reside in the home and is not institutionalized in a hospital, skilled nursing facility or nursing home. It is the Provider's responsibility to check on the Member's status prior to shipping these items. All services must be prior authorized. Reimbursement will not occur if these conditions are not met.

Provider Title: Durable Medical and/or Rehabilitative Equipment Supplier or Manufacturer

Minimum Qualifications: The Provider shall have a current AD*vantage* Program certification and Oklahoma Medicaid contract to provide Durable Medical and/or Rehabilitative Equipment and/or supplies. All items provided or modified shall meet applicable general standards of manufacture, design, and installation. Provider and/or consultants comply with all professional licensing and certification requirements applicable to any Physical, Occupational, Speech, and Respiratory Therapists, Prosthetists, Orthotists, and other specialists utilized in the provision of this service.

Agency ____

Authorized Agent ________________________ Date __________

Speech and Language Therapy Services

Service Definition: Speech/Language Therapy services are the use of special techniques for correcting disorders of speech, language, oral and pharyngeal sensorimotor function, hearing, balance, and their underlying processes. Under a physician's order, a licensed speech and language pathologist/audiologist will evaluate the member's rehabilitation potential and develop an appropriate, written therapeutic regimen. The regimen will include only those services and equipment necessary to prevent institutionalization of the recipient, as determined by the pathologist's and physician's evaluations. The regimen will include the use of paraprofessional speech therapy assistant services where possible, under the supervision of the licensed pathologist, and/or education and training for informal caregivers to assist with services, where appropriate. The pathologist will ensure monitoring and documentation of the recipient's rehabilitative progress and report to the recipient's Case Manager and physician to coordinate necessary addition and/or deletion of services, based on the recipient's condition and ongoing rehabilitation potential.

Speech-language services would be covered when the services can only be provided by a speech-language pathologist and when it is reasonable to expect that the service will materially improve the Member's ability to carry out independently any one or combination of communication activities of daily living in a manner that is measurable at a higher level of attainment than prior to the initiation of the services.

Speech and Language Therapy Service Components:

1. Evaluation

   Visit made to determine the type, severity and prognosis of communication disorder, whether speech therapy is reasonable and necessary and to establish the goals, treatment plan, and estimated frequency and duration of treatment.

2. Voice Disorders Treatments

   Procedures and treatment for members with an absence or impairment of voice caused by neurologic impairment, structural abnormality, or surgical procedures affecting the muscles of voice production.

3. Speech Articulation Disorders Treatments

   Procedures and treatment for members with impaired intelligibility (clarity) of speech - usually referred to as anarthria or dysarthria and/or impaired ability to initiate, inhibit, and/or sequence speech sound muscle movements - usually referred to as apraxia/dyspraxia.

4. Dysphagia Treatments

   Includes procedures designed to facilitate and restore a functional swallow when associated with a communication disorder.

5. Language Disorders Treatments

   Includes procedures and treatment for members with receptive and/or expressive aphasia/dysphasia, impaired reading comprehension, written language expression, and/or arithmetical processes.

6. Aural Rehabilitation

   Procedures and treatment for Members with communication problems related to impaired hearing acuity.

7. Maintenance Therapy Program

   Repetitive services required to maintain function and prevent regression do not usually require the skills of a pathologist.

   A maintenance program may be established if, after an evaluation, the restorative potential of the member is judged to be insignificant. In such situations, the evaluation, the instruction of the member or caregivers, and reevaluations until the program can be safely and effectively carried out are all considered to be covered therapy services.

Provider Title: Speech/Language Pathologist, Speech/Language Pathologist Assistant

Minimum Qualifications: Provider holds a current AD*vantage* Program certification and Medicaid contract to provide Speech/Language therapy services to AD*vantage* Program Members. Speech/Language therapy services are provided by a licensed Speech/Language Pathologist or a Speech/Language Therapy Assistant working under the direction of a licensed Speech/Language Pathologist and meeting all training and certification requirements as set forth in state regulations 59 O.S., Sec. 1601.1 et seq.

Agency ____

Authorized Agent ____________________________ Date ____________